Texas Statewide Behavioral Health
Strategic Plan

Fiscal Years 2017-2021

As Required By
2016-17 General Appropriations Act,
H.B. 1, 84th Legislature, Regular Session,
2015 (Article IX, Section 10.04)

Statewide Behavioral Health Coordinating Council

May 2016

TEXAS
Health and Human
Services Commission

Contents

Executive Summary

Message from the Council

Behavioral health services in Texas—which encompass both mental health and substance use disorders (SUDs)—have evolved and transformed over the past decade. Much of this transformation is due to the large investment and stewardship of the Texas Governor and legislators to improve the behavioral health service delivery system. The Medicaid 1115 Texas Healthcare Transformation and Quality Improvement Waiver ("the 1115 Transformation Waiver"), the movement toward managed care, the increased treatment alternatives to incarceration, the improved psychiatric crisis system, as well as enhanced local community collaboration and leveraged funding efforts, have all contributed to significant advancements in behavioral health care in Texas.

Texas has come to recognize the unique needs of individuals with complex behavioral health issues. These individuals experience a range of other risk factors, including unemployment, homelessness, and co-occurring health issues. Texas also appreciates the need for specialized services for individuals with intellectual disabilities, new mothers with depression, and military-trauma affected veterans and their families.

Technological innovations such as telehealth and telemedicine allow people to have greater access to the care they need without having to drive hours to receive it. Agencies now have increased access to behavioral health data to inform decision making. Advanced web-based resources such as 2-1-1, MentalHealthTX.org, and the Texas Veterans Phone App connect Texans to behavioral health services and live supports. Texas state agencies have continued to move toward research-based assessment tools and services that enable us do a better job defining and coordinating services.

In spite of these advancements, the behavioral health system continues to experience challenges addressing the behavioral health needs of Texans. Texas currently invests $6.7 billion biennially at the state level through General Revenue, Medicaid, and local and federal dollars to fund behavioral health services provided by various state agencies. In an effort to improve coordination between state agencies and to create a strategic approach to providing behavioral health services, lawmakers directed the creation of a statewide mental health coordinator position to through the 2014-15 General Appropriations Act, S.B. 1, 83rd Legislature, Regular Session, 2013 (Article II, Health and Human Services Commission, Rider 82). Texas lawmakers took another step through the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) by directing 18 state agencies that receive General Revenue behavioral health funding to work collectively to develop this collaborative five-year behavioral health strategic plan and coordinated expenditures proposal.

This strategic plan is the result of several months of collaboration involving these agencies that represent the diverse landscape of behavioral health services in Texas. The plan focuses on five strategic goals to be addressed later in this strategic plan.

During the strategic planning process, input and assistance was sought from a multitude of entities including providers, consumers, family members, peers, Behavioral Health Advisory Committee members, behavioral health think tanks, and local and state agency representatives. Additionally, a comprehensive survey was conducted where 745 Texans provided valuable insight into the strengths and weaknesses within the Texas behavioral health system, the results of which are detailed further in Appendix D.

Crafting this strategic plan is only the beginning. Through implementation of this strategic plan, we expect to see more efficient and effective behavioral health services delivered through Texas state agencies. Those agencies have agreed to work more collaboratively to coordinate behavioral health services, resources, competencies, and infrastructures to minimize duplication of effort and enhance prevention and early intervention services, as well as increase access to effective behavioral health services.

As state agency leaders, our vision for the implementation of this strategic plan will be to create a unified approach to the delivery of behavioral health services in Texas that allows all Texans to have access to care at both the right time and place. Our expectation is to see evidence of reductions in areas such as suicide rates, increased diversion of the mentally ill from our jails, and a better trained and informed behavioral health workforce.

This plan creates a framework for gaps and challenges to be addressed. The state agencies on the Statewide Behavioral Health Coordinating Council are invested in the implementation of the five-year strategic plan and affecting long-term change. While this plan will not solve every behavioral health problem or remedy every challenge, implementation of the strategic plan is a step in the right direction and offers a hopeful path to wellness and recovery.

Behavioral Health Coordinating Council

The Office of the Governor
Texas Veterans Commission
Health and Human Services Commission
Department of Aging and Disability Services
Department of Family and Protective Services
Department of State Health Services
Texas Civil Commitment Office
The University of Texas Health Science Center at Houston
The University of Texas Health Science Center at Tyler
Department of Criminal Justice
Texas Juvenile Justice Department
Texas Military Department
Health Professions Council representing the Texas Medical Board, Texas Board of Pharmacy, Texas Board of Dental Examiners, Texas Board of Nursing, Texas Optometry Board, and Texas Board of Veterinary Medical Examiners
Texas Education Agency

1. Legislative Charge

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) created the Statewide Behavioral Health Coordinating Council ("the Council") comprised of state agencies that receive state funding for behavioral health services, for the purpose of creating a five-year statewide behavioral health strategic plan and a statewide expenditure proposal. Table 1 lists the total All Funds appropriated for behavioral health and SUD services to the Council agencies as noted in Article IX, Section 10.04. Table 1 does not include Medicaid funding, which totaled $3.1 billion All Funds* for fiscal years 2016 and 2017.

Table 1: Behavioral Health and SUD Services Appropriations for Fiscal Years 2016 and 2017

Agency	Appropriations in Millions* FY 2016	FY 2017
Article I		
Trusteed Programs, Office of the Governor	$5.3	$5.3
Texas Veterans Commission	2.0	2.0
Total	**$7.3**	**$7.3**
Article II		
Department of Aging and Disability Services	$6.3	$12.3
Department of Family and Protective Services	24.8	27.7
Department of State Health Services	1,386.6	1,351.4
Health and Human Services Commission	38.3	40.1
Texas Civil Commitment Office	0.2	0.2
Total	**$1,456.2**	**$1,431.7**
Article III		
University of Texas Health Science Center – Tyler	$4.0	$4.0
University of Texas Health Science Center – Houston	6.0	6.0
Total	**$10.0**	**$10.0**
Article V		
Department of Criminal Justice	$247.9	$247.9
Juvenile Justice Department	84.2	84.7
Texas Military Department	0.6	0.6
Total	**$332.7**	**$333.2**
Article VIII		
Board of Dental Examiners	$0.1	$0.1
Board of Pharmacy	0.2	0.2
Board of Veterinary Medical Examiners	0.03	0.03
Optometry Board	0.04	0.04
Texas Board of Nursing	0.9	0.9
Texas Medical Board	0.5	0.5
Total	**$1.8**	**$1.8**
Cross Article Grand Total	**$1,808.1**	**$1,784.1**

Source: 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04)

* Medicaid dollars are not included. Total Medicaid funding is $3.1 billion All Funds for fiscal years 2016 and 2017.

As a result of the appropriated behavioral health funding, 18 state agencies and institutions were appointed to the Council through Article IX, Section 10.04, with six of the Article VIII state agencies represented by the Health Professions Council. The Health Professions Council was directed to appoint one representative for the: Board of Dental Examiners, Board of Pharmacy, Board of Veterinary Medical Examiners, Optometry Board, Texas Board of Nursing, and Texas Medical Board. The Texas Education Agency is voluntarily participating on the Council, increasing the total to 14 Council representatives from the following state agencies:

- The Office of the Governor
- Texas Veterans Commission (TVC)
- Health and Human Services Commission (HHSC)
- Department of Aging and Disability Services (DADS)
- Department of Family and Protective Services (DFPS)
- Department of State Health Services (DSHS)
- Texas Civil Commitment Office (TCCO)
- The University of Texas Health Science Center at Houston (UTHSC–Houston)
- The University of Texas Health Science Center at Tyler (UTHSC–Tyler)
- Department of Criminal Justice (TDCJ)
- Texas Juvenile Justice Department (TJJD)
- Texas Military Department (TMD)
- Health Professions Council has one seat representing the Texas Medical Board, Texas Board of Pharmacy, Texas Board of Dental Examiners, Texas Board of Nursing, Texas Optometry Board, and Texas Board of Veterinary Medical Examiners
- Texas Education Agency (TEA) (voluntary member)

1.1 Five-Year Statewide Behavioral Health Strategic Plan

The legislation appointing state agencies to the Council also outlines the requirements of the five-year statewide behavioral health strategic plan. This plan addresses key deliverables outlined in Article XI, Section 10.04, including a plan to coordinate programs and services to eliminate redundancy; guiding principles that emphasize utilizing best practices in contracting standards; and goals that perpetuate identified, successful models, ensure optimal delivery, and identify and collect comparable data on results and effectiveness.

Also required by legislation is an inventory of behavioral health programs and services provided by agencies on the Council, including a report on the number of persons served by each agency.

The HHSC Executive Commissioner must approve the plan and notify the LBB of such approval by May 1, 2016.

1.2 Coordination of Fiscal Year 2017 Behavioral Health Expenditures

In addition to the five-year strategic plan, the Council must create a behavioral health expenditure proposal that will describe how identified appropriations at each agency or institution will be spent in accordance with and to further goals of the approved statewide behavioral health strategic plan. A coordinated statewide expenditure proposal for fiscal year 2017 for each agency will be submitted to the HHSC Executive Commissioner for approval.

HHSC shall submit the approved coordinated statewide behavioral health expenditure proposal to the LBB by June 1, 2016. The plan shall be considered approved unless the LBB issues written disapproval by August 1, 2016.

1.3 Strategic Plan Implementation and Future Funding Coordination

The Council will seek guidance and direction from the Office of the Governor and the Texas Legislature regarding the implementation of the approved strategic plan.

The Council has agreed to continue to convene to implement the strategic plan and coordinate future funding requests.

As first steps in the implementation and accountability process, the Council will develop a timeline and operational work plan for execution of identified strategies. Council workgroups will be established to coordinate the practical implementation of strategies across Council agencies, agencies' behavioral health funding requests, and collaboration with existing advisory committees and councils. Once workgroups determine benchmarks to evaluate the success of each objective and strategy, schedules will be established to periodically review benchmark progress throughout the five-year scope of the strategic plan.

2. Strategic Planning Process

The Council is charged with developing a five-year strategic plan for the time period 2017 through 2021, with fiscal year 2017, the last year of the current biennium, serving as the base year, and projecting out the next two biennia, 2018-2019 and 2020-2021. This planning time period aligns with the development of the Council agencies' Legislative Appropriations Request (LAR).

The Council met several times to develop this strategic plan, including its vision, mission, and guiding principles which are discussed in greater detail in Chapter 3. Council members developed draft goals and objectives, and stakeholders were asked to prioritize and rank the objectives under each goal via a statewide online survey conducted December 9, 2015 to

February 28, 2016. From this effort, 5 goals and 14 objectives were identified and described in Chapter 6. Stakeholder input, obtained through surveys and workgroups, was key in identifying strengths, opportunities, and unmet needs through the gap analysis discussed in Chapter 5.

Council agencies identified wide-ranging strategies to accomplish the plan's objectives. Some strategies are short-term in nature with implementation anticipated by the end of calendar year 2016, while others may take the entire five-year planning period and beyond to accomplish. The Council will create an action plan to benchmark accomplishments, review progress on a periodic schedule, and guide implementation of the strategic plan. Such long-term collaboration opportunities underscore the commitment of the Council agencies to address the state's pressing behavioral health needs.

In developing their respective LARs for the upcoming 2018-19 biennium, each Council agency will link these strategies to its budget request as appropriate. Implementation of these strategies and activities will be monitored and evaluated for efficacy, cost-effectiveness, and efficiency to ensure that the identified unmet needs and gaps are addressed. To complete the management cycle, the results from this evaluation will inform updates to the strategic plan, and outline recommended changes to goals, objectives, and strategies.

3. Vision, Mission, and Guiding Principles

Untreated behavioral health needs can affect all aspects of life including economic productivity, student success, criminal justice, and public health and safety.[1] Article IX, Section 10.04, defines behavioral health services as "programs or services concerned with research, prevention, and detection of mental disorders and disabilities, and all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental disorder or disability, including persons whose mental disorders or disabilities result from alcoholism or drug addiction." For the purpose of this strategic plan, behavioral health is inclusive of mental health and substance use.

The vision of this strategic plan is to ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.

The mission is to develop a coordinated statewide approach to providing appropriate and cost-effective behavioral health services to Texans.

***Vision**: To ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.*

***Mission**: To develop a coordinated statewide approach to providing appropriate and cost-effective behavioral health services to Texans.*

As a first step in achieving this vision, the following guiding principles will lead the implementation and evaluation of behavioral health services.

The system must:

- Demonstrate coordination across Texas agencies and organizations to enhance continuity of care.
- Support recovery as an ever-evolving process where Texans with behavioral health challenges are empowered to take control of their lives.
- Value peers, family, friends, behavioral health professionals, and other stakeholders and their vital roles in a person's journey.
- Be trauma-informed and acknowledge the widespread impact of trauma, understand potential paths for recovery, and seek to actively resist re-traumatization.
- Utilize best practices in contracting standards and follow state guidelines.

Programs and services must be:

- Person-centered with the strengths and the needs of the person determining the types of services and supports provided.
- Culturally and linguistically sensitive with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve.
- Delivered in a flexible manner, where possible, to meet the needs of each child, family, or adult close to their community.
- Accessible to all Texans regardless of setting (i.e. prison, jail, school, etc.) through the use of innovative technologies, such as telemedicine, which increase access to treatment and address transportation barriers.
- Ensure each child, family, or adult receives care based on the person's unique needs.

Fundamental to achieving this vision is access to integrated care. At the most basic level, integrated care means that both adults and youth have prompt access to mental health care, SUD intervention and treatment, and medical care. This care encompasses outpatient and inpatient care delivered by professionals working in concert to address the needs and goals of the individual and their family. It also includes the supports that make it possible for people to consistently participate in care and move toward recovery.

This strategic plan envisions a future where there is measurable improvement in cross-agency behavioral health coordination and Texans have greater awareness of and access to mental health, SUD, and physical health care services in order to reduce the likelihood that persons with behavioral health disorders become involved in the criminal justice system, die from co-morbid conditions earlier than the average adult, or require inpatient psychiatric hospitalization. At the same time, the system must also ensure that care provided in these settings is equally accessible and maximizes the person's opportunity to work toward recovery by providing comprehensive care on-site and helping to engage them in community-based services and supports as they transition out of state care.

4. Current Behavioral Health System in Texas

4.1 Statewide Behavioral Health Populations Served

With the Texas population steadily increasing over time, both prevalence rates and workforce shortages for behavioral health have risen. The federal Department of Housing and Urban Development's 2015 Point-in-Time survey, which seeks to measure the scope of homelessness on a single night in January each year, indicated that Texas has nearly 24,000 homeless individuals[2]—many who also suffer from mental illness. Based on a survey conducted by the Texas Hospital Association, a majority of the more than 5,000 non-state owned inpatient psychiatric beds in Texas are full.[3] Increasingly, people with mental illness involved in the criminal and juvenile justice system fill state hospitals, prompting an investment in locally purchased community-based psychiatric beds for people without pending criminal charges (i.e., civil commitments or voluntary patients). Nearly 70,000 Texas Operation Enduring Freedom and Operation Iraqi Freedom veterans will confront a mental health condition.[4] Additionally, there is a growing number of young people who need behavioral health treatment, as well as intervention and prevention services in our communities, schools, and local service delivery system.

4.1.1 Texas Population

In 2014, Texas had an estimated population of almost 27 million people. Of the state's 254 counties, 172 are considered rural.[5] Given the number of rural and border areas in the state, Texas has unique cultural, ethnic, and linguistic challenges to the delivery of behavioral health care.[6]

The state's central location and strong economy have long attracted people. From 2010 to 2014, Texas' population increased by 7.2 percent which represents a 1.8 million person population increase.[7] Furthermore, the population is expected to double to 54.4 million people by 2050. The majority of the increase will be due to people moving to Texas.[8] The state's population is younger, more diverse, and increasing at a faster rate than the nation as a whole. This diverse population requires community-based and culturally sensitive behavioral health service options.

Geographic location and population density can affect how Texans access behavioral health services, the availability of behavioral health services, and the qualified workforce to provide those behavioral health services.

4.1.2 Texas Council Agencies and Populations of Focus

Texas state agencies providing behavioral health services have unique missions and populations they serve. These behavioral health populations are diverse and include children and youth, military personnel and veterans, and criminal justice populations, as well as impaired professionals providing behavioral health services by their professional licensing boards. Age and other eligibility criteria shape the populations served by each agency.

Programs funded across various Council agencies have differing criteria for eligibility, including behavioral health need or diagnosis, age, and income level. Medical indigence is often the primary indicator of financial eligibility for state behavioral health programs; however, income level may or may not be a consideration for individuals receiving behavioral health services in other state agency contexts. Therefore, the behavioral health services an individual receives will vary by state agency.

Table 2 outlines the populations served across five broad categories: youth, adults, veterans, criminal and juvenile justice, and individuals with intellectual and developmental disabilities (IDD). Appendix C further details populations served by Council agencies and includes information on eligibility requirements for funded programs and services. At a high level, intersections among populations served provide opportunities for collaboration to improve outcomes for individuals.

Table 2: Behavioral Health Population Served by Council Agencies, 2016

Agency	Youth	Adults	Veterans	Criminal & Juvenile Justice	IDD
Office of the Governor	•	•	•	•	
TVC	•	•	•		
HHSC	•	•	•	•	•
DADS	•	•			•
DFPS	•	•			•
DSHS	•	•	•	•	•
TCCO		•			
UTHSC–Houston	•	•		•	
UTHSC–Tyler	•	•			
TDCJ	•	•	•	•	•
TJJD	•			•	
TMD		•	•		
Health Professions Council*		•			
TEA	•				•

* The Health Professions Council represents the Texas Board of Dental Examiners, Texas Board of Pharmacy, Texas State Board of Veterinary Examiners, Texas Optometry Board, Texas Peer Assistance Program for Nurses, and Texas Medical Board.

4.1.3 Behavioral Health in Texas: Estimated Prevalence

It is important to discuss mental health conditions in broad terms because the goals of this strategic plan affect the populations served by Council agencies as diverse as TVC, TEA, DFPS, and TDCJ. Council agencies serve populations with differing behavioral health needs and have differing eligibility requirements often determined by funding requirements or statute.

Drawing a distinction between the different definitions of mental illness used by state agencies highlights the implications of accounting for overlap in each population, especially as it pertains to prevention and early intervention and the array of behavioral health services provided by Council agencies in Texas.

Mental Health Disorders

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) defines *serious mental illness* (SMI) as a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment among people who are age 18 and older that substantially interferes with or limits one or more major life activities.

Of the almost 27 million Texans, it is estimated that there are approximately 19.8 million adults age 18 years and older and 7.1 million children age 17 years old and younger. Based on a recent Texas study estimating prevalence at the county level[9] and using SAMHSA's SMI algorithm[10], it is estimated that close to 1 million adults, or 5 percent of the total Texas adult population, have SMI.

A subset of people with SMI have *serious and persistent mental illness* (SPMI) which is inclusive of people with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders. Those with SPMI experience significant functional impairment due to a mental health disorder that requires crisis resolution or ongoing, long-term support and treatment. Based on the SAMHSA methodology, an estimated 515,875 Texas adults lived with SPMI in fiscal year 2014.

SAMHSA refers to severe mental health needs for children ages 17 years and younger as s*evere emotional disturbance* (SED). These are diagnosable mental, behavioral, or emotional disorders in the past year, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities. Using SAMHSA's prevalence rate, the estimated number of Texas children and youth ages 17 years and younger with SED is 519, 368. [11]

Texas schools use the term *emotional disturbance* when students are eligible for special education services based on the criteria that an emotional disturbance is determined to be the primary disability that adversely affects a child's educational performance in accordance with federal law outlined in 34 Code of Federal Regulations, §300.8(c)(4).[12] The written evaluation

report for students in schools must include specific recommendations for behavioral supports and interventions.

Medical indigence is the primary indicator to determine financial eligibility for state behavioral health programs provided through DSHS. Section 552.012 of the Texas Health and Safety Code defines a medically indigent person as (1) one who does not own property; (2) is not under the care of someone who is legally responsible for the patient's support; and (3) does not have the ability to reimburse the state for the cost of the treatment and related costs.[13] At the individual level, $23,540 annual income for a family of one, or $48,500 annual income for a family of four is considered 200 percent of the Federal Poverty Level (FPL). Individuals who meet these criteria are eligible for indigent care services from the state of Texas. [14]

As an example, DSHS operationalizes medical indigence by requiring that a person or family be living at or below 150 percent FPL to receive full state funding for mental health treatment; whereas, if an individual needs SUD treatment, that person's or family's adjusted income must be at or below 200 percent FPL. If a person does not meet these criteria, a fee is assessed for services using a sliding scale.[15] Based on data available from DSHS, it is estimated that roughly one-half of the populations with SMI, SPMI, and SED meet the criteria for medical indigence.[16]

Substance Use Disorders

According to SAMHSA, SUDs occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[17]

SUD prevention and treatment programs are funded through a variety of Council agencies, including DSHS, HHSC, TDCJ, TJJD, the Health Professions Council, and the Office of the Governor.

An estimated 1.6 million adult Texans, or nearly 6 percent of the total adult population, have SUD. Of those adults, approximately 42 percent (or 679,228) live at or below 200 percent FPL. An estimated 181,938 children age 12 to 17 years have SUD. Of those children, 57 percent (or 103,559) live at or below 200 percent FPL.

One challenge to providing SUD prevention and treatment programs is the capacity of the current behavioral health system. Table 3 compares the estimated total number of individuals with SUD with the estimated numbers of individuals with SUD living at or below 200 percent FPL and those who actually accessed SUD treatment through DSHS programs and services. Of the potentially eligible population, only six percent of adults and five percent of children accessed services.

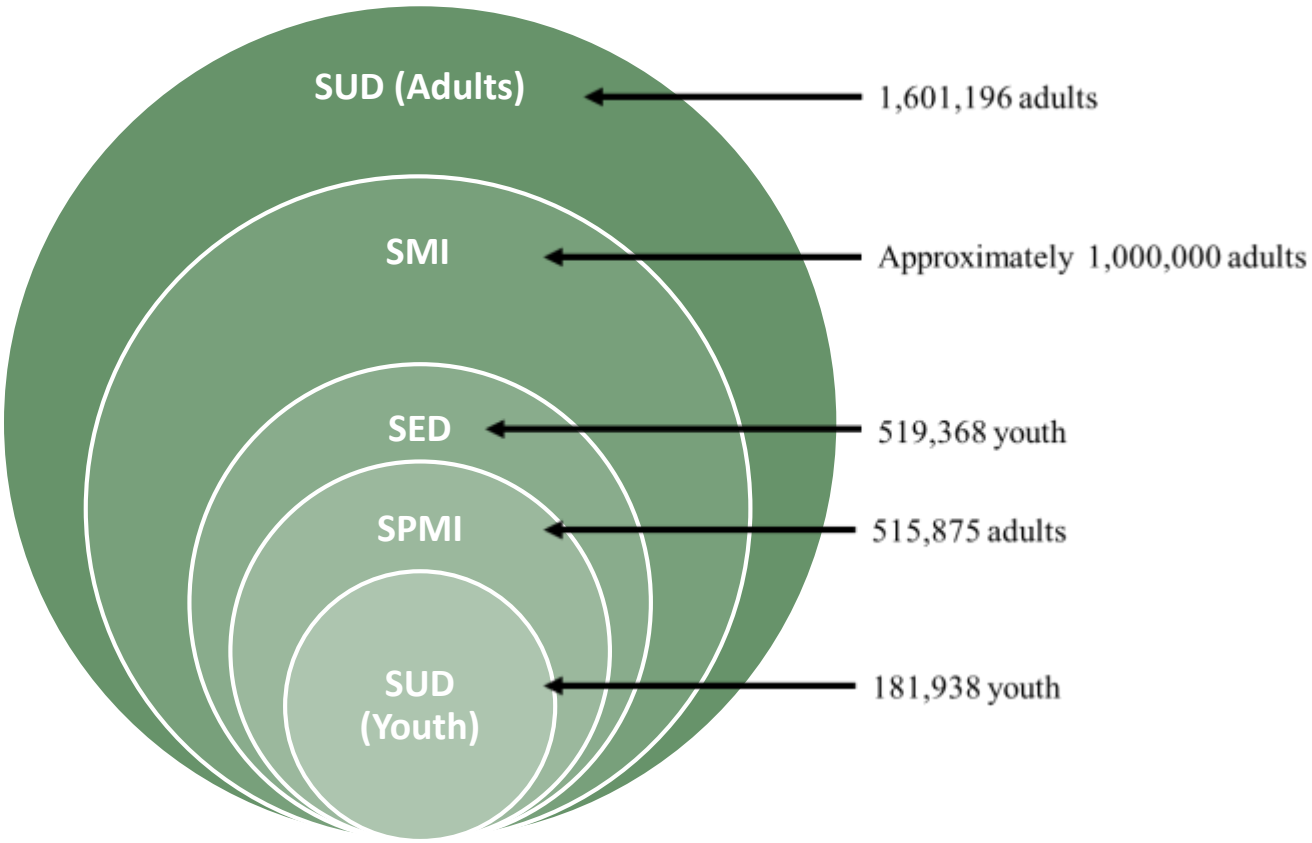
Table 3: DSHS Estimated Need: SUD (Alcohol or Illicit Drug Dependency) for Children and Adults in Texas Compared to Numbers Served, Fiscal Year 2014

SUD Population	Adults (Age 18 and Above)	Children (Age 12 to 17)
Individuals Receiving Services through DSHS	41,002	5,423
Eligible Individuals*	679,228	103,559
Individuals in Need of Services	1,601,196	181,938

* Eligibility is based on income at or below 200 percent FPL.

