MEADOWS MENTAL HEALTH POLICY INSTITUTE

the Valley Baptist LEGACY FOUNDATION™

Rio Grande Valley Behavioral Health System Strengths and Needs Assessment

March 31, 2026

Contents

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Executive Summary

Beginning in October 2024, the Meadows Mental Health Policy Institute (Meadows Institute) undertook a community mental health strength and needs assessment covering the counties the Valley Baptist Legacy Foundation (VBLF) serves – Cameron, Hidalgo, Starr, and Willacy. Drawing upon regional quantitative and qualitative data we collected through interviews, listening sessions, document reviews, and comprehensive analyses of available data on needs and services provided, we identified a broad array of strengths and opportunities for improvement grounded in the needs of the people who call these four counties home and the diverse and robust array of mental health providers working to meet their needs. This report summarizes our findings and provides data-driven and actionable recommendations to strengthen mental health response systems across all the communities of Cameron, Hidalgo, Starr, and Willacy counties (referred to as "the region" in this report).

The underlying principle of this assessment and its recommendations is simple: the best behavioral health systems should mirror the best health systems for other health conditions, with a focus on early detection and access to best-practice care. Dependence on the traditional approach that dominates most mental health systems across the nation—waiting over a decade after symptoms first emerge to provide care and treating the mind and body separately—has led to consistently worse outcomes over time for people suffering from mental illnesses, as few get access to effective care in a timely way, too many go without care, and our struggling care systems contend with an overuse of jails, emergency departments, and hospital beds.

The best behavioral health systems should mirror the best health systems for other conditions – with a focus on early detection and access to best-practice care.

The Meadows Institute centered this assessment on those principles that offer more hope and that we refer to as an "ideal system," one that no community in America has yet effectively brought to life. In the report that follows, this is the context in which we highlight the region's strengths and offer recommendations for leveraging those strengths, as well as opportunities to pursue others. Although examples of national leading best practices are increasingly available in the region, as well as an increasing number of communities nationwide, the reality is that most mental health care today is delivered without the coordinated array of supports fully needed to detect and treat those health concerns early and effectively.

The recommendations in this report offer a roadmap to crafting, refining, and sustaining continued progress towards an ideal system in Cameron, Hidalgo, Starr, and Willacy counties. The recommendations also need to be viewed in the context of the overall set of public and privately funded mental health systems in the region. Too often today in Texas, when we talk about mental health systems at a population level, the assumption is that we are talking about the publicly funded system of local mental health authorities (LMHAs) and the coordinated systems of care they anchor. In this report, we include a focus on that system, and we are

enthusiastic and hopeful about the expanded care options with additional federal funding they are now able to offer as Certified Community Behavioral Health Clinics (CCBHCs). The two CCBHCs in the region – Border Regions Behavioral Health Center and Tropical Texas Behavioral Health – are foundational to the region's overall mental health infrastructure, but interviews with their leadership and the broader array of community resources underscores that the responsibility for improving care options must encompass the entire community, including the region's leading health systems, hospitals, and networks of community clinics and providers, both those in the safety net and those serving the broader population.

Across the two CCBHC/LMHAs and the other organizations we engaged, this report describes a wide array of care, including many programs that are best practice examples in the state. But each of these providers must play a role, as none can meet every need given that the funding they all rely on is fragmented across multiple funding streams that each have complex and often conflicting rules and limitations. The issue is not just Medicare, Medicaid, state-funding, commercial insurance, and local funding. Each of those broad categories today includes multiple health plans, products, and evolving programs focused on particular subsets of the community. Each recommendation offered in this report is grounded in this complexity, including significant regulatory and resource issues that constrain the role of any one player. The building blocks are in place for tremendous progress in the region through an even more coordinated development plan over time driven by the people and communities of the Rio Grande Valley region.

Methodology: A Systematic Data-Driven Assessment

In October 2024, the Meadows Institute initiated an assessment of the region's mental health needs and service delivery systems, aiming to understand and support the improvement of the region's system. Primary data collection was completed and most findings drafted by the summer of 2025, after which the Meadows Institute team worked with leadership at Valley Baptist Legacy Foundation through the remainder of 2025 and early 2026 to identify and fill gaps and engage additional stakeholders to create a more comprehensive report responsive to the experiences of the people of the region. Across these phases, the following activities were completed as part of the assessment.

- **Interviews with Experts and Regional Leaders:** The Meadows Institute conducted interviews with over 110 leaders from across the region, representing healthcare systems, mental health providers, advocacy groups, community-based organizations, people with lived experience, academics, elected officials, state agencies, officials from local agencies, and education professionals. In addition, several listening sessions and group interviews were conducted across the region (see Appendix B for a full listing).
- **Research Literature, Reports, and Policy Review:** Our team reviewed more than 300 secondary data sets, research articles, reports, and state policies.
- **Quantitative Data Analysis:** We conducted quantitative data analysis using demographic data (including insurance coverage, education levels, and socioeconomic

information), local hospitalization data,[1] and data on the services the region's local mental health authorities provide to Rio Grande Valley residents.

Framework: An Ideal System of Care

The organizing framework for our report is an ideal system of care that comprehensively addresses the behavioral health needs of all people in the region, including access to mental health services in primary and specialty care settings. As the U.S. Surgeon General's 2021 health advisory on youth mental health articulated,[2] as with all illnesses, the earlier mental health conditions can be identified and treated, the better.

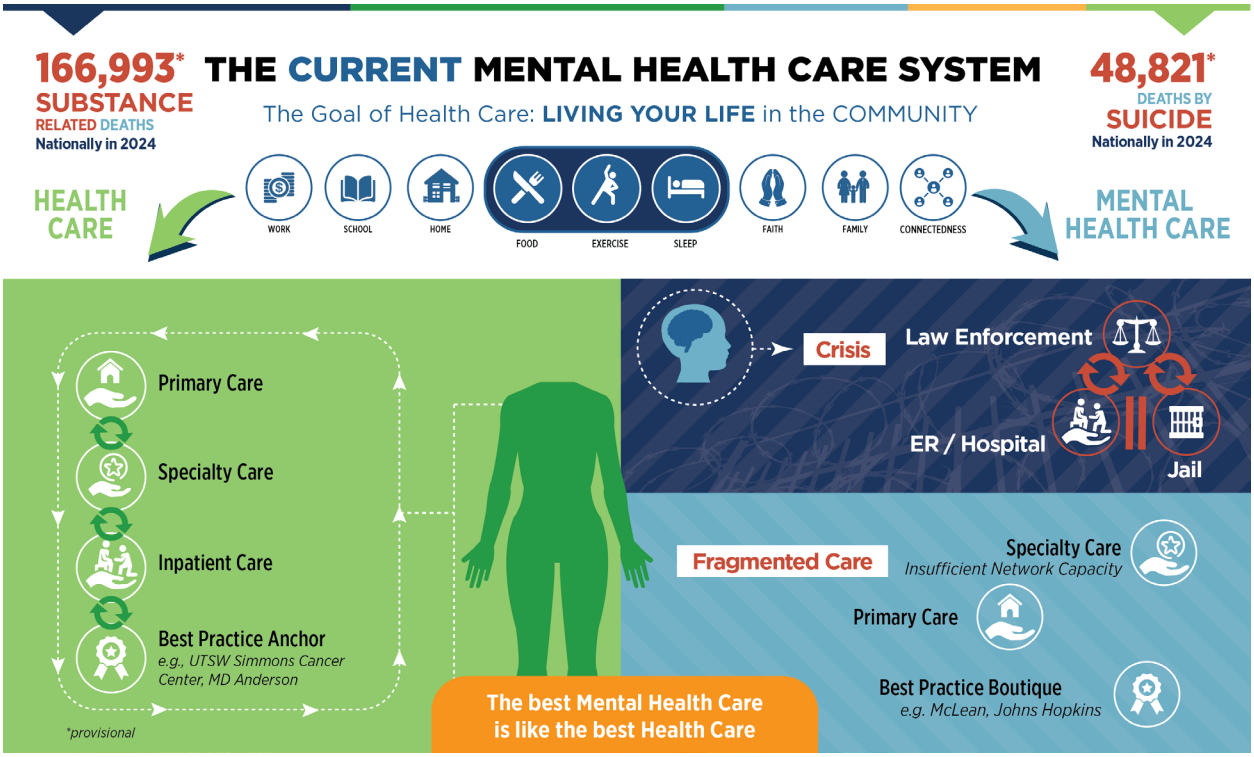
Across our nation, mental health care delivery is generally fragmented and segregated from the health care system; community mental health systems tend to reflect the system depicted in Figure 1. Today in every part of Texas, as well as every community in the United States more broadly, we do not detect or treat mental health concerns like depression or psychosis – to the extent that we detect and treat them at all – until years after the symptoms emerge.[3] Instead, we wait until suffering becomes obvious to the person (or the people around them), too often in the form of a crisis that leads to an emergency room or hospital or – particularly for Black, Indigenous, Latino, and other people of color and people in poverty – the police. Because of this, less than one in 15 of the 1.5 million Texans suffering from depression each year receive the care needed to achieve symptom remission,[4] and over 4,800 died from suicide,

As with all illnesses, the earlier mental health conditions can be identified and treated, the better.

[1] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). *Texas Hospital Inpatient and Emergency Department Discharge Research Data Files.* Austin, Texas: 2020-2022.
[2] The Office of the Surgeon General. (2021) Protecting Youth Mental Health: The U.S. Surgeon General's Advisory. https://www.hhs.gov/sites/default/files/surgeon-general-youth-mental-health-advisory.pdf
[3] Martini, R., Hilt, R., Marx, L., Chenven, M., Naylor, M., & Sarvet, B. (2012). *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*. American Academy of Child & Adolescent Psychiatry. https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf
[4] Pence, B. W., O'Donnell, J. K., & Gaynes, B. N. (2012). The Depression Treatment Cascade in Primary Care: A Public Health Perspective. Current Psychiatry Reports, 14(4), 328–335. https://doi.org/10.1007/s11920-012-0274-y

across all ages, in 2024 (134 in the region),[5] even though efficacy rates for available depression treatments are over 60%.[6,7] Suffering is profound.[8,9,10]

Figure 1: The Current Behavioral Health Care System in the United States



[5] Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February). Underlying cause of death 1999-2023 on CDC WONDER online database. Data are from the underlying cause of death files, 1999-2023, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Deaths from suicide are classified using underlying cause-of-death ICD-10 codes U03, X60–X84, and Y87.0. http://wonder.cdc.gov/ucd-icd10.html. Given the process carried out by the CDC to determine rates of death from suicide, 2024 is the most recent full year for which complete data are available.

[6] Hermann, H., Kieling, C., McGorry, P., Horton, R., Sargent, J., & Patel, V. (2019). Reducing the global burden of depression: A Lancet–World Psychiatric Association commission. *The Lancet*, *393*(10189), e42–e43. https://doi.org/10.1016/S0140-6736(18)32408-5

[7] The US Burden of Disease Collaborators. (2018). The state of US health, 1990-2016: Burden of diseases, injuries, and risk factors among US states. *JAMA*, *319*(14), 1444. https://doi.org/10.1001/jama.2018.0158

[8] Hermann, H., Kieling, C., McGorry, P., Horton, R., Sargent, J., & Patel, V. (2019). Reducing the global burden of depression: A Lancet–World Psychiatric Association Commission. The Lancet, 393(10189), e42–e43. https://doi.org/10.1016/S0140-6736(18)32408-5

[9] The US Burden of Disease Collaborators. (2018). The State of US Health, 1990-2016: Burden of Diseases, Injuries, and Risk Factors Among US States. JAMA, 319(14), 1444. https://doi.org/10.1001/jama.2018.0158

[10] Centers for Disease Control and Prevention, National Center for Health Statistics. (2024, March). Multiple cause of death 1999-2022 on CDC WONDER online database. Data are from the multiple cause of death files, 1999-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Deaths from suicide are classified using underlying cause-of-death ICD-10 codes U03, X60–X84, and Y87.0. Substance-related deaths are classified using any underlying cause of death and multiple causes of death ICD-10 codes X40–44, X60–64, X85, and Y10–Y14, or the cause of death category “alcohol-induced causes.” http://wonder.cdc.gov/mcd-icd10.html.

Communities across the nation previously faced this same problem for heart disease and cancer. Until the 1980s, we identified heart disease primarily when a person had a heart attack, and we began treatment then after the heart was damaged to resuscitate the person and prevent a recurrence. We also used to wait to detect cancer until it resulted in functional impairment – a broken bone, coughing up blood – with devastating consequences and higher mortality rates. Today, however, we have systems in place in primary care and the community that detect most heart disease and many cancers much earlier, when they are easier to treat successfully, much less likely to be disabling and burdensome to the person receiving care, and less costly to society. We also treat them proactively in primary care through measurement-informed care, routinely tracking early symptoms such as cholesterol and hormone levels and titrating care in response. Additionally, there are health systems, including those in the region, that routinely provide best practice assessment and treatment for heart disease and cancer, and most people can travel within one to two hours from most places in the state to find hope for these diseases.

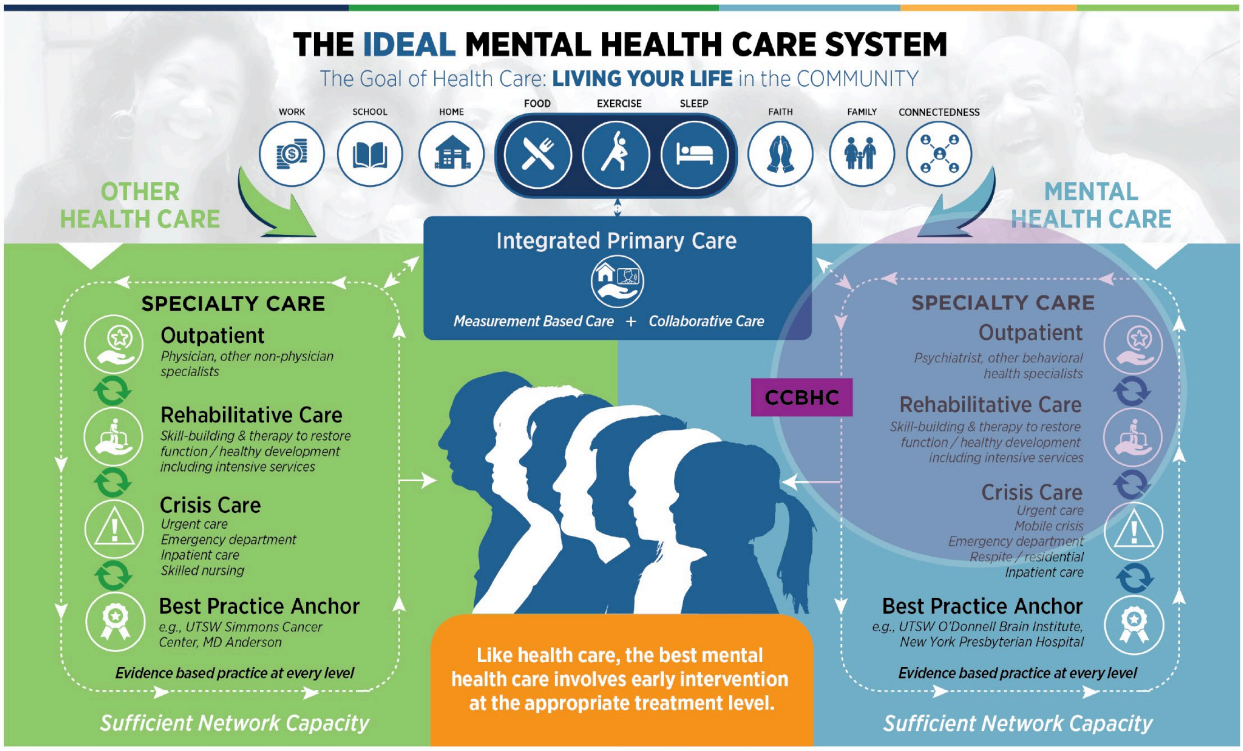
This is still not the case for behavioral health today in most parts of the nation, where decades of policies and practices shaped our behavioral health care delivery to be isolated from broader health systems. Most people must travel thousands of miles to receive top-rated care,[11] and the best care is too often reserved for people able to pay tens or even hundreds of thousands of dollars out of pocket. For mental illness, treatment is delayed for years and conditions worsen to the point of a crisis, which is too often the first point in time where health systems detect the need and initiate care. For children, youth, and their families, it is even more important to intervene at the earliest point possible because untreated mental illnesses, emotional disturbances, and substance misuse can have cascading effects on the child or youth's health, school performance, and other factors that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.

To envision a system that better reflects the principles endorsed by mental health leaders nationally, the Meadows Institute developed a framework for an ideal system, published as part of the orienting chapter of a peer-reviewed set of guidelines for redesigning mental health systems in the United States.[12] See Figure 2.

[11] U.S. News and World Report. (n.d.). *Best hospitals for psychiatry.* Retrieved, April 24, 2024, from https://health.usnews.com/best-hospitals/rankings/psychiatry

[12] Blau, G., Petrila, J., and Keller, A. (2024) The need for an improved mental health care system. In S. Harris and S. Strakowski, Redesigning the US Mental Health Care System (pp. 3 – 40). Oxford University Press

Figure 2: The Ideal System of Care



The broader principles that inform this ideal system center on the stark fact that the traditional approaches for treating the mind and body separately have led to inadequate and too often inappropriate care for people with mental illnesses and substance use disorders (SUD), an overuse of jails, emergency departments, and hospital beds; and treatment models across the board that stand in sharp contrast to the integrated care provided to people with complex physical health needs. Care for mental illnesses and SUD should generally be aligned with the best practices for physical illnesses more broadly, which warrants integration of care as the norm and not simply a goal. An ideal mental health system:

- Identifies and treat as many people as possible, as early as possible, in primary care;
- Provides best practice specialty care in outpatient settings for those with moderate to severe needs;
- Offers effective care with a rehabilitative focus for people with complex, severe needs;
- Provides a continuum of effective, accessible, and safe settings in the community and in hospitals for people with acute needs in crisis; and
- Has linkages to best practice partners for people with diagnostic complexity and treatment resistant conditions.

Recommendations

No community in the nation has a system that seamlessly incorporates all these principles. Behavioral health systems across the country are a work in progress, shaped by evolving needs, resources, and policy landscapes. The Rio Grande Valley is blessed with a rich tapestry of programs that align well to the model framework referenced throughout this report, and they offer a foundation on which the Rio Grande Valley region can develop plans to address continuing gaps in service and improved systems of care. Throughout this report, we present key findings and recommendations for short- and long-term change in an integrated approach to mental health care for people of all ages in the region. The recommendations span the full continuum of care, and we crafted them to address gaps and opportunities at each stage.

More pointedly, the programmatic recommendations are components of a broader, community-wide strategy that culminates in a need for a regional "accelerator." This regional accelerator would embody and champion a coordinated, solution-oriented approach, strengthening regional collaboration and aligning efforts to expand access to high-quality behavioral health services. Bolstered by this accelerator, the recommendations provided in this report will help local leaders and change-makers implement solutions using evidence-based practices that will improve the region's mental health care access and services. For detailed information about the regional accelerator, see page 179.

Table 1: Summary of Recommendations

Summary of Recommendations
Recommendations for Mild and Moderate Services
To improve access, address workforce shortages, and achieve long-term financial sustainability, support the ongoing implementation of integrated behavioral health in pediatric and adult primary care clinics building on existing models that can be financially sustainable.
To increase utilization of CPAN across the region, strengthen outreach and engagement strategies by the regional health-related institution.
Complex Care Recommendations
To meet complex mental health needs among children and youth, expand access to multisystemic therapy.
To bolster funding for coordinated specialty care programs, Border Region and Tropical Texas should work with regional managed care organizations to negotiate in-lieu-of Medicaid managed care contracts.
To ensure people with serious mental illness receive intensive, wrap-around care, expand and strengthen the assertive community treatment workforce.
To strengthen collaboration and support funding for new interventions, leverage the regional accelerator to expand access to evidence-based, home- and community-based mental health services for children and youth.

Summary of Recommendations
To improve access to behavioral health services for people experiencing homelessness, increase collaboration with LMHAs and expand the evidence-based intervention of permanent supportive housing.
Recommendations for Crisis Care Services
The most recent Texas Legislature expanded funding for Youth Crisis Outreach Teams (YCOT). Tropical Texas should pursue this expanded state funding for a youth crisis outreach team program when it becomes available.
To strengthen the county's crisis response, Starr County should implement a mental health emergency telehealth response program.
Expand access to crisis stabilization services for Starr County.
Recommendations for Substance Use Disorders
To improve substance use disorder service access across the region, strengthen referral pathways and increase awareness of existing services.
Recommendations for Maternal Mental Health
To better address the mental health of population subsets, including maternal mental health, expand implementation of integrated behavioral health care models.
To improve maternal health outcomes and reduce maternal vulnerability, the regional accelerator should prioritize activities that coordinate resources, increase awareness, and enhance collaboration among maternal health providers.
Recommendations for Family Violence
To provide a robust continuum of on-site behavioral health services at the new supportive housing units for survivors of domestic violence, the Friendship of Women and Tropical Texas should establish a partnership.
To promote identification and increase access to behavioral health care for people affected by family violence, District Attorneys and regional LMHAs should establish formal partnerships (such as embedding LMHA staff in county courts).
Expand family violence prevention and identification through schools, community and faith-based organizations, and healthcare settings.
Recommendations for Juvenile Justice
Conduct a planning process to establish a youth assessment and diversion center in Hidalgo County that provides screening, short-term stabilization, and warm handoffs to services.
To divert first-time felony-level THC vaping offenses away from the juvenile justice system in high-referral school districts, replicate first offender programs (led by school-based law enforcement agencies in partnership with local juvenile probation departments).

Summary of Recommendations
The South Region Juvenile Probation Association, with staff support from TJJD's South Regionalization Lead, should develop a juvenile regional reentry navigation program with post-release care coordination and county-specific youth resource guides.
Recommendations for Mental Health in Schools
School districts should routinely evaluate their MTSS framework to identify both strengths and opportunities to enhance the effectiveness of mental and behavioral health supports.
To provide increased access to mental health services for children and youth in the region through TCHATT, UTRGV should partner with a health system capable of expanding TCHATT's services.
Create opportunities for school districts to collaborate around student mental health strategies and best practices.
Strategically plan for sustainable school mental health programming by braiding and blending existing and new funding streams.
Recommendations for Child Welfare
To provide parents and caregivers with the skills and support necessary to address their child's mental health needs in appropriate ways, map the continuum of family preservation services.
Develop an interagency foster care workgroup to strengthen collaboration around foster care, prepare for community-based care implementation, and strengthen mental health coordination.
Expand the direct referral processes between local DFPS offices and LMHAs into additional counties, modeled after Hidalgo County's collaboration with Tropical Texas Behavioral Health.
Enhance supports for relative and kinship caregivers to access mental health services and supports for themselves and the children and youth in their care.
Recommendations for Older Adults
To better address the mental health of population subsets, including older adults, expand implementation of integrated behavioral health models.
Recommendations for Veteran Mental Health
Leverage state funding opportunities to bring together veteran-serving organizations, improve coordination, share resources, and strengthen collaboration across the region.
To better address the mental health of population subsets, including veterans, expand implementation of integrated behavioral health models.
Local health systems should prioritize implementation of mental health screenings for veterans and their families in clinical and healthcare settings.
Foster training opportunities for community providers focused on military cultural competency and evidence-based best practices to improve care for veterans.

Summary of Recommendations
Recommendations for Community Collaboration and Data Sharing
Each county should create a behavioral health leadership team that will lead county-wide efforts to improve behavioral health services across all types of providers, funding sources, and levels of need (building upon any existing county-level collaboration and supporting the cabinet with dedicated staff).
To support cross-county collaboration, promote a regional approach to meeting behavioral health needs, and drive system-wide innovation and alignment, establish a regional behavioral health accelerator.
To strengthen continuity of care and improve behavioral health outcomes, stakeholders should align on a shared HIE strategy, expand provider participation, and enhance functionality to enable timely data sharing and community-level analysis.

Regional Context

The Rio Grande Valley, located in the southernmost part of Texas along the U.S.-Mexico border, is a vibrant and culturally rich region encompassing four counties: Cameron, Hidalgo, Starr, and Willacy. It is considered one of the fastest-growing areas in the country,[13] known for its dynamic and diverse communities. The Health Resources and Services Administration (HRSA) designates all four counties in the region as Medically Underserved Areas (MUAs). HRSA uses this definition to identify areas with a shortage of primary care services within a specific geographic area.[14] One county (Starr) is also a federally designated Health Professional Shortage Area (HPSA), which means there are more residents than available health and mental health professionals can serve.[15]

Figure 3 displays the coverage of the four regional counties by the local mental health authority (LMHA) charged with serving each county. Tropical Texas Behavioral Health serves three counties, Cameron, Hildalgo, and Willacy, while Border Region Behavioral Health Center serves Starr County, as well as three other counties not included in this assessment.[16] Additionally, the figure maps the five hospitals in the region with psychiatric beds. Cameron County houses three hospitals; the other two are in Hidalgo County.

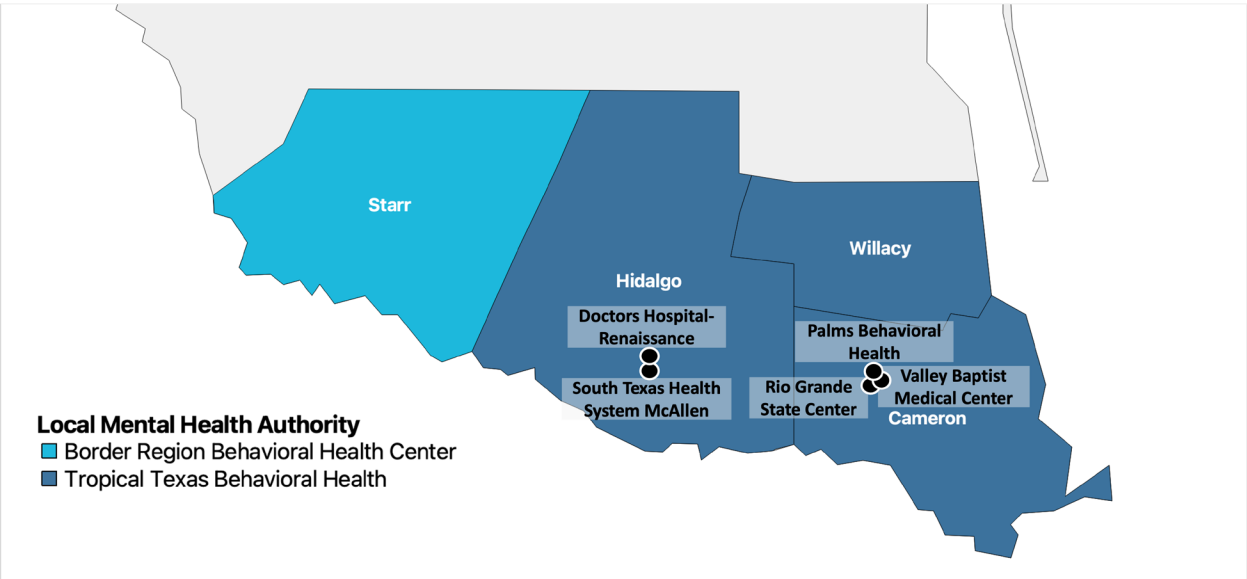
[13] UTRGV. (n.d.). *About the Rio Grande Valley*. Retrieved March 27, 2025, from https://www.utrgv.edu/som/gme/about-gme/about-the-rgv/index.htm

[14] Bureau of Health Workforce. (n.d.). *What Is Shortage Designation?* Retrieved March 26, 2025, from https://bhw.hrsa.gov/workforce-shortage-areas/shortage-designation#mups

[15] MHP Salud. (n.d.). *US Mexico Border Region*. MHP Salud. Retrieved February 11, 2025, from https://mhpsalud.org/who-we-serve/us-mexico-border-region/

[16] Other counties in the Border Region LMHA include Webb, Zapata, and Jim Hogg.

Figure 3: Counties in Rio Grande Valley by Local Mental Health Authority



Regional Behavioral Health Funding

While state appropriations are critical to local services, they are just one of the funding streams that impacts regional behavioral health access and services. Appendix C details many of the federal, state, and philanthropic grants allocated to the region for initiating or sustaining mental health projects. The following briefly spotlights governmental awards, state funding, and other sources that directly and/or indirectly fund regional programs, services, or treatments. See Appendix C for Supplemental Information on Funding, including funds for priority subgroups for which data are available such as veterans.

Federal Funding

With federal funding, there are sizeable programmatic changes that have affected access to care and that will continue to do so in 2026:

- On March 25, 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA) notified the Texas Health and Human Services Commission (HHSC) that they were immediately terminating the funding for the Coronavirus Preparedness and Response Supplemental Appropriations Act and the American Rescue Plan Act of 2021 (H.R. 1319), indirectly impacting local mental health authorities. Border Region, for example, was using approximately $698,000 to support rural mental health crisis programs in Starr and Webb counties. While Tropical Texas was able to maintain all service positions despite the decrease in funding, the funding loss further stresses the system, leaving the LMHAs to provide the same level of services with less funding.
- Beginning in February 2025 and again in February 2026, COVID-era funding through the Education Stabilization Fund through the Coronavirus Aid Relief, and Economic Security (CARES) Act for the Elementary and Secondary School Emergency Relief Fund (ESSER) Fund to address the impact of COVID-19 expired. In total, ESSER funds administered to regional districts in the Rio Grande Valley from 2020 forward totaled over $2.2 billion.

With extension periods expiring in February 2025 and February 2026, Rio Grande City Grulla ISD,[17] McAllen ISD,[18] Brownsville ISD,[19] and La Joya ISD[20] all faced budget deficits for 2024-25 and do so again in 2025-26.

State Funding

State funds support regional behavioral health services in many ways, but particularly through local mental health authorities and Medicaid.

- HHSC contracts with **LMHAs** to provide mental health services. LMHAs are funded through several different ways including state appropriations to serve the indigent population, federal and state grants, as well as billing services to Medicare, Medicaid, private insurance, private payors, and charity care. In fiscal year 2022, for example, Border Region had a community mental health grant and Tropical Texas had a mental health grant for justice-involved people and a state funder grant for veteran mental health. In fiscal year 2025, Tropical Texas also received two state grants for veterans' mental health.
- Texas' **Medicaid** program is a primary source of health coverage for children, low-income families, older adults, and people with disabilities. Many Texans with serious mental health needs qualify for Medicaid due to their disability status, especially in high-enrollment regions like the Rio Grande Valley.

Texas has also experienced significant legislative and **policy changes** in recent sessions, dramatically reshaping the mental health landscape. In 2023, the 88th Texas Legislature approved $11.68 billion in funding for behavioral health, a 30% increase from the previous session. This appropriation covers inpatient capacity issues, hospital admissions, crisis stabilization, intensive outpatient services for youth and families, and workforce development. Two years later, the 89th Texas Legislature leveraged both budget and legislative initiatives to expand mental health access, address workforce challenges, and drive innovation through research and promising new treatments. Senate Bill 1 (Huffman), the 2026-27 General Appropriations Act, included $10.41 billion for behavioral health funding across 30 state agencies.

On a positive note, funding from the 89th Legislature offered several opportunities to act on new state investments and policy changes. The region can, for instance, maximize workforce incentives and ensure rural hospitals implement the pediatric mental health access program. The table below spotlights recent regional funding by location as well as new opportunities.

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[17] KRGV. (n.d.). *Valley School District Facing Multi-Million Dollar Deficit*. KRGV. Retrieved June 3, 2025, from https://www.krgv.com/videos/valley-school-district-facing-multi-million-dollar-deficit/

[18] Zapata, O. (2024, February 14). McAllen ISD facing $13.7 million budget deficit. *MyRGV.Com*. https://myrgv.com/local-news/2024/02/14/mcallen-isd-facing-13-7-million-budget-deficit/

[19] Long, G. (2024, February 2). Brownsville ISD faces $16 million budget deficit for 2024-25. *MyRGV.Com*. https://myrgv.com/local-news/2024/02/02/brownsville-isd-faces-16-million-budget-deficit-for-2024-25/

[20] Escobedo, G. (2025, April 11). Escobedo: RGV area school districts face growing financial strain. *Rio Grande Guardian*. https://riograndeguardian.com/escobedo-rgv-area-school-districts-face-growing-financial-strain/

Table 2: Behavioral Health Funding Increases from the Texas Legislature

Behavioral Health Funding		
Description	**Amount**	**Location**
88th Legislative Session		
Construction of psychiatric hospital with up to 100 beds by DHR Health	$85 million	Pharr
50-bed maximum security unit at Rio Grande State Center	$120 million	Harlingen
Multisystemic Therapy (MST) team through Tropical Texas (second team)	$1.38 million	Cameron, Hidalgo, and Willacy Counties
Youth Crisis Outreach Team (YCOT) through Border Region Behavioral Health Center (one team)	$250,000 start-up costs, plus $875,000 in operations costs	Starr County
89th Legislative Session		
Youth Mobile Crisis Outreach Teams (YCOTs) – HHSC Rider 54	$54 million	Statewide, including Starr County
Behavioral Health Innovation Grant Program for Community Colleges*	$5 million	Potentially applicable at South Texas College and Texas Southmost College
Loan Repayment Program for Mental Health Professionals	$28 million	Eligible providers in underserved areas
Graduate Medical Education Expansion (Residency Slots)	Part of $304.4 million statewide	May benefit regional hospitals
Pediatric Collaborative Care (Via Consortium) (HB 500)	5.6 million	Statewide
Consortium: Children's Mental Health Programs (THECB Rider 38)	$207.1 million	Statewide (Supports CPAN, TCHATT, PeriPAN)
School Safety Allotment Increase (SB 260)	$430 million	Statewide, including regional school districts

*Qualifying schools must be a community college.

Texas is also receiving an estimated $1.4 billion in federal funding over five years to improve rural health care throughout the state. The Texas Health and Human Services Commission (HHSC) is receiving the funding through the Rural Health Transformation Program. As part of the One Big Beautiful Bill Act, the program is allocating $50 billion to states over five years to help transform rural health care. Rural is defined as counties with a population less than or equal to 68,750, potentially providing opportunities for funding in Starr and Willacy counties.

Philanthropic Funding

Foundations also meaningfully contribute to regional mental health, substance use, and non-medical drivers of health programs and services – most notably three foundations:

- Since 2014, the **Valley Baptist Legacy Foundation** has awarded more than $200 million in grants (across all programmatic areas) to more than 170 unique organizations in the

region.[21] Of this, over $48 million has been awarded through 86 grants to 28 unique organizations specifically for behavioral health.

- **Knapp Community Care Foundation** has awarded a total of $57 million in grants (across all programmatic areas) to over 67 organizations in the mid valley region.[22] Since 2014, the foundation has awarded over $4.5 million through 61 grants to 22 unique organizations specifically for behavioral health, representing 22% of all discretionary grants and 8% of all grants overall.
- Since 1996, **Methodist Healthcare Ministries** (MHM) has invested more than $45 million in behavioral health services in the Rio Grande Valley. Current investments include free or low-cost community-based mental health programs and services,[23] with a focus on integrated behavioral health care and policy and advocacy efforts that expand access and strengthen the behavioral health system.

The region has fewer licensed behavioral health physicians and psychologists, resulting in much higher resident-to-provider ratios.

Workforce

Behavioral Health Providers

The availability of qualified providers significantly influences access to behavioral health services in the region. An analysis of behavioral health providers in the region (Table 3) reveals significant disparities compared to statewide provider availability in Texas. Notably, the region has fewer licensed behavioral health physicians and psychologists, resulting in much higher resident-to-provider ratios. Specifically, there are 19,000 residents for each licensed behavioral health physician and 13,000 for each psychologist in the region. This starkly contrasts with statewide averages of 7,500 residents per licensed behavioral health physician and 8,000 per psychologist. The gap in provider availability is particularly acute among those specializing in child/youth and older adult care. There are four times the number of children and youth per child and youth behavioral health physicians in the region than the statewide average, and there is only one geriatric psychiatrist in the region for a population of 170,000 older adults. Additionally, the region faces a shortage of physicians specializing in substance use disorders (addiction medicine) compared to statewide averages, with 320,000 residents per physician, compared to the statewide average of 85,000 residents per physician.

Geographically, there are significant disparities in the region's behavioral health workforce. For instance, no physicians (i.e., psychiatrists) specialize in behavioral health services in Willacy and Starr counties. In addition to the workforce shortage, limited broadband access in these areas

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[21] *Valley Baptist Legacy Foundation | Advancing Health in the Rio Grande Valley*. (n.d.). Retrieved March 13, 2025, from https://www.vblf.org/

[22] *Our Impact | Knapp Community Care Foundation | Weslaco*. (n.d.). Knapp. Retrieved October 3, 2025, from https://www.communitycare.today/our-impact

[23] Methodist Healthcare Ministries of South Texas, Inc. (n.d.). *Grantmaking*. Retrieved April 15, 2025, from https://www.mhm.org/our-work/grantmaking/

further exacerbates the issue. Many residents lack reliable internet connections, which limits access to telehealth services, a critical tool for overcoming geographic barriers to care. Combined with the region's relative poverty rate, these factors severely hinder the ability to access necessary behavioral health services. This gap underscores the need for targeted solutions to address behavioral health service shortages in more rural or underserved areas, where residents may have to travel long distances to access care. See Appendix D for Meadows Institute framework for addressing mental health workforce challenges.

Table 3: Health Providers in the Region and the State of Texas (2024)[24,25,26]

Provider Type	Region		Texas (Statewide)	
	Number of Providers	Average Residents / Provider	Number of Providers	Average Residents / Provider
Licensed Behavioral Health Physicians[27]	**66**	**19,000**	**3,671**	**7,500**
Psychiatrists	61	21,000	3,470	8,000
Addiction Medicine Physicians	4	320,000	327	85,000
Children and Youth Behavioral Health Physicians	15	20,000	1,034	5,000
Geriatric Psychiatrists	1	170,000	129	30,000
Developmental-Behavioral Pediatric Physicians	4	75,000	63	85,000
Non-Physician Providers[28]				
Licensed Psychologists	94	13,000	5,069	5,500

[24] All Texas population estimates are rounded to reflect uncertainty in the American Community Survey estimates.
[25] Population data were obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[26] The resident-to-provider rate represents the number of residents aged six and older for general providers, residents aged six to 17 for pediatric and child/youth specialties, and residents aged 65 and older for geriatric/older adult providers.
[27] Texas Medical Board Open Records. (2024, April). *Licensed physician database*. https://orssp.tmb.state.tx.us/Main.aspx. Providers were considered ”behavioral health providers" if their primary or secondary specialty included: psychiatry, child and adolescent psychiatry, pediatric psychiatry, neurology and psychiatry, addiction medicine, addiction psychiatry, addictive diseases, addiction medicine – IM, addiction medicine – FP, forensic psychiatry, neurodevelopmental disabilities (psychiatry and neurology), geriatric psychiatry, pain medicine (psychiatry), internal med – psychiatry, family practice/psychiatry, developmental-behavioral pediatrics, psychoanalysis, psychosomatic medicine, and/or behavioral neurology. Physicians were geographically classified based on the address of the listed practice location.
[28] Unless otherwise noted, non-physician provider counts were obtained from Texas Behavioral Health Executive Council Records. (2024, April). Mailing lists for all registered Texas licensed behavioral health providers represent point-in-time estimates. The listed mailing address may differ from the provider's practice location. https://bhec.texas.gov/open-records/.

Provider Type	Region		Texas (Statewide)	
	Number of Providers	Average Residents / Provider	Number of Providers	Average Residents / Provider
Licensed Chemical Dependency Counselors[29]	459	2,800	9,510	2,900
Licensed Clinical Social Workers	760	1,700	21,309	1,300
Licensed Professional Counselors	874	1,400	25,396	1,100
Licensed Marriage and Family Therapists	30	42,000	3,284	8,500
Licensed Specialists in School Psychology	150	8,500	3,268	8,500
Psychiatric Nurse Practitioners[30]	80	16,000	4,985	5,500
Psychiatric/Substance Use Registered Nurses[31]	260	4,900	10,232	2,700

Retention of Local Medical Graduates

The University of Texas Rio Grande Valley (UTRGV) School of Medicine (SOM) is a young institution, with its first class graduating in 2020. As such, the total number of graduates is comparatively small compared to more established medical schools. To examine how well the region retains graduates from the UTRGV SOM who continue to train and practice in the region after graduation or post-graduation fellowship, we consulted two sources – residency matches[32] and the Texas Medical Board (TMB) registry data.[33,34]

> The region retained 33% of UTRGV graduates pursuing psychiatric specialty programs.

Residency Matches[35]

As shown in Table 4, most UTRGV SOM graduates match with residency programs outside the region. Of the 222 residency matches between 2020 and 2024, only 18 (8%) remained within

[29] Texas Health and Human Services. (2024, April). *Licensed chemical dependency counselor roster.* https://www.hhs.texas.gov/business/licensing-credentialing-regulation/professional-licensing-certification-compliance/licensed-chemical-dependency-counselor-program.
[30] Texas Board of Nursing. (2024, October). *APRN: Nurse practitioners by county and population focus*. https://www.bon.texas.gov/reports_and_data_nursing_statistics.asp.html
[31] Texas Board of Nursing. (2024, October). *RN by county and clinical practice area*. https://www.bon.texas.gov/reports_and_data_nursing_statistics.asp.html.
[32] Residency match day data was extracted from the University of Texas Rio Grande Valley School of Medicine, Office of Admissions. (n.d.). *Match day*, 2020 – 2024. https://www.utrgv.edu/som/admissions/match-day/index.htm.
[33] Texas Medical Board. (2022, September, and 2024, April). *Licensed physician database*. https://orssp.tmb.state.tx.us/Main.aspx.
[34] Texas Medical Board. (2025, March). *Permitted physician in training database*. https://orssp.tmb.state.tx.us/Main.aspx, and Texas Medical Board. (2022, September, and 2024, April). *Licensed physician database*. https://orssp.tmb.state.tx.us/Main.aspx
[35] Residency matches are the medical residency program attended after medical school graduation.

the region.[36] Nationally, 16% of medical school graduates remain at their home institution for residency,[37] suggesting that the UTRGV SOM is retaining substantially fewer medical school graduates than other medical schools. While a larger proportion of UTRGV SOM medical graduates seeking psychiatric specialty programs were retained locally (four of the 12 psychiatric residency matches, or 33%), the number of graduates remains small.[38,39]

Although this does not definitively measure whether the region is losing talent, it does raise concerns that the region may not be retaining local medical school graduates to address the region's healthcare needs. These data support the argument that effort is needed to retain the healthcare workforce trained at the UTRGV SOM to bolster overall workforce growth. For more detail, see Appendix D.

Table 4: University of Texas Rio Grande Valley School of Medicine Residency Matches (2020-2024)[40,41]

Year	All Specialties			Psychiatry Specialty[42]		
	Total Matches	Matches to Residencies in Region	%	Total Matches	Matches to Residencies in Region	%
2020	35	4	11%	2	0	0%
2021	50	6	12%	2	1	50%
2022	43	5	12%	2	1	50%
2023	49	1	2%	2	1	50%
2024	45	2	4%	4	1	25%
Total	**222**	**18**	**8%**	**12**	**4**	**33%**

Rio Grande Valley Residency Programs

We also examined data from the Texas Medical Board (TMB) registry of permitted physicians in training enrolled in residency and fellowship programs in the region. As shown in Table 5, 272 physicians in training were enrolled as of March 2025, including 17 in behavioral health-related specialties. Of all physicians in training, only 5% were graduates of the UTRGV SOM, and among those in behavioral health, 35% were UTRGV SOM graduates.

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[36] Residency match day data was extracted from the University of Texas Rio Grande Valley School of Medicine, Office of Admissions. (n.d.). *Match day*, 2020 – 2024. https://www.utrgv.edu/som/admissions/match-day/index.htm.

[37] Hasnie, A., Hasnie, U., Nelson, B., Aldana, I., Estrada, C., & Williams, W. (2023). Relationship between residency match distance from medical school and virtual application, school characteristics, and specialty competitiveness. *Cureus*, *15*(5), e38782. 10.7759/cureus.38782

[38] Psychiatry specialty includes those beginning a residency in psychiatry or psychiatry/neurology.

[39] Caution should be used in interpreting these data given the very small number of psychiatric residency matches (12 matches over a 5-year period) from UTRGV SOM.

[40] University of Texas Rio Grande Valley School of Medicine, Office of Admissions. (n.d.). *Match day*, 2020 – 2024. https://www.utrgv.edu/som/admissions/match-day/index.htm.

[41] Residency matches are the medical residency program attended after medical school graduation.

[42] Psychiatry specialty includes those beginning a residency in psychiatry or psychiatry/neurology. Caution should be used in interpreting these data given the very small number of psychiatric residency matches (12 matches over a 5-year period) from UTRGV SOM.

While UTRGV SOM graduates currently make up a small portion of the region's residency and fellowship cohort, these data highlight a different and important aspect of workforce development: the region is drawing in a significant number of trainees from outside the local medical school. This suggests that the region's growing number of graduate medical education (GME) opportunities is attracting physicians to the area, many of whom may choose to stay and practice here after training.

Spotlight: UTRGV-SOM Psychiatry Residency with Tropical Texas Behavioral Health

The UTRGV School of Medicine and Tropical Texas Behavioral Health (TTBH) partnered in 2017 to create a psychiatry residency program in which TTBH psychiatrists serve as voluntary clinical faculty and supervise residents across all four postgraduate years. Training includes primary care integration in PGY-1, child and adolescent psychiatry in PGY-2, a full year of adult psychiatry in PGY-3, and specialized programs such as ACT and First Episode Psychosis, in PGY-4. TTBH's Chief Medical Officer also functions as the program's Medical Director and participates in the Medical School's Core Competency Committee.

As the SOM continues to grow and more residency programs become available, we expect to see stronger connections between local training and long-term retention. These early data emphasize the importance of both retaining SOM graduates and recognizing the potential of residency programs to bring new physicians into the region who can contribute to meeting local health needs. Additional data on physicians and physicians in training graduates from UTRGV SOM is available in Appendix D.

Table 5: Rio Grande Valley Residency and Fellowship Program Enrollment (March 2025)[43]

Residency / Fellowship Location	Physicians in Training		Behavioral Health Physicians in Training	
	All	UTRGV SOM Graduates	All	UTRGV SOM Graduates
University of Texas Rio Grande Valley	150	11	17	6
Other Programs in the Rio Grande Valley	122	2	0	0
Total	**272**	**13**	**17**	**6**

Non-Clinical Care Models for Expanding Behavioral Health Access

Expanding behavioral health care access requires a workforce beyond traditional clinical providers. Community-based providers such as community health workers (CHWs), peer support specialists, and certified family partners (CFPs) are critical for building a more accessible, inclusive, and culturally responsive behavioral health system. These non-clinical providers are uniquely positioned to deliver support in trusted community settings, reduce

[43] Texas Medical Board. (2025, March). *Permitted physician in training database*. https://orssp.tmb.state.tx.us/Main.aspx

stigma, and bridge gaps in access to care, particularly for populations facing barriers to traditional services.

Across the region, organizations are already leveraging the strengths of CHWs, peers, and CFPs to extend behavioral health support into schools, homes, community centers, and other familiar environments. Their work provides essential models for expanding non-clinical community-based care to meet the growing need for mild to moderate behavioral health interventions, improve engagement, and strengthen overall system capacity.

- **Community health workers** provide outreach, education, and support where people live, work, and worship. Across the region, close to 400 CHWs employed by community-based organizations deliver health education and help people access services. Currently, 21 CHWs in the region have completed the EMPOWER behavioral activation (BA) training to offer basic behavioral health interventions and reduce stigma.
- **Peer support specialists** bring the powerful perspective of lived experience with mental health recovery to engage others and help navigate care. Three certified peers and one LPC supervisor currently staff The Connection Center RGV, which offers free peer services. Tropical Texas employs 10 peers across their programs, including one Military Veteran Peer Network (MVPN) coordinator for veterans and their families. Border Region does not have a peer dedicated to Starr County at this time but is actively recruiting. They are, however, training 18 new specialists to help fill workforce gaps, especially in Starr County, where recruitment has been difficult.
- **Certified family partners** are caregivers with lived experience raising children with mental health needs. They provide advocacy, emotional support, and help families navigate systems, improving family engagement and behavioral health outcomes. CFPs support families through parenting classes, school-based activities, and programs like the YES Waiver and Coordinated Specialty Care (CSC). Locally, Border Region employs two CFPs in Starr County, and Tropical Texas employs 10, with plans to expand to 17–18.

Efforts Addressing the Region's Workforce

Several local efforts are addressing the region's mental health workforce shortages:

- **UTRGV**'s School of Medicine's psychiatry residency program is expanding the pipeline of psychiatrists trained to serve the region, combining clinical rigor with a focus on culturally responsive care. Similarly, UTRGV's primary care behavioral health certificate equips non-specialist providers, such as social workers, to deliver integrated behavioral health support within medical settings, promoting early intervention and expanding access. Additionally, UTRGV hopes to expand the number of psychology practitioners providing services as well as research through its Clinical Psychology Doctoral Program.
- **DHR Health** is also investing in workforce development; they are integrating mental health into family medicine residency training and working to launch a psychiatry residency with 16 new slots over four years. A new HRSA-funded rural obstetrics residency will further support service expansion in partnership with Starr County Memorial Hospital.

- To strengthen community-based care, the **Meadows Institute and Harvard** are scaling a behavioral health training initiative for CHWs. The program equips trusted community members to deliver brief psychological support, increasing access in underserved areas. A partnership with DSHS to recruit CHWs statewide has provided regional CHWs the opportunity to train on EMPOWER BA. CHWs affiliated with organizations across the four-county area have completed or are in the process of completing their training.
- **Tropical Texas Behavioral Health** has implemented a set of workforce development strategies that are strengthening recruitment, retention, and staff advancement. Key initiatives include the launch of a Clinical Licensure Supervision Program that provides cost-free supervision and training for LPC-Associates, expanded medical education partnerships with UTRGV residents, and a competitive compensation and benefits package designed to attract and retain top talent. These efforts have reduced LPC vacancies from 29 to just 4 since 2022 and created a strong pipeline of licensed clinicians and future leaders.

Statewide, the Texas Legislature allocated over $300 million for graduate medical education for 2026–2027, aiming to retain medical graduates in-state. Additional funding supports salary increases for local mental health authority staff, a major expansion of the loan repayment program for mental health professionals, and new grants targeting psychiatry and behavioral health training. Similarly, the 89th session concluded with over $100 million allocated to expand loan repayment eligibility for mental health professionals and residency slots and to create a grant program for community colleges to develop certificate opportunities for paraprofessionals and entry-level health care providers.

Spotlight: Valley Initiative for Development and Advancement (VIDA)

VIDA, a nonprofit, supports people in the region pursuing education and training in high-demand fields, including mental health services. Through a comprehensive model that includes financial assistance, career guidance, soft-skills training, and intensive case management, VIDA helps participants overcome personal and systemic barriers to career advancement.

Please see Appendix D for additional details on regional programs, CHW workforce data, and legislative details.

Mental Health Stigma

Stigma toward mental illness is complex, and evidence across decades of research has documented that it can lead people to experience shame and reduced self-esteem. These internalized beliefs too often discourage people from engaging in care, which can worsen their mental health outcomes.[44] Despite gains, the most recent research shows that stigma continues to present generally and as a particular challenge when providing care to Hispanic and Latino

[44] Corrigan, P. W., Druss, B. G., & Perlick, D. A. (2014). The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. *Psychological Science in the Public Interest: A Journal of the American Psychological Society*, *15*(2), 37–70. https://doi.org/10.1177/1529100614531398

populations.[45] Among many Hispanic and Latino communities, stigma continues to be found to be negatively associated with the desire to engage in mental health care, manage depression symptoms, disclose mental illness to family and friends, and adhere to antidepressant medication regimens.[46] In general, Hispanic and Latino communities report higher rates of perceived stigma and lower rates of behavioral health service use,[47] which can result in delays and gaps in opportunities to discuss mental wellness, recognize early signs and symptoms associated with mental health conditions, and reduce access to needed services.

Stakeholders overwhelmingly identified stigma as a barrier to mental health care in the region.

Stakeholders overwhelmingly identified stigma as a barrier to mental health care in the region. Fear of rejection and concern about "*qué va a decir la gente*" (what will people say) often prevents people from seeking care.

- **Many young adults** hesitate to share their struggles, not wanting to burden their families or contradict cultural and religious beliefs.
- The **belief systems of many parents** affect the type of care sought, as well as strongly influences the perception of mental health care.[48] Stakeholders affirmed that parents share fears of having their child labeled at school or of being embarrassing because the child's mental illness reflects poorly on their family.
- Stakeholders also referred to the machismo mentality, which further reinforced stigma, **particularly among men**, associating help-seeking with weakness and a threat to their manhood.
- **Older generations**, having grown up in a time when mental illness was not discussed, often dismissed it as nonexistent or a choice. In our conversations with ARISE Adelante and others, we heard some parents attributed their child's struggles to being spoiled ("*son chiflados*") or lazy ("*que se pongan a hacer algo, a barrer, y se les quita*") ("Have them start doing something, like sweeping, and it'll go away").

Regional Efforts Addressing Mental Health Stigma

While stigma is often a strong force in preventing people from seeking, receiving, and continuing care, stakeholders agree it can be reduced by increasing awareness and education about mental illness and understanding the community values and cultural systems at play. The

[45] Escobar, R., Gonzalez, J. M., Longoria, D. A., & Rodriguez, N. (2021). Challenges Faced by Mexican Americans when Accessing Mental Health Care Service Utilization along the South Texas – Mexico border. *Journal of Mental Health and Social Behaviour*, *3*(1). https://doi.org/10.33790/jmhsb1100128

[46] Eghaneyan, B. H., & Murphy, E. R. (2020). Measuring mental illness stigma among Hispanics: A systematic review. *Stigma and Health*, *5*(3), 351–363. https://doi.org/10.1037/sah0000207

[47] Benuto, L. T., Gonzalez, F., Reinosa-Segovia, F., & Duckworth, M. (2019). Mental Health Literacy, Stigma, and Behavioral Health Service Use: The Case of Latinx and Non-Latinx Whites. *Journal of Racial and Ethnic Health Disparities*, *6*(6), 1122–1130. https://doi.org/10.1007/s40615-019-00614-8

[48] Platell, M., Cook, A., & Martin, K. (2023). How parents can help or hinder access to mental health services for young people. *Children and Youth Services Review*, *145*, 106760. https://doi.org/10.1016/j.childyouth.2022.106760

region has long recognized the need to reduce stigma and championed several anti-stigma initiatives. These local campaigns raise awareness, promote resiliency, and reduce the shame associated with mental illness. Notable efforts include:

- **End the Stigma Campaign** – removing shame and stigma from mental illness (Cameron County Mental Health Task Force led, VBLF funded).[49]
- **Mental Health Awareness Fun Run –** started in 2023, Tropical Texas hosts this event to highlight and celebrate Mental Health Awareness Month.
- **Rio Grande Valley Anti-Stigma Campaign** – promoting resiliency in youth and their families who have interacted with juvenile justice.
- UTRGV's **Fortify Resilience** – building resilience in students.
- **CommUNITY** – shattering the stigma surrounding mental health as a community through education, communication and support (South Texas Health System Behavioral and South Texas College led).

Addressing mental health stigma is essential for improving access to care, reducing discrimination, and ensuring a better quality of life for people with mental health disorders. Recognizing and challenging these prejudices create a more inclusive and supportive environment for mental health treatment and recovery.[50]

Spotlight: RGV Dads

RGV Dads is dedicated to supporting fathers in the Rio Grande Valley, emphasizing the importance of their role in strengthening family bonds. Recognizing the often-overlooked issue of mental health among fathers, the organization provides necessary support and resources.

Demographics and Prevalence

The Rio Grande Valley is a vibrant and culturally rich region in the southernmost part of Texas, adjacent to the U.S.-Mexico border. Our report encompasses four counties: Cameron, Hidalgo, Starr, and Willacy, collectively comprising a unique and dynamic region in the United States. The following provides an overview of relevant demographic data from the region. This information is critical to understanding regional needs, considering the population as a whole and its unique groups. We begin with an overview of children and youth demographic data and then provide data focused on adults.

Mental illness affects people of all races, ethnicities, and socio-economic backgrounds. In fact, most racial/ethnic groups have similar prevalence rates, with about 20% experiencing a mental health condition.[51] However, it is also true that there are disparities in access to treatment and minority populations often experience poor mental health outcomes for various reasons,

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[49] Grant goes to mental health awareness. (2016, September 19). *MyRGV.Com*. https://myrgv.com/uncategorized/2016/09/18/grant-goes-to-mental-health-awareness/

[50] Corrigan, P. W. et al., (2014), The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care, *Psychological Science in the Public Interest: A Journal of the American Psychological Society*, *15*(2), 37–70

[51] American Psychiatric Association. (2017). *Mental Health Disparities: Diverse Populations*. https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts

including exposure to significant risk factors, underreporting, limited access to services, cultural stigma, lack of culturally-tailored interventions, and issues with the quality of treatment.[52] Because of the large population of Hispanic or Latino residents in the region, our report seeks to contextualize the unique mental health needs of this population, particularly as it affects access to services.[53] Concerns about disparities are certainly true in the Hispanic or Latino population as barriers to care result in increased risk for more severe and persistent mental health conditions.[54]

Children and Youth (Ages 6-17)

This section presents select demographic data, projected population changes, and the prevalence of behavioral health conditions among children and youth in the region. Additional information about the approach used to generate these estimates is provided in Appendix E, and additional data stratified by the four counties is included in Appendix F.

The demographic profile of children and youth in the region highlights challenges related to poverty and mental health. A large proportion of the region's youngest residents face economic hardship, and many also experience serious emotional disturbances (SED). The Substance Abuse and Mental Health Services Administration (SAMHSA) defines SED as a diagnosable mental, behavioral, or emotional disorder that causes functional impairment, substantially interfering with a child's ability to thrive in family, school, or community settings.[55] These challenges disproportionately affect children living in poverty, and the interplay between these two factors can result in a cycle that is challenging to end.

In Table 6, we present data on the 2023 population, poverty rates, and prevalence of SED among children and youth in the region, broken down by county. Of the estimated 300,000 children and youth who live in the four counties included in this report, nearly two-thirds (190,000) lived in Hidalgo County. At the same time, approximately 30% (85,000) resided in Cameron County, with smaller populations in Starr and Willacy counties. The poverty rates were similar across the four counties, with approximately two-thirds (or 190,000 children and youth; 63%) living below 200% of the federal poverty level. This poverty rate is substantially higher than the statewide average of 40%.

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[52] American Psychiatric Association, (2017), *Mental Health Disparities: Diverse Populations*

[53] It is important to recognize the diversity of culture and life experiences within the Hispanic or Latino population, which, as defined by the U.S. Census Bureau, refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. Recent research and terminology has used Latino, Latina, Latinx, Chicano, and Hispanic to describe these people; we chose Hispanic or Latino for this report. The Hispanic or Latino population in the U.S. is far from monolithic. Collectively, those who identify themselves as Hispanic or Latino have immigrated or have ancestry from more than 20 countries and territories, speak more than six different languages, and fall all along the socioeconomic spectrum.

[54] National Alliance on Mental Illness (NAMI). (n.d.). Hispanic/Latinx. *Hispanic/* Retrieved August 4, 2025, from https://www.nami.org/your-journey/identity-and-cultural-dimensions/hispanic-latinx/

[55] Substance Abuse and Mental Health Services Administration (SAMHSA). (2021). *Serious Emotional Disturbance (SED) Definition and Criteria.* Retrieved from https://www.samhsa.gov

There is no perfect method of calculating the number of people who are living with mental illness, as many do not seek treatment (and thus, are omitted from healthcare records)[56] and many more are unreached or undetected in survey data.[57] Although promising approaches exist that link health records to survey data in order to measure the prevalence of mental illness more accurately,[58] these methods are still unvalidated. Further, because the local health information exchange does not record data on patients' mental health, these emerging approaches could not be used to estimate the prevalence of mental health in this region.

Therefore, the Meadows Institute used the most rigorous approach available[59] to estimate the number of residents in a particular region with a mental health condition (see Appendix E for a more technical overview of our approach).[60] For the Rio Grande Valley, we have rooted our methodology in local data, leveraging the most granular data available on the age, sex, race/ethnicity, marital status, education, poverty, veteran and housing status of residents from the U.S. Census Bureau's annual American Community Survey (ACS)[61] of Rio Grande Valley residents to estimate the region's mental health needs.

The Meadows Institute used the U.S. Census Bureau's most recent 5-year public microdata from the ACS available at the time of report development to avoid introducing error into our mental health and demographic prevalence estimates due to anomalies that may be present in the ACS 1-year data files. Although the 2024 5-year data files were released by the U.S. Census Bureau in March 2026, the Meadows Institute requires several months to ingest, manage, generate, and verify (for quality control purposes) the 2024 dataset and associated prevalence estimates before they are released to the public. The timing of this report prevented us from including the 2024 prevalence data; however, preliminary comparisons of prevalence rates in

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[56] Coombs, N.C., Meriwether, W.E., Caringi, J., & Newcomer, S.R. (2021). Barriers to healthcare access among U.S. adults with mental health challenges: A population-based study. *Social Science & Medicine - Population Health*, *15,* https://doi.org/10.1016/j.ssmph.2021.100847

[57] Arias-de la Torre, J., Valderas, J. M., Benavides, F. G., & Alonso, J. (2021). Cardboard floor: About the barriers for social progression and their impact on the representativeness of epidemiological studies. *Journal of Epidemiology & Community Health, 75*(2), 105-106. 10.1136/jech-2020-214978

[58] Arias de la Torre, J., Vilagut, G., Ronaldson, A., Bakolis, I., Dregan, A., Navarro-Mateu, F., et al. (2023). Reconsidering the use of population health surveys for monitoring of mental health. *JMIR Public Health and Surveillance, 9*, e48138. https://publichealth.jmir.org/2023/1/e48138

[59] Sichani, E. K., Smith, A., El Emam, K., & Mosquera, L. (2024). Creating high-quality synthetic health data: Framework for model development and validation. *JMIR formative research*, *8*(1), e53241. https://formative.jmir.org/2024/1/e53241/

[60] Jarjoura, D., McCord, G., Holzer III, C. E., & Champney, T. F. (1993). Synthetic estimation of the distribution of mentally disabled adults for allocations to Ohio's mental health board areas. *Evaluation and Program Planning*, *16*(4), 305-313. 10.1016/0149-7189(93)90043-8

[61] The U.S. Census Bureau annually samples residents from Public Use Microdata Areas (PUMAs) for the annual American Community Survey. Maps of these PUMAs and how they align with RGV Census tracts are available here: https://www.census.gov/geographies/reference-maps/2020/geo/2020-pumas.html (see Texas map). A broader overview of the methodology used by the U.S. Census Bureau to collect, weight, and validate its 5-year datasets is available at the U.S. Census Bureau. (2026, March 5). *American Community Survey 2020-2024 5-Year: PUMS User Guide and Overview.* https://www2.census.gov/programs-surveys/acs/tech_docs/pums/2020_2024ACS_PUMS_User_Guide.pdf

the Rio Grande Valley region with the 2023 dataset suggest that the region's 2024 ACS estimates closely resemble the 2023 data presented in this report.[62]

Beginning in 2023, there were roughly 24,000 children and youth living in the region (8% of total children and youth) who experienced SEDs, with 70% of those children and youth living in poverty.[63,64] This rate of children and youth in poverty who suffer from SED is dramatically higher than the statewide average of 47%.

Table 6: Children and Youth Population by County (2023)[65,66]

Children and Youth (6-17)	Texas (Statewide)	Entire Region	County			
			Cameron	Hidalgo	Starr	Willacy
Total Population	**5,150,000**	**300,000**	**85,000**	**190,000**	**14,000**	**3,400**
Population in Poverty[67]	2,050,000	190,000	55,000	120,000	9,000	1,900
Population With SED[68]	380,000	24,000	7,000	16,000	1,200	250
Population With SED in Poverty	180,000	17,000	4,900	11,000	850	200

Table 7 provides population estimates of the region's child and youth (ages 6-17) residents. The 300,000 child and youth residents are nearly evenly split between males and females, with slightly more youth aged 12-17 (150,000) than children aged 6-11 (140,000). Most of this population (93%) identifies as Hispanic or Latino, a rate significantly higher than the statewide percentage of 49%, of which 67% speak Spanish at home (200,000). Around 80% of children and youth in the region have health insurance, indicating that roughly 50,000 regional children and youth are uninsured. More children and youth in the region are uninsured compared to

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[62] U.S. Census Bureau. (2026, March). *American Community Survey 2020-2024 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2024.html

[63] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[64] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data was obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html. All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[65] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[66] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[67] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data was obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[68] Holzer, C., Nguyen, H., & Holzer, J. (2025). *Texas county-level estimates of the prevalence of severe mental health need in 2023*. Dallas, TX: Meadows Mental Health Policy Institute.

children and youth in other regions across Texas, among whom 87% have any insurance coverage. Medicaid, or other government assistance plans for people with low incomes or disabilities, covers most resident children and youth with health insurance (68%), nearly twice the state average of 41%.

Table 7: Demographic Characteristics of Children and Youth in the Region (2023)[69,70]

	Entire Region	Texas (Statewide)
Children and Youth Ages 6-17	300,000	5,150,000
Age		
Ages 6–11	140,000	2,550,000
Ages 12–17	150,000	2,650,000
Sex		
Male	150,000	2,650,000
Female	150,000	2,550,000
Race/Ethnicity		
Non-Hispanic White	11,000	1,600,000
African American	1,400	610,000
Asian American	2,400	240,000
Native American	150	6,000
Multiple Races	650	210,000
Hispanic/Latino	280,000	2,500,000
Health Insurance		
No Health Insurance	50,000	640,000
Any Health Insurance	250,000	4,500,000
Private Health Insurance	80,000	2,850,000
Public Health Insurance[71]	170,000	1,850,000
Medicaid or Other Government Assistance Plans for People with Low Incomes or Disabilities[72]	100%	100%
Language Spoken at Home		
Spanish Spoken at Home	200,000	1,450,000

[69] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[70] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[71] In the American Community Survey, public health insurance includes three subsets: Medicare, Medicaid or other government assistance plans for people with low incomes or disabilities, and Veteran Affairs (VA) insurance. Among the 3% of Texas children and youth with public insurance but not Medicaid or other government assistance plans, 73% were enrolled in Medicare and 27% in VA insurance.

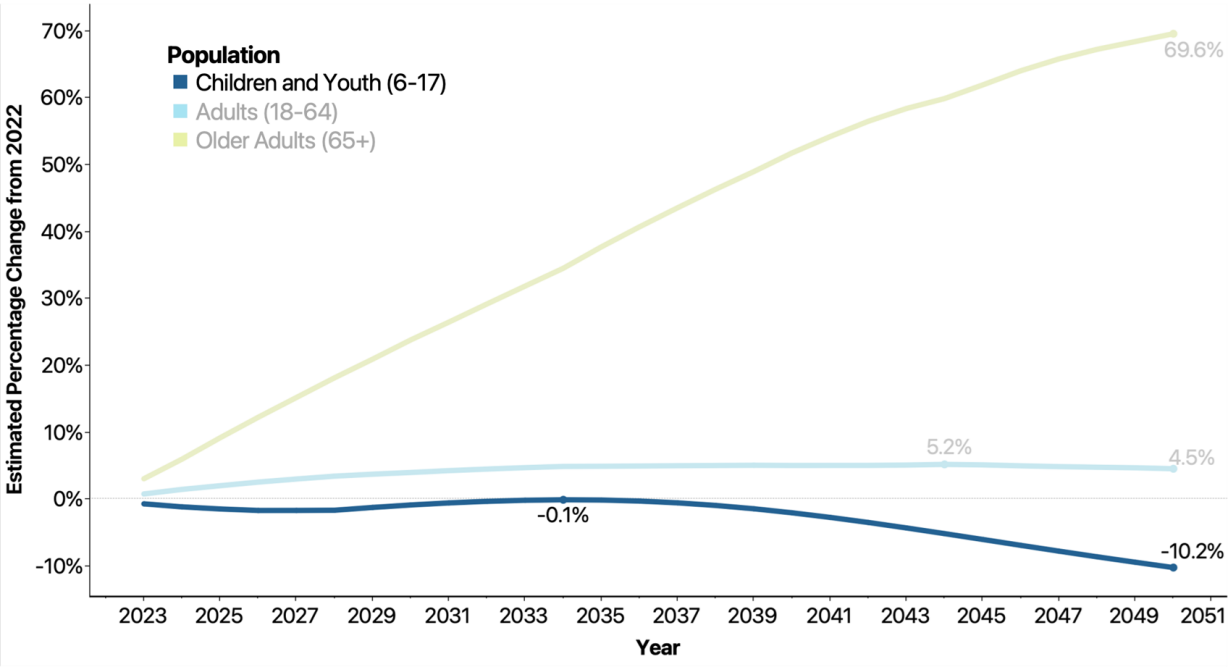
[72] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance.

