



INTERIM REPORT

to the 85th Texas Legislature



HOUSE SELECT COMMITTEE ON
MENTAL HEALTH



DECEMBER 2016

**HOUSE SELECT COMMITTEE ON MENTAL HEALTH
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2016**

**A REPORT TO THE
HOUSE OF REPRESENTATIVES
85TH TEXAS LEGISLATURE**

**FOUR PRICE
CHAIRMAN**

**COMMITTEE DIRECTOR
SANDRA TALTON**



Select Committee On
Mental Health

December 29, 2016

Four Price
Chairman

P.O. Box 2910
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The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Select Committee on Mental Health of the Eighty-fourth Legislature hereby submits its interim report including recommendations for consideration by the Eighty-fifth Legislature.

Respectfully submitted,

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Joe Moody, Vice Chair

Representative Garnet Coleman

Representative Rick Galindo

Representative Andy Murr

Representative Kenneth Sheets

Representative Chris Turner

Representative Greg Bonnen

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Representative Senfronia Thompson

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ACKNOWLEDGEMENTS

The Chairman, the Vice-Chairman and the Members of the House Select Committee on Mental Health would like to acknowledge and thank Ms. Sandra Talton, Committee Director, for her consummate professionalism and consistent and stellar dedication throughout the entire committee process and for making this report possible through her efforts as initial drafter and editor of this report.

The Chairman, the Vice-Chairman and the Members of the House Select Committee on Mental Health also express gratitude to Ms. Elizabeth Kerpon, Assistant Committee Clerk, and to each Member's respective office staff for their efforts on the success of the House Select Committee on Mental Health.

TABLE OF CONTENTS

THE SELECT COMMITTEE ON MENTAL HEALTH.....	1
EXECUTIVE SUMMARY	1
INTRODUCTION	5
INTERIM STUDY CHARGES.....	7
PUBLIC HEARING #1: MENTAL HEALTH OVERVIEW	9
Introduction.....	9
Background.....	9
Statistics	10
Overview of the current landscape of mental health services and funding mechanisms.....	11
Recent legislative actions and funding measures.....	12
Programs and Services.....	15
Detailed Funding Breakdown	15
Detail of Programs and Services Through the Department of State Health Services.....	17
Community Services Through Local Mental Health Authorities (LMHAs).....	17
Services Accessible Statewide.....	20
Community Services Directly Through Department of State Health Services.....	20
Services Through State Hospitals	21
Additional State Agencies Providing Services	21
Statewide Behavioral Health Coordinating Council in the Health and Human Services Commission (HHSC).....	22
Mental Health Advocates - Recognition of improvements and Identification of Gaps.....	23
Best Practices Identified	24
Challenges.....	25
Recommendations.....	26
PUBLIC HEARING #2: Mental and Behavioral Health Services and Treatments For Children	28
Introduction.....	28
Background.....	28
Statistics	29
Services and Providers.....	30
Physicians	30
A Center for Children	30
Services through Department of State Health Services (DSHS) and Health and Human Services Commission (HHSC)	31
School Settings.....	32
Examples of Best Practices.....	33

Urban Schools.....	33
Suburban Schools.....	34
Rural Schools.....	36
Juvenile Justice Services.....	37
Best Practice Example in Juvenile Justice.....	38
Challenges.....	40
Recommendations.....	41
PUBLIC HEARING #3: Mental and Behavioral Health Services and Treatment Access, Continuity of Care, Coordination, and Workforce	44
Introduction.....	44
Background.....	44
Statistics	45
Providers	46
Physicians in Private Practice or in a Hospital	46
Examples of Innovative DSRIP Projects by Hospitals.....	48
Workforce and Provision of Care	48
Addressing Workforce and Research of Mental Health	48
UTHealth Northeast.....	49
UTHealth Houston.....	50
Challenges.....	51
Recommendations.....	52
PUBLIC HEARING #4: Mental and Behavioral Health Services and Treatment Access, Continuity of Care, Coordination, and Workforce	53
Introduction.....	53
Providers and Services.....	53
Best Practices by LMHAs.....	53
Mental Health Professions (non-physician).....	55
Social Workers.....	55
Licensed Professional Counselors	56
Registered Nurses	56
Physician Assistants.....	56
Psychologists.....	57
Recommendations.....	58
PUBLIC HEARING #5: Insurance Coverage and Parity and Law Enforcement	59
Introduction.....	59

Background.....	60
Statistics from Mental Health Care Providers	60
Insurance.....	61
Role of Texas Department of Insurance (TDI).....	61
Examples of Innovative Collaborative Care Programs.....	64
Insurance Plan Providers.....	65
Law Enforcement and Training on Mental Health	67
Law Enforcement.....	68
Criminal Justice	69
Challenges.....	71
Recommendations.....	72
PUBLIC HEARING #6: Substance Abuse, Homelessness, and Veterans	74
Introduction.....	74
Statistics for Substance Use Disorder and Homelessness.....	74
Services and Providers.....	75
Statistics for Veterans	78
Services and Providers.....	78
A Best Practice for the Homeless	79
Advocates and Providers.....	80
Substance Abuse Programs.....	80
Veterans Programs	81
Advocates.....	83
Challenges.....	84
Recommendations.....	84
PUBLIC HEARING #7: Public Testimony	85
Introduction.....	85
PUBLIC HEARING #8: State Hospitals, Options for Addressing Needs, and Mental Health Care on Campuses of Higher Education	86
Introduction.....	86
Background - State Hospitals.....	86
State Hospitals	87
Options for Addressing Capacity Needs.....	88
Challenges.....	91
Recommendations.....	91
Higher Education	92

Current Legislative Requirements	93
Trends	94
Best Practices	95
Challenges.....	96
Recommendations.....	96
CONCLUSION.....	97
APPENDICES	98
ENDNOTES	104

THE SELECT COMMITTEE ON MENTAL HEALTH

EXECUTIVE SUMMARY

The Proclamation & Process

The Honorable Joe Straus, Speaker of the Texas House of Representatives appointed the Select Committee on Mental Health in November 2015. Speaker Straus, via a Proclamation, attached as Appendix A, instructed the Select Committee to holistically study and make recommendations on virtually every aspect of mental health in Texas, including co-occurring substance abuse issues often referred to as behavioral health. As far as known in Texas legislative history, this was the first time that one committee was tasked with studying every aspect of local and state mental health systems in Texas.

Specifically, the Proclamation charged the Select Committee with exploring major mental health components including: the identification, including preferably early identification, of mental health conditions in both children and adults; access to care (meaning the financial ability to pay for services and the availability to be readily treated in every region of Texas by a skilled mental health workforce); and the effective and timely delivery of mental health services, including the essential continuum of care. The Proclamation also instructed the committee to identify barriers to each of these components in both the mental health treatment of children and adults, in specific populations such as veterans and the homeless, and in certain settings including, but not limited to, public schools, higher educational institutions, the criminal justice arena both from city and county jail to state hospitals and state correctional facilities.

To systematically tackle the task at hand, including ascertaining an understanding of the current local and state mental/behavioral health services available in Texas, examining the existing gaps in services, and exploring the innovative approaches in each of the aforementioned settings, the decision was made to carefully examine the components by grouping like or similar components with one another for further review. For instance, the Select Committee dedicated one entire hearing solely to children's mental health issues. This in-depth analysis by grouping similar mental health issues resulted in the Select Committee conducting hearings on eight separate days with over 40 hours of hearings. The committee heard testimony from and had the opportunity to ask questions to over 100 expert witnesses, including diverse mental/behavioral health care professionals, judges, and experienced law enforcement officials. The Select Committee also received valuable insight through public testimony. The committee further placed emphasis in ensuring that testimony was heard from all areas across Texas – urban, suburban and rural.

Additionally, committee members and their staff members visited several state, county and private mental health facilities and discussed topics with varied stakeholders in office meetings and via telephone. Sites visited included medical schools, medical centers, hospitals, health science centers, adult and children psychiatric centers, local mental health authority facilities, a homeless and substance abuse facility, a county jail during mental health hearings, and state hospitals.

Summary of Major Findings

Funding

Texas spends a substantial sum on "direct" mental health and behavioral health services and treatment. General Revenue funding appropriated for the 2016-2017 biennium by the legislature was \$3.6 billion. These funds are distributed to eighteen agencies across five articles of the state's budget. Additionally, during the hearings, the Select Committee learned that \$3.1 billion is spent on mental health and behavioral health through Medicaid. Thus, at a minimum, the state is spending approximately \$6.7 billion (All Funds) on mental health and behavioral health programs and services. State funding is potentially higher as some programs are encompassed within agency budget strategies and not considered as "direct" funding.

As the recipient of the majority of the appropriated funds, the Department of State Health Services (DSHS) has been the administrator of most of the programs for mental health services for the state, including state hospitals. As of September 1, 2016, the community services portion of the agency moved to the Health and Human Services Commission (HHSC); the state hospital portion remains at DSHS until September 1, 2017.

Examining the effectiveness of every program area receiving this direct funding was beyond the scope of the Select Committee and these program areas should be thoroughly examined by the House Committee on Appropriations, including the Article II Subcommittee.

It is important to note that while significant resources are currently being invested, the demand for services throughout the state continues to increase.

Services & Treatment

There are many diverse mental health services and treatment being provided by dedicated mental health professionals throughout Texas in hospitals, local mental health facilities, schools, and through law enforcement. Testimony received by the Select Committee indicated that some regions and counties of the state have innovative and effective programs while other areas are lacking in services available. Best practices, services gaps, and ideas for addressing the identified gaps were presented. Importantly, services and treatment options including the type, extent, and the scope of the continuum of care, if any, is primarily dependent on where one resides. Thus, there is a patch work of mental health services and treatments in Texas on both a local and regional level. For instance, a person may find that crisis intervention may exist in many areas of the state but the degree in scope and length to which these services may be provided vary from one community to another.

Additionally, testimony was provided regarding many effective programs in place but expert testimony also emphasized that the system often limits the potential of progress within these programs. System limitations may consist of an area lacking the ability to build-out a continuum of care which may be due to a lack of local funding, a lack of providers, or a lack of emphasis in the locale on a particular continuum of care for certain mental health conditions.

In many instances, the Select Committee heard how effective strategies are being employed through collaboratives on a local level. Many successes in the delivery of effective services were the result of entities and/or groups who broke down barriers to work together to seek better outcomes to the problems they faced. Also, through its work, this Committee opened doors, started dialogues among stakeholders and provided a forum for the exchange of many good ideas. Improvements and progress is being made as a result of the Committee's work even in advance of any potential legislative initiatives.

One recurring message or theme stood out to the Committee - communities and stakeholders who work in partnership and collaboration provide more effective mental health/behavioral health services and in many cases to a greater number of persons and have the greatest successes. A clear example of this is the Haven for Hope model in the San Antonio community. It is clear that cooperation, coordination, planning, and provision of local matching funds by local stakeholders and assistance at the state level can successfully and effectively allow a community to identify and address its own unique mental health/substance abuse challenges.

Successful and innovative ideas are being employed throughout Texas to combat many existing problems, and plenty of the successful strategies were formulated and implemented locally. This statement should not be read, however, to imply that the state's past actions and investments have not been productive. Recent investments over the past several sessions have yielded successful outcomes. Statewide initiatives, however, just are not often as nimble or flexible since there really is not a one-size-fits-all solution to many of our existing challenges. The Select Committee heard that local input and direction is often an essential ingredient to implementing successful strategies across our geographically diverse state. Issues of statewide concern and opportunities for potential expansion of services to solve existing service gaps as identified by stakeholders included:

- truly integrated health care to treat the whole person from "head to toe," meaning a multiple healthcare provider 'team approach' to treat the patient's physical health concerns and mental health concerns;
- prioritizing early intervention and prevention measures especially among school-age children given that testimony revealed that one in five children have a mental health condition;
- expanding innovative public school-based programs;
- ensuring greater access to care by requiring parity and transparency between practitioners and insurance companies;
- sustainability of the 1115 Transformation Waiver/DSRIP funded programs;
- expanding bed capacity by expanding 'step-down' beds to provide a continuum of care;
- strengthening and expanding jail diversion for non-violent offenders;
- expanding trauma-informed care;
- continuing to address mental health workforce shortages through educational incentives and by expanding the availability and utilization of technology, such as telemedicine.

Fortunately, many of the best practices presented in the hearings addressed areas of concern and provided direction and ideas for others' potential adoption and implementation. Additionally, ideas for new programs or an expansion of programs were presented.

Working with the various stakeholders to facilitate proven and innovative methods for the provision of services to the mentally ill throughout the state is the committee's ongoing goal. However, as all are aware, the expansion of many needed services or programs commonly require funding. Additionally, as we are also all aware, funds, whether federal, state, or local, are limited. Funding has been increased during the past two legislative sessions, and the Committee is optimistic that the services being provided can be maintained and enhanced even in these challenging fiscal times. As we head into the 85th Legislative Session, all indications are that mental/behavioral health funding for the 2018-2019 biennium budget will remain a priority.

*Disclaimer -- This report is generated from information obtained in the hearings, meetings with various stakeholders, and visits to various providers by the Select Committee. On September 1, 2016, some persons and programs were transferred within the HHSC enterprise. As applicable, the information provided in this report is presented as the programs and staff placements were at the time of the hearing date.

INTRODUCTION

Recognizing that mental health issues are impacting virtually all aspects of our society and to study the provision of mental health services in Texas, the Honorable Joe Straus, Speaker of the Texas House of Representatives, on November 9, 2015, appointed thirteen members from across the state to the Select Committee on Mental Health (Committee) for the 2015/2016 interim. The Committee membership consisted of Four Price (Chairman), Joe Moody (Vice-Chairman), Greg Bonnen, Garnet Coleman, Sarah Davis, Rick Galindo, Sergio Munoz, Andrew Murr, Toni Rose, Kenneth Sheets, Senfronia Thompson, Chris Turner, and James White.

The Proclamation of the Select Committee on Mental Health can be found at <http://www.lrl.state.tx.us/scanned/leadershipdocs/proc151109.pdf> and is also included as Appendix A. Generally, the charges instructed the Committee to identify and review mental health/behavioral health services and programs currently available in Texas for both adults and children, to discover potential gaps in these services, and to recommend solutions for several specific populations and settings.

The charges were:

1. Review the behavioral health system, including substance abuse treatment, for adults and children. Make recommendations to improve the delivery and coordination of services to create an integrated system to improve early identification of mental illness, improve access and continuity of services, reduce barriers to treatment, and increase collaboration between entities responsible for the delivery of care in a manner that will ultimately reduce cost and improve care.
2. Identify educational, healthcare, law enforcement, criminal justice, judiciary, state, county, and city entities that are statutorily or contractually responsible for the identification or delivery of behavioral health services. Review how the services are directly or indirectly connected and how the entities work together.
3. Review entry points into the mental health system for both adults and children; how individuals gain access to services; what services are available; the effectiveness of services; and how to define, prioritize, measure, and improve outcomes achieved for adults and children.
4. Identify local and state cost of mental health in Texas and identify measures to reduce cost to the overall system by improving care.
5. Study and recommend solutions for the challenges within the current system, including, but not limited to, how to provide effective services in the short term and close gaps over the longer term in mental-health workforce shortage areas; access to appropriate mental health care for school-age children, including those identified through Mental Health First Aid training, to break the school to juvenile detention to prison pipeline; factors contributing to differences in communities' access to law enforcement and Judges with specific mental health training; communities' access to crises intervention and jail diversion services; communities' ability to plan and coordinate between healthcare

providers and systems, law enforcement, the judiciary, and the criminal justice systems to deliver and coordinate care; and the location and availability of inpatient treatment beds, including how the need for inpatient beds varies by the effectiveness of the entire system. Also, identify obstacles to adequate insurance coverage for mental health services.

6. Identify the challenges of providing care and increasing access to veterans, homeless Texans, and individuals with serious mental illness.
7. Examine challenges of providing services in underserved and rural areas of the state and in communities serving high numbers of Texans below 200% poverty level.

The Committee has completed its hearings and has issued the following final report with its findings and recommendations.

The recommendations included in this report include recommendations committee members submitted based on the information obtained throughout the interim hearing process. To be clear, the fact that a recommendation is listed herein does not indicate that each committee member ratifies or supports each individual recommendation without modification. They are set forth in this report to provide a representative set of recommendations for potential study, analysis or future legislative consideration. Many of the recommendations included in this report could serve as a catalyst for future study or action, both during the 85th legislative session and beyond.

The Committee wishes to express appreciation to the state agencies, local government entities, organizations, and concerned citizens who testified at the public hearings for their time and efforts. The presenters imparted much knowledge regarding many effective mental health and behavioral health services currently available in Texas, identified gaps and areas of service that need attention, and provided ideas for enhancing the provision of services.

INTERIM STUDY CHARGES

The proclamation for the appointment of the Select Committee on Mental Health is comprehensive in scope. Many of the individual charges set forth therein address related yet separate issues concerning mental health. To enable the Committee to adequately address the charges of the proclamation, the Committee divided the charges into specific topics to allow for a detailed discussion, and thus a more thorough understanding, of each issue.

The charges were addressed in eight hearings (seven hearings with invited testimony plus one hearing for public testimony). The invited testimony included state agencies, local government representatives, community organizations, community advocates, mental health professionals, and education professionals. Emphasis was placed on ensuring that all population areas – urban, suburban, and rural – were represented.

Hearing #1 – related to obtaining a detailed overview of the current landscape of mental health services and funding mechanisms to ensure that committee members had the most current and accurate information regarding the actual services being provided in Texas as well as their source of funding.

Hearing #2 – related to obtaining a thorough understanding of mental health and behavioral health services and treatments provided in the state for children, including those services provided in clinical, public education, and juvenile justice environments.

Hearings #3 and #4 – related to hearing from physicians and other mental health care providers regarding early identification, crisis intervention, access to care, continuity of care, coordination of services related to an integrated system of care, and the delivery of care to the diverse populations and regions of Texas. The hearings also concerned workforce challenges and identifying ways in which the delivery of services could be improved.

Hearing #5 – related to insurance parity, obtaining details regarding health insurance plans, and hearing some innovative ideas on billing integrated services. Hearing #5 also concerned mental/behavioral health's relationship to law enforcement and our system of criminal justice.

Hearing #6 – related to mental/behavioral health services for the homeless and veterans. The Committee also heard testimony on the co-occurrence of substance abuse and mental illness.

Hearing #7 – public testimony only.

Hearing #8 – related to gaining further insight into Texas' State Hospital system and to hearing ideas on partnerships with academic institutions and criminal justice entities for increasing psychiatric bed capacity. The hearing also related to public institutions of higher education and their efforts to ensure students have knowledge of available mental health services on college and university campuses.

Although this committee was formed as the “Select Committee on Mental Health,” its charges included the review of various aspects of mental health *and* substance abuse. As clarified in the

first hearing by the Health and Human Services Commission Associate Commissioner Sonja Gaines, "Mental health" is a diagnosis of mental illness, and "behavioral health" encompasses substance abuse.¹ Throughout this report, mental health and behavioral health are used interchangeably. Additionally, in this document, "behavioral health" does not refer to misbehavior requiring disciplinary actions in a school or law enforcement environment.

PUBLIC HEARING #1: MENTAL HEALTH OVERVIEW

To establish a framework of "the state of mental health" in Texas and to determine the amount of mental health funding appropriated in the state budget as well as the services being provided, the Committee held its initial public hearing related to mental health on February 18, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016.

The Committee invited state agencies and stakeholders to provide an overview of current programs, to discuss details on how current services are working, and to identify potential gaps in services. The following organizations/individuals were invited to testify:

Alison Mohr Boleware, HOGG Foundation for Mental Health
Rachel Carrera, Legislative Budget Board
Mike Diehl, Legislative Budget Board
Sonja Gaines, Texas Health and Human Services Commission
John Hellerstedt, MD, Texas Department of State Health Services
Lee Johnson, Texas Council of Community Centers
Andrew Keller, PhD, Meadows Mental Health Policy Institute
Lisa Kirsch, Texas Health and Human Services Commission
Lauren Lacefield-Lewis, Texas Department of State Health Services
Kelsey Vela, Legislative Budget Board

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The committee was charged with initiating a broad scope of review for the mental health / behavioral health services being provided in Texas. The scope encompassed both adult and youth populations; urban, suburban and rural regions; varied community entities, cities, counties, law enforcement, the judicial system, the criminal justice system, hospitals, schools, providers of community services, the state; and various populations of Texans such as those who are homeless, veterans, children in foster care, or individuals who are already diagnosed with a mental illness.

This general topic has been addressed by the legislature during numerous past sessions; however, the numbers of individuals requiring mental health / behavioral services across the state continues to increase. Consequently, stakeholders around the state are continuing to ask for additional assistance to address the ongoing problem of providing services to the mentally ill.

Background

"A mental illness is a condition that affects a person's thinking, feeling or mood. Such conditions may affect someone's ability to relate to others and function each day. Each person will have different experiences, even people with the same diagnosis."²

Statistics

- One in five adults experiences a mental health condition every year;
- One in seventeen lives with a serious mental illness such as schizophrenia or bipolar disorder;
- Half of mental health conditions begin by age fourteen, and 75% of mental health conditions develop by age twenty-four;³
- Just over 500,000 adults in Texas live with a serious and persistent mental illness (SPMI);
- Nearly 250,000 children have a serious emotional disturbance (SED);
- About one-half of these persons are below the 200 percent poverty level;
- Adults with untreated mental health conditions are eight times more likely to be incarcerated than the general population, and are more likely to have comorbid conditions;
- 1.7 million veterans in Texas may seek behavioral health treatment;
- Approximately 26,300 Texas students are receiving special education services with a primary diagnosis of emotional disturbance;
- Approximately 32,000 children are in Department of Family Protective Services (DFPS) conservatorship, and it is estimated that over fifty percent of those children have a diagnosed mental illness;
- Approximately 50 percent of youth in the juvenile justice system have been identified with need for mental health treatment; and
- Approximately 80 percent of state committed youth have a need for alcohol or drug use treatment.⁴

Populations identified for increased potential need of mental health services include:

- Individuals with Intellectual and Developmental Disabilities (IDD);
- Individuals involved within the Criminal Justice System;
- School-age children or those involved with the school system (over 1000 school districts in Texas);
- Veteran and military populations and their families;
- Children and adolescents in foster care;
- Individuals experiencing or at risk for homelessness;
- Individuals with physical illnesses;
- Individuals with limited English proficiencies; and
- Aging populations.⁵

The social and economic costs of untreated behavioral health conditions include:

- Joblessness - 17.5 percent of people served by LMHAs report having gainful employment (this figure does not include persons not served by LMHAs);

-
- Homelessness - 96.6 percent of people served by LMHAs report living in stable housing (this figure does not account for the unknown number of persons not receiving services through the LMHA);
 - Criminal behavior - an estimated 30 percent of inmates have one or more serious mental illnesses. This equates to nearly 20,000 people in Texas county jails with serious mental illnesses;
 - Adverse health effects - chronic medical conditions present at more advanced stages or at crisis points and more risky behavior leads to injury and illness;
 - Emergency room use - behavioral health-related conditions comprise 8.5 percent of initial Texas Medicaid inpatient admissions and 25.8 percent are potentially preventable readmissions; and
 - Suicide - in 2013, there were 3059 suicides in Texas; 90 percent of people who die by suicide experience mental illness. One in three people who commit suicide are under the influence of drugs or alcohol.⁶

Indicators of success for behavioral health continuum of care include:

- For mental health - stable housing, sustained employment, reduced incarcerations, fewer hospital admissions, and reduced emergency room visits; and
- For substance abuse - increased abstinence and reduction in relapse.⁷

Of the youth involved with juvenile justice in FY2015:

- 643 juveniles had a psychiatric diagnosis;
- 99 percent of youth needed some type of specialized treatment; and
- 83 percent of youth had two or more specialized treatment needs.⁸

Overview of the current landscape of mental health services and funding mechanisms

Texas has been providing mental health care in State Hospitals since 1861 when the facility in Austin accepted its first patients⁹. The state currently has ten state hospital facilities plus a youth facility in Waco which provide mental health services for forensic and civil, adult and youth, patients. A state hospital map is included in Appendix C.

Additionally, government funded mental health care is provided in community settings, which began, at least in part, over 50 years ago when the federal government passed the Community Mental Health Act of 1963 providing federal funding for community mental health/intellectual development disability (MH/IDD) centers with a community-based service philosophy¹⁰.

Accordingly, the Texas MH/IDD Act of 1965 was passed to authorize local taxing authorities (counties, cities, hospital districts, school districts) to create a local governmental entity and appoint a local governing board to develop community alternatives to treatment in large residential facilities; and to establish local, state and federal partnerships to create community-based system for people with mental illness and intellectual disabilities.¹¹ These entities are known as Local Mental Health Authorities (LMHAs), or community centers. Thirty-nine (39) LMHAs are positioned throughout Texas.

Various mental health services have been successfully added via legislation over the years. To a degree, however, the agencies responsible for implementing various services did not always communicate well with one another. As a consequence, House Bill 1, the General Appropriations Bill during the 84th Legislature, created the Statewide Behavioral Health Coordinating Council (Council). The Council consists of the identified eighteen agencies that receive funds "directly" appropriated for mental health programs across five articles of the budget. Information suggests that mental health matters are addressed and funded to some extent in additional agencies but funding is buried within programs and thus not considered "direct" funding. The information provided by this ongoing Council is expected to be valuable in the continued review and direction of mental health services in the state. By coordinating their efforts, the Council should be able to facilitate the provision of various services in a more efficient and effective manner. It is also believed that budget decisions and analyses will be aided by the work of this Council.

Recent legislative actions and funding measures

Actions in recent Texas legislative sessions have greatly expanded behavioral health services over the past few years. Over that period, the Legislature created positions and councils and appropriated funds to address recognized concerns. In data provided in the testimonies from The Meadows Mental Health Policy Institute¹², the Legislative Budget Board¹³, Health and Human Services Commission¹⁴, the Department of State Health Services/Health and Human Services Commission¹⁵, and Texas Tech University Health Sciences Center¹⁶ the following legislative actions were taken and appropriations made:

- \$82 million investment during the 80th Legislature for the FY 08-09 biennium that began the mental health crisis redesign. Implementation focused on ensuring statewide access to competent rapid response services, avoidance of hospitalization and reduction in the need for transportation; allowed the state to make significant progress toward improving the response to mental health and substance abuse crises. The 81st Legislature continued funding for these crisis services for the FY 09-10 biennium.¹⁷
- \$55 million for Transitional/Intensive Services; Medicaid Substance Abuse benefit by the 81st Legislature;
- \$160 million for waitlists in the 83rd Legislative Session;
- Senate Bill 58 and Senate Bill 1185 targeted specific populations through the Health Communities Homeless Collaboratives and the Harris County Jail Diversion Pilot in the 83rd Legislature;
- Senate Bill 1 created the Office of Mental Health Coordination (MHC) in the Health and Human Services Commission during the 83rd Legislative Session to "ensure that Texas has a unified approach to the delivery of behavioral health services that allows Texans to have access to the right care at the right time and place";
- Legislation in the 83rd Legislative Session directed HHSC to include covered mental health rehabilitation and mental health targeted case management in managed care; to establish an advisory committee regarding the inclusion of services in managed care and the integration of physical and behavioral health; and to develop two health home pilots for integration of physical and behavioral health. Effective September 1, 2014, certain mental health services were carved into the STAR and STAR+PLUS managed care programs. Mental health rehabilitation services and mental health targeted case

management are available to Medicaid recipients who are assessed and determined to have a severe and persistent mental illness and to children and adolescents ages 3 through 17 years with a diagnosis of a mental illness or who exhibit a serious emotional disturbance. Mental health rehabilitative services include crisis intervention services, medication training and support services, psychosocial rehabilitative services, skills training and development services, and day programs for acute needs.