According to SAMHSA, 7.9 million adults in the United States had a co-occurring disorder in 2014.[18] Co-occurring disorders describes the presence of two or more disorders at the same time. This includes the coexistence of mental illness and SUD, but may also include the coexistences of IDD and mental illness. SAMHSA indicates that there is a higher prevalence of co-occurring disorders among certain populations such as criminal justice, veterans, and homeless individuals.[19]

Chart 1: Estimated Prevalence for Texas Populations by Behavioral Health Condition, Fiscal Year 2014



4.1.4 State Hospital System

While a full array of community-based services can reduce the need for inpatient care, the state's hospital system is a critical component of the behavioral health system.

Community Beds

When an individual experiences a crisis, the goal is to intervene early and provide stabilization services in the community. However, some communities lack adequate crisis facilities, and often individuals cannot safely stabilize outside of a hospital environment.

To supplement state hospital capacity and keep individuals close to home, DSHS purchases hospital beds in community and private psychiatric hospitals to serve adults, adolescents, and youth. In addition, the state provides funding for the Montgomery County Mental Health Treatment Facility, which provides forensic services. Forensic patients include individuals determined to be "Incompetent to Stand Trial" and those found "Not Guilty by Reason of Insanity." In January 2016, the state system included 535 purchased hospital beds.

State-operated Facilities

Texas has nine state psychiatric hospitals (one with two campuses). In addition, one facility is an adolescent psychiatric residential treatment center and another is a state center that serves individuals with IDD, as well as operating as an outpatient public health clinic. Each facility provides forensic and civil inpatient psychiatric services for adults who meet statutory admission requirements. Additionally, five of these facilities provide services to children and/or adolescents. Increasingly, civil patients admitted to state hospitals are individuals with complex needs who require extended treatment and cannot be appropriately served in community beds. In January 2016, the state-operated hospital capacity was 2,463 beds.

Eight of the state hospitals serve a regional catchment area and provide adult, child, and/or adolescent, civil, and forensic services:

- Austin State Hospital (299 beds)
- San Antonio State Hospital (302 beds)
- Big Spring State Hospital (200 beds)
- El Paso Psychiatric Center (74 beds)
- North Texas State Hospital – Wichita Falls campus (289 beds)
- Terrell State Hospital (288 beds)
- Rusk State Hospital (325 beds, including 40 maximum security beds)
- Rio Grande State Center (55 mental health beds)

Three facilities provide only specialized services for the entire state:

- North Texas State Hospital – Vernon campus (Adult Maximum Security and Forensic Adolescent Services, 351 beds)
- Kerrville State Hospital (Transitional Forensic Services, 202 beds)

- Waco Center for Youth (Adolescent Psychiatric Residential Treatment Services, 78 beds)

The state hospital system has aging campuses with severe infrastructure challenges, which can present safety concerns for patients and staff. Infrastructure issues also present risk to Joint Commission accreditation and Medicare certification. In addition, building designs are based on outdated models of inpatient care and lack the information technology infrastructure necessary for modern business practices. These challenges result in high cost emergency repairs and recurring bed closures.

Decreasing revenue is a challenge for the state hospital system. Higher numbers of forensic patients decrease opportunities for third-party revenue and, for the limited number of patients with a third-party payer, the average length of stay is 30 days for civil commitments and 89 days for forensic commitments which far exceeds the average authorization of 5 days for public and private managed care organizations (MCOs). In addition, the growing reliance on contracted beds has also had an impact, as more patients with third-party revenue are diverted from the state-operated hospitals.

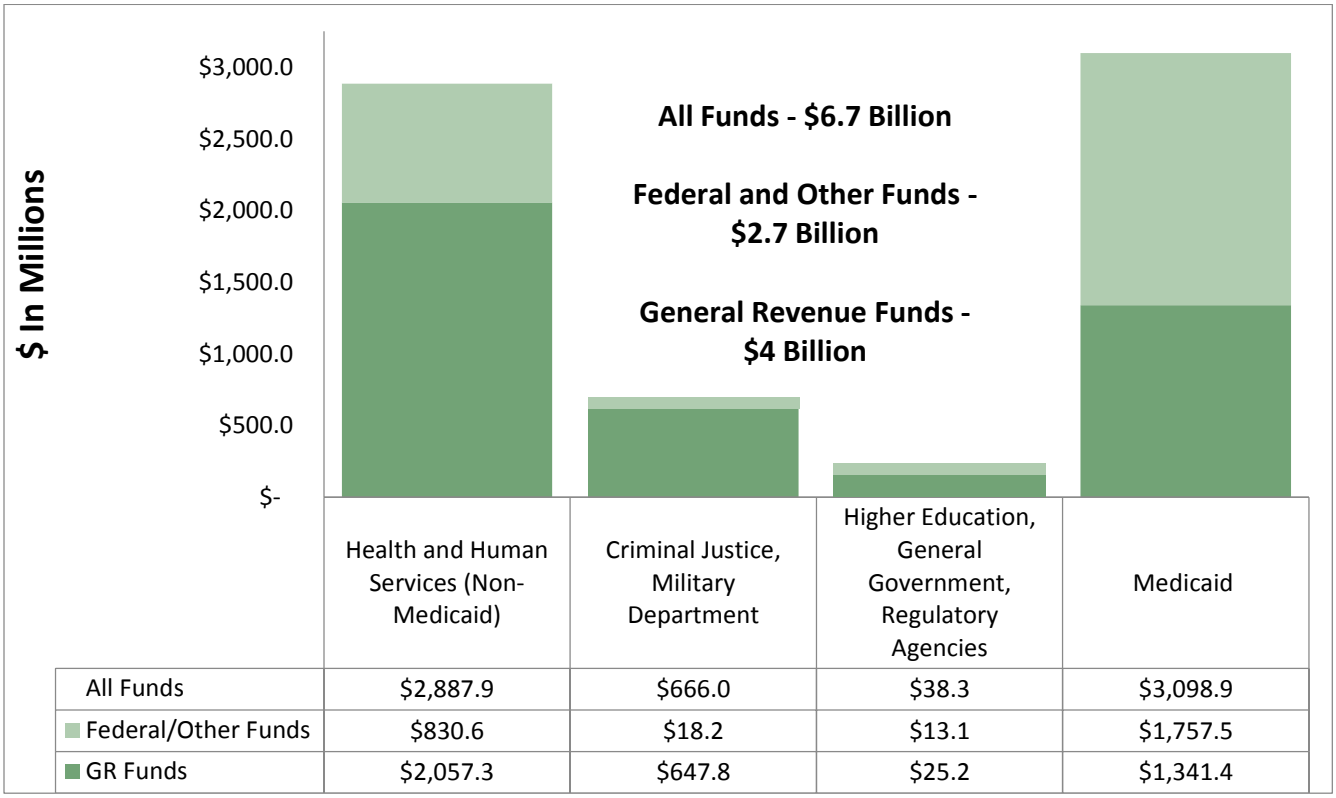
4.2 Behavioral Health Services Funding in Texas

The Texas state budget for the fiscal year 2016-17 biennium specifically identifies $3.6 billion in state General Revenue related to behavioral health services in Article IX, Section 10.04. This funding crosses 18 state agencies (per Article IX, Sec. 10.04) and several areas of state government represented on the Council, including health and human services, criminal justice, higher education, general government, and regulatory services.

In addition, to funding specifically identified in Article IX, Section 10.04, Texas Medicaid is a major source of behavioral health funding, both through payments to health care providers for behavioral services and through the Delivery System Reform Incentive Payments (DSRIP) program included in the state's 1115 Transformation Waiver. Behavioral health-related Medicaid provider payments are estimated to be $3.1 billion in the 2016-17 biennium.

Chart 2 illustrates the amount of funding Texas has allocated to behavioral health services in the 2016-17 biennium by major program areas, reflecting the significant behavioral health investment made by the 84th Legislature.

Chart 2: Behavioral Health Funding for Fiscal Years 2016 and 2017 by Program



	Health and Human Services (Non-Medicaid)	Criminal Justice, Military Department	Higher Education, General Government, Regulatory Agencies	Medicaid
All Funds	$2,887.9	$666.0	$38.3	$3,098.9
Federal/Other Funds	$830.6	$18.2	$13.1	$1,757.5
GR Funds	$2,057.3	$647.8	$25.2	$1,341.4

Notes:

- Medicaid expenditures include all claims with a primary diagnosis code that represents a behavioral health condition.
- Estimates for Medicaid do not include DSRIP.
- Estimated fiscal years 2016 and 2017 Medicaid expenditures are proportioned from prior year's mental health costs to total costs, and applied to forecasted costs. NorthSTAR costs are included with DSHS in fiscal year 2016 and four months of fiscal year 2017 as appropriated.

4.2.1 Additional Funding Mechanisms

DSRIP Projects

The 1115 Transformation Waiver is a five-year Medicaid demonstration waiver running through September 30, 2016, for the development of managed care within the Texas Medicaid program while preserving federal supplemental hospital funding historically provided under the upper limit payment program. Part of the 1115 Transformation Waiver is the DSRIP funding pool, which provides incentive payments to providers for health care innovation and quality improvements. The total amount of the DSRIP pool is $11.4 billion (All Funds) over the 5 years of the waiver. DSRIP behavioral health-related projects ending in September 2016 have the potential to earn over $2.6 billion (All Funds) based on project achievement by the end of Demonstration Year 5 (federal fiscal year 2016). As of January 2016, these projects have 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 2016. Providers have four opportunities to report achievements in federal fiscal years 2016 and 2017.

It is important to note that while DSRIP is not an ongoing funding stream, DSRIP funding has been a major catalyst for spearheading more than 400 innovative behavioral health projects across Texas that have reinforced and improved the Texas behavioral health system.

Medicaid

Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by HHSC. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups). Each state chooses its own eligibility criteria within federal minimum standards.

Because Medicaid is an entitlement program, the federal government does not, and Texas cannot, limit the number of eligible people who can enroll in Medicaid, and must pay for any medically necessary services covered under the program.

Texas Medicaid funds the following behavioral health services:

- Mental Health Targeted Case Management
- Mental Health Rehabilitation
- Individual Psychotherapy
- Family Psychotherapy
- Group Psychotherapy
- Psychological and Neuropsychological testing
- Psychiatric Diagnostic Evaluation
- Inpatient Psychiatric Hospitalization
- Pharmacological Management
- Psychotropic Medications
- Substance Use Disorder Treatment Assessment
- Medication Assisted Therapy
- Hospital-Based Detoxification
- Residential Detoxification
- Ambulatory Detoxification
- Outpatient Treatment (Individual and Group Counseling)
- Substance Use Disorder Residential Treatment
- Screening, Brief Intervention, and Referral to Treatment

As shown in Table 4, as of October 2015, 4 million of the almost 27 million Texans, or about 1 in 7 Texans, relied on Medicaid for health coverage.

Table 4: Texas Medicaid Enrollment, October 2015[20]

Texas Medicaid Program	Enrollment
Managed Care	
State of Texas Access Reform (STAR)	2,880,035
STAR+PLUS	582,700
STAR Health	30,998
Managed Care Sub-total	3,493,733
Fee-for-Service	560,975
Grand Total	**4,054,708**

4.2.2 Examples of Collaborative Funding

Many state programs effectively leverage General Revenue funding to draw down local public, private, and federal dollars to promote, support, and sustain behavioral health programs. In large measure, these programs are effective because they foster collaborations with local decision makers, ensuring the programs reflect community needs. The following information describes several examples of collaborative funding:

Neonatal Abstinence Syndrome Projects

The 84th Legislature granted DSHS an Exceptional Item request for $11.2 million in additional funds in the 2014-15 biennium to support new and existing services aimed at reducing the incidence and severity of neonatal abstinence syndrome (NAS) in Texas. DSHS is utilizing a multi-pronged approach to address NAS by increasing targeted outreach services to engage women earlier in care, increasing the availability of behavioral health intervention and treatment services to pregnant and postpartum women to improve birth outcomes, and implementing specialized programs to reduce the severity of NAS.

Residential Treatment Center Project

The Residential Treatment Center (RTC) Project is a cross-agency collaboration between DSHS and DFPS to prevent parental relinquishment of children to the state due solely to a lack of mental health resources for children with SED, in circumstances where many other treatment options have failed and RTC placement is medically necessary. To address the need of increased access to care, the 83rd Legislature allocated $2.1 million in additional funds to DSHS in the 2014-15 biennium to fund 10 beds in private RTCs for children and youth referred by DFPS. Additionally, the 84th Legislature appropriated $4.8 million in the 2016-17 biennium to expand the RTC Project from 10 to 30 beds. To help children achieve successful reunification and recovery, the RTC Project utilizes Building Bridges Initiative best practices, including weekly

family therapy and communication between the Local Mental Health Authority (LMHA) and the RTC.

Mental Health Programs for Veterans

The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article II, Department of State Health Services, Rider 62) appropriated $5 million each fiscal year of the biennium to provide specific services to veterans through a mental health program. DSHS coordinates with TVC to administer the Mental Health Program for Veterans through its partnerships with 37 LMHA in accordance with H.B. 2392, 83rd Legislature, Regular Session, 2013. The Mental Health Program for Veterans includes the provision of peer-to-peer counseling; access to licensed mental health professionals; jail diversion services; and peer training. Additionally, the program includes the ability to make grants in support of regional and local organizations to fund mental health projects that serve veterans and family members across the state. During the first quarter of fiscal year 2016, the program trained 302 individuals in peer-to-peer service skills, provided direct peer services to 18,801 veterans and family members, and served 1,806 justice-involved veterans.

Criminal Justice Diversion Funding

Since 2007, many new diversion funding initiatives have been created to reduce the prison populations. These TDCJ programs have resulted in a prison population reduction as well as three prison closures. As further indication of diversion programming success, the latest overall recidivism rate has declined to 21.4 percent.

Patient Assistance Programs

Also known as patient or medication assistance programs, prescription assistance programs (PAPs) have emerged in an effort to help patients who lack health insurance or prescription drug coverage obtain the medications they need. These programs are typically offered by pharmaceutical companies to provide free or low-cost prescription drugs to qualifying individuals. By providing financial assistance for hundreds of psychotropic medications, PAPs provide a valuable resource to patients, helping them comply with recommended drug regimens, and in turn, obtain better health outcomes. Millions of Americans use PAPs to get the medicines they need, but cannot afford. LMHAs actively support people who are medically indigent in gaining access to PAPS to secure medically necessary medications from pharmaceutical companies. In 2015, more than $126 million in medications were secured for people who otherwise would have relied on General Revenue-funded medications.

1115 Transformation Waiver: DSRIP Program

The 1115 Transformation Waiver created the DSRIP funding pool that is designed to support coordinated care and quality improvements through 20 Regional Healthcare Partnerships (RHP). Each RHP conducted a community needs assessment to identify local health care priorities for the implementation of transformative health care projects. DSRIP projects are funded at the Medicaid federal matching rate with the non-federal share of funds coming from local or state

public entities, known as intergovernmental transfer payments. DSRIP funds must be earned based on achievement of project-specific metrics each year, which may include establishing project infrastructure, serving additional clients, and demonstrating improvements in certain outcomes. There are more than 400 behavioral health projects implemented through the DSRIP program. The 1115 Transformation Waiver provides communities the opportunity to develop innovative, locally-driven DSRIP projects that address unique local needs and produce favorable outcomes that improve the behavioral health of Texans.[21] Texas made behavioral health a priority in DSRIP by allocating ten percent of the DSRIP funds to community mental health centers and including many behavioral health-focused project options. The community mental health centers receiving DSHS funding for adult, child, and crisis mental health services currently operate 340 projects.[22]

Other Local Resource Development Initiatives

Additional initiatives include:

- Local and private grants have been awarded to integrate primary and mental health care, increase access to autism services for children, provide Mental Health First Aid training, expand mental health services beyond the state target population, and enhance access to peer support services.
- As reflected in the 2014 HHSC and System Issues Staff Report for the Sunset Advisory Commission, LMHAs dramatically exceeded the state-required local match requirement. In fiscal year 2014, local taxing authorities (i.e., counties, cities, hospital districts, and school districts) invested more than $73 million across mental health and intellectual disability services, with most of this investment focused on mental health services.
- Proceeds from Texas Lottery Commission scratch-off games, and donations received via the Texas Department of Public Safety, the Texas Department of Motor Vehicles, and the Texas Parks and Wildlife Department forms fund TVC's Fund for Veterans' Assistance grant program. TVC awards reimbursement grants to nonprofit organizations and units of local government to provide direct mental health services to veterans and their families.
- Texas Department of Housing and Community Affairs awards grants to provide supportive housing services, DSHS awards grants related to postpartum intervention, and TDCJ grants local communities funding for jail diversion programs and enhanced continuity of care services.

5. Stakeholder Input Results

In developing this strategic plan, the Council determined it was important to seek and utilize stakeholder input. In an effort to gather as much statewide feedback as possible, the Council distributed surveys to various stakeholder groups and included stakeholders on workgroups to identify and describe gaps within the Texas behavioral health system.

5.1 Surveys

Two surveys were distributed to the following agencies and organizations which then forwarded the surveys to their respective networks. They include the Council agencies, the Association of Substance Abuse Programs, the Hogg Foundation for Mental Health, Meadows Mental Health Policy Institute, Texas Council of Community Centers, Texas Systems of Care, and Via Hope: Texas Mental Health Resources.

5.1.1 Objectives Survey

On December 9, 2015, the Council released a survey to seek stakeholder input on prioritizing and ranking the objectives developed under the goals initially identified by the Council. This survey was open until February 28, 2016, and collected 831 responses.

Survey respondents represented a cross-section of Texans including participants in the behavioral health system, their friends and family, as well as law enforcement, city and county government representatives. The respondents were asked to rank order the objectives under each goal in terms of importance. Additionally, respondents were given the opportunity to enter narrative comments in an "other" category under the objectives for each goal. The overall results of the survey aligned with the Council's strategic direction. Further detailed results of the survey can be found in Appendix D.

From this survey and the work of the Council, the strategic goals emerged to support the vision of ensuring that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.

5.1.2 Survey on the Current Behavioral Health System

A 2016 survey asked treatment providers, consumers, family members, and community members to identify the strengths, weaknesses, opportunities, and threats in the Texas behavioral health system. A total of 745 respondents participated.

The results of this survey served both to confirm the challenges identified and described in Section 5.2 Gaps in Services below and to acknowledge current efforts and investments that have been successful.

The top four strengths in the current system identified by respondents include the availability of peer services; a diverse array of services; an increase in the volume of services; and crisis response teams.

Additional responses related to strengths within the system include the collaboration of service providers, communities, law enforcement, and first responders; and the demonstration of genuine concern for clients by dedicated professionals. Further detailed results of the survey can be found in Appendix D.

5.2 Texas Behavioral Health Advancements and Best Practices

Due to the large investment and stewardship of the Office of the Governor and the Legislature to improve the behavioral health service delivery system, there have been significant improvements in the Texas behavioral health system. For example, transitions toward managed care, a focus on integrated health, increased treatment alternatives to incarceration, enhanced local community collaboration, and coordinated funding efforts have all contributed to significant advancements in behavioral health care in Texas.

While this strategic plan focuses on creating a framework for future improvements in cross-agency coordination, prevention, service delivery, and data collection, it is important to acknowledge the major advancements in service delivery and funding mechanisms Texas has seen over the last decade to improve the behavioral health delivery system.

Texas state agencies have implemented programs and systems that have significantly improved behavioral health outcomes in areas such as reductions in recidivism and enhanced servce intergration. Examples of these initiatives are listed below, and additional Texas best practices are provided in Appendix E:

HHSC: Managed Care Carve-in of Mental Health Rehabilitative Services and Targeted Case Management

In accordance with S.B. 58, 83rd Texas Legislature, Regular Session, 2013, HHSC was charged with integrating behavioral health services and physical health services into the Medicaid managed care program. The bill required all Medicaid MCOs to develop a network of public and private providers of mental health rehabilitative services and targeted case management to ensure adults with SMI and children with SED have access to a comprehensive array of services.

Mental health rehabilitative services and targeted case management were successfully carved-in to managed care effective September 1, 2014. HHSC worked closely with the state behavioral health authority as well as MCOs and providers to ensure that there was continuity of services when transition from the former fee-for-service model to the managed care model.

HHSC: Potentially Preventable Readmissions and Complications

HHSC currently assesses both managed care and fee-for-service hospital performance based on potentially preventable events, including potentially preventable readmissions and complications. Based on performance on these metrics, HHSC may financially withhold a set potion of the hospital payment rate (in the fee-for-service delivery system), or may reduce capitation rates (in managed care). One of the most significant reasons Medicaid members experience potentially preventable readmission is due to behavioral health issues. In fact, according to the latest statewide potentially preventable readmissions report, when measured at the 15-day window, mental health and SUD conditions comprised 9.5 percent of initial admissions, but 28.2 percent of potentially preventable readmissions. Holding MCOs and hospitals financially accountable leverages payment mechanisms to improve health care quality.

HHSC, DSHS, and DFPS: Psychotropic Medications for the Texas Foster Children

Since 2004, HHSC, DFPS, and DSHS have coordinated to better assess and implement strategies to ensure the appropriate prescribing of psychotropic medications to children in foster care and assist health care providers in prescribing psychotropic medications appropriately. The first Psychotropic Medication Utilization Parameters were distributed statewide for implementation in February 2005. Implemented in April 2008 to serve children in DFPS conservatorship and young adults who have aged out of foster care, the STARHealth program is required to review each child's psychotropic medication regimen and enforce the best practices named in the parameters. Current reports show that the overall use of psychotropic medications has decreased by 48 percent; polypharmacy in children in foster care has decreased by 74 percent; and the instance of 5 or more psychotropic medications taken concurrently has decreased by 74 percent since efforts began in 2004. Updated parameters are released on a biannual schedule with the most current version completed in March 2016.[23]

DSHS: Recovery Support Services

In May 2014, Texas implemented a recovery-oriented system of care model focusing on long-term peer recovery support services and the expansion of community-based recovery supports. Individuals with a history of alcohol and/or drug problems, including co-occurring mental health disorders, who are in or seeking recovery along with their family members and significant others are eligible to these services. Recovery Support Services encompass a wide array of non-clinical services and supports that help individuals to initiate and sustain their recovery, such as recovery coaching, peer-lead support groups, life skills training, housing, and employment supports. An interim evaluation report from the Addiction Research Institute[24] revealed:

- Housing tenancy and ownership increased by 25 percent
- Employment increased by 25 percent
- Average monthly individual wage increased by $407
- The abstinence or reduction in substance use rate was 88 percent

Additionally, the preliminary evaluation reports an estimated $3.4 million dollar savings in health care costs related to medical, mental health, and SUD treatment in the first six months of recovery coaching.

TJJD: Mental Health Treatment Program

For youth being released from the TJJD Mental Health Treatment Program, TJJD staff develop strong aftercare plans to include in-person participation in Community Resource Coordination Groups, collaboration with DADs (for qualifying youth), referrals to the Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOOMMI) continuity of care system, and family education.

It is also important to recognize the tremendous investment made during the 84th legislative session to address challenges such as increasing mental health services for veterans and their

families, improving behavioral health service availability, and workforce shortages. During the development of this strategic plan, many of these new programs and services were in the implementation phase.

TMD: Telemental Health Service for Geographically Dispersed Military and Veteran Populations

Telemental health services allows military and veteran populations to receive services in communities where counselors are not available, that have a long wait list, or when clients are not comfortable with issues related to military service. In addition, it allows TMD counselors to read facial and other non-verbal cues that help them understand the client's issues better.

5.3 Gaps in Services

Council agency members and community stakeholders groups provided valuable insight to identify gaps and challenges related to coordination, access, and service provision within the behavioral health system in Texas. Identified gaps will provide opportunities to strengthen the system as the strategic plan is implemented.

Gap 1: Access to Appropriate Behavioral Health Services

Council agency members identified specific populations that are underserved in the current behavioral health system. These populations include individuals with SUD; individuals with co-occurring psychiatric and substance use disorders; individuals with SMI; and those who are frequent users of jail, emergency room, and inpatient services.

Individuals with SUD face several challenges with accessing treatment services, including provider shortages, waiting-lists for services, and the common perception that an individual's mental health needs take priority over SUD needs when both should be treated at the same time.[25] Untreated SUD drives crisis and emergency room utilization, as well as inpatient readmissions.