Projected Population Changes

The child and youth population (ages 6-17) in the region is projected to decline by approximately 10% from 2022 to 2050 (Figure 4).[73] This demographic shift reflects a decrease in the number of children and youth despite the overall population growth in the region. Compared to Texas statewide projections, the child and youth population across Texas is expected to increase by 41% by 2050, highlighting a notable regional difference in demographic trends.

Despite the projected decrease in the child and youth population, this population remains a significant portion, representing nearly one-third of the overall population in the region. Currently, compared to the state population, a greater percentage of the region's population are children and youth. Given that stakeholder insights revealed the age of children who are experiencing mental health and substance misuse issues is getting younger, a focus on child and youth as well as family well-being initiatives and programs are equally important as those focused on adults.

Figure 4: Estimated Change in the Population of Children and Youth (2022-2050)[74]



[73] Although this report uses 2023 population estimates throughout, the most recent population projections available at the time of analysis began in 2022 and were therefore used for this report.

[74] Population projections are generated using the *American Community Survey 2018-2022 5-year estimates* and expected rates of change from the Texas Demographic Center's Population Projections Program, 2018. The 2018 population projections are available upon request from the Texas Demographic Center. For more information, please see https://demographics.texas.gov/Projections/.

Adults (Ages 18+)

This section presents demographic data and the prevalence of behavioral health conditions among adults (ages 18+) in the region. For more detailed data stratified by the region's four counties, please refer to Appendix F.

We used the same baseline comprehensive 2023 dataset to compute adult trends, too. Table 8 describes the composition of the region's adult population (ages 18+) by county for that year. Nearly one million adults reside in the region's four counties (960,000 adults), with most adults living in Hidalgo County (600,000) and Cameron County (300,000). Slightly less than half (47%) of adults in the region live in poverty, with Starr County having the highest proportion of adults living in poverty (50%) and Willacy having the lowest rate (40%). The region's poverty rate is substantially higher compared to the statewide average of 28%.

Additionally, about 5% of adults living in the region (roughly 45,000 adults) have a serious mental illness (SMI). Among these adults with SMI, nearly two-thirds (67%) also live in poverty – twenty percentage points higher than the statewide average (48%).

Table 8: Adult Population by County (2023)[75,76]

Adults (18+)	Texas (Statewide)	Entire Region	County			
			Cameron	Hidalgo	Starr	Willacy
Total Population	22,200,000	960,000	300,000	600,000	44,000	15,000
Population in Poverty[77]	6,150,000	450,000	130,000	290,000	22,000	6,000
Population With SMI[78]	980,000	45,000	14,000	28,000	2,600	900
Population With SMI in Poverty	470,000	30,000	9,000	18,000	1,700	550

Table 9 provides more detailed population estimates for adults in the region compared to Texas statewide. The region is home to nearly one million adults, with a slightly higher male population (490,000) than females (470,000). More than half of adult residents are between 25 and 54 (54% of adults fall within this age range). Most of this population (90%) identifies as Hispanic or Latino, a rate significantly higher than the statewide percentage of 36%, and of which 79% speak Spanish at home (760,000 adults).

[75] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[76] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[77] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[78] The Meadows Institute. (2025). *National, state, and county-level mental health prevalence estimates, 2023*. See Appendix E for more information.

Adult residents of the four counties are substantially underinsured compared to the State of Texas. Approximately two-thirds (65%) of adults in the region have health insurance, indicating that roughly 340,000 adults in the region are uninsured. Nearly twice as many resident adults are uninsured compared to adults across the other regions of Texas (35% of regional adults are uninsured vs. 20% of Texas adults). Most adult residents with health insurance are covered by private plans (68%), although at a lower rate than adults statewide (81%).

Table 9: Demographic Characteristics of Adults in the Region (2023)[79,80]

	Entire Region	Texas (Statewide)
Adult Population (18+)	960,000	22,200,000
Age		
18–20	70,000	1,250,000
21–24	85,000	1,650,000
25–34	190,000	4,300,000
35–44	170,000	4,150,000
45–54	160,000	3,650,000
55–64	130,000	3,300,000
65+	170,000	3,900,000
Sex		
Male	470,000	11,000,000
Female	490,000	11,200,000
Race / Ethnicity		
Non-Hispanic White	85,000	9,550,000
African American	5,500	2,650,000
Asian American	10,000	1,250,000
Native American	950	39,000
Multiple Races	2,900	520,000
Hispanic / Latino	860,000	8,050,000
Health Insurance		
No Health Insurance	340,000	4,450,000
Any Health Insurance	620,000	17,700,000
Private Health Insurance	420,000	14,300,000
Public Health Insurance[81]	270,000	5,750,000
Medicaid or Other Government Assistance Plans	56%	36%

[79] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[80] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[81] In the American Community Survey, public health insurance includes three subsets: Medicare, Medicaid or other government assistance plans for people with low incomes or disabilities, and Veteran Affairs (VA) insurance.

	Entire Region	Texas (Statewide)
for People with Low Incomes or Disabilities[82]		
Language Spoken at Home		
Spanish Spoken at Home	760,000	6,250,000

Projected Population Changes

The regional population of children, youth, adults, and older adults (ages six and older) is expected to grow by about 10%, from 1.27 million in 2022 to 1.39 million by 2050.[83] However, most of this growth will be driven by an increase in older adults, while the number of younger and working-aged adults will grow more slowly (Figure 5).

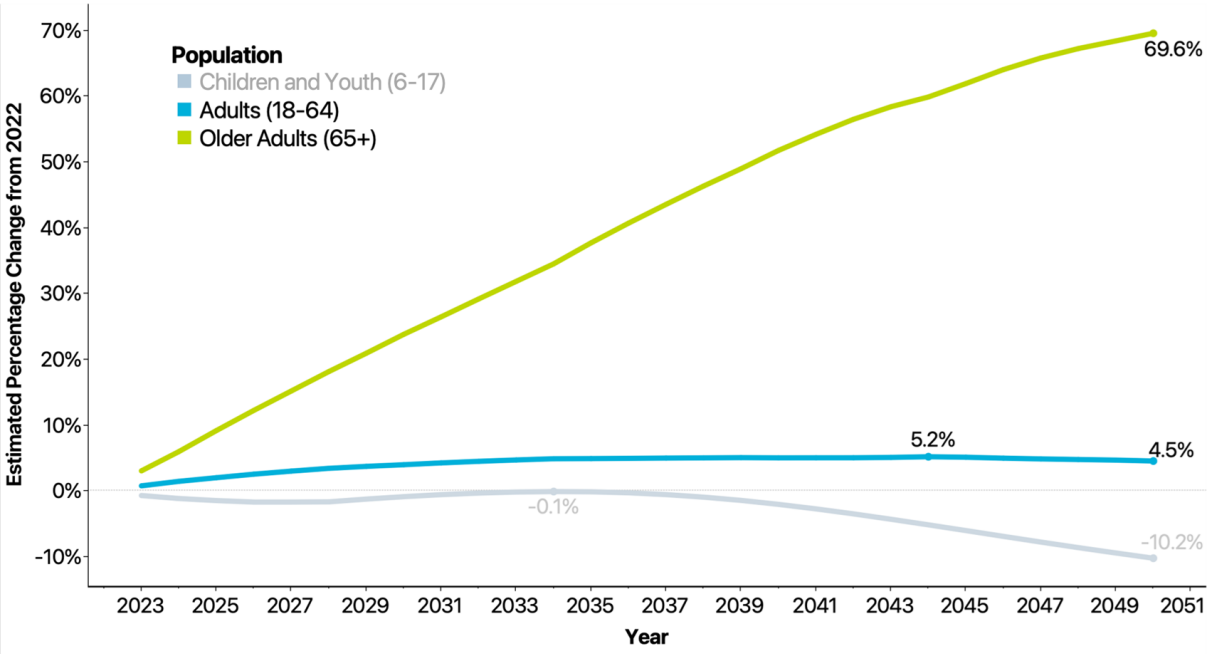
The number of older adults (ages 65 and older) in the region is projected to rise by around 70% by 2050, leading to greater demand for healthcare, senior housing, and other services. In contrast, Texas will see a 96% increase in its older adult population, nearly doubling the number of seniors statewide. While the region's growth in older adults is slightly slower than the state's, it still reflects a substantial trend toward an aging population.

Meanwhile, the working-age population (ages 18 to 64) in the four counties is expected to grow by just 5% from 2022 to 2050. This is much slower than the 51% growth anticipated across Texas during the same period, suggesting that the region's economy may not expand as quickly as the rest of the state.

[82] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance.

[83] Although this report uses 2023 population estimates throughout, the most recent population projections available at the time of analysis began in 2022 and were therefore used for this report.

Figure 5: Estimated Change in the Population of Adults and Older Adults in the Region (2022-2050)[84]



Mortality Trends

Mortality data from the Centers for Disease Control and Prevention reveals that from 2000 to 2024, the region experienced significant increases in both suicide and drug overdose deaths.[85] This upward trend is concerning and points to a growing public health crisis in the region, highlighting the urgent need for targeted interventions to address the behavioral health issues driving these tragic outcomes.

From 2000 to 2024, both suicide and drug overdose/accidental poisoning (overdose) deaths in the region and statewide in Texas showed significant increases, though the trends varied in magnitude from year to year. Figure 6 illustrates these trends, highlighting the rise in mortality over time.

[84] Population projections are generated using the *American Community Survey 2018-2022 5-year estimates* and expected rates of change from the Texas Demographic Center's Population Projections Program, 2018. The 2018 population projections are available upon request from the Texas Demographic Center. For more information, please see https://demographics.texas.gov/Projections/.

[85] Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February). Underlying cause of death 1999-2023 on CDC WONDER online database. Data are from the final Multiple Cause of Death Files, 1999-2023, and from provisional data for year 2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program.

In the region, the suicide mortality rate rose by 86%, from 5 deaths per 100,000 residents in 2000 (49 deaths) to 9.3 deaths per 100,000 in 2024 (134 deaths),[86] while drug overdose deaths surged by an even more dramatic 171%, growing from 2.4 deaths per 100,000 in 2001[87] (24 deaths) to 6.5 deaths per 100,000 in 2024 (93 deaths). The sharpest increases for both causes occurred after 2016, with drug overdose deaths experiencing a particularly steep rise. In 2024, the region recorded its highest level of suicides, while overdose deaths declined slightly from the recorded high of 7.6 deaths per 100,000 in 2023 to 6.5 deaths per 100,000 in 2024.

The suicide mortality rate among residents increased by 86% between 2000 and 2024, while the drug overdose mortality rate increased by 171% between 2001 and 2024.

Statewide, Texas experienced a 47% increase in the suicide mortality rate (from 9.8 deaths per 100,000 in 2000 to 14.4 deaths per 100,000 in 2024) and a 148% rise in drug overdoses (from 6.4 deaths per 100,000 in 2001 to 15.9 deaths per 100,000 in 2024). While both the Rio Grande Valley and the state saw upward trends since 2000, the Rio Grande Valley experienced dramatically more pronounced increases. Recent trends reveal continued, substantial differences in suicide mortality, as the regional rate increased by 15% from 2023 to 2024, while no change was observed statewide. On a more positive note, overdose mortality declined in both the region and the state in 2024 after rapid growth between 2019 and 2023, when rates increased by 55% in the region and 72% statewide.

[86] Deaths occurring in 2024 are considered provisional and are subject to change as final mortality data are finalized and certified.

[87] In 2000, the Rio Grande Valley had 11 drug overdose deaths. The CDC considers mortality rates for areas with 10 to 20 deaths 'unreliable' and not included in our trend analysis.

Figure 6: Mortality from Suicide and Drug Overdose or Accidental Poisoning Among Residents (2000-2024)[88,89,90,91]

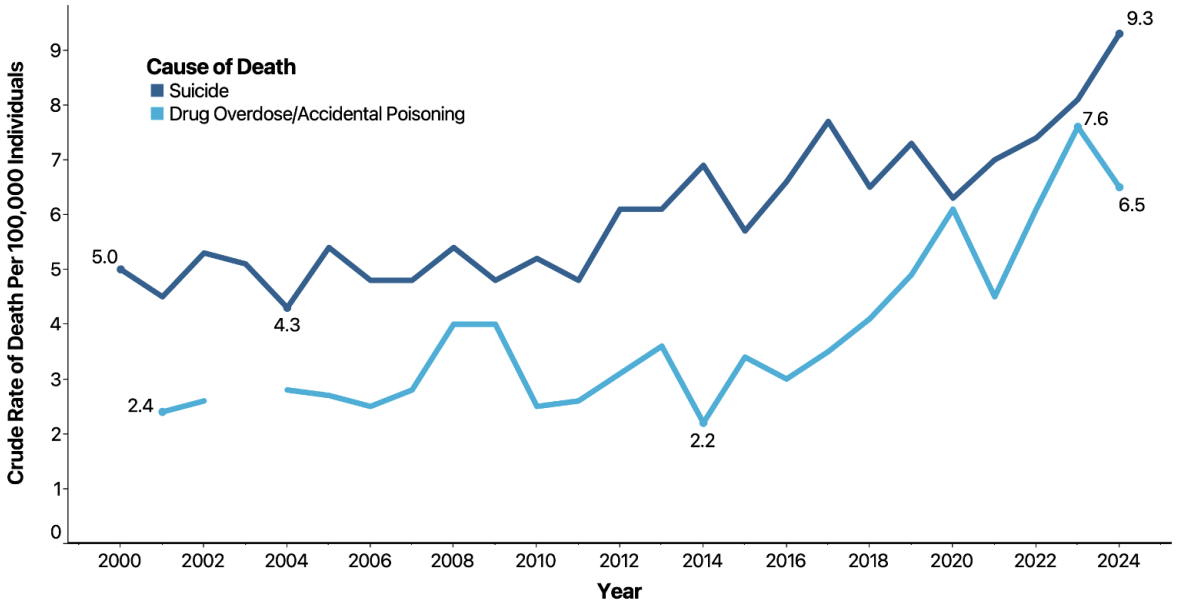


Table 10 below presents demographic details of deaths from suicide and overdose among residents of the region in 2024. Over one-third (37%) of suicide deaths occurred among people aged 15-34, while, similarly, one-third (34%) of deaths occurred in the 35-54 age group. In contrast, overdose deaths were more common among those aged 35-54 (53%), with 28% occurring in the 15-34 age group. Males were most likely to die from suicide and overdose (representing 84% of deaths from suicide and 82% of overdose deaths). Despite accounting for most suicide and overdose mortality, Hispanic or Latino Rio Grande Valley residents were slightly less likely to die from these causes (suicide or drug overdose) compared to non-Hispanic residents. Specifically, 85% of the region's deaths from suicide and overdose deaths occurred

[88] Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February). Deaths from suicide are classified using underlying cause-of-death ICD-10 codes U03, X60–X84, and Y87.0. Overdose/accidental poisoning deaths are classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.
[89] Regions with fewer than ten (1-9) deaths are suppressed by the CDC to protect decedent confidentiality. Similarly, rates including 10 to 20 deaths are considered 'unreliable' by the CDC and not included in this graphic.
[90] Random fluctuations (such as the decline in drug overdose / accidental poisoning deaths observed in 2014) are an expected part of any time series data, including death rates. While underlying trends in death rates may be influenced by long-term factors like improvements in healthcare and lifestyle, or changes in social and economic conditions, these factors do not result in perfectly smooth, uninterrupted changes over time. Therefore, when interpreting trends, it is crucial to avoid drawing definitive conclusions from small, short-term changes without considering the broader context of long-term trends and potential influences of short-term factors.
[91] Deaths occurring in 2024 are considered provisional and are subject to change as final mortality data are finalized and certified.

among Hispanic or Latino residents, while accounting for 91% of the child, youth, and adult population.[92,93]

Table 10: Demographic Characteristics of Deaths from Suicide and Drug Overdose / Accidental Poisoning Among Residents (2024)[94,95,96]

	Suicide[97]	Drug Overdose / Accidental Poisoning[98]
Total Number of Deaths	**134**	**93**
Age Group		
15-34	50 (37%)	26 (28%)
35-54	46 (34%)	49 (53%)
55+	36 (27%)	18 (19%)
Sex		
Male	113 (84%)	76 (82%)
Ethnicity		
Hispanic	114 (85%)	79 (85%)
Non-Hispanic	20 (15%)	14 (15%)

At the county level, Cameron County experienced a disproportionately higher rate of suicide and overdose deaths (10.2 deaths and 7.4 deaths per 100,000 residents, respectively) compared to the region overall (9.3 suicide deaths and 6.5 overdose deaths per 100,000 residents). Although Hidalgo County accounted for over half of the region's total suicide and overdose deaths (51% and 58%, respectively), the mortality rates of 7.4 suicide deaths and 5.9 overdose deaths per 100,000 residents were below the regional average, highlighting disparities in mortality within the region.[99]

Non-medical Drivers of Health

Meaningfully impacting access to services requires a thorough understanding of a community's population characteristics. These contextual issues are referred to as social determinants of

[92] Population data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[93] In 2024, Rio Grande Valley's Hispanic / Latino residents had a suicide and drug overdose / accidental poisoning mortality of 8.7 deaths and 6.0 deaths per 100,000 residents, respectively. The non-Hispanic / Latino population in the region had a suicide mortality rate of 16.0 deaths per 100,000, while the overdose rate was suppressed by the CDC for being unreliable (i.e., the population had between 10 and 20 deaths in 2024). Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February).

[94] Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February).

[95] Statistics representing fewer than ten persons (0-9) are suppressed to assure the confidentiality of decedents.

[96] Deaths occurring in 2024 are considered provisional and are subject to change as final mortality data are finalized and certified.

[97] Deaths from suicide are classified using underlying cause-of-death ICD-10 codes U03, X60–X84, and Y87.0.

[98] Overdose/accidental poisoning deaths are classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[99] The number and/or the mortality rate for suicide and drug overdose / accidental poisoning deaths in 2024 in Starr County and Willacy County were suppressed by the CDC (fewer than 10 deaths).

health or non-medical drivers of health (NMDOH), which Texas Health and Human Service (HHSC) defines as "the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes."[100,101] Analysis of several years of public spending on health, education, and other social services shows that investments in these areas have a statistically significant impact on the health outcomes and health factors of communities.[102] While these factors exist in all communities, we identified several of note for the four-county region discussed in the report, including income, housing, and broadband access.

For more detail on contextual factors impacting regional access to care, see Appendix H.

Faith Communities

In every community, congregations of faith have long provided the kind of meaningful, lasting social connections that are vital to recovery efforts from all sorts of afflictions. Whether a church, synagogue, mosque, or other faith community, these groups provide much-needed support to people and families fighting mental illness. In 2025, the Pew Research Center reported 67% of adults in Texas identify as Christian and 6% of adults identify with other religions.[103] Within the region, in 2020, the U.S. Religion Census found county adherence rates as a percent of population ranged from approximately 30% to 84%.

Table 11: Religious Census Summary Data by County (2020)[104]

	2020 Population	Congregations	Congregations Per 100,000 Population	Adherents*	Adherents as % of Population
Texas	29,145,505	29,750	102.1	16,045,479	55.05%
Cameron County	421,017	369	87.6	229,673	54.55%
Hidalgo County	870,781	594	68.2	535,060	61.45%
Starr County	65,920	47	71.3	55,614	84.37%
Willacy County	20,164	33	163.7	4,631	22.97%

*Adherents are members, their children, and the estimated number of other participants who are not considered members

[100] Texas Health and Human Services. (n.d.). *Non-Medical Drivers of Health*. Retrieved January 28, 2025, from https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/medicaid-chip-quality-efficiency-improvement/non-medical-drivers-health Texas Health and Human Services, (n.d.), *Non-Medical Drivers of Health*

[101] Texas Health and Human Services. (2023). *MCS NMDOH Action Plan*. https://www.hhs.texas.gov/sites/default/files/documents/nmdoh-action-plan.pdf Texas Health and Human Services, (2023), *MCS NMDOH Action Plan*

[102] McCullough, J. M., & Leider, J. P. (2019). The Importance of Health and Social Services Spending to Health Outcomes in Texas, 2010–2016. *Southern Medical Journal*, *112*(2), 91–97. https://doi.org/10.14423/SMJ.0000000000000935

[103] Pew Research Center. (2025). *2023-24 U.S. Religious Landscape Study Interactive Database* [Data set]. https://doi.org/10.58094/3zs9-jc14

[104] Grammich, C., Dollhoph, E. J., Gautier, M. L., Hauseal, R., Krindatch, A., Stanley, R., & Thumma, S. (n.d.). *2020 U.S. Religion Census*. Association of Statisticians of American Religious Bodies. https://www.usreligioncensus.org/sites/default/files/2023-10/2020_US_Religion_Census.pdf

A key component of good mental health is having meaningful and lasting social connections. One of the community entities that still regularly mediates between each individual person and the larger society and is prepared to offer ongoing community support, is the local congregation – whether it be a church or other faith community. The prospects for congregations to support people experiencing mental health issues to achieve recovery in the community are significant, especially when they collaborate with mental health providers and other agencies that can deliver evidence-based and clinically necessary treatment and supports. By providing opportunities to become members of a community and to develop and maintain positive social relationships, congregations and other faith-based groups can play a significant role in supporting people experiencing emotional and mental health issues on their journeys to recovery.

Spotlight: Abundant Grace Counseling Center

Created in 1996, Edinburg's Abundant Grace Community Church provides counseling services to approximately 200 community members a month through their counseling center, helping people dealing with crisis, trauma, and other concerns. Leveraging graduate students and licensed professional counseling interns, the center treats depression, PTSD, trauma, drug addiction, grief counseling, and more. Providing services at no cost, the wait list for their community services regularly ranges from three to five months.

For more on faith and mental health initiatives, please see Appendix I.

Comprehensive Continuum of Care

As mental illness often begins in adolescence and can persist into adulthood, it is critical that we rethink the organization of health systems serving children, youth, adults, and their families to provide care sooner and more effectively. We developed the framework for an ideal mental health care system to better achieve the goals of earlier and more effective care (see Figure 2, on page 8). These components comprise a continuum of care for all people and include strategies to support needs ranging from mild to moderate, intensive, and crisis.

In our conversations across the community, Tropical Texas Behavioral Health was consistently highlighted as a standout provider of behavioral health services. As the local mental health authorities (LMHA) serving the four-county region, Tropical Texas and Border Region carry significant responsibility in meeting community needs; however, they cannot meet those needs alone. An ideal behavioral health system relies on strong partnerships and a network of providers across the continuum of care, ensuring that people can access the right level of support in the most appropriate setting.

In an ideal system, for example, people with mild to moderate behavioral health needs, such as early-stage anxiety or depression, receive timely, effective care in integrated primary care settings using evidence-based models like the Collaborative Care Model (CoCM). This approach embeds behavioral health providers within primary care teams, enabling early identification, brief treatment, and coordinated care management that reduces escalation of symptoms. In addition to primary care settings, people can seek care at community centers or churches in their neighborhood from community health workers (CHWs) or nurses through programs such as the Wesley Nurse Program. For people with serious mental illness (SMI) or more complex behavioral health conditions, one important way care can be delivered in an ideal system is through certified community behavioral health clinics (CCBHCs). These clinics provide comprehensive, ongoing services—including psychiatry, crisis response, care coordination, and peer support, ensuring that people with high needs receive the intensive, multidisciplinary care necessary to support long-term recovery and stability.

This ideal system, and the principles that underlie it, informed this assessment. The following sections first present regional needs and then specific initiatives and opportunities that will enable the region to approach this ideal system over time.

Mild to Moderate Behavioral Health Services

People with behavioral health conditions that are mild to moderate in severity, such as mild to moderate anxiety, depression, attention issues, substance use[105] and other behavior challenges can be treated in primary care settings. Primary care behavioral health integration has been established over the last several decades as a critical opportunity for early identification and

[105] Watkins, K. E., Ober, A. J., Lamp, K., Lind, M., Setodji, C., Osilla, K. C., Hunter, S. B., McCullough, C. M., Becker, K., Iyiewuare, P. O., Diamant, A., Heinzerling, K., & Pincus, H. A. (2017). Collaborative Care for Opioid and Alcohol Use Disorders in Primary Care: The SUMMIT Randomized Clinical Trial. *JAMA Internal Medicine*, *177*(10), 1480–1488. https://doi.org/10.1001/jamainternmed.2017.3947

timely treatment, and it has been shown to be particularly effective in addressing racial, ethnic, and geographic behavioral health disparities. Being able to receive behavioral health services in a primary care setting with a trusted provider can also ease the stigma of seeking treatment.[106,107] Furthermore, in rural communities,[108] behavioral health integration can increase access by leveraging local providers more efficiently while promoting collaboration with community services. Early intervention and support can prevent these mild to moderate issues from escalating into more severe mental health problems.

Mild to Moderate Services

Child Psychiatry Access Network

Texas' Child Psychiatry Access Network (CPAN) improves access to mental health care for children and youth by providing regional PCPs with free, timely consultations and support from child and adolescent psychiatrists. The program enhances the capacity of primary care practices to screen for, diagnose, and manage mental health concerns in children, thereby improving outcomes and reducing the need for referrals to specialty care. Through CPAN, PCPs in the region can access real-time consultations, resources, and guidance on managing behavioral health conditions.

As of February 25, 2025, 14,253 providers in 3,020 clinics across the state of Texas were enrolled in the program. CPAN has completed 47,189 consultations statewide and served 41,184 patients. Unfortunately, the Consortium does not report regional data, but in the discussion below we offer multiple observations from regional stakeholders suggesting that primary care practices in the Rio Grande Valley have not benefited from this as much as those in other regions of the state. House Bill 18 (H.B. 18) (VanDeaver),[109] passed during the 2025 legislative session, provides opportunities for a Rural Pediatric Mental Health Care Access Program to use telehealth services to identify and assess pediatric patients seeking mental and behavioral health needs. Under this expansion, rural hospitals in the region can receive support if they participate in or benefit from services coordinated through the Consortium, such as telemedicine, staff training, or system-level partnerships. In other words, H.B. 18 expands CPAN services to rural hospitals.

Integrated Behavioral Health Care

Integrated behavioral health services combine behavioral health and physical health care to provide a comprehensive approach to managing a person's overall health. Integrating

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[106] Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danışman, G. T., de Vries, R., Kerkhof, A. J. F. M., Bhui, K., & Cuijpers, P. (2020a). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health*, *20*(1), 879. https://doi.org/10.1186/s12889-020-08964-3

[107] Eylem, O., de Wit, L., van Straten, A., Steubl, L., Melissourgaki, Z., Danışman, G. T., de Vries, R., Kerkhof, A. J. F. M., Bhui, K., & Cuijpers, P. (2020b). Stigma for common mental disorders in racial minorities and majorities a systematic review and meta-analysis. *BMC Public Health*, *20*(1), 879. https://doi.org/10.1186/s12889-020-08964-3

[108] Selby-Nelson, E. M., Bradley, J. M., Schiefer, R. A., & Hoover-Thompson, A. (2018). Primary care integration in rural areas: A community-focused approach. *Families, Systems, & Health*, *36*(4), 528–534. https://doi.org/10.1037/fsh0000352

[109] House Bill 18, (2025). https://capitol.texas.gov/BillLookup/history.aspx?LegSess=89R&Bill=HB18

behavioral healthcare into the primary care setting allows early detection and treatment of behavioral health needs in the same location.

Integrating evidence-based behavioral health treatment into primary care settings is an essential strategy for increasing access to behavioral health services for people with mild to moderate behavioral health conditions and providing referral pathways and effective coordination for those in need of more specialized and intensive care.[110] Integrated behavioral health care provides a framework for the prevention of mental illness and promotion of mental health by encompassing secondary prevention through universal screening, identification, and assessment and tertiary prevention through treatment that is fully integrated into the primary care setting.

Integrated behavioral health assumes all patients get timely care the moment they need it. There are two evidence-based models for integrated behavioral health: the primary care behavioral health (PCBH) model and the collaborative care model (CoCM). [111] The following briefly details both PCBH and CoCM.

Primary Care Behavioral Health Model

The primary care behavioral health (PCBH) model is a team-based approach that integrates behavioral health services into primary care settings to improve the management of behavioral and biopsychosocial health conditions. A key component of the model is the inclusion of a behavioral health consultant (BHC) who works as part of the care team. The BHC functions as a generalist and educator, offering brief, high-volume, and easily accessible services that are a routine part of primary care.[112] The PCP and the BHC may both initially see patients, but over time, the PCP typically takes the lead on patient care, consulting the BHC as needed. In Texas, BHCs must be licensed professionals such as licensed clinical social workers (LCSWs), licensed marriage and family therapists (LMFTs), or licensed professional counselors (LPCs). The model enhances the primary care team's ability to address a wide range of behavioral health needs and improves care for the entire clinic population. For more information about the PCBH model, see Appendix J.

Collaborative Care Model

The collaborative care model (CoCM) is the integrated behavioral health model with the strongest evidence base to effectively address the gaps in our current mental health care

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[110] Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health affairs, 33*(12), 2153–2161.

[111] Hunter, C. L., Funderburk, J. S., Polaha, J., Bauman, D., Goodie, J. L., & Hunter, C. M. (2018a). Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action. *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156. https://doi.org/10.1007/s10880-017-9512-0

[112] Hunter, C. L. et al., (2018a), Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action, *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156

system.[113,114,115,116] CoCM brings together an interdisciplinary team of the primary care provider, behavioral health care manager (BHCM), and psychiatric consultant (licensed psychiatrist or psychiatric nurse practitioner) to deliver high-quality, patient-centered behavioral health care. Through a collaborative approach and under the clinical direction of the PCP, the CoCM team works together to detect and provide evidence-based interventions for common mental health needs, measure the patient's progress toward treatment targets, and adjust the patient's treatment plan when appropriate. By identifying and treating mental health needs early, when they are less acute, focusing on evidence based non-pharmacologic treatments, like brief therapeutic interventions and lifestyle changes, and by providing the primary care provider (PCP) with diagnostic and treatment plan support from a psychiatric consultant, CoCM ensures that medication is used only when necessary, evidence-based, and optimized for improved mental health outcomes in primary care. Currently, no health systems in the area operate CoCM. For more information about CoCM, see Appendix J.

Regional Mild to Moderate Needs

Table 12 presents our twelve-month prevalence estimates of mild to moderate mental health needs and conditions for children and youth residents of the region. We estimate that 115,000 of the 300,000 children and youth in the area have at least one mental health need. Most (79%) of these children and youth had mild or moderate conditions that can often be treated in integrated primary care settings.

Based on our estimates, the most commonly presenting mental health conditions among children/youth in the region include attention-deficit/hyperactivity disorder (ADHD; 12% of children and youth) and anxiety (10% of children and youth).[117] Depression affects approximately 14,000 resident children and youth, with youth being more than three times as likely to experience depression as children.[118]

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[113] Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration (testimony of Anna D. H. Ratzliff), U.S. Senate Committee on Finance. (2022). https://www.finance.senate.gov/hearings/behavioral-health-care-when-americans-need-it-ensuring-parity-and-care-integration

[114] Covino, N. A. (2019). Developing the Behavioral Health Workforce: Lessons from the States. *Administration and Policy in Mental Health and Mental Health Services Research, 46*(6), 689–695. https://doi.org/10.1007/s10488-019-00963-w

[115] Lauerer, J. A., Marenakos, K. G., Gaffney, K., Ketron, C., & Huncik, K. (2018). Integrating behavioral health in the pediatric medical home. *Journal of Child and Adolescent Psychiatric Nursing, 31*(1), 39–42. https://doi.org/10.1111/jcap.12195

[116] Kepley, H.O., & Streeter, R. A. (2018). Closing behavioral health workforce gaps: A HRSA program expanding direct mental health service access in underserved areas. *American Journal of Preventive Medicine, 54*(6), S190–S191. https://doi.org/10.1016/j.amepre.2018.03.006

[117] The prevalence rates for each condition count children/youth who suffer from multiple conditions once for each condition. The unduplicated count of children/youth with one or more mental health needs is reflected in the Table's "All Mental Health Needs" row.

[118] Two percent of children and 7% of youth are estimated to have depression. Bitsko, R. H., Claussen, A. H., Lichstein, J., et al. (2022). Mental health surveillance among children—United States, 2013–2019 (underlying data from 2016-2019 National Survey of Children's Health). *MMWR Supplements*, *71*. 10.15585/mmwr.su7102a1

In addition to mental health conditions, we estimate that 44% of children and youth regional residents have experienced at least one adverse childhood experience (ACE), such as neglect, abuse, or having a household member with serious mental illness or substance use disorder.[119] This estimate is consistent with national survey findings, which indicate that more than 40% of children and youth have experienced at least one ACE.[120]

Table 12: Child and Youth Mild to Moderate Mental Health Needs (2023)[121,122,123]

	Age Range	Prevalence
Total Population – Children and Youth	**6–17**	**300,000**
Children Population	6–11	140,000
Youth Population	12–17	150,000
All Mental Health Needs (Mild, Moderate, and SED)[124,125]	**6–17**	**115,000**
Mild Conditions[126]	6–17	65,000
Moderate Conditions[127]	6–17	26,000

[119] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data includes response from across the United States.

[120] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[121] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[122] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[123] See Appendix F for county-level child and youth mental health prevalence estimates.

[124] The prevalence of all mental health needs among Rio Grande Valley children and youth aligns with the rate of adolescents who experienced persistent feelings of sadness or hopelessness in 2023, as reported by the Centers for Disease Control and Prevention and U.S. Department of Health and Human Services. (2024). *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023*. https://www.cdc.gov/yrbs/dstr/index.html; and lifetime adolescent prevalence reported in Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: Results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *Journal of the American Academy of Child and Adolescent Psychiatry, 49* (10). 10.1016/j.jaac.2010.05.017.

[125] The number of children and youth who experience any mental illness (115,000) accounts for co-morbidities across conditions (e.g., a youth with depression and anxiety is counted once in the "All Mental Health Needs" row and once in the rate of each condition reported in the text - once in the 10% of children and youth estimated to experience anxiety and once in the 15,000 resident children and youth estimated to suffer from depression).

[126] Kessler, R. C., Avenevoli, S., Costello, J., Green, J. G., Gruber, M. J., McLaughlin, K. A., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Merikangas, K. R. (2012). Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *69*(4), 381–389. https://doi.org/10.1001/archgenpsychiatry.2011.1603

[127] Kessler, R. C. et al., (2012), Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement, *Archives of General Psychiatry*, *69*(4), 381–389

	Age Range	Prevalence
Adverse Childhood Experiences (ACEs)[128]		
1 to 2 ACEs	6–17	100,000
3 or More ACEs	6–17	33,000
Specific Disorders – Children and Youth[129,130]		
Depression	6–17	15,000
Anxiety	6–17	30,000
Attention-Deficit/Hyperactivity Disorder	6–17	37,000

In Table 13, we provide twelve-month prevalence estimates for mild to moderate mental health conditions among adult residents of the region. Of the estimated 230,000 adults with mental health needs, more than three fourths (78%, or 180,000 adults) had mild or moderate conditions that can often be treated in integrated primary care settings. Common mild and moderate conditions among regional adults included: specific phobias (48,000), generalized anxiety disorder (GAD) (41,000), and panic disorder (24,000).

Table 13: Adult Mild to Moderate Needs (2023)[131,132,133]

	Prevalence
Total Adult Population	**960,000**
Population in Poverty[134]	450,000
All Mental Health Needs (Mild, Moderate, and Severe)	**230,000**

[128] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[129] As described in detail above, the Meadows Institute uses the most rigorous approach available to estimate the number of Valley residents with a mental health condition (see Appendix E for a more technical overview). This method is rooted in local data, leveraging the most granular data available on the age, sex, race/ethnicity, marital status, education, poverty, veteran and housing status of residents from the U.S. Census most updated data from the American Community Survey to estimate local mental health needs.

[130] Prevalence for specific health mild or moderate mental disorders obtained from Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[131] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[132]All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[133] See Appendix F for county-level adult mental health prevalence estimates.

[134] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).*

	Prevalence
Mild Conditions[135]	95,000
Moderate Conditions[136]	85,000
Specific Diagnoses[137]	
Anxiety Disorders	
Generalized Anxiety Disorder	41,000
Panic Disorder	24,000
Social Phobia	23,000
Specific Phobia	48,000

Regional Mild to Moderate Services

Across the region, numerous primary care clinics, including Federally Qualified Health Centers, provide access to integrated behavioral health services, primarily through the PCBH model. The table below outlines the sites and their corresponding service areas.

Table 14: Primary Care Behavioral Health Implementation Sites

Health System	Service Area
Border Region Behavioral Health Center	Starr County*
DHR Health	Hidalgo County
El Milagro Clinic	Hidalgo County
Hope Family Health Center	Hidalgo County
New Horizon Health Center (FQHC previously the Brownsville Community Health Clinic Corporation)	Cameron County
Nuestra Clinica del Valle (FQHC)	Hidalgo and Starr Counties
Rio Grande State Center Outpatient Clinic	Cameron, Hidalgo, Willacy, and Starr Counties
Su Clínica Familiar (FQHC)	Cameron and Willacy Counties
UT Health RGV	Cameron, Hidalgo, and Starr Counties

*All locations in other catchment counties (such as Jim Hogg, Starr, Webb, and Zapata).

The University of Texas Rio Grande Valley (UTRGV) has invested significant funding to leverage the PCBH model through their division of Integrated Behavioral Health. In particular, the Primary Care Behavioral Health Partnerships Advancing & Transforming Health Sciences (PCBH

[135] Kessler, R. C., Chiu, W. T., Demler, O., Merikangas, K. R., & Walters, E. E. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, *62*(6), 617–627. https://doi.org/10.1001/archpsyc.62.6.617

[136] Kessler, R. C. et al., (2005), Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication, *Archives of General Psychiatry*, *62*(6), 617–627

[137] Unless otherwise cited, prevalence rates were generated by The Meadows Institute. (2024).

PATHS) Initiative aims to improve access to behavioral health care by training health care providers in the PCBH model. The division has also created a PCBH Certificate program that trains behavioral health graduate students to become Behavioral Health Consultants in primary care settings. UTRGV is the first institution to introduce and champion integrated behavioral health in the Rio Grande Valley, establishing the foundation for its growth and regional adoption.

As seen above, FQHCs and larger clinics in the region are primarily utilizing the PCBH model of care. In our conversations, clinic leadership were familiar with the CoCM model but noted concerns around implementation of the model due to workforce limitations, including hesitancy by their providers to prescribe psychiatric medications and challenges finding psychiatrists willing to serve as CoCM consultants.

When speaking to primary care providers in small or solo practices across all age cohorts, we learned that these providers are actively delivering behavioral health services for patients with mild to moderate conditions. Several providers reported efforts to implement integrated behavioral health models—such as CoCM and PCBH—which were subsequently discontinued. The principal barriers to sustained implementation were typically attributed to workforce shortages and limited provider interest, as well as uncertainty regarding reimbursement pathways and the long-term financial viability of these programs.

Recommendations for Mild and Moderate Services

Rec. 1	**To improve access, address workforce shortages, and achieve long-term financial sustainability, support the ongoing implementation of integrated behavioral health in pediatric and adult primary care clinics building on existing models that can be financially sustainable.**

Research has shown that, compared to non-Hispanics or non-Latinos, more Hispanics and Latinos believe primary care providers should treat child mental health problems and that these parents are more willing to allow their child to receive medications or visit a therapist if recommended by a primary care provider.[138] This also suggests Hispanic or Latino adults are more likely to seek advice about mental health from a primary care provider rather than a specialist.[139,140,141] Given these findings, primary care is a good setting for mental health interventions for the Hispanic or Latino population. Integrated care methods like the

[138] Brown, J. D., Wissow, L. S., Zachary, C., & Cook, B. L. (2007). Receiving Advice About Child Mental Health From a Primary Care Provider: African American and Hispanic Parent Attitudes. *Medical Care*, *45*(11), 1076. https://doi.org/10.1097/MLR.0b013e31812da7fd

[139] Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing Racial/Ethnic Disparities in Treatment across Episodes of Mental Health Care. *Health Services Research*, *49*(1), 206–229. https://doi.org/10.1111/1475-6773.12095

[140] Brown, J. D., Wissow, L. S., Zachary, C., & Cook, B. L. (2007). Receiving Advice about Child Mental Health from a Primary Care Provider: African American and Hispanic Parent Attitudes. *Medical Care*, *45*(11), 1076–1082.

[141] Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine, 19*(2), 120–126. https://doi.org/10.1111/j.1525-1497.2004.30272.x

collaborative care model (CoCM) and the Primary Care Behavioral Health (PCBH) model expand access to behavioral health services and reduce delays in both detecting and treating mental illness and substance use disorder in children, youth, and adults.

Understanding the differences between PBHC and COCM enables selecting the most effective and scalable approach for integrating behavioral health within primary care settings. For more information on CoCM billing, see Appendix J.

Table 15: Key Features of Primary Care Behavioral Health and Collaborative Care Model[142]

Key Features of Primary Care Behavioral Health and Collaborative Care Model	
Primary Care Behavioral Health (PCBH)	**Collaborative Care Model (CoCM)**
Licensed behavioral health consultant (requires LPC, LSCW, LMFT) embedded in the PCP office	Behavioral Health Care Manager embedded in the PCP office with specialized behavioral health training, allowing for a broader and more flexible workforce pool. Licensure not required. BHCMs can include Qualified Mental Health Practitioners, Registered Nurses, Nurse Practitioners, and Licensed Psychologists.
Focus on brief, functional, and problem-focused therapies tailored to primary care.	Focus on measurement-based care using validated tools, brief therapeutic interventions (i,e, behavioral activation, psychoeducation, problem solving) and symptom tracking, systematic caseload reviews with the psychiatric consultant
Therapy services billed under mental health codes.	All services billed under primary care provider.
Treatment duration up to six months (time-limited therapy).	Treatment duration three to 12 months.
Requires more time per patient and more licensed behavioral health professionals on-site; suited to systems aiming to deliver brief therapy.	Requires fewer in-person sessions; more efficient use of workforce through supervision and caseload management; PCP provided recommendations for treatment by psychiatric consultation; better suited for systems with limited behavioral health availability.

Table 16: Key Billing Differences Between Primary Care Behavioral Health and Collaborative Care Model

Key Billing Differences		
Feature	**PCBH Billing**	**CoCM Billing**
Billing Codes	Typically, Health and Behavior (H&B) CPT Codes (e.g., 96156, 96158)	CoCM-specific CPT codes (99492, 99493, 99494)

[142] APA Office of Health and Health Care FInancing's Integrated Primary Care Advisory Group. (n.d.). *Behavioral Health Integration Fact Sheet*. Retrieved November 6, 2024, from https://www.apa.org/health/behavioral-integration-fact-sheet

Key Billing Differences		
Feature	**PCBH Billing**	**CoCM Billing**
Payment Model	Per visit/encounter	Monthly bundled payment
Provider Roles	Behavioral health providers PCP	BH care manager Consulting psychiatrist PCP
Reimbursement Rates	Depends on contracted rates	Depends on contracted rates
Documentation Requirements	Basic encounter notes	Structured tracking, caseload review, symptom monitoring

When exploring any model of integrated behavioral health care, local needs, resources, and patient demographics ultimately shape what successful integration looks like. To be both effective and sustainable, primary care practices must select an integrated behavioral health model that aligns with the unique characteristics of their population and that can be financially sustainable over time. This requires careful consideration of workforce capacity, including the availability of behavioral health clinicians and the training needs of primary care teams, as well as the realities of the payor mix, which influence reimbursement pathways and long-term financial viability.

Since the current behavioral health workforce across the region is not large enough to meet the growing demand for behavioral health across the care continuum,[143] developing the capacity of health care providers other than traditional behavioral health specialists to address behavioral health conditions upstream, including health integration practices, is an essential strategy. Models such as PCBH and CoCM effectively address workforce shortages via the following mechanisms:

- Sharing an interdisciplinary team-based structure.
- Treating a wide array of behavioral health presentations.
- Overcoming stigma by providing services in primary care instead of specialty mental health settings.
- Utilizing evidence-based measures to guide treatment planning and monitoring.
- Employing existing insurance billing codes for long-term financial sustainability for practices.
- Allowing for real-time availability of behavioral health care.
- Using brief, evidence-based interventions in a short-term care format to help patients access care faster and sooner reduce distress symptoms.

The Meadows Institute has tended to focus more on CoCM, as it tends to have more sustainable financing options in Texas, and most states nationally, and our experience suggests that it can be feasible, effective, and sustainable with sufficient supports across multiple health systems of diverse sizes. Specifically, we have found that technical assistance support in North

[143] USAFacts. (2021, June 9). Over one-third of Americans live in areas lacking mental health professionals. https://usafacts.org/articles/over-one-third-of-americans-live-in-areas-lacking-mental-health-professionals/

Texas (through the Cloudbreak initiative), in the Texas Panhandle (through the Amarillo Area Foundation initiative), and across Texas (through the Lone Star Depression Challenge) has provided proof of principle regarding CoCM implementation with varied mental health presentations, acuity levels, and nuanced regional demographics. An integral lesson learned during these initiatives is that start-up and technical assistance funding are paramount to circumvent traditional barriers to successful implementation and long-term maintenance of any integrated behavioral health programming. Unützer et al. found that clinics receiving enhanced implementation support had substantially better depression outcomes than clinics that received only basic support.[144]

As long as there is a sustainable funding pathway, both CoCM and PCBH have the capacity to increase access to evidence-based integrated behavioral health care, and we recommend funding specific strategies that decrease barriers to entry for clinics:

- *Fund implementation support:* Offset start-up costs with integrated behavioral health system transformation (e.g., behavioral health care manager (BHCM) and psychiatric consultant salaries in the first year, training costs, technical/digital infrastructure modifications) and secure robust technical assistance implementation support (e.g., billing and revenue cycle management, subject matter expertise, training resources, clinical workflow modification assistance).
- *Fund ongoing technical assistance through the creation of an IBH Technical Assistance Center* for initial and ongoing training and technical assistance for relevant personnel, including pediatric primary care providers, clinic support staff, psychiatric consultants, and BHCMs. The center will provide structured education and assistance spaces for physician engagement.

Rec. 2	**To increase utilization of CPAN across the region, strengthen outreach and engagement strategies by the regional health-related institution.**

Local pediatricians and family medicine providers demonstrated limited awareness of the CPAN program, indicating a substantial need for additional, more intensive and targeted outreach and program promotion by UTRGV (the local health-related institution responsible for supporting the implementation of CPAN). In instances requiring psychiatric consultation, stakeholders that we interviewed were clear that providers predominantly relied on established personal relationships with psychiatrists rather than formal consultation services. Beyond the lack of promotion and awareness, providers also cited concerns regarding the time burden associated with completing a CPAN consultation. Absent focused efforts to increase awareness and to support integration of CPAN into existing clinical workflows, providers anticipated that the program would remain underutilized within the region.

[144] Unützer, J., Carlo, A., Arao, R., Vredevoogd, M., Fortney, J., Powers, D., & Russo, J. (2020). Variation In The Effectiveness Of Collaborative Care For Depression: Does It Matter Where You Get Your Care? Health affairs (Project Hope), 39(11), 1943–1950. https://doi.org/10.1377/hlthaff.2019.01714

Targeted outreach to increase use of CPAN to support pediatricians has been shown to be possible in other rural regions of Texas. Perhaps the best example of a robust Education and Outreach program is that of Texas Tech University Health Science Center (TTUHSC) in West Texas. TTUHSC's Education and Outreach team provides free mental health literacy education and professional development to school district staff, students, and families, as well as pediatric and perinatal providers of care, with the goal of improving the mental health of communities through collaboration and education. The team delivers customized mental health education through both in-person and virtual settings. The team also attends health fairs and other events throughout their region to connect with providers and community members, providing information on CPAN, TCHATT and PeriPAN services.

Complex Mental Health Services

People with complex mental health needs face significant challenges in daily functioning and require intensive, specialized interventions due to their mental illness. These mental health needs often involve multiple and severe symptoms, may be chronic in nature, and typically require coordinated care from various healthcare and support professionals. This definition is consistent with the Texas criteria to determine eligibility for the public system's most intensive levels of care. Examples include severe anxiety disorders, major depressive disorders, bipolar disorder, schizophrenia, severe autism spectrum disorders, and complex trauma-related disorders.

Complex Care Services

Intensive services provide the clinical and supportive care necessary to help people maintain stability and thrive in their homes and communities. These services are critical not only for supporting those transitioning from inpatient care but also for preventing hospitalization by addressing complex needs early and effectively. Whether for children, youth, or adults, intensive services are designed to deliver treatment at the least restrictive level possible. They are person-centered, family-focused, strengths-based, culturally responsive, and tailored to each person's unique circumstances and treatment goals. When delivered in-home or in community settings, providers can better understand the person's environment, values, culture, and support system. For people with serious or complex mental health needs, a wide range of evidence-based interventions can reduce the need for inpatient care, improve functioning, and support recovery in less restrictive settings. Services should be delivered wherever is most convenient for each person—whether at home, in a clinic, or another preferred location.

One specific model used to treat people with complex behavioral health needs is Certified Community Behavioral Health Clinics (CCBHCs), as highlighted in our Ideal System framework on page 8. CCBHCs are specially designated providers that offer a comprehensive range of mental health and substance use services to anyone who needs care, regardless of their ability to pay, where they live, or whether they have insurance. Originally established through the federal Excellence in Mental Health Act of 2014, the CCBHC model was created to address long-

standing gaps in access, quality, and coordination of behavioral health care. CCBHCs are required to deliver nine core services:

- Crisis services;
- Screening, assessment, and diagnosis;
- Person- and family-centered treatment planning;
- Outpatient mental health and substance use services;
- Primary care screening and monitoring;
- Targeted case management;
- Psychiatric rehabilitation;
- Peer and family support; and
- Care coordination with social services, physical health, and other systems.

Two CCBHCs currently serve the region—Tropical Texas Behavioral Health, which operates in Cameron, Hidalgo, and Willacy counties, and Border Region Behavioral Health Center, which serves Starr County. These providers play a critical role in advancing the ideal mental health care system described earlier by offering a centralized, accountable model of care that integrates intensive, evidence-based services across behavioral and physical health.

Integrated Health for People with Complex Needs

Research consistently shows that people with serious mental illness (SMI) experience significantly higher mortality rates, dying on average 10–20 years earlier than the general population.[145] Most of these premature deaths are attributable not to unnatural causes such as suicide or homicide, but to preventable or manageable physical health conditions, including cardiovascular, respiratory, and infectious diseases, diabetes mellitus, and various forms of cancer.[146] Evidence also indicates that people with co-occurring physical health, behavioral health, and social or environmental challenges benefit most from evidence-based, integrated interventions delivered in the settings where they are already engaged. More complex, high-need populations often require higher-intensity services to achieve meaningful improvements. For example, people with serious mental illness who have unmet physical health needs show markedly better health outcomes when evidence-based physical health services are incorporated directly into behavioral health care settings.[147] Also known as reverse integration, this model of integrated care aims to bring physical and behavioral health services together in the same setting, reducing fragmentation and improving access. This approach helps people with serious mental illness receive timely medical screening, coordinated

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[145] de Mooij, L. D., Kikkert, M., Theunissen, J., Beekman, A. T. F., de Haan, L., Duurkoop, P. W. R. A., Van, H. L., & Dekker, J. J. M. (2019). Dying Too Soon: Excess Mortality in Severe Mental Illness. *Frontiers in Psychiatry*, *10*, 855. https://doi.org/10.3389/fpsyt.2019.00855

[146] Luciano, M., Pompili, M., Sartorius, N., & Fiorillo, A. (2022). Editorial: Mortality of people with severe mental illness: Causes and ways of its reduction. *Frontiers in Psychiatry*, *13*, 1009772. https://doi.org/10.3389/fpsyt.2022.1009772

[147] Registry-Managed Care Coordination and Education for Patients With Co-occurring Diabetes and Serious Mental Illness. (n.d.). *Psychiatric Services*. Retrieved April 27, 2026, from https://psychiatryonline.org/doi/10.1176/appi.ps.202000096

treatment, and preventive care in an environment where they already feel comfortable, ultimately addressing the significant health disparities this population faces.

Few communities currently offer the full array of intensive services envisioned in the ideal system. As such, community planners should prioritize the services that will have the greatest local impact and focus on implementing them with quality and fidelity. Access to a CCBHC strengthens a community's ability to meet the needs of people with serious mental illness, complex behavioral health conditions, and those in crisis, by ensuring access to a full continuum of coordinated, person-centered, and recovery-focused care in the least restrictive settings possible.

Table 17: Continuum of Intensive Services in an Ideal System

Continuum of Intensive Services in an Ideal System		
Program or Service	**Population**	**Description and Services Provided**
Clinic and Home-Based Interventions	Children, Youth	In most instances, children and youth with serious emotional disturbances and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities. There is an array of well-established treatment protocols intended to be offered in clinics, schools, or homes with the objectives of (1) decreasing problematic symptoms and behaviors, (2) increasing youth and parent skills and coping, and (3) preventing out-of-home placement. These interventions are typically tailored to specific referral problems and are often appropriate for children and youth with mild to moderate needs as well.
Assertive Community Treatment (ACT)	Adults	This program serves adults with serious mental illness and substance use disorders who have experienced multiple hospitalizations. It provides treatment, rehabilitation, and support services designed to meet the individual needs of each participant. Services include 24-hour mental health crisis support, individualized emotional support, medication management, and access to nursing care. The program emphasizes housing stability and assistance with legal matters. Services are delivered in the community or the person's home to ensure accessibility and engagement.
Forensic Assertive Community Treatment (FACT)	Adults	FACT is a team-based approach to providing care for adults involved in the criminal justice system and experiencing severe mental illness. This includes comprehensive treatment plans that integrate psychotherapy, medication management, case management, support for community reintegration, peer support, and coordination with legal and social services.

Continuum of Intensive Services in an Ideal System		
Program or Service	**Population**	**Description and Services Provided**
Assisted Outpatient Treatment (AOT)	Adults	AOT provides treatment to people with serious mental illnesses (SMI) who have difficulty engaging in outpatient services and overutilize emergency rooms and jails in times of crisis. AOT is a form of civil commitment designed to improve outcomes for adults with an SMI with a history of repeated hospitalizations attributable to nonadherence with outpatient treatment.[148] The program utilizes evidence-based treatments and focuses on engagement to provide stability and safety in the person's community.
Multisystemic Therapy (MST)	Children, Youth	MST is an intensive, home-based service model provided to families in their natural environment, at times convenient to the family, to help them function well and safely over the long term. The primary goals of MST are to reduce youth criminal activity, reduce other types of antisocial behavior such as drug abuse, and achieve these outcomes at a cost savings by decreasing rates of incarceration and out-of-home placement.
Coordinated Specialty Care (CSC)	Children, Youth, Adults	CSC is a team-based approach to providing care for people experiencing early episodes of psychosis. This includes personalized treatment plans integrating psychotherapy, medication management, supported employment and education, family education and support, and case management.
Intensive Outpatient Programs (IOP)	Children, Youth, Adults	IOPs are a critical component of the continuum of care, offering an alternative to inpatient hospitalization for children, youth, and adults with serious mental health needs. IOPs allow people to remain in the community while participating in treatment three to four days per week for several hours daily. Services are primarily delivered through group therapy and often include a strong emphasis on family support and family therapy. IOPs also prioritize safety planning and suicide prevention, providing structured support to help people manage crises and reduce the risk of hospitalization.
Partial Hospitalization Programs (PHP)	Children, Youth, Adults	PHPs serve as an alternative to inpatient hospitalization or as a step-down from inpatient care for children, youth, and adults with serious mental health needs. In a PHP, people continue to live at home while commuting to a treatment center five days a week, typically for a full day of treatment. For children and youth, educational support is incorporated into the daily schedule. This treatment modality utilizes group therapy and can have a specific focus on family support and therapy. Several PHPs and IOPs also offer virtual options, including disorder-specific programs tailored to meet individual needs.

[148] Treatment Advocacy Center. (2023, October 16). *Assisted Outpatient Treatment*. https://www.tac.org/aot/

Continuum of Intensive Services in an Ideal System		
Program or Service	**Population**	**Description and Services Provided**
Wraparound	Children, Youth	Wraparound is a strengths-based, individualized planning process designed to support children and youth with complex mental health needs and their families. It engages families as full partners in the planning and delivery of services, building on strengths and connecting with community resources and natural supports. Wraparound aims to help children and youth live successfully in their homes and communities. The Youth Empowerment Services (YES) Waiver is an example of a program that uses the Wraparound approach to deliver intensive services for children and youth with serious emotional, behavioral, and mental health needs. It coordinates care, strengthens family and community supports, and helps prevent out-of-home placements.
Caregiver, Parent, and Family Supports	Children, Youth	These services aim to strengthen the family system and equip caregivers with skills to support their child's well-being. For children and youth with intensive needs, they may be provided as part of a broader treatment plan and in addition services provided directly to the child. These services can improve family functioning, reduce stress, and increase the likelihood of overall treatment success for the child. Examples include services delivered by a family partner, collaborative problem solving, and parent skills-training modalities
Respite Care	Children, Youth, Adults	Respite care provides temporary relief for caregivers by offering short-term care for people with mental health conditions. This service allows caregivers to take a break while ensuring their loved ones receive appropriate care and supervision in a safe environment. Respite care is typically provided by trained staff through local mental health authorities or contracted community providers. Services are usually accessed by contacting the local LMHA, which assesses eligibility and coordinates placement based on the person's needs and available resources.
Integrated Health Services	Children, Youth, Adults	The provision and coordination by the treatment team of appropriately matched interventions for both primary health and behavioral health conditions, along with attention to social and environmental factors that affect health, in the setting in which the person is most naturally engaged.

Regional Complex Mental Health Needs

This section explores the prevalence of complex mental health needs among people in the region. We outlined the scope and characteristics of those experiencing multiple, overlapping behavioral health challenges that often require coordinated, intensive support.

As noted above, based on 2023 community demographics, we estimate that 24,000 children and youth had a serious emotional disturbance (SED) and likely require more intensive,

specialty care services. Notably, seven in ten children and youth with SED were living in poverty. An estimated 3,500 youth ages 12-17 experience bipolar disorder, and 200 resident youth suffer from schizophrenia.

Table 18: Child and Youth Complex Needs (2023)[149,150,151]

	Age Range	Prevalence
Total Population – Children and Youth	**6–17**	**300,000**
Children Population	6–11	140,000
Youth Population	12–17	150,000
All Mental Health Needs (Mild, Moderate, and SED)[152]	**6–17**	**115,000**
Serious Emotional Disturbance (SED)[153]	6–17	24,000
SED in Poverty[154]	6–17	17,000
At Risk of Out-of-Home / Out-of-School Placement[155]	6–17	1,700
Specific Disorders – Youth		
Bipolar Disorder[156]	12–17	3,500
Schizophrenia[157]	12–17	200

[149] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[150] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[151] See Appendix F for county-level child and youth mental health prevalence estimates.

[152] The prevalence of all mental health needs among Rio Grande Valley children and youth aligns with the rate of adolescents who experienced persistent feelings of sadness or hopelessness in 2023, as reported by the Centers for Disease Control and Prevention and U.S. Department of Health and Human Services. (2024). *Youth Risk Behavior Survey Data Summary & Trends Report: 2013–2023*. https://www.cdc.gov/yrbs/dstr/index.html; and lifetime adolescent prevalence reported in Merikangas KR, He JP, Burstein M, Swanson SA, Avenevoli S, Cui L, Benjet C, Georgiades K, Swendsen J. (2010). Lifetime prevalence of mental disorders in U.S. adolescents: results from the National Comorbidity Survey Replication--Adolescent Supplement (NCS-A). *J Am Acad Child Adolesc Psychiatry, 49* (10). doi: 10.1016/j.jaac.2010.05.017.

[153] Holzer, C., Nguyen, H., & Holzer, J. (2025). *Texas county-level estimates of the prevalence of severe mental health need in 2023*. Dallas, TX: Meadows Mental Health Policy Institute.

[154] Holzer, C., Nguyen, H., & Holzer, J. (2025). *Texas county-level estimates of the prevalence of severe mental health need in 2023*. Dallas, TX: Meadows Mental Health Policy Institute and U.S. Census Bureau. (2024, December).

[155] Based on our prior work in developing community-based service arrays in response to system assessments (in WA, MA, CT, NE, and PA), we estimate that one in 10 children with SED in poverty would require time-limited, intensive home and community-based services to reduce risk of out-of-home or out-of-school placement.

[156] Kessler, D.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M. & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. 10.1002/mpr.1359

[157] Frejstrup Maibing, C., Pedersen, C., Benros, M., & Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin*, *41*(4), 963–970. 10.1093/schbul/sbu119

Table 19 provides twelve-month prevalence estimates of adult complex mental health needs. Using the same 2023 population basis, 45,000 adults were estimated to have a serious mental illness (SMI), requiring more intensive and, likely, specialty care services. Notably, adults with SMI were more likely to live in poverty (compared to adults without SMI; 67% vs. 46%, respectively). Major depression was the most common mental health diagnosis, affecting 100,000 adults in the region. Other complex mental health conditions among the region's adult residents included post-traumatic stress disorder (41,000 adults), bipolar I disorder (14,000 adults), and schizophrenia (12,000 adults). Finally, we estimate that 100 adults ages 18-34 experience a first episode of psychosis (FEP) each year.

Table 19: Adult Complex Needs (2023)[158,159,160]

	Prevalence
Total Adult Population	**960,000**
Population in Poverty[161]	450,000
All Mental Health Needs (Mild, Moderate, and SMI)	**230,000**
Serious Mental Illness (SMI)[162]	45,000
SMI in Poverty[163]	30,000
Specific Diagnoses[164]	
Major Depression	100,000
Bipolar I Disorder	14,000
Post-Traumatic Stress Disorder	41,000
Schizophrenia[165]	12,000
Eating Disorders	
Anorexia	3,200
Bulimia	1,600

[158] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[159] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[160] See Appendix F for county-level adult mental health prevalence estimates.

[161] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).*

[162] The Meadows Institute. (2025). *National, state, and county-level mental health prevalence estimates, 2023*. See Appendix E for more information.

[163] The Meadows Institute. (2025). *National, state, and county-level mental health prevalence estimates, 2023.* See Appendix A for more information. See Appendix E for more information. Poverty data was obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).* https://www.census.gov/programs-surveys/acs/microdata.html

[164] Unless otherwise cited, prevalence rates were generated by The Meadows Institute. (2025).

[165] Ringeisen, H., Edlund, M., Guyer, H., Dever, J., Carpenter, L., Olfson, M., First, M., Geiger, P., Liao, D., Peytchev, A., Carr, C., Chwastiak, L., Dixon, L. B., Monroe-Devita, M., Scott Stroup, T., Swanson, J., Swartz, M., Gibbons, R., Stambaugh, L., … Kessler, R. C. (2025). Prevalence of past-year mental and substance use disorders, 2021–2022. Psychiatric Services, advance online publication. 10.1176/appi.ps.20240329

	Prevalence
Binge Eating	6,000
First Episode Psychoses (FEP) Incidence - Ages 18-34[166]	100

People experiencing both behavioral health conditions and homelessness face some of the most complex challenges in our communities. Homelessness is often the result of a combination of factors, including a shortage of affordable housing, lack of access to health care and supportive services, and high rates of poverty and unemployment. There is a strong and well-established connection between homelessness and behavioral health. Nationally, an estimated 67%[167] of people experiencing homelessness have a mental health condition. These people are significantly more likely to experience chronic homelessness due to untreated or undertreated behavioral health needs. At the same time, the trauma and instability of homelessness can further deteriorate a person's mental health, creating a cyclical and compounding crisis.

The following table presents the results of the annual Point-in-Time (PIT) counts for the region, offering insight into the number of people experiencing homelessness in recent years. Starr County has not completed any PIT counts and thus is not included in the table below.

Table 20: Number of Unhoused People Identified during Annual PIT Count[168]

Number of Unhoused People identified during Annual Point-in-Time (PIT) Count				
Total	**2021**	**2022**	**2023**	**2024[169]**
Cameron and Willacy	61 (Cameron County only)	354	402	777
Hidalgo	36	448	353	189
Starr	N/A	N/A	N/A	N/A

Local Mental Health Authority Utilization

LMHAs are the cornerstone of Texas's mental health system for people with complex needs, delivering essential community-based services. They ensure timely access to mental health screenings, counseling, crisis intervention, and inpatient care for all age groups. LMHAs deliver services through a structured system of "levels of care" (LOC), which range from outpatient

[166] Kirkbride, J. B., Errazuriz, A., Croudace, T. J., Morgan, C., Jackson, D., Boydell, J., Fearon, P., Murray, R. M., & Jones, P. B. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153. 10.1176/appi.ajp.2016.16010103

[167] Barry, R., Anderson, J., Tran, L., Bahji, A., Dimitropoulos, G., Ghosh, S. M., Kirkham, J., & Seitz, D. P. (2024). Prevalence of mental health disorders among individuals experiencing homelessness: A systematic review and meta-analysis. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2024.0426

[168] Paredes, A. (2024, March 6). *Final Hidalgo 2024 PIT Report*. Texas Homeless Network. https://www.thn.org/wp-content/uploads/2024/05/Final-Hidalgo-2024-PIT-Report.pdf

[169] Feedback from stakeholders report the increase in 2024 PIT count numbers is largely attributed to the inclusion of a high number of migrants in the count due to a surge in the region of people seeking asylum. Homeless service providers expect a decrease in PIT numbers for 2025/2026 due to federal immigration policy changes.

medication management and skills training to intensive residential and crisis services. Each level is tailored to meet the severity and complexity of a person's mental health needs.

Two LMHAs serve the region: **Tropical Texas Behavioral Health**, which serves a region of approximately 1.2 million children, youth, and adults residing in Cameron, Hidalgo, and Willacy counties, and **Border Region Behavioral Health**, which serves the 58,000 child, youth, and adult residents of Starr County, as part of a multi-county service area that includes three additional counties.[170]

The Meadows Institute compiles annual data reported to the Texas Health and Human Services Commission (HHSC) to analyze trends in service use by LMHAs. This data helps assess the effectiveness and reach of mental health services for residents of all ages, providing insight into how regional LMHAs are meeting the needs of people with mental health challenges, particularly those with complex needs.

Because HHSC reports utilization at the LMHA service area level rather than by county, Starr County–specific utilization data was obtained directly from Border Region Behavioral Health's internal reporting system, while HHSC data were used for Tropical Texas Behavioral Health. At the time of this report, FY 2023 was the most recent HHSC dataset available. However, due to an electronic health record system update at Border Region Behavioral Health, FY 2023 data were unavailable, requiring the use of FY 2024 data for Starr County residents. As a result, cross-LMHA comparisons reflect adjacent fiscal years and should be interpreted as directional rather than strictly contemporaneous comparisons.

The following subsections present LMHA utilization data for Tropical Texas from FY 2023 and for the Border Region from FY 2024, including levels of care provided and any deviations.

Children and Youth LMHA Utilization

Table 21 outlines the level of care (LOC) enrollments at Tropical Texas Behavioral Health and Starr County provided to children and youth in FY 2023 and FY 2024, respectively. Of the 9,051 children and youth who received LOC services from Tropical Texas, 7,605 (84%) received ongoing treatment and specialized services, primarily through targeted services (C2) and complex services (C3). Additionally, 1,446 children received care through the crisis continuum. No children and youth were transferred to Residential Treatment Centers (RTCs), as Tropical Texas works to keep children and youth at home for improved continuity of care.[171]

Border Region provided LOC services to 1,075 Starr County children and youth in FY 2024. Of these, 910 (85%) received ongoing treatment and specialized services, while 165 (15%) received services through the crisis continuum—a comparable proportion to Tropical Texas. Over 800

[170] The Border Region Behavioral Health Center serves clients from Jim Hogg, Starr, Webb, and Zapata counties. County-level utilization data were requested directly from Border Region Behavioral Health Center, where available, to support analyses specific to Starr County.

[171] Tropical Texas Behavioral Health. (July 25, 2025). Received from personal communication.

Starr County children and youth received targeted services (C2) from Border Regions, while none where enrolled in complex (C3) or intensive family (C4) services. Only one youth was served in a Residential Treatment Center (RTC) at Border Region—a service not utilized by children and youth at Tropical Texas during this period. No youth at either LMHA received transition-age services (C-TAY). Some eligible youth may have transitioned directly into adult services rather than enrolling in CTAY services.