- Senate Bill 200 in the 84th Legislative Session required HHSC to create a new Medical and Social Services division so that physical health and mental health could have an integrated delivery stream.
- Senate Bill 55 in the 84th Legislature created the Texas Veterans + Family Grant opportunity;
- House Bill 197 in the 84th Texas Legislative Session required that every public institution of higher education post on its website information identifying where a student could find mental health care services;
- Senate Bill 239 in the 84th Texas Legislative Session provides for loan repayment assistance for certain mental health professionals;
- House Bill 1, the General Appropriations Bill, during the 84th Legislative Session created the Behavioral Health Coordinating Council to consist of the identified eighteen agencies across five articles that receive funds directly appropriated for mental health programs;
- For community mental health services, the funds appropriated during the 84th Legislative Session were \$939 million in state general revenue funds (\$1.1 million All Funds) -- adult mental health services were \$554 million state general revenue funds, up 9.7 percent, (\$665 million All Funds); children's mental health services \$133 million state general revenue funds, up 14 percent, (\$205 million All Funds); community mental health crisis services \$250 million state general revenue funds, up 15.3 percent, (\$253 million All Funds);
- For substance abuse programs, the funds appropriated during the 84th Legislative Session were \$89 million in state general revenue funds, up 26.2 percent, (\$325 million All Funds);
- For state hospitals the funds appropriated during the 84th Legislative Session were \$667 million in state general revenue funds, up 4.3 percent, (\$872 million in All Funds);
- For community hospitals, the funds appropriated during the 84th Legislative Session were \$190 million in state general revenue funds, up 35.2 percent, (\$209 million in All Funds);
- For the expansion of the Residential Treatment Center Project \$4.8 million were appropriated during the 84th Legislative Session for 20 additional beds;
- To address an insufficient mental health workforce, in the 84th Legislative Session, legislation was passed that allows payment of up to \$160,000 toward the student loans of mental health professionals who agree to practice in underserved portions of the State thereby helping attract these professionals to rural areas of the state;
- For Texas Department of Criminal Justice (TDCJ), the funds appropriated during the 84th Legislative Session were \$490.7 million in state general revenue funds (\$495.8 million in All Funds), including appropriations for Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) of \$47 million in state

general revenue funds, up 14.7 percent, (\$47 million in All Funds) and correctional institution based services of \$166 million in state general revenue funds, up 10.4 percent, (\$166 in All Funds);

- For TJJJ, the funds appropriated during the 84th Legislative Session were \$155.8 million in state general revenue (\$169 million in All Funds);
- For the Office of the Governor Trusteed Programs in Article I, the funds appropriated during the 84th Legislative Session were \$1.5 million state general revenue (\$10.6 million All Funds);
- For the Texas Veterans Commission in Article I, the funds appropriated during the 84th Legislative Session were \$4.0 million state general revenue (\$4.0 million All Funds);
- To the University of Texas - Health Science Center Tyler in Article III, the funds appropriated during the 84th Legislative Session were \$8.0 million state general revenue (\$8.0 million in All Funds);
- To the University of Texas - Health Science Center Houston in Article III, the funds appropriated during the 84th Legislative Session were \$12.0 million state general revenue (\$12 million All Funds);
- To the Texas Military Department in Article V, the funds appropriated during the 84th Legislative Session were \$1.3 million state general revenue (\$1.3 million All Funds); and
- To varied medical board agencies in Article VIII, the funds appropriated during the 84th Legislative Session were \$3.7 million state general revenue (\$3.7 million All Funds).

Additionally, many behavioral health services provided by the state are funded through Medicaid monies. Four million Texans are on Medicaid. Most of the Medicaid monies are for low income children but some funds go to provide services for adults with disabilities, pregnant women, and low income adults with long term care needs. Additional funding in Texas for addressing behavioral health needs is provided through Medicaid dollars and calculated to be approximately \$3.1 billion in All Funds for the 2016/17 biennium.¹⁸

Also, a component of the Medicaid 1115 Transformation Waiver, the Delivery System Reform Incentive Payment (DSRIP) program, provides funding that allows opportunities for communities across the state, through local match monies, to earn billions of dollars. This program was designed to fund infrastructure and innovative projects to transform healthcare. Later guidance from the Centers for Medicare and Medicaid Services (CMS) indicated that the projects should become self-sustaining. The waiver was approved in 2011, and the initial waiver period ended September 30, 2016; however, the waiver has been extended for an additional fifteen months, including DSRIP. Numerous local government entities, in many cases with community organizations, generated innovative plans for increased impact on mental health in their communities and have implemented new programs which have provided additional services. As of September 2016, behavioral health-related projects in Texas had earned approximately \$1.8 billion in incentive payments with the potential to earn almost \$800 million additional payments by the end of fiscal year 2017. Overall, the DSRIP/1115 waiver projects have earned \$7.9 billion All Funds over five years.¹⁹

Programs and Services

Detailed Funding Breakdown

A chart of the eighteen state agencies that receive funds for direct utilization in behavioral health services, the budget article in which the funds are appropriated, and the amounts appropriated can be found in Appendix B. As shown therein, the appropriations for the 2016/17 biennium are \$3.6 billion (or \$1.8 billion per year) in All Funds for behavioral health and substance abuse services to the eighteen agencies identified in Article IX, Sec. 10.04 of House Bill 1, 84th Legislative Session, 2015.

As reflected in the Statewide Behavioral Health Strategic Planned and Coordinated Expenditures document, the agencies receiving the bulk of the mental health monies are:

- Department of State Health Services (DSHS) in Article II in the amount of \$2.7 billion for the biennium (76.2 percent of the budgeted behavioral health funding);
- Department of Criminal Justice (TDCJ) in Article V in the amount of \$495.8 million for the biennium (13.8 percent of the budgeted behavioral health funding), includes TCOOMMI funding;
- Juvenile Justice Department (TJJJ) in Article V in the amount of \$169 million for the biennium (4.7 percent of the budgeted behavioral health funding);
- Health and Human Services Commission (HHSC) in Article II in the amount of \$78.4 million (this figure is not inclusive of Medicaid expenditures for mental health which was later determined to be \$3.1 billion; this amount also does not include the 1115 Transformation Waiver/Delivery System Reform Incentive Payment (DSRIP) funding in which, as of January 2016, the projects had earned approximately \$1.7 billion in incentive payments with the potential to earn almost \$1 billion in additional payments by the end of federal fiscal year 2016²⁰); and
- Department of Family and Protective Services (DFPS) in Article II in the amount of \$52.5 billion for the biennium.

The balance of the referenced funds is appropriated in Article I to the Office of the Governor Trusteed Programs and to the Texas Veterans Commission; in Article III to the University of Texas - Health Science Center Tyler and to the University of Texas - Health Science Center Houston; in Article V to the Texas Military Department; and in Article VIII to varied medical board agencies.

DSHS, as the primary state mental health and substance abuse agency, is responsible for community-based inpatient and outpatient services and for inpatient services at the ten state mental hospitals. The agency is responsible for overseeing and providing public behavioral health services to persons in crisis, medically indigent persons, and certain Medicaid clients living in Texas.

Of the funds allocated to DSHS, state hospitals receive \$872.6 million in All Funds; community services for adults and children and community mental health crisis services, through performance contracts with the 39 Local Mental Health Authorities (LMHAs), receive \$1.1

billion in All Funds. The balance of the \$2.7 billion to DSHS goes to a few varied programs, including capital dollars for repairs and renovations at state hospitals and funding at the Rio Grande State Center Outpatient Clinic.²¹

Specific services may vary depending on the LMHA, but these entities are located throughout the state to provide, coordinate, and support community-based mental health services in their assigned communities. State funds do not cover all costs for the programs administered by the LMHAs; expenses are supplemented directly with local funding, Medicaid monies, Medicare monies, grants, patient assistance program funds, 1115 Waiver/DSRIP funds, and local partnerships. An LMHA service area map is included as Appendix D.²²

LMHAs work closely with community partners, including schools and the criminal justice community. LMHA services include crisis services that are designed to help adults and children avoid unnecessary hospitalization, incarceration, and use of emergency rooms.

Mental health funding to TDCJ allows the agency to provide behavioral health services and programming to offenders in the community through probation-based diversion programs, and parole services, and within the institution through correctional institution-based services. Health care, both medical and mental, is provided to incarcerated offenders in TDCJ through the Correctional Managed Health Care (CMHC) system which is comprised of The University of Texas Medical Branch and the Texas Tech University Health Sciences Center. Some behavioral health services are contracted. Specific treatment programs include substance abuse treatment and coordination, DWI treatment, and sex offender treatment.

Certain substance abuse and mental health treatment services and programs serve offenders on probation and on parole. These are through Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) or Substance Abuse Felony Punishment Facilities (SAFPF).

TCOOMMI provides grants for community-based treatment programs for probation and parole adult and juvenile offenders with special needs. This includes a continuity of care program for offenders with SMI and a system for local referrals from various entities.

TJJD provides services for juvenile offenders with behavioral needs either in state-custody or in the community through probation and parole programs. However, the majority of the funding to the juvenile probation system is provided by local county governments and is not reflected in the state funded appropriations. State based behavioral health treatment includes:

- psychiatric evaluations;
- ongoing psychiatric services and psychotropic medication;
- general rehabilitation treatment; and
- specialized rehabilitation treatment, which includes treatment for mental health and substance abuse.²³

The LMHAs also work with TJJD, TDCJ and the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) to provide behavioral health support to youth and adults involved in the state's judicial system.

Detail of Programs and Services Through the Department of State Health Services

The Texas Department of State Health Services (DSHS) is the agency responsible for state funded behavioral health programs and services. Most of the funding goes towards community services or to the state hospital facilities, although some direct services are provided.

Community Services Through Local Mental Health Authorities (LMHAs)

The bulk of community mental health services are provided through the 39 Local Mental Health Authorities (LMHAs), also referenced as Community Centers, which are positioned in communities throughout Texas. Each LMHA has assigned counties in which it provides a broad array of evidence-based, front-door, crisis, and ongoing mental health services to communities, and in which it coordinates with the various local entities, such as law enforcement, hospitals, schools, the judicial system, and health clinics, to provide behavioral health services in the community.

A LMHA/Community Center is not a state agency but a unit of the local government, locally sponsored by counties, cities, hospital districts and school districts. Each LMHA is governed by a publicly appointed Board of Trustees comprised of local leaders that represent the diversity and best interests of communities, families, and consumers. The Centers provide services and supports to people with intellectual and development disabilities, severe mental illness, and substance use disorders. They promote local control over funding, responsiveness to community needs, access to vital, cost-effective services, and recovery and self-determination. Section 533.035 of the Texas Health and Safety Code describes delegation of responsibility by the state authority to the designated local authorities for planning, policy development, coordination, resource allocation, resource development, and oversight of services.

As the LMHAs/community centers are not fully state funded, funding sources for the various community programs include monies from local match sources, Medicaid, state general revenue, Medicare, grants, patient assistance programs, 1115 waiver/DSRIP, and local partnerships. The base state funds are through Department State Health Services (DSHS) contracts with the base allocations calculated on a per capita formula. These funds help the LMHAs provide, coordinate, and support the community-based mental health services in the assigned communities.

LMHAs/community centers are involved in all aspects of mental health care in the community, whether for early intervention and prevention, essential services, psychiatric crisis emergency services, community outreach, peer support services, or with criminal justice. They are the core for providing services in the communities they serve. The biggest pressure point of communities are the indigent, the jail population, and those requiring hospitalization.²⁴

LMHAs crisis system services include:

- Access through crisis hotlines or as a walk-in;
- Crisis screening and assessment;
- Connection to crisis services; and
- Transition into ongoing community services.

Specific services vary throughout the state, but crisis system programs, crisis facilities, and alternatives to hospitalization and jail programs through LMHAs may also include:

- Mobile Crisis Outreach Teams (MCOT) which provide around-the-clock services that include crisis assessment, crisis intervention, crisis follow-up, and relapse prevention services;
- Crisis respite services;
- Crisis residential services;
- Extended observation units (EOU);
- Crisis stabilization units (CSU); and
- Rapid crisis stabilization beds.²⁵

Persons obtain access through an intake process at the LMHA and obtain a diagnosis and a standardized assessment -- Child and Adolescent Strengths Assessment (CANS) or Adult Needs and Strengths Assessment (ANSA).

The \$24 million, effective in September 2013, the 83rd Legislature appropriated to address community wait lists numbers for both children and for adults began a steep decline, and the numbers of persons served increased. Since quarter 3 of 2014, the wait list numbers for adults have been increasing, but the numbers served also continued to rise. Comparatively, during the same time frame for children, the number served continued to rise while the wait list has remained low.

Assistant Commissioner Lacefield-Lewis explained that each LMHA decides its services and programs based on resources, but funds are limited so a wait list will always exist. Priority on a wait list is determined by assessment tools utilized to determine the level of care needed. Regarding these state allocations to LMHAs, the state withholds ten percent from the allotted funding with receipt of the withhold payment being contingent on performance measures.

Measures for adults in a Full Level of Care include:

- Employment -- percentage with paid employment that is independent, competitive, supported, or self-employment;
- Adult community tenure -- percentage that avoid hospitalization in a DSHS-operated or contracted psychiatric inpatient hospital bed;
- Adult improvement in functioning -- percentage who show reliable improvement in at least one of the Adult Needs and Strengths Assessment (ANSA) domains of risk behaviors, behavioral health needs, life domain functioning, strengths, substance use, adjustment to trauma;
- Adult monthly service provision/engagement into treatment -- percentage who receive at least one face-to-face, telehealth, or telemedicine encounter of any service per month; and
- Residential stability -- percentage with acceptable or improved residential stability.

Measures for children in a Full Level of Care include:

- Juvenile justice avoidance -- percentage with no arrests or a reduction in number of arrests between the first and most recent assessments;

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- Child and youth community tenure -- percentage who avoid psychiatric hospitalization in a DSHS purchased inpatient bed after authorization into a Full Level of Care;
 - Child and youth improvement -- percentage who demonstrate reliable improvement in at least one of the Child and Adolescent Strengths Assessment (CANS) domains/modules of child strengths, behavioral and emotional needs, life domain functioning, child risk behaviors, adjustment to trauma, school performance, substance use; and
 - Child and youth monthly service provision/engagement -- percentage in Full Level of Care or YES waiver program who receive at least one face-to-face, telehealth or telemedicine encounter of any service per month.

Measures for community mental health crisis services include:

- Hospitalization -- the equity-adjusted percentage of adults and children with DSHS operated or funded psychiatric inpatient hospital stays in relation to population of the local service area;
- Effective crisis response -- the percentage of individuals who receive crisis services and avoid admission to a DSHS operated or contracted psychiatric inpatient hospital bed for 30 days after the start of the crisis episode;
- Frequent admissions -- the percentage of adults and children authorized in a Full Level of Care who are admitted 3 or more times within 180 days to a DSHS operated or contracted inpatient psychiatric bed;
- Access to crisis response services -- the percentage of true crisis hotline calls that result in face-to-face encounters within one day; and
- Adult jail diversion -- the equity-adjusted percentage of adult bookings entered into the Texas Law Enforcement Telecommunications System with a history of DSHS-funded mental health services.

Responsibilities of the LMHAs also include performing outreach to increase public awareness about available services. Outreach efforts can be broad-based via educational websites and community events or targeted to specific programs and include:

- Projects for Assistance in Transition from Homelessness (PATH);
- Mental Health First Aid (MHFA) which teaches skills to respond to signs of mental illness and substance abuse in Texas students; the 83rd Legislature authorized DSHS to provide grants to LMHAs to train staff and contractors with the focus on educator training; the 84th Legislature expanded MHFA to allow other school employees to receive training to expand the reach; and
- Speak Your Mind Public Awareness Campaign which builds broad awareness, reduces stigma, equips people to recognize warning signs of mental illness and substance abuse disorders, and connects individuals with treatment.

Historically, counties have provided the largest portions of local funds, as compared to cities, or other taxing entities, such as hospital districts, in support of the local LMHA/community center.²⁶

Services Accessible Statewide

Access to behavioral health resources statewide include:

- MentalHealthTX.org - a One-Stop Shop;
- Texas Veterans Mobile App - a One-Stop for Veterans;
- Friends and Family Guide to Adult Mental Health Services - advises where to go or whom to call;
- Children's Mental Health Services Navigation and Resource Guide - advises where to go or who to call;
- Enhanced Information & Referral services through 211 - telephone hotline;
- Mental Health First Aid - course administered through LMHAs to school personnel and persons in the community; and
- Navigatelifetexas.org - resources for children with disabilities and special health care needs.

Community Services Directly Through Department of State Health Services

Department of State Health Services programs for access to behavioral care include:

- Contracting with 12 LMHAs for substance abuse Outreach, Screening, Assessment and Referral (OSAR) services which help people navigate the continuum of care for substance abuse and link to community-based support services after treatment (previously DSHS contracted directly with OSARs and other third party entities, but for coordination of efforts, the 84th Legislature moved the contracting role to the LMHAs);
- Providing ongoing care through the Texas resilience and recovery (TRR) program which is an outpatient delivery system that is a person-centered approach to service provision that moves away from the historical disease-focused model and focuses on resilience and recovery. Basic elements of TRR include: evidence-based practices, consistent levels of care (low to high), data and outcomes. Challenges to TRR include: demand (population growth) and complex/high needs;
- Providing behavioral health services to veterans through partnerships with the Texas Veterans Commission and Texas A&M University and through the Veterans jail diversion program wherein trained peers and coordinators provide services in coordination with 24 veteran treatment courts;
- Working with the criminal justice system, generally through grants or matched funding efforts, in the outpatient competency restoration program, with Harris County in jail diversion efforts, and with TCOOMMI;
- Working through peer-centered services within the Clubhouse program which is a recovery-oriented program for adults and aimed at improving an individual's ability to function successfully in the community;
- Working toward peer reintegration with a program in development that will use certified peer specialists to assist in the transition from a county jail into community-based services;
- Working with housing assistance services for a supportive housing program, the HUD Section 811 Project Rental Assistance Program, and Healthy Community Collaboratives.
- Working to reduce suicides through prevention programs, such as Youth Suicide Prevention and Zero Suicide in Texas (ZEST); and

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- Encouraging trauma-informed care which recognizes that clients may be impacted by traumatic experiences or are survivors of traumatic events; delivers services in a way to avoid re-traumatization; and recognizes that the best practice approach fosters consumer/individual participation.²⁷

Services Through State Hospitals

The Department of State Health Services (DSHS) oversees and regulates Texas' state hospitals. The state operates ten state hospitals plus the Waco Center for Youth. The state hospitals provide inpatient psychiatric hospitalization. DSHS and state hospital personnel also work in coordination with LMHAs, substance abuse treatment providers, and the criminal justice system to ensure continuity of care upon release of a patient.

State hospitals admit persons via civil commitments and via forensic commitments. Civil commitments are for persons who are of imminent risk of serious harm to themselves or others or of substantial risk of mental or physical deterioration; forensic commitments are for persons admitted through a court order due to incompetence to stand trial or a verdict of not guilty by reason of insanity.

According to data, from 1994 through 2015, the state reduced funding by 424 psychiatric beds. That difference reflects funding for an additional 230 contracted beds, but a reduction in funding for state hospital beds by 660. In late 2013, the number of forensic commitments passed the number of civil commitments. The system currently has 2919 state funded psychiatric beds; 2463 which are state operated and an additional 456 funded within communities. The community/purchased beds help with the shorter-term stays of three to seven days.

Within the state hospital system, DSHS currently has a psychiatric residency program with participation by three universities in the 2016-2017 academic school year for enhancing services. Psychiatric residency programs throughout the state incorporate:

- San Antonio State Hospital;
- Kerrville State Hospital;
- Terrell State Hospital;
- Dallas Metrocare Services (LMHA/community center);
- El Paso Psychiatric Center (State Hospital);
- MHMRA of Harris County (LMHA/community center);
- University of Texas Southwestern Medical Center;
- Tarrant County Hospital District; and
- Austin Travis County Integral Care (LMHA/community center).²⁸

Additional State Agencies Providing Services

Additional state agencies were identified by various testifiers in this initial hearing. Details on the provision of services through those additional state agencies were heard in later hearings. These additional agencies include, Texas Department of Criminal Justice (TDCJ), Texas Juvenile Justice Department (TJJD), and Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) which provide behavioral health services for the

incarcerated, probation, paroled, or pre-trial defendant population. In addition to individuals being served in state prisons, these departments have programs and work with local entities for ongoing care when an individual is living in the community. In many instances, LMHAs are the entities that enable continuity of care after someone has been released back into the community whether from jail/prison or from a psychiatric hospital.

Additionally, the Texas Department of Veteran's Affairs provides behavioral health care services and referrals for access to behavioral health services to veterans in the state.

Statewide Behavioral Health Coordinating Council in the Health and Human Services Commission (HHSC)

The Statewide Behavioral Health Coordinating Council was created in House Bill 1 in the 84th Legislative Session and consists of members representing the eighteen state agencies that receive funds for direct utilization for mental health services plus representation from Texas Education Agency (TEA) which does not receive funds "directly" appropriated for mental health.

The Council's task and its five-year statewide behavioral health strategic plan is to:

- eliminate redundancy;
- utilize best practices in contracting standards;
- perpetuate identified, successful models for mental health and substance abuse treatment;
- ensure optimal service delivery; and
- identify and collect comparable data on results and effectiveness.

The Council's goals are for a unified approach in:

- service delivery;
- statewide data;
- prevention and early intervention;
- coordination across agencies; and
- financial alignment.

Current state initiatives identified by the Council for service delivery include:

- Department Aging and Disabilities Services (DADS) service enhancements implementation;
- TDCJ / TCOOMMI Program -- 350,000 persons are in county jails on any given day and if a person has been in treatment in an LMHA, a crossover program coordinates care during and after jail;
- Texas System of Care programs;
- United School Age Children (USAC);
- NorthSTAR transition;
- Behavioral health-focused DSRIP projects through the 1115 transformation waiver program;
- Health Community Collaboratives;
- YES waiver;
- Texas Veterans + Family Alliance Grant Program;

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- Certified Community Behavioral Health Clinics (CCBHC) Substance Abuse Mental Health Services Administration (SAMHSA) Grant; and
 - Mental Health First Aid (MHFA).

The Council's financial alignment goals include:

- Coordinating expenditures across the Council's member agencies;
- The carve-in of case management and rehabilitation in Medicaid managed care; and
- State and local investment in projects that require community collaboration and match, such as homeless projects and veterans grants.

Additionally, all mental health related exceptional items of the Council member state agencies' legislative appropriations requests (LARs) must be vetted through the Council.²⁹

Mental Health Advocates - Recognition of improvements and Identification of Gaps

As researchers, educators, and public policy authorities of mental health, and to permit a deeper understanding of mental health and longer-term considerations for addressing mental health issues, the Hogg Foundation (Hogg Foundation) and the Meadows Mental Health Policy Institute (MMHPI) were asked to discuss details on the "state of current services" and to identify and provide insight into addressing gaps in the system.

The Hogg Foundation appreciates the legislature's attempt to do away with siloed approaches, movement towards a recovery based system, and better coordination of efforts. Regarding recovery, the Foundation states, "The Texas public mental health system has been moving to a recovery-based system for a number of years and has helped many escape the sometimes endless cycle in and out of mental health hospitals and jails. Recovery is not a cure; it is a journey in which individuals with mental health or substance use conditions are able to manage their illness in a way that allows them to lead a meaningful life. Recovery is more than simply surviving, it is based on the belief that while symptoms of mental illness are not always under the individual's control, managing those symptoms and living their life can be. Recovery can break the cycle..."

Identified gaps in services identified by the Hogg Foundation include the lack of integration of care, workforce shortages, the lack of IDD population recognition, not offering the opportunity for self-directed services, not supporting peer support services, the lack of parity, the lack of early intervention programs, and the lack of affordable housing during recovery.³⁰

MMHPI asserts that of the one in five persons in Texas who need mental health help, 80 percent do not receive services because of the system, not because the services do not exist.

Targeted populations include super-utilizers; those with a first episode psychosis, and children in order to narrow the prison pipeline. MMHPI presents data showing that 22,000 persons in poverty who suffer from mental illness are repeatedly cycling through jails, emergency rooms, and hospitals and are referred to as "super-utilizers". These persons cause Texas taxpayers to incur at least \$1.4 billion in emergency room costs; at least \$450 million in local jail costs; at least \$230 million in local juvenile justice system costs; and billions of dollars of potential

Medicaid physical health spending. Services that work exist, but Texas currently only has the capacity to serve one in seven or 3,400 super-utilizers.

MMHPI also discussed that each year about 3,900 Texas adolescents and young adults first experience a psychosis and stated that these individuals, without intervention, are likely to become "super-utilizers". Dallas and Houston have programs for First Episode Psychosis, based on the RAISE Early Treatment Program, but these are available only for the indigent, not for Medicaid nor for private pay.

Programs exist through Texas A&M and the Council of State Governments Justice Center that have shown the path to reducing the pipeline. TJJD reforms are currently in place, but a gap prior to juvenile justice system entry remains. Thirty-thousand (30,000) Texas children with severe mental health needs are at high risk before entry. The current system can serve only a few hundred at the needed level of intensity.

Additionally, an overwhelming majority of Texas counties are designated as Mental Health Professional Shortage Areas (defined as more than 30,000 Texans per clinician); Texas has 1,460 psychiatrists (532 over the age of 55) and can train only 370 in Texas residencies each year; Texas needs at least 1,000 more adult and 200 more child psychiatrists today.

With intervention and coaching, one-third of persons can function fully; one-third can function sufficiently to manage; and one-third could have a full-blown psychosis.³¹

Best Practices Identified

Examples of DSRIP projects through LMHAs in Texas are:

- MHMR of Harris County (Regional Healthcare Partnership 3) -- added three additional teams to the Crisis Intervention Response Team, which partners law enforcement officers with master-level clinicians to respond to law enforcement calls;
- Tropical Texas Behavioral Health (Regional Healthcare Partnership 5) -- developed primary care clinics co-located within three Tropical Texas clinics;
- Center for Health Care Services (Regional Healthcare Partnership 6) -- established a centralized campus from which systems or families can obtain care for children and adolescents with a serious emotional and/or behavioral problem or development delay;
- Tarrant County MHMR (Regional Healthcare Partnership 10) -- established a crisis program to support Intellectual Developmental Disabilities who experience a crisis; and
- Texas Panhandle Centers (Regional Healthcare Partnership 12) -- provided a 24/7 crisis respite program focusing on rapid stabilization and averting future crises.