Studies indicate there is an overwhelming co-occurrence of substance use and psychiatric disorders. Best practices indicate treatment of psychiatric disorders and SUDs should occur simultaneously.[26] However, in fiscal year 2014, only 3 percent of the estimated 1,601,196 million adults and 3 percent of the estimated 181,938 youth with chemical dependence and medical indigence were served by DSHS-funded SUD providers, including the NorthSTAR program.[27]

Another potential barrier to treatment of mental illness is the tendency to group a range of diverse needs under a single label, such as SMI. Though generally not the practice in other areas of medicine, overgeneralizations can hinder access to care at the appropriate level of service for subpopulations with specific needs. To provide just one example, an estimated 4,000 Texans develop an initial psychosis each year.[28] Despite evidence suggesting that targeted interventions for this group are successful, these services are not widely available.

Another group with unmet behavioral health needs in the current system are sometimes referred to as "super-utilizers" which includes adults and children who experience high criminal justice, emergency room, and psychiatric inpatient utilization. The Kaiser Family Foundation found that, nationally, approximately 5 percent of Medicaid beneficiaries drove more than 50 percent of total Medicaid spending.[29] Texas is not unique in facing challenges in effectively intervening with these individuals. Texas agencies that provide behavioral health services should collaborate to identify and address the behavioral health needs of these individuals effectively, using a person-centered system of care.

Gap 2: Behavioral Health Needs of Public School Students

Recent national studies have shown that one in ten school-aged children or youth have an undiagnosed or untreated behavioral health condition that adversely affects school attendance, classroom behavior, and overall academic performance.[30] School-based mental health services may be delivered by a variety of professionals with different types of training, including nurses, school psychologists, social workers, and school counselors.

Professional school counselors provide comprehensive guidance and counseling to reduce drop-out rates, improve academic performance and increase participation in postsecondary education. Since the role of the school guidance counselor is broader than supporting student behavioral health, stakeholders indicate that often times schools lack the professional capacity to meet student needs for prevention and intervention. Students may struggle with a range of behavioral health conditions, including emotional disturbance, depression, anxiety, attention deficit, significant traumatic experience, drugs and alcohol, or a crisis situation.

Innovative prevention and early intervention programs in schools, such as Mental Health First Aid training, have helped some Texas educators learn skills to better identify and support behavioral health needs. In fiscal year 2015, approximately 6,527 educators were trained in Mental Health First Aid.[31] Schools offer professional development and implement effective strategies such as Positive Behavior Interventions and Supports and Restorative Discipline. Some schools have developed innovative mental health partnerships with community providers, while other schools have hired mental health professionals, such as psychologists and social workers, to supplement student learning supports.

However, it is difficult for the behavioral health infrastructure in school districts statewide to meet the identified need and disseminate best practices in early intervention and early detection across campuses and districts.

Gap 3: Coordination across State Agencies

State agencies serve a significant percentage of individuals with behavioral health needs. Behavioral health programs and services provided by these agencies can be better coordinated, consistent, and have a cross-agency approach to behavioral health service provision, program coordination, training, and funding.[32] Uncoordinated efforts across state agencies can result in

different treatments or services provided to individuals based on the agency or system serving them.

Individuals with unmet behavioral health needs are frequently seen throughout multiple Texas systems, often on an as-needed basis, rather than through a consistent and planned approach. These systems include the adult and juvenile criminal justice systems, hospital emergency rooms, schools, child protective services, and other social service settings where provided services may not be coordinated, and as a result, can be less effective.[33]

An additional challenge is that funding for behavioral health services in Texas is appropriated to multiple state agencies, often from federal and state sources that dictate eligibility requirements and allowable uses.

Gap 4: Veteran and Military Service Member Supports

Left untreated, veterans' and military personnel's behavioral health needs can undermine an individual's health, decrease work productivity, and damage social functioning and family relationships.[34] This is a particularly critical issue in a state like Texas that is home to 1.7 million veterans[35] and 170,680 active duty and reserve military personnel.[36, 37]

Veterans and military personnel with a mental health condition are more likely to have SUD and are at increased risk of suicide. Once discharged, veterans can face obstacles in obtaining and maintaining employment or pursuing an education. They are at an increased risk of experiencing homelessness.[38] Additionally, the stigma associated with having behavioral health needs can prevent veterans and military personnel from seeking help and adhering to treatment once help is provided.[39]

Not receiving services and supports can affect the individual veteran and military service member, and also burden relationships, strain marriages, and complicate the difficulties of parenting. As a consequence, children of veterans and military personnel are more likely to experience the effects of cross-generational trauma which can lead to inpatient psychiatric stays, as well as outpatient psychiatric treatment for children and youth with SED. [40]

Gap 5: Continuity of Care for Individuals Exiting County and Local Jails

TDCJ operates the TCOOMMI continuity of care system to address mental health continuity of care needs for those adjudicated to the juvenile justice system and those adults sentenced to probation or incarceration with a severe or persistent mental illness. By pairing specialized supervision of these offenders with intensive case management through the LMHAs there has been a resulting reduction in the re-incarceration rate. Continuity of care combined with evidence-based programming does not exist for most individuals exiting the county and local jail systems.

As of August 1, 2015, approximately 66,625 individuals were in Texas county jail.[41] It is important to recognize that many entering the criminal justice system have high criminogenic risk factors (predictive measures for criminal offense) not related to a mental illness.

The county and local jail systems need to work collaboratively to address both an individual's criminogenic risk as well as his or her mental health needs. Too often, inadequate continuity of care complicates reentry into the community and increases the risk of both recidivism and inpatient psychiatric care. Also, if individuals waiting in jail for a hospital bed do not receive appropriate care, their condition can deteriorate resulting in longer hospitalizations.

Gap 6: Access to Timely Treatment Services

Texas has invested significantly in developing a psychiatric crisis system that provides individuals with a variety of crisis alternatives. Administered through LMHAs, private providers, and NorthSTAR, the Texas public crisis system served approximately 1.1 million adults and children in fiscal years 2008 through 2013.[42]

Texas crisis system responders have demonstrated effective first response. However, the Texas SUD treatment system has not evolved in parity to the mental health crisis system. If an individual has behavioral health needs that require SUD treatment, that person may experience lengthy wait times to access the appropriate treatment option. Individuals who have a primary SUD are at increased risk of completed suicide.[43] Suicide is the third leading cause in youth age 10 to 24 years.[44]

Once stabilized in the crisis system, lengthy wait times for access to SUD treatment may cause an individual to experience another crisis episode. This situation can potentially result in a costly crisis or inpatient psychiatric stay that does not address the individual's most pressing behavioral health need which is SUD treatment.

When individuals need inpatient care, they may have difficulty accessing a bed in a timely manner. State-operated facilities are frequently on diversion, and waitlists are on the rise. Forensic referrals have increased, outstripping the state's forensic capacity and encroaching on beds available for civil patients. Forensic waitlists have been growing over the past several years. In January 2016, 424 individuals were waiting in jail for a hospital bed.[45] DSHS advisory committees have identified addressing the number of available hospital beds as a top priority, noting that many individuals in need of inpatient care wait for long periods of time, often in local emergency departments and jails.

Gap 7: Implementation of Evidence-based Practices

A substantial amount of evidence-based practices for effective and efficient treatment of behavioral health conditions exists and continues to grow. Adoption of evidence-based and promising practices across Texas has increased. Cross-agency collaborations have resulted in implementation of evidenced-based practices such as Seeking Safety, Mental Health First Aid, Individual Placement and Support, Permanent Supportive Housing, Illness Management and Recovery, Integrated Treatment for Co-Occurring Disorders, and Cognitive Behavioral Therapy for adults with SMI, and Wraparound and Trauma Focused Cognitive Behavioral Therapy for children and adolescents with SED. However, the adoption and implementation of evidence-

based practices are not coordinated across systems to ensure fidelity to treatment models and a "no wrong door" approach.[46, 47, 48]

Gap 8: Use of Peer Services

Current research indicates that peer support services decrease substance use,[49] reduce utilization of inpatient and emergency room care,[50] and increase consumer engagement in care. In Texas, mental health peer services are provided by certified peer specialists and family partners. In the case of SUD, treatment is provided by certified recovery coaches.

While Texas has been a leader in promoting self-directed care for people with mental illness through peer-delivered services, an even greater effort is needed. 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. Peers can also play an important role in crisis response and critical transitions, including community re-entry after hospitalization and incarceration.

Gap 9: Behavioral Health Services for Individuals with Intellectual Disabilities

Depression and anxiety are the most frequently identified mental health conditions among individuals with IDD, but the prevalence of schizophrenia is disproportionately high in this population. Additionally, individuals with IDD frequently have behavioral health needs that are the result of post-traumatic stress.[51]

Often, the symptoms of untreated mental health needs among individuals with IDD can be mischaracterized as "challenging behaviors." Recently, the behavioral health system in Texas has begun to focus more specifically on the mental health and wellness of this population.

While this increased focus on individuals with dual diagnoses certainly represents a step in the right direction, more extensive efforts will be needed. Individuals with IDD should have access to quality behavioral health services, trauma-informed care, and opportunities for recovery.[52] Additionally, supports should be adequate in both their approach and intensity to avoid unnecessary hospitalizations or incarcerations. When individuals with dual diagnoses end up in the hospital or in jail, appropriate interventions and supports must be targeted to their specific needs.

Gap 10: Consumer Transportation and Access to Treatment

A recent national study of chronic health conditions concluded that transportation barriers impact access to treatment as well as follow-through with ongoing treatment. Transportation challenges can result in poor clinical outcomes and increased emergency room utilization.[53]

With more than one-half of Texas counties categorized as rural, transportation challenges can impact those seeking services. Telemedicine has helped increase access to care in these areas, but challenges remain. Access to inpatient care has proved challenging for law enforcement

personnel in rural areas who are frequently part of the crisis response for behavioral crises and who often must drive long distances to transport individuals in need of state hospital care.[54]

Gap 11: Prevention and Early Intervention Services

In Texas, 600,000 children, youth, and their families experience behavioral health needs before the age of 18.[55] Fifty-eight percent of these children do not receive treatment, and the youth who do access services often do so through the education, child welfare, or the juvenile justice systems.[56]

Behavioral health needs in children and youth can increase the risk of academic failure, substance abuse, unemployment, homelessness, and developing chronic health and behavioral health conditions as adults.[8] By age 14, 50 percent of all lifetime cases of mental illness are apparent, with 75 percent becoming apparent by age 24.[57]

Early identification of and intervention for behavioral health needs can improve and mitigate the impact of disabling and serious conditions. House Bill 3793, 83rd Legislature, Regular Session, 2013, made an important investment in prevention and early intervention by allocating $5 million toward Mental Health First Aid training for educators. Continued and expanded efforts are needed.

Gap 12: Access to Housing

Behavioral health disorders can lead to or be a result of homelessness. Of the nearly 24,000 people statewide who were homeless on a single night in January 2015, 18.7 percent had a serious mental illness, and 15.7 percent had a chronic SUD.[58] Individuals who are homeless typically have more chronic physical, mental health, and substance use issues than do the general population. They are also at greater risk for infectious diseases.[59]

Without secure housing and other support services, persons with behavioral health conditions may cycle through more costly options such as emergency rooms, the criminal justice system, or service providers.[60]

Gap 13: Behavioral Health Workforce Shortage

Along with much of the nation, Texas has a shortage of behavioral health workers that is expected grow over time. More than 80 percent of Texas counties are designated as Mental Health Professional Shortage Areas, which are defined as more than 30,000 residents per clinician.

Many of the most experienced and skilled practitioners are approaching retirement, as more than one-third of Texas psychiatrists are over the age of 55. Texas higher education institutions have been unable to produce enough graduates to meet the predicted demand.[61]

These conditions have a direct impact on community providers and state hospitals, where capacity and access to services can be restricted by workforce shortages.

Gap 14: Services for Special Populations

The current behavioral health delivery system in Texas is adopting person-centered care,[62] designed to address an individuals' unique needs. However, as youth transition out of the juvenile justice, foster care, and mental health facility systems and into the adult behavioral health systems, there may be challenges to addressing their unique behavioral health needs. Evidence emphasizes that how an adolescent adjusts while in transition to adulthood has lasting implications into adulthood.[63]

This behavioral health challenge exists in serving many special populations with distinct and specialized needs, such as mothers with postpartum depression; individuals with a history of incarceration or long-term hospitalization; forensic patients; veterans and military service members with behavioral health needs; individuals with deafness or visual impairments; and individuals with IDD.

In order to see improved outpatient outcomes with special populations, providers of behavioral health services providers must engage individuals with specialized needs in community treatment, preventing the need for a higher level of care. To do so effectively, they must have access to state-of-the art service delivery and billing practices.

Gap 15: Shared and Usable Data

Population health management combines person-centered care with a focus on the overall health of a population, recognizing that a person's health is determined by more than just the services he or she receives. In a population health system, providers are rewarded not just for providing services, but also based on outcomes for a specific population under their care.

Many health care experts believe that adopting population health management principles offers great promise for improving patient outcomes and satisfaction and lowering costs. This approach requires systems to assess, track, and manage the health conditions, treatments, and results for large populations across multiple care and social service settings.

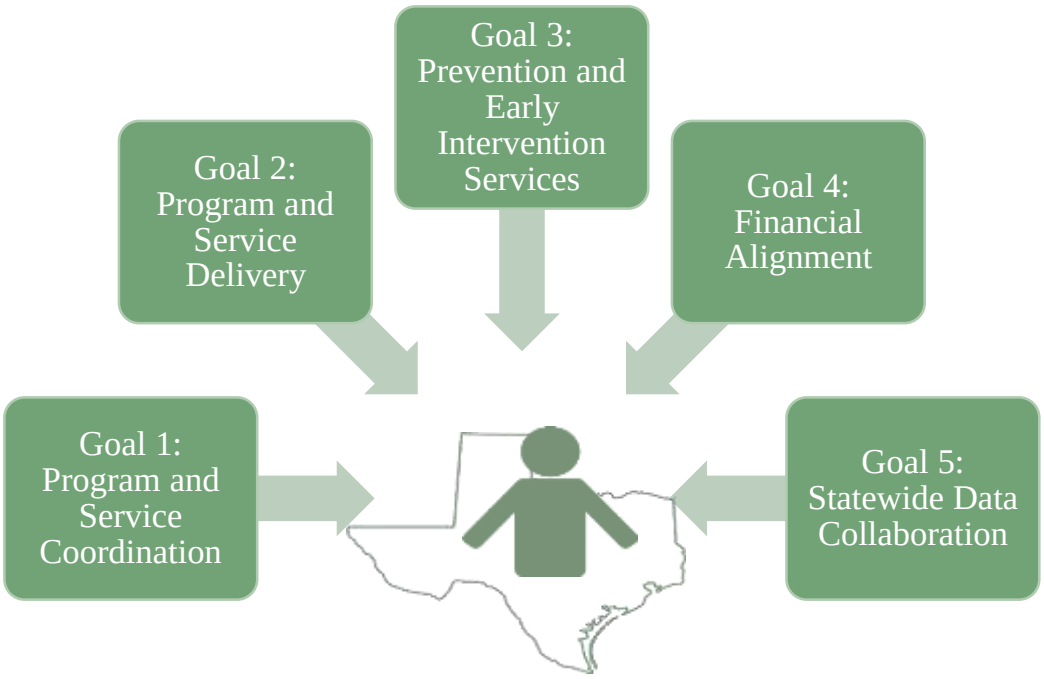
Rich data sets exist throughout the Texas behavioral health and other systems, but much is yet to be done toward developing efficient technical and administrative processes to link this information and make it available in useful formats for timely decision making.

6. Goal, Objectives, and Strategies

Building on the vision, mission, and guiding principles established by the Council, this strategic plan has been developed and is supported by a series of goals, objectives, and strategies to guide innovation, collaboration, and foster opportunities to leverage resources across state agencies. The goals are as follows:

- **Goal 1: Program and Service Coordination** – Promote and support behavioral health program and service coordination to ensure continuity of services and access points across state agencies.
- **Goal 2: Program and Service Delivery** – Ensure optimal service delivery to maximize resources in order to effectively meet the diverse needs of people and communities.
- **Goal 3: Prevention and Early Intervention Services** – Maximize behavioral health prevention and early intervention services across state agencies.
- **Goal 4: Financial Alignment** – Ensure that the financial alignment of behavioral health funding best meets the needs across Texas.
- **Goal 5: Statewide Data Collaboration** – Compare statewide data across state agencies on results and effectiveness.

Vision: To ensure that Texas has a unified approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.



Achieving the vision to develop a unified and coordinated statewide approach to providing appropriate and cost-effective behavioral health services to Texans will occur in two phases:

- Phase 1: Immediate implementation of short-term opportunities which are low- or no-cost
- Phase 2: Planning and implementation of long-term strategies

The following section outlines the five-year goals, objectives, and strategies and is then followed by a list of short-term opportunities that can be implemented immediately or within a short period of time.

6.1 Strategies: Long-term Planning and Implementation

Each goal area outlined in this section has objectives and each objective is followed by a group of supporting strategies. These strategies may evolve as a result of research, emerging best practices, or other external factors. The flexibility of strategies allows the Council the opportunity to assure that resources are maximized and that agencies are able to respond actively to new trends, the needs of populations, and regulations. Additionally, each strategy is linked to gaps identified in Section 5.2 Gaps in Services and again below for reference.

- **Gap 1:** Access to Appropriate Behavioral Health Services
- **Gap 2:** Behavioral Health Needs of Public School Students
- **Gap 3:** Coordination across State Agencies
- **Gap 4:** Veteran and Military Service Members Supports
- **Gap 5:** Continuity of Care for Individuals Exiting County and Local Jails
- **Gap 6:** Access to Timely Treatment Services
- **Gap 7:** Implementation of Evidence-based Practices
- **Gap 8:** Use of Peer Services
- **Gap 9:** Behavioral Health Services for Individuals with Intellectual Disabilities
- **Gap 10:** Consumer Transportation and Access to Treatment
- **Gap 11:** Prevention and Early Intervention Services
- **Gap 12:** Access to Housing
- **Gap 13:** Behavioral Health Workforce Shortage
- **Gap 14:** Services for Special Populations
- **Gap 15:** Shared and Usable Data

While not explicitly included as strategies, it is the intention of the Council that action taken to fulfill each objective will be measured for its effectiveness.

Goal 1: Program and Service Coordination

Promote and support behavioral health program and service coordination to ensure continuity of services and access points across state agencies.

1.1 Increase statewide service coordination for special populations by fiscal year 2018.

	Strategies	Gaps Addressed
1.1.1	Address the service needs of high risk individuals and families by promoting community collaborative approaches, e.g. Jail Diversion Program and Community Resource Coordination Groups.	**1, 3, 5, 11, 14**

	Strategies	Gaps Addressed
1.1.2	Increase diversion of people with behavioral health needs from the criminal and juvenile justice systems through the coordinated use of risk and mental health assessments.	**1, 3, 6, 7, 11, 14**
1.1.3	Ensure service eligibility and integration into the community for those transitioning from governmental custody, foster care, and hospital settings.	**1, 3, 5, 6, 14**

1.2 Reduce duplication of effort and maximize resources through program and service coordination among state agencies by fiscal year 2018.

	Strategies	Gaps Addressed
1.2.1	Identify and address duplication of effort across state agencies.	**3, 7, 14**
1.2.2	Implement improved program and service coordination and integrated program and service strategies to reduce duplication of effort and maximize resources.	**1, 3, 6**

Goal 2: Program and Service Delivery

Ensure optimal program and service delivery to maximize resources in order to effectively meet the diverse needs of people and communities.

2.1 Expand the use of best, promising, and evidence-based behavioral health practices across service agencies by fiscal year 2019.

	Strategies	Gaps Addressed
2.1.1	Identify and coordinate best, promising, and evidenced-based behavioral health practices.	**1, 2, 7**
2.1.2	Evaluate implementation of best, promising, and evidence-based practices process and outcomes.	**1, 2, 7**

2.2 Develop clinical research and innovation in behavioral health by fiscal year 2021.

	Strategies	Gaps Addressed
2.2.1	Promote research aimed at the development and implementation of new and innovative evidence-based behavioral health practices.	**1, 7, 8, 9, 11, 14, 15**
2.2.2	Promote research on current treatment methodologies to identify new or updated evidence-based practices, and improve benchmarking.	**1, 7, 8, 9, 11, 14, 15**

2.3 Ensure prompt access to coordinated, quality behavioral health services by fiscal year 2021.

	Strategies	Gaps Addressed
2.3.1	Identify strategies to improve and strengthen access to behavioral health programs and services to engage and serve individuals in remote areas, such as transportation needs.	**1, 3, 6, 10**
2.3.2	Implement strategies to improve service access and continuity of care, including outpatient and inpatient, substance use treatment, and crisis services.	**1, 3, 5, 6, 10**
2.3.3	Evaluate the effectiveness of identified access improvement strategies.	**1, 3, 5, 6, 10**

2.4 Strengthen the behavioral health workforce by fiscal year 2021.

	Strategies	Gaps Addressed
2.4.1	Expand opportunities to address behavioral health workforce shortages in rural and urban areas through such activities as residency programs, student loan forgiveness, paid internships, and collaborations with universities.	**1, 6, 13**
2.4.2	Support and increase the competency of the workforce through joint training efforts, and continuing education in identified best, promising, and evidence-based practices.	**1, 6, 7, 13**
2.4.3	Enhance the recruitment and retention of a diverse workforce.	**1, 13**

2.5 Address current behavioral health service gaps and needs across program and service agencies by fiscal year 2021.

	Strategies	Gaps Addressed
2.5.1	Identify service delivery gaps for diverse populations in the state.	**1, 3, 4, 9, 14**
2.5.2	Develop and implement programs and services to address identified gaps to include integrated approaches for special populations	**1, 3, 4, 9, 14**
2.5.3	Develop a coordinated approach to address the housing and employment needs of individuals with behavioral health issues.	**1, 12**
2.5.4	Develop a comprehensive behavioral health approach to meet the complex needs of the highest users of high cost alternatives.	**1, 3, 8, 14**

2.6 Address the most urgent challenges and needs related to both state-funded and state-operated inpatient psychiatric facilities across Texas by 2021.

	Strategies	Gaps Addressed
2.6.1	Identify opportunities for ongoing input, interagency collaboration and support for the implementation of the 10 year plan related to state psychiatric hospitals per legislation and recommendations from the 83rd and 84th Legislature.	**3, 6**
2.6.2	Address gaps related to the maintenance of the state-operated facility infrastructure to ensure quality of care and efficient operation.	**6**
2.6.3	Address gaps related to access to state funded inpatient psychiatric facilities.	**1, 6**

Goal 3: Prevention and Early Intervention Services

Maximize behavioral health prevention and early intervention services across state agencies.

3.1 Expand the use of best, promising, and evidence-based practices for prevention and early intervention by fiscal year 2019.

	Strategies	Gaps Addressed
3.1.1	Identify and evaluate current strategies used across state agencies, and additional state and national best, promising, and evidence-based practices.	**1, 2, 7, 11**
3.1.2	Develop recommendations for maintenance of currently identified best, promising, and evidence-based practices; and coordinate resources to implement new prevention and early intervention strategies.	**1, 2, 7, 11**
3.1.3	Develop a communication and outreach strategy for consumers and providers to increase awareness of and access to behavioral health services in Texas.	**1, 6**

3.2 Address behavioral health prevention and early intervention service gaps across service agencies by 2021.

	Strategies	Gaps Addressed
3.2.1	Identify prevention and early intervention service gaps for diverse and special populations in the state.	**1, 2, 4, 6, 9, 11, 14**
3.2.2	Implement programs and services to reduce identified service gaps affecting diverse and special populations.	**1, 2, 4, 6, 9, 11, 14**

Goal 4: Financial Alignment

Ensure that the financial alignment of behavioral health funding best meets the needs across Texas.

4.1 Provide recommendations biennially to maximize the use of state or federal funding.

	Strategies	Gaps Addressed
4.1.1	Identify statewide behavioral health trends and priorities**.**	**All**
4.1.2	Determine appropriate funding to effectively support and sustain behavioral health systems, services, and initiatives.	**All**
4.1.3	Examine strategies to obtain and leverage necessary funding to address and support initiatives, e.g. LAR review and collaborative grant opportunities.	**All**

4.2 Reduce utilization of high cost alternatives, such as institutional care, criminal and juvenile justice incarceration, inpatient stays, emergency room visits, and foster care by fiscal year 2019.

	Strategies	Gaps Addressed
4.2.1	Explore and promote alternative payment structures that reward or incentivize the provision of services that avert more costly care.	**1, 2, 4, 5, 6, 7, 8, 9, 11, 14**
4.2.2	Improve access to lower and flexible intensity service alternatives, e.g. crisis stabilization, crisis respite, intensive community treatment, and assisted living.	**1, 6, 9, 14**

Goal 5: Statewide Data Collaboration

Compare statewide data across state agencies on results and effectiveness.

5.1 Develop an interim means of cross-agency comparison of performance data by fiscal year 2019.

	Strategies	Gaps Addressed
5.1.1	Identify existing common or similar metrics to evaluate the effectiveness of programs and services across targeted agencies.	**3, 15**
5.1.2	Leverage existing information technology (IT) systems to match current common or similar performance measures across targeted agencies.	**3, 15**
5.1.3	Analyze and compare the interim measures on effectiveness across targeted agencies.	**3, 15**

5.2 Establish a system to allow near real-time limited data exchange of identified client data in targeted agencies by fiscal year 2020.