Table 21: Children and Youth Level of Care Utilization – Tropical Texas Behavioral Health (FY 2023) and Starr County Residents Served by Border Region Behavioral Health Center (FY 2024)[172]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health (FY 2023)[173]	Starr County (Border Region; FY 2024)[174]
Ongoing Treatment Levels	Medication Management (C1)	442	32
	Targeted Services (C2)	3,880	838
	Complex Services (C3)	2,604	0
	Intensive Family Services (C4)	122	0
	Early Onset Psychosis (CEO)	17	0
	Young Child Services (CYC)	295	40
	YES Waiver (CY)	245	0
	Transition Age Youth (CTAY)	0	0
Crisis Continuum	Residential Treatment Centers (RTC)	0	1
	Crisis (C0)	1,445	148
	Transitional Services (C5)	1	16
Total Children and Youth Served		**9,051**	**1,075**
Child/Youth Ongoing Treatment & Specialized Services Total		7,605	910
Child/Youth Crisis Continuum Total		1,446	165

Table 22 includes the estimated number of children and youth living in poverty with a serious emotional disturbance (SED),[175] or the subset of the population likely to use LMHA services, for Tropical Texas, Starr County residents served by Border Region, and LMHAs statewide in FY2023

[172] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. As a result, comparisons between LMHAs should be interpreted with caution, as they reflect adjacent fiscal years rather than the same reporting period. Differences may also reflect variations in data systems, reporting processes, and service capacity across LMHAs.

[173] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.

[174] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

[175] Serious emotional disturbance (SED) includes youth 17 years of age and under who currently have, or at any time during the past year have had, a mental, behavioral, or emotional disorder resulting in functional impairment that substantially limits functioning in family, school, or community activities. SAMHSA. (2024). Serious mental illness and severe emotional disturbances. https://www.samhsa.gov/mental-health/serious-mental-illness/about

or FY2024. Tropical Texas served just over half of the number of youths who are likely to need their services – a rate slightly lower than the statewide average (53% vs. 57%). Meanwhile, Border Region served approximately 79% of the estimated Starr County children with SED in poverty, higher than both the Tropical Texas and statewide estimates.[176]

Table 22: Children with SED in Poverty Served by LMHAs – Tropical Texas Behavioral Health (FY 2023), Border Region Behavioral Health Center – Starr County (FY 2024), and in Texas Statewide (FY 2023)[177,178]

	Tropical Texas Behavioral Health (FY 2023)	Starr County[179] (Border Region; FY 2024)	Texas (Statewide; FY 2023)
Estimated Children with SED in Poverty[180]	17,000	850	190,000
Total Children and Youth Served[181]	**9,051**	**1,075**	**109,227**
Percent of Children and Youth with SED in Poverty Served	53%	79%	57%

Adult (Ages 18+) LMHA Utilization

Table 23 shows the levels of care (LOC) of services provided to adults by Tropical Texas and Starr County residents served at Border Region in FY 2024. Of the 15,905 unduplicated adults served by Tropical Texas, 12,954 (81%) received ongoing treatment (non-crisis services). Most of these services were medication management and skills training (A1S), which accounted for 71% of non-crisis services, or psychosocial therapy and case management (A3), which accounted for 24%. The remaining 2,951 adults (19%) received care through the crisis continuum.

Border Region served 1,445 Starr County adults in FY 2024. Of these, 1,157 (80%) received ongoing treatment services, while 288 (20%) received services through the crisis continuum—a similar share of crisis services compared to Tropical Texas. Border Region's Starr County ongoing care was also primarily delivered through A1S (80% of ongoing services), with a smaller percentage utilizing other LOCs, such as psychosocial therapy and case management (A3) and assertive community treatment (ACT; A4).

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[176] Note: The state does not allocate funding based on the prevalence rated developed by Meadows.

[177] Unduplicated level of care utilization data for Tropical Texas Behavioral Health and Local Mental Health Authorities statewide were obtained from Texas Health and Human Services Commission and represent fiscal years 2023.

[178] Statewide and Tropical Texas estimates reflect FY 2023 data, while Starr County estimates reflect FY 2024 due to data availability constraints. Comparisons should be interpreted with caution due to differences in fiscal years, data systems, and reporting methodologies.

[179] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

[180] Holzer, C., Nguyen, H., & Holzer, J. (2024). *Texas county-level estimates of the prevalence of severe mental health need in 2022*. Dallas, TX: Meadows Mental Health Policy Institute and U.S. Census Bureau. (2023, December).

[181] The total number of adults served by LMHA refers to FY2023 for those served by Tropical Texas Behavioral Health and FY2024 for Starr County residents served by Border Region.

Table 23: Adult Level of Care Utilization – Tropical Texas Behavioral Health (FY 2023) and Starr County Residents Served by Border Region Behavioral Health Center (FY 2024)[182]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health (FY 2023)[183]	Starr County (Border Region; FY 2024)[184]
Ongoing Treatment Levels	Medication Management (A1M)	0	0
	Medication Management & Skills Training (A1S)	9,145	926
	Medication Management & Therapy (A2)	448	113
	Psychosocial Therapy & Case Management (A3)	3,090	35
	Assertive Community Treatment (ACT) (A4)	192	83
	Early Onset Psychosis Services (AEO)	77	0
	Adult Transition Age Youth (ATAY)	2	0
Crisis Continuum	Crisis Services (A0)	2,940	278
	Transitional Services (A5)	11	10
Total Adults Served		**15,905**	**1,445**
Adult Ongoing Treatment Levels Total		12,954	1,157
Adult Crisis Continuum Total		2,951	288

Table 24 compares the estimated number of adults with SMI in poverty to those enrolled in LOC services at Tropical Texas, Starr County residents served by Border Region, and statewide LMHAs in Texas for FY 2023 or FY 2024. Tropical Texas served a lower percentage of adults with SMI in poverty compared to the statewide average (55% vs. 66%). Border Region served 85% of adults with SMI in poverty in Starr County, a higher proportion than the statewide and Tropical Texas figures.[185]

[182] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. As a result, comparisons between LMHAs should be interpreted with caution, as they reflect adjacent fiscal years rather than the same reporting period. Differences may also reflect variations in data systems, reporting processes, and service capacity across LMHAs.

[183] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.

[184] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

[185] Note: The state does not allocate funding based on the prevalence rated developed by Meadows.

Table 24: Adults with SMI in Poverty Served by LMHAs – Tropical Texas Behavioral Health (FY 2023), Border Region Behavioral Health – Starr County (FY 2024), and Texas Statewide (FY 2023)[186,187]

	Tropical Texas Behavioral Health (FY 2023)	Starr County (Border Region; FY 2024)[188]	Texas (Statewide; FY 2023)
Estimated Adult Residents with SMI in Poverty[189,190]	29,000	1,700	480,000
Total Adults Served by LMHA[191]	**15,905**	**1,445**	**316,346**
Percent of Adults with SMI in Poverty Served	55%	85%	66%

Level of Care Deviations

This section examines instances in which children, youth, and adults received behavioral health services (administered level of care; LOC-A) that differed from their recommended level of care (LOC-R), based on clinical assessments, at Tropical Texas and Border Region in FY 2023 and FY 2024, respectively. Over- or under-treatment may be reflected by deviations and may be influenced by clinical decisions, resource availability, and individual preferences. Deviations in levels of care occur across LMHAs in Texas and are often driven by factors such as funding constraints and workforce shortages. For more details on services provided in each level of care, see Appendix L.

In FY 2023, 1,801 children and youth served by Tropical Texas (20% of the total) had deviations from the recommended levels of care. Table 25 details these deviations across levels of care. Three-fourths of deviations were for children or youth who were recommended to receive more complex services (C3) but instead received a lower level of care (C1 or C2), due to either clinical need, resource availability, or individual/family preference. Additionally, a number of children and youth (284) received YES Waiver services, and it is important to note that the YES waivers require a deviation to be administered depending on need. In general, the YES waiver offers a more comprehensive and flexible treatment plan than through private insurance (or no insurance). Therefore, if a child meets the eligibility criteria, it is often pursued as a preferred option for accessing a broader range of services, which may explain a subset of the deviations.

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[186] Unduplicated level of care utilization data for Tropical Texas Behavioral Health and Local Mental Health Authorities statewide were obtained from Texas Health and Human Services Commission and represent fiscal years 2023.

[187] Statewide and Tropical Texas estimates reflect FY 2023 data, while Starr County estimates reflect FY 2024 due to data availability constraints. Comparisons should be interpreted with caution due to differences in fiscal years, data systems, and reporting methodologies.

[188] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

[189] Meadows Mental Health Policy Institute (2024) and U.S. Census Bureau (2023, December).

[190] The total number of adults with SMI in poverty refers to the calendar year (CY) at the start of the LMHA's fiscal year (e.g., prevalence from CY 2022 is provided for the LMHA's FY 2023).

[191] The total number of adults served by LMHA refers to FY2023 for those served by Tropical Texas Behavioral Health and FY2024 for Starr County residents served by Border Region.

At Border Region, 108 of the 1,075 Starr County children and youth served (10%) experienced deviations from their recommended levels of care. Like Tropical Texas, the most common deviation was related to youth recommended for complex services (C3) served at lower levels. Additionally, five (5) youth (5%) received YES Waiver services, indicating a similar strategy to that of Tropical Texas in serving high-need populations through waiver supports.

Table 25: Children and Youth Level of Care Deviations – Tropical Texas Behavioral Health (FY 2023) and Border Region Behavioral Health – Starr County (FY 2024)[192,193]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health (FY 2023)[194]		Starr County (Border Region; FY 2024)[195]	
		LOC-Recommended	LOC-Actual	LOC-Recommended	LOC-Actual
Ongoing Treatment Levels	Medication Management (C1)	59	206	5	4
	Targeted Services (C2)	199	1,129	20	61
	Complex Services (C3)	1,430	69	70	10
	Intensive Family Services (C4)	94	71	4	14
	Early Onset Psychosis (CEO)	-	27	-	0
	Young Child Services (CYC)	3	1	-	0
	YES Waiver (CY)	0	284	-	5
	Transition Age Youth (CTAY)	-	0	-	0
Crisis Continuum	Residential Treatment Centers (RTC)	-	0	-	1
	Crisis (C0)	0	0	0	0
	Transitional Services (C5)	-	1	-	12
Refusal of Services (C6)[196]		-	12	-	1
Not Eligible (C9)		16	1	9	0
Total		**1,801**	**1,801**	**108**	**108**

[192] The reason for deviation by level of care was not available for this report.
[193] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. Comparisons across LMHAs should be interpreted with caution, as they reflect adjacent fiscal years and may also reflect differences in reporting systems, clinical documentation practices, and service capacity.
[194] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.
[195] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.
[196] For those in category C6, the Uniform Assessment indicated a Recommended Level of Care (LOC- R) of LOC-C1 through LOC-C4, LOC-CYC, or LOC-CTAY; however, the person refused services.

In FY 2023, 6,416 adults that Tropical Texas served deviated from their recommended levels of care, representing 40% of all adults served. Table 26 outlines these deviations across levels of care. Unlike the pattern identified among children/youth above, many adults recommended for Medication Management & Skills Training (A1S) and Medication Management & Therapy (A2) instead received a *higher level of care* – Psychosocial Therapy & Case Management (A3). Furthermore, only 9% of adults recommended for Assertive Community Treatment (ACT; A4) received this level of service.[197] However, two-thirds of adults who were recommended ACT deviated from it to a lower level of care. Among those deviated from ACT to A3 due to resource limitations, Tropical Texas provided a service regimen aligned with ACT under the Texas Resilience and Recovery Utilization Management Guidelines and assigned each patient a dedicated case manager.[198] Approximately 12% of adults were still awaiting authorization for services.

Of the 1,445 Starr County adults who received LOC service from Border Region, 259 (18%) had deviations from their recommended level of care, with approximately one-third receiving lower levels than recommended. Most deviations to lower levels of care involved people who were recommended Medication Management & Therapy (A2) but instead received Medication Management & Skills Training (A1S).

Additionally, more than 80 Starr County adults moved from the ineligible category (A6) into service levels—most commonly A1S. Deviations from lower levels of care into Psychosocial Therapy & Case Management (A3) and ACT (A4) were also observed. Notably, unlike Tropical Texas, Border Regions reported that no Starr County adults were waiting for all authorized services, which may reflect differences in local capacity management or intake prioritization.

[197] The rate was calculated by considering the total number of clients who received ACT services, excluding those initially recommended a different level of care.
[198] Tropical Texas Behavioral Health. (July 25, 2025). Received from personal communication.

Table 26: Adult Level of Care Deviations – Tropical Texas Behavioral Health (FY 2023) and Border Region Behavioral Health – Starr County (FY 2024)[199,200]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health (FY 2023)[201]		Starr County (Border Region; FY 2024)[202]	
		LOC-Recommended	LOC-Actual	LOC-Recommended	LOC-Actual
Ongoing Treatment Levels	Medication Management (A1M)	0	0	24	0
	Medication Management & Skills Training (A1S)	2,904	2,150	58	168
	Medication Management & Therapy (A2)	2,455	150	82	30
	Psychosocial Therapy & Case Management (A3)	203	3,047	4	28
	Assertive Community Treatment (ACT) (A4)	654	126	10	22
	Early Onset Psychosis Services (AEO)	-	97	-	0
	Adult Transition Age Youth (ATAY)	-	2	-	0
Crisis Continuum	Crisis Services (A0)	0	5	0	0
	Transitional Services (A5)	-	11	-	10
Refusal of Services (A6)[203]		-	29	-	1
Waiting for All Authorized Services (A8)		-	784	-	0
Not Eligible (A9)		200	15	81	0
Total		**6,416**	**6,416**	**259**	**259**

Table 27 shows the reasons for the 8,217 total deviations (1,801 among children and youth and 6,416 among adults) at Tropical Texas and 364 deviations among Starr County residents (105 among children and youth and 259 among adults).[204] In these deviations, clinical need was the

[199] The reason for deviation by level of care was not available for this report.
[200] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. Comparisons across LMHAs should be interpreted with caution, as they reflect adjacent fiscal years and may also reflect differences in reporting systems, clinical documentation practices, and service capacity.
[201] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.
[202] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.
[203] For those in category A6, the Uniform Assessment indicated a Recommended Level of Care (LOC- R) of LOC-A1M through LOC-A4; however, the person refused services.
[204] The deviation reason was not available for three deviations at Border Regions among Starr County children and youth.

most commonly cited reason at both LMHAs, accounting for 41% of deviations at Tropical Texas and 59% for Starr County residents. Resource limitations were more frequently cited at Tropical Texas (31%) than among Starr County residents (2%), suggesting more pronounced service capacity challenges at Tropical Texas. Conversely, customer refusal was cited more often among Starr County residents (31%) than among Tropical Texas clients (20%), suggesting potential differences in client engagement or service fit.

Table 27: Reasons for Level of Care Deviations – Tropical Texas Behavioral Health (FY 2023) and Border Region Behavioral Health – Starr County (FY 2024), All Ages[205,206]

Reason for Deviation	Number (%)	
	Tropical Texas Behavioral Health (FY 2023)[207] N=8,217	Starr County (Border Region; FY 2024)[208] N=364
Clinical need (Determined by Clinician)	3,408 (41%)	214 (59%)
Continuity of care	394 (5%)	6 (2%)
Customer refused	1,640 (20%)	113 (31%)
Resource limitations	2,520 (31%)	8 (2%)
Other	255 (3%)	23 (6%)

Regional Complex Care Services

In the region, several mental health providers operate programs as part of the continuum of intensive services for children, youth, and adults. The table below outlines the full continuum of services available across age groups, identifying the providers for each service and highlighting the gaps that an ideal system would address.

Table 28: Continuum of Intensive Services in an Ideal System, Services Available in the Region

Continuum of Intensive Services in an Ideal System, Services Available in the Region			
Program or Service	Provider(s)	Access in the Region	
		Children	Adults
Clinic and Home-Based Interventions	Tropical Texas DHR	√	

[205] The reason for deviation by level of care was not available for this report.
[206] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. Comparisons across LMHAs should be interpreted with caution, as they reflect adjacent fiscal years and may also reflect differences in reporting systems, clinical documentation practices, and service capacity.
[207] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.
[208] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

Continuum of Intensive Services in an Ideal System, Services Available in the Region			
Program or Service	**Provider(s)**	**Access in the Region**	
		Children	**Adults**
Assertive Community Treatment (Act)	Tropical Texas Border Region		√
Forensic Assertive Community Treatment (FACT)			
Assisted Outpatient Treatment (AOT)			
Multisystemic Therapy (MST)	Tropical Texas	√	
Coordinated Specialty Care (CSC)	Tropical Texas Border Region	√	√
Intensive Outpatient Programs (IOP)	Tropical Texas Palms Behavioral Health	√	√
Partial Hospitalization Programs (PHP)	Border Region		√
Wraparound	Tropical Texas Border Region	√	
Caregiver, Parent, and Family supports	Behavioral Health Solutions of South Texas Easter Seals	√	
Respite Care	Tropical Texas Border Region	√	√
Integrated Health Services	Tropical Texas	√	√

With $205 million, Texas is also expanding mental health services in the region through two significant new projects that are part of broader state efforts to improve psychiatric care. The first initiative includes a 50-bed maximum-security state hospital facility at the Rio Grande State Center in Harlingen, with $120 million allocated for its construction. This facility will address the acute shortage of maximum-security psychiatric beds, particularly for people involved in the criminal justice system, where demand exceeds current capacity. The second project, funded with $85 million, involves building up to 100 inpatient psychiatric beds at DHR Health in Hidalgo County. This hospital will require a Level 1 trauma designation and aims to enhance regional access to high-quality psychiatric care and is slated to open Summer 2026.

Of note, Tropical Texas Behavioral Health has invested significantly in improving health outcomes for people with complex needs. With the support of their board and through the use of limited general revenue funds, Tropical Texas created a robust integrated primary care program for any person receiving services through their behavioral health clinics, including both mental health and substance use services. A total of 3,488 unduplicated clients were served through their integrated primary care services in FY25. Tropical Texas has hired their own primary care providers on staff, allowing for seamless transitions of care between behavioral health and primary care as well as a shared electronic health record.

As noted above, people experiencing both behavioral health issues and homelessness are particularly vulnerable. To meet the needs of this population, TTBH has also developed the Milestone Transitional Housing program. This program serves both male and female adults who are participating in TTBH services and who are:

- Homeless or at risk of homelessness;
- Actively engaged in their recovery, and;
- In need of temporary therapeutic residential support to help them successfully transition to more permanent and independent housing.

Eligible participants typically remain in the 12-bed program for 90-days as they work towards connecting with permanent housing opportunities. Twenty-three people were housed in this program during FY25. Similar to their primary care program, TTBH leadership is supporting this program using limited general funds.

Spotlight: Tropical Texas Behavioral Health's Multisystemic Therapy Program

Tropical Texas Behavioral Health delivers multisystemic therapy (MST), an evidence-based, family-centered intervention designed to help at-risk youth reduce criminal behavior, improve academic performance, and strengthen family relationships. For the past two years, Tropical Texas has provided MST services in Willacy, Hidalgo, and Cameron counties, leveraging strong community partnerships and efficient referral pathways. The LMHA currently operates two MST teams – both running at full capacity – and supported by a well-established workforce and robust training infrastructure. Through this intensive, in-home model, Tropical Texas is expanding access to effective care for youth and families across the region.

Complex Care Recommendations

Rec. 1	**To meet complex mental health needs among children and youth, expand access to multisystemic therapy.**

To support adolescents and families facing complex behavioral health challenges, there is a growing need for multisystemic therapy (MST) services across the region. MST, an evidence-based, family-centered intervention, has proven highly effective in helping at-risk youth reduce criminal behavior, improve school performance, and strengthen family dynamics, particularly for youth at risk of concerning behavior in the community, including violence. See Appendix K for more information on MST.

Based on our assessment of the complexities involved and statewide programs in other states, we estimate that approximately 250 adolescents in the region would benefit from MST services each year.[209] Since each MST team serves about 60 families annually, the region requires five

[209] We estimated the need for Multisystemic Therapy (MST) among the region's adolescents by identifying: 1) the number released from juvenile justice custody, 2) the number placed into substitute care, and 3) the number that met both criteria. Across these populations, the number of youth who would benefit from MST was limited to those estimated to be on Medicaid. Secure and non-secure juvenile justice placement releases were obtained from

MST teams[210] – or three new teams – to meet this demand. Currently, Tropical Texas operates two MST teams serving Willacy, Hidalgo, and Cameron counties. These teams operate at full capacity and are supported by strong community partnerships and established referral pathways. Starr County accounts for 15 to 20 adolescents who could benefit from MST annually. However, Starr County currently lacks access to MST services. It falls within the Border Region service area, which does not currently provide MST. Additionally, due to its geographic location, Starr County faces higher challenges in accessing MST services in the future.[211]

Implementing MST requires a significant financial commitment to ensure effective service delivery and adherence to the model's standards. The projected annual cost for one MST team is approximately $675,000, covering staffing and operational expenses. In addition, MST requires an annual investment of $100,000 for ongoing tailored quality assurance, training, and fidelity monitoring MST Services provides.[212] This support is essential to maintain model fidelity and drive continuous quality improvement, ensuring the team's long-term success and impact.

Across the nation, MST programs have been funded by mental health systems, juvenile justice agencies, schools, child welfare agencies, local community clinics, non-profit organizations, state funds, and philanthropic funds. Braided funding is best as it optimizes sustainability and provides flexibility. In Texas, the Texas Health and Human Services Commission (HHSC) funds most MST teams, with only a few funded by the Texas Juvenile Justice Department (TJJD) and/or internal organizational funds. Currently, there are no projected increases in funding from HHSC or TJJD to support the development of new MST teams.

Given the current limitations in state-level funding for MST expansion, it is essential to explore alternative strategies, such as the following.

- **Focus investment where the need is the greatest**: Tropical Texas' service area includes the counties with the highest need for MST.
- **Regional collaboration**: In this region, there are four juvenile probation departments (Cameron, Hidalgo, Willacy, and Starr) that could collaborate by braiding internal funding to support the development of a full MST team. Strategically locating the team in Hidalgo Couty (Edinburg) would allow a therapist to serve Starr County while remaining within the required 90-minute drive time radius. Philanthropic funding can

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the Texas Juvenile Justice Department. (August 2024). *The State of Juvenile Probation Activity in Texas - Calendar Year 2023*. *(Report Number RPT-STAT-2023).* https://www.tjjd.texas.gov/wp-content/uploads/2024/08/The-State-of-Juvenile-Probation-Activity-in-Texas-Calendar-Year-2023.pdf. Substitute care placements obtained from the Texas Department of Family and Protective Services. (March 2025). *CPS 3.1 Placement Types of Children in Substitute Care During the Fiscal Year by County with Demographics FY2015-2024.* https://data.texas.gov/dataset/CPS-3-1-Placement-Types-of-Children-in-Substitute-/nhcj-etqt/about_data.

[210] MST Services. (2024). *How to become a Multisystemic Therapy (MST®) provider: A comprehensive guide*. MST Services. https://295885.fs1.hubspotusercontent-na1.net/hubfs/295885/MST%20Redesign/White%20Paper/How%20to%20Become%20an%20MST%20Provider%20Final%202024.pdf

[211] MST Services. (2024). *How to become a Multisystemic Therapy (MST®) provider: A comprehensive guide*. MST Services.

[212] MST Services is the organization that trains and supports MST teams in Texas.

play a vital role in covering initial start-up costs and the annual expenses associated with program quality assurance and monitoring.

- **Leveraging local community-based organizations** (CBOs)**:** In addition to collaboration among juvenile probation departments, CBOs present a viable alternative for delivering MST services across the region. Investing in established CBOs with MST experience would not only address the geographic limitations but enhance long-term sustainability by leveraging their existing experience in delivering evidence-based models, connections to the community, and organizational capacity.
- **Invest in creating equitable access**: Supporting Border Region's implementation of MST services is a critical step toward ensuring equitable access to evidenced-based care for Starr County's youth.

Any regional MST expansion should build on existing infrastructure, strong community partnerships, and local expertise. Workforce development is a key strength; between December 2024 and February 2025, 86% of MST positions in Texas were filled, with 80% staff retention, thanks to a collaborative hiring effort by EBA, MST Services, and local authorities. Tropical Texas brings two years of experience delivering MST in three counties, with strong referral pathways and training systems. While MST would be new to Border Region, experienced providers like Liberty Resources and Southwest Key Programs in nearby Webb County offer a valuable opportunity to support implementation using proven strategies.

Rec. 2	**To bolster funding for coordinated specialty care programs, Border Region and Tropical Texas should work with regional managed care organizations to negotiate in-lieu-of Medicaid managed care contracts.**

Early detection of psychosis is essential since people who experience psychoses typically do not receive care and treatment until five years after the onset of symptoms.[213] Coordinated specialty care (CSC) is individually tailored to the person experiencing early psychosis and actively engages their family in supporting recovery. It provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management, as well as other less common evidence-based approaches that are known to help people with serious mental illnesses retain or recover a meaningful life in the community such as supported education and supported employment. Crucially, a CSC team provides community education activities and develops strategic partnerships with key entities in the community. The team also plays a role in detecting emerging psychosis and creating channels through which youth can be referred for treatment. See Appendix K for more information on CSC.

In accordance with Texas Government Code, Section 533.005(h), Texas Health and Human Service Commission (HHSC) is required to allow Medicaid managed care organizations (MCOs)

[213] Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health services research*, *39*(2), 393–415. https://doi.org/10.1111/j.1475-6773.2004.00234.x

to provide certain services in lieu of Medicaid state plan services.[214] Coordinated specialty care is an approved Medicaid in lieu of service.[215] As Border Region and Tropical Texas both operate first episode psychosis CSC teams, they should work with regional MCOs to negotiate an in lieu of Medicaid managed care contract to help cover the cost of CSC for people enrolled in Medicaid. Specifically, they should utilize a team-based rate which allows the provider to bill for all of the services the entire team provides to a person.[216,217] In October, 2023, CMS approved two new Healthcare Common Procedure Coding System (HCPCS) codes for billing CSC, H2040, team-based for first episode psychosis billed per month and H2041, team-based for first episode psychosis billed per encounter. This Medicaid reimbursement will provide additional funding to the LMHAs for their first episode psychosis CSC programs, which today only state funds cover.

In Fiscal Year 2023, Tropical Texas served 77 people with early onset psychosis through its CSC team, while in FY 2024 Border Region served 0 Starr County residents on its CSC team. Establishing in-lieu-of agreements would directly support the continued growth and stability of these programs, ensuring young people experiencing first-episode psychosis have continued access to early, evidence-based intervention.

Rec. 3	**To ensure people with serious mental illness receive intensive, wrap-around care, expand and strengthen the assertive community treatment workforce.**

To effectively address the needs of people with chronic mental health conditions, particularly those with serious mental illness, such as schizophrenia, bipolar disorder, and major depressive disorder, it is critical to expand access to assertive community treatment (ACT) services in the region. These people often require intensive, wrap-around services to maintain stability and prevent the cyclical patterns of hospitalization or incarceration. ACT is an evidence-based practice that has been proven to reduce these cycles by providing around the clock care and medical, psychosocial, and rehabilitative services tailored to meet the unique needs of those with SMI.

While telehealth can expand the workforce for other behavioral health interventions, it is not ideal for delivering ACT services. People requiring ACT are often too ill to benefit fully from telehealth, as they need more intensive, hands-on care. ACT services are designed to provide routine, face-to-face support, which is critical for consistent, in-person monitoring and intervention for people with severe mental illness.

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[214] GOVERNMENT CODE CHAPTER 533. MEDICAID MANAGED CARE PROGRAM, 533.00257 (2025). https://statutes.capitol.texas.gov/Docs/GV/htm/GV.533.htm#533.005

[215] Texas Health and Human Services. (2024). *Medicaid Behavioral Health In-Lieu-Of Services Annual Report*. https://www.hhs.texas.gov/sites/default/files/documents/medicaid-bh-lieu-services-annual-report-nov-2024.pdf

[216] Texas Health and Human Services. (n.d.). *Coordinated Specialty Care for First Episode of Psychosis*. Retrieved April 25, 2025, from https://www.hhs.texas.gov/providers/behavioral-health-services-providers-programs/coordinated-specialty-care-first-episode-psychosis

[217] Substance Abuse and Mental Health Service Administration. (2023, October 23). *Coordinated Specialty Care for First Episode Psychosis*. https://library.samhsa.gov/sites/default/files/cfri-csc-webinar-slides-pep23-01-00-003.pdf

Currently, only 9% of adults recommended for ACT services receive this level of care at Tropical Texas, while over 80% of Starr County residents recommended for ACT receive it at Border Region.[218] Most adults (66%) who received ACT at Tropical Texas deviated into ACT from a lower level of care. Stakeholder interviews reported this is primarily due to clinical demand outpacing workforce capacity. Both Tropical Texas and Border Region report staffing shortages, made worse by competition from other local employers, especially school systems, that offer higher wages and pose challenges to providing ACT services to all that require that level of care. This competition makes it especially difficult to recruit and retain licensed professionals, such as licensed professional counselors (LPCs), licensed master social workers (LMSWs), or licensed clinical social workers (LCSWs). While ACT does not require all team members be licensed, these positions are the hardest to fill. This shortage of licensed staff limits both agencies' ability to expand access to ACT services and meet the growing demand.

Tropical has already made efforts to grow and strengthen its workforce, recognizing that recruitment and retention are central to sustaining high-quality services. Adopting similar strategies across other organizations providing ACT services would further bolster workforce capacity, enabling LMHAs to expand ACT programming and deliver consistent, community-based care to people with the most complex needs. These investments are critical not only for expanding access but also for maintaining service stability and preventing the cyclical patterns of hospitalization, homelessness, or incarceration that often result when workforce shortages disrupt continuity of care.

Rec. 4	**To strengthen collaboration and support funding for new interventions, leverage the regional accelerator to expand access to evidence-based, home- and community-based mental health services for children and youth.**

Tropical Texas and Border Region both offer a robust service array that includes intensive, community-based services for children and youth, and conducts community outreach to ensure awareness of various programs and services. Despite this, providers interviewed for this assessment consistently cited a shortage of effective outpatient care. As a result, families are frequently forced to rely on crisis or inpatient services, even when a less intensive level of care would be more appropriate. It is possible that the perception of the shortage is a result of an actual need for more specialty care for youth with complex needs and/or an even increased need for outreach and education on Tropical Texas' services. Regardless, expanding access to a full continuum of high-quality, community-based mental health services is essential to address children's needs early and effectively, while also reducing reliance on costly and restrictive interventions.

Intensive home- and community-based services offer the clinical care and support necessary to help children stabilize and thrive in their homes and communities. These services prevent unnecessary hospitalization or out-of-home placements and support smooth transitions back

[218] The rate was calculated by considering the total number of clients who received ACT services, excluding those initially recommended a different level of care.

home following more intensive treatment. Building this capacity, however, requires more than just adding services; it involves raising awareness among providers, establishing strong referral pathways, training a skilled workforce, and securing sustainable funding.

Several promising, evidence-based interventions are available in the region to support children and youth with complex mental health needs.[219] For example, dialectical behavior therapy (DBT), which DHR and UTRGV offer, teaches emotional regulation skills and has been shown to reduce self-harm and suicidal ideation. Tropical Texas' multisystemic therapy is a family-centered intervention that effectively reduces criminal behavior, improves academic performance, and strengthens family functioning among at-risk youth. While these interventions are valuable, they are not enough to meet the community's full needs, nor do they represent a robust continuum. Raising awareness and strengthening referral pathways, alongside expanding the availability of these and additional interventions, is critical to ensuring children and youth receive timely, appropriate care. A more comprehensive continuum of care is needed to adequately address the wide range of mental health needs across the region.

To advance this effort, we recommend leveraging the regional accelerator (described on page 180). The accelerator should champion efforts to increase awareness of existing services and build referral pathways among providers and community partners. Additionally, the accelerator can shape local investment in additional evidence-based interventions that strengthen the continuum of care. It should also partner with providers and payers to research viable payment models and develop financing strategies that ensure long-term sustainability of these services across the region.

Rec. 5	**To improve access to behavioral health services for people experiencing homelessness, increase collaboration with LMHAs and expand the evidence-based intervention of permanent supportive housing.**

Unhoused people often face significant barriers to accessing behavioral health care, including transportation challenges, lack of awareness of available services, and stigma. Local mental health authorities (LMHAs) are uniquely positioned to address these barriers by offering targeted, on-site support and coordinated care at homeless service sites and with agencies providing permanent supportive housing (PSH). Strengthening partnerships between the region's LMHAs (Border Region and Tropical Texas) and homeless response systems can provide a critical safety net for this vulnerable population, improve access to care, and enhance outcomes for people experiencing homelessness.

Additionally, the region's lack of SSI/SSDI Outreach, Access, and Recovery (SOAR) providers results in long wait times for people seeking disability benefits, further exacerbating financial and housing instability. Strengthening partnerships between LMHAs and homeless services can help address this gap by integrating SOAR-trained staff into service sites, expediting the

[219] For a list of clinic and home-based interventions, see Appendix M.

disability application process, and ensuring people receive the financial support they need. For more information about SOAR, see Appendix N.

One example of a successful partnership between an LMHA and a housing system is the collaboration between Dallas' North Texas Behavioral Health Authority (NTBHA) and the continuum of care lead agency, Housing Forward. Together, they provide comprehensive wrap-around behavioral health services to people exiting homelessness and entering permanent housing. This partnership ensures that behavioral health care is delivered concurrently with housing support, addressing immediate clinical needs and long-term housing stability. NTBHA's role extends beyond clinical services—its team provides SOAR assistance to help people establish critical benefits. This step is essential in building financial sustainability and preventing future episodes of homelessness.

To support people and families experiencing homelessness who also have co-occurring serious mental illness, substance use disorders, and/or are fleeing domestic violence, stakeholders should prioritize developing permanent supportive housing models that integrate housing with wraparound services such as behavioral health care, case management, and workforce support. Utilizing state and federal funding sources—such as Medicaid 1115 waivers, the Low-Income Housing Tax Credit (LIHTC), and HUD's Continuum of Care (CoC) grants—will help address the current shortage of permanent supportive housing. For example, through the efforts of Friendship of Women, Cameron County will soon gain 50 units of permanent supportive housing for people and families experiencing domestic violence. Establishing a partnership between Friendship of Women and Tropical Texas (the county's LMHA) to provide on-site behavioral health services at the new supportive housing units for survivors of domestic violence would ensure residents have direct access to the full continuum of behavioral health care available within the LMHA's levels of care, strengthening the support available for maintaining long-term housing stability.

Additionally, the Samano Flats is expected to open in 2026 in downtown Brownsville, adding 39 affordable housing units, including permanent supportive housing for people experiencing or at risk of homelessness, to the community. To ensure residents receive the care they need to remain stable and thrive, Tropical Texas Behavioral Health has plans to embed staff on site to provide comprehensive behavioral health and wraparound services. This partnership will combine housing with critical supports, creating a safe and sustainable model to address both housing insecurity and mental health needs in the community.

Crisis Care Services

The Texas Administrative Code defines "crisis" as a situation in which (a) a person presents an immediate danger to self or others, (b) a person's mental or physical health is at risk of serious deterioration, or (c) a person believes that they present an immediate danger to self or others

or that their mental or physical health is at risk of serious deterioration.[220] Common examples of a mental health crisis include thoughts or plans of suicide; a person's existing mental health disorder deteriorates, creating serious symptoms; someone whose current functioning restricts their ability to go to school or work, maintain healthy relationships, or successfully engage in activities of daily living; or major mood changes that affect functioning.

From a system intervention perspective, individual crises exist on a spectrum, with some crises requiring immediate intervention in a safe and secure place such as an emergency department. In contrast, others are best resolved and treated in a community-based setting such as a school, via telehealth, or in a home environment. While the entire crisis spectrum requires a significant response, the challenge lies in ensuring treatment occurs in the most appropriate setting.

Crisis Care Services

The ideal crisis continuum is based on the fundamental principle that people have the greatest opportunity for healthy development when they maintain their ties to community and family while receiving help.[221] The Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines provide an overview of the ideal continuum of crisis services and outline essential values for crisis services.[222] These values and guidelines emphasize:

- Rapid response.
- Safety.
- Crisis triage.
- Active engagement of the person in crisis.
- Reliance on natural supports.

In this section of the report, we focus on the region's current and potential crisis and emergency response continuum, and we define the critical elements of that continuum in Table 29. It is important to remember that the ideal crisis continuum exists within a broader system of care that identifies and responds to individual mental health needs within the community. Without the availability of community-based mental health services that address needs ranging from mild to complex, the crisis end of the services spectrum becomes the default point of entry for care. In an ideal system, most people would have their mental health needs identified long before reaching a point of crisis. Developing a strong community-based services continuum that people can access prior to being in crisis is critical to preventing crises and

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[220] Texas Administrative Code, Title 25, Part 1, Chapter 416, Subchapter a, Rule §416.3 (2014). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3

[221] Meadows Mental Health Policy Institute. (2021, September). *Sequential Intercept Mapping Report for Caldwell County, Texas*. https://www.texasjcmh.gov/media/zjwgltmg/caldwell-county-mapping-report-transmission-09-17-2021.pdf

[222] U.S. Department of Health and Human Services. (2009). *PRACTICE GUIDELINES: CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISES CORE ELEMENTS IN RESPONDING TO MENTAL HEALTH CRISES* (HHS Pub. No. SMA-09-4427.). Substance Abuse and Mental Health Services Administration. https://www.govinfo.gov/content/pkg/GOVPUB-HE20-PURL-LPS123232/pdf/GOVPUB-HE20-PURL-LPS123232.pdf

maximizing efficient use of the available crisis services.[223] When meaningful community-based alternatives to inpatient treatment are absent, many people in crisis have nowhere to turn but to the most restrictive, disruptive, and expensive care.

Table 29: Continuum of Crisis Service in an Ideal System[224]

Continuum of Crisis Services in an Ideal System		
Program or Service	**Population**	**Description & Services Provided**
24/7 Crisis Hotline	Children, Youth, Adults	These hotlines provide direct services delivered through a free telephone line that is answered 24 hours a day, 7 days a week (24/7) by licensed and trained staff. A 24/7 crisis hotline provides immediate support, appropriate referrals, and linkages to a mobile crisis team or emergency medical services (EMS) response, if appropriate.
Mental Health Integration with 9-1-1 Response	Children, Youth, Adults	When someone calls 9-1-1 and reports a mental health emergency, the call center plays a role in dispatching law enforcement as the first response includes a mental health clinician who can manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs.
Multi-Disciplinary Response Teams (MDRT)	Children, Youth, Adults	Based on the community paramedicine model, MDRTs include a paramedic, a licensed master's level mental health professional with at least five years' experience in providing mental health emergency care and a tenured law enforcement officer with advanced crisis and mental health peace officer training. They are the first line of response to for people having a mental health emergency and who need access to same day medication prescription, linkages to a housing provider, and access to community hospital beds.
Youth and Family Mobile Outreach Team (YCOT)	Children, Youth	Community-based service for children, youth, and families who feel the child or youth is in crisis. Team members specialize in working with youth and caregivers to de-escalate crises, provide limited in-home support, and link the young person and family to appropriate ongoing services. Such teams in multiple states have been shown to reduce emergency department use, psychiatric hospitalization, and out-of-home placement.

[223] Healthy Minds Policy Initiative. (2021, December 3). *The State of Children's Crisis Care in Oklahoma: Needs and treatment capabilities in the COVID era*. https://uploads-ssl.webflow.com/638f97e13417b746d0eb3763/63b71baaf89b1b57e65167d0_Childrens-crisis-report-final.pdf

[224] Meadows Mental Health Policy Institute. (2016). *Behavioral Health Crisis Services*. https://mmhpi.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf

Continuum of Crisis Services in an Ideal System		
Program or Service	**Population**	**Description & Services Provided**
Mobile Crisis Outreach Team (MCOT)	Adults	MCOTs provide a rapid response to crisis calls in the community by mental health specialists who provide outreach, de-escalate crises, and make determinations for needed treatment. Mobile outreach is a key service that can help with onsite assessment, rapid medication when a psychiatric prescriber is available by telephone or telemedicine (using mobile devices), and transportation of people who are agreeable to go to a crisis respite program, crisis residence, or a peer-operated crisis program. In most communities in Texas (and across the nation), crisis outreach services are either not sufficiently available after business hours or are hindered by inadequate geographic coverage (e.g., one crisis team may be located at a single site in a large metropolitan or geographic area). Other communities may have multiple outreach programs that are not connected, resulting in limited coordination. An effective system of care has multiple crisis sites, including mobile outreach and communication protocols among crisis teams that allow coordination and critical information sharing. This helps promote efficiency, care coordination, and sharing of after-hours coverage.
Crisis Transportation	Children, Youth, Adults	A crisis system should include transportation services that are provided in a safe and timely manner when crisis services are needed. Depending on the circumstance, this service is provided by mobile crisis teams, EMS, or local law enforcement.
Peer Crisis Services	Youth, Adults	Peer crisis services include peer-led interventions and support that are provided in a calming, home-like environment during a crisis, operated by people with life experience of mental illness. These services are intended to last less than 24 hours but can last several days. Peer crisis services may be built into many of the other crisis programs and services.
Walk-in Crisis Center or Crisis Urgent Care Center	Children, Youth, Adults	These centers are physical walk-in locations in which medical staff (including prescribers) conduct crisis assessments and triage. Crisis urgent care centers, which may or may not be based in a hospital, provide immediate walk-in crisis services, including assessment, medication administration, and support services.
Crisis Telehealth Services	Children, Youth, Adults	Crisis telehealth services provide access to emergency psychiatry services at crisis facilities and other settings, allowing highly trained staff to provide interventions over the phone without the cost of the person in crisis needing to be on site continuously, or when services would otherwise be unavailable. Crisis telehealth services include assessment, crisis de-escalation, and prescribing services.

Continuum of Crisis Services in an Ideal System		
Program or Service	**Population**	**Description & Services Provided**
Crisis Respite	Children, Youth, Adults	Crisis respite provides a safe environment to resolve crises and help people engage in services. Depending on the needs of the person, the acuity of the crisis, and the resources of the program, many people can use these services as an alternative to inpatient care. Providing respite for a person or a child/family prevents further escalation of relational stressor and decompensation, thereby avoiding a crisis that could result in hospitalization or incarceration.
Short-Term Crisis Residential	Children, Youth, Adults	Short-term crisis residential services provide urgent care treatment in a safe environment for people who are experiencing acute crisis symptoms. These units are used as a step-down out of an extended observation unit for people who need more time for stabilization and are not ready to return to the community. They may also be used for people who are at risk for decompensation such as someone who has become homeless and requires placement. Short-term crisis residential services include 24-hour supervision, prompt assessments, medication administration, individual/group treatment, meetings with family and other supports, and referrals to community treatment.
Extended Observation Unit (EOU) / Crisis Stabilization Unit	Adults	EOUs play a significant role in allowing people in crisis to be stabilized in the community rather than at an inpatient facility or a hospital emergency department. In addition, EOUs are secure facilities with the capacity to accept involuntary (via emergency detention) and voluntary patients who are experiencing a psychiatric crisis. This feature provides law enforcement officers with an alternative to taking people in crisis to jail or a hospital. An EOU is not appropriate for people with high medical needs, who need to be restrained or secluded, or who are actively violent; however, almost all other psychiatric crises can be managed in an EOU. An EOU provides intensive, time-limited treatment in a safe environment for people who have significant thoughts of suicide or significantly compromised ability to cope in the community. EOU services include prompt assessments, medication administration, meetings with extended family and other supports, and referrals to appropriate services.
Psychiatric Emergency Centers	Children, Youth, Adults	Also referred to as psychiatric emergency services, the essential functions of a psychiatric emergency center include immediate access to assessment and triage, treatment, and stabilization for people with the most serious and emergent psychiatric symptoms. Services include assessment, treatment, stabilization services, and immediate access to emergency medical care.

Continuum of Crisis Services in an Ideal System		
Program or Service	**Population**	**Description & Services Provided**
Hospital Emergency Departments	Children, Youth, Adults	Like a psychiatric emergency center, hospital emergency departments include immediate access to assessment, treatment, stabilization, and admission/referral to inpatient care for people experiencing the most serious and emergent psychiatric symptoms. Services include assessment, treatment, stabilization services, immediate access to emergency medical care, referral, and admission to inpatient psychiatric care.
Inpatient Services	Children, Youth, Adults	Inpatient treatment services are reserved for people with mental illnesses who are a danger to themselves or others or who have a psychosis or compromised ability to cope in the community and cannot be safely treated in a less-restrictive level of care. Inpatient services include treatment, assessments, medication administration and management, meetings with extended family and others, transition planning, and referrals to appropriate community services.

Crisis Care Utilization Data

Local Mental Health Authority Crisis Care Utilization Trends Over Time

This section examines crisis intervention trends at Tropical Texas Behavioral Health (Tropical Texas) through child, youth, and adult enrollment in crisis continuum Levels of Care (LOCs), specifically crisis services (LOC-0) and transitional services (LOC-5). Our primary source of service provision data is at the LMHA service area level, which typically spans multiple counties.[225] As previously mentioned, the region is served by two LMHAs, Tropical Texas whose catchment area covers Cameron, Hidalgo, and Willacy counties, and Border Region Behavioral Health (Border Region), whose catchment area covers Starr County and three additional counties. [226]

All county-specific data of service use by Starr County residents was provided by Border Region. The years of Starr County-specific data are limited because Border Region implemented an update to its electronic health record system in FY 2024,[227] which constrained the availability of LOC assessment data for prior fiscal years. As a result, this section presents trend data for Tropical Texas only and FY2024 crisis utilization data for Starr County residents provided directly by Border Region, as historical trend data were unavailable.[228]

However, due to an electronic health record system update at Border Region Behavioral Health,

[225] Texas Health and Human Services. (2023, September). *Local Mental and Behavioral Health Authorities*. https://www.hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/local-mental-health-authority-service-areas.pdf

[226] The Border Region Behavioral Health Center serves clients from Jim Hogg, Starr, Webb, and Zapata counties.

[227] The State of Texas's 2024 fiscal year is from September 1, 2023, through August 31, 2024.

[228] Additional data on the trend of ongoing treatment and crisis continuum Level of Cares enrollment for the Border Region's entire catchment area is available in Appendix F: Supplemental Prevalence & Utilization Data.

Figure 7 shows trends in the number of children and youth Tropical Texas served from FY 2019 to FY 2023. Between 2019 and 2021, the number of children and youth who received crisis services dropped by half, from 2,080 in 2019 to a low of 1,003 in 2021, likely influenced by disruptions from the COVID-19 pandemic. The number of children and youth receiving crisis services rebounded slightly in 2022 and 2023, reaching 1,446 by 2023.

The number of children and youth who received non-crisis (i.e., ongoing treatment and specialized services) declined by one-fourth from 8,936 in 2019 to a low of 6,854 unduplicated children and youth served in 2021. Since 2021, the number of children and youth served in non-crisis services has increased by around 400 patients annually.

The percentage of children and youth who received crisis services peaked at 19% (2,080 of 11,016 children and youth) of total patients served in 2019, then decreased to 13% in 2021 (1,003 of 7,857 children and youth; Figure 7). By 2023, crisis services represented 16% (1,446 of 9,051 children and youth) of the total services provided, reflecting a slight recovery after the pandemic's peak.

Figure 7: Trends in the Number of Children and Youth Served by Tropical Texas Behavioral Health (FY 2019–FY 2023)[229]

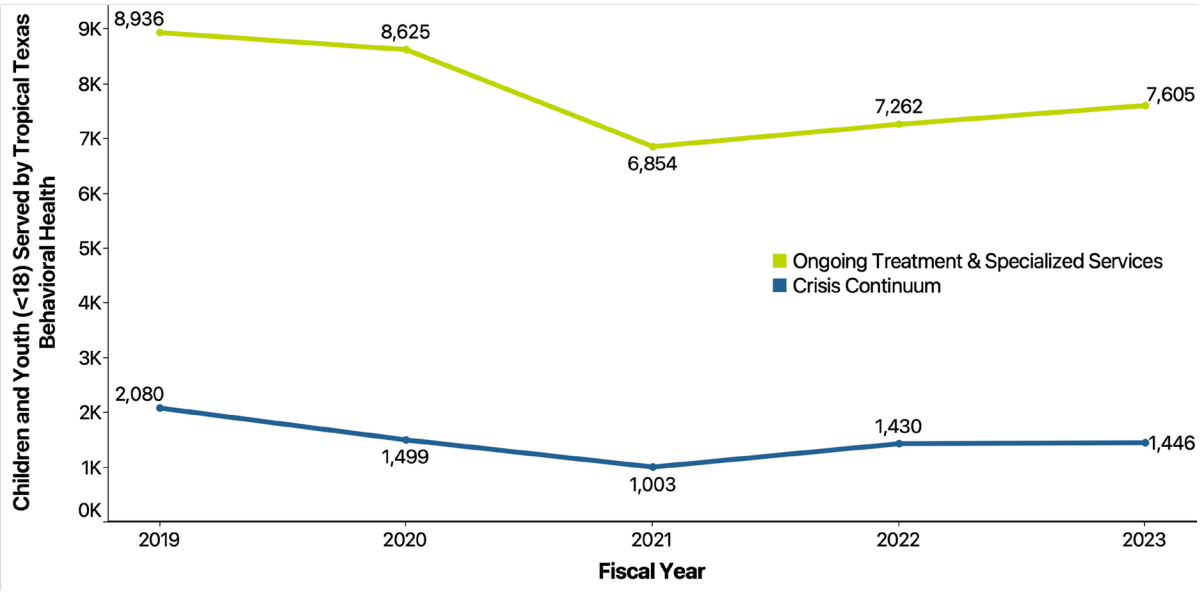


Figure 8 illustrates the number of adults Tropical Texas served, categorized by crisis status, from FY 2019 to FY 2023. The number of adults receiving crisis services gradually decreased annually, from 3,656 in 2019 to 2,951 in 2023, reflecting a decline of approximately 19%. In contrast, the number of adults receiving non-crisis services remained relatively stable over the same period.

[229] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.

This indicates that while the demand for non-crisis services remained consistent, fewer adults received crisis intervention services annually between 2019 and 2023.

Figure 8: Trends in the Number of Unduplicated Adults Served by Tropical Texas Behavioral Health (FY 2019–FY 2023)[230]

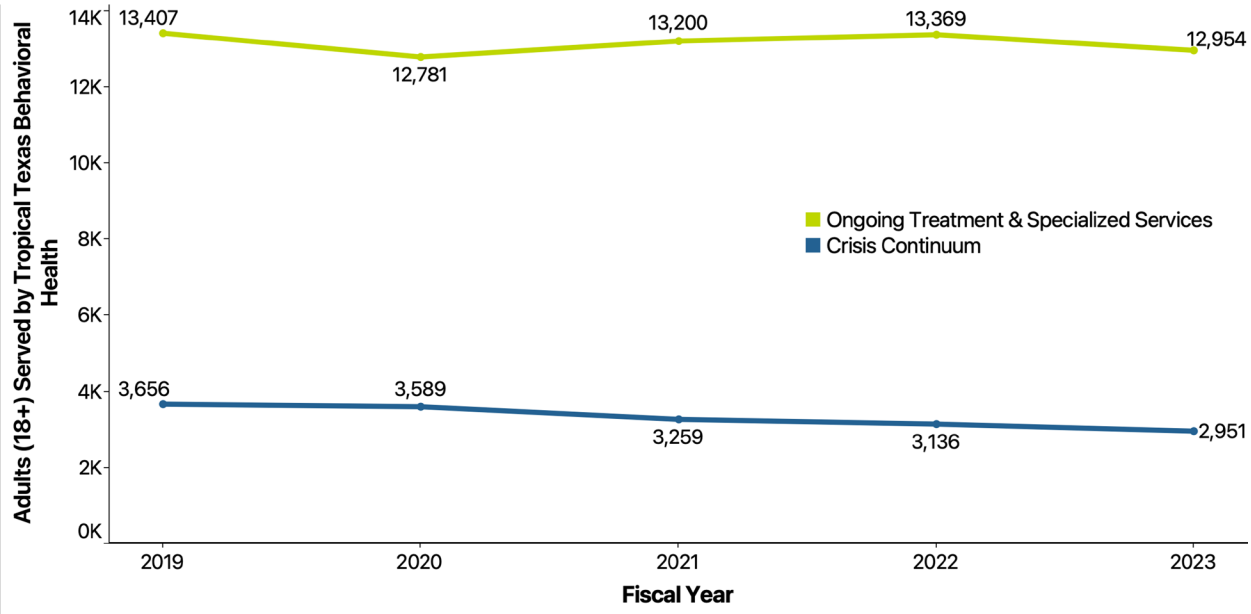


Table 30 compares utilization of crisis continuum Levels of Care at Tropical Texas in FY2023 with utilization at Border Region among Starr County residents in FY2024. Because these cross-LMHA comparisons reflect adjacent fiscal years, findings should be interpreted as directional rather than directly contemporaneous.

In FY 2024, 165 children and youth from Starr County received crisis services through Border Region, corresponding to nearly 12 individuals per 1,000 child and youth residents. The crisis service utilization rate among Starr County children and youth was more than double the rate observed among children and youth in Tropical Texas's catchment area (5.1 per 1,000 residents). Despite these differences in utilization, the two LMHAs demonstrated similar service compositions, with 15% of Starr County children and youth enrolled in crisis continuum LOCs, compared to 16% in Tropical Texas.

Adults at both LMHAs had lower utilization rates than children and youth across both crisis continuum and ongoing treatment LOCs. However, utilization rates among adults in Starr County remained approximately twice as high as those observed in the Tropical Texas service area. Similar to patterns among children and youth, service composition remained nearly identical across the two LMHAs, with 20% of Starr County adults enrolled in crisis continuum LOCs, compared to 19% in Tropical Texas.

[230] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.

Table 30: Ongoing Treatment, Specialized Service, and Crisis Continuum Level of Care Utilization at Tropical Texas Behavioral Health (FY 2023) and Starr County Residents Served by Border Region Behavioral Health Center (FY 2024)[231,232,233]

Ideal System Category	Tropical Texas Behavioral Health (FY 2023)[234]		Starr County (Border Region; FY 2024)[235]	
	Children/Youth	Adults	Children/Youth	Adults
Ongoing Treatment & Specialized Service	7,605	12,954	910	1,157
Per 1,000 Residents	*27.0*	*14.1*	*64.2*	*26.2*
Crisis Continuum	1,446	2,951	165	288
Per 1,000 Residents	*5.1*	*3.2*	*11.6*	*6.5*
Total	**19,051**	**15,905**	**1,075**	**1,445**
Per 1,000 Residents	***32.1***	***17.3***	***75.9***	***32.7***

Mobile Crisis Outreach Team Utilization

Tropical Texas and Border Region provided the Meadows Institute with mobile crisis outreach team (MCOT) activation data for fiscal year (FY) 2024. This section explores the monthly trends in crisis hotline calls and MCOT activations by age.[236] It also explores the intensity of calls and the county of residence of clients served. Although follow-up engagement data were unavailable for this report, both LMHAs indicated that providers conduct follow-up contacts after MCOT encounters.

Children and Youth Utilization

In FY 2024, Tropical Texas (all counties served) and Border Region (Starr County residents only) received nearly 3,300 child and youth crisis hotline calls, averaging 274 calls per month (Figure

[231] Data for Tropical Texas Behavioral Health reflect FY 2023, while data for Starr County residents served by Border Region Behavioral Health reflect FY 2024 due to differences in data availability. As a result, comparisons between LMHAs should be interpreted with caution, as they reflect adjacent fiscal years rather than the same reporting period. Differences may also reflect variations in data systems, reporting processes, and service capacity across LMHAs.

[232] Population data were obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[233] The utilization rates per 1,000 residents represents the number of residents aged six and 17 for children and youth, and the number of residents 18 and older for adults.

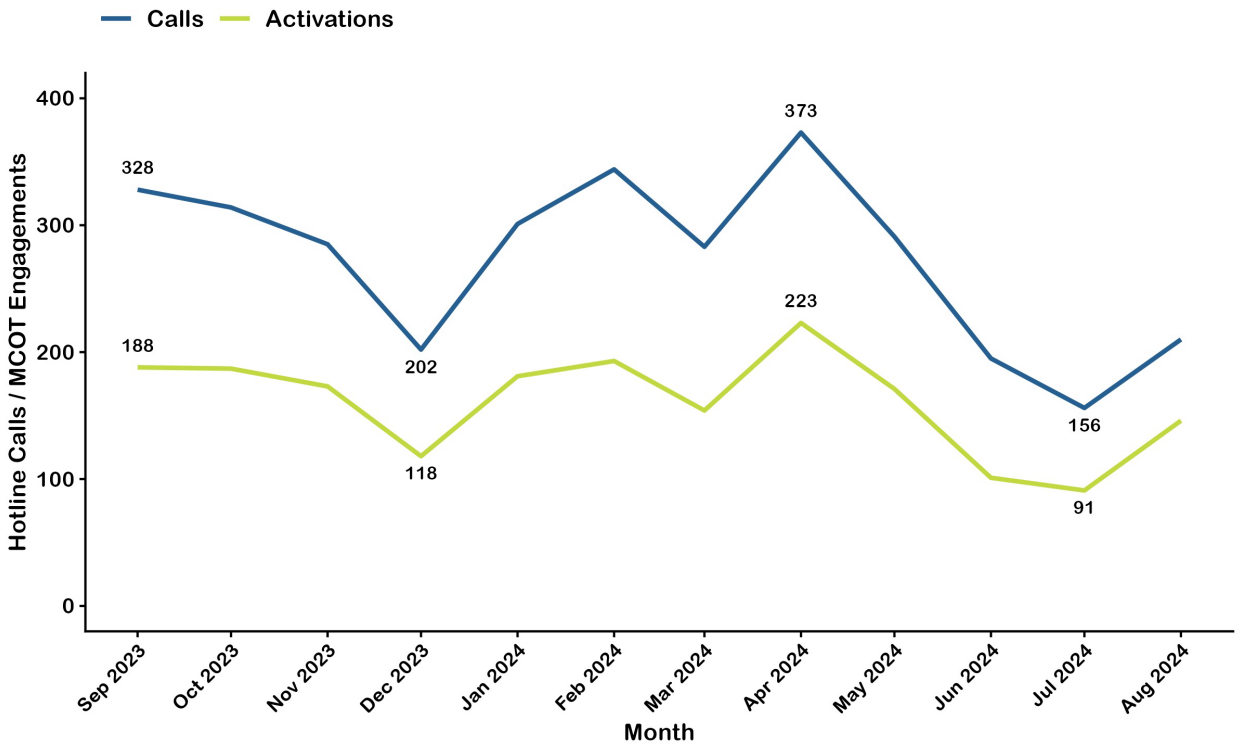
[234] Unduplicated level of care utilization data for Tropical Texas Behavioral Health was obtained from Texas Health and Human Services Commission and represent fiscal years 2023.

[235] Unduplicated level of care utilization data at the county level were requested directly from Border Region Behavioral Health Center to support analyses specific to Starr County. Border Region Behavioral Health Center. (April 13, 2026). *Border Region - Meadows Foundation Data v3.* Received from personal communication.

[236] Crisis Hotline calls ("calls") include all calls received by Tropical Texas and Boarder Region's 24-hour crisis line. MCOT activations occur when Crisis Hotline staff dispatch the MCOT team to respond to a potential mental health crisis in the community.

9). The MCOT team was activated (i.e., dispatched) in 1,926 cases (59% of calls). Call volume and activations decreased notably during school breaks, reaching their lowest point in July 2024, with just 156 calls and 91 activations. Regarding acuity, 46% of calls were classified as urgent, 16% as emergent, triggering MCOT activation,[237] and 8% were classified as routine.[238,239] Most calls and activations came from Hidalgo County (52% of calls; 47% of activations) and Cameron County (38% of calls; 39% of activations), while 8% of calls and 13% of activations were from Starr County, and 1% of calls and activations were from Willacy County.

Figure 9: Trend in Child- and Youth-Related Mobile Crisis Outreach Team Utilization – Tropical Texas Behavioral Health and Border Region Behavioral Health – Starr County (FY 2024)[240,241]



Adult Utilization

Tropical Texas (all counties served) and Border Region (Starr County residents only) received 11,164 adult-related crisis hotline calls in FY2024, averaging 930 calls per month (Figure 10).

[237] The crisis hotline activates the MCOT team when a case is classified as urgent or emergent.

[238] At Tropical Texas, urgent or emergent cases made up 62% of all cases, while MCOT activations accounted for 59% of calls. This difference reflects that multiple calls can relate to a single case's severity and that, in rare instances, the MCOT team does not activate after a case receives an urgent or emergent classification.

[239] Approximately 30% of calls were classified with an intensity of "other."

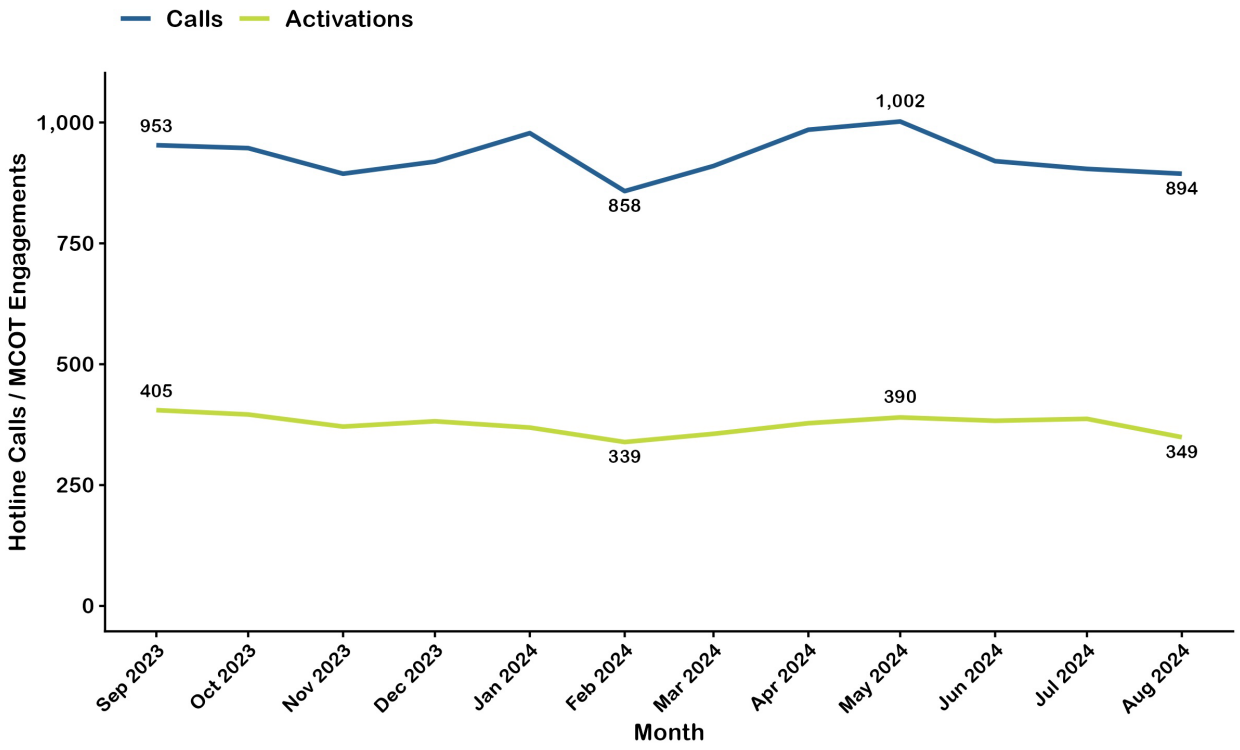
[240] Tropical Texas Behavioral Health. (2025, February 2). *Meadows Request2.xlsx* [Dataset]. Personal communication.

[241] Border Region Behavioral Health. (2026, April 13). *Border Region - Meadows Foundation Data v3.* Personal communication.

The MCOT team was activated in 4,505 cases (40%). In contrast to children and youth-related calls, adult-related calls showed no clear seasonal pattern.

Of all adult calls, 35% were classified as urgent, 9% as emergent, and 11% as routine. MCOT activations were less frequent among adults (40%) than among children and youth (59%), which may reflect differences in the distribution of call acuity between children/youth and adults. Most calls and activations came from Hidalgo County (59% of calls, 49% of activations) and Cameron County (37% of calls, 41% of activations). Starr County adults accounted for 4% of calls and 10% of activations, while Willacy County accounted for less than 1% of calls and activations.

Figure 10: Trend in Adult-Related Mobile Crisis Outreach Team Utilization – Tropical Texas Behavioral Health and Border Region Behavioral Health – Starr County (FY 2024)[242,243]



Emergency Department and Inpatient Hospital Utilization and Capacity

We analyzed emergency department (ED) encounters and inpatient admissions for regional residents and non-regional residents who used regional facilities to assess how these facilities are used for behavioral health services.[244] We obtained hospital records from the research-use Texas Health Care Information Collection (THCIC), maintained by the Texas Department of State

[242] Tropical Texas Behavioral Health. (2025, February 2). *Meadows Request2.xlsx* [Dataset]. Personal communication.

[243] Border Region Behavioral Health. (2026, April 13). *Border Region - Meadows Foundation Data v3.* Personal communication.

[244] "Behavioral health needs" refers to both mental health and substance use disorders.

Health Services, Center for Health Statistics.[245] This section includes data from calendar years (CY) 2020 to 2022 because the most up-to-date datasets available (2023 and 2024) redact patient and treatment information for mental health- and substance use-related encounters.[246,247] As a result, we were unable to identify the region's residents in the more updated datasets. Therefore, this analysis reflects the most recent complete picture available and should be interpreted as a baseline for understanding current system capacity and trends.

Emergency Department Utilization

This section provides an in-depth analysis of emergency department (ED) utilization for behavioral health encounters among residents of the region's counties. The analyses cover:

- The geographic distribution of EDs across the region,
- Trends in utilization by different age groups, and
- The primary payers for these encounters.

Overall, these data suggest that few of the region's residents used EDs outside of the region for behavioral healthcare, despite limited access to EDs among residents of Willacy and Starr counties. Behavioral health ED utilization by regional residents rose sharply from 2020 to 2022, surpassing statewide growth rates, pointing to gaps in accessible crisis services. In addition, four in ten resident adults used charity or indigent care to fund their ED encounters. Additional ED utilization data can be found in Appendix F.

Table 31 outlines the number of EDs in each county of the region in 2022. Of the 29 EDs operating in the region, 20 (69%) were in Hidalgo County, and eight (28%) were in Cameron County. The two least populated counties, Starr and Willacy counties, had only one and zero EDs, respectively.

[245] The THCIC comprises discharges from inpatient, emergency department, and outpatient services for hospitals operating throughout Texas and includes patient-level information about Texas residents and non-residents discharged from Texas hospitals. Each record included details on the client's age, length of stay, county of residence, hospital or facility name, diagnoses, and primary payer type, among other patient indicators, service provided, and facility information.

[246] Although the 2023 and 2024 Texas Health Care Information Collection (THCIC) Research Data Files are available, the Meadows Institute has been working with the Texas Department of State Health Services (DSHS) to remove unnecessary redactions that eliminate the ability to assess mental health *and* SUD service capacity for inpatient and emergency encounters. DSHS redacted these data based on its interpretation of the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2024 update to 42 U.S.C. § 290dd-2 and its implementing regulations (42 C.F.R. Part 2), which govern patient records related to substance use disorder (SUD) education, prevention, treatment, or rehabilitation in federally assisted programs. Included in these redactions are records' service dates, patient sex, and patient residency information, including county, ZIP code, and Census Block Group. DSHS has agreed to revise the data to remove redactions, but the Meadows Institute continues to await receipt of the 2023 and 2024 un-redacted data.

[247] See Appendix G for details on how COVID-19 impacted hospital utilization statewide.

Table 31: Number of Emergency Departments in the Region by County (2022)[248]

County	Number of Emergency Departments
Cameron County	8
Hidalgo County	20
Starr County	1
Willacy County	0
Total	**29**

Between 2020 and 2022, all regional EDs reported at least one patient encounter related to a primary behavioral health diagnosis. Resident adults had 36,854 primary behavioral health ED encounters, while children and youth had 4,871 encounters. Visits to facilities outside the region were rare, with 97% of resident adults and nearly 99% of children and youth receiving care at EDs within the region. Even residents of Willacy and Starr counties with limited or no local ED access seldom sought care outside the region.

Table 32: Primary Behavioral Health Emergency Department Encounters of Regional Residents by County of Residence and Age (2020 – 2022)[249,250,251]

	Entire Region	County of Residence			
		Cameron	Hidalgo	Starr	Willacy
Adults (18+)					
Encounters within region	35,838	9,728	24,132	1,554	424
Encounters outside region	1,016	318	620	63	15
Total	**36,854**	**10,046**	**24,752**	**1,617**	**439**
Children / Youth (<18)					
Encounters within region	4,805	1,091	3,498	166	50
Encounters outside region	<66	16	30	<10	<10
Total	**<4,871**	**1,107**	**3,528**	**<176**	**<60**

[248] Texas Hospital Association's Annual Survey of Hospitals (2020 - 2022). *Annual Survey of Hospitals*. Received from email communication on January 23, 2024.