Some best practices in LMHAs/community centers highlighted by the Council are:

- Telemedicine utilization related to jail services by LMHAs are through the Betty Hardwick Center, Bluebonnet Trails Community Services, Texoma Community Center;
- Telemedicine utilization related to mental health crisis services by LMHAs are through Austin Travis County Integral Care, Hill Country, and Lakes Regional;

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- Telemedicine utilization related to active jail diversion/MCOT by LMHAs through 1115 Waiver/DSRIP projects are through Helen Farabee, Harris Center, Tropical Texas, and West Texas;
 - A jail diversion project by Bluebonnet Trails is a Justice-Involved Services through Regional Mental Health Deputy project. The project involves three counties in which for four years has successfully diverted 1,613 youths and adults with mental illness from incarceration; improved law enforcement community relations; increased awareness of other officers in recognizing mental illness and accessing appropriate crisis teams; and reduced repeated detentions and incarcerations in all three counties. The project was funded through 1115 Waiver funds of \$350,000 per year and general revenue of \$50,000 per year and has shown an estimated cost savings of over \$5 million over the four years (or \$1.25 million per year).

Challenges

- Sustainability of 1115 Transformation Waiver/DSRIP projects and future funding thereof. Numerous and varied programs have been implemented because of funds received for approved initiatives to expand mental health services. The 1115 waiver program began in 2011 and was set to expire in September 2016 but was extended through December 2017. Although many services have proved to be successful, if the federal government does not further extend the program and funding, some entities will have to absorb the costs or the programs may expire.
- As the population of Texas, the complexity of the needs of individuals in crisis, and the demand for mental health and substance abuse services continue to grow in Texas, the legislature continues to hear the need for additional assistance from law enforcement, the judiciary, Local Mental Health Authorities (LMHAs) and other providers of community services, hospitals, citizens, and mental health advocates, including persons who have benefited from services.
- For the first time in state history, in 2013 the number of forensic beds passed the number of civil beds. This is in large part due to the number of individuals at the county level being placed in state hospitals for competency restoration.
- Peer support service providers are persons who have "been there" and can personally relate to the challenges being experienced. Certified peer support providers are not being utilized to the greatest extent possible as reimbursement for their services is not allowed in many situations.
- Wait lists exist for transition into state hospitals and also in communities for immediate service.
- Inpatient rehabilitation is offered in many situations when a person is released from a surgical or other medical procedure. However, for mental health, step-down beds are not provided. Thus, a reliable continuum of care, especially in an inpatient setting, is lacking. Often when an individual is released from a mental health facility or from jail, he/she will receive enough medication for "X" days and outpatient care information for follow-up care in the community. Much of the outpatient care is coordinated through the LMHAs.
- The stigma attached to mental illness and the willingness of individuals to seek help.

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- State hospitals need additional beds for the increase being seen in forensic commitments, particularly for maximum security; support for the aging infrastructures; and support for an adequate and competent workforce.

Recommendations

- Seek consideration of various forms of financing to improve operations, purchase private beds to increase needed capacity and to update, remodel and construct new state hospitals in accordance with a strategic plan.
- Improve opportunities for integrated health care.
- Develop a comprehensive plan for workforce development.
- Address instability of over-reliance on and sustainability of the 1115 Waiver.
- Provide for a definition of peer support services in the Insurance Code and require insurers to pay for peer support services. Also review considerations for the expansion of support services provided by certified substance use recovery coaches.
- Utilize and expand use of technology through the use of telemedicine & mobile applications.
- Review reciprocity of psychiatrists and other mental health professional licenses to ensure maximum utilization of providers and services.
- Review MCOs and the alignment of financial incentives as well as the loop hole regarding coverage by MCOs for persons in jail.
- Numerous programs are in place and much funding is provided for mental health and behavioral health but comments are being heard about the system not working. Create a team from the Behavioral Health Coordinating Council to ascertain the hindrances in the system and enhance the Council's plan to address the specific issues found.
- New and innovative programs are many times needed as population grows and technology changes; however, proven and best practices are being utilized throughout the state and can potentially be wholly or partially implemented by others if the knowledge is made available. The lead administrator of the state programs needs to be intricately familiar with the actual programs and practices in-place by the various entities and able to guide other areas in adoption of proven best practices across areas of the state.
- Review funding by HHSC/DSHS to LMHAs based on innovativeness of programs. The assessments and funding award are made based on "value" as determined by DSHS personnel. Some LMHAs may be more "sophisticated" and thus more innovative, others may just need additional help in retaining psychiatrists or other mental health professionals or help in realizing efficiencies in providing services. Also, there is not consistency in services that LMHAs provide, such as some do not offer any children's services. True coordination of community services should incorporate the LMHA.
- Further support LMHAs to permit additional leadership for community services -- increase funding and support for LMHAs and restructure how funding is awarded by DSHS utilizing strengthened measures and outcomes of programs; unlock local innovation and waive the current 10 percent financial withhold penalty from LMHAs who have proven records and where all local governments agree to work together, but continue with penalty of areas that continue to have silos or refuse to collaborate with other entities; streamline performance contract on flexibility and accountability; leverage

existing flexibility statute and allow LMHAs to move resources around; reduce regulatory barriers, such as with substance use disorder and mental health integration; streamline crisis stabilization units (CSU) requirements (the Texas Administrative Code currently mirrors psychiatric hospital requirements but CSUs do not provide the same level of care as a hospital); and strengthen outcome measurement.

- Define Continuum of Care and provide funding for step-down beds.
- Have targeted funding for mental health programs in rural areas.
- Increase funding for Texas Veterans + Family Alliance in underserved communities.
- Eliminate the overly burdensome prior authorization rules by insurers.
- Increase access to substance abuse treatment and housing supports and continued investment in mental health outpatient services.
- Review and address access to inpatient care in rural and high need areas, possibly through purchased beds around the state.
- Continue review of university affiliations, including provision of medical and psychiatric services and enhanced training for psychiatric residents.

PUBLIC HEARING #2: Mental and Behavioral Health Services and Treatments For Children

The second public hearing related to mental health focused on services to children and was held on March 22, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Christine Bryan, Clarity Child Guidance Center
Tushar Desai, MD, Texas Juvenile Justice Department
Jodi Duron, EdD, Elgin Independent School District
Ginger Gates, PhD, LP, LSSP, NCSP, Region 4 Education Service Center
Clynita Grafenreed, PhD, LP, LSSP, Region 4 Education Service Center
John Hathaway, JD, Travis County Juvenile Court
Daniel Hoard, PhD, Travis County Juvenile Probation Department
Gary Jessee, Texas Health and Human Services Commission
Douglas Killian, PhD, Hutto Independent School District
Lauren Lacefield-Lewis, Texas Department of State Health Services
Elizabeth Minne, PhD, Vida Clinic; Austin Independent School District
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The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The committee was charged to review of the mental health / behavioral health services being provided in Texas for children and youth populations, including those in foster care and in the criminal justice system.

Background

"Early onset of child mental illnesses is predictive of lower school achievement, an increased burden on the child welfare system and greater demands on the juvenile justice system, resulting in an annual economic cost of \$247 billion in 2007,"³² according to the American Academy of Child and Adolescent Psychiatry.

"A better-designed health system will mean more immediate access to timely, evidence-based mental health treatments, interruption of decline, and protection of child and adult outcomes... when a child has something as common as depression, anxiety, or mood disorder, we must make sure sound and safe therapies are available, accessible, and exhausted first. It is amazing to see how therapies and medications separately or together, transform a child and family's life."³³

Statistics

- Fifty (50) percent of chronic mental illness presents itself by age 14 and 75 percent by age 24³⁴;
- One in five U.S. school-age children have symptoms that meet criteria for a mental illness;
- One in ten U.S. children on any given day live with a mental illness;
- In Texas, more than 500,000 children and adolescents have a severe emotional disturbance, a condition that impairs functioning;
- Children with untreated mental illness are more likely to fail school, interface with juvenile justice, engage in high risk health behaviors, and have poor health as adults;
- Children with intellectual/developmental disabilities are more likely to have mental illness; and
- Children who live with abuse, neglect, a parent with mental illness, parent with addiction, or domestic violence, are more likely to develop mental illness in adulthood.³⁵

Further information includes:

- "In 2013 the American Academy of Child and Adolescent Psychiatry estimated that there were approximately 8300 practicing child and adolescent psychiatrists in the U.S. With 15-20% of children needing services; there is a severe unmet need.
- Only 20 percent of children who need mental health care get it on a national basis.
- Often times mental health issues that confront children and families defy a simple system of diagnosis leading to a specific treatment.
- Of children who present pre-adolescent and in early adolescence with severe mood dysregulation, most experience a high risk for depression in later adolescence as compared to continued aggression.
- Many states are addressing the unmet needs by converting...to Integrated Clinic Models...a broad concept of placing mental health care settings where children appear.
- It is difficult for families to navigate school systems to obtain appropriate accommodations for mental health disabilities. Zero tolerance policies in schools are the beginning of what justice policy advocates call "the criminalization of mental illness".
- The justice system is the largest provider of mental health services in Texas and most states. "³⁶

Additional statistics from Texas Juvenile Justice Department for state facilities show:

- 99 percent of those committed need some type of specialized treatment with 50 percent needing mental health treatment and 82 percent needing treatment for alcohol or other drug use;
- On the local level, 39.7 percent of juveniles on probation had mental health needs at intake.³⁷

Services and Providers

Physicians

Dr. Partap, a pediatrician, and Dr. Streusand, a child and adolescent psychiatrist, agree that early intervention and prevention can help children and families identify and address mental health issues. Further, they also agree that integrated health care provides care for the whole person, as factors that affect mental health affect physical health.

Dr. Partap's comments, "For every condition, except mental illness, I know I can take a history, treat the child within my scope, refer for supplemental or specialty care, and my patient will receive the highest level of care he needs to survive, recover, and rehabilitate. For mental illness, one or more of these basic health care steps is delayed....

"We are finally positioned to get it right. It's the last frontier of medicine in which we need to do a substantially better job and other conditions inform us how we get there...The easiest solution is integrating services, placing primary care and behavioral health in single sites so families have ready access to basic services when their child needs it. It just makes sense to place professionals together for common, distressing conditions that need early treatment."³⁸

Child and adolescent psychiatrist, Dr. Streusand, relays that psychiatrists work for cash because they can; it is a seller's market. Pre-approvals and filing insurance claims take time and there is no guarantee that payment will be forthcoming.³⁹

Dr. Partap further states that it is imperative that children and families receive expert care from the moment they present. Mental illness differs from other conditions in the sheer isolation and stress experienced by families. Screening, referral networks, specialized services, family supports, and integrated health care address many of the barriers families experience on the front lines when their child is in trouble. If Texas has a network adequacy issue, it is likely related to reimbursements and payments.⁴⁰

A Center for Children

The Clarity Child Guidance Center (Clarity) is Texas' only nonprofit inpatient and outpatient mental health organization serving strictly children. Clarity acts as the state hospital for children under 12, and provides overflow capacity to San Antonio State Hospital for adolescents.

Clarity provides inpatient services (four units of 66 beds with an average length of stay of 5 - 7 days) and also innovative outpatient services/projects such as day treatment (partial program) and crisis assessment units (6 23-hour observation beds -- part of the 1115 Waiver program). Their mental health professions staff includes inpatient child psychiatrists, psychologists, master's level clinicians, certified therapeutic recreation specialists and a music specialist.

Eighty (80) percent of children served by Clarity have some state supported funding; 71 percent of inpatient and 47 percent of outpatient revenue are Medicaid funded. Twenty-five (25) percent of inpatient referrals are from area LMHAs; 15 percent are from law enforcement.

Clarity's services are based on trauma-informed care and focus on triggers not misbehaviors, as behavior is not the problem but a symptom of the problem.⁴¹

Services through Department of State Health Services (DSHS) and Health and Human Services Commission (HHSC)

Children's behavioral health services in communities are provided/coordinated through the LMHAs. Services are provided according to levels of care (LOCs). Programs include:

- the Youth Empowerment Services (YES) program which serves to prevent or reduce institutionalization of children and adolescents ages 3 - 18 with serious emotional disturbance (SED). The program provides access to a flexible array of services through intensive community-based services and improved access to services. In March 2016, the program began including children in Department of Family and Protective Services (DFPS) conservatorship;
- DSHS/DFPS residential treatment center (RTC) project - collaboration to prevent parental relinquishment of children to DFPS due solely to a lack of mental health resources. In the 84th Legislative Session, \$4.8 million was appropriated to DSHS to expand the RTC project from 10 beds to 30 beds. Since January 2014, 61 children have been served; 25 have been successfully discharged from RTC to home; 89 percent have met program criteria and remained in parental custody; and 13 have remained in home with assistance through LMHA or YES services;
- Zero suicide in Texas (ZEST) is federally funded but coordinated through DSHS which partners with 22 LMHAs/community centers to develop suicide-safe care in communities through adoption of best practices; as of March 2016, 1,509 youth have received suicide screenings since implementation in FY2014;
- Mental Health First Aid (MFHA) is an eight-hour evidence based curriculum that teaches individuals how to help someone who is developing a mental health problem or experiencing a mental health crisis; helps trainees identify, understand, and respond to signs of mental illnesses and substance use disorders until professional help arrives; the program has \$5 million per biennium appropriated specifically for school personnel; in FY 2015 6,527 educators and 4,792 non-educators were trained;
- Star Health Program is a Medicaid managed care model designed to improve services and better coordinate care for children in conservatorship of DFPS; features include service management and coordination through the MCO; psychotropic medication utilization review; psychiatric hospital diversion services, such as a Mobile Crisis Team; and a health passport which is an electronic health information system.

Of over 400 behavioral health-focused projects in Texas in the 1115 Waiver/DSRIP program, 46 focus specifically on providing services to children and/or adolescents. Types of projects include:

- Interventions to prevent unnecessary use of services, such as in the criminal justice system and in hospital emergency departments;
- Enhanced behavioral health service availability, such as hours, locations, transportation, and mobile clinics;
- Development of behavioral crisis stabilization services;

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- Integration of primary and behavioral care services; and
 - Deliver of behavioral care through telemedicine/telehealth.⁴²

Of those 46, 29 are through LMHAs; others are through hospitals, physician groups and local health departments.

Examples of the 1115 Waiver/DSRIP behavioral health projects that focus on children and adolescents include:

- Center for Health Care Services (RHP 6) - Centralized campus from which systems or families can obtain care for children and adolescents with serious emotional and/or behavioral problems or development delays.
- Hill Country MHDD Centers (RHP 7) - Implemented a children's mental health crisis respite center;
- Metrocare Services (RHP 9) - Implemented the Family Preservation Program to provide services to children recently released from psychiatric hospitals or at risk for out-of-home placement;
- Texas Panhandle Centers (RHP 12) - Delivers intensive behavioral services to children and adolescents who are at high risk for CPS or juvenile justice involvement; and
- Children's Medical Center of Dallas (RHP 18) - Integrates behavioral health services into primary care setting.⁴³

School Settings

"Being mentally healthy is not just the absence of a mental illness - it means that you have the ability to handle the challenges of life.

"Children do not leave their mental health at the school house door. Schools educate students with a full continuum of mental health, from healthy living to chronic illness. Students who have mental health problems have a difficult time learning and maintaining appropriate behavior.

"Student behavior and mental health issues are inextricably linked...a natural connect to the work done by the TBS Network is that of addressing the mental health needs of students." The goal of the network is to build capacity in Texas schools for the provision of Positive Behavior Interventions and Supports (PBIS) to all students..."

"The negative consequences of not addressing students' mental health are serious, including unsafe behaviors, drug and alcohol abuse, and school failure," stated witnesses from Region 4 Education Service Center (Region 4).⁴⁴

Texas has over 342,000 teachers, on 8,656 campuses, in 1,219 school districts working with 5.2 million students. In 1967, to assist school districts and charter schools in improving efficiencies and student performance, 20 regional education service centers (ESCs) were established by the Texas Legislature. ESCs, under the direction of the Texas Education Agency (TEA), are responsible for developing significant expertise and capacity to establish and coordinate a 20-region network for their functions.

Region 4 leads the statewide Texas Behavior Support (TBS) Network. Drs. Wells, Gates, and Grafenweed with Region 4 say, "It is very difficult for the various agencies that support mental health services to efficiently and effectively collaborate with schools. ESCs have an existing relationship and communication networks with schools and are thus uniquely situated to support the efforts to collaborate on and integrate health training and services."⁴⁵

The Region 4 presenters understand the importance of collaborative relationships with community mental health provider partners. They stress, however, that "...the mental health community should be aware that their interventions must align with the major concern of the schools - academic achievement. Likewise, the education community must be aware that mental health professionals do have strategies to improve instruction and achievement as well as improving social and emotional functioning in children. The convergence of these two perspectives is the hallmark of "school-based" mental health."⁴⁶ School mental health services are generally provided by school psychologists, counselors, or social workers who are trained not only in mental health but also in school systems.

The PBIS model focuses on prevention and is designed to help educators be proactive, monitor progress, and ensure that all students are getting the necessary supports to be successful."⁴⁷

Examples of Best Practices

School environment best practices programs in urban, suburban, and rural settings testified regarding programs in place and the collaboration and partnerships necessary to have success. Testimony was provided by the Austin Independent School District, the Hutto Independent School District, and the Elgin Independent School District regarding programs that provide mental health care access in their respective school districts. All are administered somewhat differently, but all have funding through 1115 Waiver/DSRIP monies and none of the three are siloed. The schools, the community LMHAs, families, and local mental health providers are all involved in partnerships to facilitate the programs.

The Austin I.S.D. program is through the school district, but is in coordination with the LMHA/community center, Austin Travis County Integral Care (ATCIC), AISD Schools-Based Services - Seton in Schools, and also uses local funds for expansion to allow for hiring the Vida Clinic on three campuses.

The Hutto I.S.D. and Elgin I.S.D. programs are through Bluebonnet Trails Community Center, the LMHA/community center, the schools, the communities, and FQHCs.

Urban Schools

Mr. Shapiro from the Austin Independent School District (AISD) testified, "David Crockett High School was rated Academically Unacceptable in 2006 and 2008. In 2008, the Crockett federal graduation rate was 72.6 percent; the annual dropout rate was at 4.7 percent; the school-wide attendance rate was 88.9 percent; and there were 749 home suspensions." Changes were made in systems, curriculum delivery, and supports, and the school was removed from the Academically Unacceptable list. However, "the school still struggled."

In 2011, Crockett High School began development of a pilot program to introduce a mental health center on campus. A system was developed through the school and a community partner to develop processes to identify students who needed assistance and a consent system for the services. A full-time licensed psychologist was placed on campus to provide mental health services through a Campus Based Counseling Referral Center (CBCRC).

As services were provided, the school data reflected a positive shift. Also, teachers have reported a "greatly improved" school climate in which they have fewer disruptions. Additionally, the school saw a decrease in suspensions. Ms. Tracy Spinner's testimony included, "We know based on student health data that there is a need to intently focus on the mental well-being of children." Mr. Shapiro stated, "Students who are not "head ready" for class will not be receptive to quality instruction." He continued by saying that without the mental health clinics, the reforms probably would not have worked as well.

At AISD, graduation rates continue to increase, by 14 percent in 2014; attendance has risen over 5.5 percent; dropout rate has reduced by 3.8 percent; and home suspensions have dropped from 749 to 166.

Mr. Shapiro also stated, "...the mental health needs of a school population can have a profound effect on both the students who are receiving mental health services and those students who are not receiving services."

Students and families can receive mental health services by a full-time licensed therapist in the CBCRC as the therapists work collaboratively with other school based programs.

Through participation in the 1115 Waiver, the district receives \$2.4 million in valued services at the 15 Campus Based Counseling Referral Centers. From August 2015 to March 2016, 94 students have received behavioral health services through partnerships with Austin Travis County Integral Care (ATCIC) and the AISD School-based Services - Seton in Schools. In August 2015, the district committed local funds (\$480,000) to contract with a private provider for services at three additional campuses bringing the total to 18 campuses that provide mental health therapy.

Ms. Spinner comments, "Investing in students early saves money in the long run, as the cost of incarceration and inpatient mental or behavioral care is far more costly."

Dr. Elizabeth Minnie continues, "While students may initially be referred due to behavioral problems such as aggressive outbursts, we find that underlying those behaviors are struggles with prolonged stress, mood, and history of psychological maltreatment." Whole-child oriented which emphasizes a youth's healthy long-term development in addition to academic achievement." ^{48, 49, 50}

Suburban Schools

Through a connection during a MHFA course and recognizing an increase in mental health issues involving students, Bluebonnet Trails Community Services, the LMHA serving eight

counties in central Texas covering 6,910 square miles with a total population of over 790,000, took action to pair needs with available community resources.

The action entailed implementation of two school environment mental health programs. Through the utilization of 1115 Waiver/DSRIP funds, integrated health clinics were placed in schools: one in Elgin and one in Hutto. The programs are built on relationships, comprehensive treatments, and access to treatment. The behavioral health aspect of the children's service continuum includes early childhood intervention, mental health, and substance use.

In Hutto, ISD staff, families, and health care providers were engaged for an integrated clinic with medical services for physical health and for counseling services provided through licensed professionals to be opened inside the Hutto High School. The services are provided for all ISD students and their family members and for ISD staff as well. Access to services are provided throughout the school year and mirror ISD summer hours. In 2014, Hutto ISD showed that 46 percent of the students were economically disadvantaged.

In Elgin, ISD staff, families, and health care providers were engaged for an integrated clinic with medical services for physical health and for counseling services provided through licensed professionals to be opened within the Elgin ISD Administration Building. Providing services in the administration building and not on an actual school campus allows for community-wide access to health care services. The services are provided for ISD students and their family members, for ISD staff, and for the community. Access to services are provided throughout the school year and mirror ISD summer hours. In 2014, Elgin ISD showed that 71 percent of the students were economically disadvantaged.

Benefits of these integrated health clinics on school campuses include:

- Improved access of services,
- Improved school attendance,
- Better adherence to treatment and follow-up,
- Increased collaboration between community partners,
- Decreased use of unnecessary emergency services,
- Development of an integrated and individualized care plan,
- Diversion from unhealthy choices, and
- Educators and families may also receive care.

The benefits of a partnership with the LMHA include:

- The ability to offer services year-round, beyond the academic school year and during breaks when support for children and youth can be limited.
- Clinicians may see students even if the student is suspended, not attending school, in detention, or in the hospital. The LMHA will also support adolescents after hours through crisis intervention services.
- To meet the needs of the families, the ISDs may benefit from the resources of the LMHA including the latest evidence-based practices, including dialectical behavioral therapy, trauma-focused cognitive behavioral therapy and functional family therapy.
- The ISDs may also offer access to the LMHA assertive community outreach; wraparound services that include family, community, and Family Partner support; substance abuse

treatment; and additional services that school district mental health professionals may not have the capacity to provide.

Although initially funded through the Medicaid 1115 Waiver Program, financial sustainability is progressing through:

- Financial assessment data is captured so that the provider is able to seek reimbursement from private insurance, Medicaid and Medicare for services provided.
- The ISDs and ISD Health Plan reimburse the providers for care delivered to ISD employees; keeping employees healthy at work.
- The providers are now privileged on 4 of the 11 Medicaid Managed Care Health Plans serving the area.
- Working alongside the FQHC, the ability to seek an enhanced rate through Medicaid.

For continued progress, MCOs need continued education regarding the value of School-Based Programs; a focus on detection, prevention and early intervention of healthcare concerns; continued partnering benefits; and consideration of state and national metrics, measure of health outcomes over time including the impact on disciplinary actions.⁵¹

Rural Schools

The TWITR (Telemedicine, Wellness, Intervention, Triage, and Referral) Program, developed by Texas Tech University Health Science Center F. Marie Hall Institute for Rural and Community Health, provides mental health screening services for ten school districts in nine counties including and surrounding Lubbock County. The screening process utilizes Licensed Professional Counselors (LPC) that visit the partner school districts to aid in identifying the need for crisis intervention and other behavioral problems experienced by adolescents. When the screening by LPCs indicates the need for an appointment with a psychiatrist, that visit and referrals for ongoing care occurs via telemedicine almost immediately which reduces what can often be a months-long wait for an initial visit with a psychiatrist. This process is especially important in rural west Texas as the statistics below show the lack of availability of mental health professionals.

Additional national statistics:

- Approximately 50 percent of students age 14 and older with a mental illness drop out of high school;
- The suicide rate in rural areas is 1.7 times higher than in large central metropolitan areas (17.6 per 100,000 vs. 10.3 per 100,000);
- Mental illness costs the country at least \$444 billion a year in medical costs, disability payments, and lost productivity;
- Among the 20.2 million adults in the U.S. who experienced a substance use disorder, 50.5 percent (10.2 million) had a co-occurring mental illness.

West Texas workforce statistics:

- Out of 2,848 board certified psychiatrists in Texas, only 151 (5.3 percent) are located in West Texas;

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- 94 West Texas counties have no psychiatrist as the majority of psychiatrists are concentrated in Lubbock, Amarillo, El Paso, and Wichita Falls (statewide, 185 Texas counties, with a combined population of almost 3.2 million, have no general psychiatrist);
 - Out of the 7,452 psychologists in Texas, only 441 (5.9 percent) are located in West Texas;
 - Out of the 21,271 licensed professional counselors in Texas, only 2,093 (9.8 percent) are located in West Texas.

TWITR outcomes include:

- Number school staff trained = ~1,610;
- Number students impacted = ~21,174;
- Number referrals = 305;
- Number screenings = 114;
- Number triaged = 108 (all by telemedicine);
- Number removed from school = 16;
- Reduction in truancy = 17 percent;
- Reduction in student discipline referrals = 25 percent;
- Increase in student overall GPA = 3.6 percent.⁵²

Juvenile Justice Services

Unfortunately, the review of children's mental health is not complete without review of the juvenile justice system services. The Texas Juvenile Justice System involves state and county services.

The Texas Juvenile Justice Department (TJJD) services:

- Operate state secure correctional facilities and halfway houses;
- Provide rehabilitative treatment and specialized treatment to youth;
- Serve youth 10-18 who have committed felony offenses;
- Partner with 166 probation departments, providing grant funding, oversight of minimum standards for county juvenile probation; and technical assistance to juvenile probation departments.

Counties juvenile probation department:

- Serve about 98 percent of youth engaging in delinquent conduct (misdemeanors and felonies of ages 10-17);
- Contribute an average of 73 percent of local juvenile justice funds;
- Provide services to youth, including behavioral health, commitment diversion, residential placement, family engagement, and others; and
- Are governed by local juvenile boards.

County probation departments provide:

- Mental health and drug courts, prevention and intervention services, a special needs diversionary program, psychoeducation and life skills, psychological and psychiatric evaluations and services;

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- Behavioral health and trauma treatment; and
 - Specialized treatment, such as substance abuse.

Approximately 22,300 youth are on county supervision with less than 1.5 percent of referrals resulting in commitment to TJJD. Youth are committed through a court order of the juvenile court and only the most serious and/or chronic offenders are committed.