	Strategies	Gaps Addressed
5.2.1	Establish a common set of data metrics that each targeted agency will collect and share.	**3, 15**
5.2.2	Identify barriers including confidentiality, data points, and existing information technology (IT) systems regarding near real-time data exchange across targeted agencies.	**3, 15**

	Strategies	Gaps Addressed
5.2.3	Work collaboratively with IT and programs staff to determine a technically feasible and cost-effective means to share data on a near real-time basis.	**3, 15**
5.2.4	Determine any resources needed to implement identified means of near real-time data sharing.	**3, 15**

6.2 Short-term Opportunities: Addressing Service Gaps

In addition to the goals, objectives, and strategies, the Council agencies have identified several low- or no-cost opportunities to begin addressing the identified service gaps. Council agencies have already begun to implement these opportunities, and others can be implemented by December 2016. The identified gaps the opportunities addressed are listed first and demonstrate that efforts are already underway to address the behavioral health needs of Texans.

6.2.1 Short-term Opportunities

Gap 1: Access to Appropriate Behavioral Health Services

Council agencies will share behavioral health resource links on their websites with an emphasis on how individuals may access services. It is anticipated that website resource coordination will allow Texans the opportunity to gain greater knowledge of and earlier access to behavioral health services. By coordinating this information collective, Council agencies will communicate consistent messaging regarding available services.

Gap 3: Coordination across State Agencies

In collaboration with HHSC, TEA is convening United Services for All Children, an interagency workgroup focused on coordinating behavioral health services to support students, families, and schools. Additional agency participants include representatives from DSHS, DADS, DARS, DFPS, and TJJD.

DFPS and TDCJ will collaborate to create a cross-referencing process for re-entry planning to address needs and risk for those offenders identified as having been previously engaged in DFPS services.

DFPS will increase cross-training for other agencies on the use of the Texas Youth Hotline.

HHSC will coordinate opportunities for state agencies to have access to Mental Health First Aid training, which can provide skills to front-line staff who may come in contact with individuals with behavioral health conditions.

Gap 4: Veteran and Active Service Members Supports

TMD and TVC will increase collaboration related to sharing resources and knowledge to reduce duplication of effort and maximize resources to benefit veterans and their families in accessing services.

Gap 5: Continuity of Care for Individuals Exiting County and Local Jails

TDCJ has increased jail diversion projects for adults from the county and local jails to appropriate mental health services and intervention programs. These programs are partnerships with the LMHAs, district attorneys, public defender's offices, courts, and local community corrections and supervision departments. These partnerships will increase awareness related to access to available behavioral health service options for individuals in the criminal justice system with behavioral health needs; therefore, Texans exiting the county and local jail system will have increased access to appropriate treatment options which will decrease the likelihood of reentering the criminal justice system.

Gap 6: Implementation of Evidence-based Practices

DSHS and HHSC will identify and share best, promising, and evidence-based practices learned from the 1115 Transformation Waiver projects across other state agencies.

DSHS will offer its Centralized Training Infrastructure of Evidence-based Practices as a training platform across the HHS System.

Council member agencies will collaborate to provide enhanced regional training opportunities related to practices, through a training workgroup.

TMD and TVC will identify opportunities to share training resources, such as Peer to Peer Counselor training.

Gap 11: Prevention and Early Intervention Services

DSHS will increase collaboration with Texas Youth Hotline and other mental health and substance use outreach hotlines and 2-1-1.

Gap 12: Access to Housing

To expand the membership of the Council, the Chair will request that the Texas Department of Housing and Community Affairs (TDHCA) provide a representative to the Council. TDHCA will increase awareness of Council agencies about accessing available housing resources as well as the opportunity to collaborate with partner agencies to address the housing needs of Texans with behavioral health conditions.

7. Accountability and Continuous Improvement

Once approved, the framework established in this strategic plan provides the Council with steps to take to meet key objectives listed in Article IX, Section 10.04 including the elimination of redundancy, utilization of best practices in contracting standards, perpetuation of identified and successful models, ensuring optimal service delivery, and identification and collection of comparable data on results and effectiveness.

As previously noted, legislation directing the Council to create a five-year statewide strategic plan included additional requirements, such as an inventory of behavioral health programs and services currently offered and a plan to coordinate programs and services to eliminate redundancy.

This section reviews the proposed plan to identify commonalities and reduce redundancy, the process for coordinating funding in the future, implementation efforts, and the evaluation of those efforts.

7.1 Coordinating Behavioral Health Programs and Services to Eliminate Redundancy

Lack of coordination and continuity among programs in a multifaceted, complex system of state and local agencies frequently results in more expensive services with poorer outcomes for individuals.[64] One of the challenges faced by Council agencies is reducing redundancy and integrating fragmented programs into a coherent and comprehensible network through which individuals can access services and service providers.

7.1.1 Inventory of Behavioral Health Program and Services

In addition to the strategic plan, and fulfilling legislative direction, the Council agencies created an inventory of behavioral health programs and services. Included as an appendix to the strategic plan, the inventory outlines the behavioral health programs and services provided by Council agencies and describes the programs and services, and the populations and number of individuals served. The inventory also categorizes the programs and services into service categories including: prevention and promotion; screening and assessment; service coordination; treatment and rehabilitation; housing; employment; and crisis intervention.

7.1.2 Plan to Coordinate Behavioral Health Programs and Services to Eliminate Redundancy

During the process of compiling the inventory, there were a number of commonalities identified in programs and services related to either the population an agency served or the service provided, either directly or through contracts.

The inventory review identified common service types provided by more than one Council agency in the following areas:

- Peer-delivered
- Jail-diversion
- Crisis
- SUD
- Employment
- Prevention and Early Intervention

The provision of common services across more than one Council agency may, in some cases, be necessary to address unique population needs. To address commonalities identified through the review, the Council proposes a plan to develop a workgroup in order to:

1. Identify opportunities for coordination or alignments.
2. Recommend coordination activities to the Council for further exploration.
3. Coordinate with designated agencies to develop work plans that include implementation timelines and metrics to evaluate success.

The Council anticipates that this structured approach will reduce duplication of effort by state agencies, either by consolidating appropriate redundancies or by identifying opportunities to collaborate. In some instances, while similarities exist, there may not be actual redundancies, and consolidation and collaboration may not be appropriate. Regardless of the specific work plans initiated, this plan provides for the structure to identify, examine, and discuss commonalities. The Council expects overall positive results as state agencies continue to share information and seek out collaborative partnerships.

7.2 Future Financing

The coordination of behavioral health related expenditures is a key component of the legislative direction provided to the Council in Article IX, Section 10.04. Consequently, Council agencies will work to ensure that related items in their LARs are consistent with the goals of the strategic plan.

As part of the collaborative process, Council agencies will complete an expenditure proposal, detailing currently funded items which will make up the base request for behavioral health funding at each agency. Council agencies will work to coordinate, collaborate, and reduce redundancy in base-funded items listed in the expenditures proposal. This report is due to the LBB on June 1, 2016.

Council agencies will also collectively review and coordinate exceptional item requests for agencies that are not currently members of the Council to ensure that those requests are consistent with the goals of the strategic plan. During this process, the Council will work to identify opportunities to collaborate and eliminate redundancies throughout the interim leading up to the 85th legislative session.

7.3 Coordination of Council Recommendations with Existing Advisory Committees

Various advisory committees and workgroups have been established to fulfill legislative directives and advise or make recommendations to member agencies that comprise the Council. Such committees include the TCOOMMI Advisory Committee, the State Health Coordinating Council, Joint Commission on Access and Forensic Service, the Behavioral Health Advisory Committee, the IDD System Redesign Committee, the Texas Coordinating Council for Veterans Services, and the Promoting Independence Advisory Committee.

Some of these advisory committees' primary purview is behavioral health, while other committees may make occasional behavioral health-related recommendations. It is important to acknowledge these advisory committees and the work done to improve behavioral health programs and services available to Texans.

As focus shifts toward implementation of the strategic plan, the Council will coordinate with advisory committees to ensure committee recommendations and progress are shared with the Council. A workgroup will be created to oversee and coordinate this collaboration as part of the implementation plan outlined in the Accountability section below.

7.4 Next Steps and Accountability

As previously discussed, this strategic plan is the result of coordination of the 19 state agencies (18 state agencies per Article IX, Section 10.04, and TEA); input from various stakeholders; and several months of meetings, discussions, and strategy development. Developing this strategic plan is the first step toward ensuring a unified and coordinated approach to the delivery of behavioral health services that allows all Texans to have access to care at the right time and place.

Through strategic plan objectives and strategies, the Council will move forward with implementation by developing a coordinated statewide approach to providing appropriate and cost-effective behavioral health services to Texans. To assume accountability for the strategic plan, the Council will continue to convene and will implement the strategic plan in two phases. The first phase includes immediate or short-term opportunities, and the second one includes long-term strategies.

Phase One – Immediate, Short-term, and Low- or No-cost Opportunities

- Enhance cross-agency information exchanges and resource sharing
- Maximize use of existing infrastructures and competencies
- Strengthen uniform trainings and assessments
- Increase partnerships related to statewide initiatives

Phase Two – Planning and Implementation of Long-term Strategies

- Maximize behavioral health prevention and early intervention services across Council agencies
- Address behavioral health services gaps and needs
- Ensure utilization of successful best, promising, and evidence-based behavioral health services and service delivery
- Ensure prompt access to quality behavioral health services
- Improve program and service delivery coordination across Council agencies
- Strengthen the behavioral health workforce

Once this strategic plan is approved and in place, the Council will seek direction from the Office of the Governor and Legislature regarding implementation to:

- Develop a timeline and operational work plan for implementation of identified strategies
- Create workgroups related to the practical implementation of the strategies and coordinate with advisory committees and councils to incorporate existing work on specific initiatives and recommendations
- Determine benchmarks (i.e., dates and outcome metrics) for each strategy and objective to evaluate the success of implementation
- Determine a schedule to review the progress on or need to update strategic plan objectives and strategies

The Council will also provide updates to the Legislature and the Office of the Governor regarding the implementation and success of plan objectives and strategies as requested.

The statewide strategic planning process has been a cross-agency, collaborative effort that will positively impact the future of behavioral health services in Texas. The behavioral health strategic plan is expected to lead to improvements in cross-agency coordination, addressing identified gaps through a coordinated and strategic approach, and maximizing the use of existing resources and services. A more efficient and effective state government approach to behavioral health service delivery will result in Texans having a greater awareness of and access to behavioral health services. While this five-year strategic plan may not solve every behavioral health problem or remedy every challenge, implementation of the goals, objectives, and strategies is a step in the right direction and offers a hopeful path to wellness and recovery.

Appendix A: Glossary of Terms and Acronyms

Glossary of Terms

Behavioral Health – The 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04), defines behavioral health services as "programs or services concerned with research, prevention, and detection of mental disorders and disabilities, and all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental disorder or disability, including persons whose mental disorders or disabilities result from alcoholism or drug addiction."

Continuity of care – The degree to which the care of a patient is not interrupted.[65]

Co-occurring disorders – Generally refers to the coexistence of mental health disorders and SUDs. There are times when this term is used to describe individuals with IDD and mental health disorders.

Criminogenic – A predictive measure for criminal offense.[66]

Delivery System Reform Incentive Payments (DSRIP) – One of two payment pools available from the 1115 Transformation Waiver. Provides financial incentives that encourage hospitals and other providers to focus on achieving quality health outcomes. Participating providers develop and implement programs, strategies, and investments to enhance access to health care services, quality of health care and health systems, cost-effectiveness of services and health systems, and health of the patients and families served.[67]

Evidence-based practices – Integrate clinical expertise; expert opinion; external scientific evidence; and client, patient, and caregiver perspectives so that providers can offer high-quality services that reflect the interests, values, needs, and choices of the individuals served.[68] A **best practice** is a method or technique that is accepted as being correct or most effective. A **promising practice** is one that leads to an effective and productive result, and must have measurable results that demonstrate success over time.

Fee-for-Service – The traditional Medicaid health care payment system under which providers receive a payment for each unit of service they provide.[69]

Fidelity – Implementation of a program or practice as its developer intended to achieve an impact similar to where it was first implemented or tested. Maintaining fidelity means keeping most elements of the program the same. However, programs may need to be adapted to gain greater community acceptance or in response to the contexts of a particular setting. Budget constraints, staff availability, time limitations, or other issues may make adaptation necessary.[70]

Integrated care – The systematic coordination of primary and behavioral health services addressing the needs of the whole person.[71]

Intellectual and Developmental Disability (IDD) – Includes many severe, chronic conditions that are due to mental and/or physical impairments. IDD can begin at any time up to 22 years of age and usually lasts throughout a person's lifetime. People who have IDD have problems with major life activities such as language, mobility, learning, self-help, and independent living.[72]

Managed Care – A delivery system where a MCO, sometimes called a health plan, is paid a capped (or capitated) rate for each client enrolled. In managed care, clients receive health care and long-term services and supports through an MCO contracted with a network of doctors, hospitals, and other health care providers responsible for managing and delivering quality, cost-effective care.[73]

Medicaid – Medicaid is a jointly funded state-federal health care program, established in Texas in 1967 and administered by HHSC. In order to participate in Medicaid, federal law requires states to cover certain population groups (mandatory eligibility groups) and gives them the flexibility to cover other population groups (optional eligibility groups).[74]

Medicaid Rural Service Area (MRSA) – On March 1, 2012, STAR managed care expanded to serve Texas Medicaid clients in 164 rural counties. The MRSA STAR program serves clients who were previously covered by the Primary Care Case Management program—if they had Medicaid only (e.g., pregnant women and children with limited income, Temporary Assistance for Needy Families clients, and adults receiving Supplemental Security Income (SSI). Children age birth through 20 years with SSI may voluntarily choose between traditional Medicaid and managed care through participation in MRSA STAR program.[75]

NorthSTAR – Texas' managed care carve-out pilot program for behavioral health services. Implemented in 1999 in Dallas and contiguous counties, NorthSTAR integrates Medicaid-funded and public, non-Medicaid funded mental health and chemical dependency services. The program includes state and federal Medicaid funds (through a 1915(b) waiver), non-Medicaid state and federal funds, and some county funds.[76]

Peer services –Services designed and delivered by individuals who have experienced a mental disorder or SUD and are in recovery. They also include services designed and delivered by family members of those in recovery. Peer specialists foster hope and promote a belief in the possibility of recovery.[77]

Person-centered care – Individuals have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the individual.[78]

Serious Mental Illness (SMI) – A diagnosable mental, behavior, or emotional disorder that causes serious functional impairment amount people who are age 18 and older that substantially interferes with or limits one or more of major life activities.[79]

Serious and Persistent Mental Illness (SPMI) – Inclusive of people with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders, who are experiencing significant functional impairment due to a mental health disorder that requires crisis resolution or ongoing, long-term support and treatment.[80]

Severe emotional disturbance (SED) – Diagnosable mental, behavioral, or emotional disorders in the past year for children ages 17 years and younger, which resulted in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.[81]

Special populations – Populations with distinct and specialized behavioral health needs, including but not limited to mothers with postpartum depression, individuals with a history or incarceration or long-term hospitalization, forensic patients, military trauma-affected veterans and service members, individuals with deafness, visual impairment, or IDD who also have behavioral health needs.

State of Texas Access Reform (STAR) – Texas' Medicaid managed care program in which HHSC contracts with MCOs to provide, arrange for, and coordinate preventive, primary, and acute care covered services to non-disabled children, low-income families, and pregnant women. On March 1, 2012, STAR expanded to MRSA. See also Medicaid Rural Service Area**.**

STAR Health – A statewide managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits include medical, dental, and behavioral health services, as well as service coordination and a web-based electronic medical record (known as the Health Passport). The program was implemented on April 1, 2008.[82]

STAR+PLUS – Implemented in 1998, this managed care program provides integrated acute and long-term services and supports to people with disabilities, and people age 65 and older. STAR+PLUS operates in the Bexar, Dallas, El Paso, Harris, Hidalgo, Jefferson, Lubbock, Nueces, Tarrant, and Travis service areas. Acute, pharmacy, and long-term services and supports are coordinated and provided through a credentialed provider network contracted with MCOs.[83]

Substance Use Disorder (SUD) – Occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.[84]

Super-utilizer – Children and adults who experience high criminal justice, emergency room, and psychiatric inpatient utilization.

Telehealth – A health service, other than a telemedicine medical service, delivered by a licensed or certified health professional acting within the scope of the health professional's license or certification who does not perform a telemedicine medical service and that requires the use of

advanced telecommunications technology, other than telephone or facsimile technology, including: compressed digital interactive video, audio, or data transmission; clinical data transmission using computer imaging by way of still-image capture and store and forward; and other technology that facilitates access to health care services or medical specialty expertise.[85]

Telemedicine – A health care service, initiated by a physician who is licensed to practice medicine in Texas under Title 3, Subtitle B of the Occupations Code or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis, or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including: compressed digital interactive video, audio, or data transmission; clinical data transmission using computer imaging by way of still-image capture and store and forward; and other technology that facilitates access to health care services or medical specialty expertise.[86]

Texas 1115 Healthcare Transformation and Quality Improvement Program 1115 Waiver – Known as the 1115 Transformation Waiver, the waiver is a five-year demonstration running through September 2016 that allows the state to expand Medicaid managed care, including pharmacy and dental services, while preserving federal hospital funding historically received as Upper Payment Limit payments. The 1115 Transformation Waiver, which was approved in December 2011, provides new means, through regional collaboration and coordination, for local entities to access additional federal match funds.[87]

Trauma-informed care – Treatment interventions that specifically addresses the consequences of trauma on an individual and are designed to facilitate healing. A trauma-informed approach has the following principles: safety, trustworthiness, peer support, collaboration and mutuality, empowerment, voice, and choice. Trauma-informed care should also consider cultural, historical, and gender issues.[88]

List of Acronyms

Acronym	Full Name
BHP	Behavioral Health Pilot program
CFP	Certified family partners
CHIP	Children's Health Insurance Program
CJD	Governor's Criminal Justice Division
CMS	Centers for Medicare and Medicaid Services
CompKit	Competency to Stand Trial Training Curriculum
DADS	Department of Aging and Disability Services
DFPS	Department of Family and Protective Services
DSHS	Department of State Health Services
DSM	Diagnostic Statistical Manual
DSRIP	Delivery System Reform Incentive Payments
FPL	Federal poverty level
FY	Fiscal year
GED	General Educational Development test
HB	House Bill
HCPC	Harris County Psychiatric Center
HHSC	Health and Human Services Commission
HIV	Human Immunodeficiency Virus
ICF	Intermediate care facility
IDD	Intellectual and developmental disabilities
IQ	Intelligence quotient
LAR	Legislative Appropriations Request
LBB	Legislative Budget Board
LIDDA	Local intellectual and developmental disabilities authorities
LMHA	Local mental health authority
LOC	Level of care
MCO	Managed care organization
MFPD	Money Follows the Person Demonstration grant
MRSA	Medicaid Rural Service Area
MVPN	Military Veteran Peer Network
NADCP	National Association of Drug Court Professionals
NAS	Neonatal abstinence syndrome
OCR	Outpatient competency restoration
PAP	Prescription or Patient Assistance Programs
RHP	Regional health care partnership
RTC	Residential treatment center
SAMHSA	Substance Abuse and Mental Health Services Administration
SB	Senate Bill
SED	Severe emotional disturbance

Acronym	Full Name
SMI	Serious mental illness
SPMI	Serous and persistent mental illness
STAR	State of Texas Access Reform
SUD	Substance use disorder
SWOT	Strength, Weaknesses, Opportunities, and Threats
TCCO	Texas Civil Commitment Office
TCOOMMI	Texas Correctional Office on Offenders with Medical or Mental Impairments
TDCJ	Texas Department of Criminal Justice
TEA	Texas Education Agency
TEC	Texas Education Code
TJJD	Texas Juvenile Justice Department
TMD	Texas Military Department
The Council	Statewide Behavioral Health Coordinating Council
TVC	Texas Veterans Commission
UTHSC–Houston	University of Texas Health Science Center at Houston
UTHSC–Tyler	University of Texas Health Science Center at Tyler
WIN	Wellness Incentives and Navigation

Appendix B: Inventory of Behavioral Health Programs and Services

Fulfilling legislative direction, the Council agencies have created an inventory of behavioral health programs and services. The following inventory outlines the behavioral health programs and services provided by Council agencies and describes the programs and services, and the populations and number of individuals served. The inventory also categorizes the programs and services into service categories including: prevention and promotion; screening and assessment; service coordination; treatment and rehabilitation; housing; employment; and crisis intervention.

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Prevention / Promotion	Screening / Assessment	Service Coordination	Treatment / Rehabilitation	Psychosocial Rehabilitation	Housing	Employment	Crisis Intervention	Other
Article I, Trusteed Programs, Office of the Governor Criminal Justice / Drug Courts; Strategy A.1.3 (Rec. B.1.1)	Adults (charges include Drug/DWI, Mental Health related, Veteran, Family, and Commercially Sexually Exploited Persons) and Juveniles charged with a nonviolent offense and who are suffering from substance abuse problem or mental health problem.	Provide grant funds to counties, judicial districts or juvenile boards to support Specialty Courts (Drug/DWI, Mental Health, Veteran, Family, and Commercially Sexually Exploited Persons). Services provided by the drug court programs include intense supervision, drug testing, counseling and therapy and case management.	7,700	✓			✓					
Article I, Trusteed Programs, Office of the Governor Criminal Justice / Juvenile Justice and Delinquency Program; Strategy A.1.3 (Rec. B.1.1)	At-risk youth and juveniles who have had contact with the juvenile justice system. Local communities with a high population of mentally ill or population suffering from substance abuse problems.	Provide grant funding to local communities and non-profit organizations to improve the juvenile and adult criminal justice system in a variety of ways, including increased access to mental health and substance abuse programs. Services include: • Early Intervention and Prevention activities and services such as academic tutoring, truancy, suspension and expulsion prevention services. • Substance abuse, alcohol and mental health prevention services. • Work awareness and training projects. • Diversion activities to prevent youth from further involvement in the juvenile justice system.	2,000	✓								
Article I, Trusteed Programs, Office of the Governor Criminal Justice / Residential Substance Abuse Treatment; Strategy A.1.3 (Rec. B.1.1)	Adults and juveniles charged with an offense who have been identified through testing as suffering from a substance abuse problem.	Provide direct treatment services to the eligible offender populations of State agencies, counties, and community supervision and corrections departments operating secure correctional facilities.	1,500				✓					

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Prevention / Promotion	Screening / Assessment	Service Coordination	Treatment / Rehabilitation	Psychosocial Rehabilitation	Housing	Employment	Crisis Intervention	Other
Article I, Texas Veterans Commission General Assistance Grants (Veterans Mental Health Grants); Strategy B.1.1.	Texas veterans, their families, and survivors	Make grants to local nonprofit organizations and units of local governments providing direct mental health services to veterans and their families. Services include but are not limited to: clinical counseling services, peer-delivered services, and non-clinical support services.	Number unavailable until after projects are selected for funding	✓	✓	✓	✓	✓	✓	✓	✓	
Article I, Texas Veterans Commission Mental Health Program for Veterans (Military Veteran Peer Network); DSHS Strategy B.2.1. (IAC between TVC and DSHS)	Texas service members, veterans, their families	Provide the following: • Peer to Peer Services • Clinical mental health services • Peer to Peer training • Community education • Justice System training and support • Faith and Community-based organization training and support.	60,000	✓	✓	✓	✓	✓			✓	

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Article II, Department of Aging and Disability Services Intellectual and Developmental Disability (IDD) Crisis Respite and Behavioral Intervention Programs; Exceptional Item 5a, Strategy A.1.1	Individuals with intellectual and developmental disabilities (IDD) who have significant behavioral and psychiatric challenges.	Behavioral intervention and crisis respite programs at the Local Intellectual and Developmental Disability Authorities (LIDDA) to supports individuals with IDD in crisis with access to temporary stabilization resources while securing services that will meet their long term needs. • Establish, expand, or enhance Community-based Crisis Services; • Provide support to existing crisis mobile units (such as a Mobile Crisis Outreach Team [MCOT]) to include the availability of a behavioral specialist who is specifically trained on addressing crisis situations with individuals with IDD/DD; • Provide crisis respite services for individuals with IDD/DD and IDD/MI to exclude MI only; and • Provide follow-up care to monitor and provide support to individuals with IDD who received crisis services.	750	✓							✓	
Article II, Department of Aging and Disability Services Regional Medical, Behavioral, and Psychiatric Technical Support Teams; *CMS Grant Funded Initiative	Community providers and Local Intellectual and Developmental Disability Authorities (LIDDAs) who serve individuals with IDD at risk of being admitted into an institution, and those who have moved from institutional settings, including state supported living centers (SSLCs) and nursing facilities (NFs).	Provide the following: • Quarterly educational activities, webinars, videos, and other correspondence, to increase the expertise of LIDDA and provider staff in supporting the targeted population • Technical assistance, upon request from LIDDAs and providers, on specific disorders and diseases, with examples of best practices and evidence-based services for individuals with significant medical, behavioral and psychiatric challenges • De-identified (as necessary) case-specific peer review support to service planning teams that need assistance planning and providing effective care for an individual.	850	✓							✓	