[249] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[250] Data in this table is limited to patients listed as residents of the four Rio Grande Valley (RGV) counties. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request. All values between 1 and 9 are labeled as "<10" to protect confidentiality and may result in totals differing between tables.

[251] Behavioral health-related ED utilization by facility and year; and behavioral health-related ED utilization for transition-age youth and young adults (17-25) is available in Appendix F.

Table 33 compares trends in behavioral health-related ED use between regional residents and Texas residents. From 2020 to 2022, behavioral health-related ED visits among regional resident adults increased by 23%—from 10,619 to 13,120 encounters. Although this change is likely attributable to the post-COVID-19 recovery,[252] it was three times the statewide rate (8%) increase and remained stable when adjusted for population size.

Behavioral health-related ED utilization among the region's children and youth grew more rapidly than among adults, rising 39% from 1,326 encounters in 2020 to 1,840 in 2022. While the region and statewide encounter rates were similar in 2020, by 2022, the regional rate had risen to 434 per 100,000—well above the statewide rate of 375 per 100,000. While the region and statewide encounter rates were similar in 2020, by 2022, the regional rate had risen to 434 per 100,000—well above the statewide rate of 375 per 100,000.

Table 33: Trend in Behavioral Health Emergency Department Encounters Among Regional and Texas Residents by Age (2020 – 2022)[253,254]

Region		2020	2021	2022
Adults (18+)				
Regional Residents	**Behavioral Health Encounters**	**10,619**	**13,115**	**13,120**
	Encounters Per 100,000 Residents	1,138	1,399	1,375
Texas Residents	**Behavioral Health Encounters**	**278,164**	**301,298**	**301,692**
	Encounters Per 100,000 Residents	1,309	1,407	1,381
Children / Youth (<18)				
Regional Residents	**Behavioral Health Encounters**	**1,343**	**1,661**	**1,855**
	Encounters Per 100,000 Residents	308	382	434
Texas Residents	**Behavioral Health Encounters**	**22,677**	**27,049**	**27,741**
	Encounters Per 100,000 Residents	307	363	375

Figure 11 depicts the payer mix for statewide behavioral health-related ED encounters by regional residents. Two-thirds of children and youth encounters were funded through Medicaid (67%) and 25% were funded by commercial insurance. Among adults aged 18–64, uninsured patients (identified as "self-pay"),[255] represented the largest share of behavioral health-related ED visits (39%) followed by patients with commercial insurance (25%). Medicare was the

[252] Appendix G provides the monthly trend in RGV residents' behavioral health-related ED utilization for a more granular analysis of the COVID-19 pandemics impact on utilization.

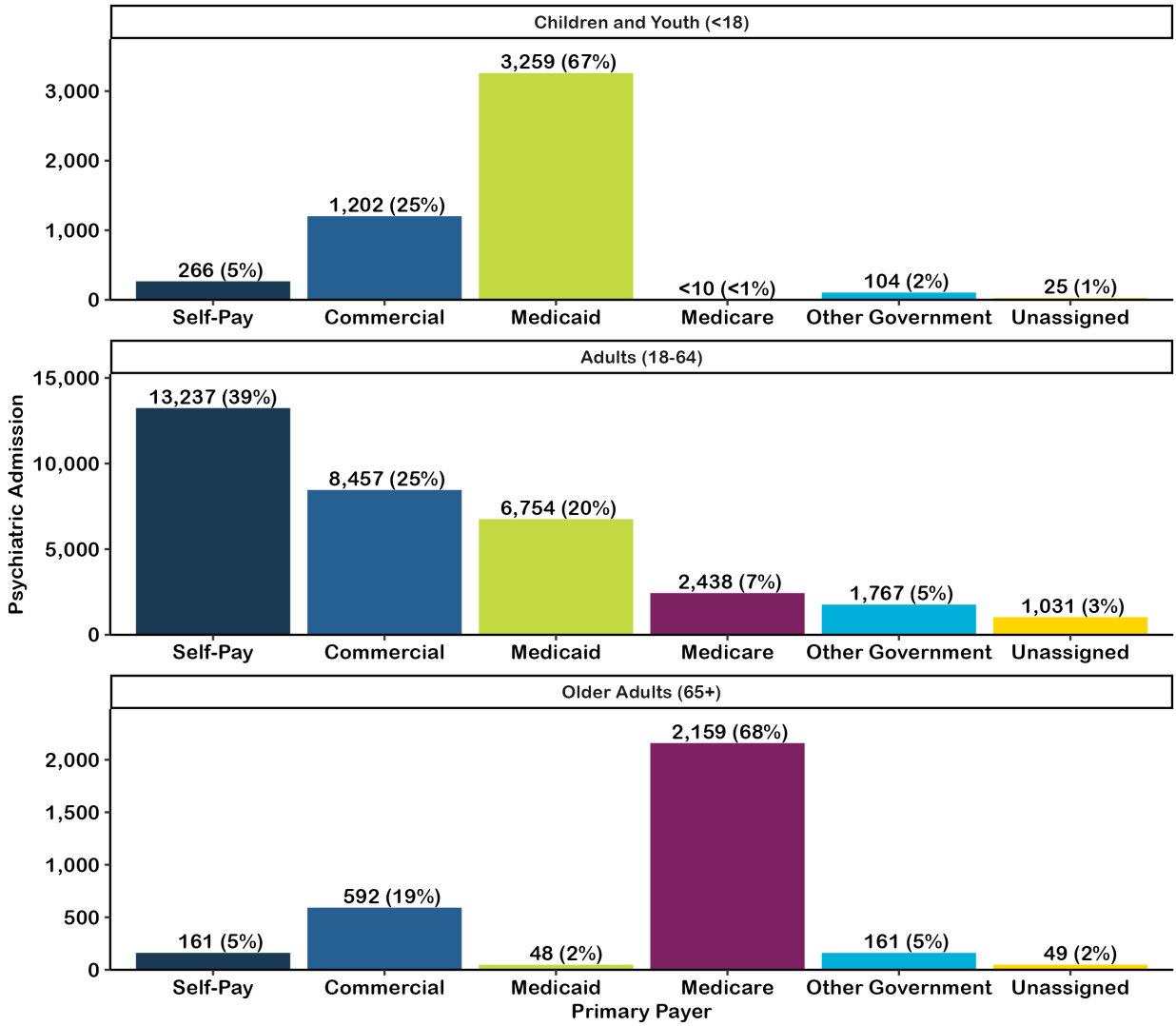
[253] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[254] Data in this table includes encounters across all Texas emergency departments. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request. All values between 1 and 9 are labeled as "<10" to protect confidentiality and may result in totals differing between tables.

[255] Self-pay includes charity, indigent, and "unknown" code ZZ payers.

predominant payer for older adults (65+), covering 68% of behavioral health-related ED encounters. Given that four in ten regional resident adults used charity or indigent care to pay for their ED encounters, the region may have a need for regional safety net hospital providers or facilities.

Figure 11: Regional Residents Primary Payer Used in Primary Behavioral Health Emergency Department Encounters Across the State – All Ages (2020 – 2022)[256,257,258]



[256] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[257] Data in this figure is limited to patients listed as residents of the Rio Grande Valley counties. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request. All values between one and nine are labeled as "<10" to protect confidentiality and may result in small discrepancies across tables.

[258] "Unassigned" payers are payment sources that are not easily collapsed into the other categorized shown in this Figure. Examples include 'automobile medical,' 'Title V,' and 'Indemnity Insurance.' Self-pay includes charity, indigent, and "unknown" payers.

Inpatient Utilization

This section provides an overview of inpatient psychiatric care utilization in the region, focusing on trends in bed availability, admissions, and patient demographics. It examines local and out-of-region psychiatric care, primary payers, and compares the region's psychiatric bed admissions to statewide admissions. Key figures and tables illustrate trends over time, including admission rates, average length of stay, and the geographic distribution of psychiatric care, offering a clear picture of inpatient psychiatric services in the region. Additional data on psychiatric bed admissions are available in Appendix F.

Our findings suggest the region has sufficient inpatient (non-state hospital) psychiatric beds to treat residents. The state hospital, the Rio Grande State Center, operated at over 80% of its capacity in 2021, indicating a possible need for additional state hospital beds with population growth. This is especially the case for pediatrics, as the state hospital does not have pediatric beds to provide local care to resident children and youth.

Psychiatric admissions among regional resident children and youth were notably higher per capita than the statewide average, with one-third readmitted between 2020 and 2022. These patterns indicate a need for state funded mental health beds that provide longer term care, stronger regional step-down care, and resource linkage options.

In 2022, the region had 19 hospitals; of those, 18 were in Cameron or Hidalgo counties. Three hospitals in Cameron County and two hospitals in Hidalgo County included dedicated psychiatric units. Additionally, three hospitals offered pediatric psychiatric units—one in Cameron County and two in Hidalgo County.[259]

Table 34: Number of Hospitals in the Region with Psychiatric Units by County (2022)[260]

County	Total Hospitals	Number of Psychiatric Units	Number of Pediatric Psychiatric Units	Number of Facilities with Psychiatric Units *and* Pediatric Psychiatric Units
Cameron County	9	3	1	1
Hidalgo County	9	2	2	2
Starr County	1	0	0	-
Willacy County	0	-	-	-
Total	**19**	**5**	**3**	**3**

Table 35 presents the count of psychiatric beds in the region by facility, as reported in the 2020-2022 Texas Hospital Association surveys. Over the three calendar years, the total number of psychiatric beds remained consistent at 372 available beds, with 107 (29%) designated for

[259] The hospitals that have pediatric psychiatric inpatient beds also have adult psychiatric inpatient beds.
[260] Texas Hospital Association's Annual Survey of Hospitals (2020 - 2022). *Annual Survey of Hospitals*. Received from email communication on January 23, 2024.

pediatric psychiatric care. Compared to the state average, the region had slightly fewer psychiatric beds per 100,000 residents—26.6 beds in the region versus 29.5 statewide. The facility with the highest bed capacity was South Texas Health System – McAllen (124 beds), followed by Palms Behavioral Health and Doctors Hospital-Renaissance with 94 and 87 beds, respectively. Additionally, the Rio Grande State Center in Cameron County offers 55 psychiatric beds, though none are dedicated to pediatrics.

Table 35: Trend in Psychiatric Beds in the Region by Hospital (2020 – 2022)[261]

Hospital	County	City	Number of Beds		
			2020	2021	2022
All Psychiatric Beds					
South Texas Health System	Hidalgo	McAllen	124	124	124
Palms Behavioral Health[262]	Cameron	Harlingen	94	94	94
Rio Grande State Center[263]	Cameron	Harlingen	55	55	55
Valley Baptist Medical Center	Cameron	Harlingen	12	12	12
Doctors Hospital - Renaissance	Hidalgo	Edinburg	87	87	87
Total			**372**	**372**	**372**
Pediatric Psychiatric Beds					
South Texas Health System	Hidalgo	Edinburg	40	40	40
Palms Behavioral Health	Cameron	Harlingen	28	28	28
Doctors Hospital at Renaissance	Hidalgo	Edinburg	39	39	39
Total			**107**	**107**	**107**

To assess whether the region has sufficient inpatient capacity to serve residents in need of inpatient psychiatric care, we examined:

1. The county of residence for patients admitted to regional psychiatric beds. In a related analysis, we examined the use of non-regional psychiatric beds by regional residents. If the flow of patients out of the region is substantially greater than the flow in, there may be a lack of local beds.
2. Then, we compared daily inpatient utilization to the reported staffed bed capacity for each regional hospital. This approach identifies hospitals operating above capacity or under capacity, relative to need. Prolonged operation at or above capacity may indicate insufficient capacity to meet need.

[261] Hospital capacity data was obtained from the Texas Hospital Association's Annual Survey of Hospitals (2020 - 2022). *Annual Survey of Hospitals*. Received from email communication on January 23, 2024.
[262] The Meadows Institute classified all beds at Palms Behavioral Health as psychiatric due to its psychiatric license and quality concerns with the THA's "Beds for Psychiatric Care" data. Beyond psychiatric care, the facility's THA records did not list other specialty care beds.
[263] The Meadows Institute classified all beds at the Rio Grande State Center as psychiatric due to its psychiatric license. Beyond psychiatric care, the facility's THA records did not list other specialty care beds.

This analysis provides additional context for psychiatric bed needs in the region. Residents' frequent use of psychiatric beds outside of the region may indicate insufficient local capacity to serve residents. Findings from our analysis suggest that the region has sufficient inpatient non-state hospital psychiatric beds to treat residents. However, additional state hospital bed capacity may be needed, particularly for children and youth who currently do not have access to local state hospital beds. As shown in Table 36, below, nearly all (97-98%) regional residents were admitted to local psychiatric beds for care, and non-regional residents represented more than one in ten psychiatric admissions. All non-state hospital facilities operated below 75% of their capacity. The state hospital, the Rio Grande State Center, operated at over 80% of its capacity in 2021 (see Figure 12 and Appendix Table F22), indicating a possible need for additional state hospital beds with population growth.[264] This is especially the case for pediatrics, as the state hospital does not have pediatric beds to provide local care to children and youth.

Table 36 details psychiatric inpatient admissions for regional residents by age group between 2020 and 2022. Adults (18+) accounted for 16,630 psychiatric bed admissions; children and youth (<18) for 9,306. However, residents of Starr and Willacy counties, which lack psychiatric beds, were slightly more likely to seek care outside the region (11% of Starr County and 7% of Willacy County resident admissions occurred outside the region). Bexar, Harris, and Nueces counties were the primary destinations of regional residents' out-of-region psychiatric bed admissions, collectively accounting for 73% of these admissions.[265]

Table 36: Admissions to Psychiatric Beds by County of Residence and Age Among Regional Residents – Statewide (2020 – 2022)[266,267,268]

	Entire Region	County of Residence			
		Cameron	Hidalgo	Starr	Willacy
Adults (18+)					
Admissions within region	16,191	4,085	11,353	585	168
Admissions outside region	439	150	192	87	10

[264] The 88th Texas Legislature approved $15 million to expand the Rio Grande State Center in Harlingen to include an additional 50 maximum security beds on campus. These beds are projected to come online in 2027. Changes to Texas State Hospitals. (2026). https://www.hhs.texas.gov/about/process-improvement/improving-services-texans/changes-texas-state-hospitals

[265] See Appendix F for more details on out-of-region psychiatric bed admissions.

[266] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[267] Data in this table is limited to patients listed as residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to observed billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. All values between 1 and 9 are labeled as "<10" to protect confidentiality.

[268] Psychiatric bed utilization by facility and year, and behavioral health-related ED utilization for transition-age youth and young adults (17-25) is available in Appendix F.

	Entire Region	County of Residence			
		Cameron	Hidalgo	Starr	Willacy
Total	**16,630**	**4,235**	**11,545**	**672**	**178**
Children / Youth (<18)					
Admissions within region	9,189	2,095	6,726	285	83
Admissions outside region	<117	25	57	25	<10
Total	**<9,306**	**2,120**	**6,783**	**310**	**<93**

As shown in Table 36 above and Table 37 below, substantially more patients from outside the region were admitted to psychiatric beds within the region than residents were admitted to out-of-region facilities—indicating a net inflow of patients due to a bed surplus. From 2020 to 2022, regional hospitals admitted 3,739 adults and 1,282 children and youth from outside the region, representing 19% of adult and 12% of child and youth psychiatric admissions, respectively. Most patients from outside the region were from neighboring South Texas counties that have no inpatient psychiatric beds. These admissions were rarely to the Rio Grande State Center; Palms Behavioral Health accounted for over 50% of non-resident admissions, South Texas Health System for 25%, and Doctors Hospital-Renaissance for 22%.[269]

Table 37: Admission to Regional Hospitals' Psychiatric Beds by Patient Residency and Age (2020 – 2022)[270,271]

Residency	Admissions to Regional Psychiatric Beds
Adults (18+)	
Regional Residents	16,191
Non-Regional Residents	3,739
Total	**19,930**
Children / Youth (<18)	
Regional Residents	9,189
Non-Regional Residents	1,282
Total	**10,471**

[269] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[270] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[271] Data in this table is limited to patients admitted to facilities in the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are reported as "<10" to protect patient confidentiality.

Table 38 displays psychiatric admission trends for regional residents and residents statewide. Between 2020 and 2022, psychiatric admissions for adults remained relatively stable in the region and across Texas, with admission rates per 100,000 residents declining by 4–5%.

In contrast, psychiatric admissions among the region's children and youth increased by nearly 20%, outpacing the statewide increase of 15%. Despite a shorter average length of stay, regional resident children and youth consistently had higher admission rates than the state. In 2022, the region's rate reached 782 admissions per 100,000 compared to the statewide average of 672. Notably, about one-third of regional children and youth admitted during this period were re-admitted to a psychiatric bed.[272] The high rate of psychiatric bed utilization and re-admission by regional children and youth suggests a need for state funded mental health beds that provide longer term care and for the region to develop stronger step-down care and resource linkage options.

Table 38: Trend in Psychiatric Bed Admissions Among Regional and Texas Residents by Age (2020 – 2022)[273,274]

Residency		2020	2021	2022	Average LoS (Days)
Adults (18+)					
Regional Residents	**Psychiatric Bed Admission**	**5,629**	**5,529**	**5,472**	**7.7**
	State Hospital Admissions	437	427	369	35.1
	Admission Per 100,000 Residents	603	590	574	-
Texas Residents	**Psychiatric Bed Admission**	**132,211**	**132,439**	**130,887**	**9.2**
	State Hospital Admissions	3,016	2,933	1,934	74.7
	Admission Per 100,000 Residents	622	618	599	-
Children / Youth (<18)					
Regional Residents	**Psychiatric Bed Admission**	**2,805**	**3,151**	**3,341**	**5.3**
	State Hospital Admissions	<10	<10	<10	167.0
	Admission Per 100,000 Residents	644	724	782	-
Texas Residents	**Psychiatric Bed Admission**	**43,280**	**51,452**	**49,731**	**8.3**
	State Hospital Admissions	430	435	320	77.4
	Admission Per 100,000 Residents	586	691	672	-

The number of inpatient beds available to the region's residents appears to be sufficient to support regional residents' demand for inpatient (non-state hospital) psychiatric beds. Figure

[272] Texas Health Care Information Collection (THCIC) 2020 to 2022 discharge records.

[273] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[274] Data in this table includes admissions to psychiatric beds across Texas. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to observed billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. All values between 1 and 9 are labeled as "<10" to protect confidentiality.

12 displays the region's psychiatric bed occupancy and capacity levels by day at each of the five regional hospitals with psychiatric units (see Appendix F for details on the average daily census). Between 2020 and 2022, all psychiatric units, except the Rio Grande State Center state hospital, operated below 75% of capacity – a functional operational capacity rate. With the addition of the 100-bed behavioral health hospital in Pharr, scheduled to open in summer 2026,[275] residents of the region should have ample non-state hospital inpatient psychiatric capacity.

The Rio Grande State Center, the region's state hospital, had the highest utilization, averaging 83% of its capacity in 2021 and sustaining a high daily census in 2022 (72% of beds were occupied on any given day).[276] Despite the facility's high operating capacity, nearly all (97%) regional residents admitted to state hospitals were admitted to the Rio Grande State Center.[277] The 88th Texas Legislature funded an expansion of the Rio Grande State Center to add 50 forensic maximum-security beds,[278] which will likely bring an influx of non-resident patients into the region for maximum-security state hospital services. As of April 2024, three-fourths of the Rio Grande State Center's capacity was dedicated to adult civil beds,[279] meaning that the children and youth who need state hospital services must continue to rely on alternative local services, and in rare cases, travel outside of the region to access state hospital beds.[280]

[275] DHR Health. (November 12, 2024). *DHR Health to build new behavioral health hospital in City of Pharr.* Retrieved on April 15, 2025 from https://www.dhrhealth.com/news-stories/dhr-health-to-build-new-behavioral-health-hospital-in-city-of-pharr/

[276] Rio Grande State Center's 2022 average daily census is low in the 2022 THCIC discharge records, given that patient admissions are not reported to the State until patients are discharged. Many patients admitted to the Rio Grande State Center in 2022, especially patients admitted in quarter four, are not yet recorded in the data.

[277] Texas Health Care Information Collection (THCIC) 2020 to 2022 discharge records. See Appendix F.

[278] Office of the Governor. (June 20, 2024). *Governor Abbott announces seven new state hospital projects*. https://gov.texas.gov/news/post/governor-abbott-announces-seven-new-state-hospital-projects.

[279] Texas Health and Human Services Commission. (April 24, 2024). *Personal communication.*

[280] Fewer than ten children and youth RGV residents were admitted to a state hospital between 2020 and 2022. See Appendix F.

Figure 12: Admissions to Psychiatric Units in Regional Hospitals Over Time – All Ages (January 2020–December 2022)[281,282,283]

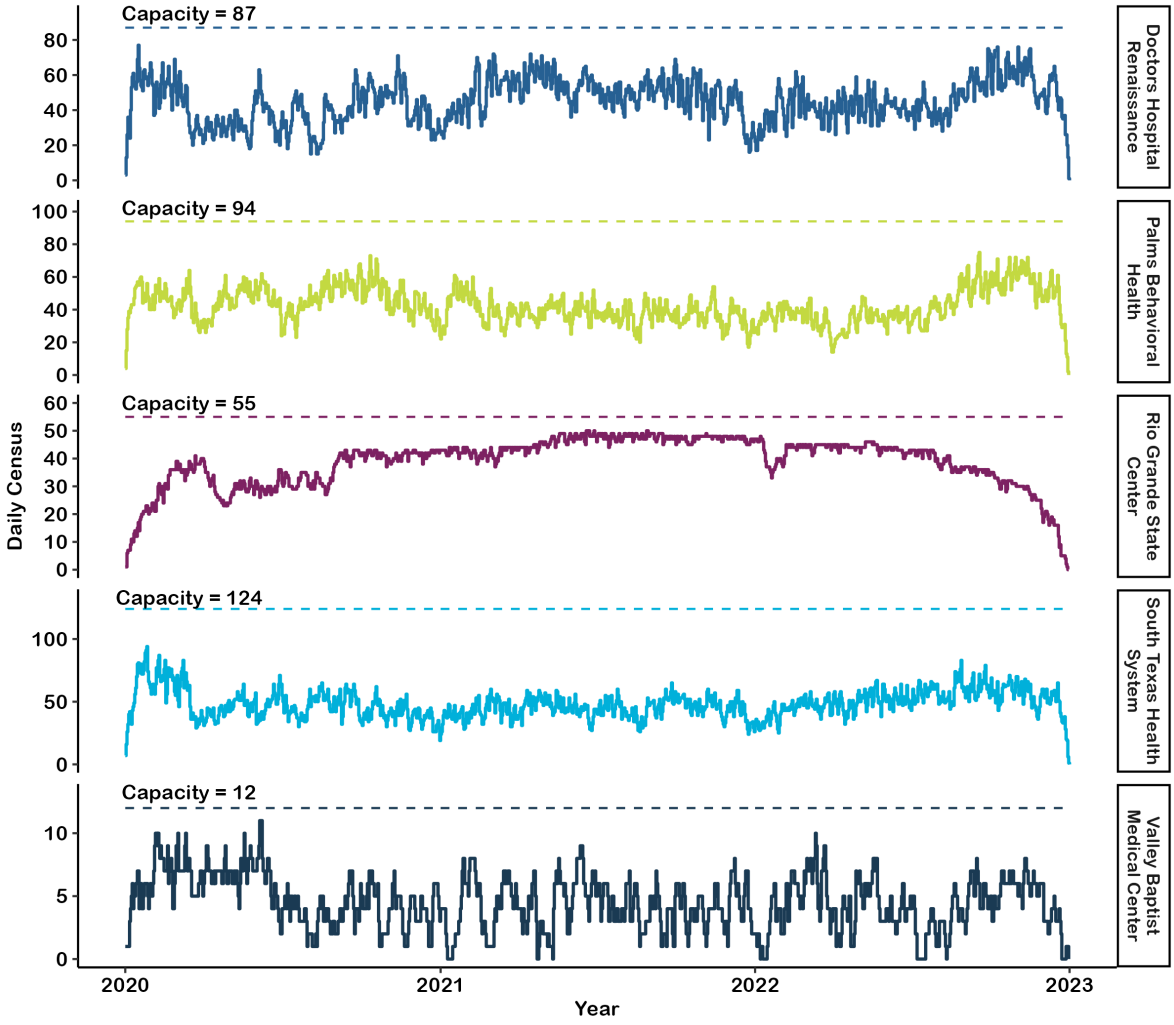


Figure 13 displays the primary payers for non-state hospital psychiatric admissions by regional residents statewide.[284] Commercial insurance, including Children's Health Insurance Program (CHIP) and other non-Medicare Health Maintenance Organization plans, covered approximately two-thirds of admissions for children and youth, with Medicaid covering an additional one-third of encounters. Among adults aged 18-64, commercial insurance was the primary payer for 60% of admissions, followed by Medicare and Medicaid (covering 13% and 10%, respectively).

[281] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

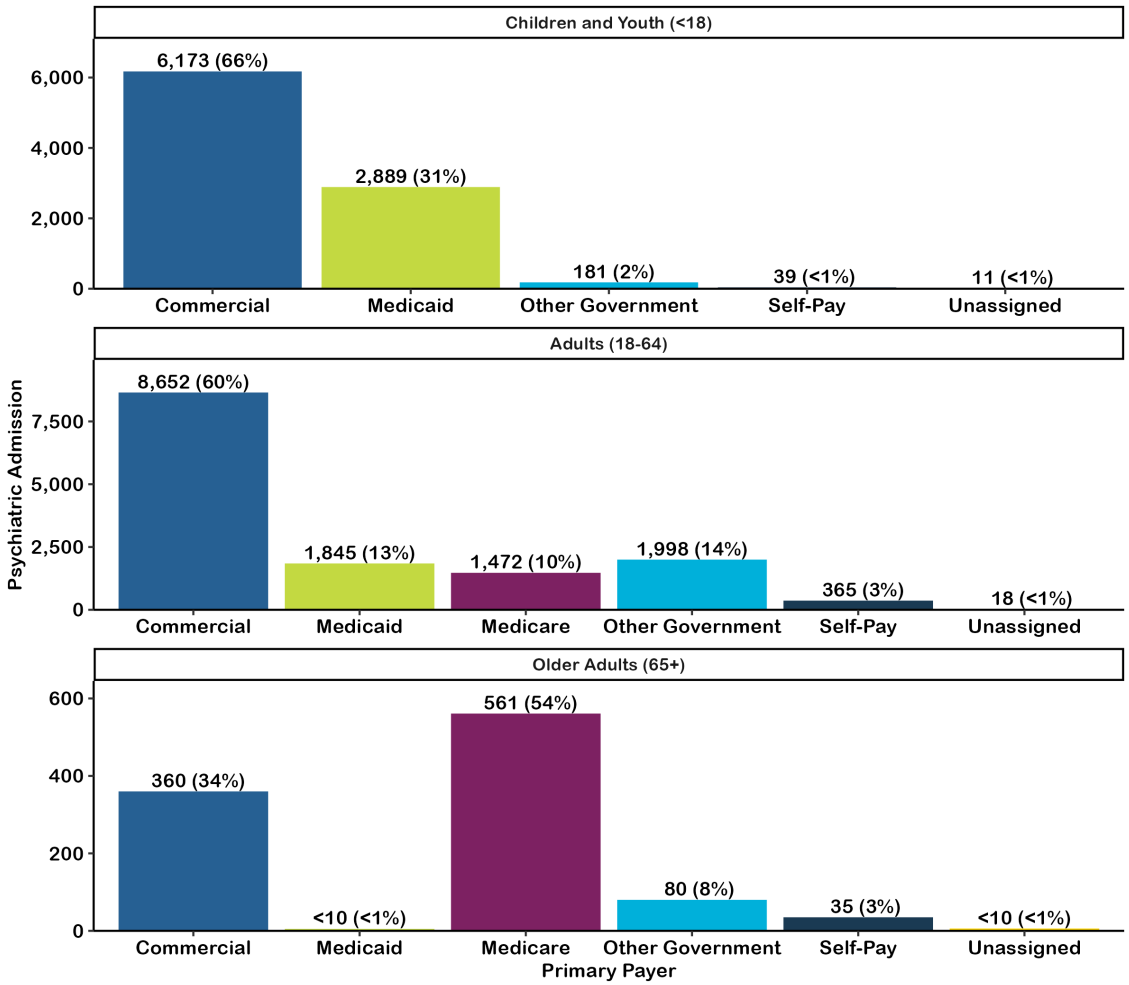
[282] Data in this figure is limited to patients listed as vising facilities Rio Grande Valley counties, regardless of their county of residence. Record counts include psychiatric specialty encounters identified by THCIC billing data. Due to billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters.

[283] Additional data on hospital capacity are available in Appendix F.

[284] All state hospital admissions' primary payer are listed as "self-pay."

Medicare was the leading payer for older adults, covering 54% of admissions, followed by commercial insurance at 34%. The rarity of charity or indigent care (i.e., self-pay) in inpatient psychiatric stays compared to its prevalence in behavioral health-related ED visits is driven by Tropical Texas's ability to provide funding mechanisms for these patients and does not reflect a barrier for the uninsured to receive inpatient psychiatric care.

Figure 13: Regional Residents Primary Payer Used in Psychiatric Bed Admission Across the State, Excluding State Hospitals – All Ages (2020 – 2022)[285,286,287,288]



[285] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[286] Data in this figure is limited to patient residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified using the THCIC billing data. Due to observed billing data quality concerns at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis and all state hospital admissions were considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

[287] All State hospital admissions are classified as having a self-pay primary payer in the THCIC.

[288] Commerial payers include non-Medicare Health Maintenance Organization plans. Unassigned refers to payment sources such as 'automobile medical,' 'Title V,' and 'Indemnity Insurance.' Self-pay includes charity, indigent, and "unknown" payers.

Regional Crisis Services

Across all four counties, multiple mental health providers, along with local emergency response, operate programs as part of the continuum of crisis services. Although Tropical Texas and Border Region are the primary providers of community-based mental health crisis response services, there are many other organizations involved in the community's response to mental health crises. In Table 39, below, we provide the full continuum of services and note who provides the services. The table also shows the gaps in services available in an ideal system.

Table 39: Continuum of Crisis Services in an Ideal System, Services Available in the Region

Continuum of Crisis Services in an Ideal System, Services Available in the Region				
Program or Service	**Provider**	**County**	**Children and Youth**	**Adult**
24/7 Crisis Hotline	Border Region	Starr	√	√
	Tropical Texas Behavioral Health (Tropical Texas)	Cameron, Hidalgo, Willacy		
	Vaqueros	UTRGV		
Mental Health Integration with 9-1-1 Response (co-mobilization with mental health deputies)	Border Region	Starr		
	Tropical Texas-Mental Health Officer Team (MHOT)	Cameron, Hidalgo, Willacy	√	√
Multi-Disciplinary Response teams (MDRT)	Tropical Texas	Hidalgo		√
Crisis Intervention Training (CIT)	Border Region	Starr	√	√
	Tropical Texas	Cameron, Hidalgo, Willacy		
Mobile Crisis Outreach Teams (MCOT)	Border Region	Starr	√	√
	Tropical Texas	Cameron, Hidalgo, Willacy		
Youth Mobile Outreach Teams (YCOT)	Border Region	Starr	√	
Peer Crisis Services	Tropical Texas	Cameron, Hidalgo, Willacy		√

Continuum of Crisis Services in an Ideal System, Services Available in the Region				
Program or Service	**Provider**	**County**	**Children and Youth**	**Adult**
Walk-In Crisis Center	Tropical Texas	Cameron, Hidalgo, Willacy		√
Crisis Transportation	Border Region	Starr	Through Border Region YCOT	Through MCOT
	Tropical Texas	Cameron, Hidalgo, Willacy		
Crisis Telehealth Services	Border Region	Starr		√
	Tropical Texas	Cameron, Hidalgo, Willacy		
	Starr Regional Medical Center	Starr		
	The Wood Group	Cameron		
Crisis Respite	Border Region	Starr		√
	Tropical Texas	Cameron, Hidalgo, Willacy		
	The Wood Group	Cameron		
Short-Term Crisis Residential	Doctors Hospital at Renaissance (DHR)	Hidalgo	√	√
	Palms Behavioral Health	Cameron		
	South Texas Behavioral	Hidalgo		
Psychiatric Emergency Centers	Doctors Hospital at Renaissance (DHR)	Hidalgo	√	√
	South Texas Health System	Hidalgo		
Hospital Emergency Departments	Cornerstone Regional Hospital	Hidalgo		√
	Doctors Hospital at Renaissance (DHR)	Hidalgo	√	√
	Driscoll Children's Hospital	Hidalgo	√	
	Knapp Medical Center	Hidalgo	√	√

Continuum of Crisis Services in an Ideal System, Services Available in the Region				
Program or Service	**Provider**	**County**	**Children and Youth**	**Adult**
	Mission Regional Medical Center	Hidalgo		√
	Rio Grande Regional Hospital	Hidalgo	√	√
	South Texas Health System	Hidalgo		
	Starr County Memorial Hospital	Starr	√	√
	Valley Baptist Health System	Cameron, Hidalgo	√	√
	Valley Regional Medical Center	Hidalgo	√	√
Inpatient Services	Doctors Hospital at Renaissance (DHR)	Hidalgo	√	√
	Valley Baptist Health System	Cameron, Hidalgo		√ (Geriatric)
	Palms Behavioral Health	Cameron	√ (12+)	√
	South Texas Health System	Cameron, Hildalgo, Willacy		√

At each entry point, a crisis assessment is conducted to assess the acuity level of the person in crisis. Rather than a standardized community assessment protocol, each system utilizes an internal instrument and protocol. The optimum outcome is that the crisis is resolved prior to moving to the next restrictive level of care. However, if the crisis cannot be resolved, the patient will be connected to the next level of intervention, whether that be contact with law enforcement, a crisis worker, an emergency department exam, or inpatient hospitalization.

Spotlight: The Wood Group Crisis Respite Unit

In partnership with Tropical Texas Behavioral Health, The Wood Group operates a crisis respite unit (CRU) that provides short-term housing for adults experiencing a behavioral health crisis or transitioning from inpatient care. The CRU offers nine beds and is staffed 24/7 to ensure continuous support. This service is designed for people who do not meet inpatient admission criteria but still require stabilization in a safe, structured environment. Services include psychosocial programming, daily observation, and medication support. The CRU plays a vital role in the local crisis continuum, offering an alternative to hospitalization and a bridge back to community living.

Spotlight: Border Region Behavioral Health Center's Youth Crisis Outreach Team

Border Region's YCOT began providing services in August 2024; between then and January 31, 2025, they served 190 youth. Border Region's YCOT program has been exemplary in prioritizing family- and community-based care, reflected through their outcomes. They have built meaningful community partnerships with local school districts, emergency departments, the juvenile justice system, and psychiatric hospitals.

Recommendations for Crisis Care Services

Rec. 1	**The most recent Texas Legislature expanded funding for Youth Crisis Outreach Teams (YCOT). Tropical Texas should pursue this expanded state funding for a youth crisis outreach team program when it becomes available.**

Youth crisis outreach teams (YCOTs) are mobile community-based teams that employ specialized, trauma-informed interventions and strategies not only to de-escalate a child in crisis but to support families during emerging crises and remain available for continued support up to 90 days. During this time, they support the family in safety planning, help build skills to prevent future crises and connect the family with the community mental health resources needed to address their needs long-term. In states with well-developed YCOT-like programs, up to 81% of youth with high needs avoided out-of-home placement, including inpatient hospitalization, when instead referred to youth mobile response. See Appendix O for additional information on YCOT programs.

While some of the counties in the region newly have YCOTs, Hidalgo, Cameron, and Willacy counties deploy mobile crisis outreach teams (MCOT) to crises involving children and youth. The MCOT model, however, was developed based on an understanding of crisis in adults and employs best practices for adults in crisis. Tropical Texas has made exemplary efforts to ensure that their MCOT is responsive to the needs of youth, including ensuring that MCOT providers are trained to respond to crisis in children and youth and that children and youth have access to MCOT services around the clock. YCOTs, however, offer a more developmentally appropriate crisis response specific to children, youth, and their families and represent an opportunity to further enhance the crisis response options for youth in the region.

Understanding the critical need to better address rising rates of child and youth behavioral health needs, the Texas State Legislature made a landmark investment with an appropriation of $14 million during the 88th Legislative Session (2023) to establish the first-ever YCOT programs in Texas. Initial YCOT funding allowed the establishment of eight teams across the state, including one with Border Region, which serves children and youth across their catchment (including Starr County).

Through appropriations made in the recently concluded 89th legislative session, the state is expanding its support for YCOT with $54 million in funding for the FY 2026/2027 biennium. This increase of $40 million from the previous biennium offers a tremendous opportunity for the expansion of YCOT. Given their strong community partnerships and children's services division, as well as the fact that 25-30% of crisis calls to Tropical Texas are for youth, we recommend

they pursue this funding when it becomes available, and they have indicated intent to do so. We recommend Tropical Texas request the highest funding level possible so they can establish a YCOT program with adequate staff levels to meet local demand and operate YCOT for as many hours as possible. (Due to funding constraints, most YCOTs currently limit their operations to eight to ten peak hours per day.)[289]

Rec. 2	**To strengthen the county's crisis response, Starr County should implement a mental health emergency telehealth response program.**

To enhance law enforcement's ability to respond to behavioral health emergencies in a timely, cost-effective, and clinically appropriate manner, Starr County should implement a mental health emergency telehealth response program. With only one emergency department in the county, and no on-staff psychiatrist, current systems are overburdened during behavioral health crises. Jurisdictional challenges and the absence of a dedicated crisis response team within the law enforcement systems further delay access to care, leaving police and EMS to manage complex situations without clinical support, often resulting in emergency room encounters. From 2020 to 2022, Starr County saw 1,554 emergency department visits for adults and 166 for children and youth due to behavioral health emergencies—all that were managed without on-site behavioral health support. A mental health emergency telehealth response program offers Starr County an innovative, cost-effective, and scalable solution to expand its behavioral health crisis response capacity and better serve its residents.

While MCOT and YCOT provide important services, there are still situations where a law enforcement or EMS response is requested or required, such as when there is a public safety risk or the crisis occurs in a remote area. The community voiced a desire for an alternative safety response team like a multi-disciplinary response team (MDRT) that embeds a clinician with police when responding to behavioral health emergencies in the community. However, given the rural nature and geography of Starr County – combined with funding and workforce limitations – we believe a mental health emergency telehealth response model would more effectively address the community's needs. This telehealth model equips first responders by ensuring timely clinical support, helps to resolve behavioral health crises in the community when possible, and reserves emergency departments for people with the most acute needs.

A mental health emergency telehealth response program allows officers and paramedics in the field to immediately connect with a licensed behavioral health clinician via mobile technology device (Surface, iPad, Toughbook, etc.), helping to resolve emergencies on-site and divert people from the emergency department or jail when clinically appropriate. FirstNet, the nationwide broadband network built specifically for first responders, ensures that all police and EMS units maintain secure and reliable connectivity, even in remote areas, mitigating potential broadband connectively issues.

[289] Tropical Texas Behavioral Health pursued and was awarded funding to establish a YCOT program. The organization is expected to provide YCOT coverage for its catchment area for 60 hours per week and received $1.5 million annually for the FY 2026–2027 biennium.

Unlike a MDRT, which requires hiring and sustaining a specialized workforce, mental health emergency telehealth response programs subcontract for immediate clinical services, creating a scalable and cost-effective program aligned with community need and culture. The LMHA (Border Region) or another vendor can staff this clinical service. With it, every officer and paramedic would have around the clock (24/7) access to a clinician without the need to wait for a crisis team to travel across the region. Clinicians can handle multiple calls simultaneously and provide support even when traditional mobile crisis teams (MCOT/YCOT) are unavailable. Plus, officers and EMS personnel would only incur costs when clinicians are accessed, rather than paying for 24/7 clinical shifts, allowing for more efficient use of resources.

Start-up costs are estimated at approximately $300,000, which includes equipment, implementation, and technical assistance. Ongoing expenses vary depending on contracting arrangements with the telehealth provider. Philanthropy could support the start-up costs, while a sustainability plan should be developed to fund ongoing clinician contracts. An initial program pilot could track key metrics such as the number of clinician consultations, emergency detentions, and successful diversions from emergency departments and jails.

Rec. 3	**Expand access to crisis stabilization services for Starr County.**

To provide short-term, community-based stabilization for people experiencing a mental health crisis, Starr County should pursue expanded access to crisis stabilization services through one of two options: establishing a crisis stabilization unit (CSU) within Starr County or developing a contractual arrangement for nearby crisis services through a partnership between Border Region and Tropical Texas.

Currently, Starr County lacks community-based crisis services and safe, short-term stabilization options. This gap often leads to unnecessary hospitalizations or prolonged emergency room stays that do not adequately resolve the crisis. Border Region operates a 16-bed crisis respite unit that is available to Starr County residents; however, it is located in Webb County approximately 2.5 hours away from Starr County. While Border Region has capacity within its current crisis services, this geographic distance creates a barrier to timely access which is compounded by workforce constraints and limited availability of public safety transportation options like local police or sheriff's offices. As a result, people in Starr County experiencing a mental health crisis are frequently left waiting in already overburdened emergency departments, delaying access to care and straining local hospital systems.

To address this, Starr County could establish a CSU locally. A CSU is a short-term, intensive mental health facility designed to stabilize people in crisis and divert them from emergency departments or inpatient psychiatric hospitalization. Crisis stabilization units offer a secure, therapeutic environment that provides psychiatric evaluation, medication management, individual and group therapy, crisis intervention, and discharge planning. Most people are stabilized within three to five days. Based on local demand and LOC-0 utilization trends, we

recommend the creation of a six-bed CSU in Starr County, consisting of one child/youth bed, three adult beds, and two flex beds. A locally based CSU would improve outcomes for people in crisis, enhance continuity of care, and allow for a more effective and community-centered use of limited behavioral health resources.

Alternatively, or as an interim solution, Starr County could pursue a contractual partnership between Border Region and Tropical Texas to deliver crisis respite or stabilization services closer to home. Tropical Texas's facilities are geographically nearer to Starr County than Border Region's location in Webb County and may offer a more easily accessible option for residents. This approach could reduce the burden on local emergency departments and address access challenges in a more immediate, cost-effective way. The access challenges Starr County residents face are not the result of any shortcoming by Border Region, but rather a function of geographic distance that limits service availability. A regional partnership with Tropical Texas could bridge this gap while long-term solutions are developed.

Either option would require additional funding from state sources and/or philanthropic partners to assist with start-up costs and sustain ongoing operations. Whether constructing and staffing a new CSU or developing an arrangement with Tropical Texas, meaningful investment will be necessary to ensure the solution is viable and responsive to the crisis care needs of Starr County residents.

Substance Use Disorders

Substance use disorders (SUDs) are a significant public health concern, affecting individual people, families, and communities across the region. We estimate that 12,000 youth (8% of the population) and 150,000 adults (16% of the population) from the region are affected by a SUD.[290] However, the impact of substance use extends beyond the person, influencing healthcare systems, law enforcement, schools, and workplaces. Addressing SUDs requires a comprehensive approach that includes prevention, early intervention, treatment, and long-term recovery support. This section examines the prevalence of substance use disorders in the community, identifies gaps in services, and highlights opportunities to strengthen the continuum of care. By understanding the scope of the issue and the available resources, stakeholders can work toward more effective, coordinated solutions to support people and families affected by substance use.

Adolescence and young adulthood are a critical period for drug use initiation, with the highest risk among those ages 12–25 for starting drug use and developing SUDs.[291] Substance use during this developmental period can have long-lasting impacts on mental and physical health, educational and occupational achievements, and social relationships. However, substance use

[290] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[291] Miech, R. A., Johnston, L. D., Patrick, M. E., O'Malley, P. M., Bachman, J. G., & Schulenberg, J. E. (2023). Monitoring the Future National Survey Results on Drug Use, 1975-2022: Secondary School Students. Ann Arbor: Institute for Social Research, The University of Michigan. https://monitoringthefuture.org/wp-content/uploads/2022/12/mtf2022.pdf

disorders are not limited to youth—adults also face significant challenges related to substance use, which can contribute to chronic health conditions, unemployment, housing instability, and involvement with the criminal justice system.

According to the National Institute on Drug Abuse,[292] by the time high school students reach their senior year, almost 70% will have tried alcohol, half will have taken an illegal drug, nearly 40% will have smoked a cigarette, and more than 20% will have used a prescription drug for a nonmedical purpose. While most adolescents do not escalate from experimentation to addiction, early substance use is a known risk factor for the later development of SUDs in adulthood.

The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that in 2022, 48.7 million people aged 12 or older had a SUD in the past year, with alcohol and illicit drug use being the most common. Adults experiencing SUDs often face barriers to care, including stigma, lack of accessible treatment, and co-occurring mental health disorders, all of which can exacerbate the challenges they face.

By the time high school students reach their senior year:

- Almost 70% will have tried alcohol.
- 50% will have taken an illegal drug.
- Nearly 40% will have smoked a cigarette.
- More than 20% will have used a prescription drug for a nonmedical purpose.

Early detection and intervention are key in reducing the risk of substance use escalating to substance abuse and addiction, as well as increasing the chances of successful recovery, improving overall outcomes, and reducing the negative impacts of substance use. Addressing substance use across the lifespan—from adolescence through adulthood—is critical to reducing its long-term societal and health implications. A comprehensive, integrated approach to prevention, early intervention, and treatment is necessary to improve outcomes for people and communities.

Substance Use Disorder Needs

In July 2023, Governor Abbott launched a fentanyl data dashboard with the Texas Department of State Health Services (DSHS). Updated four times a year by DSHS, the data have already

[292] National Institute on Drug Abuse. (2014, January). *Principles of Adolescent Substance Use Disorder Treatment: A Research-Based Guide.* https://nida.nih.gov/sites/default/files/podat-guide-adolescents-508.pdf

shown that fentanyl-related deaths have sharply increased by 575% over the past four years.[293] These provisional data indicate:

- There were an estimated 2,506 opioid-related overdose deaths in 2021.
- Of all opioid overdose deaths in 2020 among those ages 0–17, 92% involved a synthetic opioid such as fentanyl.
- Opioid use in 2020 was 7.2% in Texas, while national opioid use was lower at 5.6%.[294]

As we detail in the Mortality Trends section at the beginning of this report, 93 residents died from a drug overdose or accidental poisoning in 2024. Although the region's drug overdose mortality rate of 6.5 deaths per 100,000 residents was lower than the statewide rate of 15.9 overdose deaths per 100,000 residents, overdose deaths have become increasingly more frequent in the past 20 years. Between 2001 and 2024, the overdose mortality rate for the region increased by 171% (from 2.4 deaths per 100,000 in 2000 to 6.5 in 2024), higher than the statewide increase of 148% (from 6.4 deaths per 100,000 in 2000 to 15.9 in 2024).[295]

Children and Youth Substance Use Disorder Prevalence

Table 40 illustrates the estimated prevalence of substance use disorders (SUDs) among region resident youth ages 12-17 by county. Overall, we estimate that 12,000 youth residents had an SUD (approximately 8% of the youth population), with two-thirds (8,000) residing in the most populous county – Hidalgo. An additional 3,600 youth in Cameron County, 500 youth in Starr County, and 150 youth in Willacy County were affected by SUDs during 2023.

Table 40: Any Substance Use Disorder Prevalence Among Regional Youth by County (2023)[296,297,298,299]

	Prevalence
Entire Region	**12,000**
Hidalgo County	8,000
Cameron County	3,600

[293] Office of the Texas Governor. (2023, July 13). *Governor Abbott Unveils Texas Fentanyl Data Dashboard*. https://gov.texas.gov/news/post/governor-abbott-unveils-texas-fentanyl-data-dashboard

[294] Texas Workforce Commission. (n.d.). One Pill Kills. Retrieved August 2, 2023, from https://www.twc.texas.gov/one-pill-kills

[295] Centers for Disease Control and Prevention, National Center for Health Statistics. (2026, February). Underlying cause of death 1999-2023 on CDC WONDER online database. Data are from the final Multiple Cause of Death Files, 1999-2023, and from provisional data for year 2024, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Overdose/accidental poisoning deaths are classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14.

[296] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[297] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[298] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[299] Appendix F provides additional county-level youth substance use prevalence data.

	Prevalence
Starr County	550
Willacy County	150

Substance use and SUDs in children and youth often look, and function, differently than they do in adults. For older youth, in particular, experimentation with drugs and alcohol can be developmentally normal. However, there are several factors that would distinguish "typical" experimentation from "at-risk" or clinically significant use and abuse. Provider and community awareness and understanding of these factors, including criteria for a diagnosis of SUD, is critical – as is a multi-tiered, stepped approach to prevention, early intervention, and intensive intervention.

Stakeholder interviews and listening sessions with people with lived experience revealed that substance misuse is being seen regionally among younger children. Vaping among high school students was mentioned as very common, but middle school and even elementary school students are now being identified as vape product users. Packaging contributes to the misuse of drugs by children and youth, as it often resembles candy and salty snack items. For some, the misuse of drugs is considered a result of children and youth attempting to self-medicate from traumatic experiences, anxiety, and/or depression.

Table 41 provides detailed SUD estimates for youth across the region.[300] Of the 12,000 youth with any SUD, two-thirds experience a drug-related SUD, including 1,600 youth with opioid use disorder. An additional 4,100 youth experience alcohol-related SUDs, most of which were mild (76%), with some moderate (20%) and severe (5%). Over half of youth with SUD (63%, or 7,500) need but are not receiving treatment for the SUD.

Table 41: Twelve-Month Substance Use Disorder Prevalence Among Regional Youth (2023)[301,302]

	Youth (Ages 12-17)
Total Population	**150,000**
Any Substance Use Disorder (SUD)[303]	**12,000**

[300] Given the frequently co-occurring nature of alcohol- and drug-related SUDs, the number of youth with drug-related SUD and alcohol-related SUD do not sum to 12,000 (the number of youth with any SUD in the region).
[301] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[302] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."
[303] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

	Youth (Ages 12-17)
In Poverty with SUD[304]	7,500
Needing but Not Receiving Treatment for SUD[305]	7,500
Comorbid Major Depressive Episode and SUD[306]	5,000
Alcohol-Related SUD[307,308]	**4,100**
Mild	3,100
Moderate	800
Severe	200
Drug-Related SUD[309]	**9,500**
Opioid Use Disorder[310]	1,600

Adult Substance Use Disorder Prevalence

Table 42 presents the prevalence of substance use disorders (SUDs) among region resident adults by county. Overall, an estimated 150,000 regional adults have SUD (approximately 16% of the adult population). Two-thirds of those with a SUD (95,000) reside in the most populous county – Hidalgo. An additional 47,000 adults in Cameron County, 7,000 adults in Starr County, and 2,400 adults in Willacy County were affected by SUDs in 2023.

[304] In poverty with SUD estimates for Texas youth are generated through a cross tabulation of past year substance use and poverty. The Texas SUD rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted use data (2021-2022)*. Poverty data obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[305] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-Based Prevalence Estimates* – Texas (Tables 24 and 32).

[306] The Texas comorbid MDE and SUD rate was derived from the Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-Based Prevalence Estimates* – Texas (Tables 32); and *2023 National Survey on Drug Use and Health: National Detailed Tables* (Tables 7.1A and 7.26A).

[307] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[308] AUD severity levels are generated by applying the distribution of AUD severity to past year AUD in Texas. The Texas AUD severity rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted use data (2021-2022).* The Texas rate of past year AUD is obtained from SAMHSA's (2023) *National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 25).

[309] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 27).

[310] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 29).

Table 42: Any Substance Use Disorder Prevalence Among Regional Resident Adults by County (2023)[311,312,313,314]

	Prevalence
Entire Region	**150,000**
Hidalgo County	95,000
Cameron County	47,000
Starr County	7,000
Willacy County	2,400

Table 43 provides detailed SUD estimates for adults across the region.[315] Of the estimated 150,000 adults with an SUD in 2023, two-thirds (100,000) had alcohol-related SUDs, and 75,000 had drug-related SUDs. Of the 100,000 adults with alcohol-related SUDs, 21%, or more than one in five, were severe. Nearly half of these adults (47%) had co-occurring mental health conditions, illustrating the significant overlap between mental illness and substance use disorders in the region.

An estimated 80% of adults with a SUD in the region need – but do not receive – treatment.

Access to treatment for SUDs is a concern in the region, as an estimated 80% of adults with an SUD needed but did not receive treatment. The high rates of untreated SUDs and comorbidity with mental illness indicate a critical need for integrated and accessible treatment services in the region.

Table 43: Twelve-Month Substance Use Disorder Prevalence Among Regional Resident Adults (2023)[316,317]

	Prevalence
Total Adult Population	**960,000**

[311] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[312] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[313] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[314] Appendix F provides additional county-level adult substance use prevalence data.

[315] Given the frequently co-occurring nature of alcohol- and drug-related SUDs, the number of adults with drug-related SUD and alcohol-related SUD does not sum to the number of adults with any SUD.

[316] Population data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[317] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

	Prevalence
Population in Poverty[318]	450,000
Any Substance Use Disorder (SUD)[319]	**150,000**
In Poverty with SUD[320]	70,000
Needing but Not Receiving Treatment for Substance Use[321]	120,000
Comorbid Mental Illness and SUD[322]	70,000
Alcohol-Related SUD[323,324]	**100,000**
Mild	65,000
Moderate	15,000
Severe	21,000
Drug-Related SUD[325]	**75,000**
Opioid Use Disorder[326]	21,000

Substance Use-Related Emergency Department Utilization

Between 2020 and 2022, the region's residents had 14,125 primary substance use-related emergency department (ED) encounters—an average of 4,708 annually. Substance use accounted for roughly one-third of the region's 41,713 behavioral health ED encounters.

[318] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[319] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[320] In poverty with SUD estimates for Texas adults are generated through a cross tabulation of past year substance use and poverty. The Texas SUD rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted use data (2021-2022)*. U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[321] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Tables 24 and 32).

[322] The Texas comorbid AMI and SUD rate is derived from the Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-Based Prevalence Estimates* – Texas (Tables 32); 2023 National Survey on Drug Use and Health: National Detailed Tables (6.1A and 6.10A)

[323] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 25).

[324] AUD severity levels are generated by applying the distribution of AUD severity to past year AUD in Texas. The Texas AUD severity rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the National Survey on Drug Use and Health: 2-year restricted use data (2021-2022). The Texas rate of past year AUD is obtained from SAMHSA's (2023) *National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 25).

[325] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 27).

[326] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 29).

As shown in Table 44, alcohol-related disorders (e.g., alcohol abuse or dependence) were the second most common diagnosis in these behavioral health encounters. Stimulant-related disorders (e.g., cocaine abuse or dependence) ranked fifth.

Table 44: Five Most Common Primary Diagnoses Associated with Primary Behavioral Health-Related ED Encounters Among Regional Residents – All Ages (2020–2022)[327,328,329]

Primary Behavioral Health-Related ED Encounters Among Residents *(Number of Encounters)*			
Rank	**All ED Encounters Statewide**	**Regional Facilities**	**Non-Regional Facilities**
	N = 41,713	**N = 40,643**	**N = 1,070**
1	Anxiety and fear-related disorders (16,242)	Anxiety and fear-related disorders (15,914)	Anxiety and fear-related disorders (328)
2	Alcohol-related disorders (7,759)	Alcohol-related disorders (7,512)	Alcohol-related disorders (247)
3	Depressive disorders (3,889)	Depressive disorders (3,816)	Schizophrenia spectrum and other psychotic disorders (103)
4	Schizophrenia spectrum and other psychotic disorders (2,799)	Schizophrenia spectrum and other psychotic disorders (2,696)	Depressive disorders (73)
5	Stimulant-related disorders (2,013)	Stimulant-related disorders (1,943)	Stimulant-related disorders (70)

Regional Substance Use Disorder Services

While several organizations offer SUD services, the community overwhelmingly identifies Tropical Texas Behavioral Health as the leading provider. In response to growing demand, Tropical Texas has significantly expanded its SUD services over recent years, growing from a single program to six, including the following:

- Outreach, Screening, Assessment, and Referral (OSAR) serves 17 counties, including all four counties in the region
- An intensive outpatient program (IOP) for both adolescents and adults
- Medication-assisted treatment (MAT)
- Contracted detoxification services for adolescents and adults through local hospitals

[327] Texas Health Care Information Collection (THCIC) 2020 to 2022 discharge records.
[328] Data in this table is limited to patients listed as residents of the Rio Grande Valley counties. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request.
[329] Hospital utilization for 2023 and onwards is unavailable due to redactions made by the Department of Health Statics that mask the county of residence in records with a mental health or substance use disorder diagnosis.

- A residential treatment program for adult males

Tropical Texas's 15 bed residential treatment program, La Villa of Hope, served over 80 people in FY25. Participants can access services including group therapy, skill-building support, coping skills training, relapse prevention support, as well as 12-step recovery meetings during their stay.

Spotlight: Behavioral Health Solutions of South Texas

Behavioral Health Solutions of South Texas (BHSST) provides free, community-based services to address substance use disorders and support long-term recovery. Through its outpatient treatment program, BHSST offers individualized care for adults including counseling, case management, and recovery support services. Certified peer specialists play a central role in helping people build resilience and maintain sobriety. In addition to treatment, BHSST delivers evidence-based prevention and education programs across South Texas to reduce the risk of substance use and promote behavioral wellness. These efforts aim to break the cycle of addiction and create healthier communities.

Table 45: Regional Substance Use Services

Substance Use Services	
Organization	**Services**
Behavioral Health Solutions of South Texas (BHSST)	BHSST is a non-profit organization that provides free behavioral wellness. BHSST focuses on delivering services to prevent and reduce substance use and enhance mental wellness. They offer outpatient treatment for adults with substance use disorders and recovery support services that include peer specialists. BHSST is committed to prevention and education, providing community outreach and educational programs to raise awareness and reduce stigma surrounding substance use and mental health issues. See Appendix P for more information about BHSST.
Methodist Healthcare Ministries of South Texas	SUD services include supportive services and one on one counseling.
Tropical Texas Behavioral Health	Provides a variety services including outreach, screening, assessment, and referral (OSAR), outpatient and intensive outpatient services for adults and adolescents, residential substance use disorder treatment, detox and aftercare services, and telemedicine/telehealth services offer virtual care to increase access, with in-person options available upon request.
UT Health RGV Behavioral Health	Provides substance abuse counseling.

*Border Region LMHA does not have any SUD specific services; instead, they refer to Tropical Texas' OSAR.

Spotlight: BeWell Texas[330]

BeWell Texas, a state-funded program the University of Texas Health Science Center at San Antonio sponsors for people seeking help with substance use treatment, provides virtual, evidenced-based treatment services through a person's medical home, including primary care physicians and substance use providers. Regardless of ability to pay, BeWell provides services with an interdisciplinary team of addiction medicine specialists and people with lived experience in recovery via telehealth. BeWell partners with Tropical Texas and Behavioral Health Solutions of South Texas. Additionally, PeriPAN has a collaboration with BeWell to expand access to SUD treatment for pregnant and post-partum women. (For more on PeriPAN, see the section on maternal mental health.)

Despite these key programs, there is limited availability of SUD treatment services in the region for children, youth, and adults. Notably, there is no locally operated residential program for adolescents, leaving Tropical Texas reliant on external referrals through OSAR to meet this need outside of the region. Additionally, there is currently no formal connection to Veterans Affairs or dedicated supports in place for veterans with SUD, representing an area for potential growth and collaboration. Access to SUD treatment and recovery support is critical to an ideal behavioral health crisis system. Medically supervised detoxification, residential and outpatient treatment, and recovery support services are essential components of a functioning behavioral health system.

Recommendations for Substance Use Disorders

Rec. 1	**To improve substance use disorder service access across the region, strengthen referral pathways and increase awareness of existing services.**

Overdose deaths in the region increased by 872% from 2000 to 2023, far outpacing the 457% increase seen statewide. Most recently, the region experienced a 25% rise in overdose deaths from 2022 to 2023, compared to a 4% increase across Texas.

Providers like Behavioral Health Solutions of South Texas (BHSST), which deliver evidence-based prevention services to youth and adults, and Tropical Texas Behavioral Health, with services including outreach, screening, assessment and referral (OSAR), intensive outpatient, and detoxification, play a vital role in supporting the community. While organizations have expanded services to include intensive outpatient programs, medication-assisted treatment, and adult residential care, these resources remain underutilized; both BHSST and Tropical Texas have capacity to serve more people.

Despite the region having capacity to serve more people, 80% of adults and 60% of youth with substance use disorders in the region do not receive the treatment they need. Many residents only receive treatment in times of crisis, as evidenced by the high utilization of emergency departments for SUD-related issues, or, worse, never receive the treatment at all. Stakeholders identified cultural bias, stigma, and transportation as some of the barriers preventing people from seeking their services.

[330] Be Well Texas. (n.d.). *Home*. Be Well Texas. Retrieved February 21, 2025, from https://bewelltexas.org/

Crucial steps in addressing these gaps include raising awareness of the existing resources available in the region and making it easier for people to access them. To address these barriers and ensure that people are connected to the right care at the right time, it is essential to strengthen the referral pathways across all systems interacting with those at risk for SUD. Establishing direct referral links and improving coordination among primary care providers, behavioral health services, schools, and the justice system can reduce confusion and ensure that people and families are better supported.

This effort to improve referrals and increase awareness should be led by the behavioral health accelerator, as it would be uniquely positioned to guide these efforts across multiple sectors and ensure that all relevant community stakeholders are involved. (For more on the behavioral health accelerator, see the section on system-wide findings). The accelerator should play a central role in establishing collaborative partnerships, facilitating communication, and ensuring the referral process is streamlined and effective. This coordinated approach will not only help people access existing services more effectively but will also create a more seamless and supportive system of care, improving long-term outcomes for people, families, and the broader community.

Population Subsets

Maternal Mental Health

Maternal mental health care continues to be inadequate in Texas (and the nation). National statistics reveal that fewer than 20% of women are screened for depression during pregnancy and the postpartum period, and too few women are connected to adequate treatment.[331] According to 2021 data from the Texas Pregnancy Risk Assessment Monitoring System, 14.8% of Texas women reported experiencing depression during pregnancy, with 12.6% experiencing postpartum depression symptoms. During pregnancy, 76.3% of respondents were screened for depression, and 86.2% of all Texas women were screened for postpartum depression at least once after pregnancy.[332] The economic cost of untreated Perinatal Mood and Anxiety Disorders (PMADs) on mothers and children through age five was estimated to be $14 billion in 2017.[333] Costs exceed $2 billion annually in Texas alone.[334]

In Texas, the overall maternal mortality rate is 23.1 deaths per 100,000 people[335,336] and mental health disorders contributed to 21% of pregnancy-related deaths in 2022. Leading causes of pregnancy-related deaths in Texas include cardiac events, accidental drug poisoning, suicide, and obstetric complications. The Maternal Mortality Review Committee found that 80% of these deaths were preventable with interventions at different levels, such as patient care, healthcare systems, or community support.[337]

Mental health disorders contributed to 21% of pregnancy-related deaths in Texas in 2022.

[331] Byatt, N., Levin, L. L., Ziedonis, D., Moore Simas, T. A., & Allison, J. (2015). Enhancing participation in depression care in outpatient perinatal care settings: A systematic review. *Obstetrics & Gynecology, 126*(5), 1048-1058. https://doi.org/10.1097/AOG.0000000000001067

[332] Texas Department of State Health Services. (n.d.). *2022—2023 Healthy Texas Mothers and Babies Data Book.pdf*. Retrieved January 7, 2025, from https://www.dshs.texas.gov/sites/default/files/healthytexasbabies/Documents/2022%20-%202023%20Healthy%20Texas%20Mothers%20and%20Babies%20Data%20Book.pdf

[333] Luca, D. L., Margiotta, C., Staatz, C., Garlow, E., Christensen, A., & Zivin, K. (2020). Financial Toll of Untreated Perinatal Mood and Anxiety Disorders Among 2017 Births in the United States. *American Journal of Public Health*, *110*(6), 888–896. https://doi.org/10.2105/AJPH.2020.305619

[334] Margiotta, C., Gao, J., O'Neil, S., Vohra, D., & Zivin, K. (2022). The economic impact of untreated maternal mental health conditions in Texas. *BMC Pregnancy and Childbirth*, *22*(1), 700. https://doi.org/10.1186/s12884-022-05001-6

[335] Texas Department of State Health Services. (n.d.). *Pregnancy-related mortality ratios*. Retrieved December 10, 2024, from https://healthdata.dshs.texas.gov/dashboard/maternal-and-child-health/maternal-health/pregnancy-related-mortality-ratios

[336] Nationally, the 2022 maternal mortality rate was 22.3 deaths per 100,000 people, down from 32.9 in 2021. However, for Black mothers, the rate was significantly higher at 49.5, though it also improved from 69.9 the previous year. Hoyert DL. Maternal mortality rates in the United States, 2022. NCHS Health E-Stats. 2024. DOI: https://dx.doi.org/10.15620/cdc/152992.

[337] Texas Department of State Health Services & Texas Maternal Mortality and Morbidity Review Committee. (2022). *Joint biennial report of the Maternal Mortality and Morbidity Review Committee* (2022). Retrieved December 10, 2024, from https://www.dshs.texas.gov/sites/default/files/legislative/2022-Reports/2022-MMMRC-DSHS-Joint-Biennial-Report.pdf

Regional Maternal Mental Health Needs

The Maternal Vulnerability Index (MVI)[338] is a county-level, national-scale tool used to identify where and why mothers in the United States are vulnerable to poor health outcomes. It encompasses six themes reflecting 43 indicators associated with maternal health outcomes, offering a comprehensive view of factors influencing maternal well-being.

Communities in the region share common challenges, including high uninsured rates, a shortage of OB-GYNs, and delayed prenatal care initiation, exacerbating maternal health risks. Additionally, postpartum depression screenings, though widely conducted, often lack proper follow-up due to a shortage of mental health providers, with some women facing six-month wait times for services. The national average MVI score is 41, indicating moderate vulnerability; the four counties in this region exhibit rates at least double that (they are also higher than the state average). Addressing these gaps is crucial for improving maternal health outcomes in these regions.

Table 46: Maternal Vulnerability Index for the Region[339]

Maternal Vulnerability Index for the Region							
County	**Overall MVI Score**	**Reproductive Health**	**Physical Health**	**Mental Health and SUD**	**General Healthcare**	**Socioeconomic Determinants**	**Physical Environment**
Cameron	82	High	Moderate	Low	Very High	Very High	High
Hidalgo	84	High	High	Low	Very High	Very High	High
Starr	92	Very High	High	Moderate	Very High	Very High	Very High
Willacy	95	High	Low	Moderate	Very High	Very High	Very High

Please note that a "high" index means the population is more vulnerable to poor health outcomes where a "low" index indicates less vulnerability.

The Meadows Institute estimates that 3,000 new mothers in the region experienced postpartum depression in 2021. Nearly two-thirds (63%) of cases were estimated among Hidalgo County residents (due to the county being the most populous and, similarly, having the most live births).

[338] SURGO Ventures. (n.d.). *Maternal Vulnerability Index*. Retrieved from https://mvi.surgoventures.org
[339] SURGO Ventures. (n.d.). *Maternal Vulnerability Index*. Retrieved from https://mvi.surgoventures.org

Table 47: Postpartum Depression in the Region by County (2021)[340,341]

	Prevalence
Entire Region	**3,000**
Cameron County	850
Hidalgo County	1,900
Starr County	150
Willacy County	30

Additionally, in 2019, lack of health insurance was high for women ages 19 to 64 across the region: Cameron County at 39%, Hidalgo County at 45%, Starr County at 45%, and Willacy County at 38%. All of which exceeded the Texas average of 22%.[342]

Regional Maternal Mental Health Services

UTRGV Maternal Health Research Center

In October 2023, UTRGV received a $2.3 million grant from the U.S. Department of Health and Human Services to establish its first Maternal Health Research Center dedicated to addressing maternal health disparities in South Texas, particularly among Hispanic women. The primary goals of the center are to plan and implement multidisciplinary maternal health research studies to inform relevant, culturally appropriate, and peer-led interventions to address health disparities in the region and increase the university's capacity for maternal health research[343].