Regarding behavioral health, on the state level, during the orientation and assessment phase, juveniles have a suicide risk screening, a psychological/psychiatric evaluation, and a drug/alcohol assessment. TJJD youth are placed in state-level correctional facilities according to risk, treatment needs and proximity to home.

TJJD manages five secure correctional institutions and eight medium restriction halfway houses for a gradual transition home. TJJD also has contracts with 10 facilities where youth can be placed with three of those ten being secure facilities.

All five of the state secure institutions have mental health and alcohol/other drug treatment programs and employ full-time psychologists. Youth have access to psychiatrists in person or via telemedicine. Medication management for low needs youth is provided at all facilities. The McLennan Residential Treatment Center (MRTC) provides services for youth with high mental health needs. MRTC and the Ron Jackson facility have crisis stabilization units (for youth with unstable mental illnesses who are also dangerous to themselves or others).

TJJD's goal with the mental health treatment program is "to stabilize any acute mental health issues and teach youth techniques to manage their mental health issues as they reintegrate into the community."

TJJD offers both high and moderate intensity alcohol or other drug (AOD) treatment. Treatment may include psycho-educational classes, short-term treatment, supportive residential programs, and a relapse prevention program. Evidence-based strategies and curriculum are provided by appropriately licensed clinicians.

Regarding continuity of care upon reentry to the community, TJJD provides the youth with 30 days of prescription medications and assists them in enrolling in health care coverage. Youth with psychological and psychiatric services may be referred to the Texas Office on Offenders with Medical or Mental Impairments (TCOOMMI) and LMHAs if needed for continued services.

For youth with serious emotional disturbance, TJJD staff talk with families about the Youth Empowerment Services (YES) waiver program, one of the DSHS programs.⁵³

Best Practice Example in Juvenile Justice

A best practice presented on the county level discusses the COPE program utilized in Juvenile Court in Travis County.

"The primary purpose of Juvenile Court is to protect public safety, necessitating effective holistic interventions to meet the needs of juvenile-involved children and their families...An absence of treatment may contribute to a path of behavior that includes continued delinquency and, eventually, adult criminality...Effective assessment and comprehensive responses to court-involved juveniles with mental health needs can help break this cycle and produce healthier young people who are less likely to act out and commit crimes."

According to Travis County Juvenile Justice, "NAMI estimates that 70 percent of youths in the juvenile justice system have at least one mental health disorder with at least 20 percent experiencing significant functional impairment from a serious mental illness...Without the appropriate treatment and prevention, these juveniles will continue to cycle through the juvenile justice system. This frequent interaction with the criminal justice system can be detrimental to both the individual and their family, while also detracting from the public's safety and government budgets."⁵⁴

"While up to 34 percent of children in the U.S. have experienced at least one traumatic event, between 75 and 93 percent of youth entering the juvenile justice system annually in the U.S. are estimated to have experienced some degree of trauma." Impact of traumatic exposure shows to cause behavioral disorders, depression, anxiety, substance use disorders, school problems/truancy, suicide attempts, etc.

Mental health assessments, psychological evaluations, and substance abuse assessments are important to identifying early who needs services and then the services that are needed. This allows going beyond the behavior generating the referral and determining the potential problem. Residential services programs and interventions for the individual program plan include:

- Individual and family therapy;
- Academic and vocational training;
- Extracurricular activities;
- Reentry/aftercare planning; and
- Specific to individual needs intervention.

The Travis County's Juvenile Mental Health Court's (JMHC) purpose is to divert children with significant mental health or trauma issues from initial or deeper penetration into the juvenile-justice system by avoiding first-time adjudications, subsequent adjudications, and out-of-home placements by:

- Providing community-based, youth- and family-focused services;
- Building on youth and family strengths; and
- Supervision and tracking as needed.

In an effort to divert youth from the juvenile justice system, current programs include COPE, a pre-adjudication program, and Special Needs Diversionary Program (SNDP) which is a post-adjudication program.

COPE (Collaborative Opportunities for Positive Experiences) was Travis County's initial Juvenile Mental Health Court; the first JMHC in Texas, and the first pre-adjudication JMHC in the U.S. Judge Hathaway discussed that the initial COPE funding was through a grant in 2006 in

the amount of \$200,000 and also by some later grants. However, when the grant funds were utilized, the county considered the program effective and allocated funds to continue and to further grow the program.

The Judge also discussed being innovative and utilizing the resources available. The meetings are informal and are not called hearings; they meet every three to six weeks to discuss the treatment plan and ensure the delivery of treatment services. When he first started working with the COPE program, he wanted to work with the family and not just with the juvenile offender, but he was advised that the funding was restricted to youth. He was able to coordinate with the county's Community Resource Coordination Group (CRCG)⁵⁵ for wraparound services and began working with the families. (CRCGs are accessible to every county.) For more complex cases and aftercare services, working with the YES waiver program through DSHS is a potential resource.

A study has found that JMHCs are "an effective alternative to placement in psychiatric and detention facilities; they reduce recidivism rates among juveniles suffering with mental illness; they are an effective and efficient use of public resources; and they provide participants and their families with the essential skills and resources they need to move toward success."

COPE participated in FEDI (Front-End Diversion Initiative), a program that concentrates on the use of specialized juvenile probation officers at the point of intake to divert youth with suspected mental health needs by connecting them and their families to community resources. Preliminary data suggest that FEDI has increased access to needed mental health services while reducing further involvement in the juvenile justice system. Four local juvenile probation departments in Texas have been involved.⁵⁶

Challenges

- Early identification. In schools, attendance, graduation rates, and entire environments are affected by mental health and behavioral health issues. Identifying and addressing mental health issues early and coordinating efforts and utilizing proven programs throughout the state, can impact children in foster care, children impacted by trauma, and may help to reduce the school-to-prison pipeline.
- Mental health professionals inform that the earlier in time a mental health disorder is assessed and treated the greater the chance for successful medical intervention. Mental health professionals inform that the overwhelming number of mental health conditions manifest in childhood; thus, early childhood intervention is the key to reducing many of the issues the state is trying to remedy on the adult end, such as jail diversion, etc.
- A vast chasm and disconnect exists between mental health professionals and educators/administrators. While there are some excellent models of collaboration between mental health professionals and educators, there is a genuine disconnect in serving public school age children with mental health issues. Factors are many: the two professions speak different languages and jargons, e.g. behavioral health for educators means a disciplinary issue whereas mental health providers define the term of art as including co-concurrent mental health and substance abuse disorders.

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- In the 82nd Legislative Session, Mental Health First Aid (MHFA) was created to provide mental health training for public school personnel via LMHAs. The program has not been widely utilized, and data kept by DSHS does adequately inform as to what ISDs are utilizing the program and what categories of public school personnel have attended the training course. Effectiveness varies among the LMHA regions. Feedback from school superintendents is that there is no state stipend for travel and the course requires the entire day away from school.
 - TEA receives no direct state mental health funding, and thus, is not statutorily a member of the Texas Behavioral Health Coordinating Council.
 - More students could benefit from early intervention programs if local school districts were encouraged to create these specialized programs.
 - Support for the TWITR Project was initially provided by a criminal justice grant via the Governor's Office. That grant term ended August 31, 2016. Provide funding to sustain and expand utilization of the program to additional rural counties and other Health Science Centers.
 - Psychologists are not accepted as in-network providers with all private and government insurance companies and organizations in the area in school environments.
 - Foster care children are not timely evaluated for mental health. CPS generally does not require mental health assessment until 30 days within the system.

Recommendations

- Require at least annual mental health screenings during Texas Healthy Steps visits.
- Review creating a psychiatric and adolescent psychiatric innovation grant that will allow medical schools to create psychiatric and adolescent psychiatric programs to increase the number of physicians in these areas of practice.
- Develop referral networks that link non-mental health providers and parents to child mental health treatment specialists (depending on the progress of integrated care, as the design of blending primary care and mental health in single sites, would eliminate most referral networks). The all-too-common practice of giving a parent of a mentally ill child a phone number would be unacceptable for any other serious condition, such as hearing deficit or diabetes.
- School-age children see varied school employees on a near daily basis. Improve the access to MHFA so that mental health illness signs can be recognized as early as possible to allow for early intervention.
- Promote integrated care practices as integrated care supports mental health affect physical health. The two are intertwined in childhood in ways that require us to treat the whole child.
- Review MCOs and their non-flexibility of payment models being not timely/available for innovative programs and for too much time being spent by providers for prior authorizations on medications. Consider allowing ISDs to contract with MCOs to receive reimbursements from Medicaid for treatments.
- Link crisis mental health networks to first responders, emergency departments, and hospitals; immediate continuity of care to prevent declines after discharge.
- Link family support services to providers working with higher risk child populations.

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- Establish specialized service networks for children with serious or co-morbid conditions -
- there are varying degrees of severity.
 - Expand on best practice programs such as ones located at Elgin ISD, Hutto ISD, and Austin ISD for early intervention. Children who are affected by mental health issues are less likely to perform well in school, and early intervention will help for the long-term.
 - Restructure mental health first aid (MHFA) to address concerns about DSHS not knowing statistics regarding the breakdown of which regions, which schools, and the specific personnel benefiting from the courses offered through the LMHAs.
 - Require OSARs to interact with public schools and increase services for youth with mental health and/or substance abuse needs.
 - Statutorily include TEA as a member of the Texas Behavioral Health Coordinating Council and identify the programs and amounts of indirect funding for mental health to TEA and other state agencies.
 - Currently, classroom teachers must complete 150 clock hours every five years. School counselors, learning resource specialists/librarians, educational diagnosticians, reading specialists, master teachers, superintendents, principals, and assistant principals must complete 200 clock hours every five years. However, except for a single hour required on suicide prevention, there is no hour required on how to spot a potential mental health condition. Dyslexia CAPE training is required for educators who teach students with dyslexia. Increase the one-hour suicide prevention requirement to 3 hours of training on mental health discussion. Fund the LMHAs to provide such training at a local ESC where educators attend many times throughout the year. In other words, teach in the environment they are naturally comfortable thereby further breaking down barriers.
 - Establish and fund a Texas Center on Mental Health in Schools, similar to the Texas School Safety Center at Texas State University in San Marcos.
 - Expand the role and funding of the Texas Behavior Support Network within Region 4 Education Service Center (ESC) to include training and support to all school districts statewide on the effects of trauma, school-based trauma-informed practices, and integrating mental health training and services into a positive behavior interventions and supports (PBIS) framework.
 - Statutorily authorize ISDs to contract with LMHAs for providing mental health services on their campuses and to contract with the MCOs to receive reimbursements from Medicaid for treatment.
 - Provide funding to sustain the TWITR project and to expand the program to additional rural counties and other Health Science Centers.
 - In school environments, accept psychologists as in-network providers with all private and government insurance companies and organizations in the area, as allowing campus-based mental health providers to be designated as in-network will increase access to much needed services.
 - Consider requiring all foster care children to receive a mental assessment within 72 hours of being placed in foster care and then require that the children receive the necessary treatment as indicated by the mental health assessment. Provide a mental health medical home during permanency planning for foster care children that have mental health issues. Ensure that there is an integrated care for physical and mental health care. The model is the Rees-Jones Center for Foster Care Excellence at Dallas Children's Hospital. Require

that CPS coordinate with the child's mental health care givers regarding all aspects of placement, transition planning, and permanency. Consider revising policy to include participation by a child's actively treating medical team and mental/behavioral health treatment team in Primary Medical Needs staffing calls. Provide for a continuum of mental care when the child ages out of the foster system via mental health care at LMHAs or Health Science Centers.

- Judge Hathaway spoke of bringing in families and not just the juvenile offender for the meetings and treatment plan discussions. Children who go back into the same environment will likely continue the same actions. Review funding allocated to juvenile programs and consider making more flexible to utilize for enhanced family involvement and not be exclusively for the juvenile offender.
- Require recognition and utilization of resources available; Judge Hathaway mentioned that every county has access to a CRCG – so such resources could potentially be relied upon more for wraparound services as an example.

PUBLIC HEARING #3: Mental and Behavioral Health Services and Treatment Access, Continuity of Care, Coordination, and Workforce

The third public hearing related to mental health focused on testimony by physicians and other mental health care providers regarding services, the delivery thereof and on workforce challenges. The hearing was held on April 27, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Jeff Bullard, MD, Texas Academy of Family Physicians
Kirk A. Calhoun, MD, The University of Texas Health Science Center at Tyler
Stephen Glazier, MBA, FACHE, The University of Texas Harris County Psychiatric Center
John Hawkins, Texas Hospital Association
Ardas Khalsa, Texas Health and Human Services Commission
Thomas Kim, MD, Texas Medical Association
Jeffrey L. Levin, MD, MSPH, The University of Texas Health Science Center at Tyler
Jair Soares, MD, PhD, UT Health Science Center at Houston;
Rebecca Teng, MD, Texas Association of Obstetricians and Gynecologists
Kari Wolf, MD, Seton Health Care Family (representing psychiatric emergency room physicians)

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The committee was charged to review mental health / behavioral health services regarding early identification, crisis intervention, access to care, continuity of care, coordination of services related to an integrated system of care, and the delivery of care to the diverse populations and regions of Texas. The committee was also charged to review workforce challenges and identifying ways in which the delivery of services may be improved.

These discussions began in Public Hearing #3 and were continued in Public Hearing #4.

Background

Access to care, continuity of care and coordination thereof, and a sufficient workforce are subject matters of high interest in mental health care discussions, especially as more and more individuals are being diagnosed with a mental health illness and the gap between care providers and individuals needing care is widening.

In the past, individuals in a mental health crisis were typically taken by law enforcement either to jail or to a hospital emergency room. Today, intervention services and diversion programs are in place for assessment and treatment and are located in many communities across the state.

A multi-disciplinary field of mental health professionals provide care to individuals with mental health illnesses, and care is provided in numerous and diverse settings. Professional mental

health care providers include psychiatrists, primary care physicians, nurses, physician assistants, psychologists, counselors, and social workers. Settings include care in hospital emergency rooms, psychiatric hospitals, doctor's offices, clinics, and via telemedicine. Insurance claims, however, are often denied because mental health services have been rendered but are not covered.

Mental health illness covers a heterogeneous group of diseases. The most common mental illnesses include:

- ADHD (Attention Deficit Hyperactivity Disorder);
- Anxiety Disorders;
- Autism;
- Bipolar Disorder;
- BPD (Borderline Personality Disorder);
- Depression;
- Dissociative Disorders;
- Eating Disorders;
- OCD (Obsessive-compulsive Disorder);
- PTSD (Posttraumatic Stress Disorder);
- Schizoaffective Disorder;
- Schizophrenia; and
- Substance abuse.⁵⁷

Statistics

Regarding national primary care psychiatry:

- 80 percent of antidepressants are prescribed by primary care providers (PCPs);
- Depression goes undetected in approximately 50 percent of depressed individuals;
- Only 20-40 percent of people cared for by PCP's in depression have substantial improvement in six months;
- Over half of PCPs report difficulty finding behavioral health referral sources; and
- Only half of the people referred to a mental health professional follow-through with the referral (in large part due to stigma issues).⁵⁸

The impact of mental disorders includes:

- Untreated mental health paired with chronic disease results in higher morbidity rates;
- Patients with anxiety go to the ER or physician offices 3-4x more; and
- Treatments of mental illness are effective 60-80% of the time.⁵⁹

Costs of mental health illness - mental illness is the leading cause of disability.

- Someone depressed is 7 times more likely to be unemployed;
- Those employed lose 5-6 hours of productive time per week because of slower processing and taking longer to accomplish things; and
- A reduced life expectancy.⁶⁰

Providers

Physicians in Private Practice or in a Hospital

Family physicians, psychiatrists, and hospitals realize the significant interface between the physical health and the mental health of an individual and acknowledge the benefits of integrated care, or treating the whole person. Much emphasis is placed on the need for more integrated resources in a clinical setting in the community and better discharge planning between parties. They acknowledge the stigma of the illness and stress that parity continues to be unrealized. They are also proponents of early identification and telemedicine.

As a psychiatrist and provider of care in hospital settings, including in emergency rooms, Dr. Wolf noted that three mental health groups typically visit emergency rooms: ones with chronic mental illness, ones with anxiety, and people who do not know where to go for services. She advises that patients with depression and anxiety are clogging up emergency rooms and primary care clinics.

She comments that patients should have a follow-up visit within a week after discharge from an emergency room, but a lack of service providers sometimes pushes this time frame to as much as three months, especially in relation to services with the LMHAs. She comments that some states have opened up funding to other providers in addition to the LMHAs.

Dr. Wolf encourages investing upstream and not waiting for crises and advises that a focus on prevention, early identification, access to outpatient care, and outpatient care can make a difference. Her testimony includes that pre-1115 Waivers, inpatient psychiatric beds in the community were full and patients were in the emergency room in emergency detention until an inpatient psychiatric room became available, usually between one and seven days. She emphasizes that emergency rooms are the most expensive arm of health delivery and most mental health patients do not need to be there.⁶¹ Under EMTALA, regardless of ability to pay, hospitals must provide behavioral care to treat and stabilize, but hospital emergency rooms may not have the right expertise or medication for mental health matters.⁶²

Some hospitals have opted to now also have separate emergency rooms or areas just for psychiatric patients. In these situations, Dr. Wolf references that the benefits of a psychiatric emergency room are more than just the provider; the environment also makes a difference. Her example entailed a patient contained in a regular emergency room which escalated the individual's agitation; when transferred to a psychiatric emergency room the individual was allowed to pace to control the agitation.

Specifically regarding payments through managed care, Dr. Wolf advises that her employer subsidizes payment for the Medicaid population and that payments are "nowhere close to breakeven."

In response to a question specifically regarding psychologists being allowed to prescribe medications, Dr. Wolf discussed that mental health treatment is a multi-disciplinary practice and everyone needs to practice at the top of their license. She also states that the issue is related to the

fact that a psychiatrist has four years of medical school which provides an understanding of physiology and pharmacokinetics; mental health professionals who are not physicians do not have the understanding of the interactions of how the brain is connected to all of the other organs in body. Initially the thought was that "psych" drugs were benign and safe as there was limited understanding of the drug/drug interactions, but this thought has changed with more understanding of medicines.

She stressed that the complimentary roles need to be recognized, and identified psychologists as excellent with safety assessments and level of care assessments, and excellent in preventive, resiliency, and cognitive behavioral therapy services.⁶³

In his testimony, Dr. Bullard, a family physician, depicts a patient and how a physician having knowledge of mental health issues up-front makes a difference in an initial office visit. He is a proponent of embedding mental health professionals in clinical practice settings, but says that claim payments must be available. He would like to eliminate the "carve-out" mentality. His practice's zip code is saturated with mental health providers and this affects billing capabilities as mental health care workers cannot get credentialed for billing purposes. He also references stigma related to mental health and that patients do not want to park in front of a mental health facility but will seek treatment at a clinic.

Dr. Bullard comments about differences in coordinated, co-located, and fully integrated care. Issues include the exchanging of information and he stresses that the communication gap needs to close. For referrals, creating registries of mental health care providers would help, although many providers are cash only and do not accept insurance. He has a counselor in his practice, but if insurance does not pay for the services, the services become cash based and billed to the patient.

He further comments that with more of an integrated approach to patient care, patients receive better care, and providers are happier with the results.⁶⁴

Dr. Bullard says that anxiety is the most common mental health illness addressed by family physicians.⁶⁵

Mr. Hawkins, with the Texas Hospital Association, discusses the transitioning from fee-for-services (separate payments for varied services) to managed care, preventive care and community based services (bundled, integrated models). He stresses the need for the system to reinvest the managed care savings into a payment system that provides the right incentives for care providers. "Hospitals" are now health systems and collaborate with community partners.

Mr. Hawkins further states that the reality is that depending on where one is, Texas is different and all communities have different needs, so although the state may be funding programs appropriately in certain areas, the service delivery system may not be built for the best use of those resources.

Examples of Innovative DSRIP Projects by Hospitals

- Memorial Herman Northwest Hospital is currently expanding home health services to include psychiatric services. The goal is to provide care to patients with mental health issues in a home and community-based setting, and in turn, reduce ER visits.
- DeTar Hospital Navarro is currently providing the first intensive outpatient program for behavioral health patients in Victoria County, thereby decreasing the likelihood that those patients will only obtain treatment through the ER.
- John Peter Smith Hospital's project will provide telemedicine services by linking psychiatrists to 1,802 primary care providers in Region 10.
- Christus Spohn Corpus Christi is relocating the psychiatric assessment unit from the hospital to the Hector P. Garcia facility. The relocation will allow them to pool resources and better service patients' behavioral health care needs, thus reducing ER visits.⁶⁶

Dr. Teng stressed the importance of recognizing and treating postpartum depression. Postpartum depression (PPD) is not just the "baby blues," which affects as many as 85 percent of new mothers. PPD is a persistent and debilitating form of depression that occurs soon after delivery up to as much as a year afterwards and is serious and potentially fatal when left untreated.⁶⁷

Specifically regarding telemedicine, Dr. Kim, an internist and psychiatrist, stressed that with limited workforce resources, telemedicine offers additional options needed for the many varied communities in Texas. Regarding billing, however, he comments that he has to go to "rural provider poor areas," health provider service areas (HPSA) and nonmetropolitan statistical areas, to be reimbursed for services; he feels that if reigns are loosened on telemedicine regarding this geographic limitation, more residents may be interested in entering the psychiatry field.⁶⁸

According to Mr. Hawkins, much disinformation exists about what is or is not allowed by state regulations regarding telemedicine.⁶⁹

Dr. Kim's message regarding parity is that: mental health care provider services should be optimized not considered a cost to avoid. He stresses that creative thinking is needed for new models of care.⁷⁰

Workforce and Provision of Care

Addressing Workforce and Research of Mental Health

UTHealth Northeast, The University of Texas Health Science Center at Tyler and The University of Texas Health Science Center at Houston, UTHealth, are each appropriated funds by the Texas Legislature for direct expenditures regarding mental health and each have representation on the Behavioral Health Coordinating Council. Both entities were invited to testify regarding the utilization of these appropriated funds.

UTHealth Northeast

Dr. Calhoun with UTHealth Northeast discussed that separating physical and mental health "makes no good sense." For individuals with mental illness, the costs for care increases and life expectancy lessens; when substance use disorder co-occurs, the costs are higher and life expectancy further lessens.

UTHealth Northeast is the only academic medical center in northeast Texas serving 1.3 million in population covering 28 counties. An estimated 85,000 individuals in the region have a serious mental illness; approximately 113,000 need treatment for substance abuse, but do not have access to needed care; and the region has a suicide rate that is 65 percent higher than the average rate for Texas (typical for rural areas).

A few years ago, no mental health was available at the hospital; they referred out. As the hospital personnel became more aware of the intensity of the matter, they began using 1115 Waiver funds to address issues. UTHealth Northeast also received, through a "special item" appropriation from the legislature of \$8 million for the 2016-2017 biennium, funds to address the mental health concerns in northeast Texas.

Several of the DSRIP projects are in the areas of telemedicine, integrated care, crisis stabilization units and expansion of services to underserved populations. The 1115 waiver behavioral health projects in RHP 1 account for 30 percent of projects valued at \$78.5 million over 5 years .

Additionally, UT Northeast is partnering with DSHS to improve mental health services. In March 2013, a 30 bed residential unit was opened to provide mental health services and alleviate overcrowding at state mental facilities. In September 2014, a 14 bed acute care unit was opened to provide additional beds to the state to provide better care for patients in acute mental illness crisis. Also, in September 2014, a 21 bed geriatric psychiatric inpatient unit was opened to treat elderly patients with mental illness. Additionally, for patients requiring commitment hearings, a tele-court room into the county judge's office has been created on campus; thus, no transportation is needed.

These facilities relieve the demand on emergency rooms and space for the state hospitals, and time spent by law enforcement who need a place for an individual in a mental crisis.

To support its integrated care effort, UTHealth Northeast is integrating mental health services into UTHealth primary care clinics and embedding nurse practitioners into the LMHAs to provide physical care services.

UTHealth Northeast identifies patient payment issues, especially with same day/same location visits, and payment rates as ongoing challenges.

In a discussion regarding drug costs, Dr. Calhoun says that one of the biggest problems and high cost areas are drugs; staff members want to utilize the most modern drugs, as typical drugs tend to be sedating and have other side-effects. However, upon release, the individual often is not able to obtain the same drug in many cases, due to cost, and just stops taking the needed medication, which places him/her back into crisis.

The \$8 million for the 2016/17 biennium has permitted the development of mental health workforce training programs for rural and underserved areas and has allowed doubling the size of the clinical psychology internship program (now 6 psychology interns); recruitment of two board certified child psychiatrists with other faculty positions being recruited; and deployment of technology and telecommunication infrastructure to connect UTHealth Northeast to Rusk State Hospital; allowed expansion of rotations to Rusk State Hospital; and in 2017, the psychiatry residency program on campus will be established which will be 24 when fully populated.⁷¹

UTHealth Houston

UTHealth Houston was appropriated \$12 million as a "special item" for the 2016/17 biennium for spending directly related to mental health matters. Faculty recruitment from 2014-2016 has included 16 research faculty members, 7 MD clinician researchers, 4 PhD research faculty, 5 PhD clinical psychologists; 16 postdoctoral researchers; and 6 research coordinators.

"Special item" new programs include: early psychosis research, fMRI laboratory, psychologist's intervention research program for mood spectrum disorders, post-traumatic stress disorder program, center for molecular psychiatry, center for experimental models in psychiatry, UTHealth trauma and grief center for youth, psychology intern training program, psychiatric genetics program, brain bank program, and a geriatric research program.

During 2014-2016, UTHealth Houston has published 432 articles in peer-reviewed journals, and submitted 82 grant proposals. Research activities include deep brain stimulation, psychiatric genetics (biomarkers), and some piloting innovation in trauma and grief center for youth, standardized trauma assessment tools, and early diagnosis and treatment of psychosis.

UTHealth is directly affiliated with the Harris County Psychiatric Center (HCPC), a 276 bed acute care psychiatric hospital and the second largest academic psychiatric hospital in the country. HCPC is jointly owned between the state and county, is operated and staffed by UTHealth Department of Psychiatry, is a teaching hospital, and is funded primarily by the state through a contract between UTHealth and The Harris Center, the LMHA.

Three key challenges HCPC identified in mental health services are workforce shortages, lack of integration of substance abuse and mental health services, and gaps in the continuum of care.

Regarding the continuum of care gap, Mr. Glazier with UTHealth HCPC discusses that chronic recidivism and rapid re-admissions to acute care hospitals, the most expensive forms of care, are two of the consequences. The over reliance on acute inpatient care drives costs up and results in less than optimal outcomes including, super-utilizers (individuals with 4+ admissions per year) equals 1,244 admissions and costs HCPC over \$5 million; rapid re-admitters (readmissions

within 30 days) equals 1,207 patient days and costs HCPC over \$5 million; and discharges to shelters are 2,910. That gap also over-utilizes law enforcement and jail services.