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Article II, Department of Aging and Disability Services Enhanced Community Coordination	Individuals with IDD residing in an institution, such as an SSLC or NF, who are transitioning to a community Medicaid waiver program or community Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).	Provide information to: • The individual and the individual's legally authorized representative (LAR) about available community living options, services, and supports, in addition to the information provided during the community living options process • The individual and LAR are provided opportunities to visit community resources • The individual is provided intensive and flexible support to achieve success in a community setting • The individual is provided enhanced pre- and post-transition services	850			✓						
Article II, Department of Aging and Disability Services Mental Health Wellness for Individuals with IDD (MHW-IDD);* CMS Grant Funded Initiative	• Direct service workers who support individuals with IDD with behavioral health needs • Individuals with IDD who have behavioral health needs and co-occurring mental illness (MI)	Provide eLearning courses designed to support the enhancement and development of a highly skilled workforce staff (i.e. direct support workers, clinicians, and physicians) to: • Support the behavioral health needs of individuals with an IDD and a co-occurring mental health condition • Promote their successful placements in community settings of their choice.	Unknown. Trainings are available publically, free of charge, and are not required courses.	✓								

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Article II, Department of Aging and Disability Services DADS Nurse and Behavioral Health Line. Axis Point Health contract; funded by appropriations, which is a combination of general revenue and federal funds.	Providers, direct service workers, and families who are supporting individuals with medical and/or behavioral health needs during their first 12 months of transitioning from the SSLCS to the community	Provide support to community providers with concerns regarding an individual's medical or behavioral status during transition to ensure a successful and stable transition to the community. Assistance includes identification of local resources for medical issues, connections to the local crisis hotline, notification to the SSLCs regarding the individual contacts, and a behavioral health stabilization team at each Center for phone consultation or on-site assistance depending upon the individual need.	Unable to project precisely; 233 transitions took place in FY 15	✓		✓					✓	
Article II, Department of Aging and Disability Services Intellectual and Developmental Disability (IDD) Community Services and Supports; *Strategy A.1.4.2	Individuals in 1915(c) Home and Community-Based Services Waiver (HCS) with high behavioral needs that are at risk for out-of-home placement due to severely challenging behavior.	Addition of enhanced behavioral/crisis services to HCS waiver for individuals in HCS with challenging behavior that will address behavioral crisis situations, divert individuals from emergency services, support their success in the community, and decrease their chance for institutionalization or hospitalization.	149	✓							✓	

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Article II, Department of Family and Protective Services Substance Abuse Prevention and Treatment Services; Strategy B.1.7	Families who either have a child in foster care or are receiving in-home family based safety services due to the high-risk of having a child removed and placed in foster care absent preventive measures. Services are provided to children who are in substitute care, children who remain in their homes, and to their caregivers and families.	Provide payments to contractors for substance abuse prevention and treatment services (education, counseling, and treatment) delivered to individuals to meet their needs, where not met by DSHS services. Services may include: • Substance abuse assessment and diagnostic consultation • Individual, group and/or family substance abuse counseling and therapy, including home-based therapy	3176		✓		✓	✓			✓	
Article II, Department of Family and Protective Services Counseling and Therapeutic Services; Strategy B.1.8	Families who need assistance to facilitate the achievement of the child's or family's service plan. Services are provided to children who are in substitute care, children who remain in their homes, and to their caregivers and families including those in family-based safety services.	Provide payments to contractors for counseling and therapeutic services delivered to individuals to meet their service plan needs, where not met by STAR Health services. Services may include: • Psychological and developmental evaluation and testing, psychiatric evaluation, and psychosocial assessments • Individual, group, and/or family counseling and therapy, including home-based therapy	4730		✓		✓	✓			✓	

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Article II, Department of Family and Protective Services Foster Care Payments, Sub-Acute Inpatient Treatment; Strategy B.1.9	Children in the conservatorship of DFPS with serious mental/behavioral health needs.	Provide payments to contractors for specialized treatment to children in the conservatorship of DFPS with serious mental health needs in an inpatient non-hospital setting.	14				✓	✓			✓	
Article II, Department of Family and Protective Services APS Emergency Client Services; Strategy D.1.3	Persons 65 and older and adults 18 to 64 with a disability in APS cases that are receiving services, and their family members.	Provide payments to contractors for mental health services to individuals to assess capacity and meet their service plan needs where services are not already provided through other funding sources.	675		✓		✓	✓			✓	

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Article II, Department of State Health Services Mental Health Services for Adults; Strategy B.2.1	Adults with mental illness	Provide an array of community-based services designed to support adults' movement toward independence and recovery, including: • Assessment (eligibility and crisis) • Crisis intervention • Case management • Skills training (individual/group) • Psychiatric services • Rehabilitation • Psychosocial rehabilitation • Co-occurring psychiatric and substance abuse disorders • Supported housing • Supported employment • ACT Team • Counseling (CBT,CPT) • Veterans services (CPT) • Peer Services (skills training, rehabilitation) • Other special projects (NorthSTAR Restructure)	LBB Annual Target: 124,057 (equity funding, NS transition, waiting list)		✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services 1915(i) Home and Community Based Services; Strategy B.2.1	Adults with extended tenure in state mental health facilities	Provide intensive home and community-based services to the target population in lieu of their remaining long term residents of those facilities.	Program Projection Current HCBS-AMH SPA: 100 HCBS-AMH Expansion for Jail Diversion: 250 ER Diversion: 150	✓	✓	✓	✓	✓	✓	✓	✓	

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Article II, Department of State Health Services Development and Expansion of Recovery-Focused Clubhouses; Exceptional Item 6d, Strategy B.2.1	Adults who have been diagnosed with a mental illness	Develop and expand recovery-focused Clubhouses based on the model from the International Center for Clubhouse Development, providing a day treatment program for rehabilitation.	Program Projection Annual Total Member: 3,880	✓	✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services Preadmission Screening and Resident Review Medicaid Costs for MH for Adults; Exceptional Item 6b.3, Strategy B.2.1	PASRR positive individuals who are eligible for specialized services.	Ensure sufficient matching dollars to ensure access to entitlement to Medicaid case management and rehabilitation. • Assessment,(eligibility and crisis) • Crisis intervention • Case management (skills training) • Medication • Rehabilitation • Psychosocial rehabilitation: COPSD, PSH, SE, ACT Team • Routine case management (This service is also subject to the <180 day stay requirement) • Skills training and development (group/individual)	LAR Annual: 4,791	✓	✓	✓	✓	✓	✓	✓	✓	

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Article II, Department of State Health Services Mental Health Services for Children; Strategy B.2.2	Children (ages 3 through 17) with mental illness	Provide outpatient services, inpatient services, family support services, new generation and other medications, and medication-related services.	LBB Annual Target: 30,365 (equity funding, NS transition)	✓	✓	✓	✓	✓		✓	✓	
Article II, Department of State Health Services Relinquishment Slots (DFPS); Exceptional Item 6c, Strategy B.2.2	Children and youth ages 5 to 17 referred to DFPS who are at risk for parental relinquishment of rights due solely to a lack of mental health resources to meet the needs of severe emotional disturbance, to the point where the child's symptoms make it unsafe for the family to care for the child in the home.	• Provide an additional 20 residential treatment beds • Provide intensive residential treatment for additional 40 children • Has funding for 30 RTC beds (base 10 beds plus 20 new beds)	LAR Annual: 60		✓	✓	✓					
Article II, Department of State Health Services YES Waiver, Strategy B.2.2	Children at risk of hospitalization or parental relinquishment due to a need for services to treat serious emotional disturbance (SED).	Includes the following services: community living supports, family supports, flexible funding for transition services, minor home modifications, adaptive aids and supports, respite, specialized therapies, and paraprofessional services. Children enrolled in YES are eligible for all Medicaid behavioral health services as well as those that are specific to the YES service array.	Program Projection Annual: 1,400		✓	✓	✓	✓	✓	✓	✓	

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Article II, Department of State Health Services Community Mental Health Crisis Services; Strategy B.2.3	Adults and children with mental illness or in crisis and at risk of unnecessary hospitalization, incarceration, or use of emergency rooms.	Provide an array of community services for mental health and substance abuse crisis to ensure statewide access to crisis hotlines, mobile crisis response, and facility-based crisis services, including community-based competency restoration services and other specialized projects to support persons in periods of crisis. Crisis Service Expansion and Enhancement; Exceptional Item 5a, Strategy B.2.3 - to improve crisis services based on assessment of community needs, to fill gaps in the current system or to enhance services currently being provided.	LBB Annual Target Residential: 30,915 Outpatient: 72,200		✓	✓	✓	✓			✓	
Article II, Department of State Health Services Jail-Based Competency; GAA (84-R) Rider 70, Strategy B.2.3.	• Defendants in county jails participating in the program • Persons first not able to be served in outpatient competency restoration in designated pilot site.	Contract with a mental health provider for competency restoration treatment for up to 60 days at a county jail participating in the program.	Program Projection: 120		✓		✓	✓				
Article II, Department of State Health Services Clinical Management Behavioral Health Services (CMBHS) System; Exceptional Item 5e, Strategy B.2.3.	Infrastructure for Community Mental Health and Substance Abuse.	Upgrade the CMBHS system to: • Track services and outcomes for additional programs; • Support third-party billing/attestations; • Develop required interfaces with the contract management system; • Automate invoicing and client services tracking for the Home and Community-Based Services program; • Develop a mobile application with up-to-date information to assist with referrals to crisis facilities and to aid in hospital diversion.	N/A									

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Article II, Department of State Health Services NorthSTAR Behavioral Health Waiver; Strategy B.2.4, Sept. 1 – Dec. 31, 2016.	Residents of Dallas, Ellis, Collin, Hunt, Navarro, Rockwall, and Kaufmann counties who receive Medicaid benefits or are indigent and have mental illness or substance abuse disorders.	Serve both Medicaid and non-Medicaid indigent clients and provides a publicly funded managed care approach for the delivery of mental health and substance abuse services.	LBB Annual Target: 29,716	✓	✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services Health Insurance Fee; Exceptional Item 1d, Strategy B.2.4	Infrastructure for Managed Care Contract - NorthSTAR	Fund Health Insurance Issuer Tax fee imposed by the Affordable Care Act on all managed care organizations, including NorthSTAR.	N/A									

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Article II, Department of State Health Services Preadmission Screening and Resident Review Medicaid Costs for NorthSTAR; Exceptional Item 6b.4, Strategy B.2.4	PASRR positive individuals who are eligible for specialized services.	Ensure sufficient matching dollars to ensure access to entitlement to Medicaid case management and rehabilitation. • Assessment (eligibility and crisis) • Crisis intervention • Case management (skills training) • Medication • Rehabilitation • Psychosocial rehabilitation • Co-occurring psychiatric and substance abuse disorders • Supported housing • Supported employment • ACT Team • Routine case management (This service is also subject to the <180 day stay requirement) • Skills training and development (group/individual)	LAR Annual: 547		✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services Substance Abuse: Neonatal Abstinence Syndrome; Exceptional Item 5b, Strategy B.2.4 (NorthSTAR area allocation)	Pregnant women who may ingest alcohol and other drugs, including certain prescription medications, during pregnancy, possibly causing Neonatal Abstinence Syndrome (NAS)	Expand or create health care services, products, and community-based activities to reduce the incidence, severity, and costs associated with NAS.	Program Projection Annual: 225 PPI; 44 OST; 14 Fully Funded; 2 Wrapped	✓	✓	✓	✓					

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Article II, Department of State Health Services Substance Abuse Prevention; Strategy B.2.5	Primarily youth and young adult populations. Some services target risk factors and some are aimed at the general population.	Prevent substance abuse problems from developing.	Adult: LBB Avg. Monthly Prevention: 46,878 Youth: LBB Avg. Monthly Prevention: 184,529	✓	✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services Substance Abuse Intervention; Strategy B.2.5	Persons who are involved with or have completed treatment services and who need support of their efforts to address their substance use disorder.	Intervention services are designed to work with individuals that have risk factors and behaviors that could lead to a substance abuse problem if not addressed.	Adult: LBB Avg. Monthly Intervention: 6,764 Youth: LBB Avg. Monthly Intervention: 600	✓	✓	✓	✓	✓	✓	✓	✓	

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Article II, Department of State Health Services Substance Abuse Treatment; Strategy B.2.5	• Adults above the age of 17 who are diagnosed with a Substance Use Disorder • Youth between the ages 13-17 who meet DSM-5, criteria for substance use or dependence	Treat individuals that have been diagnosed as having a substance use disorder that meets the DSM-V criteria, including RBI and HIV Services	Adult: LBB Avg. Treatment: 8,758 Youth: LBB Avg. Monthly Treatment: 1,439	✓	✓	✓	✓	✓	✓	✓	✓	
Article II, Department of State Health Services Substance Abuse: Neonatal Abstinence Syndrome; Exceptional Item 5b, Strategy B.2.5	Pregnant women who may ingest alcohol and other drugs, including certain prescription medications, during pregnancy, possibly causing Neonatal Abstinence Syndrome (NAS)	Expand or create health care services, products, and community-based activities to reduce the incidence, severity, and costs associated with NAS.	LAR Annual OST: 424; Wrapped: 28; Fully Funded: 86; Outreach: 597; Mothers: 313	✓	✓	✓	✓					
Article II, Department of State Health Services Substance Abuse Intervention, PPI / PADRE, Strategy B.2.5	• PPI women who are or may become pregnant who are at risk of substance abuse • PADRE current or potential fathers at risk of substance abuse	Pregnant Post-Partum Intervention Program (PPI) and Parenting Awareness & Drug Risk Education (PADRE).	LAR PPI Annual: 1,347 PADRE Annual: 573	✓	✓	✓	✓					

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Article II, Department of State Health Services Texas Center for Infectious Disease; Strategy C.1.1	Individuals with TB, multi-drug resistant (MDR TB) and extensively drug resistant (XDR TB) receive care along with any comorbid diagnosis while at TCID. Additionally, TCID's Outpatient Clinic also serves as one of the state's Hansen's disease clinics.	This hospital provides patient care, scientific investigation, and therapeutic and educational services supporting public health needs. TCID contracts with the University of Texas System and other hospitals for the provision of acute hospitalization, surgery, interventional testing, and various other outpatient services.	Program Projection Annual: 108 LBB Target Number Admissions: 68		✓	✓	✓	✓			✓	
Article II, Department of State Health Services Rio Grande State Center Outpatient Clinic; Strategy C.1.2	Adults living in the lower Rio Grande Valley in four counties: Cameron, Hidalgo, Willacy, and Starr.	Provide the following: • A physical healthcare clinic that also makes referrals to local mental health authorities for mental health services. • Funding includes all RGSC activity and not just activity related directly to Behavioral Health	LBB Annual Target Outpatient Visits: 37,404		✓	✓	✓	✓			✓	
Article II, Department of State Health Services Mental Health State Hospitals; Strategy C.1.3	Seriously mentally ill persons from all regions of Texas, regardless of their financial status in need of inpatient care or forensic commitment.	Provide intensive inpatient diagnostic, treatment, rehabilitative, and referral services at 10 state mental health facilities across the state.	LBB Annual Target: 12,100		✓	✓	✓	✓			✓	

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Article II, Department of State Health Services Hospital Cost Increases; Exceptional Item 1b, Strategy C.1.3	State Hospital Infrastructure	Fund inflation-related direct cost increases for operating the current state hospital system.	N/A									
Article II, Department of State Health Services Replace Vehicles; Exceptional Item 1c, Strategy C.1.3	State Hospital Infrastructure	Purchase additional vehicles for state hospital facilities to continue to provide vital services to individuals, resulting in reduced fuel, maintenance, and repair costs	N/A									
Article II, Department of State Health Services Patient Transition Support into Communities; Exceptional Item 2c, Strategy C.1.3 (Guardianship)	Seriously mentally ill persons who are currently in State Hospitals, from all regions of Texas, regardless of their financial status, who need assistance with decision making/guardianship.	Create a supported decision-making program within DSHS to reduce the number of patients who cannot be discharged from the state hospitals because they lack the capacity for independent decision-making.	Program Projection Annual: 50		✓	✓						✓

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Article II, Department of State Health Services Hospital IT Infrastructure Strategy C.1.3.	State Hospital Infrastructure	Provide: • Clinical record system • Administration records • Medication administration records • Pharmacy system • Inventory/supply warehouse • Dietary services and inventory • Computer Assisted Facilities Management • Trust fund software • Staffing software • Telephone systems • Video surveillance equipment • Video conferencing • Telemedicine	N/A									✓
Article II, Department of State Health Services Enterprise: DSHS Regional Laundry; Exceptional Item 4b Strategy C.1.3	State Hospital Infrastructure	Replace laundry equipment at state hospitals.	N/A									✓

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Article II, Department of State Health Services Mental Health Community Hospital Beds; Exceptional Item 21, Strategy C.2.1	Seriously mentally ill persons from all regions of Texas, regardless of their financial status, in need of inpatient psychiatric care	Provide inpatient psychiatric services, including hospital services and crisis stabilization in communities throughout the state based on local needs. • Purchase 150 additional psychiatric beds outside the state hospital system to address growth in the state hospital beds.	LBB Annual Target: 8,200		✓	✓	✓				✓	✓
Article II, Department of State Health Services Repair and Renovation of Mental Health Facilities; Strategy F.1.2	State Hospital Infrastructure	Repair, renovate, and construct projects required to maintain the state's 10 psychiatric hospitals at acceptable levels of effectiveness and safety.	N/A									

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Article II, Health and Human Services Commission System of Care Expansion; Strategy A.1.1	• Children or youth who have mental health difficulties or other behavioral challenges and are at risk of out-of-home placement due to their mental health condition • Families of these children or youth	Implement the System Of Care (SOC) cross-systems framework through a five-year strategic plan to local communities throughout the state with support of state child/youth agency leadership and advice from additional stakeholders. • Expand from pilot/demonstration to statewide implementation for developing local systems of care. • Maintain and implement a comprehensive strategic plan and supportive infrastructure for statewide delivery of mental health services and supports to children and families using a collaborative 'system of care' framework or approach, increasing: • Access to services and supports, • Community implementation capacity, • Use of cross-system data, and • Diverse funding opportunities. See: http://www.txsystemofcare.org/	75	✓		✓		✓		✓	✓	
Article II, Health and Human Services Commission Certify Community Behavioral Health Centers (CCBHC), SAMHSA Planning Grant Rider 79	1) children/youth with mental health issues, 2) children/youth with substance use disorders, 3) adults with mental health issues, and 4) adults with substance use disorders.	HHSC is developing and submit an application to Centers for Medicare and Medicaid Services for an Excellence in Mental Health planning grant as authorized in the Protecting Access to Medicare Act (H.R. 4302 84-R). SAMHSA Planning Grant to develop and certify community behavioral health centers (CCBHC) to provide integrated mental health, substance abuse, and targeted physical health services. HHSC will also develop a prospective payment system (methodology) in order to reimburse these centers for services provided to Medicaid clients.	No clients served through the planning grant. If selected as a pilot state by SAMHSA, services would begin in July 2017. Numbers served not determined yet.			✓						

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Article II, Health and Human Services Commission Children with Special Needs; Strategy A.1.1	Children younger than 22 years of age diagnosed with a chronic illness, intellectual or other developmental disability, or serious mental illness	• Make recommendations to the Legislature for improving services to families with disabled children, including youth with behavioral health conditions. It has no appropriation authority and no budget. • The Task Force on Children with Special Needs and the Council on Children and Families have been abolished. • The CPC continues in operation for the remainder of SFY 16 when a successor committee with a similar purpose will be established.	N/A, Gathers external stakeholder input to inform policy development on behalf of all families having children with disabilities									✓
Article II, Health and Human Services Commission Veterans Services (Clearinghouse)	• Veterans, including current Guard and Reserve, with PTSD, depression, TBI, or other conditions • Military/veteran families • Veteran service providers and volunteers • Other state, federal, and local agencies/entities	• Provide agencies and veteran organizations with coordination, outreach and innovation • Facilitate peer-to-peer assistance groups that provide comradeship, inspiration, and support without stigma • Support Texas Veterans App outreach and education • Consult with entities wishing to assist veterans and/or their families • Serve as HHSC liaison to legislatively mandated Texas Coordinating Council for Veteran Services	Direct: 45,000 Indirect: 1,000,000	✓		✓						
Article II, Health and Human Services Commission Veterans Services Veterans Mobile App; Strategy A.1.1	• Veterans, including current Guard and Reserve, • Military/veteran families • Veteran service providers and volunteers • Other state, federal, and local agencies/entities	The Texas Veterans App provides one location for veterans to get information about the local, state, and national resources available to them. The app gives direct access to the Veterans Crisis Line from the U.S. Department of Veterans Affairs. This line is a free, confidential, 24-hour phone line to help veterans transitioning back to civilian life with mental health or any other challenges. Additional features on the app are Connect With Texas Veterans, which provides veterans with information about community resources, and the Texas Veterans Portal that includes a comprehensive list of services and benefits. The app also has a direct connection to the national Hotline for Women Veterans.	Direct: 45,000 Indirect: 1,000,000	✓		✓						

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Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Prevention / Promotion	Screening / Assessment	Service Coordination	Treatment / Rehabilitation	Psychosocial Rehabilitation	Housing	Employment	Crisis Intervention	Other
Article II, Health and Human Services Commission Mental Health Coordination; Strategy A.1.1	Coordination of state agencies including but not limited to, the Texas Education Agency, the Office of the Attorney General, Texas Department of Criminal Justice, Texas Juvenile Justice Department, Texas Military Department, Office of Court Administration, Texas Department of Housing and Community Affairs, Department of Public Safety, Commission on Jail Standards, Texas Workforce Commission and other health and human services agencies as appropriate.	Oversee statewide mental health coordination, and consult and coordinate with other state agencies and local governments to ensure a strategic statewide approach to mental health.	N/A other - Does not provide direct service									✓
Article II, Health and Human Services Commission Community Resource Coordination Group (CGRG) Program Support (Information Technology); Strategy A.1.1	Individuals (children, youth, and adults) with complex needs (physical, health, social, behavioral, emotional, and/or developmental) which can best be addressed through a coordinated multiagency approach.	• Provide complex, individualized service planning utilizing local resources and interagency coordination and collaboration. Local CRCG members identify service gaps and barriers and assist CRCG consumers in avoiding duplication in service provision through local CRCGs. •Provide program oversight, technical assistance, training support, and policy guidance, subject matter expertise to local CRCGs through State CRCG Office and Workgroup. The State CRCG Workgroup is made up of the 11 state agencies mandated to participate in CRCG service planning and coordination at the state and local level.	1,500-2,000	✓	✓	✓			✓	✓		

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Article II, Health and Human Services Commission Mental Health for Veterans Grant Program, Rider 68	Texas veterans and their families.	Provide grants to support community programs that offer mental health care services and treatment to veterans and their families and that coordinate mental health care services for veterans and their families with other transition support services.	Number unavailable until after grants are awarded.			✓	✓		✓	✓		✓
Article II, Health and Human Services Commission Family Violence Program Exceptional Item Funding Mental Health Projects Strategy, 4.2.1	Survivors of Family Violence in rural areas with mental health and/or substance abuse services needs.	Provide the following: • Professional counseling for children and adults to deal with trauma associated with family violence. • Direct professional mental health services through individual and group counseling for child, adolescent, and adult clients regarding mental symptoms, crisis intervention, intake and assessment of mental health needs, and advocacy and case management related to mental health and domestic violence issues. • Direct professional mental health services with a focus on substance abuse treatment for survivors of family violence. This project will utilize an integrated model that provides treatment for both post-traumatic stress disorder and substance abuse at the same time. • Culturally and linguistically competent mental health assessments and trauma informed care counseling to survivors of family violence in underserved areas.	800		✓	✓	✓				✓	

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Article II, Health and Human Services Commission Child Advocacy Programs (Child Advocacy Centers); Strategy D.2.4	Victims of child abuse and the non-offending care taker. Target population age range is between 0 and 18 and older. Victims over the age of 18 can include those who are developmentally delayed.	• Provide assistance and coordination for victims in local law enforcement agencies and district attorney's offices. • Assess victims of child abuse and their families to determine their need for services relating to the investigation of child abuse • Provide the services determined to be needed • Provide a facility at which a multidisciplinary team appointed under Family Code §264.406 can meet to facilitate the efficient and appropriate disposition of child abuse cases through the civil and criminal justice systems • Coordinate the activities of governmental entities relating to child abuse investigations and delivery of services to child abuse victims and their families • Expand vendor-delivered services to state hospitals.	Total Number of Children Receiving Services: 32,000 Total Number of Forensic Interviews: 29,000 Total Number of Child Abuse Cases Reviewed by Child Advocacy Centers' Multidisciplinary Teams: 25,000									✓