Beyond UTRGV's research center, NIH and THCS-funded community engagement projects are expanding maternal health services and research efforts through partnerships with local organizations. These projects focus on increasing maternal healthcare accessibility, particularly in areas where social determinants of health pose significant barriers to care. UTRGV and its partners are, for instance, exploring ways to train community health workers to deliver preventive mental health interventions. Furthermore, UTRGV collaborates with organizations like the South Texas Promotora Association (STPA) to train and deploy community health workers across the border region, enhancing outreach and service delivery.

Additionally, current UTRGV initiatives at Tropical Texas have successfully supported adolescent mothers, and newer programs now target young parents with parenting education

[340] Postpartum depression was estimated using the number of births in the RGV from the Texas Health and Human Services. (n.d.). *Texas Vital Statistics, Live Births in Texas* - 2021. https://healthdata.dshs.texas.gov/dashboard/births-and-deaths/live-births and the rate of postpartum depression in Texas from America's Health Rankings analysis of CDC, Pregnancy Risk Assessment Monitoring System or state equivalent, United Health Foundation, AmericasHealthRankings.org, https://www.americashealthrankings.org/explore/measures/postpartum_depression/TX.

[341] All Texas population estimates are rounded to reflect uncertainty in the underlying data sources. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[342] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[343] https://www.utrgv.edu/school-of-medicine/departments/maternal-health-research-center/index.htm

opportunities. To sustain and expand these efforts, UTRGV is exploring long-term funding opportunities, including Title V programs, while also strengthening collaboration among stakeholders in maternal health. The research center's long-term vision includes creating a regional resource map to track maternal health services across counties, improving access to care, and ensuring that interventions are both sustainable and impactful.

Spotlight: DHR Health's Nurse Family Partnership

The Nurse-Family Partnership (NFP) at DHR Health Women's Hospital is a voluntary, home-visiting program that supports first-time, low-income mothers during pregnancy and their child's first two years. Registered nurses provide personalized guidance through regular home visits, focusing on prenatal care, child development, parenting skills, and maternal self-sufficiency. Nurses also connect families with community resources such as healthcare, education, and employment support. NFP nurses routinely screen for postpartum depression, provide education on its symptoms, and offer referrals for treatment. Research shows that participants experience better mental health outcomes, including reduced anxiety and depression, with significantly lower rates of postpartum depression compared to non-participants. While the program has existed in the region since 2012, referrals have recently decreased, and the program has the capacity to enroll more mothers and families. Fluctuations in leadership among key community partners have contributed to inconsistent referral rates, highlighting the need for sustained collaboration and outreach to ensure connections between eligible families and this vital resource.

The Perinatal Psychiatry Access Network[344]

The Perinatal Psychiatry Access Network (PeriPAN) is a specialized program within the Texas Child Mental Health Care Consortium (Consortium) that supports local healthcare providers in addressing the mental health needs of pregnant and postpartum women. Like the Child Psychiatry Access Network (CPAN), this initiative enhances providers' capacity to recognize, manage, and treat perinatal mental health conditions such as depression, anxiety, and postpartum psychosis. Through a toll-free consultation line, PeriPAN connects regional providers, including OB-GYNs, midwives, and primary care physicians, to expert perinatal psychiatrists who offer real-time guidance on mental health assessments, treatment planning, and safe medication use during pregnancy and breastfeeding. PeriPAN also has a new partnership with the BeWell Texas Recovery Network to equip perinatal providers with the training, consultation, and support needed to improve care for pregnant and postpartum women experiencing substance use disorders (SUD).

In addition to consultations, PeriPAN provides free training and educational resources to help providers integrate mental health care into routine obstetric and primary care practices. By leveraging a statewide network, the program ensures that women, particularly in rural and underserved areas, have access to high-quality mental health support through their existing

[344] Texas Child Mental Health Care Consortium. (n.d.). *Perinatal Psychiatry Access Network (PeriPAN)*. Retrieved March 31, 2025, from https://tcmhcc.utsystem.edu/perinatal-psychiatry-access-network-peripan/ Texas Child Mental Health Care Consortium, (n.d.), *Perinatal Psychiatry Access Network (PeriPAN)*

healthcare providers. In short, the program exists to improve maternal and infant health outcomes by addressing mental health needs early and effectively.[345]
As of February 28, 2025, 1,099 OB-GYNs were enrolled statewide across 262 OB clinics, 66 women's/maternal health clinics, and 31 midwifery practices.[346] The program has received 2,638 calls and completed 56.9% of cases successfully. Unfortunately, the Consortium only shares statewide data; it does not report anything regionally. While UTRGV is the primary source for PeriPAN consultations in the Rio Grande Valley, to best ensure comprehensive statewide coverage and address workforce shortages, other Texas medical schools may at times step in to support other medical schools including UTRGV.[347] This collaborative approach allows the network to maintain consistent support for healthcare providers managing perinatal mental health concerns, ensuring no gaps in service delivery despite any regional challenges.

Recommendations for Maternal Mental Health

Rec. 1	**To better address the mental health of population subsets, including maternal mental health, expand implementation of integrated behavioral health care models.**

Expanding integrated behavioral health is especially critical in this region, where maternal health challenges are exacerbated by a shortage of OB-GYNs and mental health providers, high uninsured rates, and lengthy wait times for services. Stakeholders indicate that the limited availability of OB-GYNs has led many women to delay prenatal care, increasing the risk of poor maternal health outcomes. Additionally, while postpartum depression screenings exist and take place, they often lack structured follow-up and referral pathways (in part due to provider shortages), leaving many women without timely intervention.

Specifically, we recommend implementing the collaborative care model in OB-GYN practices because it has been shown to significantly improve mental health outcomes for women, particularly in managing perinatal depression. Women enrolled in CoCM through their women's health providers experience greater improvements in depressive symptoms, better overall functioning, and higher satisfaction with their care.[348] They are also more likely to adhere to prescribed antidepressant medications, which can be crucial for managing their mental health during and after pregnancy. Furthermore, mothers benefit even more when CoCM programs are culturally relevant, showing significant improvements in the quality of care they receive, as

[345] Texas Child Mental Health Care Consortium, (n.d.), *Perinatal Psychiatry Access Network (PeriPAN)*
[346] Wakefield, S. (2025, February 28). *Perinatal Psychiatry Access*. https://tcmhcc.utsystem.edu/wp-content/uploads/2025/03/2025-Mar-COSH-Presentation_IE.pdf
[347] Including Texas A&M University System Health Science Center, Dell Medical School at The University of Texas at Austin, and The University of Texas Health Science Center at San Antonio.
[348] Melville, J. L., Reed, S. D., Russo, J., Croicu, C. A., Ludman, E., Larocco-Cockburn, A., & Katon, W. (2014ah). Improving care for depression in obstetrics and gynecology: A randomized controlled trial. *Obstetrics and Gynecology*, *123*(6), 1237–1246. https://doi.org/10.1097/AOG.0000000000000231

well as in the severity and remission of their depression.[349] For more on supporting the region's implementation of the collaborative care model, please see the section on mild to moderate mental health services.

Rec. 2	**To improve maternal health outcomes and reduce maternal vulnerability, the regional accelerator should prioritize activities that coordinate resources, increase awareness, and enhance collaboration among maternal health providers.**

While many parties have made significant efforts to support maternal health in the region, there is no coordinated system for sharing resources, and many communities remain unaware of the services available to them. Without a structured approach to collaboration and communication, it is difficult to assess what care is available and where critical service gaps exist—especially in maternal mental health.

To address this, the regional accelerator (detailed on page 180) should establish a maternal health workgroup including representatives from every county—such as healthcare providers, community-based organizations, and policymakers—to coordinate resources, raise awareness, and drive a data-informed strategy to meet maternal health needs. The workgroup would inventory existing services, including prenatal and postpartum care, mental health supports, and parenting programs, and determine whether current resources meet community demand. It would also facilitate consistent information-sharing across providers and partners to ensure that families and frontline staff know how to access available services.

For example, DHR Health Women's Hospital's Nurse-Family Partnership (NFP) is a free home-visiting program that improves maternal and child health outcomes, particularly mental health. Research shows that NFP participation is associated with lower rates of anxiety, depression, and postpartum depression.[350] Despite strong outcomes and regional availability since 2012, NFP remains underutilized, mainly due to inconsistent referrals and lack of awareness. The program has the capacity to serve more families, but referral pathways from OB-GYN providers, schools, and government agencies have weakened.

A regional workgroup could address this disconnect directly, strengthening referral systems, learning about available community resources, identifying gaps in care, and ensuring that maternal health resources are fully leveraged across the region. Coordinated collaboration is essential to improving maternal well-being and reducing vulnerability during a critical time for mothers and families.

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[349] Grote, N. K., Katon, W. J., Russo, J. E., Lohr, M. J., Curran, M., Galvin, E., & Carson, K. (2015ai). Collaborative Care for Perinatal Depression In Socioeconomically Disadvantaged Women: A Randomized Trial. *Depression and Anxiety*, *32*(11), 821–834. https://doi.org/10.1002/da.22405

[350] Olds, D. L., Kitzman, H., Hanks, C., Cole, R., Anson, E., Sidora-Arcoleo, K., Luckey, D. W., Henderson, C. R., Holmberg, J., Tutt, R. A., Stevenson, A. J., & Bondy, J. (2007). Effects of Nurse Home Visiting on Maternal and Child Functioning: Age-9 Follow-up of a Randomized Trial. *Pediatrics*, *120*(4), e832–e845. https://doi.org/10.1542/peds.2006-2111

Family Violence

Family violence, including intimate partner violence (IPV) and exposure to family violence, has profound and lasting impacts on behavioral health. Understanding these impacts is critical to developing effective community interventions and support services.

The Texas Department of Public Safety (DPS) defines family violence as any act by a family or household member against another that causes or threatens physical harm, bodily injury, assault, or sexual assault, excluding self-defense. The department defines abuse as substantial physical harm, credible threats, sexual conduct, or coercion of a child into sexual activity. For reporting purposes, "family" includes people related by blood, marriage (current or former), shared parenthood, foster relationships, and current or former household members, including roommates.[351]

Research demonstrates that children exposed to IPV are at an increased risk of experiencing other adverse childhood experiences (ACEs), such as abuse, neglect, and household dysfunction. Children who witnessed IPV were two to six times more likely to experience other ACEs, indicating that frequent exposure to IPV increases the likelihood of additional ACEs.[352] These experiences have cascading effects on mental health, with people exposed exhibiting a higher risk of depression, anxiety, posttraumatic stress disorder, and substance use disorders in adulthood. Childhood maltreatment, a frequent co-occurrence with IPV exposure, further compounds these risks. The cumulative nature of childhood maltreatment—physical, emotional, sexual abuse, and neglect—heightens vulnerability to IPV in later life, perpetuating a cycle of victimization and adverse behavioral health outcomes.[353]

For adults, the mental health effects of IPV are both severe and multifaceted. There is a heightened prevalence of depression, anxiety, and post-traumatic stress disorder (PTSD) among IPV survivors.[354] Again, the frequency and severity of IPV directly correlate with the intensity of these mental health symptoms. Importantly, psychological violence has been found to have an equally, if not more, profound impact on mental health. IPV exposure more than doubles the risk of developing mental health conditions such as depression and anxiety and triples the risk of serious mental illnesses like schizophrenia and bipolar disorder.[355] Additionally, gender plays

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[351] Texas Department of Public Safety. (2018). *Crime in Texas: Family Violence*. Retrieved from https://www.dps.texas.gov/sites/default/files/documents/crimereports/18/citch5.pdf.

[352] Dube, S. R., Anda, R. F., Felitti, V. J., Edwards, V. J., & Williamson, D. F. (2002). Exposure to abuse, neglect, and household dysfunction among adults who witnessed intimate partner violence as children: Implications for health and social services. *Violence and Victims*, *17*(1), 3–17. https://doi.org/10.1891/vivi.17.1.3.33635

[353] Shields, M., Tonmyr, L., Hovdestad, W. E., Gonzalez, A., & MacMillan, H. (2020). Exposure to family violence from childhood to adulthood. *BMC Public Health*, *20*(1), 1673. https://doi.org/10.1186/s12889-020-09709-y

[354] Lagdon, S., Armour, Cherie, & and Stringer, M. (2014). Adult experience of mental health outcomes as a result of intimate partner violence victimisation: A systematic review. *European Journal of Psychotraumatology*, *5*(1), 24794. https://doi.org/10.3402/ejpt.v5.24794

[355] Chandan, J. S., Thomas, T., Bradbury-Jones, C., Russell, R., Bandyopadhyay, S., Nirantharakumar, K., & Taylor, J. (2020). Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness. *The British Journal of Psychiatry*, *217*(4), 562–567. https://doi.org/10.1192/bjp.2019.124

a critical role in the dynamics and consequences of IPV as women are disproportionately affected, with higher rates of mental health challenges resulting from IPV exposure.[356]

Family Violence in the Latino Community

Studies have shown that one in three Latinas will experience IPV in their lifetime, a statistic that mirrors national averages but is influenced by unique cultural and social dynamics that heighten risks for this population.[357] Compared to other demographic groups, Hispanic women are particularly vulnerable, with factors such as immigration status, socioeconomic disparity, and traditional cultural values like male dominance (machismo) and female sacrifice (marianismo) contributing significantly to their increased risk.[358] For Latinas, the mental health consequences are severe, including heightened risks for depression, anxiety, post-traumatic stress disorder (PTSD), and other psychological conditions. Chronic physical symptoms, such as pain, injury, and gynecological problems, are also common, further exacerbating the mental health challenges.[359] The intersection of these mental and physical health effects complicates the ability of survivors to heal and seek appropriate care.

Cultural factors often intertwine with IPV to create barriers to help-seeking behavior. Norms, such as machismo and marianismo often discourage Latinas from reporting abuse or accessing support, as they may perceive the violation of these norms as a personal failure or dishonor to the family.[360] These cultural factors, combined with fears of deportation, lack of trust in law enforcement, and limited access to culturally sensitive services, often result in underreporting the violence.[361] This is particularly true for immigrant Latinas, who face compounded challenges such as legal uncertainty and language barriers that further hinder their ability to seek help or understand their rights.

Family Violence in the Region

Much like the rest of the country, family violence is a significant issue in the region, with a high prevalence of intimate partner violence. Despite above-average family violence incidents, the Hidalgo County DA estimates that the prevalence of family violence is likely higher than data shows, as only 30% of cases are reported due to many victims reporting an incident as a last resort.

As seen in Table 48, below, the state of Texas reports 247,896 incidents of family violence in 2023, resulting in a rate of 836 incidents per 100,000 residents. The region has a higher rate,

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[356] Chandan, J. S. et al., (2020), Female survivors of intimate partner violence and risk of depression, anxiety and serious mental illness, *The British Journal of Psychiatry*, *217*(4), 562–567

[357] Esperanza United. (2021). *Latinas and Intimate Partner Violence Evidence-Based Facts*. https://esperanzaunited.org/wp-content/uploads/2021/11/3.11.73-Factsheet_GeneralIPV2021.pdf Esperanza United, (2021), *Latinas and Intimate Partner Violence Evidence-Based Facts*

[358] García, M. C., & Morey, S. M. (2014). Intimate partner violence among Hispanics: A review of the literature. *Journal of Interpersonal Violence*, 29(14), 2451–2474. https://doi.org/10.1177/0886260514522282

[359] Esperanza United, (2021), *Latinas and Intimate Partner Violence Evidence-Based Facts*

[360] Esperanza United, (2021), *Latinas and Intimate Partner Violence Evidence-Based Facts*

[361] Esperanza United, (2021), *Latinas and Intimate Partner Violence Evidence-Based Facts*

with 13,289 incidents, or 956 incidents per 100,000 residents in the same period. Within this region, Hidalgo County experiences the highest rate, with 8,828 incidents translating to 1,002 incidents per 100,000 residents. Cameron County follows with 3,977 incidents, showing a slightly lower rate of 940 per 100,000 residents. Willacy County reports 201 incidents, resulting in a rate of 994 per 100,000 residents. Compared to the statewide rate, the region and most of its counties exhibit higher rates of family violence, suggesting a localized need for targeted intervention and resources.

Table 48: Family Violence Incidents in Texas and the Rio Grande Valley (2023)[362]

Region/County	Family Violence Incidents	Per 100,000 Residents (All Ages)[363]
State of Texas	**247,896**	**836**
Rio Grande Valley Region	**13,289**	**956**
Cameron County	3,977	940
Hidalgo County	8,828	1,002
Starr County	283	430
Willacy County	201	994

Regional Family Violence Services

Regional family violence centers report a rise in requests for their services, surpassing pre-COVID levels, and find themselves unable to provide adequate support. Services domestic violence organizations offer typically include assistance with basic needs, housing (emergency shelter, rehousing funds, and rental assistance), counseling, and advocacy (court accompaniment and liaising with law enforcement and the district attorney's office). They provide these services free of charge.

Victim advocacy centers such as Mujeres Unidas and the Family Crisis Center offer counseling services based on trauma-informed, evidence-based approaches, including Eye Movement Desensitization and Reprocessing[364] (EMDR) and Cognitive Behavioral Therapy[365] (CBT), and other modalities such as play therapy and prolonged exposure. Strong referral partnerships help victims access mental health services,

The region exhibits high rates of family violence, suggesting a localized need for both interventions and resources.

[362] Texas Department of Public Safety. (2024). *The Texas Crime Report for 2023* - Crime by Jurisdiction. Retrieved from: https://www.dps.texas.gov/section/crime-records/crime-texas.
[363] U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 5-year estimates.* https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[364] Chen, Y.-R., Hung, K.-W., Tsai, J.-C., Chu, H., Chung, M.-H., Chen, S.-R., Liao, Y.-M., Ou, K.-L., Chang, Y.-C., & Chou, K.-R. (2014). Efficacy of eye-movement desensitization and reprocessing for patients with posttraumatic-stress disorder: A meta-analysis of randomized controlled trials. *PloS One*, *9*(8), e103676. https://doi.org/10.1371/journal.pone.0103676
[365] Kar, N. (2011). Cognitive behavioral therapy for the treatment of post-traumatic stress disorder: A review. *Neuropsychiatric Disease and Treatment*, *7*, 167–181. https://doi.org/10.2147/NDT.S10389

including those from Tropical Texas, South Texas Behavioral Center, and UTRGV Counseling Center. Tropical Texas recognizes and collaborates with intimate partner violence serving agencies, such as Mujeres Unidas. Tropical Texas also reports that it is embedded in training procedures with Mujeres Unidas and collaborates in training on service array and trauma during new volunteers' orientation as its staff are also trained in trauma informed care, family partner services, and seeking safety. Additionally, Tropical Texas is scheduled to be part of the upcoming conference at Mujeres Unidas.

Spotlight: Friendship of Women, Inc.

Friendship of Women, Inc. (FOW) is a Cameron County-based organization committed to ending violence against women, men, and children. Their mission is to provide leadership and comprehensive services that empower people while promoting the safety, health, and well-being of adults and children affected by violence. FOW offers a range of programs and services designed to support survivors, including a 24-hour crisis hotline staffed by trained advocates who offer immediate assistance. They also provide counseling services that specifically address the mental health needs of survivors, offering professional mental health support to help people cope with the emotional and psychological trauma caused by domestic violence and sexual assault. In addition, FOW operates an emergency shelter that serves as a safe haven for women and children fleeing abusive relationships or recovering from sexual assault, providing a secure environment where survivors can begin the healing process.

There are other notable strengths in the region's response to domestic violence. The Hidalgo County District Attorney's office, for example, has a robust reporting and victim support system, including a notification system to alert victims when their aggressor is released from jail. Additionally, Strength, Hope, and Empowerment (SHE) Wellness centers, or community driven clinics that provide medical services and basic needs support as well as forensic interviewing and advocacy services, have opened in Harlingen and McAllen. Local advocate donations support these clinics, along with health care providers offering pro bono services. There are also plans to open a clinic in Rio Grande City.

While these efforts demonstrate a commitment to improving the support system for domestic violence victims in the region, there is a significant gap in service availability, with limited numbers of domestic violence counselors and long waitlists. Shelter availability is also constrained, with many centers at capacity, especially for male victims. Financial barriers, low trust in law enforcement, transportation challenges, and immigration status concerns further complicate access to services. Additionally, the lack of a streamlined system for accessing services and resources, alongside systemic barriers such as long wait times for crime victim compensation, exacerbates the situation.

Recommendations for Family Violence

Rec. 1	**To provide a robust continuum of on-site behavioral health services at the new supportive housing units for survivors of domestic violence, the Friendship of Women and Tropical Texas should establish a partnership.**

Through the Friendship of Women's successful efforts, Cameron County will soon gain 50 units of permanent supportive housing for adults and families experiencing domestic violence through the redevelopment of the Buena Vida public housing site. Given the region's elevated rates of family violence and likely significant underreporting of incidents, this development presents a critical opportunity to integrate comprehensive behavioral health services directly into the housing program. People who experience domestic violence are at heightened risk for a range of behavioral health challenges, including post-traumatic stress disorder, depression, anxiety, and substance use disorders. These needs, if left unaddressed, can hinder long-term recovery and housing stability.

Friendship of Women provides critically needed counseling services and maintains a partnership with the county's local mental health authority (Tropical Texas) to enable access to a more robust continuum of behavioral health care. Both organizations participate in the Cameron County Homeless Coalition and are formalizing an MOU. To strengthen this partnership, a formalized agreement is recommended for Tropical Texas to provide higher-intensity behavioral health services for people with more complex needs. These LMHA-offered services include access to licensed mental health clinicians trained in domestic violence and trauma, peer support specialists who can provide culturally responsive, lived-experience-based support, and care coordination services to connect residents with additional resources such as substance use treatment, primary care, children's mental health services, and employment supports. Embedding these behavioral health supports within the supportive housing setting can provide a strong foundation for safety, recovery, and long-term well-being.

Rec. 2	**To promote identification and increase access to behavioral health care for people affected by family violence, District Attorneys and regional LMHAs should establish formal partnerships (such as embedding LMHA staff in county courts).**

Mental health services often take a backseat in family violence cases due to the immediate safety concerns and essential support needs of victims. While safety remains paramount, the long-term psychological impact of family violence, including trauma, depression, anxiety, and substance use disorders, must also be addressed. Unfortunately, there is often a lack of dedicated resources and systems to ensure that victims and witnesses of family violence receive adequate trauma-informed behavioral health services. Moreover, critical windows for support are missed due to prolonged delays in the legal process and with the disbursement of crime victims' compensation funds, compounded by long waitlists for counseling, shelter, and other support services. These delays can result in survivors remaining in unsafe environments, increased trauma, and a higher likelihood of case withdrawal due to frustration or fear. In some cases, children exposed to family violence may also miss early intervention opportunities, exacerbating long-term mental health and behavioral issues.

One approach to addressing these concerns is to embed the respective LMHAs within each county's court system (i.e., Tropical Texas and Hidalgo County). As seen in Dallas County, where that region's LMHA has staff in the county's specialty court, embedding mental health professionals within the justice system creates referral pathways and enables timely access to

trauma-informed services. Through shared protocols, joint staffing, and regular communication, these county-specific partnerships promote early identification and seamless transitions into care, ultimately improving outcomes and preventing further trauma. Although not embedded within the court systems, it should be noted that Tropical Texas is involved with the county court systems through the Mental Health Diversion Courts and the Tropical Texas psychiatrist meets monthly with court staff to provide mandated treatment.

Additionally, the existing Rio Grande Valley District Attorney's Coalition, which includes District Attorney's from all four counties in the region, has the ability foster a region-wide, interagency task force focused on improving the timeliness and effectiveness of responses to family violence. This task force is an ideal place for developing a blueprint in each county to meet defined family violence system performance goals. These goals should include:

- **Streamlining legal proceedings** by identifying and replicating best practices, such as Hidalgo County's fast-track docketing for protective orders and pre-trial hearings.
- **Reducing time to financial relief** by coordinating with the Crime Victims' Compensation Program to pilot expedited processing for family violence cases.
- **Prioritizing service connection** by implementing a "triage" model similar to emergency medical response, where survivors receive an immediate needs assessment and rapid referral to available services—within hours, not weeks.
- **Tracking and accountability** through a shared data dashboard that flags bottlenecks and ensures that no case stalls without a response.

Without improvement, regional survivors may continue to disengage or get lost in the system, remain in danger, or experience compounded harm due to bureaucratic delays—turning what should be a pathway to safety into a retraumatizing process.

Rec. 3	**Expand family violence prevention and identification through schools, community and faith-based organizations, and healthcare settings.**

The region would benefit from a comprehensive, multi-sectoral approach to preventing family and intimate partner violence, starting in early adolescence. Stakeholders highlighted the harmful effects of witnessing family violence during childhood, noting that it often contributes to a cycle of violence that continues into adolescence and adulthood. They also reported an increase in incidents of family and intimate partner violence among youth, with cases increasingly beginning in middle and high school.

In response to these trends, it is crucial to implement proactive, evidence-based prevention and identification strategies across community and faith-based organizations, schools, and healthcare settings. Below we offer opportunities that would impact prevention and identification in the region:

- By offering culturally relevant relationship education and providing safe spaces for people to discuss intimate partner violence and even receive mentorship, **community and faith-based organizations** can reach people, including youth, in a trusted

environment. Community leaders and clergy, for example, could receive trauma-informed training to recognize signs of violence and to act as resources for affected youth.

- **Schools** could integrate evidence-based programs such as Start Strong: Building Healthy Teen Relationships[366] and Safe Dates,[367] which focus on promoting healthy relationships and reducing dating violence. These curricula educate students about the dynamics of emotional, sexual, and physical abuse, early warning signs, how to seek help, and bystander intervention. For students who have experienced violence, group-based interventions such as trauma and grief component therapy[368] can effectively reduce posttraumatic stress, depression, and suicide risk, and enhance learning and school connectedness.
- Family violence has profound and lasting impacts on both mental and physical health, yet it is often addressed only as a legal or social issue. **Healthcare settings** offer a critical, underutilized opportunity to identify victims and provide timely, trauma-informed care. Routine screening for domestic and family violence should be standard practice across healthcare settings, including primary care, emergency departments, OB-GYN, and behavioral health. Routine screenings for intimate partner violence should also be integrated into **pediatric care**,[369] especially for girls aged eight and older, during regular checkups.
- Healthcare providers can be trained to screen using validated tools, such as the PTSD Reaction Index, Brief Form, and to respond to positive screens with immediate safety assessments, brief interventions, and referrals to specialized services like grief counseling or trauma-informed therapy. The Meadows Institute's Trauma and Grief (TAG) Center, for example, offers a range of trauma-informed trainings tailored to pediatric settings, helping clinicians build the skills needed to recognize and respond effectively to trauma-impacted youth. Or, for instance, evidence-based, grief-focused interventions such as multidimensional grief therapy can be administered by non-mental health professionals to address the grief-related mental health needs of youth who have experienced losses due to violence.

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[366] Miller, S., Williams, J., Cutbush, S., Gibbs, D., Clinton-Sherrod, M., & Jones, S. (2015). Evaluation of the Start Strong initiative: Preventing teen dating violence and promoting healthy relationships among middle school students. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *56*(2 Suppl 2), S14-19. https://doi.org/10.1016/j.jadohealth.2014.11.003

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[368] Saltzman, W., Layne, C.M., Pynoos, R. S., Olafson, E., Kaplow, J.B., & Boat, B. (2017). *Trauma and grief component therapy for adolescents: A modular approach to treating traumatized and bereaved youth.* Cambridge University Press.

[369] Harper, C. C., Jones, E., Brindis, C. D., Watson, A., Schroeder, R., Boyer, C. B., Edelman, A., Trieu, S., & Yarger, J. (2023). Educational Intervention Among Adolescents and Young Adults on Emergency Contraception Options. *Journal of Adolescent Health*, *72*(6), 993–996. https://doi.org/10.1016/j.jadohealth.2023.01.007

Juvenile Justice

Juvenile justice involvement among children and youth is often driven by unaddressed behavioral health needs, family instability, exclusionary school discipline, and limited early intervention pathways. Youth, including those regionally, are frequently referred to the justice system as a last resort due to the absence of community-based stabilization options or diversion infrastructure, resulting in missed opportunities to identify and address underlying mental health causes of behavior and increases the risk of deeper system involvement, recidivism, and poor long-term outcomes. A regional, trauma-informed, and community-embedded approach to juvenile justice can help redirect youth toward healing and accountability while preserving family and community ties.

Regional Justice-Involved Youth

Each county's Juvenile Probation Department is the agency charged with supervising children and youth referred to the juvenile justice system. Referral numbers for CY 2023 are listed below by type of offense in each of the four counties. Of the 177,095 youth ages 10-16 residing in the region, 2,552 were referred to the juvenile justice system in 2023. The combined referral rate in 2023 was 20 per 1,000 youth, slightly higher than the statewide referral rate of 18 youth per 1,000. Almost half of the referrals were for felonies (44%), misdemeanors made up 41%, and only 14% of referrals were for violations of probation (VOP) or status offenses (conduct that would not be considered criminal if committed by an adult).

Table 49: Juvenile Probation Referral Activity in the Region, Calendar Year 2023[370]

County	Juvenile Population (10-16)	Violent Felony	Other Felony	Misdemeanors A&B	VOP	Status	Total Referrals	Referral Rate per 1,000
Cameron	55,531	77	534	481	84	106	1,282	23
Hidalgo	111,243	239	481	827	57	213	1,817	16
Starr	7,906	10	99	68	2	8	187	24
Willacy	2,415	5	31	7	0	0	43	18

While most youth offense types decreased across the region from 2019 to 2023, "other felony" offenses, including some forms of assault and vaping-related drug offenses, increased significantly in all four counties. Stakeholders reported upticks in the following, which they believe may be driving the trend:

- Firearm-related offenses;
- Assault family violence; and
- School-based incidents involving THC vape pens, which remain classified as a felony in Texas (other forms of THC consumption are classified as misdemeanors).

[370] Texas Juvenile Justice Department. (2024). *THE STATE OF JUVENILE PROBATION ACTIVITY IN TEXAS STATISTICAL AND OTHER DATA ON THE JUVENILE JUSTICE SYSTEM IN TEXAS: Calendar Year 2023*. https://www.tjjd.texas.gov/wp-content/uploads/2024/08/The-State-of-Juvenile-Probation-Activity-in-Texas-Calendar-Year-2023.pdf

Table 50: Trends in Juvenile Referrals by Offense in the Region, 2019-2023 % Change[371]

Offense	Cameron	Hidalgo	Starr	Willacy
Violent Felony	-46%	10%	-44%	67%
Other Felony	**92%**	**45%**	**206%**	**300%**
Misdemeanor	-28%	17%	-30%	-50%
VOP	-58%	-64%	-88%	-100%
CINS/Status	-43%	4%	-14%	0%
Grand Total	-10%	11%	12%	-4%

The region is doing an excellent job diverting youth prior to court involvement, with most juvenile referrals being either dismissed, issued a supervisory caution (warning), or deferred from formal system involvement (2,313 or 82%). Only 18% of cases referred to the juvenile justice system in 2023 received formal probation, and only 19 youth across the four counties were committed to the Texas Juvenile Justice Department (state prison) or transferred to the adult system. This shows that the region prioritizes early intervention and diversion over formal court involvement, which aligns with best practices for reducing recidivism and improving youth outcomes.

Table 51: Juvenile Justice Dispositions (Sentences) in the Region, CY 2023[372]

County	Dismissed	Supervisory Caution	Deferred	Formal Probation	Commitment & Adult Transfer	Total Dispositions
Cameron	205	109	196	297	6	813
Hidalgo	680	35	869	185	13	1784
Starr	30	37	120	13	0	200
Willacy	12	0	20	7	0	39
Total	927	181	1,205	502	19	2,836

Regional Services for Justice-Involved Youth

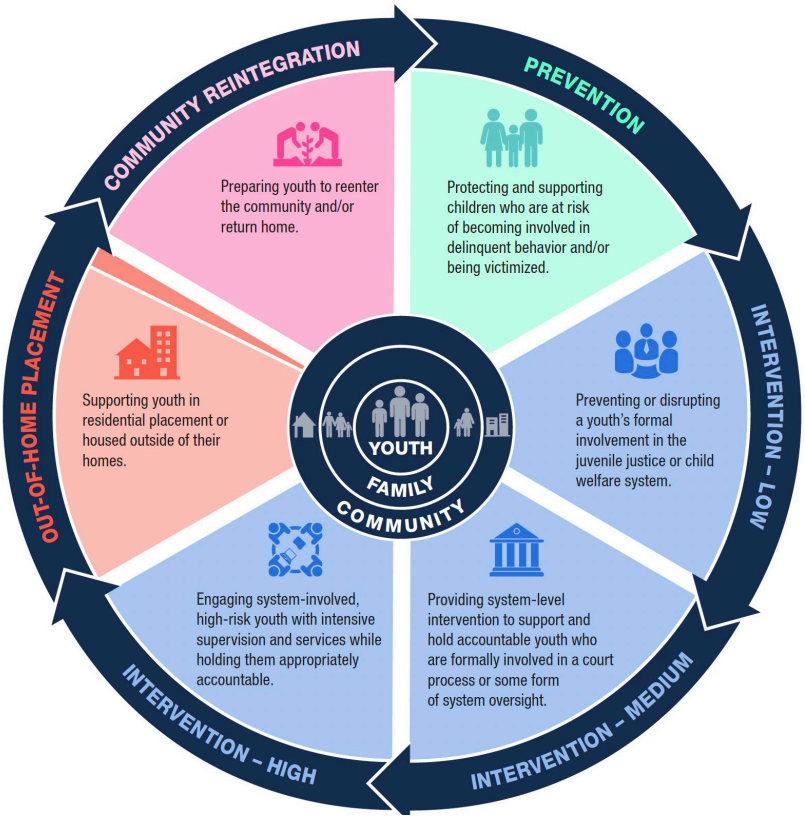
To address the needs of justice-involved youth, the region must have a robust community-based system with a continuum of resources and programs to quickly match them to services at

[371] Texas Juvenile Justice Department. (2024, August). Juvenile probation department profiles - fiscal years 2019-2023. Received from email communication. In August and September 2024, the Meadows Institute analyzed and re-aggregated the juvenile probation department profiles provided by the Texas Juvenile Justice Department (TJJD). The Institute converted TJJD's department-level data into region- and department size-based profiles by aggregating and averaging the individual department data. Additional information is available upon request.

[372] Texas Juvenile Justice Department, (2024), *THE STATE OF JUVENILE PROBATION ACTIVITY IN TEXAS STATISTICAL AND OTHER DATA ON THE JUVENILE JUSTICE SYSTEM IN TEXAS: Calendar Year 2023*

the earliest intercept point, as described by the Office of Juvenile Justice and Delinquency Prevention (OJJDP)'s Continuum of Care model.[373]

Figure 14: OJJDP CoC Model



Below is a summary of some of the behavioral health services and supports provided by each of the four regional juvenile departments, as well as some key gaps and challenges regional stakeholders identified. See Appendix Q for a full inventory of programs and services provided in-house or through contracts with community-based providers.

Cameron County Juvenile Justice Department

The Cameron County Juvenile Justice Department (CCJJD) provides a wide range of rehabilitative, educational, and therapeutic services aimed at supporting youth and families at-risk of or involved in the justice system. The department has placed strong emphasis on behavioral health, expanding its dedicated mental health division to include licensed clinicians, crisis counselors, and a qualified mental health professional, who serve youth across residential and community programs. Tropical Texas has staff co-located at the county's juvenile detention facility, and partners closely with CCJJD to facilitate Community Resource Coordination Group (CRCG) meetings to support youth and families with complex needs. CCJJD operates in-house initiatives such as the Building Trades project, Project Phoenix, reentry aftercare program, and school collaborative program, and leverages strong partnerships with external providers for services like substance use treatment, trauma recovery, parenting classes, and the special needs diversionary program. Their approach integrates education, vocational training, mentorship, and mental health services, with a goal of promoting well-being and reducing recidivism.

The department's efforts are guided by a 2024 Sequential Intercept Model (SIM) mapping process the Texas Judicial Commission on Mental Health facilitated, which brought together

[373] The Meadows Institute is leading an OJJDP-funded Continuum of Care project statewide, which included in-person mapping and strategy sessions in each of the TJJD regions. Through this project, we invited all juvenile probation chiefs and some additional probation staff in the region on February 6, 2025 to a half-day focus group to review juvenile justice data and explore gaps and opportunities for building a regional Continuum of Care.

over 60 cross-sector stakeholders to identify systemic gaps and opportunities. The resulting action plan identified four strategic priorities: enhancing family engagement, expanding youth residential options (including a crisis center), strengthening reentry supports, and improving collaboration between mental health and juvenile justice systems. CCJJD benefits from strong judicial leadership which champions trauma-informed practices and restorative interventions like the Juvenile Specialty Court[374] for youth who have been diagnosed with mental health or a co-occurring disorder, and their Border Children's Justice Program[375] which provides in-home services for undocumented youth. Cameron County is actively building a cross-system response to ensure that interventions are developmentally appropriate and community-based whenever possible, but limited access to psychiatric services and treatment for substance use remains a persistent challenge.

Spotlight: Cameron County Juvenile Probation Department's Building Trades Program

Housed at the CCJD's Amador R Rodriguez Vocational and Academic Center in San Benito, this program provides vocational training support to youth residents in the post-residential program while under community supervision. Youth participants can learn building trades skills and receive OSHA safety training all while providing home renovation/construction for residents in the community, including veterans.

Hidalgo County Juvenile Probation Department

The Hidalgo County Juvenile Probation Department (HCJPD) is the largest department in the region and operates a robust system of services designed to address the needs of youth at every stage of justice system involvement, with a strong emphasis on behavioral health, community-based alternatives, and family engagement. HCJPD manages the Juvenile Justice Center, which houses the detention facility, boot camp, and the 449th District Court dedicated to juvenile cases, with staff from Tropical Texas co-located at each facility to provide onsite behavioral health services and linkages to the community-based mental health resources. HCJPD also offers internal programs ranging from anger management, substance use treatment, and a dedicated mental health unit, to intensive supervision and wraparound reentry support. Hidalgo County has a number of specialty courts unique to the region, including the Juvenile Drug Court and the Lifelines Girls Mental Health Court, which connect youth to specialized services and enhanced judicial supervision.

In addition to its internal programming, Hidalgo County collaborates with local and regional providers to expand services through a comprehensive continuum of care. Programs like the special needs diversionary program and the family empowerment initiatives reflect efforts to strengthen family systems and address underlying behavioral and mental health needs. A range of external providers offer counseling, transitional programs, and restorative alternatives such as a volunteer-led court conference committee program. For example, youth who have been

[374] Cameron County Juvenile Justice Department. (n.d.). *Juvenile Specialty Court*. Cameron County Juvenile Justice Department. Retrieved May 5, 2025, from https://www.cameroncountytx.gov/ccjjd/probation-services/a-c-t/

[375] Cameron County Juvenile Justice Department. (n.d.). Programs. *Cameron County Juvenile Justice Department*. Retrieved May 5, 2025, from https://www.cameroncountytx.gov/ccjjd/probation-services/programs-2/

expelled from school, who violate probation, or exhibit criminal behavior are able to access education services thorough the Juvenile Justice Alternative Education Program (JJAEP), operated by Southwest Key Program. Despite its many strengths, stakeholders knowledgeable about the juvenile justice system in Hidalgo County note the system continues to face challenges, including gaps in school-based supports, family engagement, access to culturally competent care, and coordination at key decision points. Still, the recent SIM mapping initiative and formation of a cross-sector behavioral health leadership team signal a county-wide effort to align services and identify new ways to address system gaps.

Starr County Juvenile Probation Department

The Starr County Juvenile Probation Department (SCJPD), located in Rio Grande City, provides some rehabilitative services aimed at addressing the behavioral health needs of justice-involved youth. While the department operates on a smaller scale compared to Hidalgo and Cameron counties, it offers targeted interventions to promote behavioral change, substance use recovery, and family engagement. For example, the department offers a 90-day individual counseling program for youth on probation to address behavioral and emotional challenges. It also partners with the South Texas Council on Alcohol and Drug Abuse Counseling Services to provide their 90-day substance use treatment program, which helps around 30 youth each year in overcoming addiction-related issues. SCJPD's Stars At Risk Program, which is a 60-day initiative designed to support at-risk youth through provider-developed curricula, serves about 10 participants annually.

The department also operates the Starr County Juvenile Justice Center, a 14-bed, minimum-security facility primarily used for pretrial detention. Mental health services at the facility are limited, with contractual access to a psychologist and a qualified mental health professional (QMHP). Crisis intervention and mental health assessments are available, but there are no on-site psychiatric services or licensed professional counselors. The facility does not currently have access to family counseling, transition or reentry services, or job placement assistance.

Willacy County Juvenile Probation Department

While also smaller in scale compared to neighboring counties, the Willacy County Juvenile Probation Department, headquartered in Raymondville, offers services to promote skill development and family stability, including Cognitive Behavioral Treatment (CBT) contracted providers deliver to help youth recognize and change harmful thought patterns and behaviors. They also offer an in-house family preservation program aimed at strengthening family dynamics and preventing out-of-home placements, as well as a sex offender counseling program for youth adjudicated for sexual offenses.

Gaps and Challenges in the Regional Juvenile Justice System

Based on site visits and discussions, stakeholder interviews, and regional data, the following top juvenile justice-related challenges emerged.

High Rates of Assault Family Violence with No Alternative Response Options

Justice system stakeholders report that assault family violence (AFV) is a common offense leading to youth arrest and detention in the region that would be better addressed outside the justice system.[376] In 2023, the region had a family violence rate of 956 per 100,000 residents, higher than the Texas state average of 836. Hidalgo County reported the highest AFV rate at 1,002 per 100,000, followed by Willacy (994), Cameron (940), and Starr (430) (see Table 48: Family Violence Incidents in Texas and the Rio Grande Valley (2023)). In Hidalgo County, referrals to the juvenile justice department for offenses related to family violence increased by 70% (from 109 to 186) from 2017 to 2024.[377]

AFV cases in the juvenile justice system often involve verbal or physical conflicts between youth and caregivers, where law enforcement is called to de-escalate, and the youth is arrested as a safety measure. Arrest and transport to a juvenile detention facility is often used as a tool to physically separate the youth from the home situation in the absence of crisis response or safe drop-off alternatives. According to community stakeholders, youth referral profiles across counties show that most referrals occur between ages 13 and 16, which overlaps with the peak developmental window for family conflict, identity formation, and trauma-related behavior. This suggests that many AFV incidents reflect unaddressed mental health or family systems issues rather than delinquency.

Law enforcement lacks options outside of juvenile detention, such as a centralized triage and stabilization center where youth can receive rapid assessment, care coordination, and diversion services. Stakeholders also shared that long delays in accessing psychological evaluations can also result in youth being detained simply to expedite assessments, an approach frequently used not due to youth risk, but due to gaps in the broader behavioral health system. Hidalgo County stakeholders described a vision for a local diversion center modeled after the Harris County Opportunity Center, but tailored to the region, offering recreation, mental health services, and long-term engagement to facilitate access and a shift away from punitive responses.

Vaping Fuels School Discipline and Justice Referrals

Across the region, juvenile justice leaders report that school responses to student vaping have contributed to an increase in school-based arrests. Although the specifics vary by district, schools frequently resort to punitive measures such as Disciplinary Alternative Education Program (DAEP) placements or juvenile justice referrals, often in the absence of clear behavioral protocols or access to appropriate diversionary supports.[378] The passage of House Bill 114, which took effect on September 1, 2023, has intensified this trend. The law requires that any student found in possession of an e-cigarette on school property—regardless of the

[376] See also the preceding section on family violence.

[377] Texas Juvenile Justice Department. (2025, April). Family Violence Referrals - fiscal years 2017-2024. Received from email communication on April 29, 2025.

[378] A DAEP is a separate disciplinary educational setting where students are placed for behavioral violations, providing continued instruction while removing them from their regular school environment.

substance inside—must be placed in a DAEP.[379] This policy has significantly increased DAEP placements across the region, overwhelming existing alternative education programs and straining local school and juvenile justice systems. In their school districts with a population of over 9,000 students, both Cameron and Hidalgo saw a 30% increase in the number of students removed to a DAEP in school year 2023-2024 compared to school year 2018-2019.[380]

Local educators and justice system partners expressed concern about the lack of adequate educational, behavioral health, and counseling supports within DAEPs, noting that these settings rarely address the root causes of students' behaviors. In the case of most DAEPs, youth are removed from their home campuses and the DAEP is a punitive environment lacking access to substance use education, mental health support, or ongoing academic instruction. These placements can also disrupt relationships with trusted adults and peers, increasing the risk of disengagement from school.

Without consistent districtwide protocols or diversion alternatives around school vaping —such as first offender programs or school-based interventions—many students in the region are being funneled into DAEPs or the justice system for behavioral health-related or low-level conduct issues.

Gaps in System Navigation and Reentry Services

Reentry supports, which include critical services and guidance offered to youth as they transition out of probation supervision, detention, or residential placement, are fragmented in the region. These supports are intended to help youth reconnect with school, access mental health and substance use care, find positive community activities, and rebuild family relationships. In practice, strong reentry services might include individualized transition planning, peer mentors or case navigators who maintain contact post-release, and warm handoffs to trusted community providers. Currently, there is no formal care navigation system in place to support these transitions. Re-entering youth in the region frequently experience long delays in accessing follow-up mental health treatment, face difficulties re-enrolling in school, and lack consistent adult guidance to help them stay on track. Probation departments often lack capacity for sustained outreach and follow-up. Without dedicated reentry staff or coordinated cross-system follow-up, many youth "drop off the radar" after programming ends, placing them at higher risk of reoffending and further justice involvement.

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[379] EDUCATION CODE CHAPTER 37. DISCIPLINE; LAW AND ORDER, 37.006(a) Texas Education Code. Retrieved May 5, 2025, from https://statutes.capitol.texas.gov/Docs/ED/htm/ED.37.htm#37.006

[380] Texas Education Agency. "D*iscipline Reports: Annual District Summary, 2018-19 and 2023-24*." https://rptsvr1.tea.texas.gov/adhocrpt/Disciplinary_Data_Products/Discipline_Summary_Download.html. Accessed 27 April, 2025.

Recommendations for Juvenile Justice

Rec. 1	**Conduct a planning process to establish a youth assessment and diversion center in Hidalgo County that provides screening, short-term stabilization, and warm handoffs to services.**

Across the region, youth are frequently detained not because they pose a public safety risk, but due to lack of other options during behavioral or family crises, particularly in cases involving family violence or unmet mental health needs. While youth crisis outreach teams (YCOT) can help in some of the instances, the program is insufficient on its own (for more on YCOT, see the section on crisis services.) A youth assessment and diversion center would address this critical gap by offering a neutral, trauma-informed space where youth can be stabilized, assessed, and connected to appropriate services without being criminalized. Modeled on successful initiatives[381] in Philadelphia, Houston, and Las Vegas in alignment with the National Assessment Center Association's model and best practices,[382] such a center would function as a triage hub and an alternative to arrest for law enforcement, reducing unnecessary detention and improving system navigation from the very first point of contact.

The center would be a welcoming, youth-centered space integrating behavioral health supports with activities that promote connection and healing such as art, recreation, mentoring, and connection to vocational opportunities. Rather than serving only justice system-involved youth, the center could advance a broader vision of early intervention, family-centered support, and prevention, ensuring youth and caregivers have access to help long before system involvement deepens. Co-located partners could include education liaisons, youth-serving nonprofits, and bilingual staff to ensure cultural and linguistic accessibility. Operating potentially around the clock, the center would offer immediate assessment, crisis stabilization, and warm handoffs to services such as referrals to Tropical Texas, substance use treatment, or in-home family supports. It would also serve as a trusted referral resource for schools, law enforcement, and caregivers, reducing overreliance on courts and law enforcement as default crisis responders.

As a precursor to implementation, stakeholders should conduct a comprehensive planning process to develop the centralized youth assessment and diversion center. This planning process would utilize the assessment data included in this report as the foundation for developing an implementation plan, which would include identification of a lead agency, viable operational models, potential physical locations, and sustainable funding strategies.

We recommend that Hidalgo County's 449th State District Court serve as the lead coordinating entity and contract with a consultant to act as a project coordinator. This coordinator would convene a cross-sector planning team, co-design engagement strategies, and oversee the planning process. Key tasks would include analyzing referral and detention data for low-level, family-related, and behavioral health cases, identifying decision points and service gaps,

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[381] *National Assessment Center Spotlights*. (n.d.). Retrieved May 5, 2025, from https://www.nacassociation.org/spotlights

[382] *National Assessment Center*. (n.d.). Retrieved May 5, 2025, from https://www.nacassociation.org/

consulting with the National Assessment Center Association (NAC) on best practices, and gathering input from law enforcement, behavioral health providers, educators, probation staff, youth, and caregivers. The planning process should also explore co-location options at the Boys and Girls Club site.

This process should explicitly coordinate with Tropical Texas, which recently opened an adult diversion center with plans to expand access to early intervention and support for youth in its catchment area. Leveraging Tropical Texas's experience, facilities, and expansion plans would help ensure regional alignment, avoid duplication, and potentially fast-track implementation. Estimated costs for the planning phase range from $125,000 to $150,000 and would support contractual project coordination, technical assistance from the NAC, stakeholder engagement, and production of a comprehensive plan. Deliverables could include recommended design and operational models; a proposed staffing and service plan; analysis of potential locations; a financial model and sustainability strategy; and a final recommendation on implementation. Funding for the study could be secured through county or court resources, supplemented by a TJJD Discretionary State Aid Grant.

As of summer 2025, Hidalgo County leaders have already begun exploring options for using land acquired by the local Boys and Girls Club to support diversion-focused programming. By aligning with Tropical Texas' regional diversion strategy, the Hidalgo County center could become a cornerstone of a broader, South Texas continuum of care, serving as both a local resource and a model that can be replicated in other counties. As the limited-scope Texas Juvenile Justice Department Sunset review, focused on identifying barriers to diverting youth from state facilities to local care, continues to unfold, there may be opportunities to further this recommendation during the 90th session of the Texas Legislature.

Rec. 2	**To divert first-time felony-level THC vaping offenses away from the juvenile justice system in high-referral school districts, replicate first offender programs (led by school-based law enforcement agencies in partnership with local juvenile probation departments).**

Juvenile justice departments in the region are experiencing a rise in felony-level referrals tied to student THC vaping in schools, often resulting in long-term consequences that do little to address the underlying behavior. Law enforcement agencies may, with the approval of their local Juvenile Board, establish a first offender program (FOP) to divert certain low-level, nonviolent offenses.[383] These programs are implemented in partnership with local law enforcement, juvenile probation, and school districts and typically include components such as substance use education, voluntary community service, and periodic check-ins with the administering agency. If a youth successfully completes the program and avoids new offenses for 90 days, the law enforcement agency must destroy all records linking the youth to the offense, preserving confidentiality and preventing long-term system entanglement.

[383] First Offender Program, 52.031 Texas Family Code 52.031 (2024). https://statutes.capitol.texas.gov/Docs/FA/htm/FA.52.htm#52

Brownsville ISD and its police department have piloted a vape intervention first offender program in partnership with local courts, prosecutors, and the Cameron County Juvenile Probation Department. The program offers a more effective approach that emphasizes education, accountability, and behavioral support over formal system involvement. Other school districts in the region should consider replicating their model.

County juvenile departments could begin by analyzing referral and arrest data to identify school districts with the highest rates of THC vaping or other FOP-eligible school-based offenses. These "hotspot" areas are ideal sites for establishing FOPs. Juvenile probation departments could then engage local law enforcement and school officials to build buy-in, identify a program champion, and then form a planning team with representatives from law enforcement, the school district, juvenile probation, and local behavioral health providers to design the program. Planning teams would ideally begin by drafting a memorandum of understanding outlining referral processes, participant criteria (first-time offense, felony THC vaping), confidentiality and record destruction protocols, and roles of each partner. They should also identify and secure a peer-reviewed, evidence-based youth vaping prevention program, such as Catch My Breath.[384]

For schools without a dedicated school-based police department, FOPs can be led by municipal police or county sheriff's departments. One such program exists in Hidalgo County operated by the Weslaco Police Department,[385] which could be used as a model for non-school personnel.

A typical FOP can be staffed by one designated law enforcement officer or program coordinator (0.25–0.5 FTE), a juvenile probation liaison for referral tracking and coordination (existing role or 0.1 FTE), and a behavioral health partner, sourced from the LMHA or a local nonprofit provider. With the state mandate placing an armed officer in every school, school resource officers newly assigned to elementary campuses may be ideal candidates to oversee the program, as they often have greater capacity and fewer behavioral incidents to manage. Estimated operational costs range from $400–$600 per youth. The programs could be funded with blended contributions from school district or law enforcement discretionary or prevention funds, juvenile board discretionary funds, or local foundations. Notably, the Hutto ISD Police Department in Williamson County (Round Rock, Texas) implemented their FOP with no fiscal impact to the department by utilizing the staff and programming already provided by the juvenile department's prevention and intervention team. Moreover, many existing FOP programs offer program manuals, training materials, and lessons learned to support replication, including the Socorro ISD Police Department in El Paso, Hutto ISD Police FOP in Williamson County, and the Southwest ISD Police Department's P.R.O.M.I.S.E. Program[386] in San Antonio.

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[384] Coordinated Approach to Child Health (CATCH). (n.d.). *Comprehensive Vaping Prevention Programs For Schools*. CATCH. Retrieved May 5, 2025, from https://catch.org/program/vaping-prevention/

[385] Weslaco Police Department. (n.d.). *First Time Offender Program*. Retrieved May 5, 2025, from https://www.weslacotx.gov/departments/first_offender_s_program.php

[386] Southwest Independent School District. (n.d.). *P.R.O.M.I.S.E. Program*. Retrieved May 5, 2025, from https://www.swisd.net/apps/pages/index.jsp?uREC_ID=2624471&type=d&pREC_ID=2651296

Rec. 3	**The South Region Juvenile Probation Association, with staff support from TJJD's South Regionalization Lead, should develop a juvenile regional reentry navigation program with post-release care coordination and county-specific youth resource guides.**

Youth in the region often "drop off the radar" after completing probation or being released from juvenile detention or placement, encountering long wait times for mental health services, barriers to school reentry, and a lack of sustained support. Caregivers (particularly grandparents and Spanish-speaking families) face significant challenges navigating digital tools, court processes, and fragmented service systems. To ensure continuity of care and reduce recidivism, the region should establish a coordinated reentry effort that extends case management and support beyond system involvement.

The Rio Grande Valley's juvenile probation departments already collaborate through the TJJD South Region Juvenile Probation Association, with facilitation and staff support from TJJD's South Regionalization Lead. This structure is well-positioned to develop and pilot a regional reentry navigation program offering 60–90 days of post-release care coordination for youth exiting probation or juvenile placements.

The first step in piloting this navigation program is creating a youth and family reentry resource guide—a practical, county-specific tool that includes vocational and educational programs, peer and mentoring supports, interpreter-accessible services, and caregiver-friendly digital resources. This guide could be developed at low or no cost by leveraging existing assets: TJJD's South Regionalization Lead, local juvenile parole officers, and findings from the asset and gap mapping continuum of care study the Meadows Institute recently conducted in the region. Resources could be tracked via a shared spreadsheet or web-based tool hosted by TJJD.

Following the guide's development, the South Region Probation Association could jointly apply for a TJJD Discretionary State Aid Grant[387] to fund a regional reentry coordinator, shared across the four counties, at an estimated cost of $50,000–$75,000 annually. Ideally, this coordinator would be a certified peer support specialist or certified family partner with lived justice system experience, housed within either an LMHA or TJJD's regionalization or parole office.

The reentry coordinator would serve as a navigator and liaison for youth and families, supporting them during the critical 60–90 days following release. Services would include in-person or virtual check-ins, appointment scheduling and reminders, support with school reentry and educational transitions, linkage to behavioral health and vocational services, and help accessing interpreter-supported digital and court compliance tools. The coordinator would leverage the reentry resource guide to connect families to mentorship, peer support, and family

[387] Texas Juvenile Justice Department. (n.d.). *County Grants*. Texas Juvenile Justice Department. Retrieved May 5, 2025, from https://www.tjjd.texas.gov/probation-services/county-grants/

strengthening programs, ensuring every youth has a tailored, supported path back into their community.

Schools

While schools are not behavioral health providers, they can play a vital role in identifying students' mental health needs and connecting families to services. Given that children and youth spend much of their time at school, campuses often serve as the primary point of care, with at least 70% of students receiving mental health interventions doing so in a school setting.[388] Moreover, untreated or inadequately treated mental illness can lead to high rates of school dropout,[389] unemployment, substance use, and justice-involvement (among other adverse life circumstances),[390] underscoring the importance of access to school-based and school-connected services.

At least 70% of students receiving mental health interventions receive it in a school setting.

In short, schools in the region are uniquely positioned to help connect children and youth to mental and behavioral health care.

For the 2024-2025 academic year, the four-county region of Cameron, Hidalgo, Starr, and Willacy was home to approximately 327,000 students. Districts in the region vary widely in size, with Brownsville ISD, the largest, serving over 36,000 students that year, and San Isidro, the smallest, serving 153 students. Across these counties, student demographics reflect a predominantly Hispanic student population, with an average of 97% of students identifying as Hispanic. Additionally, an average of 86% of students in the region are considered economically disadvantaged, a designation the Texas Education Agency (TEA) defines as students from families with an annual income at or below the poverty level, or those who qualify for free or reduced lunch.[391]

School-based Mental Health Services and Supports

To support the mental and behavioral health needs of students, TEA recommends adopting a Multi-tiered System of Supports (MTSS)[392] model. MTSS is an evidence-based, comprehensive,

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[388] Texas Education Agency (TEA). Statewide Plan for Student Mental Health Senate Bill 11. (2020). https://tea.texas.gov/about-tea/government-relations-and-legal/government-relations/sb11mhsp.pdf

[389] Porche, M. V., Fortuna, L. R., Lin, J., & Alegria, M. (2011, May/June). Childhood Trauma and Psychiatric Disorders as Correlates of School Dropout in a National Sample of Young Adults. *Child Development*, *82*(3), 982-998. https://doi.org/10.1111/j.1467-8624.2010.01534.x

[390] National Association for Mental Illness (NAMI). Mental Health in Schools. (2021, April 8). https://www.nami.org/advocacy-at-nami/policy-positions/improving-health/mental-health-in-schools/

[391] Texas Education Agency. (n.d.). *Counties, Districts, Campuses 2024-25*. https://tealprod.tea.state.tx.us/visual-public-reports/?workspace=5fdcbbbe-ce38-49d1-a07b-9f56b173cc48&report=fefa1dbd-c6c4-47bd-8eaa-16e520ecfa4b

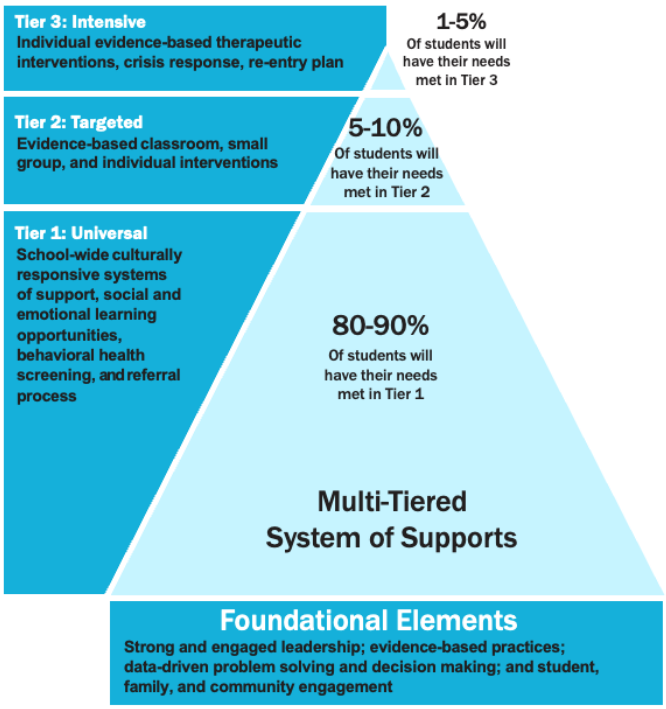
[392] Texas Education Agency. (n.d.). *Multi-Tiered Systems of Support.* https://tea.texas.gov/academics/special-student-populations/special-education/mtss.pdf

"whole-child" framework that organizes school and community-level resources to address students' academic, behavioral, mental health, and wellness needs within three intervention tiers that vary in intensity. When fully integrated, MTSS leverages several systems including response to intervention, positive behavioral interventions and supports, school mental health, and other supports for prevention and early intervention.

MTSS helps school staff with early identification of students who are at risk for being academically unsuccessful or who need additional support, including those with behavioral or mental health needs. The increasingly intensive tiers are also a continuum of supports available to students. The following spotlights how schools can leverage the tiered model for students' mental and behavioral health needs.

- **Tier 1: Universal supports and interventions** are mental health promotion strategies schools deliver to all students to meet the needs of the majority, including positive behavioral supports, high-quality instruction, and proactive classroom strategies.
- **Tier 2: Targeted supports and interventions** are for subsets of students with mild to moderate mental or behavioral health needs that schools identify as needing additional support. They typically deliver these interventions in small groups to address specific needs.
- **Tier 3: Intensive supports and interventions** are specialized interventions for students with complex mental or behavioral health needs who require individualized support and increased progress monitoring. Tier 3 supports include services such as individual counseling, re-entry protocols, and crisis response plans.

Figure 14: Multi-Tiered System of Supports



The continuum of interventions within each tier of the MTSS framework varies across school districts and campuses, based on identified needs available resources, and district priorities. Notably, while there is intervention variation, there is a set of foundational elements that are critical to successfully implementing and sustaining MTSS. These elements include; strong and engaged leadership, the implementation of evidence-based practices, data-driven problem solving and decision making, and student, family, and community engagement. Among these, strong and engaged administrative leadership is a critical driver of success. Leadership commitment ensures the alignment of student mental health initiatives with broader district priorities and supports the allocation of time and resources necessary to develop and sustain comprehensive school-based mental health programs. Moreover, leaders champion adoption of evidence-based practices, leveraging data to inform decision-making, and investing in staff training and development.

Mental Health Services and Supports Available in Regional Schools

One of the most notable trends across the region's school districts is the growing recognition that student mental health is integral to educational outcomes. Superintendents, school boards, and district leaders alike acknowledge that when students are mentally well, they are more likely to succeed. This has led to increased investment in psychoeducation, counseling services, and behavioral health initiatives. At the systems level, the region's school districts are at varying stages of developing and implementing MTSS to address their students' needs. While some districts have established tiered supports such as positive behavioral interventions and supports (PBIS), licensed professional counselors (LPCs), and structured referral pathways with community providers, others are in earlier phases of implementation involving planning or training. In addition to internal systems and initiatives, regional school districts strategically leverage community partnerships and external funding opportunities to enhance their mental and behavioral health services, which we detail later in this assessment.

Spotlight: McAllen ISD's Family Treatment Program

Launched in 2008, McAllen ISD's Family Treatment Program aims to increase access to mental health services by promoting mental health awareness and offering both prevention and intervention services to families. The program provides a range of supports including case management services, suicide prevention, crisis and threat assessment, and referrals to community organizations.

Regional Multi-tiered System of Support

MTSS Tier 1: Universal Services and Supports

Across the region, school districts are investing in Tier 1 practices that promote mental wellness, positive school climate, and strong family partnerships. Districts have adopted social-emotional and character development learning curriculum (e.g., Move this World, Character Strong, Capturing Kids' Hearts) to help students build emotional intelligence, self-regulation skills, improve behavior, and strengthen problem-solving skills. To further support these efforts, schools have introduced mental health workshops, shared wellness newsletters with families, and offered digital literacy programs to help caregivers engage with online wellness curricula.

Other proactive approaches include launching Hope Squad, a peer-led suicide prevention program. Hope Squad was developed by an educator in Utah who recognized the power of peer support in preventing youth suicide. Students are nominated for Hope Squad membership by their peers based on qualities such as kindness, empathy, and approachability. Selected students receive ongoing training and support, enabling them to serve as a bridge between peers who may be struggling and trusted adults on campus. Hope Squad is listed on the Suicide Prevention Resource Center's Best Practices Registry, and local administrators report improvements in school climate and culture—outcomes that align with national findings.[393] See Appendix W for more information on the Hope Squad Program.

Similarly, in 2024, after three student suicides, the Rio Grande City Grulla ISD established a committee dedicated to suicide prevention. Comprised of administrators, psychologists, and current and retired staff members, the committee implements strategies that support student mental health by raising awareness of available mental health resources, training teachers to recognize signs of mental health distress, and equipping teachers with the skills to support students.

Spotlight: IDEA Public School and Harlingen CISD Hope Squad Programs

IDEA Public Schools (IDEA) championed mental health awareness and suicide prevention by implementing Hope Squad across its campuses in Cameron, Hidalgo, Starr counties, directly impacting 17,000 middle and high school students. To deepen the program's impact, IDEA partnered with UTRGV to offer parent training, helping to further engage families and offer support for mental health, and youth suicide prevention at home.

Harlingen CISD is in its fourth year of implementing Hope Squad. Years 1-2 focused on starting the program in their secondary schools while expanding to elementary schools during year 3. There are 250 Hope Squad Students at the secondary level, and the district is planning its first Hope Squad Leadership Conference to bring secondary student leaders together for skill-building and panel discussions.

MTSS Tier 2: Targeted Services and Supports

To address the diverse mental and behavioral health needs of students in the region, school districts have launched innovative initiatives and built strong partnerships with community organizations. Counselors and licensed mental health professionals provide direct services in schools: districts have licensed professional counselors (LPCs) and licensed social workers (LSWs) in school counseling roles, with many professionals holding dual licensure in both mental health and education counseling. One district reported regularly implementing restorative discipline practices with students and training the entirety of its staff on Collaborative Problem-Solving®[394] to better address challenging student behavior. In addition to school-based services, some districts have formed crisis response teams that deploy staff

[393] Suicide Prevention Resource Center. (n.d.). *Best Practices Registry*. Retrieved February 12, 2026, from https://bpr.sprc.org/program/hope-squad/

[394] Think:Kids Massachusetts General Hospital. (n.d.). Collaborative Problem Solving (CPS). https://thinkkids.org/cps-overview/

during high-stress events. These teams assist students and staff through psychological first aid and grief counseling, offering emotional support when incidents such as student deaths or traumatic events occur.

Spotlight: Brownsville ISD's Evening Counseling Program

To increase access to counseling services, Brownsville ISD offers evening counseling hours for students and families seeking support outside of the traditional school day. Over the last three and a half years, their counselors have responded to over 1,000 referrals related to stress, anxiety, grief, coping skills, and self-harm.

MTSS Tier 3: Intensive Services and Supports

To expand student access to mental and behavioral health services, school districts in the region have strategic partnerships with community organizations, healthcare providers, and mental health agencies. These partnerships strengthen school-based mental health efforts by integrating external capacity and expertise to help districts overcome barriers related to staffing shortages, funding constraints, and service accessibility. Partner organizations often collaborate with schools and work in tandem with school counselors, administrators, and teachers to provide access to basic needs, targeted support for mental health challenges, substance use concerns, or other life stressors that impact their well-being and academic success. Tropical Texas is one such partner, as they have staff located at various schools to provide mental health services to students. By leveraging these partnerships, school districts enable access to comprehensive resources beyond those that districts can provide. See Appendix R for details on those relationships with schools in the region.

Spotlight: Harlingen CISD's Student Mental Health Taskforce

Harlingen CISD's mental health taskforce, which is comprised of a robust array community partners (Tropical Texas, the Children's Bereavement Center, the Children's Advocacy Center, Buckner, Loaves & Fishes, Judge Adela Kowalski-Garza, DPS, and law enforcement), meets monthly to collaborate on how to best serve students and maximize their community impact. This approach offers students and families direct access to support.

Region One Education Service Center

The Region 1 Education Service Center (ESC),[395] a key partner to school districts across the Rio Grande Valley, plays a vital role in supporting both Tier 2 and Tier 3 efforts in the region. In addition to building capacity through training and technical assistance, Region 1 ESC also provides direct services to districts, at times even addressing gaps in student mental health support and crisis response, especially when districts experience school or district-wide traumatic events. Region 1 ESC can also deploy LPCs and trained personnel to deliver immediate, on-site assistance to students and staff during moments of acute need. Beyond crisis intervention, Region 1 ESC helps districts better understand emerging trends, target their

[395] In Texas, regional education service centers serve as a liaison between the Texas Education Agency and the school districts within its region. The Region 1 ESC catchment is made up of an eight county area including Brooks, Cameron, Hidalgo, Jim Hogg, Starr, Webb, Willacy and Zapata counties.

resources, and make data-informed decisions by conducting surveys and needs assessments. This support is complemented by their coordination with McKinney-Vento liaisons[396] to assist students and families experiencing homelessness.