These issues continue in part due to persons receiving needed care in programs only to relapse once released because of the lack of step-down programs within the continuum of care. When released from a facility or program, persons typically receive medication for "X" days. When that medication is depleted, the person is responsible for refills, but may choose not to or may not understand how to navigate the system.

To address the continuum of care gap, Mr. Glazier states that the most severe and persistently mentally ill patients need to be treated in a continuum of progressively less intensive and less restrictive forms of care. Specifically, to address the continuum of care gap for the Houston area, the suggestion is for 299 additional beds distributed to cover hospital based short- and long-term sub-acute patient care and community based residential treatment, crisis respite housing, and supported housing.

The anticipated outcomes for this type of continuum of care program include:

- better patient outcomes;
- reduced demand on law enforcement and jails;
- reduced demand on psychiatric emergency intake systems;
- cost savings from reduced utilization of higher level services;
- reduced waits for beds;
- movement towards less restrictive, less costly, more community-based levels of care;
- treatment of patients in their own communities;
- moving of the infrastructure towards value-based reimbursement;
- evaluation of clinical and economic outcomes; and
- replicable model in urban areas significantly reducing the demand for typical state hospital services and the reduction of utilization and faster throughput for psychiatric patients in hospital emergency rooms.⁷²

Challenges

- Workforce shortages. A majority of Texas counties are designated as Mental Health Professional Shortage Areas, and many have no psychiatrist. However, the shortfall is not limited to just psychiatry. Universities and care providers are studying and implementing ways to address the shortfall in the workforce.
 - Too few mental health (MH) professionals, especially child mental health providers.
 - Too few nurses going into mental health, in part, because nursing curriculum is physical health centered.
 - Too few mental health professionals in rural and frontier areas.
- Postpartum mental health. Increased postpartum mental health assessments are needed to permit more women to receive the assessment and treatment, including interconception care.

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- Lack of continuum of care causes overutilization of emergency rooms, law enforcement, and jails.

Recommendations

- Review creating a psychiatric and adolescent psychiatric innovation grant that will allow medical schools to create psychiatric and adolescent psychiatric programs to increase the number of physicians in these areas of practice.
- Provide grant funding to nursing and medical schools to address the workforce shortage.
- Increase number of psychiatry residency slots.
- Realize potential of each of the varied mental health professionals, and increase utilization accordingly. Review allowing such professionals to practice to the full scope of their authority and knowledge.
- Provide loan forgiveness for varied mental health professionals who practice for 4 years in rural and frontier areas.
- Amend Medicaid rules to allow Masters of Social Work to be reimbursable service providers.
- Increase service provider rates in rural regions.
- Increase the use of telemedicine-psychiatry especially in rural and frontier areas, including use the school and criminal justice settings. Example is Telemedicine Wellness, Intervention, Triage and Referral Project (TWITR) of The F. Marie Hall Institute for Rural and Community Health at TTUHSC.
- Provide additional funding to address post-partum care. Increase the length of treatment to one year after the date a woman gives birth to her child. Consider allowing pediatric providers to conduct and bill for post-partum screenings.
- Provide funding for continuum of care programs to further enable programs to have a long-term effect.
- Review and address capacity needs for growing forensic commitments.

PUBLIC HEARING #4: Mental and Behavioral Health Services and Treatment Access, Continuity of Care, Coordination, and Workforce

The fourth public hearing related to mental health focused on some best practices of certain LMHAs and on services provided by various mental health care professionals and was held on April 28, 2016 at 9:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Terry Crocker, MBA, MA, Tropical Texas Behavioral Health
Sharon K. Cunningham, LPC-S, NCC, Texas Counseling Association
Carson Easley, BSN, MS, RN, Texas Nurses Association
Will Francis, LMSW, National Association of Social Workers - Texas
Catherine Judd, MS, PA-C, CAQ Psychiatry, DFAAPA, Texas Academy of Physician Assistants
Beth Lawson, Sunrise Canyon Behavioral Health Network
Gregory Simonsen, PhD, Texas Psychological Association
Cindy Zolnierek, PhD, RN, Executive Director, Texas Nurses Association

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The fourth public hearing was held as a continuation of Public Hearing #3 for the review of mental health / behavioral health services regarding early identification, crisis intervention, access to care, continuity of care, coordination of services related to an integrated system of care, and the delivery of care to the diverse populations and regions of Texas. Also, the hearing was held to review workforce challenges and to identify ways in which the delivery of services may be improved.

Providers and Services

Best Practices by LMHAs

Tropical Texas Behavioral Health (TTBH) is the LMHA and IDD authority for Cameron, Hidalgo, and Willacy counties. TTBH found that their patients, who had chronic and co-morbid medical conditions, were unable or unwilling to access primary care services in the community. TTBH decided to establish primary care clinics inside mental health clinics; two were funded through the 1115 Waiver program; one was funded through Methodist Healthcare Ministries. Recognized advantages of integrated care and being co-located include, "warm-handoffs" from mental health care providers to primary care providers and with all providers utilizing the same electronic medical records and good communications capabilities. An example case showed that upon providing cross-services to a person presenting with diabetes, high triglycerides, obesity and schizoaffective disorder, the person's physical test results improved dramatically. TTBH advises that they serve more children than any other LMHA in the state.

Challenges expressed include growth in demand for services, clinical staff resources, over-capacity, sustainability of programs, and quantifying value across the system.

Although not exclusive to TTBH, another program discussed concerned a mental health officer program. For TTBH, this program is funded through the 1115 Waiver program. The program provides funding for 17 law enforcement officers to cover the 3000 square mile, three county region, 24/7/365. The officers are assigned through memorandums of understanding to the mental health center. Duties of these officers include: responding to individuals in mental health crisis, welfare checks, and assisting Mobile Crisis Outreach Teams (MCOT) when needed; providing transportation; decreasing preventable admission/readmission to criminal justice; decreasing utilization of local hospital emergency rooms; and intervening when requested in mental health situations with other members of law enforcement.

The challenge expressed is sustainability of the program at a cost of approximately \$1.7 million annually.⁷³

StarCare Specialty Care Health System (StarCare) is the LMHA for Lubbock, Lynn, Crosby, Cochran, and Hockley counties. StarCare is the only LMHA that operates an inpatient psychiatric hospital. Sunrise Canyon is the name of their hospital and affiliated services include a full range of non-emergent access into care and emergent/crisis and inpatient psychiatric services. According to Ms. Lawson, these services are possible because "StarCare and other community leaders had the foresight to envision a community psychiatric hospital as a part of an entire continuum of care to meet both crisis/acute and non-crisis/ongoing needs.... The success of Sunrise Canyon's community-based hospital model hinges upon local collaborations, which result in substantial local benefits." The community partners include: the Lubbock County Hospital District, the Lubbock County Judge, Institutions of higher education, law enforcement and the city of Lubbock which donated the land on which the buildings sit.

The continuum of care/system array includes: Outreach, screening, assessment, and referral (OSAR) services; Non-crisis services, including outpatient services, rehabilitative services, targeted case management, peer services, as well as veterans' services; and crisis services, including a crisis hotline, mobile crisis outreach (MCOT), 23-hour extended observation services and inpatient psychiatric services, along with the associated aftercare.

Challenges expressed include, system strain, forensic involvement, recruitment and retention of medical professionals, regulatory barriers, being a state mental health facility diversion site, and some unique challenges because they operate a psychiatric hospital.⁷⁴

Mental Health Professions (non-physician)

Numerous licensed, registered, and certified professions are involved in the care for individuals with mental health illness, with addiction issues, affected by abuse, and with a disability. Regulations allow some to provide direct treatment care; others are more limited. The professions invited to testify included:

- Social Workers;
- Counselors;
- Nurses;
- Physician Assistants; and
- Psychologists.

These behavioral health professionals work in varied environments including in schools, criminal justice, LMHAs, medical clinics, hospitals, and private practice.

Social Workers

Texas has 23,000 social workers. Nationally, social workers make up 60 percent of all mental health providers. The practice requires knowledge of human development and behavior, of social, economic and cultural institutions, and of how these areas intersect. Social workers work with individuals, families, and groups to prevent and respond to crises and to enhance capacity for social functioning. Many are involved in child welfare services.

Social workers have three main levels of licensure (Licensed Clinical Social Worker (LCSW), Licensed Masters Social Worker (LMSW), and Licensed Bachelor of Social Work (LBSW)) and in Texas, are regulated by the Texas State Board of Social Work Examiners. LBSWs perform service coordination and referrals to community resources; LMSWs are involved in assessment and care related to case management and evaluations. LCSWs are authorized by The Center for Medicare/Medicaid to practice independently and are authorized to practice autonomously in Texas. One hundred seventeen counties in Texas do not have a LCSW.

Social workers have title protection and must have a degree from an accredited university and be licensed to be called a social worker. The United States has no licensure reciprocity around social work, and Texas does not have any agreements with other states. The reciprocity issue is currently being addressed nationally by the Association of Social Work Boards (ASWB). The ASWB writes the licensing exam for most of the states, and although there are requirements among the states, many of the details are largely technical. Canada recently adopted reciprocity among their provinces.

An example of a social worker providing services in a criminal justice setting is Harker Heights where the Chief of Police hired a social worker to work within the department to offer "a needs response" and not wait to be called for a "crisis response" at locations where police were frequently called.⁷⁵

Licensed Professional Counselors

Licensed Professional Counselors (LPCs) in Texas work directly with persons with mental health illness including depression, anxiety, PTSD, and suicidal ideation. The lack of parity for insurance coverage (or enforcement thereof) and a lack of consistency of what services are allowed by the various health plans are challenges for LPCs and their receiving payment for services rendered. Some insurance providers pay below the Medicaid rate. Additional challenges include LPC interns are not allowed to bill under the Medicaid program for services, the Medicaid reimbursement rate is not consistent across the board for mental health professionals (currently at 70 percent for LPCs); and reimbursement rates are not standard across all health insurance providers.⁷⁶

Registered Nurses

All registered nurses receive education and clinical training caring for persons with mental disorders; psychiatric/mental health nurses (PMH) identify this area as their primary population of focus. Additionally, PMH Advanced Practice Registered Nurses (APRNs), including nurse practitioners and clinical nurse specialists are prepared with graduate degrees and advanced education in the diagnosis and treatment of mental disorders, including the prescribing of therapeutic medication. PMH nurses practice in varied clinical settings including, crisis intervention and psychiatric emergency services, acute inpatient care, intermediate and long-term care, partial hospitalization and intensive outpatient treatment, residential services, community-based care, and assertive community treatment.

In 2015, Texas had 286,442 registered nurses; 7517 advised working in psychiatric/mental health/substance abuse practice settings; 545 were APRNs. Nursing shortage is expected to more than triple from the deficit of 17,000 in 2015 to over 66,000 in 2030.

To recruit and retain nurses, the Texas Nurses Association recommends continuing the nursing shortage reduction program and extending the student loan repayment program for nurses in a PMH setting; helping to provide safe work environments by enabling state psychiatric hospitals and community mental health centers to be firearms free work environments; and continuing the Texas peer assistance program for nurses (TPAPN) to provide peer assistance to nurses who have mental health and/or substance use issues so they can safely return to practice (the funds appropriated for the nurse substance abuse program are funded through nursing fees and provide a case manager for the nurse; the monies do not pay for counseling services for the nurse receiving treatment).⁷⁷

Physician Assistants

Texas has 8000 physician assistants (PAs) with over one-half in family practice settings. According to testimony, their skill set includes being first responders as their education/and clinical training is "founded and grounded in physician like medical model of medical education closely resembling and modeling medical school content and curriculum for a physician." They have 27-43 months of training which includes pharmacology, clinical pathophysiology, clinical medicine, clinical clerkship in obstetrics/gynecology, psychiatry, physiology, anatomy, and

biochemistry. Upon completion of their training, they have essentially the same level of training as a medical school graduate. Ten percent of their national certification exam covers mental health and psychiatry related content.

Texas Academy of Physician Assistants expresses that the barrier for physician assistants being limited in the provision of mental health services in Texas has to do with the Health and Safety Code 571-000 and physician assistants not being identified as a non-physician provider of mental health services. Often, when insurance providers look at that code, they will not reimburse.⁷⁸

Psychologists

According to Dr. Simonsen with the Texas Psychological Association (TPA), Texas has 4,176 licensed psychologists, 3,009 licensed specialists in school psychology, 3,000 LSSPs in schools, and 1,041 licensed psychological associates who work under a psychologist for services. With a workforce shortage, uninsured and underinsured individuals and families end up in crisis and using "free" organizations.

Barriers to entry for becoming a psychologist include the high cost of education as the student loan debt for a PhD is \$70,000, but the salary is \$60,000; reimbursement rates are low; and psychologists are not able to practice at full capacity. Additionally, regarding student loan debt and forgiveness thereof, the playing field is not level. For example, Dr. Simonsen advised that certain zip codes cannot seek reduction in student loan debt even though the psychologist works solely with Medicaid and CHIP populations, although in the same organization and building psychiatrist residents and psychiatrists have massive debt release.

Dr. Simonsen further states that Texas:

- lacks early intervention strategies and does not consider the population and cultural diversity; one size does not fit all, but if access to care falls into one's cultural belief systems, persons and families tend to buy-in and follow-up;
- does not allow competencies of mental health practitioners to be utilized to their fullest capacity;
- should create transparency between practitioners and insurance companies regarding reimbursement rates (one needs to know information upfront from insurance companies);
- should engage in student debt forgiveness and increase grants and scholarships;
- should allow and improve access to emerging technologies teletherapy or telemedicine; and
- should utilize psychologists in integrated and behavioral health, engage underserved populations at the local level through technological assessment and educational programs.

In a discussion regarding the underutilization of psychologists, Mr. Simonsen advises that neuropsychologists are specially trained and equipped to diagnose and treat concussions but are not in plans for use in the treatment plans for secondary education and college campuses, as that role is limited to physicians; and that some psychologists are specially trained in prescription writing after two additional years of education time, but in Texas they cannot prescribe medicine.

Currently four states and the Department of Defense allow prescribing psychologists.

Psychologists are regulated by the Texas State Board of Examiners of Psychologists. To be licensed one must pass the EPPP national exam, a jurisprudence exam for laws of Texas, and an oral exam before a panel of psychological peers to ensure education and experience to interact.⁷⁹

Recommendations

See Public Hearing #3 for recommendations related to this hearing.

PUBLIC HEARING #5: Insurance Coverage and Parity and Law Enforcement

The fifth public hearing related to mental health focused on insurance and law enforcement and was held on June 2, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Ayo Afejuku, MD, Molina Healthcare of Texas
Wendy Baimbridge, Captain, Houston Police Department
John Burruss, MD, Metrocare Services
Doug Danzeiser, Texas Department of Insurance
Barbara Dawson, The Harris Center for Mental Health and IDD
Jamie Dudensing, Texas Association of Health Plans
Tamela Griffin, Texas Health and Human Services Commission
Brian Guthrie, Texas Teacher Retirement System
Gary Henschen, MD, Magellan Health
Ron Hickman, Sheriff, Harris County
Ken Janda, Community Health Choice
Chris Kirk, Sheriff, Brazos County
Debra Diaz Lara, Texas Department of Insurance
Kevin Lawrence, Texas Municipal Police Association (TMPA)
Michael Massey, MD, Baylor Scott & White
Joseph Penn, MD, UTMB Correctional Managed Care for Texas Department of Criminal Justice
Mary D. Peterson, MD, MSHCA, Driscoll Health Plan
Kim Vickers, Texas Commission on Licensing Enforcement (TCOLE)
Dennis Wilson, Sheriff, Limestone County; Texas Sheriffs Association; Texas Council of Community Centers
Porter Wilson, Texas Employee Retirement System
April Zamora, Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI)

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The committee was charged to review coverage and parity of mental health and behavioral health services by health insurance plans and to review the services provided by law enforcement and criminal justice.

Background

Insurance coverage has been a recent topic of great interest in the United States with the passage of the Patient Protection and Affordable Care Act and as medical services continue to move from a fee-for-services model to a managed care model. Specifically regarding mental health, the issue of parity, which is the provision of equal coverage for mental health care as compared to physical health care, entered discussions.

Parity is a complex issue. Generally regulations began in the 1990s with the federal Mental Health Parity Act (MHPA), expanded in 2008 with federal Mental Health Parity and Addiction Equity Act (MHPAEA) to include substance use disorder coverage, and further expanded coverage requirements with the federal Affordable Care Act.⁸⁰ In 2011, Texas implemented mental health parity regulations under the Texas Administrative Code.

However, citizens continue to advise that mental health services are not being covered under insurance plans and that in many cases they are having to pay cash for services or are not receiving services. Also, service providers continue to advise that they are unable to obtain pre-authorizations to provide mental health care or are denied payment if a claim is submitted.

*Disclaimer -- parity is a very complex issue with numerous caveats depending on the type of health care plan held, the coverage offered in the health plan, and the insurance provider. The details provided in this report provide only high level information and do not provide a complete description of the intricacies of parity rules and regulations.

Statistics from Mental Health Care Providers

- 80% of people with a behavioral health diagnosis will visit a primary care provider at least once a year;
- 50% of all behavioral health disorders are treated in primary care;
- 48% of appointments for all psychotropic agents are with a non-psychiatric primary care provider;
- 67% of people with a behavioral health disorder do not get behavioral health treatment;
- Two-thirds of primary care physicians report not being able to access outpatient behavioral health for their patients;
- Use of health care services decreased by 16% for those receiving behavioral health treatment, while it increased by 12% for patients who were not treated for their behavioral health care needs;
- Behavioral health disorders account for half of all disability days;
- Annual medical expenses--chronic medical & behavioral health conditions combined -- cost 46% more than those with only a chronic medical condition;
- Of the top five conditions driving overall health care costs (work related productivity + medical + pharmacy cost), depression is ranked number one.⁸¹

Additional statistics regarding children and mental health:

- Nearly 1 in 10 hospital admissions for children age 3-17 have a primary diagnosis of a mental health condition;
- 44.1% of pediatric primary mental health admissions are depression, 18% are bipolar, and 12% are psychosis;
- 75% of children diagnosed with mental illness are seen in primary care; half of those are treated within the primary care practice.⁸²

Insurance

Role of Texas Department of Insurance (TDI)

Issues in regulating mental health parity in insurance coverage include:

- Health insurance regulation;
- Parity regulations -- history, state and federal requirements, and compliance;
- Network adequacy; and
- Medical necessity.

Population coverage estimates in Texas for 2014 were:

- Private (Fully insured) coverage at 19 percent;
- Publically funded coverage at 25 percent;
- Self-funded coverage at 40 percent; and
- Uninsured at 16 percent.

The breakdown of the Fully insured sources in 2014 was 82 percent Employer-based profile (small employer at 41 percent; large employer at 59 percent) and Direct purchase was 18 percent.

The breakdown of Self-funded coverage in 2014 was 14 percent military, 5 percent ERS, 7 percent TRS, 6 percent FEHBP, and 68 percent other self-funded employer groups.

Types of coverage for Fully insured major medical plans in 2014 were:

- Individual major medical (HMO, PPO, EPO);
- Small and large group medical;
- Small and large employer health group cooperatives;
- Major medical plans by group hospital service corporations, approved nonprofit health corporations, stipulated premium companies, fraternal benefit societies, and reciprocal exchanges;
- Child only plans;
- Professional employer organization plans (PEOs) and multiple employer welfare arrangements (MEWAs); and
- Group health plans issued by unlicensed carriers outside of Texas but covering Texas residents.

Types of coverage by Self-funded group health plans in 2014 were:

- Local governmental employee plans (city and county employees);

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- State employee plans (ERS);
 - State university plans (UT, A&M, etc.);
 - Church employee plans;
 - Local government plans offered to the public;
 - Public school employee plans (TRS);
 - Private employer plans (ERISA);
 - Federal employee plans; and
 - Military employee plans (Tricare).

Types of coverage by Public plans in 2014 were:

- Medicaid;
- Children's health insurance program (CHIP); and
- Medicare.

TDI does not regulate most of the health plans covering citizens of Texas. Regarding parity complaints, TDI advises that the total number of complaints received in 2014 were seven with three confirmed; ten parity complaints were received in 2015. TDI acknowledges that more complaints may be received but coding may not recognize the complaint as a "parity issue."

Regarding mental health parity coverage in Texas, the state passed a bill in 1989 to address chemical dependency and then a bill in 1991 to require all group plans to offer coverage for severe mental illness (SMI). In 1996, the Federal Mental Health Parity Act (large group) was passed. The state and federal governments have continued to address parity for varied diagnoses and certain groups. The Mental Health Parity and Addiction Equity Act (MHPAEA) passed in Congress in 2008 with the regulations becoming effective in 2014. Regulations for EHB (to add individual and small groups) also became effective.

The MHPAEA:

- Extended parity to substance use disorder benefits in addition to mental health;
- Expanded parity to coverage terms related to:
 - Financial requirements, including deductibles, copayments, coinsurance, and out-of-pocket expenses; and
 - Treatment limitations, including limits on the frequency of treatment, number of visits, days of coverage, or similar limits on scope/duration of treatment; and
 - Coverage terms for mental health/substance use disorder benefits cannot be more restrictive than the predominant coverage terms that apply to substantially all of the medical/surgical benefits.

The MHPAEA requirements include:

- That plans may not impose any financial requirements or treatment limitations that only apply to mental health/substance use disorder benefits;
- If a plan covers out-of-network coverage for medical/surgical benefits, it must provide out-of-network coverage for mental health/SUD;
- Requires plans to use the same type of processes and standards to determine medical necessity and require prior authorization; and

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- Standards for medical necessity criteria and reasons for denial of mental health/SUD services must be disclosed upon request.

Federal MHPAEA rules:

- Create classifications of benefits under which parity rules apply
 - A financial requirement or treatment limit that applies to MH/SUD may not be more restrictive than the predominant requirement or limit that applies to substantially all medical/surgical benefits in the same classification:
 - Inpatient in-network; inpatient out-of-network;
 - Outpatient in-network; outpatient out-of-network;
 - Emergency; and
 - Prescription drugs.
 - If MH/SUD is covered under the plan, benefits must be provided in all classifications in which medical/surgical benefits are provided;
 - All cumulative financial requirements (e.g., deductible, out-of-pocket limit) in a classification must combine medical/surgical and MH/SUD benefits.
- Distinguishes between quantitative and nonquantitative treatment limitations and requires parity for both:
 - Nonquantitative treatment limitations include:
 - Medical management standards limiting benefits based on medical necessity, experimental/investigative status;
 - Formulary design;
 - For plans with multiple network tiers, network tier design;
 - Standards for provider admission to participate in a network, including reimbursement rates;
 - Plan methods for determining usual, customary, and reasonable charges;
 - Step therapy protocols or fail-first policies;
 - Exclusions based on failure to complete a course of treatment; and
 - Restrictions based on geographic location, facility type, provider specialty, and other criteria that limit the scope or duration of benefits for covered services.
 - Any nonquantitative treatment limit for MH/SUD benefits must be comparable to and applied no more stringently than medical/surgical limits, including with respect to the processes and standards used to apply the limit

Parity regulation utilizes a dual regulatory approach wherein, TDI reviews group health policy forms for compliance with Texas requirements (SMI, quantitative parity) and federal regulators review individual and small group policies for compliance with essential health benefits and enforce parity consistent with rules that address quantitative and non-quantitative limits.

Each health plan defines the phrase “medically necessary” in accordance with the health plan’s policies and benefits described in the evidence of coverage. TDI does not define or determine what is “medically necessary” for approval/denial of medical services. Medical necessity decisions are made through a system of utilization review, defined at TIC §4201.002(13) as “a system for prospective, concurrent or retrospective review of medical necessity and appropriateness of health care services....”

TDI reviews and approves processes and policies of certified or registered utilization review agents (URAs). TDI does not review or approve medical/clinical guidelines that these entities utilize to determine medical necessity.⁸³

Examples of Innovative Collaborative Care Programs

Dr. Burruss with Metrocare in Dallas advises that psychosis is a symptom, not a diagnosis, and if psychosis goes untreated it causes brain damage; thus, early treatment is the answer. In Texas, about 4000 people develop a new psychotic disorder every year. The disorder usually has an onset during one's teens or twenties. Early treatment has been proven to reduce symptoms and hospitalization, and increased chances of one staying in care and improving one's quality of life.

He explained and described Metrocare's First Episode Psychosis program which is based on the proven RAISE program. The program reduces symptoms and as a person stays in care over the long-term improves the quality of life by diminishing disability, incarceration and estrangement from family, and keeps one employed which helps to maintain insurance. In the long term, this program reduces the number of super-utilizers and high users of mental health services. However, he stresses the program is only effective if implemented early and fully.

When asked how much of this program is covered by insurance, Dr. Burruss responded that although Metrocare accepts all forms of insurance, paradoxically this program is more available for the indigent, less available for those covered by Medicaid, and in many cases difficult or non-existent for third party private insurance holders as the program is typically considered medically unnecessary. He noted that the hurdles of trying to receive support from insurance companies has been difficult.

He further stated that by not providing care at the first sign of symptoms is an injustice to 3900 young people who develop conditions every year where services are not covered to address the condition in its early stages; one would expect insurance to provide full and thorough care for a knee or other physical injury.

Specifically regarding Medicaid coverage, due to waivers in Medicaid services Metrocare has been able to create some interventions by working through issues with the payer. Dr. Burruss continues that, in general, many MCO programs are more ready to support treatment than third party insurances because of an insurance company considering the treatment "not medically necessary" and the inability to obtain preapproval/prior authorization. He compares follow-up services to a rehabilitation program for a stroke patient, but in mental health care, the treatment is not typically covered. One can appeal, but if the language is not in the original contract/agreement, the services are not pre-authorized for coverage and require an extensive amount of work to get approval, if one can actually be achieved.⁸⁴

Dr. Massey representing Baylor Scott & White discusses a new practice of embedding a LCSW in clinics with a primary care physician. He states that many persons with an underlying chronic disease also have depression and the depression, or anxiety, needs to be controlled first before a patient typically can focus on his/her chronic illness.

He discussed that people feel more comfortable getting mental health care services in a primary care office. The BSW IMPACT (Depression) Model program needs a team with both primary care treatment and a LCSW to coach, counsel, and monitor patients.

When asked what is needed to help, Dr. Massey commented on insurance problems with coding, and billing and reimbursement. If a primary care provider sees and refers a patient, both visits can be billed, but services for both physical and mental health cannot be billed on the same day at the same location. He also comments that with certain services, mental health diagnoses are not recognized under medical benefits and under managed care “carve outs” are typically contracted with licensed behavioral health professionals only and do not reimburse primary care physicians for treatment, which leads to fragmented care for the patient. He discussed that not all insurance plans include mental health benefits and there has been a decrease in mental health coverage being provided by employers, leaving many patients without access. Thus, the norm has become for behavioral health providers to accept cash only due to reimbursement challenges, further segregating care providers. He emphasizes the need to build teams around physicians to provide care.⁸⁵

Insurance Plan Providers

Texas Association of Health Plans (TAHP) states that health plans and behavioral health organizations support and are committed to the protections established by the MHPAEA, and that health plans meet network adequacy and benefit requirements under federal and state laws. TAHP further comments that in addition to parity, health plans have demonstrated strong leadership in pioneering innovative programs to meet the health care needs of patients with mental health and substance use disorders, often through partnerships with behavioral health care organizations.