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Article II, Health and Human Services Commission Children's Health Insurance Program; Strategy C.1.1	CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. CHIP is administered by the Centers for Medicare & Medicaid Services (CMS) and is jointly funded by the federal government and the states. CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance.	• Inpatient mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals and state-operated facilities. • Outpatient Mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) • Inpatient Substance Abuse Treatment Services including but not limited to: • Inpatient residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs • Outpatient substance abuse treatment services including • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment and referral for chemical dependency disorders. • Intensive outpatient services • Partial hospitalization • Intensive outpatient services is defined as an organized non-residential service providing structured group and individual therapy, educational services, and life skills training which consists of at least 10 hours per week for four to 12 weeks, but less than 24 hours per day.	Average monthly caseload as of February 2016: 374,086 This number does to include the CHIP perinatal caseload.	✓	✓	✓	✓	✓			✓	

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Article II, Texas Civil Commitment Office Texas Civil Commitment Office (TCCO); Strategy G.1.1 Sexually Violent Predator Mental Health Services	Sexually violent predators who suffer from a behavioral abnormality which is not amenable to traditional mental health treatment modalities. A portion of the sexually violent predators have concurrent mental health diagnoses that require traditional mental health or substance abuse treatment.	Contract for behavioral health services, for clients in the community, which include but are not limited to: • Substance abuse treatment • Assessments • Psychiatric case management • Medication • Rehabilitation • Counseling • Crisis services • Psychiatric hospitalization • Other related services Execute interlocal agreements or contracts to provide behavioral health services for the identified areas of need in order to provide services for civilly committed sex offenders who reside in the community.	15		✓	✓	✓	✓			✓	
Article III, Texas Education Agency Unified for School Aged Children - A Mental Health Collaborative (USAC)	State agencies including TEA, HHSC, DSHS, DARS, DFPS, DADS, and TJJD.	Create and expand opportunities for education and training on behavioral health for providers at state, local, and individual levels. USAC identifies services across systems to facilitate common language and knowledge. The collaboration identifies barriers to collaboration and explores opportunities to enhance collaboration across systems that impact school-aged children.	N/A	✓								
Article III, Texas Education Agency Mental health and substance abuse best practices	Public elementary, junior high, middle, and high schools students	Identify and make available a list of recommended best practice-based programs for early mental health intervention, mental health promotion and positive youth development, substance abuse prevention and intervention, and suicide prevention through a collaborative of TEA, regional education service, and the Department of State Health Services (DSHS).	Data not collected	✓								

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Article III, Texas Education Agency Required Suicide Prevention Training for Educators	All new and existing school district and open-enrollment charter school educators	Training must be selected from the list of recommended best practice-based programs that is provided by the DSHS, in coordination with TEA. School districts and open-enrollment charter schools may also select programs through an independent review of suicide prevention training material that complies with the guidelines developed by the TEA and offered online.	Data not collected	✓								
Article III, University of Texas Health Science Center - Houston Psychiatric Services [UTHealth Department of Psychiatry & Behavioral Sciences] This strategy is an Article III appropriation for research. The other services listed in column C are not funded through a State appropriation.	Adults and children with mental health issues treatable in outpatient settings, including UT Physicians Clinics, Harris Health, and integrated-care community-health centers	• Provide outpatient care for more than 40,600 patient visits for persons with mental illness yearly. • Implement clinical training and interventions to enhance the ability and capacity to treat mental illness. • Conduct evidence-based research to allow for long-term follow-up with validation of treatment and its effect.	• >13,000 estimated unduplicated patient count • 540 medical students	✓	✓	✓	✓	✓			✓	

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Article III, University of Texas Health Science Center - Houston UTHealth Harris County Psychiatric Center Funding for the services listed comes through a State appropriation to DSHS in Article II	Adults and children assessed with mental health disorders (73% non-resource funding, i.e. state or county funds))	• Provide acute inpatient care with screening, stabilization and planning for aftercare services. • Educate professionals in the fields of nursing, medicine, pharmacy, psychology, and social work. • Conduct research into the treatment of mental illness.	• >9,000 estimated unduplicated patient count • 1,700 students		✓	✓	✓	✓			✓	

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Article III, University of Texas Health Science Center - Tyler Mental Health Training Programs; Strategy D.1.2	This strategy does not fund direct patient services; it funds new educational programs designed to increase the mental health workforce in rural underserved areas. Strategy D.1.2 provides funding for workforce training programs (ie: psychiatry residency, psychology internship, and training for other mental health professionals and providers).	• Support mental health workforce training programs in underserved areas including, but not limited to, Rusk State Hospital and Terrell State Hospital. This strategy funds a new pyschiatry residency, psychology internship, and training for other mental health professionals and providers.	This strategy does not fund direct patient services; it funds new educational programs designed to increase the mental health workforce in rural underserved areas.									✓
Article III, University of Texas Health Science Center - Tyler UT Health Northeast Department of Behavioral Health (Outpatient) (These patient care services are not funded through state appropriations.)	Adults (18 years and older) and children (3 to 17 years) with mental health issues treatable in an outpatient setting, including UT Physicians Clinics and Intensive Outpatient Clinic (IOP) programs.	• Provide outpatient visits for persons with mental illness that includes screening, evaluation, treatment and follow-up care. • Integrate behavioral health services with primary care.	These programs are new to UT Health Northeast; therefore, an accurate patient served count cannot be determined at this time.	✓	✓	✓	✓	✓			✓	

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Article III, University of Texas Health Science Center - Tyler UT Health Northeast (Inpatient)	Adults (18 years and older) assessed with mental health disorders.	Provide acute inpatient care with screening, crisis stabilization, and aftercare planning services.	DSHS contracts with UT Health Northeast to provide 30 dedicated inpatient beds for long term/chronic mental illness inpatient care and 14 dedicated beds for crisis stabilization and acute care.	✓	✓	✓	✓	✓			✓	
Article V, Texas Department of Criminal Justice Diversion Programs / Specialized Mental Health Caseloads; Strategy A.1.2	Offenders on probation.	Support specialized community supervision caseloads for offenders with mental health disorders.	7,756	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice Diversion Programs / Discretionary Grants – Substance Abuse Programs; Strategy A.1.2	Offenders on probation.	Provide grants to local adult probation departments for outpatient programs to divert offenders with substance abuse disorders from further court action and/or prison.	19,054	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Diversion Programs / Discretionary Grants – Substance Abuse Programs; Strategy A.1.2	Offenders on probation.	Provide grants to local adult probation departments to divert offenders with substance abuse disorders from prison through residential beds for substance abuse treatment.	7,061	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Diversion Programs / Substance Abuse Felony Punishment Facilities (SAFPF) Aftercare; Strategy A.1.2	Offenders on probation.	Provide funding to local adult probation departments for continuum of care management services and aftercare outpatient counseling for felony substance abuse probationers after their release from a TDCJ SAFPF.	10,739	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice Community Corrections; Strategy A.1.3	Offenders on probation.	Provide formula funding to Community Supervision and Corrections Departments for substance abuse services to serve primarily as diversions from prison.	21,163	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Treatment Alternatives to Incarceration Program; Strategy A.1.4	Offenders on probation.	Provide grants to local adult probation departments for treatment to divert offenders from incarceration, including screening, evaluation, and referrals to appropriate services.	14,761	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Special Needs Programs and Services / Texas Correctional Office on Offenders with Medical/Mental Impairments (TCOOMMI) – Adult; Strategy B.1.1	Adult incarcerated offenders, paroled offenders, offenders on probation, pre-trial defendants.	Provide grants for community-based treatment programs, funding a continuity of care program and responsive system for local referrals from various entities for adult offenders with special needs (serious mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities).	29,940	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice Special Needs Programs and Services / TCOOMMI – Juvenile; Strategy B.1.1	Juvenile detainees, incarcerated juveniles, paroled juveniles, juveniles on probation, discharged youth.	Provide grants for community-based treatment programs, funding a continuity of care program and responsive system for local referrals from various entities for juvenile offenders with special needs (serious mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities).	700	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Unit and Psychiatric Care; Strategy C.1.8	Incarcerated offenders.	Provide mental health care for incarcerated offenders.	23,570	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Managed Health Care – Pharmacy; Strategy C.1.10	Incarcerated offenders.	Provide pharmacy services, both preventative and medically necessary care, consistent with standards of good medical practice for mental health cases.	Included in Unit and Psychiatric Care above				✓	✓	✓			
Article V, Texas Department of Criminal Justice Treatment Services / Parole Special Needs; Strategy C.2.3	Paroled offenders.	• Provide specialized parole supervision and services for offenders with mental illness, intellectual disabilities, developmental disabilities, terminal illness, and physical disabilities. • Provide subsidized psychological counseling to sex offenders.	6,855	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice Treatment Services / Sex Offender Treatment Program; Strategy C.2.3	Incarcerated offenders.	• Provide sex offender education for lower risk offenders, though a four-month program addressing healthy sexuality, anger management, and other areas. • Provide sex offender treatment for higher risk offenders, through a 9-month or 18-month intensive program using a cognitive-behavioral model.	2,613	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Reentry Initiatives / Transitional Coordinators; Strategy C.2.3.	Incarcerated offenders.	Provide for 10 designated reentry transitional coordinators for special needs offenders.	1,300	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Substance Abuse Felony Punishment Facilities (SAFPF); Strategy C.2.4	Incarcerated offenders.	• Provide a six-month substance abuse program for offenders (nine-months for offenders with special needs) who are sentenced by a judge as a condition of community supervision or as a modification to parole or community supervision. • Upon completion of the incarcerated phase, offenders must complete a Transitional Treatment Center for residential and outpatient care/counseling.	6,567	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice In-Prison Substance Abuse Treatment & Coordination; Strategy C.2.5	Incarcerated offenders.	• Provide a six-month substance abuse program for offenders within six months of parole release. • Upon completion of the incarcerated phase, offenders must complete a Transitional Treatment Center for residential and outpatient care/counseling.	3,130	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Driving While Intoxicated (DWI) Treatment; Strategy C.2.5	Incarcerated offenders.	• Provide a six-month program that offers a variety of educational modules that accommodate the diversity of needs presented in the DWI offender population, including treatment activities, and group and individual therapy.	2,015	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice State Jail Substance Abuse Treatment; Strategy C.2.5	Incarcerated offenders.	Provide a substance abuse program for offenders who have been convicted of a broad range of offenses and are within four months of release. The program is designed to meet the needs of the diverse characteristics of TDCJ's state jail population.	3,420	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Department of Criminal Justice Substance Abuse Treatment and Coordination; Strategy C.2.5	Incarcerated offenders.	Provide support services for pre-release substance abuse facilities, to include alcoholism and drug counseling, treatment programs, and continuity of care services.	2,855	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Substance Abuse Treatment; Strategy F.2.1.	Paroled offenders.	Provides outpatient substance abuse counseling to parolees.	7,126	✓	✓	✓	✓	✓	✓	✓	✓	
Article V, Texas Department of Criminal Justice Intermediate Sanction Facility Treatment; Strategy F.2.3	Paroled offenders.	Provide substance abuse and or cognitive treatment slots for Intermediate Sanction Facility beds.	11,915	✓	✓	✓	✓	✓	✓	✓	✓	

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Article V, Texas Juvenile Justice Department Probation Grants: Special Needs Diversionary Program; Strategy A.1.3	Juvenile offenders under the jurisdiction of a juvenile probation department	Provide mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system.	1,329	✓	✓	✓	✓	✓			✓	
Article V, Texas Juvenile Justice Department Probation Grants: Community Programs; Strategy A.1.3	Juvenile offenders under the jurisdiction of a juvenile probation department	Provide assistance to local juvenile probation departments for community-based services for misdemeanors, enhanced community-based services for felons, special needs programs, and Federal Title IV-E placements and services.	39,168	✓	✓	✓	✓	✓			✓	
Article V, Texas Juvenile Justice Department Probation Grants: Commitment Diversion Initiatives; Strategy A.1.5	Juvenile offenders under the jurisdiction of a juvenile probation department	Provide funding to local juvenile probation departments for community-based and/or residential alternatives to commitment to state residential facilities.	5,818	✓	✓	✓	✓	✓			✓	

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Article V, Texas Juvenile Justice Department Probation Grants: Mental Health Services; Strategy A.1.7	Juvenile offenders under the jurisdiction of a juvenile probation department	Provide grants to local juvenile probation departments for mental health services.	2,980	✓	✓	✓	✓	✓			✓	
Article V, Texas Juvenile Justice Department State Programs: Psychiatric (Mental Health) Services; Strategy B.1.1	Youth at the intake and orientation unit with mental health problems who require psychiatric treatment and psychotropic medication and/or require a comprehensive psychiatric evaluation based on the assignment of a 12 Minimum Length of Stay or longer.	Provide psychiatric services via contracted providers for youth who are assigned to the intake and assessment unit.	640		✓		✓				✓	
Article V, Texas Juvenile Justice Department State Programs: Psychiatric (Mental Health) Services; Strategy B.1.7	Juveniles in residential care who are receiving ongoing psychiatric services as part of their rehabilitation program. Youth are assigned to any of the state-operated programs.	Provide psychiatric services via contracted providers to juveniles while in residential care, includes assessments for youth who do not require services at the intake unit, but who later develop a mental health need.	845		✓	✓	✓				✓	

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Article V, Texas Juvenile Justice Department State Programs: General Rehabilitation Treatment; Strategy B.1.8	Juveniles in state-operated residential care except orientation and assessment and the designated mental health residential treatment center.	Support all rehabilitative treatment services to the target population including case management, correctional counseling, ongoing assessment of risk and protective factors, case planning, review by multi-disciplinary team (MDT), crisis intervention and management, reintegration planning and family involvement. Includes proportional share of strategy set-asides.	1,920		✓	✓	✓	✓			✓	
Article V, Texas Juvenile Justice Department State Programs: Specialized Rehabilitation Treatment; Strategy B.1.8	Juveniles in state-operated residential care except orientation and assessment who require specialized treatment services in addition to general rehabilitation treatment.	Administer four types of specialized treatment programs: • Sexual behavior treatment • Capital and serious violent offender treatment • Alcohol and other drug treatment • Mental health treatment programs 97% of youth entering TJJD state programs have a need for one or more of these programs. Services, which include assessment, group and/or individual counseling, MDT collaboration, re-integration planning, are provided by licensed or appropriately certified staff in the "dosage" appropriate to the youth's need, using approved curricula. Includes proportional share of strategy set-asides.	1,825		✓	✓	✓	✓			✓	

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Article V, Texas Juvenile Justice Department State Programs: Parole Programs and Services; Strategy C.1.2	Juveniles who have been released from residential programs to parole status and who require after-care services in addition to general parole services. A youth may reside in an approved home or home substitute while receiving aftercare services.	Provide required aftercare services to youth who have completed specialized treatment in residential placements as a condition of their parole in order to improve outcomes.	425				✓	✓				
Article V, Texas Military Department Mental Health Services; Strategy C.1.3	• Texas Military Forces members (Texas Army National Guard, Texas Air National Guard, and Texas State Guard) • Active Duty (any branch) • Adult Family Members of military and veterans • Veteran/Prior Military (any branch) • Service Members Surviving family • Texas Military Forces Civilian Staff and Contractors	• Provide mental health and counseling services on the topics of stress, anxiety, depression, anger, grief, family/relationship problems, and more. • Develop support plans for individuals and/or their families. • Respond to critical incidents and provide post-vention care. • Coordinate with TXMF unit leadership to support behavioral health awareness and wellness promotion plans. • Conduct behavioral health training for TXMF. • Provide support through the 24/7 Counseling Line. • Coordinate with TXMF Family Support Services (FSS) programs to offer holistic care to all clients. • Assist and execute plans for behavioral health assistance to TXMF Soldiers and employees during disaster response missions.	13,500	✓	✓	✓	✓	✓			✓	

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Article VIII, Board of Dental Examiners Peer Assistance Program; Strategy A.1.2	• Dentists impaired by chemical dependency or mental illness.	Provide services to impaired dentists to support recovery and monitor individuals to allow for continued employment, prevent unsafe professional practice: • Monitor impaired dentists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery • Identify dentists with a potential impairment and coordinate evaluation to assess impairment for dentists • Provide referrals to qualified mental health professionals to evaluate and provide mental health services (MHS) to dentists, including treatment and counseling • Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services • Allow for self-referral of dentists to access MHS in a confidential manner through a support agreement without professional disciplinary action • Provide crisis intervention through peer assistance program	85									✓
Article VIII, Board of Pharmacy Peer Assistance Program; Strategy B.1.2	Pharmacists or eligible pharmacy students impaired by chemical abuse or mental or physical illness	Provide services to impaired pharmacists to support recovery and monitor individuals to allow for continued employment, prevent unsafe professional practice: • Monitor impaired pharmacists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery • Identify pharmacists with a potential impairment and coordinate evaluation to assess impairment for pharmacists • Provide referrals to qualified mental health professionals to evaluate and provide mental health services (MHS) to pharmacists, including treatment and counseling • Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services • Allow for self-referral of pharmacists to access MHS in a confidential manner through a support agreement without professional disciplinary action • Provide crisis intervention through peer assistance program	180									✓

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Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Prevention / Promotion	Screening / Assessment	Service Coordination	Treatment / Rehabilitation	Psychosocial Rehabilitation	Housing	Employment	Crisis Intervention	Other
Article VIII, Board of Veterinary Medical Examiners Peer Assistance Program; Strategy A.2.2	• Veterinarians impaired by chemical dependency or mental illness.	Provide services to impaired veterinarians to support recovery and monitor individuals to allow for continued employment, prevent unsafe professional practice: • Monitor impaired veterinarians to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery • Identify veterinarians with a potential impairment and coordinate evaluation to assess impairment for veterinarians • Provide referrals to qualified mental health professionals to evaluate and provide mental health services (MHS) to veterinarians, including treatment and counseling • Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services • Allow for self-referral of veterinarians to access MHS in a confidential manner through a support agreement without professional disciplinary action • Provide crisis intervention through peer assistance program	22									✓
Article VIII, Optometry Board Peer Assistance Program; Strategy A.1.4	Optometrists impaired by chemical abuse or mental or physical illness.	Provide services to impaired optometrists to support recovery and monitor individuals to allow for continued employment, prevent unsafe professional practice: • Monitor impaired optometrists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery • Identify optometrists with a potential impairment and coordinate evaluation to assess impairment for optometrists • Provide referrals to qualified mental health professionals to evaluate and provide mental health services (MHS) to optometrists, including treatment and counseling • Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services • Allow for self-referral of optometrists to access MHS in a confidential manner through a support agreement without professional disciplinary action • Provide crisis intervention through peer assistance program	Licensees - 4,500 Students - 680									✓

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Prevention / Promotion	Screening / Assessment	Service Coordination	Treatment / Rehabilitation	Psychosocial Rehabilitation	Housing	Employment	Crisis Intervention	Other
Article VIII, Board of Nursing Peer Assistance Program; Strategy B.1.2	Registered and licensed vocational nurses, whose practice is impaired or suspected of being impaired by chemical dependency, mental illness, or diminished mental capacity.	Provide services to registered and licensed vocational nurses, whose practice is impaired or suspected of being impaired by chemical dependency, mental illness, or diminished mental capacity. TPAPN identifies, monitors, and assists with locating appropriate treatment so that they may return to practice safe nursing. • Statewide peer advocacy • Statewide monitoring • A network of trained peer volunteer advocates • Physical and psychological evaluations; • Substance abuse treatment • Drug screening • Individual and group psychotherapy	Registered Nurses: 600 Licensed Vocational Nurses: 175	✓		✓				✓		
Article VIII, Medical Board Physician Health Program; Strategy B.1.2	Licensees of the Medical Board and associated boards (physicians, physician assistants, acupuncturists, and surgical assistants).	Provide for the oversight and monitoring of licensees who may have a substance abuse disorder, mental health issue, or physical illness or impairment that has the potential to compromise a licensee's ability to practice.	As of August 2015, 377 participants were currently enrolled. The number is difficult to predict due to the fact that this is a voluntary, self-funded program.									✓

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services
Medicaid

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Service Categories
Article II, Health and Human Services Commission STAR	Pregnant women, newborns, and children with limited income	• Mental Health Targeted Case Management • Mental Health Rehabilitation • Individual Psychotherapy • Family Psychotherapy • Group Psychotherapy • Psychological and Neuropsychological testing • Psychiatric Diagnostic Evaluation • Inpatient Psychiatric Hospitalization • Pharmacological Management • Psychotropic Medications • Substance Use Disorder Treatment Assessment • Medication Assisted Therapy (e.g., methadone for opioid addiction) • Hospital-Based Detoxification • Residential Detoxification • Ambulatory Detoxification • Outpatient Treatment (Individual and Group Counseling) • Substance Use Disorder Residential Treatment • Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Average monthly caseload as of February 2016: 3,063,014 BCCP managed care carve in included in STAR caseload.	• Prevention / Promotion • Screening / Assessment • Treatment / Rehabilitation • Psychosocial Rehabilitation • Employment • Crisis Intervention Other Service Coordination is a component of the managed care model that delivers Medicaid services and is available to many individuals with behavioral health needs. There are also case management functions within the TCM benefit that include coordination activities. There are no stand-alone Medicaid services in STAR, STAR+PLUS or STAR Kids that specifically address housing. However, Service coordination includes linkages to non-capitated services which may include housing. Additionally, some housing supports are included in the benefit package of Mental Health Rehabilitative Services.

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services
Medicaid

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Service Categories
Article II, Health and Human Services Commission STAR+PLUS	The Medicaid STAR+PLUS program provides acute care services plus long-term services and supports (LTSS) by integrating primary care, pharmacy services, and LTSS for individuals who are age 65 or older or have a disability. The STAR+PLUS program serves SSI, SSI-related individuals, and adults who qualify for Medicaid because they meet medical necessity criteria and, as a result, receive Home and Community Based Services (HCBS) STAR+PLUS waiver services. Services are delivered through managed care organizations (MCOs) under contract with the Health and Human Services Commission (HHSC).	• Mental Health Targeted Case Management • Mental Health Rehabilitation • Individual Psychotherapy • Family Psychotherapy • Group Psychotherapy • Psychological and Neuropsychological testing • Psychiatric Diagnostic Evaluation • Inpatient Psychiatric Hospitalization • Pharmacological Management • Psychotropic Medications • Substance Use Disorder Treatment Assessment • Medication Assisted Therapy (e.g., methadone for opioid addiction) • Hospital-Based Detoxification • Residential Detoxification • Ambulatory Detoxification • Outpatient Treatment (Individual and Group Counseling) • Substance Use Disorder Residential Treatment • Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Average monthly caseload as of February 2016: 506,455	• Prevention / Promotion • Screening / Assessment • Treatment / Rehabilitation • Psychosocial Rehabilitation • Employment • Crisis Intervention Other Service Coordination is a component of the managed care model that delivers Medicaid services and is available to many individuals with behavioral health needs. There are also case management functions within the TCM benefit that include coordination activities. There are no stand-alone Medicaid services in STAR, STAR+PLUS or STAR Kids that specifically address housing. However, Service coordination includes linkages to non-capitated services which may include housing. Additionally, some housing supports are included in the benefit package of Mental Health Rehabilitative Services.

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services
Medicaid

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Service Categories
Article II, Health and Human Services Commission STAR Kids	Beginning November 1, 2016, children and youth age 20 or younger who either receive SSI Medicaid or are enrolled in the Medically Dependent Children Program (MDCP) will receive all of their services through the STAR Kids program. STAR Kids is the managed care program that will provide acute and community-based Medicaid benefits to children with disabilities.	• Mental Health Targeted Case Management • Mental Health Rehabilitation • Individual Psychotherapy • Family Psychotherapy • Group Psychotherapy • Psychological and Neuropsychological testing • Psychiatric Diagnostic Evaluation • Inpatient Psychiatric Hospitalization • Pharmacological Management • Psychotropic Medications • Substance Use Disorder Treatment Assessment • Medication Assisted Therapy (e.g., methadone for opioid addiction) • Hospital-Based Detoxification • Residential Detoxification • Ambulatory Detoxification • Outpatient Treatment (Individual and Group Counseling) • Substance Use Disorder Residential Treatment • Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Average monthly caseload as of February 2016: 180,754	• Prevention / Promotion • Screening / Assessment • Treatment / Rehabilitation • Psychosocial Rehabilitation • Employment • Crisis Intervention Other Service Coordination is a component of the managed care model that delivers Medicaid services and is available to many individuals with behavioral health needs. There are also case management functions within the TCM benefit that include coordination activities. There are no stand-alone Medicaid services in STAR, STAR+PLUS or STAR Kids that specifically address housing. However, Service coordination includes linkages to non-capitated services which may include housing. Additionally, some housing supports are included in the benefit package of Mental Health Rehabilitative Services.