Texas Child Health Access Through Telemedicine (TCHATT)

In 2019, the legislature created the Texas Child Mental Health Care Consortium (Consortium), which coordinated implementation of the Texas Child Health Access Through Telemedicine (TCHATT), along with four other initiatives.[397,398] Through TCHATT, regional medical schools, or health-related institutions (HRIs), like UTRGV, provide schools with free Tier 2 services such as telehealth and telepsychiatry services to help identify and assess the behavioral health needs of children and youth and meet those needs with counseling or others direct care services. Tier 3 supports, such as urgent assessments and short-term stabilization care, are also available at no cost through TCHATT, which helps increase community-wide urgent care capacity. Through TCHATT, UTRGV also provides regional linkages to follow-up care through referrals to outpatient mental health providers. As of October 2025, there are 475 active, onboarding, pending, and planned TCHATT campuses in the region.

Table 52: Active, Onboarding, Pending, and Planned TCHATT Campuses[399,400]

County	Campuses	Student Population
Cameron	153	82,534
Hidalgo	194	111,776
Starr	28	15,488
Willacy	14	3,889
Charters	86	50,666

For more details on TCHATT programs by county, please see Appendix S.

In only a few years, TCHATT has achieved remarkable successes across the state. In the academic years spanning from fall 2022 to spring 2024, 27,332 students received more than

[396] Mckinney-Vento liaisons serve as one of the primary contacts between unhoused families and school staff, district personnel, shelter workers, and other service providers. See more at https://tehcy.tea.texas.gov/mckinney-vento-liaisons

[397] *TCMHCC – Texas Child Mental Health Care Consortium*. (n.d.). Retrieved June 2, 2025, from https://tcmhcc.utsystem.edu/

[398] Initially, TCHATT was not available in every Texas school district due to funding limitations; however, the 88th Legislative Session expanded TCHATT's reach – the 2024–25 budget funded TCHATT's expansion statewide to any interested districts.

[399] *Texas Child Health Access Through Telemedicine (TCHATT) – TCMHCC*. (n.d.). Retrieved October 6, 2025, from https://tcmhcc.utsystem.edu/tchatt/

[400] Please note that TCHATT does not use county information when tabulating data. Instead, it uses Regional ESC, District, and HRI identification. The Meadows Institute divided the districts into the county they primarily serve. Charter schools can span multiple counties.

129,345 telehealth sessions.[401] In a recent survey of parent/guardians, 80% strongly agree that they would recommend TCHATT to other families.[402] Similarly, surveyed school staff reported TCHATT-related student improvements included better grades, decreased behavioral incidents, better attendance and more involvement in school. Plus, 91% of school staff reported increased capacity to meet students' non-educational needs.[403]

Grant Funded Services

Districts often pursue grants to fund mental health programs. These grants strengthen district efforts across the MTSS framework, including, for example:

- Tier 1: Funds support implementation of universal mental health awareness training, school climate initiatives, and social-emotional learning programs.
- Tier 2: Districts have expanded access to group interventions and targeted supports for students exhibiting emerging mental health concerns.
- Tier 3: Funding enables hiring and training specialized mental health professionals to deliver individualized services for students with intensive needs.

Furthermore, many grants have supported and/or are supporting collaborations with local organizations, community agencies, and mental health providers to ensure that students can access care both in school and beyond. The following outlines key funding sources helping regional school districts build a comprehensive, tiered continuum of mental health supports.

Table 53: Grants Awarded to Regional Districts and Institutions

Project Bridging the Way	SAMHSA awarded a $625,000 grant to UTRGV to train school personnel (teachers, counselors, administrators, school law enforcement, and human resource employees) as well as parents and undergraduate clinical teachers to recognize signs of mental concerns in youth and staff – and to make referrals to mental health providers.
Mental Health Access Grants	The U.S. Department of Education awarded two grants totaling $11.3 million to UTRGV to expand access to mental health services for K-12 students. Together, the grants aim to train 180 graduates in school psychology, counseling, and social work to serve ten school districts: Edcouch-Elsa ISD, McAllen ISD, PSJA ISD, Sharyland ISD, Harlingen CISD, Mission CISD, Laredo ISD, Mercedes ISD, United ISD, and Valley View ISD. UTRGV expects 75% of these professionals to be employed within these districts, helping build a sustainable workforce that better meet student needs.

[401] Texas Child Mental Health Care Consortium. (n.d.). *Texas Child Mental Health Care Consortium BIENNIAL REPORT September 1, 2022 – August 31, 2024*. Retrieved June 2, 2025, from https://tcmhcc.utsystem.edu/wp-content/uploads/2024/11/TCMHCC-Biennial-Report-2024-FINAL.pdf

[402] Texas Child Mental Health Care Consortium, (n.d.), *Texas Child Mental Health Care Consortium BIENNIAL REPORT September 1, 2022 – August 31, 2024*

[403] Texas Child Mental Health Care Consortium. (2024, November). *TCMHCC External Evaluation FY 2023 Survey Findings*. https://tcmhcc.utsystem.edu/wp-content/uploads/2024/08/External-Evaluation-Presentation-November-2024.pdf

STOP Violence Program Grant	With the support of a district-employed grant writer, the Bureau of Justice awarded Harlingen CISD $1 million to promote safety, address the mental health needs of students, and hire dedicated staff to oversee the implementation of these efforts.
Stronger Connections Grant	Awarded to 12 school districts through the Bipartisan Safer Communities Act, this grant helps schools create safer and healthier learning environments by supporting student mental health and well-being. The funds, ranging from $1 million to $1.5 million per district, support efforts to expand school-based mental health programs in Weslaco ISD, Mission CISD, Point Isabel ISD, Lasara ISD, Mercedes ISD, Rio Hondo ISD, San Benito CISD, Santa Rosa ISD, Triumph Laredo, Triumph RGV, Valley View ISD, and Vanguard Academy.
Grants for Hope Squad Implementation	Harlingen CISD and IDEA Public Schools respectively received $99,000 and $703,000 from the Valley Baptist Legacy Foundation to implement Hope Squad, a peer-led suicide prevention program that trains and empowers students to identify peers who may be struggling with their mental health and connect them with trusted adults. Additional funding from the Valley Baptist Legacy Foundation grant ($789,000) also supports the implementation of Capturing Kids' Hearts – a culture-shifting initiative focused on social-emotional learning and student connectedness in Harlingen CISD.

Challenges Regional School Districts Face

By integrating mental and behavioral health into district priorities, investing in psychoeducation and behavioral health, and securing partnerships and funding, regional school districts are taking significant steps toward addressing mental health and improving student well-being. However, ongoing challenges remain with stigma, scaling mental health interventions, ensuring equitable access to services, workforce, and sustainable funding.

Engagement

Districts face challenges in engaging families around mental health. Despite efforts to normalize mental health topics, cultural perceptions that frame mental health struggles as temporary or non-existent remain a significant barrier to students receiving mental health supports. Stakeholders shared that caregivers hesitate to accept services offered at school, using phrases such as *"Nothing's wrong with my child,"* and *"It's just a phase,"* that reflect beliefs that mental health concerns do not require professional intervention. These local experiences are consistent with broader literature, which has found that among many Hispanic or Latino families, stigma is negatively associated with seeking care, managing symptoms, and disclosing mental health conditions to others.[404] Compounded by the cultural fear of being viewed as "crazy" or being socially ostracized for discussing mental health concerns,[405] parents may be especially hesitant to pursue services when a formal diagnosis could result in labeling their

[404] Eghaneya, B. H., & Murphy, E. R. (2020). Measuring mental illness stigma among Hispanics: A systemic review. *Stigma and Health, 5*(3), 351–363. https://doi.org/10.1037/sah0000207

[405] Jimenez, D. E., Bartels, S. J., Cardenas, V., & Alegría, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care: Stigma in older adults. *International Journal of Geriatric Psychiatry, 28*(10), 1061–1068. https://doi.org/10.1002/gps.3928

child, with some opting out of therapy sessions or failing to provide consent for intensive treatment. Overall, stigma contributes to resistance to services, delays in care, and missed opportunities for early intervention.[406]

Gaps in Tiered Services and Supports

While districts increasingly recognize the importance of integrating a comprehensive framework like MTSS to address student mental health, implementation remains inconsistent across the region, resulting in regional gaps in services and supports. Districts noted two key issues that hinder MTSS adoption: 1) varying levels of training and understanding of the framework and 2) an absence of systems to collect and monitor mental health data, including interventions and referrals, often leaving districts reliant on external partners to collect this information. The below outlines a few tier-specific challenges.

Table 54: Gaps in Tiered Services and Supports

Tier 1
Prevention
Some districts do not implement comprehensive Tier 1 mental health programming, while others struggle to scale existing efforts to meet rising levels of need. Schools are seeing an increase in mental health concerns at younger ages, with elementary school staff reporting new challenges not previously observed at this level. By middle school, students face heightened issues related to social media use, bullying, cyber-bullying, anxiety, and depression. While many districts offer some form of Tier 1 support, such as social-emotional learning (SEL) lessons or programs, these can be under-resourced or not fully aligned with student needs. As a result, early signs of distress may go unaddressed, causing challenges to worsen by the time students reach high school.
Tier 2
Substance Use Disorders
Districts report high rates of vaping in middle schools, with growing concerns even among elementary school-aged students. Moreover, despite increased report rates, stakeholders noted that the reported numbers were likely conservative estimates, as some districts prioritize maintaining a strong academic reputation over full transparency about behavioral health challenges in their districts. In addition, many districts see vaping and other substance use as a legal or disciplinary issue rather than a behavioral health concern — which current anti-vaping legislation that mandates school-based citations reinforces. If, despite these impediments, schools identify students as needing SUD support, districts generally lack the capacity for in-house intervention, often relying on a very limited pool of external providers to provide interventions. Among stakeholders, there is a strong consensus that the need for formal SUD treatment greatly exceeds available resources. Absent less punitive legislation and expanded options for substance use support, students struggling with substance use will continue facing barriers to care.
Military-connected Families
These students face unique challenges related to mobility, family separation, and the stress of having parents deployed. However, many school counselors and staff are unaware that these students

[406] Benuto, L. T., Gonzalez, F., Reinosa-Segovia, F., & Duckworth, M. (2019, December). Mental health literacy, stigma, and behavioral health service use: The case of Latinx and non-Latinx Whites. *Journal of Racial and Ethnic Health Disparities, 6*(6):1122–1130. doi: 10.1007/s40615-019-00614-8

require specialized mental health support. Without targeted interventions, military-connected students can struggle with social-emotional adjustment, academic disruptions, and mental health concerns, leaving critical gaps in their support system.

Undocumented Families

Stakeholders reported students experiencing high levels of mental health distress, fear, and anxiety due to their own or a family member's immigration status or due to family separation as a result of deportation. This uncertainty creates emotional and psychological strain, and many schools lack specialized resources to support these students through counseling or crisis intervention.

Tier 3

Crisis Care

Crisis responses are straining schools; stakeholders shared that responding to crises has become a daily occurrence, lowering staff capacity to provide proactive or preventative support. One district noted that the top 5% of students with the most intensive needs require a disproportionate share of mental health resources, placing added pressure on already limited staff. For students with severe mental health needs, accessing immediate and intensive intervention can be difficult due to inefficiencies in crisis response systems.

The Mobile Crisis Outreach Team (MCOT), which provides emergency mental health screenings, operates under standard response timeframes: within one hour for emergent calls, eight hours for urgent situations, and 24 hours for routine cases. Although these response times meet prescribed standards, schools report that they are not always able to wait, even when MCOT arrives within the required window. In practice, schools have reported waits of three to four hours for an emergency mental health screening, leading to disruptions in both care and the educational environment. As a result, some districts have developed workarounds, such as directly admitting students to hospitals rather than waiting for MCOT. While this may expedite access to care, it also highlights the limitations of the current system. Direct admission to inpatient care is not always clinically necessary and may not align with the best interest of the student, whose needs might be more appropriately met in a community-based setting. These workarounds reflect an urgent need for a more functional, school-responsive crisis continuum that helps stabilize students without defaulting to higher levels of care.

Suicide Risk and Threat Assessment

Districts across the region report being under-resourced and underprepared to address suicide risk and other critical threats, such as the recent rise in campus-based terroristic threats.

Funding Challenges

Funding challenges severely limit the region's districts from expanding school-based mental health programs, including sustainability of programs and services implemented with pandemic relief funds. Additionally, the region has experienced dramatic charter expansion over the past few years.[407] While charter campuses are considered part of the public school system, there is some debate over their funding; as enrollment at charter schools increases, revenues reduce at the local school districts (average daily attendance drops while fixed costs often remain the same).

[407] *Texas AFT :Fiscal Impact of Charter School Expansion on Texas Public Schools ‣ Texas AFT*. (2024, June 28). https://www.texasaft.org/fiscal-impact-of-charter-school-expansion-on-texas-public-schools/

Many of the mental health programs and interventions implemented during the COVID-19 pandemic were funded through the Elementary and Secondary School Emergency Relief (ESSER) Fund.[408] Over three years, school districts in the Rio Grande Valley received $2.2 billion in ESSER dollars to fund mental health programs, mental health training, and school-based counselors and mental health professionals.[409] For example, districts in the region received over $155 million in money under ESSER III.[410]

As the temporary ESSER funds sunset and districts face reduced revenues, they risk losing vital mental health personnel, reducing service availability, and limiting student access to care; 39% of districts in Texas report that they are unlikely to sustain any staffing or programs once ESSER funds fully expire.[411] La Feria ISD, Donna ISD, Rio Grande City Grulla ISD, McAllen ISD,[412] Brownsville ISD,[413] and La Joya ISD[414] all face budget deficits for 2024-25 and 2025-26. Without alternative funding sources, schools risk losing counseling positions, intervention programs, and partnerships with external mental health providers, leading to a reduction in services available for students. Absent sustained financial support or replacement funding, the region may experience a reversal in progress made to address student mental health, especially among high-need populations.

The recommended ratio of students to counselors and social workers in Texas is 250 to 1.

Regional counselors serve an average of 343 students, nearly 40% above the recommended rate.

One district reports counselors support nearly 700 students.

See Appendix C for a breakdown of ESSER funding allocations by district.

Workforce Challenge

On average, schools in the region exceed the recommended ratios of counselors, social workers, and licensed specialists in school psychology (LSSPs).[415] In Texas, the recommended

[408] On March 27, 2020, Congress set aside approximately $13.2 billion of the $30.75 billion allotted to the Education Stabilization Fund through the Coronavirus Aid Relief, and Economic Security (CARES) Act for the ESSER Fund to address the impact of COVID-19.

[409] U.S. Department of Education. (n.d.). Education Stabilization Fund. https://covid-relief-data.ed.gov/profile/state/TX

[410] Texas Education Agency. (2024). *Texas Education Agency Department of Grant Compliance and Administration ARP Act, Elementary and Secondary School Emergency Relief (ESSER) III Grant Reallocation Amounts (Alphabetical by District)*. https://tea.texas.gov/finance-and-grants/grants/grants-administration/entitlements/2020-2021-arp-act-esser-iii-reallocation-amounts-by-lea.pdf

[411] Collaborative Task Force on Public School Mental Health Services. (2025).

[412] Zapata, O., (2024, February 14), McAllen ISD facing $13.7 million budget deficit, *MyRGV.Com*

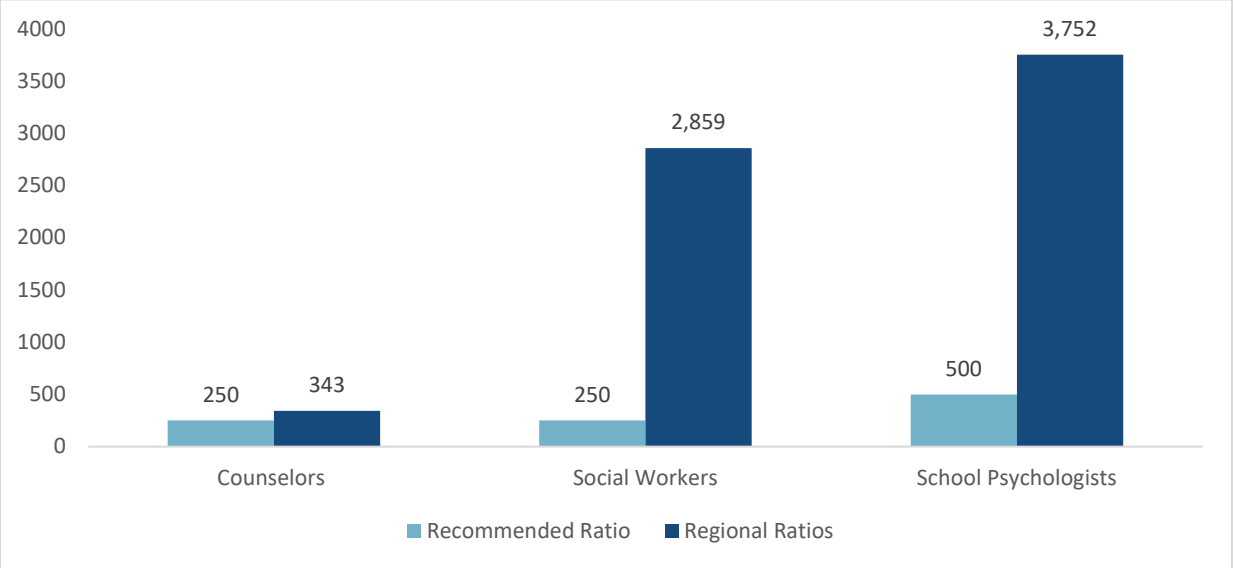
[413] Long, G., (2024, February 2), Brownsville ISD faces $16 million budget deficit for 2024-25, *MyRGV.Com*

[414] Escobedo, G., (2025, April 11), Escobedo: RGV area school districts face growing financial strain, *Rio Grande Guardian*

[415] UTRGV Newsroom. (2023). UTRGV awarded $17M to train mental health professionals for Valley schools. https://www.utrgv.edu/newsroom/2023/05/16/utrgv-awarded-17m-to-train-mental-health-professionals-for-valley-schools.htm#:~:text=VALLEY%20SCHOOL%20PARTNERSHIPS,UTRGV%20Photo%20by%20David%20Pike)

ratio for counselors and social workers is 250:1.[416] In the 2020-21 school year, however, counselors in the region served an average of 343 students, nearly 40% above the recommended rate, with one district reporting almost 700 students per counselor. Similarly, social workers and LSSPs were also stretched thin with each social worker serving 2,859 students, and each LSSP responsible for 3,752 students, nearly 1,000 students above the state average, highlighting an urgent need for additional mental support staff.

Figure 15: School Mental Health Staffing Gaps



Additionally, qualified school counselors, including designated licensed mental health professionals, regularly transition from school districts to private practice or other sectors due to low wages and burnout. In school settings, counselors are expected to handle multiple responsibilities, including academic advising, student retention, crisis intervention, and compliance with state mandates, leaving limited time for direct mental health support to students. This heavy administrative burden contributes to overwhelming workloads, prompting many to seek alternate roles where they can focus more on clinical care and receive higher compensation.

Limited Collaborative Infrastructure

While regional school districts have established valuable partnerships with community mental health providers, access to these resources varies widely across the region. Several factors contribute to these disparities, including fragmentation and geography.

- **Fragmented Systems:** While it is common for school districts to operate independently, a lack of regional coordination creates a patchy system for delivering student mental health and substance use services. Most mental health initiatives are typically managed and implemented at the district level, resulting in variable service delivery models,

[416] Collaborative Task Force on Public School Mental Health Services. (2025). https://schoolmentalhealthtx.org/wp-content/uploads/2025/02/The-Collaborative-Task-Force-on-Public-School-Mental-Health-Services-Final.pdf

referral pathways, and a fragmented landscape of community partnerships. This siloed approach limits the exchange of information, coordination of resources, and adoption of best practices across districts. As a result, some districts offer robust mental health supports, while others, often due to limited capacity, struggle to meet student needs. Although this decentralized model is typical, greater cross-district collaboration would enhance access, efficiency, and equity in student mental health care.

- **Geographic Challenges:** The region encompasses a large geographical area, creating logistical and transportation challenges for students and families seeking mental health care services. The distance between school districts and community providers can be a barrier to receiving timely access to care, particularly for students and families who live in more rural areas.

A more coordinated approach—including cross-district collaboration, shared resources, and regional planning efforts—could help bridge these gaps and ensure that all students and families are connected to the array of services and community partners available in the region.

Recommendations for Mental Health in Schools

Rec. 1	**School districts should routinely evaluate their MTSS framework to identify both strengths and opportunities to enhance the effectiveness of mental and behavioral health supports.**

Although most districts in the region implement some kind of school mental health-related service, implementation of a comprehensive Multi-tiered System of Supports (MTSS) remains inconsistent. Data from the Collaborative Task Force on Public School Mental Health Services[417] shows that this is true across the state, with most districts reporting they were either in planning or early implementation stages (36%) or in early to late implementation stages (40%) of MTSS, with only 6% reporting no planning or implementation. Though the data reflects statewide self-reports, 40% of all Region 1 schools contributed to this data. Stakeholders supported these findings, sharing that due to varying levels of planning and staff training, educators and administrators are not operating from the same foundational understanding of MTSS. This inconsistency, coupled with gaps in processes and mental health data collection, leads to variable and ineffective identification and support for students needing mental or behavioral health interventions.

Strengthening MTSS training and implementation is critical to addressing student mental health needs and supporting overall student success. School districts in the region can start this process and chart a clear path forward by assessing where they are in their implementation of MTSS, leveraging the following strategies and tools:

- Designate a district MTSS lead or team to oversee the evaluation process, ensuring support and buy-in from senior leadership to guide system-wide implementation efforts.

[417] Collaborative Task Force on Public School Mental Health Services. (2025). https://schoolmentalhealthtx.org/wp-content/uploads/2025/02/The-Collaborative-Task-Force-on-Public-School-Mental-Health-Services-Final.pdf

- Conduct a comprehensive evaluation of the district's MTSS framework using validated tools such as the District Systems Fidelity Inventory (DSFI),[418] the Tiered Fidelity Inventory (TFI),[419] or the School-Wide Evaluation Tool (SET).[420] These tools assess system-level readiness, fidelity of implementation, and help identify areas needing improvement. For example, Midland ISD used SET to evaluate a pilot campus' MTSS implementation. The initial results showed that MTSS was not being implemented to fidelity. With continued use of SET and intentional implementation efforts, the district saw a 40% reduction in aggressive behaviors across campuses—from 451 documented incidents in the 2021–2022 school year to 271 in 2023–2024, further highlighting the importance of evaluating MTSS annually to track progress and make data-informed adjustments that improve student outcomes and school climate.
- Identify gaps in current practice and prioritize targeted enhancements to strengthen MTSS implementation. Key areas for consideration may include:
  - Establishing clear and consistent protocols for identifying and referring students across all tiers to ensure uniformity in support across campuses.
  - Providing ongoing, role-specific training for school counselors, educators, administrators, and support staff to build capacity and shared ownership of the MTSS framework.
  - Strengthening data collection and monitoring systems to track student progress, assess intervention effectiveness, and guide data-informed decision-making.
  - Embedding social-emotional learning and mental health strategies into Tier 1 supports to promote early identification and prevention.
  - Facilitating cross-district collaboration to share promising practices, address common challenges, and support collective problem-solving.

By approaching MTSS as an ever-evolving system and aligning efforts to district needs and capacity, schools can enable all students to receive timely, equitable, and effective mental and behavioral health support.

Rec. 2	**To provide increased access to mental health services for children and youth in the region through TCHATT, UTRGV should partner with a health system capable of expanding TCHATT's services.**

Through UTRGV, TCHATT has increased access to mental health services for children and youth in the region, particularly for students with moderate (Tier 2) to serious (Tier 3) needs. By offering short-term, solution-focused virtual therapy sessions, TCHATT helps fill gaps for

[418] Center on PBIS. (n.d.). *Resource: PBIS District Systems Fidelity Inventory (DSFI) Manual*. Retrieved May 5, 2025, from https://www.pbis.org/resource/dsfi
[419] PBISApps. (n.d.). *Tiered Fidelity Inventory (TFI) 3.0 Manual*. Retrieved May 5, 2025, from https://www.pbisapps.org/resource/tiered-fidelity-inventory-tfi-3-0-manual
[420] Center on PBIS. (n.d.). *School-wide Evaluation Tool (SET)*. Retrieved May 5, 2025, from https://www.pbis.org/resource/school-wide-evaluation-tool-set

students who need targeted or intensive mental health interventions but may not otherwise have access due to workforce shortages or geographic barriers.

Despite this improved access, UTRGV, the health-related institute (HRI) that supports regional children and youth through TCHATT, has at times lacked the necessary workforce to fully support all the needs of participating schools in the region. These workforce concerns are not unique to UTRGV, though, and TCHATT programs in other regions of the state have formed partnerships to help address workforce issues in their respective regions. For example, UT Southwestern Medical School (Dallas' HRI) partners with Children's Health (a provider in the Dallas region) to operate their Dallas region TCHATT program. This partnership provides that region's HRI (UTSW) with both increased staffing and increased capacity to provide mental health services across their TCHATT region. Similarly, UTRGV could explore a partnership with Driscoll Children's Hospital, a major pediatric care provider in South Texas, which could offer additional workforce support and clinical capacity to strengthen the TCHATT program. Driscoll leadership has expressed interest in supporting UTRGV in this way, similar to how Children's Health in Dallas supports UT Southwestern and Texas Children's Hospital in Houston supports UT Health Houston and Baylor College of Medicine.

Of note, pediatricians and family medicine doctors we spoke to in the region were overwhelmingly unfamiliar with TCHATT. Similar to CPAN, a continued need for targeted outreach and program promotion by UTRGV among regional providers would be beneficial in increasing awareness of this resource amongst child serving systems. It also seems clear that there are substantial capacity gaps that will require either expansion of the UTRGV program or partnership with an entity such as Driscoll.

Rec. 3	**Create opportunities for school districts to collaborate around student mental health strategies and best practices.**

Districts across the region are navigating many of the same barriers to meeting the mental health needs of their students, including limited access to services, provider shortages, and disconnected systems of care. Yet most school leaders and mental health staff are working in isolation. Creating intentional opportunities for district leaders to collaborate—whether through regional learning networks, shared problem-solving sessions, or structured peer groups—can accelerate learning, build trust, and strengthen local capacity. In under-resourced areas where schools often serve as the primary access point for mental health services, cross-district collaboration helps scale promising practices and reduce duplication of effort. Whether through existing district-led task forces or new regional initiatives, school systems should identify and invest in collaborative structures to strengthen mental health systems. The following examples demonstrate the potential and flexibility of school mental health collaboration:

- **Harlingen CISD's Mental Health Task Force** is a locally led initiative that convenes district leaders and community partners for monthly meetings focused on trend analysis, collective problem-solving, and coordinated response. Originally formed to map the district's mental health landscape and strengthen service alignment, the task

force has grown into a trusted team that helps identify student and family needs and create direct referral pipelines to available services. Rather than replicate this model elsewhere, a more immediate opportunity is expanding its reach by inviting nearby school districts to participate. Doing so would extend the task force's regional impact, support shared learning, and enhance continuity of care across district lines without the need to build entirely new structures.

- Another collaboration example is the Meadows Institute's school mental health **executive learning communities** (ELCs), which convene district leaders around shared goals in a structured cohort model. In North Texas, ELC participants developed action plans, built cross-district partnerships, and sustained peer learning long after the cohort ended. ELCs demonstrate fruitful capacity building but require investment—typically $150,000 to $250,000, depending on cohort size and frequency; they have been fully funded in the past through private philanthropy.
- San Antonio's **Mobile Mental Wellness Collaborative**[421] represents a regional model that brings together school districts, healthcare providers, and community organizations under a shared infrastructure to coordinate services, align strategy, and pursue joint funding. While complex and costly to establish, the collaborative illustrates what is possible with sustained leadership and investment.

Each model reflects a different level of coordination and investment, demonstrating options for collaboration depending on commitment and available funding. Districts and partners should choose an approach that aligns with their goals, available resources, and capacity for ongoing engagement. With the right support and structure, these collaborative efforts can strengthen regional alignment and expand access to high-quality mental health services.

Rec. 4	**Strategically plan for sustainable school mental health programming by braiding and blending existing and new funding streams.**

Districts across Texas report that funding is the primary barrier to having adequate resources to address mental health, citing "insufficient funding for school-based mental health staff" as the number one barrier.[422] Similarly, regional districts and stakeholders share that they have had to "make do with what [they] have" as a result of not having the financial capacity to hire mental health professionals, difficulties that are arguably exacerbated with the temporary ESSER funds expiring.

Due to the fluctuating landscape of public education and the federal, state, and local dollars that fund it, creatively and cooperatively addressing funding challenges for school mental health is essential. By securing stable and diversified funding, schools can prevent service disruptions, retain essential mental health personnel, and expand student access to high-quality, long-term mental health support. Implementation strategies to accomplish this include the following:

[421] San Antonio Mobile Mental Wellness Collaborative. https://mentalwellnesscollaborative.org/
[422] Collaborative Task Force on Public School Mental Health Services. (2025).

- Utilize available financial guidance, such as the *Meadows Mental Health Policy Institute's School Mental Health Financing Toolkit,*[423] to develop a comprehensive funding strategy.
- Identify and braid diverse funding sources, including State Compensatory Education (SCE) allotment, School Safety Allotment, Medicaid programs (such as SHARS and MAC), federal education funds (Title I, Title IV), ESSA-authorized programs, local government investments, and private philanthropic support.
- Leverage partnerships with community organizations, healthcare providers, and universities to apply for joint funding opportunities.
- Establish funding sustainability plans within districts to ensure mental health initiatives remain operational beyond short-term grant cycles.
- Advocate for state and district-level policy changes to allocate dedicated funding streams for mental health services.

Child Welfare

We use the term "child welfare" to encompass children, youth, and families that have come to the attention of the Department of Family and Protective Services (DFPS) for risk of neglect or abuse. This includes those receiving services to mitigate the risk of removal and those who have been removed and are in the conservatorship of the state (foster care). In Texas, Child Protective Services (CPS) oversees these programs across 12 regions. Cameron, Hidalgo, Starr, and Willacy counties are all part of DFPS Region 11, which also includes 15 additional South Texas counties.

> Up to 80% of children and youth who enter foster care have a significant mental health need and at least half have more than one mental health diagnosis.

How child welfare services are overseen and delivered in Texas is rapidly changing, however. The state is moving from a fully state-run model (via DFPS) to a program with more regional autonomy called community-based care (CBC), where private (usually non-profit) organizations called single source continuum contractors (SSCC) deliver foster care services for their region. While some DFPS regions are now fully integrated into CBC, DFPS Region 11, which includes the Rio Grande Valley, is still part of the state-run legacy system. The Legislature directed DFPS to transition all regions to CBC by 2029, but the agency has not indicated when the transition will begin for DFPS Region 11.[424]

Child Welfare and Mental Health

Across child welfare systems, more than two thirds of the children and youth entering foster care have a documented history of maltreatment. A majority have been exposed to violence, including domestic violence, and many have parents with histories of substance use, criminal

[423] *Resource Allocation to Support Well-Being in Public Schools—MMHPI - Meadows Mental Health Policy Institute*. (n.d.). Retrieved May 5, 2025, from https://mmhpi.org/resource-allocation-to-support-well-being-in-public-schools/
[424] Department of Family Protective Servicess. (n.d.). *Community-Based Care*. Retrieved May 5, 2025, from https://dfps.texas.gov:443/CBC/default.asp

justice involvement, and mental illness.[425,426] Further, removal from home and placement in foster care can be traumatic — loss of contact with family and friends, separation from siblings, changes in school, and unstable foster care placements can result in emotional and behavioral problems. Nationally, up to 80% of children and youth who enter foster care have a significant mental health need and at least 50% have more than one mental health diagnosis.[427,428] Children and youth in foster care are more likely to experience anxiety, depression, and behavioral problems; in addition, those in care use mental health services at a rate that is roughly 10 times higher than rates for children and youth in the general community.[429,430]

Texas Child Welfare System

The child welfare system in Texas is responsible for investigating reports of child abuse and neglect, strengthening and stabilizing families so that they can safely care for their children at home and, when necessary, providing substitute care (foster care) for children and youth whom the court has determined cannot live safely at home. These components are often referred to as "stages of service". Each stage of service involves a distinct type of engagement with a child and their caregivers and rules and requirements.

Table 55: Texas Child Welfare Stages of Service

Child Welfare Stages of Services
Child Protective Investigations (CPI)
Involvement in child welfare typically begins when CPI examines reports of child abuse or neglect to determine if a child has been abused or neglected and/or if there are any threats to safety for the children in the home. If CPI determines there are not threats to the safety of the children or if the parents are willing and able to adequately manage the threats, children remain in the home and do not enter substitute care. Most families involved with the child welfare system are only engaged in this stage of service. If mental health needs are identified during an investigation, the caseworker may provide referrals to community based mental health supports or other community resources, but no formal services are available or required unless the family is referred to and agrees to participate Family Based Safety Services.

[425] Szilagyi, M. A., Rosen, D. S., Rubin, D., Zlotnik, S., COUNCIL ON FOSTER CARE, ADOPTION, AND KINSHIP CARE, COMMITTEE ON ADOLESCENCE, & COUNCIL ON EARLY CHILDHOOD. (2015). Health Care Issues for Children and Adolescents in Foster Care and Kinship Care. *Pediatrics*, *136*(4), e1142-1166. https://doi.org/10.1542/peds.2015-2656

[426] Engler, A. D., Sarpong, K. O., Van Horne, B. S., Greeley, C. S., & Keefe, R. J. (2022). A Systemic review of Mental Health Disorders of Children in Foster Care. *Trauma, Violence, & Abuse*, *23(i)*, 255–264.

[427] Lehmann, S., Havik, O. E., Havik, T., & Heiervang, E. R. (2013). Mental disorders in foster children: A study of prevalence, comorbidity and risk factors. *Child Adolescent Psychiatry Mental Health, 7*(39), 1–12. http://www.capmh.com/content/7/1/39

[428] Szilagyi, M. A. et al., (2015), Health Care Issues for Children and Adolescents in Foster Care and Kinship Care, *Pediatrics*, *136*(4), e1142-1166

[429] Leslie, L. K., Landsverk, J., Ezzet-Lofstrom, R., Tschann, J. M., Slymen, D. J., & Garland, A. F. (2000). Children in foster care: Factors influencing outpatient mental health service use. *Child Abuse & Neglect*, *24*(4), 465–476. https://doi.org/10.1016/s0145-2134(00)00116-2

[430] Turney, K., & Wildeman, C. (2016). Mental and Physical Health of Children in Foster Care. *Pediatrics*, *138*(5), e20161118. https://doi.org/10.1542/peds.2016-1118

Child Welfare Stages of Services
Family-Based Safety Services (FBBS)
If CPI determines that a child's safety can be reasonably assured while remaining in the home, CPI can provide the family with the option of engaging in FBSS.[431,432,433] These services support the family with resources aimed at stabilizing presenting challenges and reducing the future risk of abuse and neglect. Most children remain in their home during involvement in this stage of service, but some may temporarily live with a relative or close friend of the family. The scope and availability of these services varies – they may include specific supports for the caregiver such as support obtaining resources for basic needs, parent education, and clinical interventions such as mental health screening and assessment, mental health treatment services, and/or substance use treatment. Support during this stage of service also may include help accessing needed services for the children in the home, including mental health screening, assessment, and treatment services.
Conservatorship
When CPS confirms abuse or neglect and determines a child or sibling set is not safe in their home and there is not an appropriate non-custodial parent, relative, or close family friend able to care for them, they are placed under the state's conservatorship. In circumstances where placement in foster care is necessary, the aim is for the child to be placed in a family-like home setting whenever possible. Placement is often dependent upon the child's needs and availability of an appropriate placement. When a child is in a home-based placement, this may be in a licensed foster home or, ideally, with a relative or family friend, known as a kinship placement. When a home setting is not an option, a child may be placed in other settings such as an emergency shelter or a residential treatment center. There are also instances when a child is in conservatorship, but the state cannot find a placement. These cases, known as "child without placement" or CWOP, require a significant number of resources from the state and communities. The experience of not having a place to go can be extremely harmful for the child who may spend nights in hotels and other temporary and non-homelike settings. In March of 2025, 76 children across the state experienced a CWOP event, which is defined as being without placement for at least two consecutive, uninterrupted nights.[434] Children in conservatorship qualify for Medicaid through Texas' STAR Health program, which Superior Health Plan administers. STAR Health is the primary source through which children and youth in conservatorship obtain primary care, medical, dental, and behavioral health services.

[431] FBSS refers to the specific stage of service facilitated by DFPS, but this type of support is part of a broader category of family support and intervention known as Family Preservation Services. The goal of Family Preservation Services is twofold: the "front-end" goal is to strengthen and improve parenting, family function, and child well-being by providing the scaffolding, resources, and education for parents to enhance their caregiving capacity and ability; the "back-end" goal is to ultimately avoid unnecessary out-of-home placements for children and speed the closing of cases in the child welfare system.

[432] Littell, J. H. (n.d.). Client participation and outcome of intensive preservation services. *Social Work Research*, *25*(2), 103–113. https://doi.org/10.1093/swr/25.2.103

[433] McCroskey, J. (2001). What is Family Preservation and Why Does it Matter? *Journal of Family Strengths*, *5*(2). https://doi.org/10.58464/2168-670X.1131 McCroskey, J., (2001), What is Family Preservation and Why Does it Matter?, *Journal of Family Strengths*, *5*(2)

[434]Texas Department of Family and Protective Services. (2025). *Children Without Placement Agency Efforts*. https://www.dfps.texas.gov/Child_Protection/State_Care/documents/2025_03_CWOP_Agency_Actions_Visual.pdf

Mental Health Services and Supports

The scope of mental health services and support available to children, youth, and families involved in child welfare varies depending on the nature of the family's involvement. Families engaged in the investigation phase are more likely to have access to discreet programs aimed exclusively at supporting families at risk of entering foster care – often referred to as family preservation services. Children who are in conservatorship, or foster care, do not have access to any exclusive services or programs; however, they do become eligible for Texas Medicaid's STAR Health program, which serves as a payor source for healthcare services, including mental health services.

Services Available Prior to Conservatorship

Children and families engaged in the investigation phase may be offered mental health related services and supports if needs related to either the caregiver or child's mental health are identified. Stakeholders in the region reported similar experiences to those occurring statewide, wherein many families may have become engaged in child welfare due to needs unrelated to mental health, but in supporting their safety goals the department identifies that mental health needs either of the caregiver or children in the home are impacting the family's ability to safely remain together. This is often due to additional stress the caregiver may experience as a result of either their own mental health needs or the challenges supporting their child and challenges related to accessing services.

DFPS contracts with community providers to support families involved in investigations or otherwise at risk of child welfare involvement, but these services are most often for caregivers. These services vary by region, county, and community, and there is not a standard array of services available. In addition to support obtaining resources for basic needs, and parent education, there also may be resources available for clinical interventions such as mental health screening and assessment, mental health treatment services, and/or substance use treatment. Supports may also include connecting the family to services for the children in the home, including mental health screening, assessment, and treatment services.

In many cases, the caseworker refers the family to community-based resources rather than a specific contracted program. This is especially true regarding mental health services. While some of the prevention and FBSS programming DFPS funds may include mental health supports for children and youth, DFPS does not operate or contract for standalone mental health services and primarily refers to the services and programs available in communities – the same services and programs to which children and families can be referred regardless of child welfare involvement.

Services Available in Conservatorship

Children in conservatorship qualify for Medicaid through the STAR Health program, which Superior Health Plan administers state-wide. STAR Health is the primary source through which children and youth in conservatorship obtain primary care, medical, dental, and behavioral health services. As their source of medical and behavioral health care, they have access to STAR

Health's continuum of community-based, Medicaid reimbursable mental health and substance use services including collaborative care, screening and assessment, psychotherapy (which can include delivery of outpatient evidence-based modalities), and mental health targeted case management and rehab services such as medication management, skills training, and family partner services. STAR Health also provides service coordination to members. Like all children in Medicaid, those in conservatorship with more intensive needs have access to programs like the YES Waiver and CSC. Some child placing agencies (CPAs) in the region reported that they employ clinicians to deliver mental health services to the children and youth placed in their licensed homes, but services are primarily available through Medicaid enrolled providers such as the region's two LMHAs, non-profit behavioral health provider groups, and health-system affiliated outpatient programs. DFPS occasionally contracts directly with behavioral health providers in the community, however this is a rare exception and most often the services provided are not distinct from those available as part of their STAR Health Medicaid benefit.

Regional Child Welfare Data

In fiscal year 2024, CPI completed 11,375 investigations (17 per 1,000 children and youth) in DFPS Region 11. Cameron, Hidalgo, and Starr County investigations were consistent with this Region 11 average; however, Willacy County is a notable outlier in the region, averaging 27 investigations per 1,000 children.[435] Furthermore, a higher proportion of these investigations resulted in "Reason to Believe," – meaning that the investigation identified it is more likely than not that the reported abuse or neglect occurred – in Willacy County than across DFPS Region 11 as a whole. In other words, in contrast to the other three counties included in this assessment (or the state as a whole), in FY 2024, Willacy County had higher per child averages of investigations into reports of abuse or neglect ***and*** a higher volume of investigations with confirmed findings of abuse and neglect per child.

Table 56 provides a point in time snapshot of regional data for children and youth in state conservatorship on August 31, 2024, when there were 637 children and youth in state conservatorship across the four counties. The remaining columns show the placement type for these children. Notably, Region 11 has a higher average of children and youth placed in kinship care than the statewide average.

Table 56: **Children in Conservatorship by Placement Type on August 31, 2024**

County	Total in Substitute Care	Foster Home	Kinship Care	Residential Treatment Center	Emergency Shelter	Adoptive Home
Hidalgo	226	107	78	13	9	1
Cameron	263	107	103	15	4	12

[435] In fiscal year 2024, Texas Child Protective Investigations completed 1,896 abuse or neglect investigations in Cameron County (15 per 1,000 children and youth), 4,209 in Hidalgo County (16 per 1,000), 214 in Starr County (11 per 1,000), and 143 in Willacy County (27 per 1,000). Texas Department of Family and Protective Services. (2025). *DFPS Data Book – CPI Completed Investigations: Activity*. Retrieved on June 9, 2025 from https://www.dfps.texas.gov/About_DFPS/Data_Book/Child_Protective_Investigations/Investigations/Activity.asp

County	Total in Substitute Care	Foster Home	Kinship Care	Residential Treatment Center	Emergency Shelter	Adoptive Home
Willacy	36	9	17	1	1	0
Starr	17	6	10	0	0	0
Region 11	1,441	637	579	73	59	20
Statewide	16,707	7,836	5,804	1,153	310	223

Regional Child Welfare Mental Health Findings

Regional stakeholders acknowledge the unique challenges impacting youth in foster care with mental health needs, including the following:

- **Increasing intensity of behavioral health needs, including with younger children**. Stakeholders working with children in foster care in the region report their mental health needs are becoming more acute and often at an earlier age than has historically been the case. This perspective was shared for children and families engaged in investigations and for those in conservatorship. We heard this theme from multiple organizations, who also shared observing an increase in challenging, externalizing behaviors among child welfare involved children and youth. While most children without placements are older, the DFPS reports that behavioral health needs are driving placement instability across age groups. According to DFPS's Q1–Q2 performance report, 74% of children without placements have psychiatric hospitalization needs.[436] This experience mirrors trends reported consistently across the state. This information is reported consistently by both DFPS staff and non-DFPS child welfare providers and stakeholders, however assessment and other data related to the needs, behaviors, and diagnoses of children in conservatorship are not made public at this time.
- **Lack of accessible mental health services and providers**. While children and youth in conservatorship are entitled to all services covered under STAR Health, they often encounter barriers to accessing care. Stakeholders report that, with the exception of a limited number of health-system connected behavioral health group providers and the LMHAs serving the region, many of the mental health professionals who specialize in children's mental health interventions do not accept Medicaid (STAR Health). Some also do not accept private insurance.
- **The short-term nature of foster care complicates service constancy.** The temporary and at times unstable nature of foster care placement impacts the ability for children and their caregivers to consistently access appropriate mental health interventions. Impacts of the temporary placements include the following:
  - Many interventions, especially those available for youth with intensive needs, need to be provided for a longer duration to ensure desired and expected outcomes, which is not always possible due to how rapidly foster care placements can change and end.

[436] Texas Department of Family and Protective Services. (2024). *Quarterly performance report: Fiscal year 2024, quarters 1 and 2.* https://www.dfps.texas.gov/About_DFPS/Reports_and_Presentations/Quarterly_Performance/

- Certain rules, regulations, and policies, such as those governing LMHA catchment areas and location specific grant funding, inhibit the ability of providers to continue serving a client once they are outside of a certain service area. This is a significant challenge for children and youth in foster care since the majority (around 69% in DFPS Region 11) are placed outside of their home county.
- There is an understandable desire to begin or reinitiate mental health services quickly when a child is placed in foster care or when they have a placement change. However, trying to initiate services too quickly after these events can be problematic. Many youth with experience in foster care report having to repeatedly share their experience and challenges, often without time to build rapport or trust. This experience sometimes leads to disengagement from and disillusionment toward the mental health system and mental health providers in general for many young people who have been in foster care.

Recommendations for Child Welfare

Rec. 1	**To provide parents and caregivers with the skills and support necessary to address their child's mental health needs in appropriate ways, map the continuum of family preservation services.**

Stakeholders in the region report that, while the mental health needs of a child or youth involved in a child welfare investigation are rarely the initial cause of the investigation, these needs and the caregiver's capacity to address them are often eventually identified as a stressor contributing to the caregiver's overall ability to safely care for their child(ren). Family Preservation Services (FPS) aim to strengthen and improve parenting, family function, and child well-being by providing the support, resources, and education for parents to enhance their caregiving capacity and ability, including in addressing challenging child behaviors – and this approach to child welfare is well supported in research. Various theories of child mental well-being – including crisis theory, family systems theory, social learning, behavioral, and cognitive theories, attachment theory, and resilience theory – illustrate that children do best in family preservation models when compared to out-of-home placements.[437]

As a strategy to support family functioning and to avoid unnecessary out-of-home placements for children, we recommend bolstering FPS in the region. The Title IV-E Prevention Services Clearinghouse[438] lists a variety of FPS shown to support families, and while the goal of strengthening families is the same, different interventions address unique needs. Developing an array of FPS services tailored to the unique needs of children and families in the region is critical for addressing diverse family stressors and child mental health needs such as substance abuse, mental health needs, and parenting skills.

[437] McCroskey, J., (2001), What is Family Preservation and Why Does it Matter?, *Journal of Family Strengths*, *5*(2)
[438] Administration on Children and Families. (n.d.). *Title IV-E Prevention Services Clearinghouse*. Retrieved May 6, 2025, from https://preventionservices.acf.hhs.gov/

Although there are FPS services being provided in the region, there is no resource or guide tracking what is offered or available, who is getting these services, or aligning what is provided to what families need. A first step in creating an effective continuum of FPS requires researching and articulating the current landscape of FPS and then an analysis on the alignment between services offered and what families need.

To accomplish this, regional DFPS leadership should support and provide the necessary data for the provider community (child placement agencies and other child and youth serving organizations) to conduct an analysis of the alignment between the most prevalent needs of families involved in the investigations or FBSS stages of service and the FPS services available in the community. The analysis should include:

- An in-depth review of the primary needs identified by the families upon their initial engagement with CPI. While a more in-depth review is recommended, needs related to parental substance use, parent education regarding mental health for themselves and their children, parental skill building related to child behaviors, and caregiver mental health assessment and treatment were all highlighted in our stakeholder interviews.
- A review, via resource mapping or similar method, of the full landscape of FPS currently available in the region. This review should include identification of the types of services available and the specific capacity of each of these programs relative to anticipated need. A list of contracted services should be available to access from the regional DFPS office; however, there are other resources available in the community that would fall into the category of family preservation services but that may not be funded by DFPS and therefore would not be available via a department provided list.
- A gap analysis comparing the family needs identified and the types of services being provided within the FPS landscape. The analysis should address what needs are not currently being met by an existing service offering, either due to the service not being available or lack of sufficient capacity.

Once the FPS landscape is better understood and key service gaps are identified, we recommend a lead agency seek a grant to develop a plan for how to best scale capacity to address identified needs. This agency should work with local providers to determine their ability to expand service capacity and with DFPS to identify relevant funding opportunities. Some of these services may be funded through DFPS' FPS while additional funding opportunities are available through the Texas Families First pilot program[439] or the Community Mental Health Program.[440]

[439] Department of Family Protective Services. (n.d.). *Texas Family First (TFF)*. Retrieved May 5, 2025, from https://www.dfps.texas.gov/Investigations/TFF/default.asp

[440] Texas Health and Human Services. (n.d.). *Community Mental Health Grant Program*. Retrieved May 5, 2025, from https://www.hhs.texas.gov/business/grants/grant-programs/behavioral-health-services-grants/community-mental-health-grant-program

Rec. 2	**Develop an interagency foster care workgroup to strengthen collaboration around foster care, prepare for community-based care implementation, and strengthen mental health coordination.**

Children involved in child welfare are part of multiple systems and often with multiple agencies within the same system. These systems and agencies may include their CPA, STAR Health, school, juvenile justice, a health home, an LMHA or other mental health provider, and community-services providers. While these entities all have different priorities, when foster care is highlighted most are eager for opportunities to collaborate.

Now is an excellent time to establish an interagency workgroup focused on foster care in the region. In their FY 2026/27 Legislative Appropriation Request, DFPS listed Region 11 as one of two regions for the next community-based care expansion. While the timing of community-based care (CBC) in Region 11 is still unclear, the implementation process will be much smoother if an interagency group begins preparing now.

We recommend at least one of the CPAs serving the region establish and lead or co-lead an interagency workgroup to highlight key foster care regional needs and to help inform CBC planning efforts that are soon to follow. The size and scope of an interagency foster care workgroup for the region could vary depending on resources available to support collaboration. Such a group could begin informally and grow overtime as appropriate. While this is not an exhaustive list, we recommend at a minimum the following groups be included in the workgroup:

- DFPS Region 11 staff;
- Tropical Texas Behavioral Health;
- Border Region Behavioral Health Center;
- Education Service Center, Region 1;
- Child serving health systems like Driscoll and DHR;
- STAR Health;
- Local CPAs including Buckner Children and Family Services, Arrow Child and Family Ministries, the Bair Foundation and Family Services, Upbring, A World for Children, Families Especial Foster Care and Adoption Services;
- County juvenile probation agencies;
- Child protection judges; and
- Youth and family representatives with lived experience in the child welfare system.

We also recommend that mental health be a central focus for the workgroup. As we identified previously, the temporary nature of foster care complicates mental health service provision for children and youth in foster care. Yet, children and youth in foster care tend to have more complex mental health needs than the general child population. As such, a regional foster care workgroup that includes a focus on mental health could make a significant impact in terms of improving mental health pathways and determining where additional mental health investments are most needed.

An example of this type of group is the North Texas Foster Care Consortium (NTFC Consortium).[441] The NTFC Consortium serves a 19-county area and involves hundreds of participants from across child serving sectors. The NTFC Consortium played an instrumental role in helping to plan and prepare for CBC in their DFPS region and is actively engaged in strengthening the program now that the North Texas community has implemented it.

Rec. 3	**Expand the direct referral processes between local DFPS offices and LMHAs into additional counties, modeled after Hidalgo County's collaboration with Tropical Texas Behavioral Health.**

While children and youth in conservatorship have access to the services available to other youth in the community enrolled in Medicaid, they often encounter additional barriers to accessing care. Stakeholders reported challenges understanding eligibility for certain services and complications in accessing services, especially following placement changes. Misunderstandings regarding eligibility for services, both by providers and child welfare staff were reported as a barrier to initial access to services. This challenge occurs both for specific programs and interventions, such as multisystemic therapy (MST), as well as more broadly when non-child welfare related stakeholders are not aware that a child's placement in foster care, in most cases, does not make them ineligible for services. In both types of instances, these kinds of misunderstandings can be mitigated when there is a strong culture of collaboration between child welfare stakeholders and mental health providers.

Mental health providers in the region acknowledge it can be especially hard for children and youth in foster care to connect to the right mental health services and have made efforts to address these challenges. Tropical Texas and Hidalgo County DFPS staff meet monthly to coordinate services, share updated information regarding new or updated programming, and to discuss other trends impacting their mutual goal of identifying and treating the mental health needs of the children and youth in foster care. This practice of ongoing coordination and communication has resulted in improved access to services for youth in foster care in Hidalgo County. We recommend replicating this practice, first with Cameron County DFPS staff and Tropical Texas, and then allowing Tropical Texas to determine if the same level of coordination is appropriate for Willacy County; the same applies for Border Region and Starr County DFPS staff.

While the nature of the coordination may look different due to unique factors in each county and the availability of services, the initiation of regular communication and a shared commitment to coordinating the care of people who are both involved in child welfare and in need of mental health supports will improve the access to and effectiveness of necessary mental health services and supports. Eventually, these efforts could even be folded into the regional interagency foster care workgroup via a focused subcommittee on mental health.

[441] North Texas Foster Care Consortium. (n.d.). *North Texas Foster Care Consortium – Improving outcomes for children in care*. Retrieved May 5, 2025, from https://fostercareconsortium.com/

Rec. 4	**Enhance supports for relative and kinship caregivers to access mental health services and supports for themselves and the children and youth in their care.**

A significant strength of the child welfare system in the region is a high-level of willingness and engagement of extended family members who contribute to the care of children and youth in their family. Stakeholders for this assessment shared a high rate of grandparents, aunts, and uncles willing to take temporary custody when a child from their family is removed from home. Furthermore, stakeholders said these relative caregivers are also highly engaged in connecting the children and youth in their care to needed services, including mental health services. We heard that kinship caregivers were more likely to request an assessment or services to identify the cause of a concerning behavior or symptom they observe, and when presented with opportunities for intervention, are more likely to engage in recommended services than non-relative foster parents.

Given the known benefits of placement with a kinship caregiver, it is critical they receive appropriate support. There are a variety of ways to support kinship caregivers, ranging from formal kinship navigator programs to dedicating specialized staff for kinship families to support them in navigating and accessing the resources. Below are several recommendations for improving how kinship care providers are supported in the region.

- **Open a local chapter of Texas Grandparents Raising Grandchildren.** Grandparents Raising Grandchildren are local chapters that facilitate support groups and provide education and resources for grandparents caring for their grandchildren, whether through a formal kinship placement or as part of informal support for their family. There are currently no local chapters in the region. Local stakeholders can initiative a chapter in partnership with the statewide organization. Due to the flexible nature by which chapters are formed, interested stakeholders should reach out directly to the statewide organization to initiate a local affiliate.
- **Develop a specialized family partner role at each LMHA with lived experience as a kinship caregiver or experience and knowledge in supporting kinship caregivers.** Family partner services are reimbursable as part of the mental health rehabilitation Medicaid benefit. The region's LMHAs, Tropical Texas and Border region, already excel at effectively utilizing this type of provider to support families as they navigate the mental health system and related needs, making them well positioned to support this type of specialized role aimed at supporting kinship caregivers.
- **Establish a formal kinship navigator program and resource.** Kinship navigator programs, which may vary in scope and structure, assist kinship caregivers in learning about, finding, and using programs and services to meet the needs of the children and youth for which they are caring. Though there is not currently a standalone funding source for kinship navigator programs in Texas, other jurisdictions in the state have established these through a combination of federal, local, and philanthropic grant-based funding. In most cases, local CPAs have established these programs and there are several CPAs in the region who would be well suited to do the same.

Older Adults

Adults ages 65 and older comprise a large portion of the regional population at 13.15%,[442] and they face unique challenges when accessing and receiving mental health care. The most common barriers older adults report in seeking mental health treatment include stigma, negative perceptions of mental health services, and the cost of care.[443] Research shows that the stigma surrounding mental illness negatively affects older adults' attitudes toward seeking mental health services.[444] (And, as noted above in the regional context section, stigma can also be negatively associated with the desire to engage in mental health care for Hispanics and Latinos.[445]) In the U.S., less than 3% of older adults receive mental health care from a psychiatrist, with most seeking treatment through primary care instead.[446] While nearly 72% of U.S. adults believe they can discuss emotional and mental health issues with their PCP, this number rises to 84% among adults aged 65 and older.[447]

Additionally, rising healthcare costs are impacting older Americans. More and more older adults are skipping necessary medical care and not filling prescriptions because they cannot afford it. Among adults aged 65 and older, the percentage who went without needed care increased from 9% in 2022 to 14% by mid-2023. The number who did not purchase prescribed medication also rose from 7% to 10% in the same period.[448] All told, West Health's 2024 survey found about 8.1 million older Americans went without necessary care "in the past three months," and 5.8 million did not purchase prescribed

Increasing amounts of older adults are skipping necessary medical care and not filling prescriptions because they cannot afford it.

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[442] *U.S. Census Bureau QuickFacts: Texas; Willacy County, Texas; Starr County, Texas; Cameron County, Texas; Hidalgo County, Texas*. (n.d.). Retrieved February 10, 2025, from https://www.census.gov/quickfacts/fact/table/US,TX,willacycountytexas,starrcountytexas,cameroncountytexas,hidalgocountytexas/PST045224

[443] Elshaikh, U., Sheik, R., Saeed, R. K. M., Chivese, T., & Alsayed Hassan, D. (2023). Barriers and facilitators of older adults for professional mental health help-seeking: A systematic review. *BMC Geriatrics*, *23*(1), 516. https://doi.org/10.1186/s12877-023-04229-x

[444] Conner, K. O., Copeland, V. C., Grote, N. K., Koeske, G., Rosen, D., Reynolds, C. F., & Brown, C. (2010). Mental health treatment seeking among older adults with depression: The impact of stigma and race. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, *18*(6), 531–543. https://doi.org/10.1097/JGP.0b013e3181cc0366

[445] Eghaneyan, B. H., & Murphy, E. R., (2020), Measuring mental illness stigma among Hispanics: A systematic review, *Stigma and Health*, *5*(3), 351–363

[446] Gerlach, L. B., Maust, D. T., Solway, E., Kirch, M., Kullgren, J. T., Singer, D. C., & Malani, P. N. (2022). Perceptions of Overall Mental Health and Barriers to Mental Health Treatment Among US Older Adults. *The American Journal of Geriatric Psychiatry: Official Journal of the American Association for Geriatric Psychiatry*, *30*(4), 521–526. https://doi.org/10.1016/j.jagp.2021.09.006

[447] Gallup Inc. (2024). *West Health-Gallup 2024 Survey on Aging in America*. https://westhealth.org/wp-content/uploads/2024/06/West-Health-Gallup-2024-Aging-in-America-Survey-Report-FINAL.pdf Gallup Inc, (2024), *West Health-Gallup 2024 Survey on Aging in America*

[448] Gallup Inc, (2024), *West Health-Gallup 2024 Survey on Aging in America*

medication due to cost. These trends highlight the deepening struggle many older adults face in accessing affordable healthcare, compounded by the stigma surrounding mental health care.[449]

Regional Mental Health Services for Older Adults

Medicare covers 94% of older adults in Cameron County, 93% in Hidalgo County, 95% in Starr County, and 98% in Willacy County.[450] Medicare covers inpatient psychiatric hospitalization and several outpatient mental health SUD services, such as one annual primary care depression screening, individual and group therapy, family counseling, diagnostic tests, psychiatric evaluation, medication management, and newly added benefits partial hospitalization and intensive outpatient program services.[451] Additionally, Medicare covers integrated behavioral health in primary care, including the collaborative care model.[452]

Federal bipartisan legislation was introduced to advance the Connecting Our Medical Providers with Links to Expand Tailored and Effective (COMPLETE) Care Act. The bill would improve access to mental health and substance use disorder services by helping primary care providers adopt integrated care models. Increasing Medicare reimbursement rates for behavioral health integration services will reduce financial barriers to implementing evidence-based approaches such as the collaborative care model and the primary care behavioral health model. Given the region's high percentage of Medicare beneficiaries, this legislation, were it to pass, could significantly expand access to integrated care for older adults in South Texas.

Stakeholders we spoke to identified loneliness as a contributor to behavioral health symptoms for the older adults residing in the RGV. Research shows that social isolation and loneliness are associated with an increased risk of physical and mental health conditions, including high blood pressure, heart disease, obesity, weakened immune function, anxiety, depression, cognitive decline, Alzheimer's disease, and even premature death.[453] People who become isolated due to life changes—such as the loss of a spouse or partner, separation from friends or family, retirement, reduced mobility, or limited access to transportation—are especially vulnerable. In contrast, people who participate in meaningful and productive activities with others tend to live longer, experience improved mood, and develop a stronger sense of purpose.[454] Research

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[449] Gallup Inc, (2024), *West Health-Gallup 2024 Survey on Aging in America*
[450] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[451] Medicare.gov. (n.d.). *Outpatient Mental Health Coverage*. Retrieved March 20, 2025, from https://www.medicare.gov/coverage/mental-health-care-outpatient
[452] Center for Medicare and Medicaid Services. (2024). *Behavioral Health Integration Services.* https://www.cms.gov/files/document/mln909432-behavioral-health-integration-services.pdf
[453] Somes, J. (2021). The Loneliness of Aging. *Journal of Emergency Nursing*, *47*(3), 469–475. https://doi.org/10.1016/j.jen.2020.12.009
[454] Cacioppo, S., Grippo, A. J., London, S., Goossens, L., & Cacioppo, J. T. (2015). Loneliness: Clinical Import and Interventions. *Perspectives on Psychological Science : A Journal of the Association for Psychological Science*, *10*(2), 238–249. https://doi.org/10.1177/1745691615570616

suggests these social connections help sustain overall well-being and may even support better cognitive health.[455]

Spotlight: Buena Vida y Salud's Senior Buddy Program

Buena Vida y Salud (ACO) created the Senior Buddy Program, a free home visitation program connecting a senior volunteer to identified high risk patients. Volunteers visit patients 2-3 times per month, completing an assessment on general health and basic needs as well as spending time socializing with the person and building relationships. Although the program is a small pilot with a single primary care provider, that provider noted a reduction in emergency room visits for patients enrolled in the program.

Physicians we spoke to who specialized in working with older populations highlighted Dementia-related behavioral disturbances as being common and challenging issues their patients face. Alzheimer's disease (AD) and related dementias (ADRD) disproportionately affect Hispanic Americans—one of the fastest-growing elderly populations in both the United States and Texas—yet this community remains significantly underrepresented in research studies and within the scientific workforce studying these conditions.[456] The Rio Grande Valley Alzheimer's Disease Resource Center for Minority Aging Research (AD-RCMAR) was created in 2018 to study the impact of Alzheimer's Disease and related brain disorders among Hispanics. AD-RCMAR leadership has also created the Memory & Aging Center, a community where people and families can learn about the work being done in the RGV regarding Alzheimer's and related dementias, and find resources for themselves or loved ones, including community activities and events to help seniors in the community remain active and engaged.

Relatedly, Texas has launched a $3 billion, 10-year investment in dementia and brain health research through the newly created Dementia Prevention Research Institute of Texas (DPRIT). This unprecedented initiative will impact research priorities, funding pathways, and partnership strategies to drive innovation and accelerate solutions across the field. Funding will be available to institutions of learning, advanced medical research facilities, public or private persons, and collaboratives in Texas. Although funding is not yet available, it will be important for the region to track these opportunities as they arise.

Recommendations for Older Adults

Rec. 1	**To better address the mental health of population subsets, including older adults, expand implementation of integrated behavioral health models.**

Expanding use of integrated behavioral health is a critical strategy for addressing the growing need for comprehensive mental health care for older adults. Older adults face significant

[455] Cacioppo, J. T., & Cacioppo, S. (2014). Older adults reporting social isolation or loneliness show poorer cognitive function 4 years later. *Evidence Based Nursing*, *17*(2), 59–60. https://doi.org/10.1136/eb-2013-101379

[456] Vega, I. E., Cabrera, L. Y., Wygant, C. M., Velez-Ortiz, D., & Counts, S. E. (2017). Alzheimer's Disease in the Latino Community: Intersection of Genetics and Social Determinants of Health. *Journal of Alzheimer's Disease: JAD*, *58*(4), 979–992. https://doi.org/10.3233/JAD-161261

barriers to accessing mental health treatment, including stigma, negative perceptions of behavioral health services, and financial constraints. CoCM for example, is uniquely positioned to overcome these challenges by integrating behavioral health care into primary care settings, allowing older adults to receive mental health support from a trusted provider in a familiar environment. As noted above, this population is more inclined to believe they can discuss emotional and mental health issues with their PCP (84% of older adults vs. 72% for all adults).

Additionally, a CoCM team can deliver these services telephonically, removing transportation barriers and mitigating issues related to broadband access and telehealth navigation. The model is also financially sustainable, with reimbursement available through Medicare and other insurance plans, making it a cost-effective solution for expanding access; Medicare covers 94% of older adults in Cameron County, 93% in Hidalgo County, 95% in Starr County, and 98% in Willacy County.[457]

Research supports the efficacy of CoCM in treating common mental health conditions in older adults, particularly depression and anxiety, which are frequently underdiagnosed and undertreated in this population. Given that older adults make up 13.15% of the region's population and are more likely to seek care through primary care settings rather than specialty mental health providers, expanding the use of CoCM presents a practical, evidence-based approach to improving mental health outcomes while reducing stigma and increasing access to care.

For more on supporting the region's implementation of integrated behavioral health models, please see the section on mild to moderate mental health services.

Veterans

According to the Department of Veterans Affairs (VA), this region is home to approximately 39,000 veterans and 13,000 veteran households with dependents.[458] Veterans comprise approximately 4% of the region's adult population, with two of the top three highest veteran populations in the region in Cameron and Hidalgo counties, respectively. Most veterans, over 97%, live in Cameron and Hidalgo counties, while Starr and Willacy counties are home to the remaining 3%. Across the region, about 24% of veterans live in poverty, and roughly 5% have a serious mental illness (SMI). Among veterans with SMI, nearly half (45%) live in poverty, which is ten percentage points higher than the statewide average among veterans (35%). Additionally, location significantly influences access to health care, with Cameron and Hidalgo counties having the majority of veteran mental health services.

Veterans in the Rio Grande Valley have two options when seeking mental health care:

- Veteran-specific service organizations (e.g., Department of Veterans Affairs) or

[457] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[458] U.S. Department of Veteran Affairs. (n.d.). *Veteran households with children FY15*. Veterans Affairs. https://www.va.gov/vetdata/report.asp

- Community organizations that serve veterans (e.g., Tropical Texas, Endeavors, DHR).

Please note, there is an essential distinction between the two: a veteran-serving organization is designed *only* to serve veterans and their families, while community organizations that *also* serve veterans have community-first models that augment their services with veteran programs. Stakeholders shared that the difference in organizational focus significantly influences veterans' decisions when seeking care, with specific considerations being given to the organization's military cultural competency, lived experience of staff providing care, and the quality of veteran-centric programming and services.

Prevalence Data

This section presents demographic data and the prevalence of behavioral health conditions among veterans (ages 17+) for the entire region. Insights into the demographics of veterans in the region, including age, sex, race/ethnicity, poverty rates, and health insurance coverage, are essential to understand the unique needs and challenges of the region's veteran population. For detailed data stratified by the four counties, please refer to Appendix F.

Key Demographic Characteristics

Table 57 presents 2023 estimates of the veteran population, poverty rates, and the prevalence of serious mental illness (SMI) across the counties. The total regional veteran population was approximately 39,000 (about 4% of the adult population), which is lower than the average of 7% across Texas. Most veterans in the region reside in Hidalgo County (23,000) and Cameron County (15,000), with smaller numbers in Starr County (750) and Willacy County (700).
The poverty rate among regional veterans was 24%—lower than the region's adult poverty rate (47%) but higher than the poverty rate among veterans statewide (18%). Starr County had the highest veteran poverty rate (27%), while Willacy County had the lowest rate (21%).
Additionally, about 5% of veterans living in the region, or 1,900 veterans, have a SMI. Among these veterans with SMI, nearly half (45%) also live in poverty, which is ten percentage points higher than the statewide average among veterans (35%).

Table 57: Population of Regional Veterans by County (2023)[459,460,461]

Veterans (18+)	Texas (Statewide)	Region	County			
			Cameron	Hidalgo	Starr	Willacy
Total Population	1,550,000	39,000	15,000	23,000	750	700

[459] National Center for Veterans Analysis and Statistics. (2024). *Veteran Population Projection Model 2023 (VetPop2023).* https://www.va.gov/vetdata/veteran_population.asp
[460] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."
[461] To determine demographics, weights were applied to the base population. Weights are from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).