TAHP clarifies that the MHPA of 1996 and the MHPAEA of 2008 do not mandate coverage, only require that when such benefits are offered through an employer, they be offered at full parity. Also, the Texas Mental Health Mandate applies to large employer groups to provide coverage for SMI for at least 45 inpatient days and 60 outpatient visits, and requires financial limitations be the same for medical care. Additionally, the Affordable Care Act expanded the federal parity requirements to qualified health plans and plans offered through the small employer and individual market.⁸⁶

Challenges identified by the insurance providers regarding mental health services include shortage in child psychiatrists in Texas, the aging mental health workforce, the need exceeds the number of graduating psychiatrists, and the lack of internship sites. Barriers to recruitment are low reimbursement rates, the large Medicaid and the large indigent populations; and the lack of cultural and linguistic diversity and competence in workforce.

Suggested short-term solutions by Driscoll include additional Continuing Medical Education (CME) for primary care physicians in behavioral health, a consultation program between PCPs and psychiatrists for advice and triage, telemedicine, and a decreased hassle factor with current edits in the formulary. Longer term solutions suggested by Driscoll include loan repayment programs, exposing medical students earlier in their rotations to psychiatry, having more GME

slots across Texas for psychiatry, and increasing Medicaid fee schedules for psychiatry. Driscoll is involved with a telepsychiatry pilot program with UTMB and Behavioral Health Services of Nueces County (BHSNC).⁸⁷

Considered a Safety Net Health Plan under the ACA, Community Health Choice (Community) is a non-profit corporation created by Harris County Hospital District in 1996. Over 80 percent of their revenue comes from Medicaid or other government programs focused on the underserved population. Community advises a strong support of mental health parity and collaborates with Beacon Health Options for behavioral health network and care management systems. It has strong relationships with the LMHAs, FQHCs, and other safety-net and private providers.

Community's primary focus is on low income populations. Challenges identified include lack of psychiatrists, especially in rural areas; eligibility challenges, for example loss of eligibility for women 60 days after delivery (post-partum), persons' inability to be certified for SSI, coordination with jail health, and others; creation of value based payment system integrating behavioral and physical health; and the lack of a sustainable funding source for DSRIP projects involving mental health for those currently uninsured.

Community comments that a disproportionate number of people with mental health conditions are low-income and uninsured and thus have difficulty in maintaining employment, but by treating and stabilizing persons with mental and behavioral needs, local economies could be strengthened. They advocate that care coordination and integration are much better in a managed care system as the current fragmented system is inefficient and difficult to navigate and that managed care plans can create and pay for non-traditional home and community services.⁸⁸

Behavioral Health at Magellan Health (Magellan) advises that since the MHPA was signed, much progress has been made for considerations of mental health and physical health, but more needs to be done. For instance, gaps across providers need to close, and an understanding and implementation of sound and effective treatments is needed for behavioral and substance use disorders to treat not just one issue but the whole person.

Magellan says they have performed a full analysis of every component of parity. In Texas, "all members served by BCBS of Texas and Magellan are approved for all mental health services based on Medical Necessity Criteria." They are reviewing programs to fully integrate acute and behavioral health care for the STAR+KIDS program; teams for joint clinical rounds; working with two certain providers for adults with SMI, children with SED and individuals with long term and serious substance use disorders; and poly pharmacy to have a heightened and intense case management of members who prescribed more than four psychotropic meds or two or more antipsychotics. They are also studying the opiate crisis and are committed to being part of the solution in battling opiate addiction.

Benefits being seen in Texas for parity include from 2013 to 2015, an increase of behavioral health providers and acute care providers coordinating care.⁸⁹

Molina Healthcare of Texas health plan provided testimony regarding pre-authorization challenges and pilot programs for utilizing varied mental health professionals in the provision of care and coordination of traveling to the patient.⁹⁰

The Texas Teacher Retirement System (TRS) advises coverage of inpatient and outpatient services for mental health and chemical dependency. Mental health and chemical dependency accounted for approximately two percent, or \$44 million, of \$1.98 billion in total medical services rendered by TRS in FY2015. Mental health and chemical dependency drugs made up six percent, or \$40.8 million, of \$730 million in total prescription drug claims during that year.⁹¹

The Texas Employee Retirement System (ERS) advises coverage of mental health illnesses and substance use disorders. Of the top five most common conditions, mental health and substance abuse is fifth with a seven percent need. In FY2015, mental health benefits cost \$36.7 million in medical services and \$115 million in pharmacy services. ERS insurance providers provide a 24 hour toll-free telephone number for quick access to a team with information about mental health and substance abuse coverage; websites provide resources and director of network providers; and the HealthSelect wellness program offers telephonic behavioral health coaching for management of stress, anxiety, sleep, anger, grief, and relationship difficulties.⁹²

Medicaid in Texas is provided through HHSC and all people receiving any services through Texas Medicaid and CHIP MCOs are protected by mental health parity requirements, even if some services are provided in fee-for-service (FFS). HHSC and the MCOs determine which Medicaid services are included in each of the four classifications, inpatient, outpatient, emergency care, and prescription drugs used in parity analysis. Limitations on behavioral health services in each classification cannot be more restrictive than limitations on physical health services in the same classification. When determining the classification, the MCO must apply "the same reasonable standards to medical/surgical benefits and to mental health or substance use disorder benefits."

CMS will continue to issue technical guidance related to parity implementation in the coming months. Texas must be fully compliant with final parity rules by October 2017.⁹³

Law Enforcement and Training on Mental Health

According to Texas Commission on Law Enforcement (TCOLE), all Texas peace officers go through a minimum of 643 hours for their basic licensing course; 16 hours of Crisis Intervention Training (CIT) is included. The CIT course includes training on how to identify a person in crisis and techniques to calm them down and deescalate a situation.

Officers also have the opportunity to obtain a Mental Health Officer Proficiency Certificate through a 40-hour course. There are 6,256 peace officers in Texas with these certificates. This number was up by 528 from September 2015 to June 2016.

Currently the course material is being reviewed and updates are being made. Changes will include incorporating some legislation passed during the 84th Legislative Session such as

training on how to respond to situations involving persons with traumatic and acquired brain injury and trauma affected veterans. The committee is reviewing the current CIT course to determine if training on mental health issues needs to be increased or improved. Experts from Texas Council of Community Centers and DPS's Division of Victim and Employee Support Services are having input on the subject.

The basic peace officer course also includes a section on professional policing as well as professionalism and ethics.

TCOLE is also responsible for licensing all county jailers. The basic licensing course for jailers is a minimum of 96 hours. The basic jailer course includes two hours of training on suicide detection and prevention and three hours of persons with mental impairments, including information on diseases such as Alzheimers, schizophrenia, and PTSD.

Jailers also have the opportunity to obtain a Mental Health Officer proficiency certificate; 2,144 jailers hold these certificates.

A jail curriculum update committee was set to begin in June. A representative from TCOOMMI and from the Texas Commission on Jail Standards are working on the task to update jail suicide screening and its processes.

To obtain an intermediate proficiency certificate, jailers must also go through courses on Suicide Detention and Prevention and Interpersonal Communications in the Jail Setting.⁹⁴

Mr. Lawrence with the Texas Municipal Police Association (TMPA) advised that TMPA is a provider of Crisis Intervention Training and advocates that additional mental health training is needed for peace officers. He also referenced that when law enforcement is called, the situation is a crisis and more up-front resources are needed.⁹⁵

Law Enforcement

Law enforcement, including a large police department and rural, urban, and suburban sheriffs, emphasize the importance of law enforcement and LMHAs working together to provide crisis services involving calls related to mental health matters. Houston Police Department has teams with an officer and a mental health professional to respond to calls known to be a potential mental health crisis.

Although many cities and counties utilize their own Crisis Intervention Training (CIT) programs and Mobile Crisis Outreach Teams (MCOT) as jail diversion measures, Sheriff Wilson of Limestone County advises that rural counties may not have the means to do so but that the LMHAs do offer services. He stresses that LMHAs are critical for individuals needing mental health services in areas of support for housing, transportation, employment, medications and peer support.⁹⁶

According to Sheriff Kirk of Brazos County, through utilization of programs since 2006, the county has diverted 1,400 people from jail at a costs savings of about \$500,000. Through an

1115 Waiver project, the LMHA is performing screenings to keep persons from potentially going to the emergency room.⁹⁷

Sheriffs throughout the state continue to stress the need for additional beds, especially in maximum security facilities. Sheriff Wilson suggests an option to open maximum security beds in a quicker manner could be to make the Kerrville facility a step-down facility from maximum security units. He also emphasizes treatment on the front-end, as opposed to the back end.

Sheriff Hickman of Harris County advises that Harris County taxpayers have been the default providers of mental health care "to the tune of \$22 million for FY2016". To address, he created a hospital environment on one floor that allows for concentration of the majority of the medical and mental health services in one place for patients with greater medical needs or ones diagnosed as being "in crises" for mental health. He also enhanced relationships with the County Mental Health Authority, has full time psychiatrists on staff, and started a work group led by the county's LMHA, and including the County Attorney's Office, the Sheriff's Office, and the Mental Health Authority. With these enhanced services, he argues that "the application of the Jail Commission's mandated screening form is projected to actually impede upon the standards of evaluation already in place in our booking process. Forms developed to help untrained detention personnel identify possible risk factors cannot replace the evaluations of the licensed medical and mental health professionals that screen every inmate in Harris County upon intake. In a recent assessment of the State's new mental health screening tool, we found that a 21 percent increase of prisoners would be erroneously forced to the front of the line for a detailed mental health evaluation that could otherwise be assessed by a medical professional in out intake process."⁹⁸

Criminal Justice

In Texas Department of Criminal Justice (TDCJ) the mental health assessment begins at intake and continues at the unit of assignment. The services are comprehensive including evaluation, observation, diagnostic evaluation, case consultation, and medication treatment services, psychotropic medication treatment and monitoring, individual and group psychotherapy, psychometric/psychological testing, psychoeducation, suicide and violence risk assessments, case management services (outreach and tracking), crisis management and inpatient psychiatric services, and specialized mental health programs.

TDCJ inpatient psychiatric prison units are:

- TDCJ Montford in Lubbock which is affiliated with Texas Tech University Health Science Center for mental health services;
- TDCJ Skyview in Rusk affiliated with University of Texas Medical Branch for mental health services; and
- TDCJ Jester IV in Sugarland affiliated with University of Texas Medical Branch for mental health services.

Additionally, the TDCJ Mountain View Unit provides crisis management counseling and evaluations services, and the Bill Clements Unit in Amarillo has a Program for Aggressive Mentally Ill Offenders (PAMIO). Special Programs for the IDD population are provided through

the Developmental Disabilities program at the Hodge Unit in Rusk for males and at the Crain Unit in Gatesville for females.

Other special programs include:

- the Chronic Mentally Ill Treatment program for those needing structured monitoring and supervision;
- the Chronic Mentally Ill, Sheltered Housing program designed to provide structured, secure and supportive environment with programmatic activity for offenders in single cell housing;
- the Mental Intermediate Care Program in the TDCJ Gib Lewis Unit in Woodville;
- Administrative Segregation and other Restrictive Housing Settings programs; and
- Mental Health Therapeutic Diversion Program in the Hughes Unit in Gatesville and in the Michael Unit in Tennessee Colony.

TDCJ mental health services has 154,896 inpatient encounters per year; 8,325 crisis management encounters per year; and 31,676 outpatient encounters per year. Telemedicine and telepsychiatry are utilized by TDCJ. Psychotropic drug costs for TDCJ are \$4 million and 8.8 percent of the total drug costs.

The challenges identified by TDCJ are that prisons are not designed to be state hospitals or mental health treatment centers, compliance with federal standards for access to mental health care, and recruitment and retention of psychiatrists, psychologists, and other mental health professionals.

Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) was established in 1987 and is enabled by the Health and Safety Code, Chapter 614. Aspects of the criminal justice continuum addressed are:

- Juvenile Continuity of Care;
- Adult Continuity of Care;
- Probation Case Management;
- Parole Case Management;
- Jail Diversion and Court Resource; and
- Competency restoration while awaiting trial.⁹⁹

TCOOMMI funds a Continuity of Care (COC) Program designed to provide a responsive system for local referrals from parole, probation, jail, family and other related agencies. They provide pre-release screening and referral to aftercare treatment services and monitors, coordinates, and implements a continuity of care system for offenders with special needs. They contract with LMHAs for care in the community. Through their research informed case management processes, they have intensive outreach and engagement with a main goal to prevent re-arrests and/or re-incarcerations.

Texas is one of three states with a statutorily mandated coordinating body for clients with special needs; the only state with Continuity of Care legislation; one of few states with targeted funds for juveniles and adult clients with special needs; one of few states with specialized juvenile and adult probation/parole caseloads; and is the most proactive state in regulatory, statutory, procedural and programmatic practices for clients with special needs.

TCOOMMI advises that their community-based programs work because of:

- Joint staffing between local and state criminal justice agencies (Jail, CSCD or Parole), the local mental health authority and other treatment providers as well as juvenile justice when appropriate;
- Cross-training (courts, supervising agencies, treatment providers);
- Co-location of staff to improve coordination and communication regarding services for clients;
- Identification and referral process; and
- Sharing of relevant information (HSC 614.017).¹⁰⁰

Challenges

- Integration of health care, physical, mental, and substance abuse. Regarding a truly integrated system of care, the Hogg Foundation comments that, "To date most of what has been integrated has been the funding streams...The evidence supporting integrated health care is significant and research demonstrates that integrating mental health/substance use services with primary care can improve quality outcomes and reduce costs." Statistics show that patients with anxiety go to the hospital emergency room or physician offices 3-4 times more often; untreated mental health paired with chronic disease results in higher morbidity rates; and treatments of mental illness are effective 60-80% of the time. Many persons go to their primary care physician for mental health purposes, but many persons visit their primary care physician for physical symptoms and have mental health determined to be the underlying cause. Integrated care treats the whole person and increases access and the quality of the care.
- Parity. Parity is a complex issue involving health insurance companies and equal (or lack thereof) coverage for mental health care as compared to physical health care. Citizens advise that although they receive treatment for physical illnesses and accidents, their insurance plans are not providing equal coverage and that they can only receive mental health care through cash payments to a psychiatrist. Additionally, because of the various types of insurance plans, the Texas Department of Insurance (TDI) has limited authority or enforcement capabilities.
- Insurance. Providers of care advise that insurance plans do not pay both a physical health visit claim and a mental health visit claim if conducted at the same location on the same day. This hinders integrate care efforts.
- TDI has woefully insufficient FTEs to investigate mental health plans regarding compliance with current law and the investigation of consumer complaints.
- Social workers, licensed professional counselors and licensed marriage and family therapists receive 70% of the full rate for the exact same billing codes for mental health services, with psychologists and psychiatrists receiving 100%. This rule was put into effect in 2000 through HHSC, and in fact, this would not be permissible for an insurance company under TDI rules, but the MCO's are excluded from this rule.
- Masters of Social Work hours are coded/billed as a medical product instead of as a mental health service.

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- Criminal Justice. Sheriff and police departments are many times the first responder to address a person potentially needing mental health treatment. By default, many persons with mental illness have been taken to county jails whether for a crime committed or for their own safety or for the safety of others. This is costly to the counties. Jail diversion programs are an alternative and are being utilized, for both adults and juveniles, in many areas of the state to prevent persons needing mental health or behavioral treatment from ever going to jail. The judiciary is also involved with jail diversion programs. While many cities and counties have benefited greatly from the implementation of programs to address mental health needs, all areas have not been able to adopt the measures.
 - Extensive forensic commitments by district courts have stressed the state hospital system which has a crumbling physical infrastructure. These other factors have strained county jails and the ability to place civil commitments.

Recommendations

- Increase TDI's investigative budget regarding behavioral health plans.
- Address the billing disparity by modifying or eliminating the HHSC rule affecting rates for social workers, licensed professional counselors and licensed marriage and family therapists.
- Require mental health parity & protect against arbitrary claims denials – require HHSC and have TDI require transparency and parity in reimbursement rates of MCOs and insurers.
- Provide TDI with the specific authority and resources to enforce compliance with the Mental Health Parity and Addiction Equity Act commonly referred to as the 'Parity' law.
- Require insurers to make good faith efforts to include more mental health providers in their networks and demonstrate such efforts to TDI.
- Enact a mental health "Parity" state law: either full parity for all mental health conditions or a scaled version requiring parity coverage of specific mental health conditions or all serious mental illnesses.
- Enhance funding of the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) due to the program's success rate.
- Expand crisis intervention services and jail diversion programs. Specifically enhance support for regional crisis intervention teams.
- Review suspension rather than "termination" of Medicaid benefits for those in jail.
- Provide judges more options for restoring competency in addition to commitment to a state hospital.
- Expand judicial education on how to address mental health issues. Require all judges to receive mental health education.
- Review requirements for competency restoration and the potential for diversion of nonviolent offenders and restoration in jail and outside of jail settings.
- Review the possibility for the expansion of the Houston pilot program across the state.
- Require specialty courts to provide for consistent data collection to evaluate specialty court outcomes, recidivism, etc.

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- Expand best practices such as mental health court in jail or having a mental health docket.
 - Improve transfer procedures both following competency restoration and by clarifying exactly who has authority to transport a person during and outside of a mental health emergency.

PUBLIC HEARING #6: Substance Abuse, Homelessness, and Veterans

The sixth public hearing related to mental health focused on substance abuse, homelessness, and veteran programs in Texas and was held on August 16, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Leon Evans, The Center for Health Care Services
Matthew Feehery, Texas Hospital Association
Sonja Gaines, Texas Health and Human Services Commission
Susan Garnett, MHMR of Tarrant County, Fort Worth
Amy Granberry, Charlie's Place
Sean Hanna, Texas Veterans Commission
Greg Hansch, National Association Mental Illness (NAMI) Texas
Cynthia Humphrey, Association of Substance Abuse Programs
Suzanna Hupp, Texas Health and Human Services Commission
Lauren Lacefield-Lewis, Texas Department of State Health Services
Janie Metzinger, Mental Health America of Greater Dallas (MHA Dallas)
Josette Saxton, Texans Care for Children
Tony Solomon, Mental Health America of Greater Houston (MHA Houston)
Gyl Switzer, Mental Health America of Texas (MHA Texas)
Naomi Trejo, Texas Department of Housing and Community Affairs
Kenneth Wilson, Haven for Hope

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

The committee was charged with reviewing services provided for substance abuse and homelessness, and for veterans.

Many argue that if an individual has no home, he/she has nowhere to remain stabilized after treatment and release from a hospital, treatment facility, jail, or as a parolee.

Statistics for Substance Use Disorder and Homelessness

In 2015, the estimated population in Texas with a substance use disorder (SUD):

- 1,626,126 adults (8.1 percent of the adult population; 42.4 percent below 200 percent federal poverty level (FPL) with 5.7 percent served); and
- 161,755 youth, aged 12-17 (6.7 percent of the youth population; 56.9 percent below 200 percent FPL with 5.2 percent served).¹⁰¹

In January 2015, a U.S. Department of Housing and Urban Development's Point-in-Time survey found nearly 24,000 homeless in Texas statewide.

- 18.7% had a serious mental illness, and
- 15.7% had a chronic SUD.¹⁰²

According to Association of Substance Abuse Programs

- Over one-half of adults with a drug use disorder also have a co-occurring mental health disorder;
- A little over one-third of adults with an alcohol use disorder also have a psychiatric disorder;
- When the mental health problem goes untreated, the substance abuse problem usually gets worse as well and vice-versa;
- Parental substance use disorders are estimated to be a contributing factor in one-third to two-thirds of CPS cases;
- 38 percent of homeless people were dependent on alcohol and 26 percent abused other drugs;
- People with substance use disorders have overall health care costs that are more than twice as high per year than people without these disorders, and those with both substance abuse and mental disorders have costs that are even higher;
- Among offenders admitted to prison and state jail who were assessed for chemical dependency, more than half (58.5 percent) were chemically dependent in fiscal year 2012; and
- A 2004 survey by the U.S. Department of Justice (DOJ) estimated that about 70 percent of State and 64 percent of Federal prisoners regularly used drugs prior to incarceration.¹⁰³

According to Behavioral Health Council at Texas Hospital Association:

- 80 percent of heroin users started when the individual was no longer able to obtain the painkiller drug.¹⁰⁴

Services and Providers

According to Associate Commissioner Gaines with HHSC, the challenge to providing SUD services and treatment programs is the capacity of the current behavioral health system. In a February 2016 survey, the HHSC Behavioral Health Coordinating Council, with participation from 745 individuals, 69 percent from large urban (population greater than 50,000), 24 percent from small urban areas (population between 2,500 and 50,000), and 7 percent from rural areas (population less than 2,500), identified strengths, weaknesses, opportunities, and threats for mental health services in Texas. They are:

- Strengths
 - Availability of peer services;
 - Diverse array of available services; and
 - Availability of crisis response teams.
- Weaknesses
 - Limited available services;
 - Shortage of psychiatrists, clinical staff, behavioral health providers and lack of substance use treatment; and

-
- Low coordination between providers, lack of follow-through, organization and attention to effective outcomes.
 - Opportunities
 - To expand telemedicine/telehealth;
 - To increase stakeholder involvement and front line staff input; and
 - To expand existing services.
 - Threats
 - Lack of appropriate and adequate funding and funding cuts;
 - Sustainability of innovative and grant-funded programs; and
 - High costs of services, lack of insurance, claims and reimbursement issues.

She continued that the large investments and stewardship of the governor and the legislature have made positive change in increased treatment alternatives to incarceration, enhancements for local community collaboration, and coordinated funded efforts, but that gaps and challenges related to coordination, access, and service provision continue to exist.

Identified gaps related specifically to substance use and homelessness are:

- Access to appropriate behavioral health services;
- Access to timely treatment services;
- Use of peer services; and
- Access to housing.

Identified underserved populations include individuals with:

- Substance Use Disorder (SUD);
- Co-occurring psychiatric disorders and SUD;
- Severe Mental Illness; and
- Super-utilizers of jail, emergency room and inpatient services.

Provider shortages, wait lists for services, and the common perception that an individual's mental health needs take priority over SUD needs when both should be treated simultaneously are identified issues caused by lack of access to SUD treatment services. The unavailability of SUD treatment drives crisis and emergency room utilization and inpatient readmissions.

Behavioral health disorders can lead to or be a result of homelessness. Individuals typically have more chronic physical, mental health, and substance use issues than the general population and without secure housing may cycle through the more costly options of care, such as emergency rooms, the criminal justice system, or service providers.¹⁰⁵

Of the mental health monies appropriated to DSHS, 85 percent are state funds with 15 percent being from the federal government or other funding sources; for substance abuse funding 77 percent is from the federal government with 23 percent from the state.

For adults, substance abuse programs include detoxification, residential treatment, and outpatient treatment. For Texas residents ages 13-17, substance abuse programs include intensive residential treatment (for individuals assessed as high severity), supportive residential treatment (for individuals assessed as moderate severity), and outpatient treatment (for individuals assessed as lower severity).

The state also has specialized substance abuse treatment programs for women with dependent children and pregnant women, programs for opioid-dependent treatment, programs for co-occurring psychiatric and substance use disorder (COPSD), and neonatal abstinence programs.

Regarding homelessness services, supportive housing programs through DSHS include:

- Supportive Housing Program - a rental and utility assistance program working in concert with mental health services; currently 18 LMHAs receive Supportive Housing funding;
- Healthy Community Collaboratives - a program for chronically homeless individuals in Houston, Dallas, Fort Worth, San Antonio, and Austin with mental illness and/or co-occurring substance use issues;
- U.S. Department of Housing and Urban Development (HUD) Section 811 Project Rental Assistance Program;
- Projections for Assistance from Homelessness (PATH) - a street outreach, case management, housing services, and services that are supported by mainstream mental health programs for individuals who have a serious mental illness and may also have co-occurring substance use disorders and are homeless or at imminent risk of becoming homeless;
- Home and Community-Based Services - a program offering supervised living, assisted living, supported home living and host home/companion care for individuals with severe mental illness (SMI) with extended tenure in state mental health facilities, repeated arrests and frequent emergency department visits (program showed very limited service areas at time of hearing, but some pending areas for growth);
- Oxford Houses - a program for individuals in recovery from substance abuse disorders where the persons must pay an equal share of housing expense; and
- Money Follows the Person - a grant program that helps individuals with co-occurring physical and mental health/substance abuse conditions transition from institutions to community care (currently a pilot in Bexar, Atascosa, Wilson, Guadalupe, Williamson, Hays, and Travis Counties with the services for enrolled participants continuing through December 31, 2017).
- Project Access Pilot Program - a program operating through collaboration with The Texas Department of Housing and Community Affairs (TDHCA) offering housing vouchers to disabled individuals currently in or recently discharged from state-funded psychiatric hospitals or Local Mental Health Authority services.¹⁰⁶

An additional program through TDHCA is the Homeless Housing and Services Program which provides housing funding to cities with a population of 250,000 or higher. Twenty-five (25) percent of the persons who benefit from this program have a mental illness. The agency also works with the Emergency Solutions Grant which is funded through HUD with \$8 million in competitive awards.

Statistics for Veterans

- Texas is home to approximately 1.6 million veterans;
- Approximately 2,400 Texas veterans were considered homeless in 2015 due to mental health issues, PTSD, depression, substance abuse and brain injury;
- Thirty-eight percent of the approximately 2,400 homeless Texas veterans received no shelter assistance;
- Texas veterans represent about 10 percent of the Texas population, but represented about 18 percent of suicides in Texas;
- Among veterans of all ages, suicides are responsible for 1.4 percent of all deaths - among younger veterans (under the age of 30) suicides are responsible for 32 percent of deaths.¹⁰⁷

Services and Providers

In accordance with HB 19 passed during the 83rd Legislative Session, Texas Veterans Commission (TVC) and DSHS coordinate to administer the Veterans Mental Health Program (VMHP). The bulk of the effort is concentrated in the LMHA based Military Veteran Peer Network (MVPN). Thirty-seven (37) MVPN coordinators across the state and trained volunteer peers, provide community based one-on-one peer support, peer support groups, Veteran Treatment Court peer mentoring and community engagement events. Veterans and their families find the camaraderie, trust and support useful. VMHP also provides Military Cultural Competence training for licensed mental health professionals, Veterans Mental Health awareness training for community-based organizations and faith-based organizations; and coordination of Justice Involved Veteran programming through engagement, training and cooperation with justice system agencies.¹⁰⁸

Dr. Hupp with the Health and Human Services Commission advises that the principal causes of homelessness among veterans are mental health issues, including Posttraumatic Stress Disorder (PTSD), depression and feelings of hopelessness, substance abuse, and brain injury; difficulty re-integrating into home and community life, and difficulty finding and maintaining stable employment.