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services
Medicaid

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Service Categories
Article II, Health and Human Services Commission STAR Health	STAR Health is a statewide program designed to provide medical, dental, vision, and behavioral health benefits, including unlimited prescriptions, for children and youth in conservatorship of the Department of Family and Protective Services (DFPS), including those in foster care and kinship care. Services are delivered through a single managed care organizations (MCO) under contract with the Health and Human Services Commission (HHSC).	• Mental Health Targeted Case Management • Mental Health Rehabilitation • Individual Psychotherapy • Family Psychotherapy • Group Psychotherapy • Psychological and Neuropsychological testing • Psychiatric Diagnostic Evaluation • Inpatient Psychiatric Hospitalization • Pharmacological Management • Psychotropic Medications • Substance Use Disorder Treatment Assessment • Medication Assisted Therapy (e.g., methadone for opioid addiction) • Hospital-Based Detoxification • Residential Detoxification • Ambulatory Detoxification • Outpatient Treatment (Individual and Group Counseling) • Substance Use Disorder Residential Treatment • Screening, Brief Intervention, and Referral to Treatment (SBIRT)	30,998	• Prevention / Promotion • Screening / Assessment • Treatment / Rehabilitation • Psychosocial Rehabilitation • Employment • Crisis Intervention Other Service Coordination is a component of the managed care model that delivers Medicaid services and is available to many individuals with behavioral health needs. There are also case management functions within the TCM benefit that include coordination activities. There are no stand-alone Medicaid services in STAR, STAR+PLUS or STAR Kids that specifically address housing. However, Service coordination includes linkages to non-capitated services which may include housing. Additionally, some housing supports are included in the benefit package of Mental Health Rehabilitative Services.

Statewide Behavioral Health Strategic Plan
Inventory of Behavioral Health Programs and Services
Medicaid

Appropriation Article and Agency Name	Target Population	Goal/ Services Description	Fiscal Year 2017, Projected Number of People Served	Service Categories
Article II, Health and Human Services Commission Medicaid Fee-for-Service	Some Medicaid clients are served through a traditional fee-for-service (FFS) delivery system in which health care providers are paid for each service they provide, such as an office visit, test, or procedure. The FFS model allows access to any Medicaid provider. The provider submits claims directly to the Texas Medicaid claims administrator for reimbursement of Medicaid covered services.	• Mental Health Targeted Case Management • Mental Health Rehabilitation • Individual Psychotherapy • Family Psychotherapy • Group Psychotherapy • Psychological and Neuropsychological testing • Psychiatric Diagnostic Evaluation • Inpatient Psychiatric Hospitalization • Pharmacological Management • Psychotropic Medications • Substance Use Disorder Treatment Assessment • Medication Assisted Therapy (e.g., methadone for opioid addiction) • Hospital-Based Detoxification • Residential Detoxification • Ambulatory Detoxification • Outpatient Treatment (Individual and Group Counseling) • Substance Use Disorder Residential Treatment • Screening, Brief Intervention, and Referral to Treatment (SBIRT)	Average monthly caseload as of February 2016: 334,684	• Prevention / Promotion • Screening / Assessment • Treatment / Rehabilitation • Psychosocial Rehabilitation • Employment • Crisis Intervention Other

Appendix C: Agency Profiles

The following is information on each Council agency, outlining its populations of focus and eligibility requirements.

The Office of the Governor: Criminal Justice Division	**Populations Served:** • Juveniles (10 years up to age of maturity or 17) • Adults (17 years and older) with substance abuse problems or mental illness and who are charged with a non-violent offense
Eligibility Requirements: • Specialty and Drug Courts: Individuals are eligible to participate in specialty or drug court if charged with a non-violent offense and are referred to a court program usually by the district attorney or Judge. • Mental Health Court program participants must be charged with a non-violent offense and suffer from a mental illness. • Residential Substance Abuse Treatment: Individuals in correctional and detention facilities in need of substance abuse treatment. • Juvenile Justice and Delinquency Program participants: Individuals involved in the juvenile correctional system.	

Texas Veterans Commission (TVC): Fund for Veterans' Assistance and Military Veteran Peer Network (MVPN)	**Populations Served:** All ages
Eligibility Requirements: • Fund for Veterans Assistance: Individual grantees define their target populations within the larger population of veterans, their families and surviving spouses. • MVPN provides training and technical assistance to the Department of State Health Services (DSHS)-contracted MVPN Coordinators at the Local Mental Health Authorities (LMHAs). Within the MVPN program, TVC also contracts with a non-profit organization for field clinician services, serving the acute mental health needs of service members, veterans and their families.	

Health and Human Services Commission (HHSC)	**Populations Served:** All ages

Eligibility Requirements:
• A child or youth:
  ○ With a severe emotional disturbance and/or intellectual and developmental disabilities and their families.
  ○ With complex needs (chronic illness, intellectual or other developmental disability, or serious mental illness).
  ○ Who is a victim of child abuse.	

- An adult:
  - Who is a veteran, current Guard and Reserve, with post-traumatic stress disorder, depression, traumatic brain injury, or other conditions; and their families.
  - With complex needs (chronic illness, intellectual or other developmental disability, or serious mental illness).
- A child, youth, adult, senior who is Medicaid eligible.
- A child who is eligible for Children's Health Insurance Program.

Department of Aging and Disability Services (DADS)	**Populations Served:** All ages

Eligibility Requirements:

- For Medicaid Intellectual and Development Disabilities (IDD) Programs, meet Intermediate Care Facilities (ICF) level-of-care (LOC) 1 or 8 as follows:
  - ICF LOC 1: A person must:
    1. Have a full scale intelligence quotient (IQ) score of 69 or below, obtained by administering a standardized individual intelligence test; or
    2. Have a full scale IQ score of 75 or below, obtained by administering a standardized individual intelligence test, and have a primary diagnosis by a licensed physician of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by DADS and posted on its website; and
    3. Have an adaptive behavior level of I, II, III, or IV (i.e., mild to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.
  - ICF LOC 8: A person must:
    1. Have a primary diagnosis by a licensed physician of a related condition that is included on the list of diagnostic codes for persons with related conditions that are approved by DADS and posted on its website; and
    2. Have an adaptive behavior level of II, III, or IV (i.e., moderate to extreme deficits in adaptive behavior) obtained by administering a standardized assessment of adaptive behavior.
- For General Revenue IDD services – Meet one of the following criteria:
  - Have an intellectual disability (i.e., IQ ≤ 69 and mild to extreme deficits in adaptive behavior if determined April 1, 2016 or later) or (IQ ≤ 70 and mild to extreme deficits in adaptive behavior if determined before April 1, 2016).
  - Have a diagnosis of autism spectrum disorder.
  - Be a nursing facility resident who is eligible for specialized services for an intellectual disability or a related condition pursuant to §1919(e)(7) of the Social Security Act (United States Code, Title 42, §1396r(e)(7)).
  - Be a child who is eligible for Early Childhood Intervention services through the Department of Assistive and Rehabilitative Services.
  - Be diagnosed by an authorized provider as having a pervasive developmental disorder through a diagnostic assessment completed before November 15, 2015.

Department of Family and Protective Services (DFPS)	**Populations Served:** All ages

Eligibility Requirements:

- Families who either have a child in foster care or are receiving in-home family based safety services due to the high-risk of having a child removed and being placed in foster care absent preventive measures. Services are provided to children who are in substitute care, children who remain in their homes, and their caregivers and families.
- Families who need assistance to facilitate the achievement of the child's or family's service plan. Services are provided to children who are in substitute care, children who remain in their homes, and to their caregivers and families including those in family-based safety services.
- Children in DFPS conservatorship with serious mental or behavioral health needs.
- Persons 65 and older and adults 18 to 64 with a disability in Adult Protective Services cases that are receiving services.

Department of State Health Services (DSHS)	**Populations Served:** • Children and youth ages 3 to 17 years (age 13 years and older for Substance Use Disorder [SUD] treatment) • Adults 18 years and older who are low-income

Eligibility Requirements:

- Behavioral Health - Children: The children's mental health priority population are children ages 3 to 17 years with serious emotional disturbance (excluding a single diagnosis of substance abuse, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impairment or who:
  - Are at risk of disruption of a preferred living or children care environment due to psychiatric symptoms, or
  - Are enrolled in special education because of a serious emotional disturbance.
- Behavioral Health - Adults: The adult mental health priority population includes people with diagnoses such as schizophrenia, bipolar disorder, major depression, post-traumatic stress disorder, schizoaffective disorder, obsessive-compulsive disorder, anxiety disorder, attention deficit disorder, delusional disorder, and eating disorders who are experiencing significant functional impairment due to a mental health disorder that requires crisis resolution or ongoing, long-term support and treatment.
- Substance Abuse
  - Prevention: Substance abuse prevention services are available to children, youth, and adult populations. Prevention programs are designed to reach: 1) the entire population; 2) target subgroups determined to be at risk for substance abuse; and 3) identify individuals who are experiencing early signs of substance abuse and other related behavioral associated with substance abuse.
  - Intervention and Treatment: Low-income adults and youth with a maladaptive pattern of substance use (abuse or dependence) leading to clinically significant impairment or distress, as defined by the most recently published version of the Diagnostic Statistical Manual (DSM). In addition, state and federal law specifies priority access groups including identified substance abusers infected with human immunodeficiency virus

(HIV) and person at risk for HIV, person who use intravenous drugs, and women with SUDs who are pregnant and/or parenting or have had their children removed from the home because of a SUD.

State Hospital System

- Emergency Detention: Persons with a mental illness who are determined to be at substantial risk of serious harm to themselves or others and evaluated by a physician for admission at the hospital. Some admissions may be delayed until acute or chronic medical conditions are addressed that the network state psychiatric hospitals do not have the capability to treat.
- Civil Commitments: Requires a physician's medical certificate filed with the court and a judge issued civil commitment for persons in the community determined to be a danger to themselves or others or at risk of deterioration and would benefit from inpatient care.
- Criminal Code Commitments: Persons determined Incompetent to Stand Trial or Not Guilty by Reason of Insanity.

Texas Civil Commitment Office (TCCO)	**Populations Served:** Adults ages 18 years and older (currently male only)
Eligibility Requirements: Clients are sexually violent predators who have been civilly committed as defined by Chapter 841 of the Health and Safety Code. The populations served by TCCO are sexually violent predators that suffer from a behavioral abnormality which is not amenable to traditional mental health treatment modalities whereby the clients receive sex offender specific treatment. These sexually violent predators targeted for services under this strategy also suffer from concurrent behavioral health diagnoses and require mental health or substance abuse treatment.	

Texas Education Agency (TEA)	**Populations Served:** • Children and youth ages 5 to 21 years • Adults ages 21 to 26 years
Eligibility Requirements: A person who, on the first day of September of any school year, is at least 5 years of age and under 21 years of age, or is at least 21 years of age and under 26 years of age and is admitted by a school district to complete the requirements for a high school diploma is entitled to the benefits of the available school fund for that year in accordance with Chapter 25 of the Texas Education Code (TEC). Any other person enrolled in a prekindergarten class or Special Education Program under Chapter 29 is entitled to the benefits of the available school fund. All persons who meet the admission criteria are eligible to be served in Texas public school programs.	

University of Texas Health Science Center at Houston (UTHSC–Houston)	**Populations Served:** • Children and youth ages 4 to 17 years • Adults ages 18 years and older
Eligibility Requirements: • Individuals are eligible for services if they meet clinical criteria for admission to an acute care inpatient psychiatric hospital. • Individuals are eligible for outpatient services if they exhibit serious emotional, behavioral, mental health or SUDs.	

University of Texas Health Science Center at Tyler (UTHSC–Tyler)	**Populations Served:** • Children and youth ages 3 to 17 years • Adults ages 18 years and older
Eligibility Requirements: • Inpatient Acute (Crisis Stabilization) Behavioral Health – This is a contract with DSHS for inpatient beds. Patients must be screened by the local MHA (mental health authority) prior to admission. Individuals must meet the following criteria: o Exhibit behavior which is threatening, destructive, or disabling to self or others, may include: "active" suicidal or homicidal threats, plans or attempts within the last 72 hours. o Have symptoms or behaviors which indicate the need for 24-hour continued monitoring and assessment of a patient's condition. • Inpatient Subacute Behavioral Health - This is a contract with DSHS for inpatient beds. Criteria for consideration of eligibility for admission are as follows: o Patient may be male or female adults (18 years or older); o Patient must be hospitalized in a State Hospital for more than 3 months; o Patient must be on a civil commitment or 46C Not Guilty by Reason of Insanity; and o Patient's barriers to discharge make discharge in the near future highly unlikely. • Inpatient Geriatric Behavioral Health - The criteria for admission includes the following: o Individual must exhibit behavior which is threatening, destructive, or disabling to self or others, may include: "active" suicidal or homicidal threats, plans or attempts within the last 72 hours; and/or o Have symptoms or behaviors which indicate the need for 24-hour continued monitoring and assessment of a patient's condition. • Outpatient Behavioral Health Clinic – This is by referral only. Individuals may exhibit any number of symptoms that warrant an evaluation by a psychiatrist. • Intensive Outpatient Program – Individuals must be 55 years or older and meet all of the following: o The individual demonstrates symptomatology consistent with a DSM (current version) diagnosis which requires and can reasonably be expected to respond to therapeutic intervention. o There are significant symptoms that interfere with the individual's ability to function in at least one life area. o There is an expectation that the individual has the capacity to make significant progress toward treatment goals. Individuals must be evaluated by a physician and an order for intensive outpatient services obtained.	

Texas Department of Criminal Justice (TDCJ)	**Populations Served:** • Youth ages 10 to 17 years • Adults ages 18 years and older

Eligibility Requirements:

Mental Illness:

- Youth on Probation must be concurrently enrolled with the Special Needs Diversionary Program at the Texas Juvenile Justice Department. This program pairs a TCOOMMI funded mental health case manager and a local juvenile probation officer to manage the case implement coordinated treatment goals.
- Youth on Parole from the Texas Juvenile Justice Department are served through continuity of care and must have a mental health diagnosis.
- Adults on Pre-trail, Probation, or on Parole who have a mental health diagnosis that is severe or persistent in nature. Diagnosis include but are not limited to bipolar disorder, schizophrenia, major depressive disorder, post-traumatic stress disorder and anxiety.
- Adults incarcerated are served regardless of severity of the mental health disorder or intellectual disability.

Substance Abuse:

- Programs are targeted to adults on probation, incarcerated or on parole. The programs are responsive to prevention, intervention, and treatment. These program are offered based on a variety of assessment outcomes and individualized need. The programs span the course of addressing those with chemical dependency disorders as noted in the latest version of the Diagnostic Statistical Manual.

Texas Juvenile Justice Department (TJJD)	**Populations Served:** Youth ages 10 to 18 years

Eligibility Requirements:

- TJJD serves youth who have been adjudicated delinquent of felony offenses and committed to the agency by a juvenile court. In order for a youth to be committed to TJJD, the delinquent act must occur when the youth is between 10 and 17 years of age. TJJD may retain jurisdiction over a youth until his or her 19th birthday. The youth sent to TJJD are the state's most serious or chronically delinquent offenders.
- In addition to providing services to state-committed youth, TJJD provides support to 166 county probation departments across the state of Texas. County Probation Departments provide a wide variety of community-based programs to promote positive outcomes for youth, increase resilience, decrease risk factors, and ultimately divert youth form penetrating deeper into the juvenile or criminal justice systems.

Texas Military Department (TMD)	**Populations Served:** Adults 18 years and older

Eligibility Requirements:

- Texas Military Force members (Army and Air National Guard, State Guard)
- Active Duty (any branch)
- Adult Family Members of military and veterans
- Veteran and Prior Military (any branch)

- Service Members Surviving family
- Texas Military Forces Civilian Staff and Contractors

Health Professionals Council	**Populations Served:** Adults 18 years and older

Eligibility Requirements:

The Health Professions Council represents the following:

- Board of Dental Examiners
- Board of Pharmacy, Texas State Board of Veterinary Examiners
- Optometry Board
- Texas Peer Assistance Program for Nurses
- The Texas Medical Board

There are several agencies within the Health Professions Council which operate in some form a peer assistance program. The agencies themselves do no provide mental health services.

Appendix D: Surveys

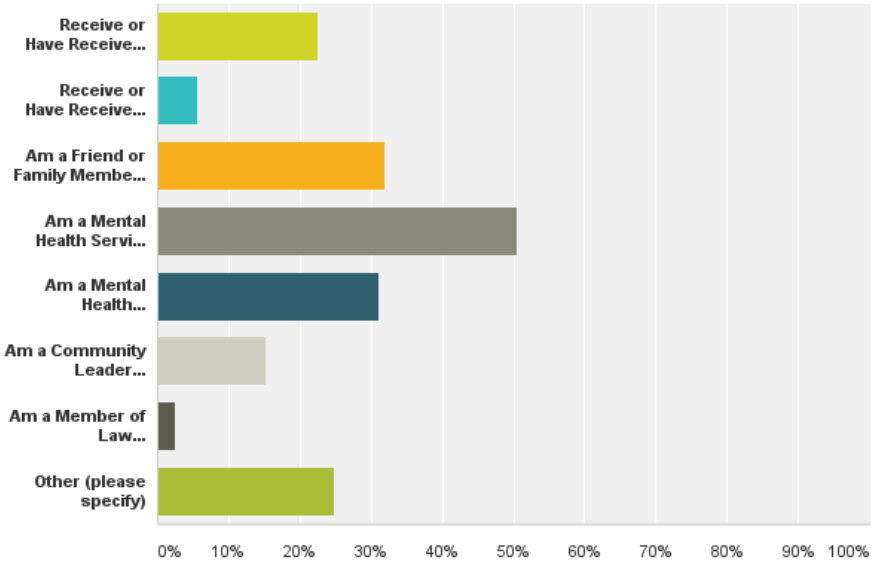
As part of the development of this strategic plan, two surveys were conducted to gather statewide stakeholder input. The results are included in this appendix.

Survey: Statewide Behavioral Health Coordinating Committee Stakeholder Survey Results

Respondents

This survey asked respondents to identify themselves by any of the following categories:

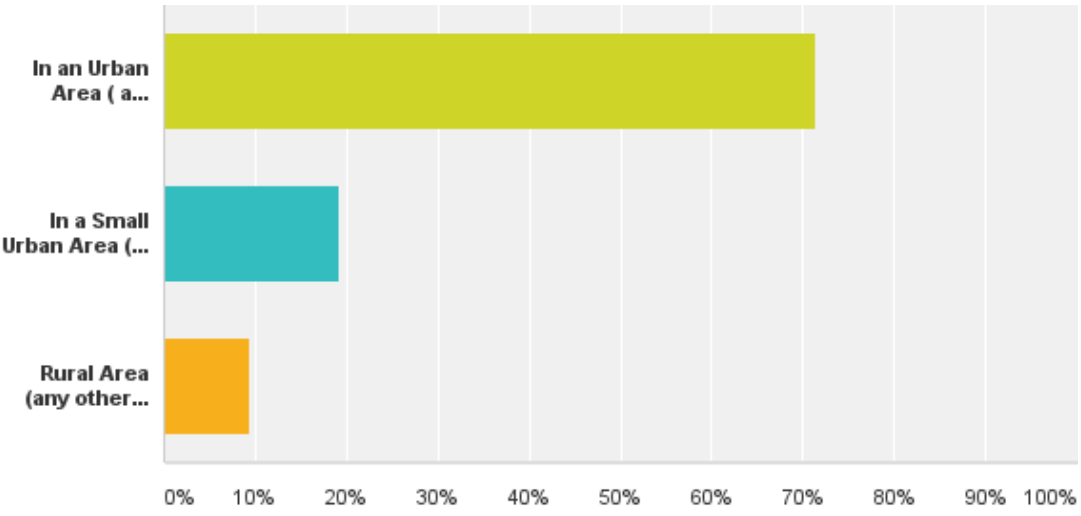
Answer Choices	Responses	
Receive or Have Received Mental Health Services.	**22.69%**	184
Receive or Have Received Treatment for an Alcohol or Drug Problem.	**5.67%**	46
Am a Friend or Family Member of a Recipient of Mental Health Services.	**31.81%**	258
Am a Mental Health Service Provider.	**50.80%**	412
Am a Mental Health Advocate.	**31.07%**	252
Am a Community Leader (City/County/State Government).	**15.04%**	122
Am a Member of Law Enforcement.	**2.59%**	21
Other (please specify)	**24.91%**	202
Total Respondents: 811		



Where Respondents Reside

The survey asked respondents to pick where the resided based on the following definitions:

Answer Choices	Responses	
In an Urban Area (a community of 50,000 or more people)	71.50%	587
In a Small Urban Area (a community with at least 2,500 but less than 50,000 people)	19.24%	158
Rural Area (any other community with less than 2,500)	9.26%	76
Total		821



Rank Ordering Objectives by Goal Areas

Respondents were asked to rank in order of importance, objectives related to the goals:

- Prevention and Early Intervention
- Service Delivery
- Statewide Data
- Financial Alignment

For each goal area, respondents were given opportunity to enter relevant objectives in narrative form.

Prevention and Early Intervention

The goal for Prevention and Early Intervention is: *Maximize behavioral health prevention and early intervention services across state agencies.*

There was one objective for the Prevention and Early Intervention goal: Utilize best practices for prevention and early intervention.

Since there was only one objective for Prevention and Early Intervention, a number of respondents entered comments in the other box. A high-level summary is as follows:

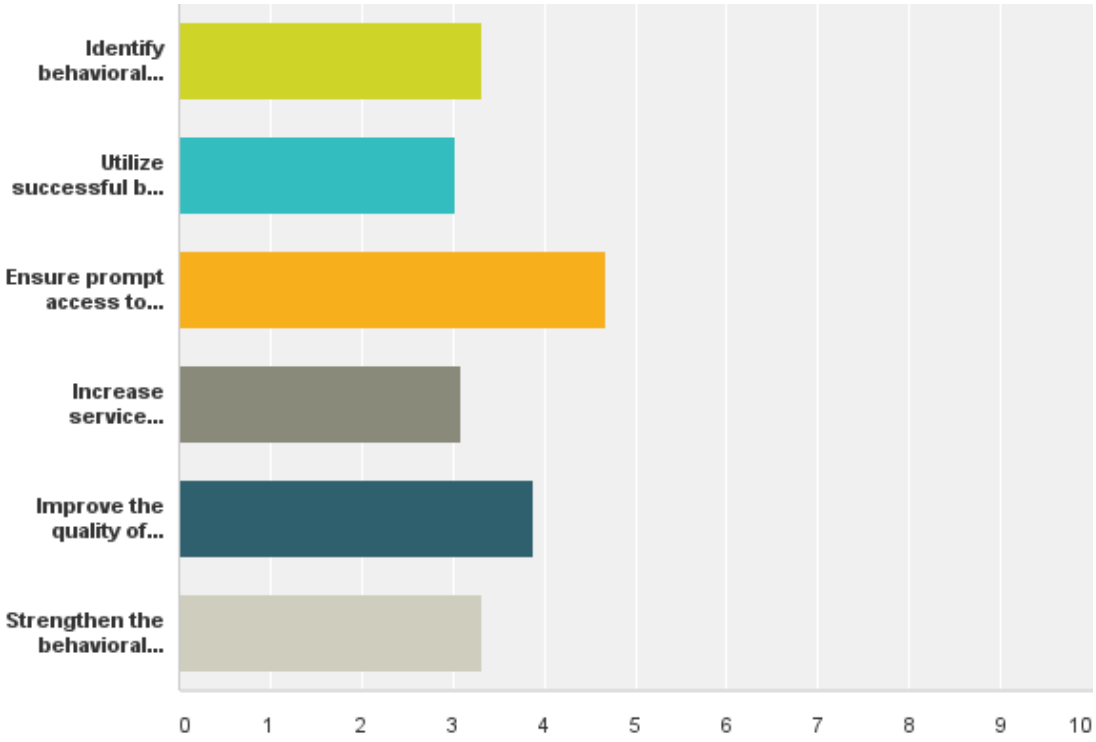
- Ensure All Services are Trauma-Informed
- Eliminate Stigma
- Strengthen Screening Programs
- Increase Awareness Through Public Service Announcements
- Coordination with School Districts, Children's Providers, and Parent Advocacy Groups for Early Intervention
- Training

Service Delivery

The goal for Service Delivery is: *Ensure optimal service delivery to maximize resources in order to effectively meet the diverse needs of people and communities.*

The summary data from the survey is listed below:

	1	2	3	4	5	6	Total	Score
Identify behavioral health gaps across service agencies.	16.33% 114	12.75% 89	16.62% 116	16.33% 114	17.91% 125	20.06% 140	698	3.33
Utilize successful best and promising behavioral health practices across service agencies.	7.34% 51	11.51% 80	16.55% 115	24.17% 168	20.86% 145	19.57% 136	695	3.02
Ensure prompt access to quality behavioral health services.	42.31% 300	19.75% 140	16.50% 117	10.72% 76	7.62% 54	3.10% 22	709	4.69
Increase service delivery coordination across state agencies.	5.63% 40	16.32% 116	17.58% 125	20.53% 146	21.24% 151	18.71% 133	711	3.08
Improve the quality of behavioral health services.	17.43% 125	25.66% 184	17.29% 124	15.48% 111	14.92% 107	9.21% 66	717	3.88
Strengthen the behavioral health workforce.	15.85% 116	15.98% 117	16.39% 120	11.61% 85	14.75% 108	25.41% 186	732	3.30



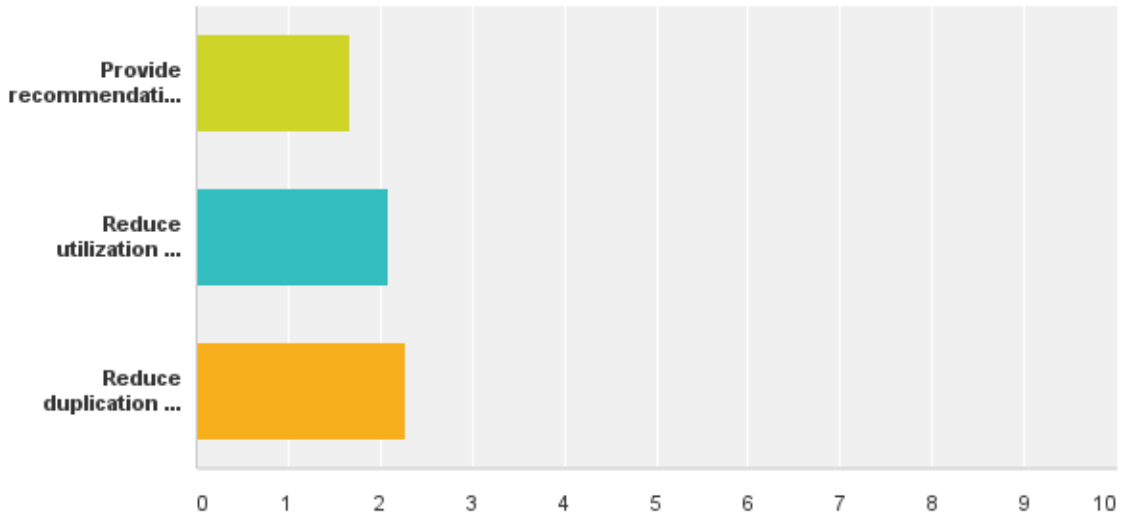
In the Other category, the majority of the respondents discussed access to services and behavioral health workforce issues.