Veterans (18+)	Texas (Statewide)	Region	County			
			Cameron	Hidalgo	Starr	Willacy
Population in Poverty[462]	280,000	9,500	3,300	6,000	200	150
Population With SMI[463]	75,000	1,900	650	1,200	40	40
Population With SMI in Poverty	26,000	850	250	550	20	10

Table 58 provides detailed population estimates for veteran residents of the region. Of the 39,000 veterans, the majority were male (92%), with nearly 75% aged 45 or older and 44% aged 65 or older. Veterans in the region were predominantly Hispanic/Latino (64%), followed by non-Hispanic White (31%). Health insurance coverage among veterans in the region was higher than the region's overall adult population, with 95% of veterans having some form of insurance, compared to 65% of the general adult population. Veterans in the region often rely on both private and public insurance plans.

Table 58: Demographic Characteristics of Regional Veterans (2023)[464,465,466]

	Entire Region	Texas (Statewide)
Veteran Population (17+)	39,000	1,550,000
Age		
17–20	150	5,500
21–24	750	24,000
25–34	3,600	160,000
35–44	6,000	230,000
45–54	6,000	250,000
55–64	6,000	270,000
65+	17,000	590,000
Sex		
Male	36,000	1,350,000
Female	3,100	200,000
Race / Ethnicity		
Non-Hispanic White	12,000	900,000
African American	600	230,000

[462] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[463] Meadows Mental Health Policy Institute (2025). *Texas county-level mental health prevalence estimates, 2023*. See Appendix E and F for more information.

[464] National Center for Veterans Analysis and Statistics. (2024). *Veteran Population Projection Model 2023 (VetPop2023).* https://www.va.gov/vetdata/veteran_population.asp

[465] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[466] County-level veteran demographic data is available in Appendix F.

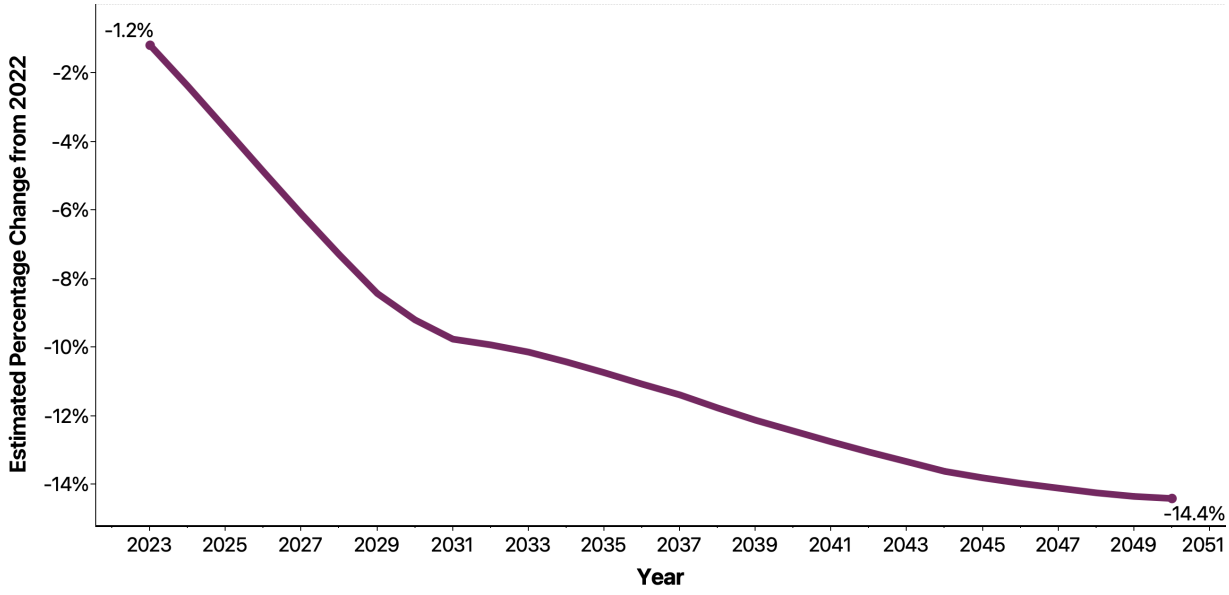
	Entire Region	Texas (Statewide)
Asian American	300	26,000
Native American	150	4,800
Multiple Races	350	47,000
Hispanic / Latino	25,000	320,000
Health Insurance		
No Health Insurance	2,300	80,000
Any Health Insurance	37,000	1,450,000
Private Health Insurance	25,000	1,100,000
Public Health Insurance[467]	29,000	990,000
Medicaid or Other Government Assistance Plans for People with Low Incomes or Disabilities[468]	14%	12%
Language Spoken at Home		
Spanish Spoken at Home	22,000	220,000
Broadband Internet Access		
Internet Access Available	35,000	1,400,000

Veteran Projected Population Changes

The veteran population in the region is projected to decline by nearly 15%, from approximately 38,000 in 2022 to 32,000 in 2050 (Figure 16).[469] This decrease, averaging around 200 veterans per year, is primarily due to the aging of the veteran population, with older veterans passing away and fewer new veterans entering the region. Similarly, the statewide veteran population in Texas is expected to decrease 16% by 2050. While the decline is gradual, it indicates a long-term trend that may reduce the overall demand for veteran services. Nevertheless, continued attention to healthcare, housing, and support services remains critical for addressing the ongoing needs of the remaining veteran population.

[467] In the American Community Survey, public health insurance includes three subsets: Medicare, Medicaid or other government assistance plans for people with low incomes or disabilities, and Veteran Affairs (VA) insurance.
[468] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance.
[469] Although this report uses 2023 population estimates throughout, the most recent population projections available at the time of analysis began in 2022 and were therefore used for this report.

Figure 16: Estimated Change in the Population of Regional Veterans (2022-2050)[470]



Veteran Mental Health and Substance Use Disorder Prevalence

This section provides an overview of the prevalence of mental illness and substance use disorders (SUDs) among veterans living in the region. Unless otherwise noted, all prevalence estimates are for calendar year (CY) 2023.

Veteran Mental Health Prevalence

Table 59 presents estimates of mental health conditions among veterans in the region. In 2023, an estimated 1,900 veterans in the region were living with SMI, with nearly half of them experiencing poverty. Common mental health conditions among veterans included major depression (3,000 veterans), post-traumatic stress disorder (PTSD) (2,300 veterans), and generalized anxiety disorder (GAD) (1,700 veterans). Additionally, 550 veterans were estimated to have bipolar I disorder, and 10 veterans died from suicide in 2022.

[470] National Center for Veterans Analysis and Statistics. (2022). *Veteran Population Projection Model 2020 (VetPop2020)*. https://www.va.gov/vetdata/veteran_population.asp

Table 59: Twelve-Month Mental Health Prevalence Among Regional Veterans (2023)[471,472,473]

	Prevalence
Total Veteran Population	**39,000**
Population in Poverty[474]	9,500
Mental Health Needs[475]	
Serious Mental Illness (SMI)	1,900
SMI in Poverty[476]	850
Major Depression	3,000
Bipolar I Disorder	550
Anxiety Disorders	
Generalized Anxiety Disorder	1,700
Panic Disorder	900
Social Phobia	950
Specific Phobia	1,400
Post-Traumatic Stress Disorder (PTSD)	2,300
Eating Disorders	
Anorexia	70
Bulimia	20
Binge Eating	150
Estimated Number of Deaths from Suicide[477]	10

Veteran Substance Use Disorder Prevalence

Table 60 details the estimated substance use disorder (SUD) prevalence among veterans in the region. An estimated 14% of the region's veterans, or 5,500 people, experienced SUDs in 2023.

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[471] National Center for Veterans Analysis and Statistics (2024). *Veteran Population Projection Model 2023 (VetPop2023)*. https://www.va.gov/vetdata/veteran_population.asp. To determine demographic characteristics, weights were applied to the base population. Weights are from the from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[472] Veteran estimates were rounded to reflect uncertainty in the *Veteran Population Projection Model* estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[473] County-level veteran mental health prevalence estimates are available in Appendix F.

[474] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[475] Unless otherwise cited, prevalence rates were generated by the Meadows Institute. (2025). *County-level mental health prevalence estimates among Texas veterans*, 2023. See Appendix E and F for more information.

[476] Poverty data was obtained from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[477] U.S. Department of Veterans Affairs. (2024, November). *Texas veteran suicide data sheet, 2022*. https://www.mentalhealth.va.gov/suicide_prevention/data.asp

Approximately 3,100 veterans in Hidalgo County were estimated to have an SUD, followed by 2,000 in Cameron County, 100 in Starr County, and 100 in Willacy County.

Table 60: Any Substance Use Disorder Prevalence Among Regional Veterans by County (2023)[478,479,480]

	Prevalence
Entire Region	**5,500**
Hidalgo County	3,100
Cameron County	2,000
Starr County	100
Willacy County	100

In Table 61, we provide detailed estimates of SUD among veterans in the region. Of the approximately 14% of veterans that had an SUD in 2023, most experienced an alcohol-related SUD (3,600 veterans) and 2,300 experienced a drug-related SUD. Notably, 600 veterans had a "severe" alcohol-related SUD, and 40% of veterans with an SUD had a co-occurring mental illness.

Table 61: Twelve-Month Substance Use Disorder Prevalence Among Regional Veterans (2023)[481,482]

	Prevalence
Total Veteran Population	39,000
Substance Use Disorder (SUD) Needs[483]	**5,500**
Comorbid Mental Illness and SUD	2,200
Alcohol-Related SUD	**3,600**

[478] Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS). (2024, September). *National Survey on Drug Use and Health: Public use data (2023).* https://datatools.samhsa.gov/das/nsduh/2023/nsduh-2023-ds0001/variable-list

[479] National Center for Veterans Analysis and Statistics (2024). *Veteran Population Projection Model 2023 (VetPop2023)*. https://www.va.gov/vetdata/veteran_population.asp. To determine demographic characteristics, weights were applied to the base population. Weights are from the from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[480] Additional county-level veteran substance use disorder prevalence estimates are available in Appendix F.

[481] The estimated population of veterans was obtained from the National Center for Veterans Analysis and Statistics (2024). *Veteran Population Projection Model 2023 (VetPop2023)*. https://www.va.gov/vetdata/veteran_population.asp. To determine demographic characteristics, weights were applied to the base population. Weights are from the from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[482] Veteran estimates were rounded to reflect uncertainty in the *Veteran Population Projection Model* estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[483] Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS). (2024, September). *National Survey on Drug Use and Health: Public use data (2023).* https://datatools.samhsa.gov/das/nsduh/2023/nsduh-2023-ds0001/variable-list

	Prevalence
Mild	2,100
Moderate	900
Severe	600
Illicit Drug Use Disorder	**2,300**

Regional Services for Veterans

Veterans Affairs Health Care Services

The largest healthcare system for veterans in the region is coordinated through the Department of Veterans Affairs (VA). In 2010, the VA created the Texas Valley Coastal Bend Health Care System (VATVCBHCS) to better address the health care needs of veterans in the twenty county South Texas area, including the cities of Laredo, McAllen, Harlingen, and Corpus Christi.[484]

VA Eligibility

VA clinics and hospitals only provide health care to veterans who meet VA eligibility standards. The minimum eligibility is a 0% service-connected disability rating, which may incur a co-payment for services depending on the veteran's reason for visiting the VA. As a veteran's service-connected disability percentage increases, the co-payment for services can be reduced or eliminated.

According to the US Census, there are almost 18,000 veterans with a service-connected disability in the four counties. Slightly more than half of all veterans have at least a 0% disability rating, while 25% have a disability rating of 70% or higher. Collectively these veterans have a significant economic impact on the region, receiving more than $544 million in payments from the VA for compensation and pensions in fiscal year 2023. The table below details the number and service-connected rating percentage of veterans in Cameron and Hidalgo counties (Starr and Willacy data were unavailable).

Table 62: Veterans with VA Service-Connected Disability in Cameron and Hidalgo Counties[485]

VA Service-Connected Disability Rating	Cameron County	Hidalgo County
No Service-Connected Disability	7,280	10,256
0 percent	458	325
10 to 20 percent	2,525	1,608
30 to 40 percent	704	834
50 to 60 percent	524	1,851
70 percent or higher	3,838	5,330

[484] U.S. Department of Veteran Affairs. (n.d.). *VA Texas Valley health care*. Veterans Affairs. Retrieved January 10, 2025, from https://www.va.gov/texas-valley-health-care/

[485] United States Census Bureau. *Service-Connected Disability-Rating Status for Civilian Veterans 18 years and Over.* https://data.census.gov/table/ACSDT1Y2023.B21100?q=United+States&t=Disability:Veterans&g=050XX00US48061,48215,48427,48489. Retrieved February 26, 2025.

VA Utilization

More than half (55%) of the veteran population meets the minimum eligibility for VA services. In fiscal year 2023 in Cameron, Hidalgo, Starr, and Willacy counties, the VA spent an average of $19,000 per veteran on services provided by the VA, which is significantly more than the national average of $14,750.[486,487] The summary below details the number of veterans the VATVCBHCS[488] served in the Cameron, Hidalgo, Starr, and Willacy counties.

Table 63: Texas Valley Coastal Bend Health Care System Statistics in South Texas[489]

Texas Valley Coastal Bend Health Care System Statistics in South Texas			
County	**VATVCBHCS Spending on Medical Care**	**Total Veterans**	**Unique Patients Seen by VATVCBHCS**
Cameron	$172,124,000	14,482	8,366
Hidalgo	$208,132,000	21,458	11,599
Starr	$5,985,000	752	369
Willacy	$8,849,000	623	381

Compared to our last community needs assessment in 2016, the overall veteran population decreased (almost 43,000 veterans in 2016 compared to roughly 38,000 in 2025), while the number of veterans using VA services increased (slightly over 16,000 in 2016 compared to almost 21,000 in 2025). The increase in VA utilization can likely be attributed to an increase VA footprint in the area, with additional clinics and more services offered than were available in 2016. The VA has strategically improved and placed multiple outpatient clinics, a Vet Center, and a mobile clinic to help provide a full array of services throughout the Rio Grande Valley. The below table details the locations and services offered at VA facilities.

Table 64: Department of Veterans Affairs Services in the Rio Grande Valley

VATVCBHCS Service Type*	VA – Harlingen Clinic	VA - McAllen Clinic	VA - Brownsville Clinic	VA – Harlingen: Treasure Hills Clinic	VA-Mobile Clinic
Addiction & Substance Use Care	√				
Behavioral Health	√	√	√	√	√
Homeless Veteran Care	√				
Primary Care	√	√	√	√	
Psychiatry	√		√		

[486] Congressional Budget Office. (2021). *The Veterans Community Care Program: Background and Early Effects*. https://www.cbo.gov/system/files/2021-10/57257-VCCP.pdf

[487] The last published cost of VA spending per veteran was 2021.

[488] U.S. Department of Veterans Affairs. Summary of Expenditures by State for Fiscal Year 2016.

[489] U.S. Department of Veterans Affairs. Summary of Expenditures by State for Fiscal Year 2023.

VATVCBHCS Service Type*	VA – Harlingen Clinic	VA - McAllen Clinic	VA - Brownsville Clinic	VA – Harlingen: Treasure Hills Clinic	VA-Mobile Clinic
Social Work	√	√	√	√	
Women Veteran Care	√	√			√

*For some clinics, service type extends beyond those listed here.

Vet Centers are VA-sponsored community-based counseling centers that provide social and psychosocial services to eligible veterans, active-duty service members, National Guard and Reserve members, and family members. Eligibility for Vet Center services is based on theaters of war and operations the veteran supported; current eligibility is for veterans of Operation Iraqi Freedom (Iraq), Operation Enduring Freedom (Afghanistan), and subsequent operations in support of the Global War on Terrorism.

To encourage access of military members struggling with the stigma of mental health struggles and those fearful to engage in mental health services, all counseling at a Vet Center is considered confidential and is not shared with VA offices, the Department of Defense (including military units/commands), or community providers. Additionally, most counselors at Vet Centers are veterans themselves and have experience leading discussions on war, grief, loss, and the transition/post-war adjustment back to civilian life.

Services offered at the Vet Center McAllen include readjustment counseling and individual, group, marriage and family counseling. Vet Centers also offer bereavement counseling to surviving parents, spouses, children, and siblings of service members who die while on active duty. All services are free to eligible veterans and their family members.

VA Wait Times

The VATVCBHCS clinics in the above table have an average wait time of 1.95 days to access mental health services, according to the most recent VA data, which is better than the national VA average of 3.53 days and an improvement from the 2016 needs assessment when wait times were 2.81 days. Additionally, the region's VATVCBHCS clinics provide better access to primary care (2.92 days) and specialty care (6.40 days) compared to the VA's national averages of 4.63 and 7.75 days, respectively.[490]

Accessing Care in the Community

Another driver of increased utilization of VA services is likely the VA's Veterans Community Care Program (VCCP). The VCCP is an initiative that, for eligible veterans, authorizes and pays community providers for services that are not available at the VA. Stakeholders shared that many veterans are more willing to use VA services, knowing they can benefit from utilizing the VCCP to access the community's preferred healthcare services. While the VCCP accounted for

[490] U.S. Department of Veteran Affairs. (n.d.). *Veterans Affairs: Patient Access Data* [General Information]. Retrieved January 10, 2025, from https://www.va.gov/health/access-audit.asp

nearly 40% of the VA's total contract obligations nationwide,[491] stakeholders shared that about half of the region's veterans prefer the VCCP, and use it as often as the service is available since services offered by VCCP are usually closer to home (compared to traveling to a VA clinic) and are with community providers with whom they may already have an established relationship.

As mentioned earlier, roughly 55% of the Rio Grande Valley's veteran population participates in VA health care, meaning a minimum of 45% of veterans rely on services provided by community organizations. The region's options include Tropical Texas Behavioral Health, DHR, Endeavors, Chicanos Por La Causa, and the Hidalgo County - Patriot Support Center. Through our research and regional engagement, we found these to be the most notable regional organizations offering veteran-specific programming as part of their service portfolio. The table below outlines the community veteran programs, eligibility, and services offered.[492]

Table 65: Community Services for Veterans in the Rio Grande Valley

Community Program Providing Veteran Services	Description of Program/Services
Chicanos Por La Causa	Provides peer support services, mental health screening for suicide risk, case management services, recreational programs, and lethal means safety and storage training. Activities are supported through the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant (SSG Fox SPGP).
DHR Health	Does not have a veteran specific program**,** but it is a member of the VA's VCCP, enabling DHR to receive referrals from the VA to provide care when VA services are not available.
Endeavors	Provides short term emergency housing, rental/utility payment assistance, connection to VA benefits and services, mental health resources, access to substance abuse programs, job placement assistance, skills and parenting workshops, and assistance with other public benefits. Activities are supported by the VA Supportive Services for Veterans Families (SSVF) grants, partnerships with the Steven A. Cohen Military Family Clinics, and TVC and TV+FA grant funds.
Hidalgo County - Patriot Support Center	Provides peer support services for people and groups. Activities are funded by TVC FVA grants.
Tropical Texas Behavioral Health – Brownsville	Provides peer support services and free mental health clinical counseling (based on availability of one funded clinician shared between Weslaco and Brownsville locations). Activities are funded by TVC FVA and TV+FA grants. They also provide CCBHC services to veterans, expanding access to comprehensive behavioral health care.
Tropical Texas Behavioral Health - Harlingen	Provides peer support services and free mental health clinical counseling (based on availability of one funded clinician onsite at Harlingen location). Activities are funded by TVC FVA grants.

[491] U.S. Government Accountability Office. *Veterans Community Care Program: VA needs to strengthen contract oversight.* https://www.gao.gov/products/gao-24-106390

[492] Valley-specific details on veteran county service officers, veteran treatment courts, and other community veteran service organizations and coalitions are included in Appendix T.

Community Program Providing Veteran Services	Description of Program/Services
Tropical Texas Behavioral Health - Weslaco	Provides peer support services and free mental health clinical counseling (based on availability of one funded clinician shared between Weslaco and Brownsville locations). Activities are funded by TVC FVA grants.
Tropical Texas Behavioral Health – Military Veteran Peer Network	Provides TVC-certified peer support services, training on suicide prevention and military cultural competency, coordination of mental health first aid, and referrals to local resources based on the individual needs of the veteran and family. This program is supported by the TVC Veterans Mental Health Department.
South Texas Afghanistan Iraq Veterans Association (STAIVA)	Provides peer-to-peer support groups, assistance with VA benefits, food pantry and emergency assistance, medical vouchers, and financial or housing support for veterans and their families. STAIVA also offers counseling, transition support, and referrals to community resources to address mental health, social, and basic needs of veterans in the Rio Grande Valley.

It is important to note that the VA cares for veterans exclusively, so the only option for a veteran's family members and dependents is community care. With more than 30,000 veterans and family members relying on community providers, there is an inherent responsibility for those providers to identify veterans and their family members in their client population and provide culturally competent care to them. However, stakeholders shared that most organizations do not formally identify or track veterans, instead relying on self-disclosure to access veteran specific programming. This lack of data results in an underrepresentation of the veteran community and works against funders, community leaders, and organizations trying to make informed decisions about programs in the regions that support veterans and their families.

Stakeholders also shared some concerns about the quality-of-care veterans and their families receive from community providers not connected to veteran-serving organizations. While some services are more convenient, the providers often lack an understanding about military culture, and military-related trauma and injuries. With more veterans choosing to receive care outside of the VA, in addition to those veterans and their families who do not or cannot use the VA, there is a growing importance of having trained military culturally competent providers in the community.

Stakeholders universally agree the region's mental health providers would benefit from having a military culturally competent workforce that can deliver care tailored to veterans' beliefs, values, and practices.

Stakeholders universally agree the region's mental health community would benefit from having a military culturally competent workforce that can deliver care that is tailored to the

veteran's beliefs, values, and practices, leading to enhanced trust and engagement and, ultimately, improved health outcomes. According to stakeholders, there is not a concerted effort to ensure community providers are trained to provide culturally sensitive care.

> Of the $10 million in Texas Veterans Commission's Fund grants awarded to support veterans in the region, only $1.5 million went to organizations physically located in the region.

State Funds for Veteran Programs

State support comes in the form of grant programs through the Texas Veterans Commission's Fund for Veterans Assistance (FVA) grant program and the Health and Human Services Commission's Texas Veteran and Family Alliance (TV+FA) grant program. In fiscal year 2025, more than $10 million in FVA grants were awarded to support a variety of activities in support of Rio Grande Valley veterans and their families. However, of that $10 million, only $1.5 million went to organizations physically located in Cameron, Hidalgo, Starr, or Willacy counties (Appendix C). The remaining $8.5 million went to organizations that included Cameron, Hidalgo, Starr, or Willacy counties as part of their service area, but whose physical locations were spread across the state.

Suicide Prevention

The most recent suicide prevention report from the Department of Veteran Affairs revealed that national veteran suicide rates remained stable in 2022 over the previous year; however, the number of veteran suicides in Texas (582) significantly exceeded the national rate.[493] To address the veteran suicide crisis, the 2023 Veterans Comprehensive Prevention, Access to Care, and Treatment Act (COMPACT Act) expanded VA services to more veterans and increased options for care by:

- Allowing all veterans (including those not enrolled in the VA) to access crisis care in the community or at the VA, both as a VA benefit and
- Providing, paying for, or reimbursing for treatment of eligible people's emergency suicide care, transportation costs, and follow-up care at a VA or non-VA facility for up to 30 days of inpatient care and 90 days of outpatient care" for all eligible veterans (including those not currently enrolled in the VA).

Regional mental healthcare providers like Palms, DHR, and South Texas Health System Behavioral can leverage the COMPACT Act to treat veterans experiencing suicidal crises and be reimbursed for treatment and transportation costs. Stakeholders shared that they believe this program is valued but rarely accessed. That said, no data were available to demonstrate that veterans in the four counties are utilizing this program with any regularity or provide any insight into the efficacy of services for veterans that accessed care through this program.

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[493] U.S. Department of Veteran Affairs. (n.d.). *2024 National Veteran Suicide Prevention Annual Report*. https://www.mentalhealth.va.gov/docs/data-sheets/2024/2024-Annual-Report-Part-2-of-2_508.pdf

Referral Technology

The Unite Us coordinated care network is a technology platform that receives and coordinates referrals for the entire community, including veterans and their families, helping them access supportive services across a spectrum of needs. As the regional partner, Tropical Texas acts as the hub and referral center for Unite Us in the Rio Grande Valley. Stakeholders shared that Unite Us continues to be a positive influence in the mental health space for veterans where, from 2022 to 2024, individual counseling was the top health related need for veterans and their families each year, followed by behavior skills training and psychiatric services. The table below provides a three-year comparison of Unite Us utilization of all requested services, with the veteran population broken out.

Table 66: Unite Us Utilization 2024

Unite Us Utilization 2024				
Year	**All Clients**	**Veterans and Families (% of Total Clients)**	**Requests Resolved (All Clients)**	**Requests Resolved (Veterans/Families)**
2022	1,139	763 (67%)	53%	63%
2023	1,133	745 (66%)	51%	62%
2024	1,507	691 (46%)	47%	60%

The Combined Arms technology platform, Texas Veterans Network (TVN), also has a membership of resources and referrals for veterans and family members in the region. No TVN data was made available for comparison, so it is not possible to see what platform is being used more efficiently or effectively. However, during interviews stakeholders shared an interest in the community committing to one platform to reduce confusion and isolation of resources. Stakeholders also shared a strong preference for Unite Us since it serves both the veteran and family population *and* the general community, versus TVN which is exclusively veterans and families.

Miliary Stigma: An Additional Barrier to Accessing Care

As mentioned elsewhere in this report, stakeholders consistently identified stigma as a barrier to seeking mental health care in the Rio Grande Valley. This proves doubly so for veterans. In addition to the regional stigma surrounding mental health, which has deep roots in Hispanic and Latino culture, veterans must also contend with the stigma of mental health associated with those who have served in the armed forces. The military stigma of mental health being seen as “weak” or “broken” can be a major obstacle in preventing veterans from seeking, receiving, and continuing care.

Veterans seeking care in the community may feel that civilians do not understand what they have gone through, their values, or beliefs, which were all formed by diverse military experiences and traumas. This cultural and experiential divide between those who have served and those who have not can perpetuate the idea that veterans are dangerous or

mentally broken can create further disconnection and division, leading to further difficulty in seeking assistance.[494]

However, communities can take active steps to combat this. Evidence indicates that cultural competency training is effective in creating connections with service members and veterans seeking care, such as the military/veteran cultural competence training, which is based on the three key areas of awareness, knowledge, and skills.[495] Research also shows that cultural competence for professionals correlates with positive outcomes, patient satisfaction, engagement, and higher retention in care.[496,497]

Recommendations for Veteran Mental Health

Rec. 1	**Leverage state funding opportunities to bring together veteran-serving organizations, improve coordination, share resources, and strengthen collaboration across the region.**

South Texas supports many veteran service organizations. Staple organizations like the Veterans of Foreign Wars (10 posts),[498] the American Legion (13 posts)[499] and the Disabled Veterans of America have multiple locations throughout the area, while additional community programs, like those funded by TVC FVA, provide niche and wraparound services. There are also multiple veteran coalitions across the region. From longstanding Cameron County Veterans Coalition started in 2011 and hosted by United Way of Southern Cameron County to the newest coalitions hosted by Community Veteran Service Organizations, there are a lot of well-intentioned community members dedicated to and actively working on improving the lives of the region's veterans and their families.

However, stakeholders shared concerns about the unwillingness of these organizations to work together or even refer to each other's services when one coalition does not have what they need, ultimately to the detriment of the veterans and families they are trying to serve. At the time of this assessment, there is no unified veteran's collaborative in the region and no person or organization has been identified as the region's "veteran champion" – a member of the community who is ubiquitously trusted and can help the veteran serving community align with a direction and purpose.

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[494] Geraci, J. C., Edwards, E. R., May, D., Halliday, T., Smith-Isabell, N., El-Meouchy, P., Lowell, S., Armstrong, N., Cantor, G., DeJesus, C., Dichiara, A., & Goodman, M. (2024). Veteran Cultural Competence Training: Initial Effectiveness and National-Level Implementation. *Psychiatric Services*, *75*(1), 32–39. https://doi.org/10.1176/appi.ps.202100437

[495] Geraci, J. C. et al., (2024), Veteran Cultural Competence Training: Initial Effectiveness and National-Level Implementation, *Psychiatric Services*, *75*(1), 32–39

[496] Sue, D. W. (Ed.). (2010). *Microaggressions and marginality: Manifestation, dynamics, and impact* (pp. xiii, 360). John Wiley & Sons, Inc.

[497] Alizadeh, S. & Chavan, M. (2016). Cultural competence dimensions and outcomes: A systematic review of the literature. *Health & Social Care in the Community*, *24*(6), e117–e130. https://doi.org/10.1111/hsc.12293

[498] Veterans of Foreign Wars. (n.d.). *Find a Post*. Retrieved January 10, 2025, from https://www.vfw.org/find-a-post

[499] American Legion Post Locator. https://mylegion.org/PersonifyEbusiness/Find-a-Post

Leveraging grants like HHSC's Texas Veterans + Family Alliance, there is an opportunity to develop region-wide collaborative that brings together veteran-serving organizations under a single, inclusive structure, that can in turn leverage philanthropy as match for State funding. A regional entity could facilitate the creation of a cohesive, regional veterans' collaborative that strengthens relationships among service providers, aligns priorities, and improves the overall system of care. Such a collaborative could also improve the accuracy and utility of referral platforms like Unite Us, helping to ensure that veterans are connected to appropriate services more efficiently. Additionally, a centralized collaborative would allow for more consistent data collection across providers—identifying service gaps, highlighting emerging needs, and informing future investments in community-based programs and partnerships that directly support veterans and their families.

There is potential for philanthropic support to facilitate the creation of this regional collaborative. Early-stage funding could help establish the infrastructure needed to convene veteran-serving organizations, design an inclusive governance model, and support initial staffing and coordination. Philanthropic investment at this stage would lay the groundwork for a sustainable, community-driven initiative that aligns fragmented efforts, enhances service delivery, and produces actionable data to guide future improvements—ultimately leading to better outcomes for veterans across the region.

Rec. 2	**To better address the mental health of population subsets, including veterans, expand implementation of integrated behavioral health models.**

Expanding integrated behavioral health is also critical for the veteran population, where mental health challenges are compounded by barriers to timely access, shortages of specialized providers, stigma, and the complex needs of those experiencing conditions like PTSD and depression. Despite improvements in mental health screenings and referrals, many health providers still do not identify veterans in their care, contributing to significant delays in receiving structured follow-up care, leading to worsening symptoms and preventable hospitalizations. Additionally, veterans seeking mental health support often encounter fragmented care pathways, making it challenging to access coordinated services when they are most urgently needed.

In particular, we recommend implementing the collaborative care model for veterans because it has been shown to significantly improve mental health outcomes, particularly for managing depression and PTSD.[500] Veterans enrolled in integrated behavioral health programs experience greater improvements in symptom severity, better overall functioning, and higher satisfaction with their care. A study by the U.S. Department of Veterans Affairs found that veterans receiving team-based collaborative care experienced approximately a 14% per quarter

[500] Fortney, J. C., Pyne, J. M., Kimbrell, T. A., Hudson, T. J., Robinson, D. E., Schneider, R., Moore, W. M., Custer, P. J., Grubbs, K. M., & Schnurr, P. P. (2015ac). Telemedicine-based collaborative care for posttraumatic stress disorder: A randomized clinical trial. JAMA Psychiatry, 72(1), 58–67. https://doi.org/10.1001/jamapsychiatry.2014.1575

reduction in hospital admission rates compared to those receiving standard mental health clinic care.[501] The model has also demonstrated effectiveness in expanding access to mental health services by integrating behavioral health into medical settings, ensuring that more veterans receive timely, evidence-based care.[502] Furthermore, despite higher initial costs, collaborative care approaches are cost-effective strategies for managing depression and PTSD in military health systems, making them a wise investment for improving veteran health outcomes.[503] By embedding structured, team-based mental health care into general medical settings, CoCM offers a scalable and sustainable solution to address the mental health needs of veterans across diverse healthcare environments.

For more on supporting the region's implementation of integrated behavioral health models, please see the section on mild to moderate mental health services.

Rec. 3	**Local health systems should prioritize implementation of mental health screenings for veterans and their families in clinical and healthcare settings.**

The lack of data on the mental health needs of veterans and their family members in the region makes it difficult for community leaders, health systems, and providers to make informed decisions about care. To effectively address this issue, local health systems should make efforts to understand the mental health needs of this population. A critical step is the systematic collection of data to identify veterans and their families within healthcare settings and to implement mental health screenings. This enables health systems to better understand the specific challenges faced by veterans and their families, ensuring that care is tailored to their unique needs. Additionally, providing training to healthcare staff on how and when to administer mental health screenings improves the identification of people who may be struggling, leading to earlier intervention and better outcomes.

As discussed above and elsewhere, implementing integrated behavioral health models, which includes the identification and screening of veterans and their families, is an ideal solution. The ability for veterans and their families to access mental health services in a primary care setting significantly reduces barriers to receiving care such as transportation issues and societal stigma.

If collaborative care is not implemented, local health systems could still adopt procedures to identify and screen veterans in need of mental health care. For health systems without mental health services, the region is privileged to have outstanding community partners, such as DHR

[501] U.S. Department of Veterans Affairs. (2019). Collaborative care in mental health reduces hospital admissions. Retrieved from https://www.research.va.gov/currents/0319-Collaborative-care-in-mental-health-reduces-hospital-admissions.cfm

[502] U.S. Department of Veterans Affairs. (2019). Collaborative care for mental health. Retrieved from https://www.research.va.gov/research_in_action/Collaborative-care-for-mental-health.cfm

[503] Tara A. Lavelle, P., Kommareddi, M., Lisa H. Jaycox, P., Bradley Belsher, P., Michael C. Freed, P., & Charles C. Engel, M. D. (2018). *Cost-Effectiveness of Collaborative Care for Depression and PTSD in Military Personnel*. *24*. https://www.ajmc.com/view/costeffectiveness-of-collaborative-care-for-depression-and-ptsd-in-military-personnel

and Tropical Texas, that can support local health systems by providing access to free or low-cost mental health services to veterans and their families. By addressing these gaps, the community can create a more informed, responsive, and supportive healthcare environment for veterans and their families.

Philanthropy could support this effort by providing one-time funding to help local health systems integrate mental health screenings for veterans into their workflows. Philanthropic investment can also fund training programs to ensure healthcare staff are equipped with the knowledge and skills to administer the screenings effectively. By supporting these foundational steps, philanthropy could help local health systems build the capacity to address the mental health needs of veterans and their families, leading to more accessible and effective care.

Rec. 4	**Foster training opportunities for community providers focused on military cultural competency and evidence-based best practices to improve care for veterans.**

The region is home to a large population of veterans and their families, many of whom rely on community-based providers for behavioral health services. Local providers expressed a strong interest in strengthening their ability to serve this population by building a workforce that understands the unique cultural context, beliefs, and experiences of military and veteran communities. To strengthen provider capacity, we recommend offering targeted training opportunities that combine military cultural competency with evidence-based clinical practices —such as trauma and grief component therapy (TGCT), eye movement desensitization and reprocessing (EMDR), or other trauma-informed approaches—would equip providers to deliver more effective and culturally responsive care to veterans and their families.

TGCT is an evidence-based treatment originally developed for adolescents who have experienced trauma or loss. It uses a structured, modular approach to help people process traumatic experiences, manage grief reactions, develop coping skills, and rebuild a sense of safety and resilience. Recognizing the therapy's versatility, the Meadows Institute championed introducing TGCT concepts for use with adult veterans, incorporating military cultural elements to address the unique grief and trauma experiences common in this population. EMDR is an evidence-based psychotherapy developed to help people recover from the emotional distress associated with traumatic memories. Numerous studies have demonstrated EMDR's effectiveness in treating PTSD and other trauma-related conditions, making it a gold standard treatment recognized by organizations such as the American Psychological Association and the Department of Veterans Affairs.

The Meadows Institute has successfully facilitated TGCT and EMDR trainings in Texas, helping organizations expand local capacity for trauma-informed, culturally responsive care for veterans and their families. These trainings strengthen the ability of community providers to address the complex behavioral health needs of military populations using proven clinical approaches. Investing in similar training efforts in this region would build a stronger, more culturally attuned behavioral health workforce equipped to deliver high-quality care to military-connected people and families.

System-Wide Findings and Recommendations

Community Collaboration

Community collaboration remains essential to ensuring people receive timely and appropriate mental health care—especially for those in rural areas.[504] The Meadows Institute's 2017 regional assessment highlighted the lack of a system-wide approach to behavioral health planning, which created inefficiencies and fragmented care – and that observation holds true today. Many systems, both within counties and across the region, remain siloed, and families, providers, and employers continue to struggle with knowing where to turn for help. While there has certainly been progress in expanding services and treatments since 2017, many stakeholders noted ongoing gaps in awareness and coordination. Although some organizations know about specific resources, no one entity has a comprehensive view of what is available, much less champions advancement, leading to missed opportunities for connection and improved access to care.

Despite progress, families, providers, and employers continue to struggle with knowing where to turn for help.

Effective collaboration crucially enhances mental health services and barriers to care. Several key county-specific initiatives demonstrate this commitment:

- **Cameron County Mental Health Task Force** (CCMHTF):[505] Established in 2009, CCMHTF is a local non-profit organization that brings together representatives from over 25 local mental health and social service agencies. The task force improves coordination, increases education and awareness among providers, and addresses gaps in county mental health services.
- **Cameron County Judicial Council on Mental Health** (CCJCMH): Cameron County has also established the CCJCMH to focus on mental health policy and system collaboration and transformation. Chaired by Judge Sheila Garcia Bence, the council is comprised of 10 – 12 representatives from the LMHA, law enforcement, and hospitals. Council efforts model those of the Texas Judicial Commission on Mental Health.
- **Hidalgo County Mental Health Coalition**:[506] Launched in 2019 by Judge Richard F. Cortez, this coalition developed a network to exchange and enhance local resources, services, awareness, and funding to address local access to care barriers across four major sectors:
  - Law enforcement (enhance police diversion by creating a Mental Health Response Team and diversion programs);
  - Education (increase community awareness with additional Wellness PSA's and partner with providers who are available during non-traditional hours);

[504] RHIhub Toolkit. (n.d.). *Community Partnerships for Rural Mental Health Programs*. Retrieved March 20, 2025, from https://www.ruralhealthinfo.org/toolkits/mental-health/4/partnerships
[505] Cameron County Mental Health Task Force. (n.d.). Cameron County Mental Health Task Force. https://cameroncountymentalhealth.org
[506] Hidalgo County. (n.d.). Hidalgo County mental wellness. Hidalgo County, Texas. https://www.hidalgocounty.us/2440/Hidalgo-County-Mental-Wellness

- Mental health authorities (promote strong partnership with sponsors to meet the matching requirements required by certain grant opportunities); and
- Community/nonprofit (increase community awareness of available programs and services).

Officials in Starr County have publicly identified mental health as one of the two top legislative agendas for the 89th Legislative Session.[507]

Still, throughout the region, the greatest need we heard articulated was for a comprehensive and coordinated response from all sectors, especially in Willacy County which struggles with service availability. Similarly, in Cameron County, stakeholder interviews with CCMHFT board members revealed that residents of the county experience similar barriers when accessing mental health and substance use services as others across the region. The board highlighted, for example, the need to retain mental health professionals that are too often lured away by higher paying jobs.

In other parts of Texas, counties have formed behavioral health leadership teams made up of cross-system leaders from hospitals, mental health providers, primary care, schools, crisis services, county governments, and people with lived experience. The leadership team members engage in a collaborative effort to adopt a mission and core values, identify priority areas, develop a set of deliverables, and form workgroups to meet goals aimed at best addressing behavioral health needs in their community.

Throughout the region, the greatest need we heard articulated was for a comprehensive and coordinated response.

Data Sharing

One vital component of community planning and regional service provision is data sharing infrastructure. Health information exchanges (HIEs) seamlessly share health information such as hospital admissions between health care providers.[508] Benefits include real time alerts to a clinician when a patient is admitted or discharged in a hospital. Research demonstrates potential reductions in healthcare utilization and costs when HIEs are effectively incorporated in community planning and intervention efforts.[509]

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[507] Taylor, S. (2025, January 28). Vera: When it comes to mental health services, Starr County should be part of the RGV, not Webb County. *Rio Grande Guardian*. https://riograndeguardian.com/vera-when-it-comes-to-mental-health-services-starr-county-should-be-part-of-the-rgv-not-webb-county/

[508] HealthIT.gov. (n.d.). *What is HIE?* Retrieved May 5, 2025, from https://www.healthit.gov/topic/health-it-and-health-information-exchange-basics/what-hie HealthIT.gov, (n.d.), *What is HIE?*

[509] Menachemi, N., Rahurkar, S., Harle, C. A., & Vest, J. R. (2018). The benefits of health information exchange: An updated systematic review. *Journal of the American Medical Informatics Association: JAMIA*, *25*(9), 1259–1265. https://doi.org/10.1093/jamia/ocy035

The region currently has Connected Care Exchange, doing business as the Rio Grande Valley Health Information Exchange (RGV HIE), which is the only HIE organization serving the area. It stores data for more than 800,000 patients from eight hospitals and 30 clinics across Cameron, Hidalgo, Starr, and Willacy counties. While the RGV HIE is the sole platform available, stakeholder buy-in has been limited, and few entities actively use the system, even among those already connected.

Recognizing this challenge, the Valley Baptist Legacy Foundation recently conducted a request for proposals (RFP) process to help hospitals in the region evaluate what other HIEs could offer in terms of services and costs. The findings demonstrated that HIEs vary widely in their capabilities and pricing. The Foundation indicated a willingness to assist with initial implementation costs if hospitals would commit to adopting the same HIE platform; however, hospitals do not appear ready to move forward at this time.

Community stakeholders have nonetheless expressed interest in enhancing HIE functionality to better support aggregation of patient data and community-level trend analysis. They also emphasized the need for real-time data sharing to alert clinicians promptly when patients are admitted to hospital inpatient units for crises, enabling timely follow-up and continuity of care.

Recommendations for Community Collaboration

Across the region, there are strong examples of collaboration among individual providers and local entities; however, within counties and across the region as a whole, coordination and planning remain unstructured. There is no consistent, organized approach to collaborative planning that includes public and private sectors, mental health and substance use disorders, inpatient and outpatient care, and specialty populations. This absence of coordinated planning impacts the shared management of behavioral health resources and systems within each county and across the region, affecting services for people with mild to moderate needs as well as those with more severe behavioral health conditions. Correspondingly, while there is a clear need for expanded services in certain areas, there are also instances where existing resources are underutilized due to limited awareness or fragmented referral pathways—for example, maternal mental health services through the Nurse-Family Partnership program are not operating at full capacity due to lack of consistent referrals. Without formal, system-wide collaborative structures grounded in shared values, progress remains hindered.

Rec. 1	**Each county should create a behavioral health leadership team that will lead county-wide efforts to improve behavioral health services across all types of providers, funding sources, and levels of need (building upon any existing county-level collaboration and supporting the cabinet with dedicated staff).**

Community collaboration is critical to sustainable, impactful change. Each county's leadership cabinet would serve as the primary forum for discussing county-specific behavioral health needs and collectively addressing solutions. We recommend that each team or cabinet be composed of key community stakeholders engaged with behavioral health services,

representing a variety of locations and perspectives within their county. Each cabinet should have an appointed facilitator to manage the group's objectives and drive efforts to improve behavioral health services across all types of providers, funding sources, and levels of need.

While the region shares many commonalities in behavioral health challenges, each county also has its own unique characteristics, population needs, available resources, and funding sources (that are sometimes county-specific). County-based leadership groups can effectively identify and respond to these local factors, ensuring that solutions are appropriately tailored to the people and communities they serve. This approach builds on successful models used across Texas, where counties have established their own behavioral health leadership structures to drive improvements at the local level. Initiatives such as the Bexar County Behavioral Health Collaborative and the Harris County Behavioral Health Leadership Team have demonstrated the power of strong, county-specific leadership in advancing behavioral health system improvements, aligning funding opportunities, and coordinating provider efforts.

At a minimum, the leadership cabinets should include executives from major health and hospital organizations, hospital systems, outpatient community mental health organizations, primary care providers, crisis response systems, public and private school leaders, representatives from each county, and people and families with lived experience. To ensure sustained leadership and coordination, the cabinet should designate a leading organization to organize and support these leadership groups. Given it will be difficult for a group of leaders to implement change over time and across populations and systems, we recommend that focused workgroups or subcommittees be convened under the auspices of the leadership group to take charge of county specific recommendations (i.e., Starr County's crisis stabilization needs).

With focused attention, the county cabinets could craft and advance plans in each workgroup, prioritizing implementation, timelines, and needed resources.

Rec. 2	**To support cross-county collaboration, promote a regional approach to meeting behavioral health needs, and drive system-wide innovation and alignment, establish a regional behavioral health accelerator.**

While county-based leadership cabinets are critical to ensuring that local needs are met, particularly within county-specific funding structures, there is also a compelling need for a coordinated regional approach to advancing the behavioral health system. A regional entity charged with accelerating behavioral health system improvements would complement and bolster the county-level leadership cabinets by creating a structured, facilitated environment for cross-county collaboration. This entity would bring together programs, providers, and payers to share resources, align on regional initiatives, and meaningfully address challenges that extend beyond county lines, while ensuring that the perspectives and priorities of each county cabinet are integrated and elevated in regional planning.

This assessment determined the immediate need to jump-start regional progress, build the leadership and infrastructure needed for long-term collaboration, and position the community

to sustain efforts independently after the accelerator's responsibilities sunset. We recommend establishing a regional behavioral health accelerator as a time-limited initiative operating over five to six years, depending on local interest and funding priorities.

A helpful comparison can be drawn from El Paso's approach. In that region, the existing El Paso Behavioral Health Consortium was reinforced with a regional center, forming a complementary collaboration. In its first five years, the regional center served as an accelerator, convening, supporting, and building upon what the community had already developed – and helping implement the findings of a regional assessment. The partnership between the Behavioral Health Consortium and the regional center has helped bring approximately $31.5 million in federal and state grant funding to the El Paso community to expand behavioral health services. While not identical to the model recommended here, El Paso's experience illustrates how a strategic regional function can support existing leadership structures, drive progress, and lay the foundation for lasting, impactful, community-led collaboration. For more information about the El Paso Behavioral Health Consortium, see Appendix U.

In South Texas, the accelerator would provide technical assistance, strategic facilitation, and policy expertise to unite the region around a shared vision for improving behavioral health services. Its primary focus would be launching key initiatives and supporting implementation of recommendations outlined in this report. Local control over resources often results in siloed systems and competition for funding, with progress in one area occasionally coming at the expense of another. Fragmentation can lead to uneven access to care, duplication of services, and missed opportunities for shared investment. Without regional coordination, entities, including counties, risk developing isolated solutions that fail to address broader system-level gaps. At the same time, working together as one region is not without its challenges; counties may worry about losing local autonomy, or that larger or more resourced areas could dominate decision-making or receive a disproportionate share of benefits. Competition for limited funding can also create tension among partners. These dynamics must be acknowledged and carefully managed through a clear structure, inclusive facilitation, and a commitment to equity across all counties.

Specifically, the accelerator's priorities should include the following:

- Facilitate regional mental health literacy and public education efforts to promote community-wide understanding and support for behavioral health initiatives.
- Optimize fast-tracking the flow of state and federal funding to the region.
- Coordinate technical assistance for collaborative care model implementation in regional cohorts, promoting cost efficiency and peer learning.
- Bolster the region's evidence-based interventions that strengthen the continuum of care for children and youth with complex mental health needs, and partner with providers and payers to research viable payment models and develop financing strategies that ensure long-term sustainability of these services across the region.
- Support community-based crisis implementation with an understanding of how system changes in one county affect access and flow in neighboring communities.

- Strengthen and align county-based leadership cabinets, ensuring they evolve in a coordinated manner that supports both local responsiveness and regional cohesion.

These efforts are amplified when accomplished together. Shared implementation reduces redundancies, promotes learning from early adopters, and ensures that progress in one community reinforces, not undermines, that of its neighbors. Then, over time, this shared knowledge, regional alignment, and collaboration strengthens the behavioral health infrastructure across all communities *and* better positions the region to pursue joint funding opportunities and drive policy change. The regional behavioral health accelerator model presents an opportunity to hasten progress, establish a sustainable model for ongoing collaboration, and build a stronger behavioral health system that continues to adapt and respond to the region's needs.

Rec. 3	**To strengthen continuity of care and improve behavioral health outcomes, stakeholders should align on a shared HIE strategy, expand provider participation, and enhance functionality.**

To strengthen continuity of care and improve behavioral health outcomes, the region should move toward a shared, universally adopted platform for communication and data sharing. While infrastructure for a health information exchange exists regionally, participation remains inconsistent, with some organizations connected but not actively using available systems and others not participating for varying reasons. Without broad engagement, critical opportunities for coordination are lost.

Barriers such as the requirements of Title 42 CFR Part 2, which mandates strict protections for behavioral health information, have made some providers hesitant to engage. Yet, stakeholders emphasize that greater functionality, clarity, and a focus on shared priorities would increase adoption and trust. By working together to define the most urgent data-sharing needs, such as timely hospital admission and discharge notifications, and ensuring that confidentiality protections are embedded from the start, the community can design a platform that meets both regulatory and clinical requirements.

A universally agreed-upon system would transform the way care is coordinated across the region. It would allow providers to anticipate patient needs, reduce duplication of services, and close gaps in care for people with complex behavioral health needs who often navigate multiple systems. Beyond improving individual outcomes, it would create a stronger foundation for regional collaboration, enabling behavioral health data to meaningfully inform community planning, resource allocation, and public health strategy.

There is philanthropic support in the region that could be leveraged to help advance this effort, providing both the initial resources and the long-term momentum needed for success. The regional behavioral health accelerator is well positioned to champion this work – convening stakeholders, aligning priorities, and ensuring that an agreed upon platform becomes a trusted, sustainable tool for strengthening the community's behavioral health access and care.

Appendices

Appendix A: Summary of Recommendations

Summary of Recommendations
Recommendations for Mild and Moderate Services *(See pages 46 – 50)*
To improve access, address workforce shortages, and achieve long-term financial sustainability, support the ongoing implementation of integrated behavioral health in pediatric and adult primary care clinics building on existing models that can be financially sustainable.
To increase utilization of CPAN across the region, strengthen outreach and engagement strategies by the regional health-related institution.
Complex Care Recommendations *(See pages 68 – 74)*
To meet complex mental health needs among children and youth, expand access to multisystemic therapy.
To bolster funding for coordinated specialty care programs, Border Region and Tropical Texas should work with regional managed care organizations to negotiate in-lieu-of Medicaid managed care contracts.
To ensure people with serious mental illness receive intensive, wrap-around care, expand and strengthen the assertive community treatment workforce.
To strengthen collaboration and support funding for new interventions, leverage the regional accelerator to expand access to evidence-based, home- and community-based mental health services for children and youth.
To improve access to behavioral health services for people experiencing homelessness, increase collaboration with LMHAs and expand the evidence-based intervention of permanent supportive housing.
Recommendations for Crisis Care Services *(See pages 101 – 104)*
The most recent Texas Legislature expanded funding for Youth Crisis Outreach Teams (YCOT). Tropical Texas should pursue this expanded state funding for a youth crisis outreach team program when it becomes available.
To strengthen the county's crisis response, Starr County should implement a mental health emergency telehealth response program.
Expand access to crisis stabilization services for Starr County.
Recommendations for Substance Use Disorders *(See page 113 – 114)*

Summary of Recommendations
To improve substance use disorder service access across the region, strengthen referral pathways and increase awareness of existing services.
Recommendations for Maternal Mental Health *(See pages 119 – 120)*
To better address the mental health of population subsets, including maternal mental health, expand implementation of integrated behavioral health care models.
To improve maternal health outcomes and reduce maternal vulnerability, the regional accelerator should prioritize activities that coordinate resources, increase awareness, and enhance collaboration among maternal health providers.
Recommendations for Family Violence *(See pages 125 – 128)*
To provide a robust continuum of on-site behavioral health services at the new supportive housing units for survivors of domestic violence, the Friendship of Women and Tropical Texas should establish a partnership.
To promote identification and increase access to behavioral health care for people affected by family violence, District Attorneys and regional LMHAs should establish formal partnerships (such as embedding LMHA staff in county courts).
Expand family violence prevention and identification through schools, community and faith-based organizations, and healthcare settings.
Recommendations for Juvenile Justice *(See pages 136 – 139)*
Conduct a planning process to establish a youth assessment and diversion center in Hidalgo County that provides screening, short-term stabilization, and warm handoffs to services.
To divert first-time felony-level THC vaping offenses away from the juvenile justice system in high-referral school districts, replicate first offender programs (led by school-based law enforcement agencies in partnership with local juvenile probation departments).
The South Region Juvenile Probation Association, with staff support from TJJD's South Regionalization Lead, should develop a juvenile regional reentry navigation program with post-release care coordination and county-specific youth resource guides.
Recommendations for Mental Health in Schools *(See pages 153– 157)*
School districts should routinely evaluate their MTSS framework to identify both strengths and opportunities to enhance the effectiveness of mental and behavioral health supports.
To provide increased access to mental health services for children and youth in the region through TCHATT, UTRGV should partner with a health system capable of expanding TCHATT's services.

Summary of Recommendations
Create opportunities for school districts to collaborate around student mental health strategies and best practices.
Strategically plan for sustainable school mental health programming by braiding and blending existing and new funding streams.
Recommendations for Child Welfare *(See pages 164 – 168)*
To provide parents and caregivers with the skills and support necessary to address their child's mental health needs in appropriate ways, map the continuum of family preservation services.
Develop an interagency foster care workgroup to strengthen collaboration around foster care, prepare for community-based care implementation, and strengthen mental health coordination.
Expand the direct referral processes between local DFPS offices and LMHAs into additional counties, modeled after Hidalgo County's collaboration with Tropical Texas Behavioral Health.
Enhance supports for relative and kinship caregivers to access mental health services and supports for themselves and the children and youth in their care.
Recommendations for Older Adults *(See pages 172 – 173)*
To better address the mental health of population subsets, including older adults, expand implementation of integrated behavioral health models.
Recommendations for Veteran Mental Health *(See pages 187 – 191)*
Leverage state funding opportunities to bring together veteran-serving organizations, improve coordination, share resources, and strengthen collaboration across the region.
To better address the mental health of population subsets, including veterans, expand implementation of integrated behavioral health models.
Local health systems should prioritize implementation of mental health screenings for veterans and their families in clinical and healthcare settings.
Foster training opportunities for community providers focused on military cultural competency and evidence-based best practices to improve care for veterans.
Recommendations for Community Collaboration and Data Sharing *(See pages 194 – 197)*
Each county should create a behavioral health leadership team that will lead county-wide efforts to improve behavioral health services across all types of providers, funding sources, and levels of need (building upon any existing county-level collaboration and supporting the cabinet with dedicated staff).

Summary of Recommendations
To support cross-county collaboration, promote a regional approach to meeting behavioral health needs, and drive system-wide innovation and alignment, establish a regional behavioral health accelerator.
To strengthen continuity of care and improve behavioral health outcomes, stakeholders should align on a shared HIE strategy, expand provider participation, and enhance functionality to enable timely data sharing and community-level analysis.

Appendix B: List of Key Informant Interview Participants

Table B1: List of Key Informant Interview Participants

List of Key Informant Interview Participants		
Name	**Organization**	**Role**
Dr. Brian Dutremaine, D.D., D.B.S, LPC-S	Abundant Grace Community Church Outreach/Counseling	Counseling Pastor
Dr. Rashmi Chandran, PT	AltaCair Foundation	President/Chief Executive Officer
Dr. Rodrigo Argenal, MD	Argenal Pediatrics and Family Care	Board-Certified Pediatrician
Lourdes Flores	ARISE Adelante	President
Monica Hernandez Sanchez	Behavioral Health Solutions of South Texas	Chief Executive Officer
Adriana Garza	Border Region Behavioral Health Center	Supervisor of Adult Behavioral Unit
Veronica G. Hernandez	Border Region Behavioral Health Center	Youth SUD
Marylou Ibarra, MA	Border Region Behavioral Health Center	Crisis Stabilization Unit Director
Sandra Maldonado	Border Region Behavioral Health Center	PATH Coordinator
Laura Palomo	Border Region Behavioral Health Center	Director, Adult Behavioral Health Unit
Maria A. Sanchez	Border Region Behavioral Health Center	Executive Director
Sandra Villarreal	Border Region Behavioral Health Center	Current Supervisor for the PATH Program
Dalinda Gonzalez-Alcantar	Boys and Girls Club McAllen	Chief Executive Officer
Sara M. Garza	Brownsville ISD	Director, Guidance and Counseling
Criselda Cuevas	Buckner Family and Youth Services RGV	President, Buckner Children & Family Services
Jorge Rodriguez	Buckner Family and Youth Services RGV	Major Gift Officer
Dr. Sheila Magoon, MD	Buena Vida Y Salud	ACO Primary Contact
Dayana Zamora	Cameron Couty Mental Health Taskforce	Board Member
Esmeralda Guajardo	Cameron County Public Health Department	Health Administrator
Judge Sheila Garcia Bence	Cameron County, County Statutory Probate Court 1	Cameron County Judicial Council on Mental health
Wendy Hanson	Cameron County Veterans Coalition	Meeting Facilitator-United Way
Dr. Martin Rodriguez	Cameron County Veterans Service Office	Director

List of Key Informant Interview Participants		
Name	**Organization**	**Role**
Liliana Mendez	Cameron County Victims Unit (Cameron County Family Violence Taskforce)	Program Coordinator
Sister Norma Pimentel	Catholic Charities of the Rio Grande Valley	Executive Director
Jerry Peña	Chicanos Por La Causa	Director
Cindy Perez-Waddle	Children's Bereavement Center RGV	Former Interim Chief Executive Officer
Julia Lash	City of McAllen	Grant Administrator
Eva Perez	Communities in School- Cameron County	Executive Director
Elsa Roman, LPC, PS	Connection Center RGV	Program Director (Peer Support)
Gabriela Calzada	DHR Health System	Nurse Family Partnership/Maternal MH
Annabelle Salinas	DHR Health System	Nurse Family Partnership/Maternal MH
Vanessa Vale-Saenz, MA, LPC	DHR Health System	Vice President of Behavioral Health
Dr. Ana Almeda, MD	Driscoll Children's Hospital Rio Grande Valley	Senior Team
Dr. Mary Dale Peterson, MD	Driscoll Children's Hospital Rio Grande Valley	Executive Vice President & Chief Operating Officer
Matt Wolthoff	Driscoll Children's Hospital Rio Grande Valley	President
Victoria Rodriguez, MA, LPC-S	Driscoll Health Plan	Sr. Director of Population Health
Margarita Alvarez	El Milagro Clinic	Executive Director
Dr. Melissa Escamilla, PhD	Endeavors	Program Director - Veteran Supportive Services Rio Grande Valley
Martha Sanchez, LPC, LDCI, CCPT	Family Crisis Center	Registered Play Therapist
Dr. David Schnaiderman, MD	Family Medicine & Geriatric Center	Board-Certified Family Medicine
Gloria Ocampo	Friendship of Women	Executive Director
Astrid Dominguez	Good Neighbor Settlement Home	Executive Director
Thessla Luna Trevino	Good Samaritan Center Brownsville	Program Manager
Sylvia Gamboa	Harlingen CISD	Director of Guidance and Counseling
Dr. Erwin Sanchez, MD	Harlingen Pediatrics Associates	Board-Certified Pediatrician
Judge Renee Rodriguez-Betancourt	Hidalgo County, 449 District Court	449th Judicial Court Judge
Judge Richard F. Cortez	Hidalgo County Mental Health Coalition	Steering Committee

List of Key Informant Interview Participants		
Name	**Organization**	**Role**
Roxanne Ramirez	Hildalgo County Mental Health Coalition	Coalition Chair
Rosie Martinez, CA, DVT	Hidalgo County District Attorney	Crime Victims Unit Director
Samuel Perez, Jr.	Hidalgo County Veterans Service Office	Director of Veteran Services
Elizabeth Germain	IDEA Public Schools	Regional Student and Family Manager
Dr. Ashley Wheeler, Ed.D	IDEA Public Schools	Vice President of Special Programs
Dr. Daniel Lozano, MD	Knapp Community Care Foundation	Board Member
Cristina Trejo-Vasquez, LCSW	Knapp Community Care Foundation	Chief Executive Officer
Victor Rivera	Loaves and Fishes	Executive Director
Armando Lopez, MPH	Lower Rio Grande Valley Area Health Education Foundation (South Texas AHEC)	Director
Adrian Garza	McAllen ISD	Family Treatment Program Manager
Jennifer Garza, LPC	Methodist Healthcare Ministries	Behavioral Health Supervisor
Monica Gonzalez	Methodist Healthcare Ministries	Community Initiatives Manager
Jennifer Knoulton, RN	Methodist Healthcare Ministries	VP Community Health and Wellness
Perla Rivera	Methodist Healthcare Ministries	Wesley District Manager
Naomi Alvarez	Molina	Associate Vice President of Behavioral Health
Dr. Esmeralda Rivera, PhD	Mujeres Unidas/Women Together	Executive Director
Dr. Aaron Salinas, DNP	NAMI Texas of South Texas Rio Grande Valley	Designated Affiliate Leader
Cristela Gonzalez	New Horizon Health Center (FQHC)	Clinical Operations Director
Dr. Henry Imperial, MD	New Horizon Health Center (FQHC)	Medical Director
Jason Wallace	New Horizon Health Center (FQHC)	Chief Executive Officer
Dr. Carlos Medina, MD	Nuestra Clinica Del Valle (FQHC)	Chief Medical Officer
Lucy Ramirez Torres	Nuestra Clinica Del Valle (FQHC)	Chief Executive Officer
Victor Maldonado	Ozanam Center	Executive Director
Yovann Salinas	Region 1 ESC	Director Counseling and Mental Health
Jesus T. Peña, M.Ed.	RGV Dads	Executive Director and Founder
Andrew Lombardo	Rio Grande Valley Health Information Exchange	Executive Director

List of Key Informant Interview Participants		
Name	**Organization**	**Role**
Fernando Villarreal	Rio Grande Valley Health Information Exchange	Technical Clinical Analyst
Angela Belton	Salvation Army- McAllen	Social Services Provider
Tricia Barrera	South Texas Behavioral Health	Senior Business Development
Dr. Elena Marin, MD	Su Clinica Familiar (FQHC)	Executive Director
Dr. Jesus Rodriguez, MD	Su Clinica Familiar (FQHC)	Chief Medical Officer
Dr. James Cazares, MD	Su Clinica Familiar (FQHC)	Chief of Behavioral Wellness
Amanda Valencia	Su Clinica Familiar (FQHC)	Clinic Manager for Behavioral Wellness
Nathan Hoover	Superior Healthplan	Vice President of Behavioral Health Services
Braden Wood	The Wood Group	Chief Executive Officer
Anthony Beltran	Tropical Texas Behavioral Health	Veterans Programs/MVPN
Christina Botello	Tropical Texas Behavioral Health	Senior Manager
Terry Crocker	Tropical Texas Behavioral Health	Chief Executive Officer
Adam De La Torre	Tropical Texas Behavioral Health	SUD Services Director
Monika Flores	Tropical Texas Behavioral Health	Senior Manager, Adult Specialty Services
Hilda Garcia	Tropical Texas Behavioral Health	Director of Programs
Luis Landez	Tropical Texas Behavioral Health	Unite Us/TXServes
Perla Lopez	Tropical Texas Behavioral Health	Data Analyst Manager
Amy Perez	Tropical Texas Behavioral Health	Managed Care Director
Monica Rodriguez	Tropical Texas Behavioral Health	Senior Manager, Children's Mental Health Services
Laura Soule	Tropical Texas Behavioral Health	Crisis Services Director
Moises Arjona, Jr.	Unidos Contra La Diabetes	Chief Executive Officer
Dr. Suad Ghaddar, PhD	UTRGV, College of Health Professions Research	Associate Professor Health Science
Dr. Nancy Peña Razo, PhD, LSSP	UTRGV, Department of Human Development	Mental Health Service Professional Demonstration Program
Maritza Fuentes	UTRGV, Human Development and School Services	TCHATT School Liaison
Dr. Alfonso Mercado, PhD	UTRGV Department of Psychological Services	Multicultural Clinical Lab
Dr. Diana Chapa, MD	UTRGV, School of Medicine	Chief, Department of Psychiatry
Dr. Deepu George, PhD	UTRGV, School of Medicine	Assistant Professor/Clinical; Department of Family and Preventative Medicine; Director of Integrated Care
Dr. Michael B. Hocker, MD, MHS	UTRGV, School of Medicine	Former Dean
Priscilla Palacios	UTRGV, School of Medicine	Office for Advocacy and Violence Prevention (OAVP)
Alyssa Reyes	UTRGV, School of Medicine	OAVP

List of Key Informant Interview Participants		
Name	**Organization**	**Role**
Dr. Candace Robledo, PhD, MPH	UTRGV, School of Medicine	Maternal Health Research Center
Rebekah Batot	Valley Baptist Health System	VBLF board member, Compliance Officer
Michael Gonzales, RN	Valley Baptist Health System	Clinical Supervisor
Stephen Hill	Valley Baptist Health System	Chief Nursing Officer
Becky Tresnicky	Valley Baptist Health System	Director of Behavioral Health Services
Vanessa Villarreal, RN	Valley Baptist Health System	Registered Nurse
Felida Villarreal, CPA	Valley Initiative for Development and Advancement (VIDA)	President and Chief Executive Officer
Judge Aurelio "Keter" Guerra	Willacy County	County Judge
Jessica Rodriguez	Willacy County	Community Development Specialist
Hon. Micaela Zamorano-Alaniz	Willacy County	County Commissioner
Martha C. Acevedo, RHIA	Willacy County Hospital District	District Administrator

In addition to our interviews with stakeholders, we also held listening sessions and group interviews as included in Table B2.

Table B2: Listening Sessions and Group Interviews

Listening Sessions and Group Interviews		
Name	**Type**	**Organization**
Family Partners	Group Interview	Border Region Behavior Health Center and Tropical Texas Behavioral Health
Peer Providers	Group Interview	Border Region Behavior Health Center
Peer Providers	Group Interview	Tropical Texas Behavioral Health
Clients	Listening Session	Behavioral Health Solutions of South Texas
Board Members	Listening Session	Cameron County Mental Health Taskforce
Juvenile Justice Department Staff	Listening Session	South Region Juvenile Chief's Association, Texas Juvenile Justice Department
Students	Listening Session	UTRGV

Appendix C: Supplemental Information on Funding

While state appropriations are critical to local services, they are just one of the funding streams that finances regional mental health. The following outlines governmental awards and grants (both federal and state) as well as other sources used to directly and/or indirectly fund regional programs, services, or treatments. Of particular note are COVID-19 pandemic-era funds that are expiring. shortly.

Federal Funding

Regional American Rescue Plan Act Funding

As with most of the U.S., the counties in this report received American Rescue Plan Act (ARPA) funds. Although we are not reporting on the actual amounts that was spent on mental health programming, the Rio Grande Valley received the following ARPA funding: from American Rescue Plan Act (ARPA) funding:

- Cameron County: $169 million
- Hidalgo County: $213 million
- Starr County: $12.5 million
- Willacy County: $4.1 million

Counties must have obligated these funds by December 31, 2024, and must finish spending them by December 31, 2026. Entities funded through ARPA were aware that this was one-time funding, so projects were generally designed with this in mind. However, some initiatives funded under ARPA have demonstrated significant value and would be beneficial to sustain beyond the funding period.