Outreach and inter-agency collaboration and coordination of veteran services, identification and connection of existing homeless veteran programs, and public-private partnerships to provide veteran homeless shelters, resource centers, peer networks, and information and referrals related to training and employment opportunities are identified as the state's best practices for addressing homelessness for veterans.

The Texas Veterans Portal, managed by the Texas Veterans Commission (TVC) is a collaborative effort of several state agencies and commissions to provide assistance, services, and benefits for Texas veterans, their families, and services providers. HHSC is working with county governments to include the portal on their websites and to further promote it at the local level by extending TVP to city government and private industry.

In 2013, Texas joined 45 other states as a member of the Substance Abuse and Mental Health Administration's Service Members, Veterans and their Families Interagency Leadership Initiative. The Texas interagency team represents all HHSC agencies, the Texas Veterans Commission, the Texas Workforce Commission, the Texas Military Forces, and the Texas Councils of Government.

Senate Bill 55 in the 83rd Legislative Session required HHSC to establish a grant program to support community mental health programs providing services and treatment to veterans and their families. Grant funds totaling \$21 million were appropriated: \$1 million for a pilot project to be matched by another \$1 million from the pilot program administrator and \$20 million for the full program (\$10 million each fiscal year of the 2016/17 biennium with the full grant program administrator securing or obtaining matching private and local matching funds up to \$20 million).

Expected outcomes include local communities will increase access for veterans to mental health care; reduction of barriers to accessing care, including community stigma; community partnerships supported as they develop projects and integrate services to strengthen their collaborative planning capacity.¹⁰⁹

A Best Practice for the Homeless

Haven for Hope (Haven) and the Center for Health Care Services (the area's LMHA) are located in San Antonio. Before Haven, many agencies provided food, shelter, and clothing but not transformation services. Further, San Antonio had a blighted area of the city that was "home" to the homeless, primarily those who were drug and alcohol-addicted and mentally ill.

Haven was created to offer a place of hope and new beginnings. Comprehensive services are provided on a 22-acre campus with 31 co-located partners, and include services that offer collaborative care for recovery. Additionally, Haven works with 47 referral partners off-campus and 13 community support agencies. Major local collaboration efforts include: Bexar County, Bexar County Sheriff, San Antonio Police, Bexar County Services, Bexar County Judicial Services, City of San Antonio, University Health System, Haven for Hope, University Health System, and numerous business partners.

Programs and services offered include:

- Intensive treatment programs for drug and alcohol addiction;
- Intensive treatment programs for mental illness;
- Initiated trauma-informed care and jail outreach program;
- Use of peer support specialists;
- Courtyard sick bay and day sleeping;
- Courtyard integrated care clinic;
- Development of CSG call center on campus; and
- Kennels for animals.

The in-house recovery and wellness programs provided to help the addicted and mentally ill have a 58 percent success rate (1,267 have completed) and a 49 percent success rate (1,114 have completed) respectively.

Their "Summary of Our Success!" includes:

- Almost 8,000 lives saved;
- Almost 3,000 from homelessness to homes;
- Almost 5,000 off the streets and into higher levels of care;
- Downtown homeless count down by 80%;
- Over \$96 million in cost avoidance at jail, emergency rooms and courtrooms;
- Over 35,000 individuals helped with sobering, detoxification and crisis intervention;
- Over 1,000 open jail beds;
- Jail bookings in 2015 were 1,700 lower than 2014;
- Recidivism rate at Haven is 24%-32%, compared to County's 80%;
- Over 40,000 medical, dental & vision services annually, over a \$16 million value;
- A once blighted area of San Antonio transformed; and
- 340 jobs created.

Also, with the provision for law enforcement to drop off persons needing services, officers are back on the streets quickly which has been valued at \$2 million per year.

Haven is a true public/private initiative with private, city, county, and state monies provided for the construction funding. In 2016, private contributions funded over 40 percent of the operational budget.¹¹⁰

Advocates and Providers

The Association of Substance Abuse Programs (ASAP) is a membership organization representing substance use disorder prevention, treatment and recovery service providers across the state of Texas. The majority of ASAP members are community based non-profit organizations who contract with DSHS to provide SUD safety-net services for Texans.

Public mental health and substance use disorder treatment is provided in different systems; a cross-systems goal would be to enhance the co-occurring capabilities of both systems.

Continued investment is needed to expand treatment and prevention capacity, develop a system of recovery support services that will cost effectively leverage treatment investments, strengthen the fragile treatment infrastructure, improve co-occurring services and effectively integrate behavioral health and primary care.¹¹¹

Substance Abuse Programs

Charlie's Place Recovery Center is an inpatient/outpatient treatment center in Corpus Christi, the only one with a full array of services south of San Antonio and west of Houston. Charlie's Place has 155 licensed beds (20 detox and 28 inpatient funded through DSHS) and 30 outpatient slots (10 funded through DSHS). Services include ambulatory and inpatient withdrawal management,

intensive and supportive inpatient/residential, specialized female intensive and supportive inpatient/residential, co-occurring psychiatric and substance use disorder case management services, recovery support services (peer recovery coaches), and outpatient treatment. The facility serves over 2,000 patients per year.

Funding sources are DSHS, Medicaid, Veterans Association, Texas Veterans Commission, federal probation, SAMHSA, local foundations, United Way, donors, private pay, and local government.

Identified barriers are:

- Accessibility and availability of treatment for patients (travel distances; long wait times - for Charlie's Place the detox wait is typically 5-10 days; for inpatient/residential the wait is typically 6-8 weeks);
- Capacity building for providers (low reimbursement rates; five percent cash match required in addition to rates; increased costs associated with compliance to increased regulatory burdens; rising cost of providing treatment that meets best practices in the field without corresponding rate increases; and provision of interim services for all patients on wait list with no reimbursement available)
- Difficult for patients to obtain treatment for both disorders at the same time;
- Charlie's Place has four local mental health authorities in its primary region and serves patients from across the state creating difficulty in helping patients access the mental health services and medications they require.

Treatment does work; recovery is possible and achievable; patients across the state are entering treatment and the journey to recovery on a daily basis; families are reunited, the workforce is stronger, and communities are safer for each person who takes that step and lives in recovery. Peer support offers better chance of recovery.¹¹²

Another concern on behavioral health care is the opioid epidemic. Statistics from 2014 show that drug overdose was leading cause of accidental death in the United States, with 47,000 plus deaths. Prescription related deaths equaled 18,900 and heroin related deaths equaled 10,600. This reflects a five-fold increase since 2000 in overdose deaths with four-fold being since 2010. The number of pain killer prescriptions to persons in Texas ranged from 72 to 82.1 for every 100 persons. Texas is in the third tier, so lower than other states in opioids prescribed and thus not a leader in opioid deaths.

When dependency is developed, tolerance increases and dosage needs increase. Eighty (80) percent of heroin users started with painkillers and an inability to obtain a prescribed drug. THA's Behavioral Health Council wants physicians to prescribe less - not a 30 day supply when a two to three day supply will suffice.¹¹³

Veterans Programs

Many veteran support programs are in place around the state. Mental Health America of Greater Houston and MHMR Tarrant County were invited to testify regarding their specific programs for veterans.

Mental Health America of Greater Houston (MHA-Houston) provides support to veterans for Veteran Courts, peer support, and jail diversion.

Since 2007, the Houston-Harris County Veterans Behavioral Health Initiative (VBHI) at MHA of Greater Houston has employed strategic and collaborative community engagement and trainings in support of the overall goal of shaping the mental health of people and communities. The VBHI impacts the community on numerous levels and strives to ensure that veterans behavioral health needs are met. As the regional coordinator for the state of Texas' Military Veteran Peer Network (MVPN), the mission is to connect service members, veterans and their families to local, state and national resources. As the mentoring arm for Harris County, Veterans Treatment Courts MHA-Houston engages the justice system to involve veterans with peer to peer support, health and wellness and activities that connect them to supportive services through dedicated and highly trained volunteers. They have integrated and holistic programs; peer support; and self-accountability.

Additionally, the VBHI provides behavioral health education to volunteer veteran court mentors statewide through its Veterans Court Advocacy and Mentoring Program (VCAMP) to better serve Harris County veterans and increase capacity for veteran treatment courts across the state.

MHA of Greater Houston provides services and other programs including school behavioral health, integrated health care, women's mental health, mental health and aging, and children's mental health public awareness.¹¹⁴

MHMR Tarrant County, has nearly 2,000 employees and serves almost 50,000 individuals every year. They had 82,071 crisis calls screened and assessed last year.

The facility's SUD treatment for adolescents include residential treatment, and outpatient treatment which are funded through DSHS, local funds, Medicaid and other insurance. SUD treatment for adults include detox - residential and ambulatory, residential treatment, and outpatient treatment which are funded through DSHS, local funds, 1115 Waiver, Medicaid and other insurance.

For individuals who receive mental health or substance use disorder services while in the Tarrant County jail, one in three also reports being homeless.

Regarding veterans, MHMR Tarrant services include Military Veteran Peer Network, Liberty House, TVC funded counseling program, VA contract for psychiatry and counseling, support in veterans court, VETCO Collaborative, and Texas Lawyers for Texas Veterans.

Collaboration in Tarrant County allows for local public and private partnerships, reduced barriers to access to care and enhance continuity of care, and community problem solving.¹¹⁵

Advocates

Numerous and varied mental health advocate associations exist throughout the country and state. Some of the advocates were invited to provide broad insight on gaps and needs within the programs.

Mental Health America of Greater Dallas stresses the need for continuity of care; recovery-orientated; bed capacity, mental health professionals and fund disparity.¹¹⁶

Texans Care for Children advises that there are effective interventions and services for children, but many children in need do not receive them. Thoughts on addressing mental health issues in children include: addressing maternal mental health; helping schools address the "whole child"; improving outcomes of children in foster care; improving outcomes of children in the juvenile justice system; helping bring best and promising practices, including those that are trauma-informed to more programs and services through coordinated training and technical assistance; improving state and local coordination of services to children and youth with complex needs; and supporting and empowering families of children with mental illness.¹¹⁷

"NAMI Texas is dedicated to improving the quality of life of all individuals living with mental illness and their families."

Policy priorities include --

- 1) Expanding the mental health system capacity and best practices through investment in services, addressing workforce shortages, establishing enough capacity for all civil and forensic patients; invest in First Episode Psychosis programming for early intervention and prevention, reducing future costs.
- 2) Closing the insurance gap;
- 3) Pairing jail diversion and reentry strategies with increased access to quality mental health care;
- 4) Expanding the availability of safe Permanent Supportive Housing;
- 5) Maintaining medication access and continuity across treatment systems;
- 6) Supporting mental health of children in foster care and families involved in kinship care;
- 7) Strengthening suicide prevention policies; and
- 8) Ensuring mental health parity.¹¹⁸

Mental Health America Texas (MHAT) emphasizes "parents as teachers" and suicide prevention programs. "Parents as teachers" is an evidence-based program for prevention and early intervention with an intentional approach to increasing protective factors in families and connecting families to community resources. Suicide prevention is training for licensed mental health providers.¹¹⁹

Challenges

- Workforce shortage. Current research shows that peer support provided by certified recovery coaches for SUD treatment decrease substance use, reduce utilization of inpatient and emergency room care and increase consumer engagement in care. Increasing access to peer support services offers a cost-effective strategy for expanding the behavioral health workforce and reducing reliance on crisis, inpatient, and other more restrictive types of care. Additionally, peers can play an important role in crisis response and critical transitions, including community re-entry after hospitalization and incarcerations.
- Access to Housing.
- Coordination of services, intensity and funding alignment.

Recommendations

- Increase access to peer support services by defining "peer services" so that more service locations may be able to employ and bill for services potentially increasing the ability to provide continuity of care and reduce recidivism. Allow substance abuse recovery coaches, certified mental health peer specialists for "peer services" and "certified family partner services" to be reimbursed for services provided in a manner appropriate to the scope of their practice; define in rule the scope of peer services; expand the Loan Repayment Program (SB239, 84th) to include college debt for certified peer specialists and certified recovery coaches; billing codes reimburse care but also shape and limit the extent of a specialist's practice, currently operating under mental health rehabilitation services is not only insufficient to cover the range of services provided by peer specialists, it is also provided only through LMHAs - these restrictions severely limit the settings in which peer specialists may practice.
- Ensure the Statewide Behavioral Health Coordinating Council remains intact and the plan produced continues to coordinate and financially align the programs among the various state agencies and various entities to address the various needs of the mentally ill. All mental health related funds are not considered "direct," and the Council should learn what other mental health spending is included within the various strategies for the varied agencies and encompass those programs in the coordination of services program.

PUBLIC HEARING #7: Public Testimony

The seventh public hearing related to mental health was public testimony only and was held on August 16, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following individuals testified:

Candace Aylor, Self

Kevin Banks, Self

David Bass, Self

Deloris Biagas, Self, NAMI Greater Houston

Andrea Brauer, Texas Gun Sense

Patti Derr, Self

Stephen Ellsesser, Emergence Health Network

Tony Farmer, Self, Young People in Recovery

Claudette Fette, Self

Jaclyn Finkel, Self

Marita Heyden, Self

Coleen Horton, Hogg Foundation for Mental Health

Jason Howell, Self, SoberHood

Katharine Ligon, Center for Public Policy Priorities

Jane Malin, Self, NAMI Greater Houston

Benny Malone, Self, NAMI Greater Houston

Evelyn Marquez, Self, People's Community Clinic

Amelia Murphy, Self, Santa Maria Hostel, Inc.

Patricia Pickles, Self

Valerie Romness, Self, Challenger Street Newspaper

Apryl Rosas, Texas Office for Prevention of Developmental Disabilities

Paul Rowan, Self

Nikki Saurage, Self, Kerrville Recovery Community, Sober Kerrville and The White Lily House

Miranda Simmons, Self

Jobi Weinstein, Teen and Family Services

Laurie Zapinski, Self

Introduction

The committee was charged to review the behavioral health system in Texas. For a thorough review of mental health, an opportunity for public testimony was provided.¹²⁰

PUBLIC HEARING #8: State Hospitals, Options for Addressing Needs, and Mental Health Care on Campuses of Higher Education

The eighth public hearing related to mental health focused on Texas' State Hospitals infrastructures and mental health bed allocation and on Texas' institutions of higher education, both two-year and four-year programs, and was held on September 22, 2016 at 10:00am in Austin, Texas in the Capitol Extension, Room E2.016. The following organizations/individuals were invited to testify:

Christopher Albert, PhD, The University of Texas Rio Grande Valley
Tim Bray, JD, MA, Texas Department of State Health Services
Chris B. Brownson, PhD, The University of Texas at Austin
Kathlyn Dailey, PhD, Texas State University
Jon Davis, West Texas A&M University
Maggie Gartner, PhD, Texas A&M University
Cynthia Hernandez, PhD, Texas A&M University
David Lakey, MD, The University of Texas System, Austin; The University of Texas Health Science Center, Tyler
Richard A. Lenox, PhD, Texas Tech University
Drew Miller, PhD, Sam Houston State University
Norma Ngo, PsyD, University of Houston; Texas University and College Counseling Directors Association
Lee Scott Rinker, PhD, LPCS, Houston Community College
Dayna Schertler, West Texas A&M University
Rito Silva, PhD, Del Mar College
Ron Stretcher, Criminal Justice Director for Dallas County
Richard Walker, EdD, University of Houston System
John Warner, MD, University of Texas Southwestern Medical Center

The following section of this report related to mental health is produced in large part from the oral and written testimony of the individuals identified above.

Introduction

To further cover the scope of the Proclamation, the committee heard testimony regarding state hospitals, mental health services on campuses of higher education, and ideas on options for providing services through partnerships with academic institutions.

Background - State Hospitals

Texas has ten psychiatric state hospitals located around the state plus the Waco Center for Youth. The properties include 584 buildings on approximately 2,000 acres. Building construction dates ranged from 1857 to 1996.

Bed capacity continues to be an issue for both the forensic and the civil populations; the forensic population in Texas' state hospitals surpassed the civil population in late 2013. DSHS and state hospitals continue to express infrastructure and workforce concerns. County officials continue to advise that their jails have a wait list for individuals with a forensic commitment and these persons are having to be held in the jails at county expense.

State Hospitals

In January 2015, the Department of State Health Services issued a report entitled *State Hospital System Long-Term Plan* which can be found at www.dshs.texas.gov/legislative/2015/Rider83-State-Hospital-Long-Term-Plan.pdf. The report included recommendations to:

- Transform and clarify the role of state and local hospitals;
- Expand access through local contracting;
- Replace and renovate state hospitals;
- Pursue academic affiliations; and
- Address other critical issues.

Efforts by the 84th Legislature to address the mental health issue included:

- Patient Transition into Communities program;
- \$50 million for purchased private psychiatric beds;
- Additional feasibility reports on state hospital replacement;
- Analysis of current and potential academic partnerships and Psychiatric Residency Stipend program; and
- \$18.3 million for critical state hospital repairs and \$1.4 million for targeted nursing increases.

With the consolidation of the health care service agencies, on September 1, 2016, the client services (community mental health) moved from DSHS to HHSC. Operations of the state hospitals are scheduled to move to HHSC in 2017, but currently remain at DSHS.

The role of state hospitals in Texas is generally to provide inpatient psychiatric care to forensic and civil commitment patients. Commitment can be voluntary or via a court mandate. Forensic patients are placed in state hospital facilities after being determined by a judge to be either incompetent to stand trial or unable to stand trial for reason of insanity.

Regarding the condition and infrastructure of Texas' state hospitals, a long-term plan was provided to DSHS in January of 2015 that recommended state hospitals have a specialized role to serve the most complex forensic and civil commitment patients with community beds serving less-complex cases. DSHS is currently working towards this new model. However, according to Mr. Bray, infrastructure issues, increased demand for inpatient care, and other factors are barriers to this new focus.

As of September 20, 2016, the state hospital population by commitment type (including Montgomery County and Waco Center for Youth) was:

- Forensic, maximum security population equaled 233;
- Forensic, non-maximum security population equaled 1073; and
- Civil patient population equaled 914.

The Waco Center for Youth, and child adolescence units in Austin, El Paso, North Texas, and Terrell provide services for children. The Rusk and the North Texas units are the designated maximum security units, but their patient populations are intermixed with civil and non-maximum security.

As of Sept 20, 2016, 354 individuals were on the wait list for transfer to a state hospital; 269 of the 354 were waiting for a MSU. The increased appropriations for capacity by buying beds in the Montgomery County and the HCPC facilities had an immediate impact, but not for MSU capacity.

Currently the average civil/voluntary length of stay at a state hospital is 44 days; the average incompetent to stand trial length of stay is 217 days; the average length of stay for MSU is 190.1 days; the average length of stay for individuals with multiple disabilities including intellectual developmental disorders is 363 days; and the average length of stay for individuals found not guilty by reason of insanity (NGRI) is 615 days.

Funded capacity and actual capacity for the state hospital facilities are not the same on any given day due to varied circumstances including, staffing and retaining workers, special needs for certain patients, and construction maintenance. As of September 20, 2016, 2,557 beds were funded; 2,220 beds were actually being utilized.

Additionally, all beds at all state hospital facilities are not funded, and the agency has not included a request to fund the beds during the upcoming legislative session.

Factors affecting reduced bed capacity are:

- Aging campuses and maintenance issues;
- Building designs based on outdated models of inpatient care;
- Workforce shortage;
- Staff turnover in critical positions;
- Specialized care for unique patients; and
- Repairs required by regulatory surveys (CMS, Joint Commission).

Additional challenges include high turnover in staffing and the accumulated deferred maintenance expenses over the years.¹²¹

Options for Addressing Capacity Needs

Dr. Lakey of The University of Texas System and The University of Texas Health Science Center - Tyler (UTHSC - Tyler) and Dr. Warner of University of Texas Southwestern presented

options and estimated costs for improving the Texas mental health hospitals through academic partnerships.

Dr. Lakey advocates for state hospitals partnering with academia to provide treatment to the mentally ill. He advises that state hospitals are poorly designed for modern healthcare. He also suggests that the state agency should perform a contract management role and not directly operate the state hospitals.

Models for academic partnerships provide for psychiatric residency training in state mental health hospitals; combining psychiatric faculty/ practice plans; making all clinical staff university staff; complete management of the hospital; and university ownership of the facility.

Ways in which academic partnerships could improve care identified include:

- Bringing telehealth & telepsychiatry to hospitals;
- Increasing training opportunities for psychiatry residents and other critical mental health workforce;
- Improving clinical settings;
- Improving coordination with other healthcare providers in community through reducing outside medical costs and increasing nursing homes and discharge placements;
- Improving treatment of forensic patients in public psychiatric hospitals; and
- Expanding prevention and early treatment programs.

Opportunities include improved cost efficiency with better designed facilities for more effective use of staff; potential to decrease length of stay due to ability to serve more people with same resources; minimizing outside medical costs; and utilization of technology such as telehealth.

Potential risks to academic institutions include prestige, accreditation, financial risk, and future funding. Options for funding include state GR or debt; philanthropy; public/private or non-profit partnership; and university HHS partnerships. Criteria for full partnership with University of Texas System Hospitals would include that hospitals in poor condition have to be replaced to not risk loss of accreditation of the academic institution and reimbursement would need to include true operating costs.

Presented possibilities of partnerships between academic institutions and state hospitals include:

- UTHSC and Rusk State Hospital (Rusk) with UTHSC providing residency training, incorporation of RSH physicians into the UT Practice plan, and management of the RSH for the state; allowing initially for 100 additional maximum security unit beds and 200 forensic beds; moving the current civil capacity to Tyler and Houston; and would likely require full funding by the Texas Legislature for new construction.
- UT Dell Medical School and Austin State Hospital (ASH) with UT integrating ASH physicians into the UT practice plan and expanding psychiatric residency by using ASH as a primary training site; potentially having a role for the LMHA and community partners for wrap around services such as crisis services, psychiatric emergency room, alcohol and substance abuse services; potentially the state legislature could fully fund replacement of 300 bed mixed civil/ forensic facility with a public-private (non-profit)

partnership to build and operate facility based on future funding of full operational/ debt service/ depreciation of facility.

- UTHHealth Houston and Harris County Psychiatric Center to increase inpatient and community based residential bed capacity.
- UTHSC Tyler to increase the residential bed capacity for civil and low-risk forensic patients;
- UT Southwestern Medical Center (UTSW) to provide approximately 150 inpatient beds on the campus; legislature would have to pay for initial debt service one session and full operating/ debt/ depreciation costs the following sessions.
- UTSW and UTHSC - Tyler and Terrell State Hospital to move 150 civil capacity to UTSW if/when capacity is constructed; backfill these 150 beds with forensic capacity; improve residency training opportunities with UTSW and UT Health Science Center Tyler with the possibility of incorporating clinical staff into UT practice plan; funding would have to be secured from the legislature for construction of new mostly forensic facility.¹²²

Dr. Warner with UTSW provided details of the costs of the potential UTSW academic partnership to provide care for the mental health. Additionally, he stressed the university's location and proximity to other care providers for sharing faculty resources and expertise.

The study undertaken considers a 148 bed purpose-built psychiatry hospital for the most complex civil patients. The cost is estimated to be \$180 million including land cost at an estimated \$24 million; construction cost at an estimated \$156 million (upfront or amortized into daily rate) and includes parking garage; and operations with a required contracted rate of \$790/bed/day with capital costs incorporated or \$538/bed/day with capital costs funded upfront.¹²³

Mr. Stretcher expressed that the primary concern for Dallas County criminal justice is the wait time for a bed. As of August 31, 2016, 59 individuals in Dallas County were waiting in jail for forensic beds. Forty-one (41) have been waiting over 60 days and the wait list has been as many as 93 individuals in the past months. He advises that the wait time, in jail, for maximum security beds has averaged 154 days in 2016 with some admissions waiting as long as 278 days. The wait time for a non-maximum security bed averages 73 days.

He advises that DSHS is a good partner but the system presents so many barriers.

He states that local behavioral health funding for inpatient and 23-hour observation services has grown from 30 percent of funding to 39 percent from 2012 to 2016, and that as more funding is spent on inpatient treatment, less is available for community based treatment.

He argues that state hospitals are an important part of the continuum, but many complex factors are barriers to their full integration into local care systems, including:

- Their location in non-urban areas make coordination with local services very difficult, especially impacting discharge planning and warm handoffs to the community.
- The staffing and facility pressures make access to beds difficult to predict.
- The State Hospital Allocation Methodology (SHAM) for allocating beds among the local authorities is complex and difficult to understand and does not lead to fair access

to beds across the state. NTBHA regularly has access to less than 90% of its allocation due to overuse by other parts of the state.

- Managing wait lists is a difficult challenge and leaves people who simply need care stuck in correctional settings and local community leaders frustrated with not knowing when to expect admissions.

Local communities actually bear the bulk of the expense, risks, and negative impacts of the lack of an adequately funded and locally integrated delivery system as access to services start locally, either by voluntary access by consumers or involuntary access that requires local law enforcement, hospitals and local courts. Persons treated at the hospitals will return to their community and long term success requires strong community based support services.

He emphasizes that more traditional state hospital beds are not the primary solution; that state hospitals an important part of local continuum if focused on the appropriate target population treating the maximum security forensic commitments for competency specialized and longer stays; and that options exists for both short and long term reduction of state hospital waiting lists and better integration of services into the local continuum of care.¹²⁴

Challenges

- **Bed Capacity.** In late 2013, the need for forensic beds in state hospitals passed the need for civil beds. Thus, beds that were previously deemed as "civil" have been transitioned to "forensic". This has affected county jails and hospitals that need to transfer patients to a facility for care. Although the Legislature has been funding community beds for patients, the need for beds continues to exceed the beds available.
- **Capital costs to maintain state hospitals.** State hospital maintenance costs have been deferred for many years. Some facilities are irreparable.
- **Workforce shortage of mental health medical staff and care providers.**

Recommendations

- **Conclusively determine and adopt a feasible long-term plan for addressing the infrastructure and staffing problems at the various state hospital facilities and fund accordingly.** Consider the adopted new method by DSHS at the suggestion of the consultant to funding community beds for the less complex needs patients, academic partnerships to provide care, utilization of the varied mental health professionals, changes in the criminal justice system for fewer forensic placements, and the benefits of early identification. Compare the costs of rebuilding or refurbishing the current state hospital facilities, funding community beds, and creating academic partnerships. Consider the availability of workforce. Consider the loss of funds to state hospitals by private insurers for the care of civil patients.
- **Determine the number of beds the state actually has available in state hospital facilities and ascertain if these beds should be funded versus buying beds in the community.**

Consider in the analysis the locations around the state where beds are most needed; if staffing issues are due to the location of the current facilities, determine a plan to best address the needs of the patients.

- Consider a study to reallocate or relocate patients across our hospitals to determine if efficiencies can be gained.
- Consider legislation banning guns on State Hospital campuses except by peace officers or military personnel acting in an official capacity.