Financial Alignment

The goal for Financial Alignment is: *Ensure that the financial alignment of behavioral health funding best meets the needs across Texas.*

The survey summary data is listed below:

	1	2	3	Total	Score
Provide recommendations biennially to maximize the use of state or federal funding.	**17.71%** 122	**32.66%** 225	**49.64%** 342	689	1.68
Reduce utilization of high cost alternatives, such as, institutional care, criminal justice incarceration, inpatient stay, and foster care.	**39.60%** 276	**29.70%** 207	**30.70%** 214	697	2.09
Reduce duplication of effort, and maximize resources.	**45.30%** 323	**36.61%** 261	**18.09%** 129	713	2.27



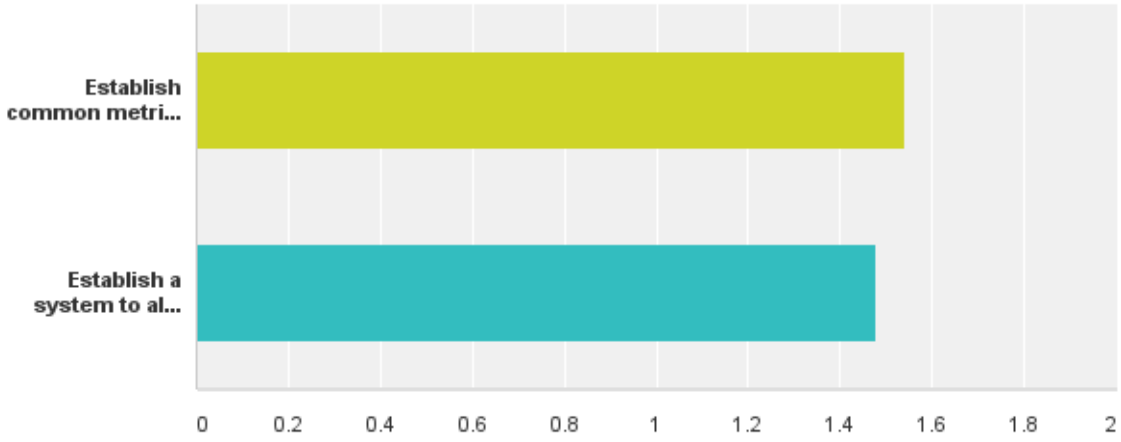
In the Other category, the majority of the respondents discussed the need for more funding and parity as well as issues related to uncompensated care.

Statewide Data

The Goal for Statewide Data is: *Compare statewide data across state agencies on results and effectiveness of behavioral services.*

The survey summary data is listed below:

	1	2	Total	Score
Establish common metrics to evaluate the quality of services and effectiveness of program results.	53.86% 377	46.14% 323	700	1.54
Establish a system to allow real-time limited data exchange.	47.99% 346	52.01% 375	721	1.48

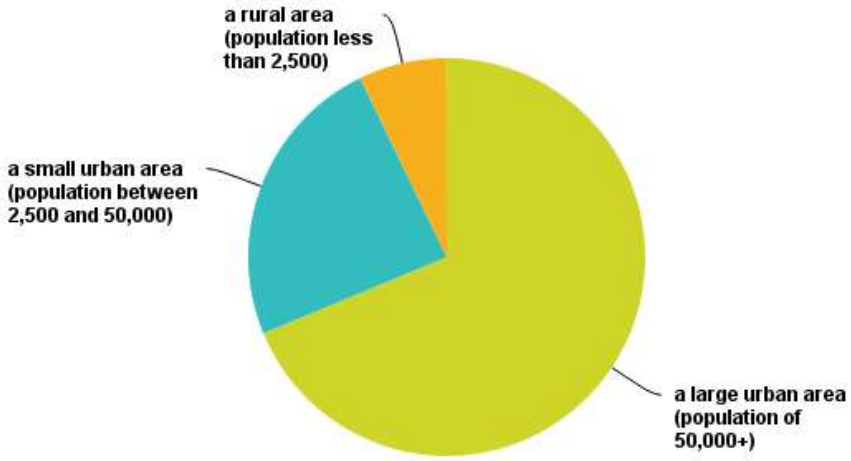


In the Other category, the majority of the respondents provided comments focused on needs for a single online healthcare record, outcomes-based metrics, data elements that need real-world application, and the need to measure quality of life and recovery.

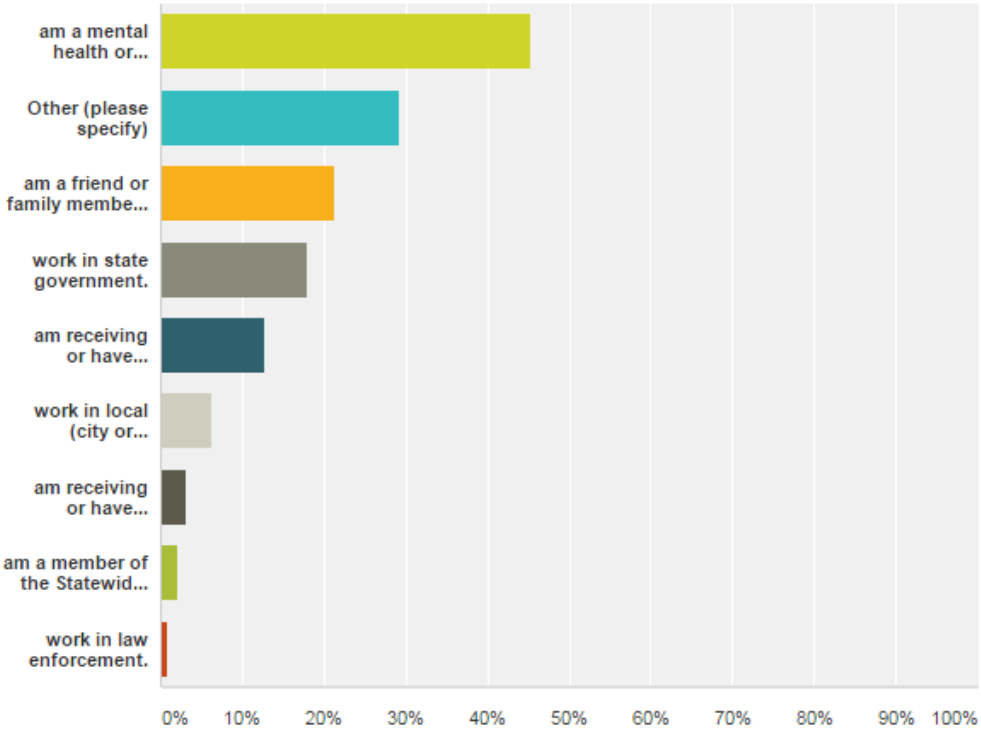
Survey: Strengths, Weaknesses, Opportunities, and Threats of the Current Behavioral Health System in Texas

A survey of the current Strengths, Weaknesses, Opportunities, and Threats (SWOT) related to the Texas behavioral health system was conducted February 3 and 17, 2016. Stakeholders, providers, end users, Council agencies, Behavioral Health Advisory Committee Members, and local and state government representatives were all invited to participate in the survey. A total of 745 respondents participated.

Of those 745, 69 percent live in a large urban area (area with a population of greater than 50,000), 24 percent live in a small urban area (area with a population between 2,500 and 50,000), and 7 percent live in a rural area (area with a population of less than 2,500).



Respondents were also asked to identify their role in the behavioral health system. The largest percentage of respondents were mental health or substance use disorder (SUD) treatment providers (45 percent). "Other" respondents – made up of largely school administrators, teachers, and staff, as well as community nonprofit representatives – constituted 29 percent of participants. Friends and family members of someone who has received mental health or SUD services were 21 percent, state government staff 18 percent, and someone who is or has received mental health services represented 13 percent The remaining respondents were local government representatives (6 percent), someone receiving or having received substance use disorder services (3 percent), Statewide Behavioral Health Advisory Committee Members (2 percent), and law enforcment (1 percent).



For each area – Strengths, Weaknesses, Opportunities, and Threats – a sample was used to review and analyze responses. The top three results, represented in the graphic above, are as follows:

Strengths:

1. Availability of Peer Services
2. Diverse array of available services; increased services available
3. Availability of crisis response teams

Weaknesses:

1. Limited available services
2. Shortage of psychiatrists, clinical staff, and behavioral health providers **and** lack of substance use treatment
3. Low coordination between providers; lack of follow-through, organization, and attention to effective outcomes

Opportunities:

1. Expand telemedicine/telehealth
2. Increase stakeholder involvement and front line staff input
3. Expand existing services

Threats:

1. Lack of appropriate and adequate funding; funding cuts
2. Sustainability of innovative and grant-funded programs
3. High cost of services; lack of insurance; claims and reimbursement issues

Breakdown of sample sets for each area:

- Strengths: 507 total responses, sample set size – 147
- Weaknesses: 553 total responses, sample set size – 82
- Opportunities: 472 total responses, sample set size – 80
- Threats: 484 total responses, sample set size – 81

In addition to the top three responses identified in each area, there were also responses collected related to significant areas of interest.

- Strengths: Collaboration of service providers, communities, law enforcement, and first responders; dedicated professionals demonstrating genuine concern
- Weaknesses: Inability to maintain, develop, and sustain a trained behavioral health workforce; lack of adequate services and access to available services in rural areas
- Opportunities: Utilize technology and data to enhance infrastructure and service delivery; assist clients with other needs and services, such as housing
- Threats: lack of public awareness, stigma associated with behavioral health conditions

Of particular note are the following responses regarding strengths in the current behavioral health system:

- "There is a genuine concern to provide support services to this population, especially to individuals with chemical and/or mental health issues."
- "There appear to be several supports for mental health treatment [in my area] and there are supports for substance abuse treatment for adults. The mental health services agency in this town [have] recently implemented wraparound services for children and teens which I feel will be a huge support."
- "Psychiatric inpatient care and peer-delivered services are improving. There is also an improvement in supported housing and supported employment services."
- "The development of the peer network and providers [is a strength]. Often clients feel they are alone in their struggles and it helps to be connected and know are not [alone]."
- "Different agencies have the ability to work together to get the client the help they need in the least restrictive environment."
- "Attention is being paid to the continuum of services available, with emphasis on identifying gaps in access to care and sustained engagement in services."

Appendix E: Texas Behavioral Health Advancements and Best Practices

Texas state agencies have implemented programs and systems that have significantly improved behavioral health outcomes in areas such as reductions in recidivism and enhanced servce intergration. Examples of these initatives are listed below in addition to those described in Section 5.2:

Office of the Governor

National Association of Drug Court Professional's Adult Drug Court Best Practice Standards

Texas Government Code Sections 772.0061 and 121 require the Governor's Criminal Justice Division (CJD) work with the Specialty Advisory Council to make recommendations for programmatic best practices for specialty courts in Texas. The National Association of Drug Court Professionals (NADCP) conducted a longitudinal study that targeted drug courts to identify Adult Drug Court Best Practice Standards[89]. These are also widely accepted in the field as generally applicable to all specialty and problem-solving courts.

On February 26 2016, CJD recommended that the Texas Judicial Council approve the adoption the NADCP's Adult Drug Court Best Practice Standards, which is anticipated to be on the Specialty Advisory Council's June 2016 agenda for approval.

Department of Aging and Disability Services

Transition Support Teams and Enhanced Community Coordination

In March 2015, the Health and Human Services Commission (HHSC) and the Department of State Health Services (DADS) received approval from the Centers for Medicare and Medicaid Services (CMS) for a three-year grant to support a new initiative under the Texas Money Follows the Person Demonstration (MFPD) grant to strengthen services for individuals with IDD relocating from an institution by strengthening medical, behavioral and psychiatric supports, and enhanced community coordination. This funding makes available an array of safety net services and supports that assist local intellectual and developmental disabilities authorities (LIDDAs) and program providers in ensuring successful relocation of individuals into community settings.

In June 2015, DADS contracted with eight LIDDAs to serve as administrators of funds within an appropriate catchment area, and to address the distinct issues and challenges within the coverage area. Additionally, standardized reporting processes support the identification of systemic issues and potential solutions to be implemented at the local or statewide level.

The LIDDAs are critical to these coordination and community preparedness activities and established eight regional transition support teams to provide medical, behavioral, and

psychiatric support services. The goals of the teams are to provide support services to the 39 LIDDAs and service providers across all 254 Texas counties.

Additionally, Enhanced Community Coordination was implemented with the LIDDAs to ensure access to necessary medical and/or behavioral services for individuals with complex needs and services are delivered in a person-centered manner. Through this type of care planning, the LIDDAs:

- Ensure organization and coordination of care across providers and other specialized service systems to fully meet the individual's needs in the community.
- Ensure the individual's service coordinator is supported and has necessary resources.
- Identify barriers individuals experience during pre- and post-placement into the community.
- Act as a model for how flexible supports, such as one-time emergency assistance for crisis respite services, rental or utility assistance, food or nutritional supplements, clothing, and medications, can address the unique challenges of these individuals.

Crisis Respite and Behavioral Intervention Teams

The 84th Texas Legislature provided funding to support individuals with intellectual and developmental disabilities (IDD) and significant behavioral and mental health challenges, many of whom transitioned or were diverted from institutional settings. These individuals often exhibit significant needs requiring additional support beyond the array of services typically provided within community programs. The development of behavior intervention services and crisis respite programs across the state will provide assistance to individuals with IDD in crisis, allowing them access to temporary stabilization resources while identifying long-term supports to meet their needs.

DADS conducted a gap analysis to determine areas of the state lacking behavior intervention and crisis respite services for individuals with IDD such as mobile crisis response units, 24-hour crisis hotlines, accessible community behavior support services, on-call programs, respite support services, and psychiatric emergency services. These activities will be coordinated within local crisis support service efforts occurring through DSHS. Based on results of the gap analysis, DADS is establishing or expanding crisis intervention supports, including behavioral intervention supports and crisis respite programs at LIDDAs will provide supports for individuals with an IDD in crisis to have access to temporary crisis respite on a short-term basis while securing services that will meet their long term needs. Crisis support services are estimated to be available in June 2016. Key components of the program include:

- Establishing, expanding, or enhancing community-based crisis services.
- Providing support to existing crisis mobile units such as a mobile crisis outreach team to include the availability of a behavioral specialist who is specifically trained on addressing crisis situations with individuals with IDD.
- Providing crisis respite services for individuals with an IDD and co-occurring mental illness, to exclude mental illness only.
- Providing follow-up care to monitor and provide support to individuals.

Department of Family and Protective Services

Sub-acute Psychiatric Hospital Inpatient Treatment Program

The Sub-acute Psychiatric Hospital Inpatient Treatment Program has been added to the continuum of residential child-care services to address the needs of children for whom there is no appropriate 24-hour residential child-care treatment program following a psychiatric hospitalization. This program has not yet begun, but has anticipated start date of June 2016. An extended psychiatric and residential treatment program is ideal in stabilizing the treatment needs of this population of youth in care as well as preparing them for the level of expectations in a facility and/or community-based residential child-care setting.

Department of State Health Services

Certified Family Partners

Certified Family Partners (CFP) are parents or guardians who have a lived experience raising a child with mental or emotional challenges and who have learned to successfully navigate the systems of care. A family partner engages families in services, assists families in navigating various systems, and serves as a role model for families to teach parents how to advocate for their children. CFPs are available in each of the local mental health authorities (LMHAs) across the state. An evaluation of Texas' CFP program has shown that families who receive family partner services are more likely to show improvement than those not receiving family partner services. Families who received family partner services were also more likely to show improvement in family functioning, reducing the likelihood of parental relinquishment. Family partner services are intended to primarily assist caregivers and create a more stable and resilient family unit.

Outpatient Competency Restoration

Texas operates 12 outpatient competency restoration (OCR) programs, constituting the largest initiative of its kind in the country. These programs are located across the state and served roughly 1,700 individuals as of the end of fiscal year 2015. The program provides access to housing alternatives with supports, access to substance use treatment (inpatient and outpatient), connections to mental health providers, and assistance with obtaining social security disability income, which can increase a participant's ability to live independently in the community. In a 2015 report published by the Hogg Foundation for Mental Health[90] regarding Texas OCR programs, the most important factors impacting the overall success of the programs included the following initiatives:

- Identifying and/or fostering "champion" judges or judges that strongly support the program.
- Obtaining the support of the district attorney.
- Building good relationships with law enforcement and county jail staff.
- Developing a good reputation for restoring clients to competency.
- Establishing a mental health docket or court.
- Increasing community awareness of OCR programs as a treatment alternative.

Health and Human Services Commission Medicaid

Appointment Availability Studies

In 2015, HHSC began looking at member access to care by sampling managed care organization (MCO) provider directories and calling providers to determine how quickly appointments are available and whether access standards are being met. Behavioral health providers are one of the provider groups that were evaluated for STAR, STAR+PLUS, and the Children's Health Insurance Program (CHIP) in the 2015 and 2016 appointment availability studies.

Member Surveys

HHSC surveys managed care members biennially to assess member satisfaction with their behavioral health care, including getting treatment quickly, how well clinicians communicate, getting treatment and information from the plan or behavioral health organization, information about treatment options, and perceived improvement.

Money Follows the Person Behavioral Health Pilot

Nationally, significant numbers of nursing facility residents have a primary diagnosis of mental illness, with 25 percent being younger than age 65. In 2008, the Department of State Health Services (DSHS), in partnership with HHSC and DADS, began a Behavioral Health Pilot (BHP) under the federal MFPD grant from CMS. BHP operates in several central Texas counties, including Travis and Bexar. The BHP is designed to help adult Medicaid clients with serious mental illness (SMI) and substance use disorder (SUD) leave nursing facilities and successfully live in the community. MFPD has enabled Texas to test the efficacy of new services and techniques for this special population. Pilot participants have multiple health challenges, including chronic health conditions, physical disabilities, SMI, and SUD. Pilot services include community-based substance abuse treatment and Cognitive Adaptation Training, a rehabilitative service designed to help individuals establish daily routines, organize their environment, and build social skills.

The BHP has been independently evaluated by the University of Texas at Austin and is very successful. Outcomes include improved functioning and quality of life. These gains are sustained over time. Almost 70 percent of people who completed BHP services remain in the community. Examples of increased independence include getting a paid job at competitive wages, driving to work, volunteering, passing a General Educational Development (GED) test, teaching art classes, leading substance use peer support groups, and working toward a college degree. Additionally, the cost of living in the community under MFPD is 71 percent of the cost of living in a nursing facility, so the net savings over time could be significant.

In 2016, Texas obtained CMS approval to use MFPD resources to help bring successful BHP interventions and practices to scale and sustain them in the state-wide Medicaid managed care system. Since inception of BHP in 2008, Texas has transitioned from a traditional fee-for-service system into a state-wide, capitated managed care system with service packages that now include

mental health rehabilitation, SUD treatment and targeted case management, all of which can be provided using the techniques tested in the BHP. The plan is intended to continue to support the transition of individuals from nursing facilities to community settings through BHP, and to create a statewide training and technical assistance program through the University of Texas Health Science Center – San Antonio.

Wellness Incentives and Navigation Study

CMS is conducting a nationwide demonstration to evaluate the effectiveness of providing incentives to Medicaid beneficiaries who participate in prevention programs and demonstrate changes in health risk and outcomes, including the adoption of healthy behaviors. DSHS and HHSC partnered to compete for this 100 percent federally-funded grant opportunity. Texas chose to focus on people with behavioral health (mental health and SUD) conditions because individuals with these conditions are more likely to suffer chronic physical co-morbidities, experience debilitating chronic physical illnesses earlier in life, and have elevated health care costs. The Texas project, known as Wellness Incentives and Navigation (WIN), completed its final year of incentives on December 31, 2015. The project targeted non-elderly adult STAR+PLUS members with SMI and those with other mental health and SUD conditions coupled with chronic physical health diagnoses. The WIN project goals include improved health self-management, increased use of preventive services, and more appropriate use of health care services. WIN employed person-centered incentives to help participants manage chronic health conditions.

Interim evaluation results indicated significantly improved mental health-related quality of life in the intervention group from baseline to year 1. In addition, participants in the intervention group had higher activation (knowledge, skill, and confidence for managing their health) at year 1 as compared to the control group. Research consistently demonstrates that those who are more activated are engaged in preventative and healthy behavior and more likely to be engaged in disease specific self-management behaviors. In 2016, the independent evaluator continues analysis of various study outcome measures, with a final report anticipated in late 2016.

University of Texas Health Science Center – Houston

Competency Restoration Program

In 2012, Texas established a competency restoration program on a 23-bed unit at the UTHealth Harris County Psychiatric Center (HCPC), an academic acute psychiatric hospital. This collaborative program engaged a local hospital, the felony and misdemeanor courts, the district attorney's office, the public defender's office, the county jail, and the LMHA to serve as coordinating council for the program.

The program aimed to restore patients to competency as quickly as possible while maintaining an overall restoration percentage in line with national and state norms. By the end of fiscal year 2015, the program had achieved an overall length of stay of 38 days, with a restoration percentage of 87 percent. Of 220 patients admitted that year, 191 were restored to competency.

These results compare favorably to national norms. A sample of 10 studies examining time to restoration demonstrated a range of 64 to 175 days. Restoration percentages generally range from 75 to 85 percent. Assuming an average of 100 days to restoration based on the reviewed studies, HCPC restores patients 2.6 times faster. Stated differently, other programs would have required 60 beds to restore the same number of patients in a year that HCPC's program was able to restore with 23.

HCPC has adopted the Florida State Hospital's Competency to Stand Trial Training Curriculum (CompKit), modified to align with Texas statute and codes. CompKit is a nationally recognized, evidence-based curriculum proven to be effective in inpatient and outpatient competency settings across the United States.

The unit is staffed and run as an acute-care psychiatric inpatient unit. It is staffed by clinical professionals, including two board-certified forensic psychiatrists, a forensic psychologist, two master's level clinicians, nurses, recreation therapists, and psychiatric technicians.

Treatment services include:

- Inpatient bed-day services, including initial psychiatric assessment, pharmacological management with individual therapy, individual psychotherapy, family and group psychotherapy.
- Individualized treatment plans, including daily treatment with a psychiatrist.
- Medication stabilization.
- Nurse-administered medication.
- Daily competency restoration training (court education groups).
- Lab work.
- Psychological evaluations to determine competency.

HCPC's competency restoration program has demonstrated success. The collaborative involvement of the various agencies, combined with the intensive nature of the treatment delivered in an academic hospital, has resulted in better outcomes for the patient, quicker restoration times for the jail and courts, and a significantly lower cost per patient restored.

Texas Department of Criminal Justice

Criminal justice best practices pair a supervision professional with a criminal justice-trained clinical professional that addresses all needs including criminogenic risk and needs to facilitate a care plan and intervention.

Texas Military Department

Texas Military Department (TMD) counselors conduct outreach by attending unit drills, annual training, and multiple family events, allowing them to meet service members and their families where they are, creating relationships of trust in delivering services.

End Notes

Vision, Mission, and Guiding Principles

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Current Behavioral Health System in Texas

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