Higher Education

The need for early intervention-related mental health services does not end upon graduation from high school. The state of Texas is home to 37 public universities and upper-division centers, 50 public community college districts that have multiple campuses across the state, 10 health-related institutions, 4 Texas State Technical College systems, 3 state colleges and 42 independent institutions.¹²⁵ In 2014, the most recent year for which the Higher Education Coordinating Board has data, there were 1,464,489 total students enrolled in some form of higher education in Texas; 713,033 of those students were enrolled in two year community college programs and 751,456 were enrolled in four year college or universities.¹²⁶

In August, the Texas Tribune reported that the appointment wait times for on-campus mental health services is two to three weeks at Texas' largest public institutions. Schools claimed this is largely due to workforce shortages.¹²⁷ The provider-to-student ratio recommended by the International Association of Counseling Services is 1:1,000 - 1,500, depending on other services offered by the institution.¹²⁸ Of the University Systems and/or college campuses that were invited to testify, only the University of Houston-Victoria is in compliance with the staff-to-student ratio recommendation with a ratio of 1:1,403.¹²⁹ Other invited campuses have ratios ranging from 1:1,600 to 1:7,000.

From the testimony offered, the committee was able to learn about the strengths and shortfalls of the mental health services available to students currently enrolled in institutions of higher education. It was important to hear from two year and four year programs because of the distinct challenges the different campuses face. The committee reached out to the Texas Association of Community Colleges to best determine which two year programs to invite to testify, and Houston Community College and Del Mar College enthusiastically responded to the prospect of testifying before the committee. The committee also prioritized hearing from institutions from different geographic regions and across varying demographics of the state, and did not invite any institution who was not in compliance with House Bill 197, authored by Chairman Price. That bill required the placement of mental health resources on the school's website.¹³⁰

During the 84th Legislative Session, the state appropriated \$13,587,830,138 to higher education for the 2016-17 biennium; \$5.4 billion to general academic institutions, \$3.1 billion to health-related institutes, \$162.2 million to technical colleges, \$60.3 million to state colleges and \$2.097 billion to community colleges.¹³¹ Funding for counseling services provided by public institutions primarily comes from student fees, and the majority of the counseling centers' budgets go

towards personnel salaries. Funds are also dedicated to campus marketing, training and screening programs.¹³² Each counseling center budget is determined by their college or university.

Per the invited testimony, all four-year institutions provide a minimum of individual, group and couples counseling services. The institutions vary in levels of crisis intervention and marketing strategies to inform students about the services their centers provide.¹³³ Two-year institutions have more limited resources and because their students do not tend to live on campus, some campuses provide very little in the way of physical health services.

Current Legislative Requirements

Counseling services are required to be made available at public institutions of higher education both through federal and state regulation, however, due to broad language and limited resources, the availability of mental health services varies across Texas's two and four year institutions.

At the federal level, Section 504 of the Rehabilitation Act under the Americans with Disabilities Act, requires arranging reasonable accommodations for all qualified students. The language is written such that it broadly prohibits the denial of public education participation or the enjoyment of the benefits of public school programs because of a disability.¹³⁴ Title IX ensures equality among genders in a higher education setting and promotes alcohol, drug and sexual misconduct programs on campus.¹³⁵ Both federal codes emphasize equal rights and the importance of adequate treatment for those with either a mental illness, or someone experiencing residual effects from the trauma of a sexual assault or substance abuse addiction.

The Texas 84th Legislative Session prioritized addressing mental illness in the states' higher education institutions. Regulations that were passed in 2015 provide more specific guidance on access to mental health resources in higher education. Senate Bill 1624 that was signed into law on June 18, 2015 and went into effect on September 1, 2015 states that,

A general academic teaching institution shall provide to each entering full-time undergraduate, graduate, or professional student who transfers to the institution, information about; (1) available mental health and suicide prevention services offered by the institution or by an associated organization or programs; and (2) early warning signs that are often present in and appropriate intervention for a person who may be considering suicide. (b) The information required under this section: (1) may be provided through: (A) a live presentation; or (B) a format that allows for student interaction, such as an online program or video; and (2) may not be provided in a paper format only.¹³⁶

SB 1624 is seen as a baseline for early intervention and prevention efforts regarding suicide and mental illness on college campuses in Texas. House Bill 197, signed into law on June 15, 2015 and also went into effect on September 1, 2015, develops that idea to include the presence of university and community mental health resources on the website of the institution. The language reads that,

Each institution to which this section applies [any institution receiving state aide] shall create a web page on the institution's Internet website dedicated solely to information

regarding the mental health resources available to students at the institution. The webpage must include the address of the nearest local mental health authority.¹³⁷

The legislature found that if a student was in crisis, it was often times difficult for another student to quickly find information like what number to call, or where to take the student. HB 197 was designed to make that information readily available for any student, staff or faculty member who is in a position to help a student in crisis. Representative Price's office followed up on compliance with the bill in August of 2016, and found that 54 higher education institutions were not in compliance; 40 two year programs and 14 four year programs. The numbers are subject to change after the office had discussions with each school that was not in compliance.

To various degrees, counseling services are offered at higher education institutions across the state, however, the committee determined there are wide gaps in services. Depending on differences in geographic location, staff, college/university resources and community partnerships, the committee has learned that there is not a blanket solution, and all relevant factors must be taken into consideration when working towards a solution to mental health resource shortages in higher education.

Trends

Higher education institutions receive students at a vulnerable stage of their life. Early adulthood presents changes and challenges many students have not yet faced. The committee heard various examples from the invited testimony of challenges and trends regarding mental health faced by higher education institutions across Texas.

Invited witnesses pulled trends specific to two-year institutions from a recent nationwide study conducted by the University of Wisconsin Hope Lab regarding mental illness on community college campuses. The study found that students at a community college are more likely to suffer from a mental illness than students at a four-year college/university, and that disparity grows when discussing students aged 25 years or younger (56% of community college students suffer from a mental illness as opposed to 46% of four-year students).¹³⁸ However, "57% of four-year colleges and universities have on-site psychiatric facilities appropriate for treating mental illness compared to just 8% of community colleges."¹³⁹ Students attending community colleges are also less likely to have health care coverage or access to health care services outside of school.¹⁴⁰

Observed trends across the entire spectrum of higher education include an increasing number of overall students, leading to an increasing number of counseling center appointments. Texas A&M University, College Station provided the committee with information stating that they serve 10-12% of their student population of 58,920, that is 832 appointments in FY 2016 and a 236% increase in appointments since FY 2015.¹⁴¹ This trend does not only affect four-year campuses. The committee heard testimony from Dr. Rito Silva of Del Mar Community College that their counseling center saw a 429% increase in appointments from FY 2015 to FY 2016.¹⁴² Other professional testimony echoed the same drastic increase in appointments over the past year. This trend is severely stretching higher education mental health resources across the state.

The witnesses also testified to a shift in the number one presenting issue they see. They agreed that anxiety has surpassed depression as the most common presenting mental health disorder among students.¹⁴³ Dr. Drew Miller of Sam Houston State described higher expectations and increasing pressures on college age students as a primary driver for this trend, while Dr. Maggie Gartner of Texas A&M University discussed weaker coping mechanisms among students.¹⁴⁴ Dr. Gartner also expressed to the committee the evolving challenge of meeting higher expectations of parents and students, "We are wondering what students and their parents are entitled to in the counseling centers" she stated during her invited testimony. She went on to say, "We are there to support the academic mission of the institution...educating and researching."¹⁴⁵ Students and parents are expecting more services from higher education institutions than ever before. More students are entering college having already received professional mental health services, they come with lower coping skills and high pressures to succeed, and higher education counseling centers are expected to take on the burden.¹⁴⁶

The four-year program professionals drew consensus on the fact that, although there are more students attending college in general, students also feel more comfortable acknowledging that they may need help. This trend is significant because it is a step in the right direction for reducing the stigma surrounding mental illness. Two-year programs educate more students who are not full-time students and who do not live on campus; therefore, this trend is not as prevalent on their campuses.¹⁴⁷

Best Practices

A repeated trend heard throughout the testimony is that resources are limited and very few schools meet the recommended staff-to-student ratio of 1:1,000-1,500. However, despite widespread staffing shortages, different programs are able to leverage peer supports, training and community services outside of the university to increase mental health awareness and prevention efforts.

Del Mar College, located in Corpus Christi, not only operates a full-time counseling center, but also uses a faculty/staff consultation program to help delegate assistance for students who are in need of services but are not in a crisis situation. This model allows the counselors to,

"Provide consultation to faculty or staff who are concerned about a student and need assistance with next steps. Consultations are confidential and do not become part of the student's record. Counselors can share approaches for assisting and referring a student of concern as well as how other campus resources may be helpful."¹⁴⁸

Instead of referring the student straight to the counseling center or having the student go untreated until they reach a point of crisis, the faculty/staff is now equipped with knowledge on how to best proceed with the student, while freeing up counseling center resources at the same time.

Del Mar also focuses on wellness outreach and intervention, implementing programs like "Let's Talk" or "Be Well", that place wellness checkpoints out on campus, not just in the counseling center, and allow students to interact with their peers as well as licensed professionals.¹⁴⁹

Texas A&M University in College Station is uniquely situated in rural East Texas but is home to just under 55,000 students.¹⁵⁰ With increasing numbers of students both on campus, and coming into the counseling center, and limited community resources, A&M also focuses on prevention and early intervention.¹⁵¹ All housing staff and Resident Assistants are trained using the QPR (question, persuade, refer) training technique.¹⁵² Dr. Gartner estimated over 6,000 faculty, staff and students have been QPR trained on campus. Additionally, the counseling center partners with the student health center so that any student who has an appointment at the student health center also receives the PHQ9 depression screening¹⁵³ upon arrival. If a student scores within a certain range, the student is automatically referred to the counseling center.¹⁵⁴ Should a student experience a crisis on campus, the student will be seen immediately by a professional in the counseling center. Texas A&M maintains a no waitlist policy for students in crisis situations.¹⁵⁵

Other schools utilize community resources to make up for limited staff. West Texas A&M University employs a "Health Integration Specialist" funded by the 1115 waiver, who coordinates all referrals and connects students with outside care.¹⁵⁶ They also partner with the Amarillo area Local Mental Health Authority (LMHA) and local respite recovery center that serves as a stabilization unit to help keep students in class and not in the hospital. The University of Texas at Austin implements a similar model with an FTE designated to be a liaison between the students and community services.¹⁵⁷ By referring students who have the means to be able to afford outside resources to community service providers, the university is able to keep the counseling center waitlist to a minimum.

A university-LMHA partnership like the one in Amarillo cannot always be replicated due to geographic restraints. However, having a place like an LMHA that is convenient and relatively inexpensive where students can receive services would ease the burden of school counseling centers.¹⁵⁸

Challenges

- Many students in higher education institutions suffer from mental health illness, especially anxiety. Second only to financial constraints, mental health issues cause students to drop out of school. Institutions of higher learning at a minimum are required to have information on their websites about the availability of mental health services, but students may need additional services provided and not all campuses are compliant.
- Mental health services on campuses of two year institutions are sparse to non-existent although these facilities serve a great number of students.
- Mental health services provided by four year institutions have a disparity in the degree provision, from stellar to sparse.

Recommendations

- House Bill 197 should be amended to tighten compliance and ensure crisis resources are readily available to anyone on the school's website.

-
- Require the crisis hotline number to be displayed on the back side of every student ID card.
 - Require a PHQ9 depression screening for every student who presents to the general campus student health center to increase collaboration between health and counseling centers, as well as emphasize early intervention. If a student falls within a specified guideline on the scale, the student must then be referred to the campus counseling center for a consultation.
 - Model after Texas A&M College Station program.
 - Promote community resources to help ease the burden of higher education counseling centers. Though community resources vary across the state and each school has access to different kinds of resources, they are valuable and necessary partnerships to help students stay in school and receive services at the same time.
 - Promote the psychological health of the counseling center staff with routine staff wellness checks.
 - Provide statutory guidance regarding the minimum services state institutions of higher education should provide along with state funding and requiring these institutions to interact with their LMHA.

CONCLUSION

Texas is well-positioned to be the country's leader for mental and behavioral health care. We have accessible world-class resources available throughout Texas. We also have a statewide desire and leadership in every region of our state to make world-class resources available to every community of Texas so that access to mental health services and treatment is not determined by a patient's zip code. This is an achievable reality – just as we have already done in other areas of medical science.

Several years ago, as an example, we created the Cancer Prevention and Research Institute of Texas (CPRIT) and pioneered the way to bring innovative ideas, research and professionals to fight cancer in Texas. As a result, Texans across our state are benefitting from breakthroughs, research and successful initiatives. Similarly, it is clear that we have opportunities to creatively combat mental and behavioral health challenges here that can be both a catalyst for our state as well as a model for other states all across our country. Access to services; early intervention, assessment and treatment for both school-age children and adults; adequate bed capacity, including types of beds from acute to less-intensive; and workforce challenges are just a few of the issues that need immediate and ongoing attention; but, improvement in these areas is absolutely achievable. If we fail to adequately invest and earnestly address the issues now, we do so at our own peril because the societal, medical and criminal justice costs alone will be extremely high. In short, the problems will not simply go away on their own. In fact, they will only increase as Texas continues to grow and so will the costs – loss in human potential; detrimental social impact on families, communities and businesses; and financially. Because mental health affects so many segments of our daily lives (i.e. education, medical care, health insurance, criminal justice, homelessness, etc.), it is absolutely one of the most critical areas of concern facing Texas today.

APPENDICES

PROCLAMATION

**APPOINTMENT OF
SELECT COMMITTEE ON MENTAL HEALTH**

Pursuant to Rule 1, Section 16, House Rules, I, Joe Straus, Speaker of the Texas House of Representatives, create the House Select Committee on Mental Health. The committee shall:

1. Review the behavioral health system, including substance abuse treatment, for adults and children. Make recommendations to improve the delivery and coordination of services to create an integrated system to improve early identification of mental illness, improve access and continuity of services, reduce barriers to treatment, and increase collaboration between entities responsible for the delivery of care in a manner that will ultimately reduce cost and improve care.
2. Identify educational, healthcare, law enforcement, criminal justice, judiciary, state, county, and city entities that are statutorily or contractually responsible for the identification or delivery of behavioral health services. Review how the services are directly or indirectly connected and how the entities work together.
3. Review entry points into the mental health system for both adults and children; how individuals gain access to services; what services are available; the effectiveness of services; and how to define, prioritize, measure, and improve outcomes achieved for adults and children.
4. Identify local and state cost of mental health in Texas and identify measures to reduce cost to the overall system by improving care.
5. Study and recommend solutions for the challenges within the current system, including, but not limited to, how to provide effective services in the short term and close gaps over the longer term in mental-health workforce shortage areas; access to appropriate mental health care for school-age children, including those identified through Mental Health First Aid training, to break the school to juvenile detention to prison pipeline; factors contributing to differences in communities' access to law enforcement and Judges with specific mental health training; communities' access to crises intervention and jail diversion services; communities' ability to plan and coordinate between healthcare providers and systems, law enforcement, the judiciary, and the criminal justice systems to deliver and coordinate care; and the location and availability of inpatient treatment beds, including how the need for inpatient beds varies by the effectiveness of the entire system. Also, identify obstacles to adequate insurance coverage for mental health services.
6. Identify the challenges of providing care and increasing access to veterans, homeless Texans, and individuals with serious mental illness.
7. Examine challenges of providing services in underserved and rural areas of the state and in communities serving high numbers of Texans below 200% poverty level.

This committee may request the assistance of other committees in obtaining information.

The committee shall have 13 members.

The following members are hereby appointed to the House Select Committee on Mental Health:

Four Price, Chair
Joe Moody, Vice-Chair
Greg Bonnen
Garnet Coleman
Sarah Davis
Rick Galindo
Sergio Muñoz
Andy Murr
Toni Rose
Kenneth Sheets

Senfronia Thompson
Chris Turner
James White

The committee shall file a final report in the manner provided by Rule 4, Section 61, House Rules, not later than December 31, 2016. The committee expires on the date the 85th Legislature convenes.

November 9, 2015


Joe Straus
Speaker of the House

Behavioral Health Appropriations

Article IX, Sec. 10.04, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures

Article IX, Sec. 10.04 (a): Informational Listing – Behavioral Health and Substance Abuse Services Appropriations

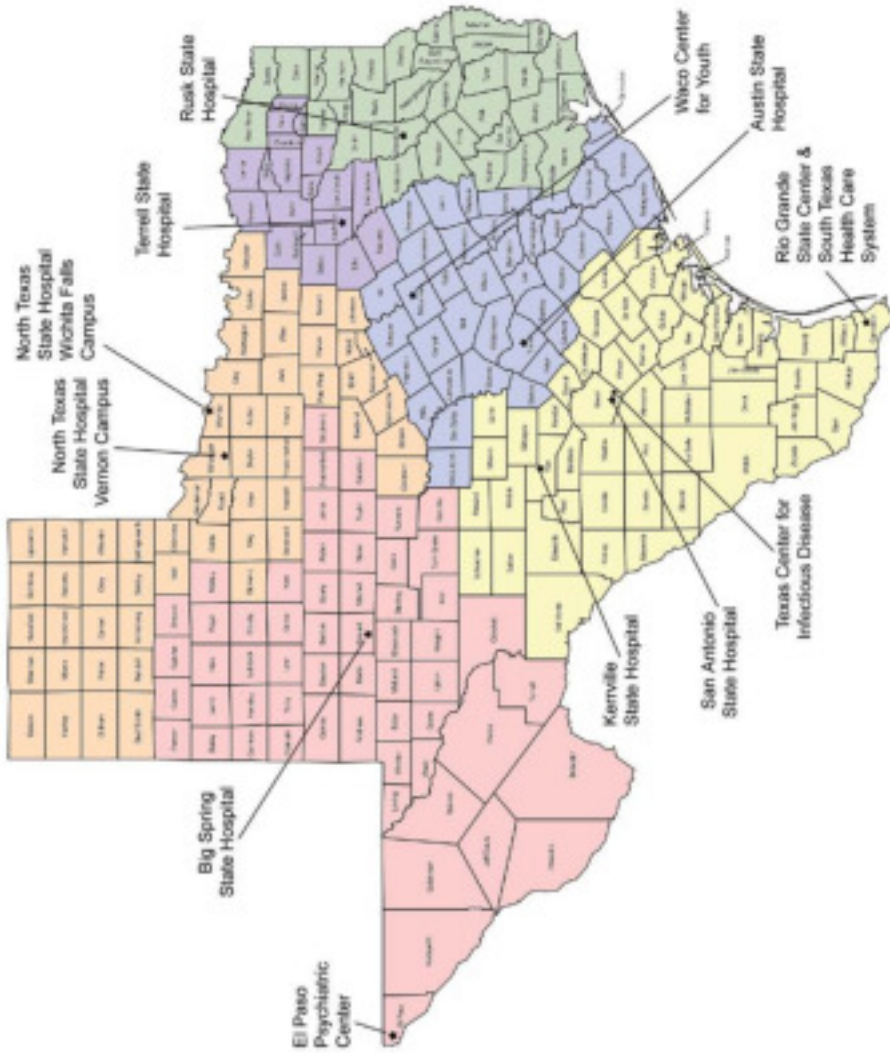
Agency	Fiscal Year 2016-17	
	GR-Related	All Funds
Trusteed Programs, Office of the Governor	\$1.5	\$10.6
Veterans Commission	\$0.0	\$4.0
Article I Total	\$1.5	\$14.6
Department of Aging and Disability Services	\$18.3	\$18.6
Department of Family and Protective Services	\$26.7	\$52.5
Department of State Health Services ¹	\$1,983.4	\$2,738.1
Health and Human Services Commission ²	\$28.4	\$78.4
Texas Civil Commitment Office	\$0.3	\$0.3
Article II Total	\$2,057.3	\$2,887.9
University of Texas - Health Science Center Tyler	\$8.0	\$8.0
University of Texas - Health Science Center Houston	\$12.0	\$12.0
Article III Total	\$20.0	\$20.0
Department of Criminal Justice	\$490.7	\$495.8
Juvenile Justice Department	\$155.8	\$169.0
Military Department	\$1.3	\$1.3
Article V Total	\$647.8	\$666.0
Board of Dental Examiners	\$0.2	\$0.2
Board of Pharmacy	\$0.5	\$0.5
Board of Veterinary Medical Examiners	\$0.1	\$0.1
Optometry Board	\$0.1	\$0.1
Texas Board of Nursing	\$1.7	\$1.7
Texas Medical Board	\$1.1	\$1.1
Article VIII Total	\$3.7	\$3.7
Cross Article Total	\$2,730.2	\$3,592.2

Source: 2016-17 General Appropriations Act, Governor's Veto Proclamation.

Notes: 1) These amounts have been updated for the final version of the bill, including the Governor's vetoes. 2) These amounts do not include Medicaid expenditures within the Health and Human Services Commission.

Appendix C - State Hospitals Map

State Mental Health Hospital Service Area Map - FY 2015



December 2014

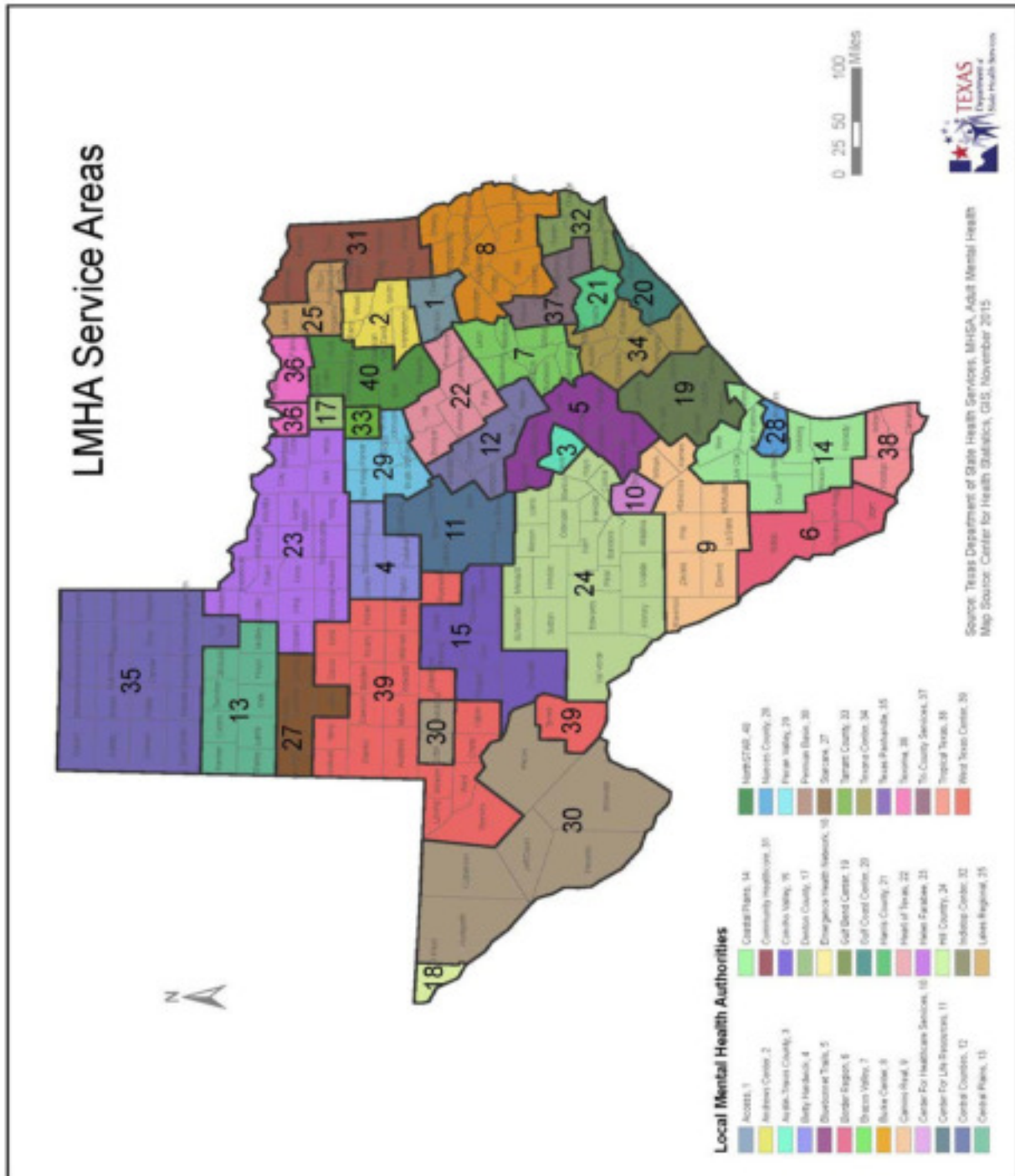
The map at right shows the State Hospital service areas by county.

In addition to serving their designated service areas, Big Spring and Rusk State Hospitals provide transitional forensic services, while Austin State Hospital, El Paso Psychiatric Center, North Texas State Hospital - Wichita Falls, Rio Grande State Center, Rusk State Hospital, San Antonio State Hospital and Terrell State Hospital also provide competency restoration services to patients admitted directly from jail.

Waco Center for Youth serves the entire state, as does Kerrville State Hospital, which provides transitional forensic services, and Rusk State Hospital and North Texas State Hospital - Vernon, both of which provide maximum security services. North Texas State Hospital - Wichita Falls provides an intermediate security program.

Child and adolescent services are provided at five hospitals, which expands the number of counties those hospitals serve.

Appendix D - Local Mental Health Authorities (LMHAs)



ENDNOTES

- ¹ Gaines, S. and Kirsch, L., Health and Human Services Commission, February 18, 2016, <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/bbf3829e-f919-49e3-aafa-f18bcd16833.PDF>; http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11770.
- ² National Alliance on Mental Illness (NAMI), *Mental Health Conditions*, <https://www.nami.org/Learn-More/Mental-Health-Conditions>, (last visited on October 17, 2016).
- ³ Id.
- ⁴ Gaines, S., Id.
- ⁵ Id.
- ⁶ Hellerstedt, J. and Lacefield-Lewis, L., Department of State Health Services presentation, February 18, 2016; <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/5fc9614b-41a4-436e-9eba-67b14f00ad22.PDF>; http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11770.
- ⁷ Hellerstedt, Id.
- ⁸ Diehl, M., Legislative Budget Board, Statewide Behavioral Health Strategic Plan and Coordinated Expenditures Overview and Funding, February 18, 2016, <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3738c396-61ed-4aae-8d75-a800bd306277.PDF>; http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11770.
- ⁹ Department of State Health Services, Welcome to Austin State Hospital – Over 150 Years of Continued Excellence, retrieved from <https://www.dshs.texas.gov/mhhospitals/AustinSH/default.shtm> (last visited on October 21, 2016).
- ¹⁰ Johnson, L., Texas Council of Community Centers, February 18, 2016, <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/3ea17faa-4c5b-4a15-9b2d-5af88e9cd4a9.PDF>, p3; http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11770.
- ¹¹ Id.
- ¹² Keller, A., February 18, 2016, <http://www.legis.state.tx.us/tlodocs/84R/handouts/C3822016021810001/512216a8-6dd0-4ebc-aaf1-889ee91922f4.PDF>; http://tlchouse.granicus.com/MediaPlayer.php?view_id=37&clip_id=11770.
- ¹³ Diehl, M., Id.
- ¹⁴ Gaines & Kirsch, Id.
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