Table C1: ARPA Efforts by County

ARPA Efforts by County	
County	**Project**
Cameron[510]	San Benito Boys & Girls Club
Cameron	Harlingen Boys & Girls Club
Cameron	Los Fresnos Boys & Girls Club
Cameron	Sunny Glen Children's Home
Hidalgo[511]	Assistance to the UTRGV School of Medicine- Integrated Behavioral Healthcare with Pediatrics and Psychiatry
Hidalgo	Hidalgo County Juvenile Mental Health Facility
Hidalgo	La Joya Independent School District Youth Wellness Camps
Hidalgo	Mission Consolidated School District Youth Wellness Camps
Hidalgo	Boys & Girls Club of Pharr - San Juan Project Learn

[510] Cameron County Department of the Treasury. (n.d.). *American Rescue Plan Act*. Cameron County. Retrieved October 1, 2024, from https://www.cameroncountytx.gov/american-rescue-plan-act/ Cameron County Department of the Treasury, (n.d.), *American Rescue Plan Act*, Cameron County

[511] Hidalgo County Department of Budget & Management. (2024). *2024 Recovery Plan Performance Report*. https://tx-hidalgocounty.civicplus.com/DocumentCenter/View/68143/2024-Recovery-Plan?bidId= Hidalgo County Department of Budget & Management, (2024), *2024 Recovery Plan Performance Report*

ARPA Efforts by County	
County	**Project**
Hidalgo	Hidalgo County Precinct 2 Boys & Girls Club Community Development Project
Hidalgo	Assistance to Boys and Girls Club of Edinburg Rio Grande Valley Legacy Center
Hidalgo	Boys and Girls Club of McAllen, South Community Development Project
Hidalgo	Assistance to Children's Advocacy Center of Hidalgo County

Detailed plans for Starr and Willacy Counties have not been made publicly available. However, Willacy County's Commissioners' Court held a committee meeting for ARPA to discuss how remaining funds should be spent.[512]

Moreover, on March 25, 2025, the Substance Abuse and Mental Health Services Administration (SAMHSA), gave notice to the Texas Health and Human Services Commission (HHSC) that they were immediately terminating the funding for the Coronavirus Preparedness and Response Supplemental Appropriations Act and the American Rescue Plan Act of 2021 (H.R. 1319) that was appropriated to HHSC. HHSC gave notice to all the LMHAs in the state on March 30, 2025, that this grant funding would be ending and effective immediately to discontinue enrollment in the funded programs.[513] Regional LMHAs report the following expected impact:

- Border Region Behavioral Health Center noted that they were using this funding (of approximately $698,000) was being utilized to support rural mental health crisis programs in Starr and Webb counties, and that the programs would be ending as result of these funding cuts unless they could find other ways to continue to support the programs.
- Tropical Texas indicated that the funding supported the cost of five mental health direct care staff but reported that they would be able to continue to cover the cost of those staff through attrition. Tropical Texas Behavioral Health indicated that the funding supported the cost of five mental health direct care staff but reported that they would be able to continue to cover the cost of those staff through attrition. Though they prepared for the funding to end eventually, they had not anticipated the funding to end as abruptly as it did.

Elementary and Secondary School Emergency Relief Grant Programs

On March 27, 2020, Congress set aside approximately $13.2 billion of the $30.75 billion allotted to the Education Stabilization Fund through the Coronavirus Aid Relief, and Economic Security (CARES) Act for the Elementary and Secondary School Emergency Relief Fund (ESSER) Fund to address the impact of COVID-19. Extension periods are set to expire in February 2025 and February 2026.[514] With extension periods expiring in February 2025 and February 2026, Rio

[512] Willacy County. (2023). *Willacy County Commissioner's Court Minutes*.- Willacy County, (2023), *Willacy County Commissioner's Court Minutes-*

[513] Texas Health and Human Services. (2025, March 30). *Coronavirus Preparedness and Response Supplemental Appropriations and American Rescue Plan Act Funding* [Personal communication].

[514] Texas Education Agency. (2023, September 21). *Planning for ESSER Closeout*. Texas Education Agency. https://tea.texas.gov/about-tea/news-and-multimedia/correspondence/taa-letters/planning-for-esser-closeout

Grande City Grulla ISD,[515] McAllen ISD,[516] Brownsville ISD,[517] and La Joya ISD[518] all face budget deficits for 2024-25 and 2025-26.

Below are the Elementary and Secondary Education Relief (ESSER) funds administered to the region's districts over a three-year period, 2020-2023.

Table C2: ESSER Funds Administered to Districts

District	ESSER Funds
BRILLANTE ACADEMY	$0
BROWNSVILLE ISD	$289,087,341
DONNA ISD	$118,018,304
EDCOUCH-ELSA ISD	$43,018,733
EDINBURG CISD	$197,274,391
EXCELLENCE IN LEADERSHIP ACADEMY	$1,547,568*
HARLINGEN CISD	$102,285,878
HIDALGO ISD	$21,290,984
HORIZON MONTESSORI PUBLIC SCHOOLS	$5,543,990*
IDEA PUBLIC SCHOOLS	$240,790,992*
LA FERIA ISD	$18,717,990
LA JOYA ISD	$229,410,795
LA VILLA ISD	$5,950,565
LASARA ISD	$3,562,762
LOS FRESNOS CISD	$43,403,654
LYFORD CISD	$11,287,636
MCALLEN ISD	$139,994,933
MERCEDES ISD	$44,002,382
MISSION CISD	$103,645,581
MONTE ALTO ISD	$6,528,735
PHARR-SAN JUAN-ALAMO ISD	$193,003,788
POINT ISABEL ISD	$16,840,925
PROGRESO ISD	$12,852,653
RAYMONDVILLE ISD	$18,079,293
RIO GRANDE CITY GRULLA ISD	$66,622,662
RIO HONDO ISD	$10,145,138
ROMA ISD	$52,757,560
SAN BENITO CISD	$71,359,638
SAN ISIDRO ISD	$2,470,605
SAN PERLITA ISD	$1,875,528
SANTA MARIA ISD	$4,134,981
SHARYLAND ISD	$32,604,837

[515] KRGV, (n.d.), *Valley School District Facing Multi-Million Dollar Deficit*, KRGV
[516] Zapata, O., (2024, February 14), McAllen ISD facing $13.7 million budget deficit, *MyRGV.Com*
[517] Long, G., (2024, February 2), Brownsville ISD faces $16 million budget deficit for 2024-25, *MyRGV.Com*
[518] Escobedo, G., (2025, April 11), Escobedo: RGV area school districts face growing financial strain, *Rio Grande Guardian*

District	ESSER Funds
SOUTH TEXAS ISD	$16,355,660
TRIUMPH PUBLIC HIGH SCHOOLS-RIO GRANDE VALLEY	$2,415,467*
VALLEY VIEW ISD	$75,783
VANGUARD ACADEMY	$21,351,903*
WESLACO ISD	$99,140,879
Total	**2,247,450,514**

*ARPA amounts paid to charter schools reflect the total amount paid to that charter statewide and may not be indicative of spending amounts for schools in the region.
Note that Brillante Academy did not receive funding as they were not yet established.

Additional Federal Funding

The tables below are a partial list of monies and awards to the region.

Table C3: Federal Funding for Integrated Behavioral Health

Primary Care Behavioral Health Funding			
Project Name	**Amount**	**Program/Description**	**Source**
Sí Texas	$5.6 million	Social Innovation for a Healthy South Texas. Supporting integrated behavioral health models in behavioral health and chronic disease	Corporation for National Community Service[519]
PCBH Paths	$2 million	UTRGV. Training healthcare professionals in the evidence-based Primary Care Behavioral Health (PCBH) model	Health Resources and Services Administration (HRSA)
I^2PBH	$1.92 million	UTRGV. Training 6 graduate students each year from 4 mental health disciplines through the evidence based PCBH model	HRSA

[519] Includes Social Innovation for a Health South Texas, Methodist Healthcare Ministries, and Valley Baptist Legacy Foundation.

Table C4: Other Federal Funding

Other Federal Funding			
Project Name	**Amount**	**Program/Description**	**Source**
Angels of Love Emergency Shelter	$2,365,400[520]	Emergency shelter and resource center for domestic violence survivors.	2024 Consolidated Appropriations Act
City of San Juan Northside Park and Recreation Center	$2 Million[521]	San Juan Northside Park Youth and Recreation Center	2024 Consolidated Appropriations Act
Weslaco Village Apartments	$750,000[522]	Affordable housing	Affordable Housing Program
Tropical Texas: Pharr Police Department	$550,000[523]	Mental Health/Law Enforcement Co-responder Team	Bureau of Justice Assistance
Tropical Texas: Harlingen/ Brownsville Police Department	$550,000[524]	Mental Health/Law Enforcement Co-responder Team	Bureau of Justice Assistance
Tropical Texas: Mission Police Department Justice Collaboration	$229,963[525]	Mental Health/Law Enforcement Co-responder Team	Bureau of Justice Assistance
UTRGV: Accessing Mental Health Services (six districts)	$5.7 Million[526]	Train 120 school psychology, counseling, and social work graduate students in Brownsville ISD, Edcouch-Elsa ISD, McAllen ISD, PSJA ISD, Sharyland ISD, Harlingen CISD, and Mission CISD to complete training and be employed to provide mental health services.	Department of Education

[520] Villa, B. (Director). (n.d.). *McAllen non-profit building emergency shelter for domestic violence survivors*. KRGV. Retrieved February 12, 2025, from https://www.krgv.com/videos/mcallen-non-profit-building-emergency-shelter-for-domestic-violence-survivors/

[521] Yañez, A. (Director). (2024, March 12). *5 Hidalgo County cities to receive part of $25M funding for 2024 Consolidated Appropriations Act*. KVEO-TV. https://www.valleycentral.com/news/local-news/5-hidalgo-county-cities-to-receive-part-of-25m-funding-for-2024-consolidated-appropriations-act/

[522] Steve Taylor. (2024, November 3). Weslaco gets $18.9 million affordable homes project. *Rio Grande Guardian*. https://riograndeguardian.com/weslaco-gets-18-9-million-affordable-homes-project/

[523] Bureau of Justice Assistance. (n.d.). *Mental Health-Law Enforcement Co-Responder Team—Hidalgo County*. Retrieved January 14, 2025, from https://bja.ojp.gov/funding/awards/15pbja-21-gg-04291-ment

[524] Bureau of Justice Assistance. (n.d.). *Mental Health—Law Enforcement Co-Respondent Harlingen PD Team*. Retrieved January 14, 2025, from https://bja.ojp.gov/funding/awards/15pbja-22-gg-02989-ment

[525] Bureau of Justice Assistance. (n.d.). *City of Mission Mental Health Program*. Retrieved January 14, 2025, from https://bja.ojp.gov/funding/awards/15pbja-22-gg-03057-ment

[526] KVEO-TV (Director). (2023, February 3). *RGV children to receive better mental health treatment through federal grant*. https://www.valleycentral.com/news/local-news/rgv-children-to-receive-better-mental-health-treatment-through-federal-grant/

Other Federal Funding			
Project Name	**Amount**	**Program/Description**	**Source**
UTRGV: Accessing Mental Health Services (four additional districts)	$5.6 Million[527]	Place 70 school psychology, counseling, and social work graduate students in Laredo ISD, Mercedes ISD, United ISD, and Valley View ISD to complete training and be employed to provide mental health services.	Department of Education
Region 1 ESC: Project LIFT	$3.9 Million[528]	Support student academic outcomes at Monte Alto ISD, San Isidro ISD, Webb CISD and Zapata County ISD.	Department of Education
Region 1 ESC: Building Mental Health Leaders	$5.9 Million[529]	Increase school counseling capacity in mental health, social and emotional learning and help build a strong talent pool of licensed professional counselors and licensed social workers.	Department of Education
Region 1 ESC: GEAR UP	$33.6 million[530]	Increase the number of low-income students in the class of 2030 at Hidalgo, La Feria, Mercedes, PSJA, Rio Hondo, Roma, San Benito and Santa Rosa school districts	Department of Education
Brownsville Community Health Clinic[531]	$600,000	Behavioral health service expansion	Department of Health and Human Services (HHS)
Tropical Texas: Mental-Health/Law Enforcement Co-Responder Teams	$1.6 Million	Mental Health/Law Enforcement Co-responder Team	Department of Justice (DOJ)

[527] *Grants & Projects | UTRGV*. (n.d.). University of Texas at Rio Grande Valley. Retrieved November 5, 2024, from https://www.utrgv.edu/cep/research/grants-and-projects/index.htm *Grants & Projects | UTRGV*, (n.d.), University of Texas at Rio Grande Valley

[528] Zapata, O. (2024, February 19). Mental health grants awarded to Valley school districts. *MyRGV.Com*. https://myrgv.com/local-news/2024/02/19/mental-health-grants-awarded-to-valley-school-districts/

[529] Jesse Mendez, & Jeremiah Marshall. (2023, January 16). Region One receives $5.9M mental health counseling grant. *KVEO-TV*. https://www.valleycentral.com/news/local-news/region-one-receives-5-9m-mental-health-counseling-grant/

[530] Zapata, O. (2024, September 4). Region One Education Service Center gets $33.6M grant for low-income students. *MyRGV.Com*. https://myrgv.com/featured/2024/09/03/region-one-education-service-center-gets-33-6m-grant-for-low-income-students/

[531] Assistant Secretary for Public Affairs. (2024, September 19). *Biden-Harris Administration Announces Historic Investment to Integrate Mental Health and Substance Use Disorder Treatment into Primary Care* [News Release]. https://www.hhs.gov/about/news/2024/09/19/biden-harris-administration-announces-historic-investment-integrate-mental-health-substance-disorder-treatment-primary-care.html

Other Federal Funding			
Project Name	**Amount**	**Program/Description**	**Source**
UTRGV: Area Health Education Centers (AHECs)[532]	$3.75 Million	Creates three AHECs in region to increase access to primary care for rural and underserved areas, provide medical students with medical practice training environments, and teach medical students about health disparities and the social determinants of health	HRSA
UTRGV: Maternal Health Research Center[533]	$2.3 Million[534]	Establish first Maternal Health Research Center in Rio Grande valley	HRSA
UTRGV: Rio Grande Valley Cancer Health Disparity Research Center (RGV-CHDRC)	$18.4 million[535]	Establish Rio Grande Valley Cancer Health Disparity Research Center (RGV-CHDRC)	National Institute of Health (NIH)
UTRGV: Nurse Practitioners (services to sexual assault victims on campus or SANE)	$499,000	Establish or expand SANE programs, which offer medical forensic care, advocacy and other victim services to sexual assault survivors on college campuses[536]	Office for Crime Victims
Tropical Texas: Zero Suicide Program	$1.2 Million	Implement the Zero Suicide intervention and prevention model for adults	Substance Abuse and Mental Health Service Administration (SAMHSA)
Tropical Texas: Edinburg PD Community Crisis Response Program	$3 Million	Mental Health/Law Enforcement Co-responder Team	SAMHSA

[532] Salomon Torres. (2018). *Health Care Access in the Rio Grande Valley: The Specialty Care Challenge*. https://www.lrgvdc.org/downloads/packets/5C1-01-30-2019.pdf

[533] Saira Cabrera. (2023, October 23). *UTRGV School of Medicine awarded $2.3M to open Valley's first Maternal Health Research Center*. https://www.utrgv.edu/newsroom/2023/10/24/valleys-first-maternal-health-research-center.htm

[534] This grant will extend the work of Dr. George's PCBH training to meet the needs of female patients and provide access to a promotoria or community health worker.

[535] *UTRGV awarded $18.4M NIH grant to establish cancer research center*. (n.d.). Retrieved March 27, 2025, from https://www.utrgv.edu/newsroom/2024/10/3/utrgv-awarded-184m-nih-grant-to-establish-cancer-research-center.htm

[536] *UTRGV awarded grant to empower and support sexual assault survivors and victims*. (n.d.). Retrieved April 10, 2025, from https://www.utrgv.edu/newsroom/2020/10/29-utrgv-awarded-grant-to-empower-and-support-sexual-assault-survivors-and-victims.htm

Other Federal Funding			
Project Name	**Amount**	**Program/Description**	**Source**
UTRGV: Project Bridging the Way	$625,000[537]	Train school personnel, parents, and undergraduate clinical teachers in the UTRGV College of Education to recognize signs and symptoms of mental illness and/or emotional disturbances in youth and school district staff and make appropriate referrals to licensed mental health providers	SAMHSA
VIDA: Nursing Expansion Grant	$3 million	Train and upskill 725 participants in high demand nursing occupations and ultimately help them secure employment at a partner hospital[538]	U.S. Department of Labor
VIDA: FHI 360's CRC	$620,000	Provide education, job readiness, and mentorship to justice-impacted youth[539]	U.S. Department of Labor
Texas Department of Agriculture	$280 Million[540]	Water relief in Rio Grande Valley	U.S. Department of Agriculture

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State Funding

State funds support regional behavioral health services in many ways, but particularly through local mental health authorities and Medicaid.

Local Mental Health Authorities

HHSC contracts with 37 LMHAs to provide mental health services throughout the state. LMHAs are funded through several different ways including state appropriations to serve the indigent population, federal and state grants, as well as billing services to Medicare, Medicaid, private insurance, private payors, and charity care. They are considered the "safety net" for mental and behavioral health care. The below table below outlines state funding to LMHAs in 2022.

[537] *Grants & Projects | UTRGV*, (n.d.), University of Texas at Rio Grande Valley *Grants & Projects | UTRGV*, (n.d.), University of Texas at Rio Grande Valley

[538] *VIDA awarded $3M grant to help address nursing labor shortage, STC to receive funds*. (2023, August 3). https://news.southtexascollege.edu/vida-awarded-3m-grant-to-help-address-nursing-labor-shortage-stc-to-receive-funds/

[539] VIDA. (2024, November 7). VIDA Receives $620,000 Grant from FHI 360 to Empower Justice-Impacted Youth in the Rio Grande Valley. *VIDA*. https://www.vidacareers.org/vida-receives-620000-grant-from-fhi-360-to-empower-justice-impacted-youth-in-the-rio-grande-valley/

[540] *USDA Announces $280 Million Grant Agreement to Support Rio Grande Valley Agricultural Producers Amid Severe Water Shortages | Home*. (2025, March 19). https://www.usda.gov/about-usda/news/press-releases/2025/03/19/usda-announces-280-million-grant-agreement-support-rio-grande-valley-agricultural-producers-amid

Table C5: Regional LMHA Funding (Fiscal Year 2022)

Funding to LMHAs		
	Tropical Texas	**Border Region**
Directed Payment for Behavioral Health Services[541]	$12,733,306	$3,869,904
Delivery System Reform Incentive Payment[542,543]	$9,440,118	$1,552,156
Public Health Provider-Charity Care Program[544]	$5,759,797	$2,790,830
Community Mental Health Grant[545]		$850,128
Mental Health Grant for Justice-Involved Individuals[546]	$1,599,642	
Demonstration Programs to Improve Community Mental Health Services[547]		$4,000,000
Certified Community Behavioral Health Clinic Improvement and Expansion (CCBHC-IA) and Mental Health First Aid[548]	$893,750	

Increased Legislative Investments

Texas has seen significant legislative and policy changes in recent sessions, dramatically reshaping the mental health landscape. In 2023, the 88th Texas Legislature approved $11.68 billion in funding for behavioral health, a 30% increase from the previous session. This appropriation covers inpatient capacity issues, hospital admissions, crisis stabilization, intensive outpatient services for youth and families, and workforce development. The table below spotlights regional funding by location.

Table C6: Behavioral Health Funding Increases from 88th Texas Legislature

Behavioral Health Funding		
Description	**Amount**	**Location**
Construction of psychiatric hospital with up to 100 beds by DHR Health	$85 million	Pharr
50-bed maximum security unit at Rio Grande State Center	$120 million	Harlingen

[541] Texas Health and Human Services. (n.d.). *Report on Mental Health Appropriations and Federal Matching Opportunities*. https://www.hhs.texas.gov/sites/default/files/documents/mental-health-appropriations-fed-match-opp-dec-2023.pdf Texas Health and Human Services, (n.d.), *Report on Mental Health Appropriations and Federal Matching Opportunities*

[542] Texas Health and Human Services, (n.d.), *Report on Mental Health Appropriations and Federal Matching Opportunities*

[543] DSRIP Funding ended on September 30, 2021. See page 3. Report on Mental Health Appropriations and Federal Matching Opportunities.

[544] Texas Health and Human Services, (n.d.), *Report on Mental Health Appropriations and Federal Matching Opportunities*

[545] Texas Health and Human Services. (n.d.). *Report on the Behavioral Health Matching Grant Programs*. https://www.hhs.texas.gov/sites/default/files/documents/behavioral-health-matching-grant-programs-report-2024.pdf

[546] Texas Health and Human Services, (n.d.), *Report on the Behavioral Health Matching Grant Programs*

[547] Texas Health and Human Services, (n.d.), *Report on the Behavioral Health Matching Grant Programs*

[548] Texas Health and Human Services, (n.d.), *Report on the Behavioral Health Matching Grant Programs*

Behavioral Health Funding		
Description	**Amount**	**Location**
Multisystemic Therapy (MST) team through Tropical Texas (second team)	$1.38 million	Cameron, Hidalgo, and Willacy counties
Youth Crisis Outreach Team (YCOT) through Border Region Behavioral Health Center (one team)	$250,000 start-up costs, plus $875,000 in operations costs	Starr County

Other key legislative initiatives from the 88th Legislature include Senate Bill 292, which supports county programs serving justice-involved people with mental illness, and House Bill 13, which provides matching funds to help counties improve their local mental health systems. Additionally, the state invested in modernizing psychiatric hospitals, added collaborative care management as a Medicaid benefit, and launched the Texas Child Mental Health Care Consortium (TCMHCC).

With an initial appropriation of $99 million, TCMHCC implemented TCHATT, along with four other initiatives. Health-related institutions (HRIs) across the state, including UTRGV, provide schools telehealth and telepsychiatry services through TCHATT to help identify and assess the behavioral health needs of children and adolescents and provide access to mental health services. Urgent assessments and short-term stabilization care are available through TCHATT, which helps increase community-wide urgent care capacity. TCHATT also provides linkages to follow-up care through referrals to outpatient mental health providers. Initially, TCHATT was not available in every Texas school district due to the limited funding allocated to medical schools; however, as previously noted, the 88th Legislative Session culminated with historic funding for mental health, which funded TCHATT's statewide expansion. As of May 2025, over 4.3 million students across more than 7,100 campuses had access to TCHATT services.

Most recently, the 89th Texas Legislature leveraged both budget and legislative initiatives to expand mental health access, address workforce challenges, and drive innovation through research and promising new treatments. Senate Bill 1, 2026-27 General Appropriations Act, included $10.41 billion for behavioral health funding across 30 state agencies and HB 500 (Bonnen), the supplemental budget, included an additional $214.9 million for specific mental health projects. Senate Bill 646 (West) expands program eligibility for the loan repayment program for mental health professionals to licensed master social workers (LMSWs), licensed professional counselor associates (LPC Associates), licensed marriage and family therapist associates (LMFT Associates), and certain certified school counselors.

Texas Medicaid and Managed Care

The Texas Medicaid program primarily covers children whose families have low incomes, children with disabilities, pregnant women with low incomes, SSI recipients, adults aged 65 and older with low incomes, adults with disabilities, and current and former foster care youth. The eligible Medicaid population includes many people with significant mental health needs who

may qualify for SSI based on their disability which makes them automatically eligible for Medicaid.[549]

Detailed Medicaid enrollment data is available in the Demographic Data section of this report and provides additional context for understanding coverage trends. Notably, the region has a higher Medicaid enrollment rate than the statewide average, highlighting the program's significant role in providing healthcare access in the region.

Medicaid State Plan
The basis for the Texas Medicaid program is the Medicaid State Plan, a contract between the state and the Centers for Medicare & Medicaid Services (CMS) that outlines Medicaid eligibility, benefits, provider qualifications, and reimbursements allowed by the state.

Texas Medicaid Managed Care Organizations
Medicaid managed care organizations (MCOs) have the responsibility of overseeing the service delivery of physical and behavioral health care. MCOs may directly manage behavioral health care or contract with behavioral health managed care organizations (BHOs) that oversee the utilization and quality of services. Also, MCOs and their respective BHOs may contract for various Medicaid managed care programs that cover different populations as well as different health and mental health benefits for children, youth, and adults. These programs include:

- **STAR** is a program for children, pregnant women, and some families with low incomes who receive Temporary Assistance for Needy Families (TANF). The program also covers young adults ages 21 to 26 years who are eligible for Medicaid under the Former Foster Care Children (FFCC) program and children and youth who were formerly in foster care and eligible for Medicaid as part of their Adoption Assistance benefits.
- **STAR+PLUS** is a program for people with disabilities or who are age 65 and older and adults who are eligible for STAR+PLUS Home and Community-Based Services (HCBS) Waiver services.
- **STAR Health** is a program for children under the age of 18 years who are in Texas Department of Family and Protective Services (DFPS) conservatorship, young adults in DFPS extended foster care, and young adults ages 18 to 20 who were previously under DFPS conservatorship and have returned to foster care through voluntary foster care agreements. Superior Health Plan is the only MCO to offer STAR Health and covers children and youth in foster care statewide.
- **STAR Kids** is a program for children and youth under the age of 21 who have disabilities or receive SSI or who are eligible for Medically Dependent Children Program HCBS Waiver services or Youth Empowerment Services Waiver services; reside in a long-term care facility; receive services through a Medicaid buy-in program; or are enrolled in a Medicaid waiver program.

[549] U.S. Social Security Administration. (n.d.). Understanding supplemental security income and other government programs. Retrieved from https://www.ssa.gov/ssi/text-other-ussi.htm

In the region, the following MCOs provide health and behavioral health services in the Medicaid managed care service delivery area (SDA) known as Hildago:

- STAR MCOs are Driscoll, Molina, Superior, and United
- STAR+PLUS MCOs are Molina, Superior, and United
- STAR Health MCO is Superior
- STAR Kids MCOs are Driscoll, Superior, and United
- CHIP MCOs are Molina and Superior

State Funded Veteran Programs

The Texas Veterans Commission (TVC) provides program staff and resources for employment assistance, claims representation and counseling, and education services in the Rio Grande Valley. Currently, eight TVC staff members, co-located within Texas Workforce Commission and VA buildings, provide direct services to veterans in the area. Additional state programs, such as the Texas Veterans Commission's entrepreneurship program and women veterans' program, do not have dedicated staff in the region but do convene classes and events on-site for veterans in the region.

Additional state support comes in the form of grant programs through the Texas Veterans Commission's Fund for Veterans Assistance (FVA) grant program and the Health and Human Services Commission's Texas Veteran and Family Alliance (TV+FA) grant program. In fiscal year 2025, more than $10 million in FVA grants were awarded to support a variety of activities in support of regional veterans and their families. However, **of that $10 million, only $1.5. million went to organizations physically located in Cameron, Hidalgo, Starr, or Willacy counties**. The remaining $8.5 million went to organizations that included Cameron, Hidalgo, Starr, or Willacy counties as part of their service area, but whose physical locations were spread across the state.

Applicants may apply for state funds and offer a statewide service area. In the table below, grantees with a "*" next to their name are not physically located within the four counties in this assessment but offer grant funded services to one or more counties in the region.

Table C7: State Funded Veteran Clinical Counseling Projects[550]

State Funded Veteran Service Projects			
State Program	**Grantee**	**Grant Type**	**Total State Award**
Clinical Counseling Projects			
TVC -FVA	Baylor Scott & White Research Institute*	Clinical Counseling	$500,000
TVC -FVA	Cenikor Foundation*	Clinical Counseling	$340,000
TVC -FVA	Collin County*	Clinical Counseling	$270,000

[550] Fund for Veterans' Assistance (FVA). (2025, June 12). *Texas Veterans Commission*. https://tvc.texas.gov/grants/

State Funded Veteran Service Projects			
State Program	**Grantee**	**Grant Type**	**Total State Award**
TVC -FVA	Endeavors (Family Endeavors Inc.) *	Clinical Counseling	$500,000
TVC -FVA	Refuge Services, Inc.*	Clinical Counseling	$200,000
TVC -FVA	Samaritan Center for Counseling and Pastoral Care (Hope for Heroes) *	Clinical Counseling	$500,000
TVC -FVA	West Texas Counseling & Guidance, Inc*	Clinical Counseling	$500,000
Employment Support Projects			
TVC -FVA	Goodwill Industries of South Texas, Inc.	Employment Support	$115,000
Financial Assistance Projects			
TVC -FVA	Camp SHiEld (After Military Service) *	Financial Assistance	$150,000
TVC -FVA	Community Action Corporation of South Texas*	Financial Assistance	$300,000
TVC -FVA	Endeavors (Family Endeavors, Inc.) *	Financial Assistance	$500,000
TVC -FVA	Hope for the Warriors*	Financial Assistance	$215,000
TVC -FVA	Houston Area Urban League*	Financial Assistance	$500,000
TVC -FVA	Stephen Siller Tunnel to Towers Foundation*	Financial Assistance	$300,000
TVC -FVA	Texas National Guard Family Support Foundation*	Financial Assistance	$300,000
TVC -FVA	Tropical Texas Behavioral Health	Financial Assistance	$300,000
Homeless/Housing Projects			
TVC -FVA	American GI Forum (AGIF) National Veterans Outreach Program *	Homeless Veteran Support	$500,000
TVC -FVA	Operation FINALLY HOME*	Housing for Texas Heroes	$500,000
Peer Support Projects			
TVC -FVA	American Odysseus Sailing Foundation (Skeleton Crew Adventures) *	Peer Support Services	$100,000
TVC -FVA	Marriage Management*	Peer Support Services	$100,000
TVC -FVA	Outdoor Association for True Heroes, Inc.*	Peer Support Services	$150,000
TVC -FVA	Tropical Texas Behavioral Health	Peer Support Services	$500,000
Referral Services Projects			
TVC -FVA	United Way of Tarrant County*	Referral Services	$275,000
Service Dog Projects			
TVC -FVA	Canine Companions for Independence*	Service Dog Program	$100,000

State Funded Veteran Service Projects			
State Program	**Grantee**	**Grant Type**	**Total State Award**
TVC -FVA	Patriot PAWS Service Dogs*	Service Dog Program	$500,000
Support Services Projects			
TVC -FVA	Project MEND*	Support Services	$300,000
TVC -FVA	Honor Veterans Now*	Support Services	$500,000
Business Support Projects			
TVC -FVA	Transition Skills Training Inc*	Veteran Small Business Support	$50,000
Treatment Court Projects			
TVC -FVA	Tarrant County*	Veterans Treatment Court	$200,000
TVC -FVA	Webb County 406th District Court*	Veterans Treatment Court	$305,000
County Service Officer Projects			
TVC -FVA	Cameron County	Financial Assistance	$120,000
TVC -FVA	Hidalgo County	Financial Assistance	$300,000
TVC -FVA	Hidalgo County	Peer Support Services	$300,000
TVC -FVA	Willacy County	Financial Assistance	$150,000

**more counties served than listed in this table*

Philanthropic Funding

The Meadows Institute catalogued Texas funders who currently support mental health and non-medical drivers of health, or social determinants of health, in the region. The Meadows Institute also identified funders who are not currently funding the region but have an interest in funding mental health in this area. The funders focus on both youth and adult health initiatives and funding opportunities include direct mental and behavioral health services, healthcare access, workforce development, education access, humanitarian aid, medical research, and community resilience. Funding availability varies by geographic area, including county specific regions like those served in the Valley Baptist Legacy Foundation, as well as broader regional areas.

Table C8: South Texas Foundations

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
SSA Foundation (McAllen)	Per request, following consideration by review committee; letter	Funds education, funeral expense, food and housing assistance, medical expenses, food program, tuition assistance, and feeding homeless animals	Grants, scholarships, and micro-grants for organizations outside of UT system entities	• UTRGV scholarships • Hour of Grace Outreach • Children's Advocacy Center

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
	of inquiries are welcome			• Our Lady of Sorrows • RGV Careers Foundation • Proyecto Desarrollo Humano • Vannie E. Cook Jr. Cancer Center
The Raul & Hortensia Tijerina Foundation (aka The Raul Tijerina Jr Foundation)	Year-round	Organizations eligible for grant support from the Tijerina Foundation must operate and/or provide programming and services to people living in these south Texas counties: Cameron, Hidalgo, Starr, and Willacy. Focus areas: • Energizing youth by introducing them to new worlds • Opening doors to dreams through new higher education • Caring for health and well-being at every stage of life • Keeping alive the Valley's multi-cultural heritage	Scholarships and grants	• The Children's Museum of Brownsville • Girl Scouts of Greater South Texas • Arte Público Press • Texas A&M Medical • Sunshine Haven, Inc. • Museum of South Texas History • Rio Grande Valley Ballet
Patel-Desai Foundation for CARES	Year-round	Five major areas of focus: charities, arts, research, engineering, and sciences.	Grant funding and collaborative partnerships for aligned organizations	• Make-A-Wish Rio Grande Valley
Brownsville Foundation for Health and Education	Year-round	Focus areas: the provision of financial assistance, the creation or continued operation of a variety of health care, educational and charitable activities designed to improve the quality of life in the Brownsville community.	Grants	• Amikids Rio Grande Valley • Good Neighbor Settlement House
Knapp Community Care Foundation	*Spring:* Information session/funding forum *Summer:* Applications due *Mid- to late fall:* Funding award notifications	Requests must meet at least one of the five Social Determinants of Health in the three county (Cameron, Willacy, Hidalgo) service area: • Economic Stability • Education Access and Quality	Scholarships grants, programmatic grants, community grants	• Children's Bereavement Center RGV • Hope Family Health Center • El Milagro Clinic • Monte Alto Recreation Center

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
		• Health Care Access and Quality • Neighborhood and Built Environment • Social and Community Context		• RGV Dads • Girls/Boys Club of Weslaco • VIDA • Knapp Medical Center
Hector & Gloria Lopez Foundation	Invitation only	Focused on securing advanced education and combatting obstacles for the under resourced in South Texas, the Rio Grande Valley, El Paso, San Antonio, and Austin	Scholarship grants, endowed scholarships, community grants	
The Trull Foundation	Year-round; 1/year	Children in rural areas or those affected by substance abuse	Grants	• Children's Bereavement Center of the RGV • UTRGV Foundation • South Texas Juvenile Diabetes Association
Valley Baptist Legacy Foundation	Twice per year with most applications: May and November	• Obesity/ Diabetes • Healthy Lifestyles • Access to Care • Mental Health • Aging in Place • Dental Health • Other funding areas • Scholarship Program • Medical Education	Grants and matching funds grants	List of funded partners: 2023 Funded Partners – The Valley Baptist Legacy Foundation

Table C9: Texas Statewide Foundations

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
Alice Kleberg Reynolds Foundation	May – August	• Specific programmatic opportunities, campaigns or projects (RGV counties included) • No capital campaigns but do fund grants for "brick and mortar" • No scholarship grants	Scholarships, grants, event sponsorships	• Big Brothers Big Sisters • Children's Museum of Brownsville • Esperanza Peace and Justice Center • Fuerza Unida • Grow Local South Texas • Girlstart • Planned Parenthood Gulf Coast

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
Greater Texas Foundation	Stage 1: Concept and Discussion Stage 2: Proposal	RGV only if the grant requests include mental health support for opportunity youth and/or college students. Strong intersection with K-12 school success.	Scholarships and programmatic grants	• Achieving the Dream, Inc. • Texas Community College Education Initiative • Instruction Partners
Hogg Foundation for Mental Health	Request for Proposals; no unsolicited grant requests	Focus is mental health (not SUD or IDD)	Planning grants, collaboration grants and evaluation grants.	• Psychology Internship - UTRGV
IBC Foundation	Invitation only	Education, humanitarian aid, medical research, community resilience	Scholarships, endowed chairs, etc.	• UT Health system
The John G and Marie Stella Kenedy Memorial Foundation	Due: October Reviewed: May	Foundation CEO has expressed interest in mental health and the intersection with homeless populations and the need to address both simultaneously	**Sectarian**: 90% are faith based; do not have to be Catholic organizations **Non-sectarian**: 10% explore collaborating non-sectarian organizations	• St. Mary's Catholic School • St. Joseph Academy • Our Lady of Perpetual Help
Meadows Foundation	Timeline One proposal every 12 months. Review timing: 4-5 months from	Statewide funder will consider grant applications from throughout Texas, including the RGV. List of Program Areas: • Arts & Culture • Civic & Public Affairs • Education • Environment • Health • Human Services Five Initiatives linked to their long-term goals and requests	Types of Funding	• The University of Texas at Austin College of Education: teacher residency model in the Rio Grande Valley • Valley Initiative for Development and Advancement • American Forests, Washington, D.C., Toward restoring thorn scrub forests in the Lower RGV • The Conservation Fund, Arlington, Virginia, toward the permanent protection of high-quality coastal prairie, wetlands, and thorn scrub in the Lower RGV • Children's Bereavement Center Of The Rio Grande Valley Inc., Harlingen.

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
Methodist Healthcare Ministries	September	76 counties Access to Care: Mental & Behavioral Health, Access to Care: General, Digital Equity, Food Security, Housing, Education & Workforce Development	Open grant cycle; Cornerstone grants invitation only	• List of grants in RGV: Grantmaking – Methodist Healthcare Ministries of South Texas, Inc. • Digital Equity Grants: Brownsville Housing Opportunity Corporation City of Mercedes, City of Pharr, MHP Salud
Moody Foundation	Letters of inquiry: year-round	Statewide funders who will consider grant applications from throughout Texas, including the RGV. Have a particular interest in rural Texas and the RGV.	Education M-Pact Fund, general grants for programmatic support	List of Moody Grants in Texas can be found here
Superior Health Plan	Q1 – March 31 Q2 – June 30 Q3 – September 30 Q4 – December 31	Medicaid population, Non-Medical Drivers of Health (also known as Social Determinants of Health), including food insecurity, economic stability, education, neighborhood and built environment, access to health care, social and community context	Healthcare provider (contracted medical and/or behavioral health provider) Community organization (community/social services agency)	• Area Agency on Aging Lower Rio Grande Valley • Harlingen Pediatrics Services • South Texas Vocational Technical School • Valley Associates of Independent Living
Texas Mutual	April: Generational Learning August: Workforce Development and Safety Training	Improving the health and wellness: integrated care, strengthening the early childhood education system, providing holistic wraparound support, creating strong pathways for in-demand middle-skill jobs, upskilling and reskilling adult learners using earn-and-learn initiatives	Generational learning workforce development and safety training	• Community Action Corporation of South Texas • South Texas College • Valley Initiative for Development and Advancement (VIDA)
Trellis Foundation	Send a Project Idea This form is an opportunity for you to share a potential idea for a grant.	RGV only if grant requests include mental health support for opportunity youth and/or college students (including nontraditional students such as working adults, parenting students, etc.). Mental health supports with intersection on school readiness and success.	Grants and scholarships	• Intercultural Development Research Association (IDRA) • Postsecondary Mental Health and Well-being Learning Community included UTRGV
Texas Pioneer Foundation	Invitation only	Funds RGV if the grant requests include mental health support for opportunity youth and/or college students. Grant funding areas listed here.	Grant	• University of Texas Foundation • Texas A&M Foundation

Funder	Funding Cycles	Funding Areas	Grant Types	Grantees in Region
Mercy Caritas	Call for application process	Social determinants of health		• ARISE Adelante
United Way South Texas	For grant/partner information, contact VP of Development.	United Way South Texas funds programmatic or general operating support for local organizations making an impact on social emotional health of youth in South Texas	Funding amounts range	• Boys & Girls Club of McAllen • City of Hidalgo Youth Center • Palmer Drug Abuse Program • Serving Children and Adults in Need • Su Casa de Esperanza • Mujeres Unidas
Robert J. Kleberg , Jr. And Helen C. Kleberg Foundation	Spring – March 31; Fall – September 30	Community services (health services): funds that improve health outcomes or provide access to high-quality healthcare Social services: funds services to low-income children and families, interventions and treatment services, education.	Grants	• UTRGV School of Medicine
Paul L. Foster Family Foundation	Rolling application – by invitation only	Education, child welfare, mental healthcare, food aid, Alzheimer's disease	Grants	• UTGRV School of Medicine • United Way South Texas • Boys & Girls Club • STARS Scholarship Fund (McAllen)

Appendix D: Workforce

Supplemental UTRGV Residency Data

UTRGV School of Medicine Graduates Registered with the Texas Medical Board

We also examined data from the Texas Medical Board (TMB) registry of licensed physicians and permitted physicians in training.[551] These data identified 31 fully licensed physicians practicing in the State of Texas and 90 permitted physicians in training statewide[552] who graduated from the UTRGV SOM.

As shown in Table D1, only five of these 31 fully licensed UTRGV SOM graduates (16%) practice in the region. Of the remaining graduates who are fully licensed to practice medicine, more than three-fourths (77%, or 24 physicians) practice in Texas but outside of the region, and two providers are licensed with the Texas Medical Board but designate their primary practice location as outside of Texas (7%).[553] Only two of the 31 fully licensed graduates, or 6%, are behavioral health physicians, and neither of these providers practice in the region.

Table D1: UTRGV SOM Graduates in Texas Medical Board Licensed Physician Data (2022, 2024)[554]

Practice Location	All Physicians	Behavioral Health Physicians[555]
In the Region	5	0
Other Texas	24	2
Out-of-State	2	0
Total	**31**	**2**

We also examined permitted trainee registry data from the TMB given the relative youth of the UTRGV SOM, as many graduates are likely to be in postgraduate training programs. In March 2025, 90 UTRGV SOM graduates were registered with the TMB as physicians in training (Table D2). Of these 90 trainees, 13 physicians, or 14% of permitted physicians in training, were retained in local residency programs.

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[551] Texas Medical Board. (2022, September, and 2024, April). *Licensed physician database*. https://orssp.tmb.state.tx.us/Main.aspx and Texas Medical Board. (2025, March). *Permitted physician in training database*. https://orssp.tmb.state.tx.us/Main.aspx

[552] A "Physician-in-Training (PIT) Permit" allows a qualified person to participate in a postgraduate medical training or fellowship program. Trainees with these permits are restricted to the supervised practice of medicine in the training or fellowship program and are not independently licensed to treat patients.

[553] The Texas Medical Board registry includes providers licensed to practice medicine in Texas only. This represents a subset of UTRGV SOM graduates who remain in-state, and it is unknown how many graduates are registered outside of Texas.

[554] Texas Medical Board Open Records. (2022, September, and 2024, April). Previously cited.

[555] Caution should be used in generalizing these numbers due to the relatively small number of behavioral health physicians graduating from UTRGV SOM.

The TMB registry listed ten behavioral health trainees statewide, or 11% of all permitted physicians in training. Six of the ten permitted behavioral health trainees (60%) remained in the local UTRGV–Harlingen residency program.

Table D2 below shows the number of UTRGV medical school graduates completing their residency training in the region versus other areas in Texas. Of the 90 physicians in training across all specialties, 13 are training in the region, with 6 specializing in behavioral health. In contrast, 77 physicians are training in other parts of Texas, with only 4 specializing in behavioral health. This highlights the significant concentration of psychiatric training within the region but also underscores the limited number of behavioral health physicians compared to the broader physician workforce.

Table D2: UTRGV SOM Graduates Registered with the Texas Medical Board as Permitted Physicians in Training (2025)[556]

Program Location	Physicians in Training	Behavioral Health Physicians in Training[557,558]
In the Region	13	6
Other Texas	77	4
Total	**90**	**10**

Local and State Workforce Efforts

The UTRGV School of Medicine and its Psychiatry Residency Program

The UTRGV School of Medicine and its Psychiatry Residency Program offer a unique opportunity to address mental health workforce shortages in the region. By training a new generation of psychiatrists who understand the region's specific needs, the program combines rigorous clinical training with a focus on serving diverse populations, preparing residents to deliver culturally competent care. In a region where provider shortages and economic barriers limit access to mental health services, this program is a vital asset. Expanding the pipeline of trained mental health professionals, it strengthens the local workforce, increases the availability of psychiatric services, and fosters a more comprehensive, community-based approach to care.

UTRGV Primary Care Behavioral Health Certificate

Developing the capacity of health care providers beyond traditional behavioral health specialists to address mental health conditions upstream is a critical strategy for improving access to care. The Primary Care Behavioral Health Certificate[559] at the UTRGV equips social workers and other professionals with the skills to integrate behavioral health into primary care

[556] Texas Medical Board. (2022, September, and 2024, April). *Licensed physician database*.
[557] Caution should be used in generalizing these numbers due to the relatively small number of behavioral health physicians graduating from the UTRGV SOM.
[558] All UTRGV SOM graduates in the TMB permitted trainee data were registered as psychiatrists.
[559] University of Texas Rio Grande Valley. (2023). *Primary Care Behavioral Health Certificate (Social Work)*. Retrieved from https://utrgv.smartcatalogiq.com/en/2023-2024/graduate-catalog/graduate-academic-programs-by-college/school-of-social-work/primary-care-behavioral-health-certificate-social-work/

settings, ensuring earlier identification and intervention for mental health and substance use concerns. In the region where economic barriers, provider shortages, and stigma often prevent people from accessing behavioral health services, this program serves as a vital asset. By training professionals to deliver behavioral health support within medical settings, the certificate strengthens the region's workforce, expands service availability, and promotes a more holistic approach to care. Graduates of this program play a key role in addressing workforce shortages by bringing behavioral health expertise directly into primary care, helping bridge critical gaps in service delivery and improving health outcomes for underserved communities.

DHR Health

DHR Health has been an Accreditation Council for Graduate Medical Education (ACGME) accredited Sponsoring Institution since 2020. Additionally, the Graduate Medical Education (GME) program integrates a therapist into the family medicine residency, modeling how to incorporate mental health-friendly practices into primary care.

DHR Health is in the process of applying for a psychiatry residency, with plans to add 16 residency positions - four per year over the next four years. In 2024, DHR Health was awarded a federal grant to develop a rural residency training program. This initiative, funded by the Health Resources and Services Administration (HRSA) through its Rural Residency Planning and Development Grant, will support the establishment of an obstetrics rural residency program in partnership with Starr County Memorial Hospital. The grant provides funding over three years to increase access to maternal health services in rural communities.

EMPOWER

EMPOWER is a flagship program of Harvard University's Global Mental Health initiative that builds on path-breaking research demonstrating how non-specialist care providers can be trained and supervised to deliver brief psychological treatments for depression with just as much effectiveness as specialist-delivered treatment protocols.[560] By training Community Health Workers (CHWs)—many from marginalized communities—the program increases access to care, overcoming cultural and language barriers. EMPOWER recruits, trains, and places CHWs, many with lived experience overcoming depression, to help community members access mental health support.[561]

The Meadows Institute is scaling the EMPOWER Behavioral Activation (BA) program, a DSHS-approved CHW certification curriculum, across the region to address workforce shortages.

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[560] Kessler, R. C. et al., (2012), Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement, *Archives of General Psychiatry*, *69*(4), 381–389

[561] Patel, V., Weobong, B., Weiss, H. A., Anand, A., Bhat, B., Katti, B., Dimidjian, S., Araya, R., Hollon, S. D., King, M., Vijayakumar, L., Park, A.-L., McDaid, D., Wilson, T., Velleman, R., Kirkwood, B. R., & Fairburn, C. G. (2017). The Healthy Activity Program (HAP), a lay counsellor-delivered brief psychological treatment for severe depression, in primary care in India: A randomised controlled trial. *Lancet (London, England)*, *389*(10065), 176–185. https://doi.org/10.1016/S0140-6736(16)31589-6 10.1001/archgenpsychiatry.2011.1603

CHWs, particularly in rural areas, can access the program through a self-paced, self-guided platform. Early feedback from CHWs in Cameron and Hidalgo counties has been positive.

Table D3: Baseline Number of Community Health Workers in the Region

Baseline Number of Community Health Workers in the Region		
County	**Number of CHWs in 2022**	**Number of CHWs in 2023**
Cameron County	153	159
Hidalgo County	186	223
Starr County	7	7
Willacy County	1	1
Total	**347**	**390**

The Lower Rio Grande Valley AHEC trained 21 CHWs in March 2025 through an asynchronous, 12-week EMPOWER Behavioral Activation program. The Meadows Institute and Harvard Medical School will host two virtual workshops during the training, providing CHWs the opportunity to discuss their learning and explore ways to integrate it into their daily work. Upon completion, participants will receive DSHS-certified continuing education credits and a certificate of completion from Harvard Medical School. Additionally, DSHS is conducting statewide CHW training using EMPOWER, with 20 CHWs from the Rio Grande Valley already registered through UT Houston School of Public Health – Brownsville, MHP Salud, and Texas A&M Colonias Program. By equipping trusted community members with evidence-based training, the program strengthens the local workforce and empowers CHWs to serve as vital connectors, bridging the gap to mental health services and expanding access for underserved populations. Once trained, the CHWs will be prepared to advance to the next level of internship training with the goal of delivering interventions.

State Workforce Efforts

In the 2026–2027 biennium, the Texas Legislature allocated $304.4 million in All Funds to expand Graduate Medical Education (GME), including $282.4 million in General Revenue Funds—a $71.3 million increase from the previous biennium.[562] This funding aims to increase first-year residency positions to maintain the state's goal of a 1.1-to-1 ratio of residency slots to medical school graduates. Achieving this ratio ensures that all Texas medical school graduates have access to in-state residency programs, which is crucial for retaining physicians within the state.[563] Without sufficient residency slots, graduates may seek training opportunities outside Texas, reducing the likelihood of returning to practice within the state. The funding supports

[562] Texas Legislative Budget Board. (2023). *Bill summary: House appropriations recommendations for the 2024–2025 biennium* (S02). Retrieved from https://lbb.texas.gov/Documents/Appropriations_Bills/89/lbb_recommended_house/8776_S02_Bill_Summary_House.pdf

[563] Texas Higher Education Coordinating Board. (2024). *The Graduate Medical Education Report: An assessment of opportunities for graduates of Texas medical schools to enter residency programs in Texas*. Retrieved from https://reportcenter.highered.texas.gov/reports/legislative/the-graduate-medical-education-report-an-assessment-of-opportunities-for-graduates-of-texas-medical-schools-to-enter-residency-programs-in-texas-2024

the expansion of residency programs across various medical specialties, enhancing the capacity to meet the growing healthcare needs of Texas residents.

88th legislative session actions addressing Mental Health Workforce:

- $23.9 million allocated for salary increases at community centers serving as local mental health authorities.
- $28 million for the Loan Repayment Program for Mental Health Professionals, representing a $25.9 million increase.
- $5 million to support the development and expansion of forensic psychiatry fellowship programs.
- HB 400 creates a psychiatric specialty innovation grant program aimed at increasing the number of physicians specializing in adult or pediatric psychiatry. The bill also establishes a behavioral health innovation grant program, which will award incentive payments to higher education institutions to boost the number of mental health professionals.

During the ongoing 89th Texas Legislative Session, several initiatives have been passed that address the mental health workforce in Texas:

- Senate Bill 1401 (West) Seeks to establish the Texas Mental Health Professional Pipeline Program. This initiative is designed to create clear educational pathways for students pursuing careers in mental health, facilitating their progression from public junior colleges to four-year institutions. The program targets professions like psychology, counseling, and social work, aiming to address the projected shortage of mental health professionals in Texas.
- Senate Bill 646 (West) Focuses on the repayment of education loans for certain mental health professionals. While specific details are pending, the bill underscores the legislature's commitment to supporting mental health practitioners through financial incentives.
- $5 million was provided for the Behavioral Health Innovation Grant Program, offering incentive payments to public community colleges to develop certificate programs for paraprofessionals and entry-level mental health workers. This expands access to the behavioral health field for students in economically disadvantaged or rural regions.

Meadows Institute Framework for Addressing Mental Health Workforce Challenges

Addressing labor challenges requires solutions designed optimize, sustain, and extend the state’s existing mental health workforce. The table below outlines terms, definitions, and examples of solutions in each category, framing language found throughout this report.

Table D4: Meadows Institute Framework for Addressing Mental Health Workforce Challenges

Term	Definition(s)	Example(s)
Optimize	To make best use of provider skills, enabling providers to operate at the top of their training.	Application of the Collaborative Care Model (CoCM) to fidelity.
		AI-assisted charting technology.
		Development of Behavioral Health Care Manager (BHCM) certification training programs.
	To connect patients to the most appropriate care for their needs as efficiently as possible, reducing unnecessary load on the care system.	Measurement Informed Care (MIC)
Sustain	To support the existing workforce, so its members will (a) remain in the workforce and (b) continue to serve effectively those with mental health needs.	Programs to address provider burnout.
Extend	To increase the reach and impact of the existing mental health workforce.	Training and inclusion of paraprofessionals in mental health care.
		Contracting with digital mental health tech companies for services.
		Utilize BHCMs in primary care settings to increase access to behavioral health care and expand workforce quickly.

Appendix E: Prevalence Estimation Methodology

Introduction

To provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding the prevalence of mental illness, the Meadows Institute uses horizontal synthetic estimation, a well-established method that has been extensively published and validated through scientific research.[564,565,566] The Meadows Institute believes that our methodology is among the most cutting-edge and rigorous methods available to estimate the current prevalence of mental illness.

Summary of The Meadows Institute's Prevalence Estimation Methodology

Horizontal synthetic estimation is a statistical method that is built on the premise that a region's socio-demographic characteristics (e.g., age, sex, race/ethnicity, marital, education, poverty, and housing distribution), [567] coupled with the most granular data available on the demographic composition of Texas, could be used to estimate mental health needs.

In 2023, the Meadows Institute developed new prevalence models and matrices for adults and veterans using restricted-access 2012-2013 National Epidemiologic Survey of Alcohol and Related Conditions III (NESARC-III) data.[568] All diagnoses in the NESARC-III survey were measured according to the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-V). These new models expanded upon the sociodemographic inputs to include veteran status, unemployment status, and first-generation immigration status. Including these variables in the model allows us to generate prevalence estimates specifically for these population subgroups.

Quality Assurance and Validity Comparisons

As a quality improvement measure, we verified that our newly generated estimates were comparable to estimates that the Institute used previously (based on data from 2001–2003) and a large national survey (the National Survey on Drug Use and Health). Substantial increases in both major depressive disorder (MDD) and major depressive episode (MDE) of 3-5% were observed. These increases in MDD and MDE may be partly attributable to changes in the

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[564] Sichani, E. K., Smith, A., El Emam, K., & Mosquera, L. (2024). Creating high-quality synthetic health data: Framework for model development and validation. *JMIR formative research*, *8*(1), e53241. https://formative.jmir.org/2024/1/e53241/

[565] Holzer III, C., Jackson, D. J., & Tweed, D. (1981). Horizontal synthetic estimation: A strategy for estimating small area health-related characteristics. *Evaluation and Program Planning*, *4*(1), 29-34. 10.1016/0149-7189(81)90051-3

[566] Herman-Stahl, M., Wiesen, C. A., Flewelling, R. L., Weimer, B. J., Bray, R. M., & Rachal, J. V. (2001). Using social indicators to estimate county-level substance intervention and treatment needs. *Substance Use & Misuse, 36*(4), 501-521. 10.1081/JA-100102639

[567] Jarjoura, D., McCord, G., Holzer III, C. E., & Champney, T. F. (1993). Synthetic estimation of the distribution of mentally disabled adults for allocations to Ohio's mental health board areas. *Evaluation and Program Planning*, *16*(4), 305-313. 10.1016/0149-7189(93)90043-8

[568] National Institute on Alcohol and Alcohol Abuse. (n.d.). *National Epidemiologic Survey of Alcohol and Related Conditions-III (NESARC-III).* https://www.niaaa.nih.gov/research/nesarc-iii

diagnostic criteria during the transition to DSM-IV and DSM-V.[569,570] The rate of serious mental illness was comparable across all data sources.

Prevalence Estimation Methodology - Veterans

The Meadows Institute is the first organization to have independently developed models to estimate the county-level prevalence of mental illness among veterans. In 2023, the Meadows Institute generated mental illness prevalence estimates, including serious mental illness (SMI), major depressive disorder (MDD), major depressive episode (MDE), post-traumatic stress disorder (PTSD), bipolar I, generalized anxiety disorder, agoraphobia, social phobia, specific phobia, panic disorder, manic episode, hypomania, anorexia nervosa, bulimia nervosa, and binge eating disorder, for veterans using the same method and dataset described above.

We defined a "veteran" as any person who reported previously being on active duty in the armed forces, excluding those active only for training in the Reserves or National Guard.

[569] American Psychiatric Association. (2013). *Highlights of Changes from DSM-IV-TR to DSM-5.* www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM_Changes_from_DSM-IV-TR_-to_DSM-5.pdf

[570] The removal of the 'bereavement exclusion' in the DSM-V is one the most notable changes to the MDD diagnostic criteria that changed between the DSM-IV-TR and the DSM-V. In the DSM-IV, a major depressive episode following the death of a loved one could not have counted towards the MDD criteria if the episode lasted less than 2 months. In the DSM-V, this exclusion was lifted and this change could elevate the MDD prevalence rate.

Appendix F: Supplemental Prevalence & Utilization Data

Supplemental Children and Youth (Ages 6-17) Prevalence Data

Table F1: Demographic Characteristics of the Region's Children and Youth by County (2023)[571,572]

	Cameron	Hidalgo	Starr	Willacy
Children and Youth Ages 6-17	85,000	190,000	13,000	3,400
Age				
Ages 6–11	42,000	95,000	7,000	1,600
Ages 12–17	44,000	100,000	7,000	1,800
Sex				
Male	44,000	100,000	7,000	1,600
Female	42,000	95,000	7,000	1,800
Race/Ethnicity				
Non-Hispanic White	3,800	6,000	500	500
African American	300	1,100	20	30
Asian American	700	1,700	<10	<10
Native American	90	30	10	<10
Multiple Races	200	400	<10	40
Hispanic/Latino	80,000	180,000	14,000	2,700
Health Insurance				
No Health Insurance	15,000	33,000	2,700	450
Any Health Insurance	70,000	160,000	11,000	2,900
Private Health Insurance	25,000	50,000	3,800	1,300
Public Health Insurance	49,000	110,000	8,000	1,700
Medicaid or Other Government Assistance Plans for People with Low Incomes or Disabilities[573]	98%	100%	100%	100%
Language Spoken at Home				
Spanish Spoken at Home	50,000	140,000	9,500	900
Broadband Internet Access				
Internet Access Available	80,000	180,000	13,000	2,700

[571] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[572] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimates between 1 and 9 are rounded to "<10."

[573] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance.

Table F2: Twelve-Month Mental Health Prevalence Among the Region's Children and Youth by County (2023)[574,575]

	Age Range	Cameron	Hidalgo	Starr	Willacy
Total Population – Children and Youth	**6–17**	**85,000**	**190,000**	**14,000**	**3,400**
Children Population	6–11	42,000	95,000	7,000	1,600
Youth Population	12–17	44,000	100,000	6,000	1,800
Any Mental Health Need(s)	**6–17**	**34,000**	**75,000**	**5,000**	**1,300**
Mild Conditions[576]	6–17	19,000	43,000	3,100	750
Moderate Conditions[577]	6–17	7,500	17,000	1,200	300
Serious Emotional Disturbance (SED)[578]	6–17	7,000	16,000	1,200	250
SED in Poverty[579]	6–17	4,900	11,000	850	200
At Risk of Out-of-Home or Out-of-School Placement[580]	6–17	500	1,100	80	20
Adverse Childhood Experiences (ACEs)[581]					
Population with 1 to 2 ACEs	6–17	29,000	65,000	4,700	1,100
Population with 3 or More ACEs	6–17	9,500	22,000	1,600	400
Specific Disorders – Youth					
Depression[582]	12–17	3,700	8,500	600	150
Anxiety[583]	12–17	5,500	13,000	900	200

[574] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[575] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimates between 1 and 9 are rounded to "<10."

[576] Kessler, R. C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389. 10.1001/archgenpsychiatry.2011.1603

[577] Kessler, R. C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement.

[578] Holzer, C., Nguyen, H., & Holzer, J. (2025). *Texas county-level estimates of the prevalence of severe mental health need in 2023*. Dallas, TX: Meadows Mental Health Policy Institute.

[579] Holzer, C., Nguyen, H., & Holzer, J. (2025). *Texas county-level estimates of the prevalence of severe mental health need in 2023*. Dallas, TX: Meadows Mental Health Policy Institute. Poverty data was obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[580] Based on our prior work in developing community-based service arrays in response to system assessments (in WA, MA, CT, NE, and PA), we estimate that one in 10 children with SED in poverty would require time-limited, intensive home and community-based services to reduce risk of out-of-home or out-of-school placement.

[581] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[582] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[583] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

	Age Range	Cameron	Hidalgo	Starr	Willacy
Bipolar Disorder[584]	12–17	1,000	2,300	150	40
Attention-Deficit/Hyperactivity Disorder[585]	12–17	5,500	14,000	900	250
Schizophrenia[586]	12–17	60	150	<10	<10
Specific Disorders – Children					
Depression[587]	6–11	550	1,200	190	20
Anxiety[588]	6–11	3,300	7,500	550	150
Attention-Deficit/Hyperactivity Disorder[589]	6–11	4,900	11,000	850	200

Table F3: Twelve-Month Substance Use Disorder Prevalence Among the Region's Youth by County (2023)[590,591]

	Cameron	Hidalgo	Starr	Willacy
Total Population	**44,000**	**100,000**	**7,000**	**1,800**
Population in Poverty[592]	28,000	60,000	4,400	1,000
Any Substance Use Disorder (SUD)[593]	**3,600**	**8,000**	**550**	**150**
In Poverty with SUD[594]	2,200	4,700	350	80

[584] Kessler, D.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M. & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. 10.1002/mpr.1359

[585] Health Resources and Services Administration, & U.S. Census Bureau. (2025, February). *2021–2023 National Survey of Children's Health: Public use microdata files.* https://www.census.gov/programs-surveys/nsch.html. Data used were limited to responses from the state of Texas.

[586] Maibing, C. F., Pedersen, C. B., Benros, M. E., Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin, 41*(4), 963–970. 10.1093/schbul/sbu119

[587] Kessler, D.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M. & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. 10.1002/mpr.1359

[588] Kessler, D.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M. & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. 10.1002/mpr.1359

[589] Kessler, D.C., Petukhova, M., Sampson, N.A., Zaslavsky, A.M. & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184. 10.1002/mpr.1359

[590] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[591] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[592] In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[593] Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 24).

[594] In poverty with SUD estimates for Texas youth were generated through a cross-tabulation of past year substance use and poverty. The SUD rate was derived from the Substance Abuse and Mental Health Services Administration

	Cameron	Hidalgo	Starr	Willacy
Needing but Not Receiving Treatment for SUD[595]	2,200	4,900	350	90
Comorbid Major Depressive Episode and SUD[596]	1,400	3,300	250	60
Alcohol-Related SUD[597,598]	**1,200**	**2,700**	**200**	**50**
Mild	900	2,100	150	40
Moderate	200	500	40	<10
Severe	60	150	<10	<10
Drug-Related SUD[599]	**2,700**	**6,000**	**450**	**100**
Opioid Use Disorder[600]	450	1,000	70	20

Supplemental Adults (Ages 18+) Prevalence Data

Table F4: Demographic Characteristics of the Region's Adults by County (2023)[601,602]

	Cameron	Hidalgo	Starr	Willacy
Adult Population (18+)	300,000	600,000	44,000	15,000
Age				
18–20	21,000	45,000	3,400	1,000
21–24	25,000	55,000	4,200	1,400
25–34	55,000	120,000	9,000	3,100
35–44	50,000	110,000	7,500	2,700
45–54	49,000	100,000	7,500	2,200
55–64	42,000	75,000	5,500	2,000
65+	60,000	100,000	7,500	3,000

(SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted-use data (2021-2022).* Poverty data was obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).

[595] Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – (Tables 24 and 32).

[596] The Texas comorbid MDE and SUD rate was derived from the Substance Abuse and Mental Health Services Administration. (2025). 2023 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas (Tables 32); and 2023 National Survey on Drug Use and Health: National Detailed Tables (Tables 7.1A and 7.26A).

[597] Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – (Table 25).

[598] AUD severity levels were generated by applying the national distribution of AUD severity to past year AUD in Texas. The AUD severity rate was derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted-use data (2021-2022).* The Texas rate of past year AUD was obtained from SAMHSA's (2023) National Survey on Drug Use and Health: Model-based prevalence estimates – Texas (Table 25).

[599] Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 27).

[600] Substance Abuse and Mental Health Services Administration (SAMHSA). (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* – Texas (Table 29).

[601] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[602] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimates between 1 and 9 are rounded to "<10."

	Cameron	Hidalgo	Starr	Willacy
Sex				
Male	150,000	290,000	21,000	8,500
Female	150,000	310,000	23,000	7,000
Race / Ethnicity				
Non-Hispanic White	32,000	45,000	3,100	3,300
African American	1,500	3,200	400	300
Asian American	2,500	7,500	80	200
Native American	300	600	40	60
Multiple Races	1,200	1,400	100	200
Hispanic / Latino	260,000	550,000	41,000	11,000
Health Insurance				
No Health Insurance	95,000	230,000	16,000	4,200
Any Health Insurance	210,000	380,000	28,000	11,000
Private Health Insurance	130,000	260,000	17,000	8,000
Public Health Insurance	90,000	160,000	14,000	5,000
Medicaid or Other Government Assistance Plans for People with Low Incomes or Disabilities[603]	51%	56%	64%	44%
Language Spoken at Home				
Spanish Spoken at Home	220,000	500,000	37,000	8,000
Broadband Internet Access				
Internet Access Available	260,000	540,000	34,000	12,000

Table F5: Twelve-Month Mental Health Prevalence Among the Region's Adults by County (2023)[604,605]

	Cameron	Hidalgo	Starr	Willacy
Total Adult Population	**300,000**	**600,000**	**44,000**	**15,000**
Population in Poverty[606]	130,000	290,000	22,000	6,000
All Mental Health Needs (Mild, Moderate, and Severe)	**70,000**	**140,000**	**11,000**	**3,800**
Mild Conditions[607]	29,000	60,000	4,300	1,500
Moderate Conditions[608]	27,000	55,000	4,000	1,400

[603] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance.
[604] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[605] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."
[606] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html
[607] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 64*, 617–627. 10.1001/archpsyc.62.6.617
[608] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 64*, 617–627.

	Cameron	Hidalgo	Starr	Willacy
Serious Mental Illness (SMI)[609]	14,000	28,000	2,600	900
SMI in Poverty[610]	9,000	18,000	1,700	550
Specific Diagnoses[611]				
Major Depression	30,000	60,000	4,900	1,600
Bipolar I Disorder	4,400	9,000	750	250
Anxiety Disorders				
Generalized Anxiety Disorder	13,000	25,000	2,000	750
Panic Disorder	7,500	15,000	1,300	450
Social Phobia	7,500	14,000	1,200	450
Specific Phobia	15,000	30,000	2,400	850
Post-Traumatic Stress Disorder	13,000	25,000	2,100	750
Schizophrenia Spectrum Disorders [612]	3,600	7,500	550	200
Eating Disorders				
Anorexia	1,000	2,000	150	50
Bulimia	500	1,000	80	30
Binge Eating	1,800	3,600	300	100
First Episode Psychoses (FEP) Incidence (Ages 18-34)[613]	40	80	<10	<10

Table F6: Twelve-Month Substance Use Disorder Prevalence Among the Region's Adults by County (2023)[614,615]

	Cameron	Hidalgo	Starr	Willacy
Total Adult Population	**300,000**	**600,000**	**44,000**	**15,000**
Population in Poverty[616]	130,000	290,000	22,000	6,500

[609] The Meadows Institute. (2025). *Texas county-level mental health prevalence estimates, 2023*. See Appendix E for more information.

[610] The Meadows Institute. (2025). *Texas county-level mental health prevalence estimates, 2023*. See Appendix E for more information. Poverty data was obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[611] Unless otherwise cited, prevalence rates were generated by The Meadows Institute. (2025). *Texas county-level mental health prevalence estimates, 2023*. See Appendix E for more information.

[612] Ringeisen, H., Edlund, M., Guyer, H., Dever, J., Carpenter, L., Olfson, M., First, M., Geiger, P., Liao, D., Peytchev, A., Carr, C., Chwastiak, L., Dixon, L. B., Monroe-Devita, M., Scott Stroup, T., Swanson, J., Swartz, M., Gibbons, R., Stambaugh, L., … Kessler, R. C. (2025). Prevalence of past-year mental and substance use disorders, 2021–2022. *Psychiatric Services*, advance online publication. 10.1176/appi.ps.20240329

[613] Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174,* 143–153. 10.1176/appi.ajp.2016.16010103

[614] Population data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[615] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[616] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

	Cameron	Hidalgo	Starr	Willacy
Any Substance Use Disorder (SUD)[617]	**47,000**	**95,000**	**7,000**	**2,400**
In Poverty with SUD[618]	21,000	45,000	3,500	950
Needing but Not Receiving Treatment for SUD[619]	36,000	75,000	5,500	1,900
Comorbid Mental Illness and SUD[620]	22,000	44,000	3,200	1,100
Alcohol-Related SUD[621,622]	**32,000**	**65,000**	**4,700**	**1,600**
Mild	20,000	41,000	3,000	1,000
Moderate	4,800	9,500	700	250
Severe	6,500	13,000	950	350
Drug-Related SUD[623]	**23,000**	**46,000**	**3,400**	**1,200**
Opioid Use Disorder[624]	6,500	13,000	950	350

Supplemental Veterans (Ages 17+) Prevalence Data

Table F7: Demographic Characteristics of the Region's Veterans by County (2023)[625,626]

	Cameron	Hidalgo	Starr	Willacy
Veteran Population (17+)	15,000	23,000	750	700
Age				

[617] Substance Abuse and Mental Health Services Administration. (2025). 2023 National Survey on Drug Use and Health: Model-based prevalence estimates – Texas (Table 24).

[618] In poverty with SUD estimates for Texas adults are generated through a cross tabulation of past year substance use and poverty. The Texas SUD rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the National Survey on Drug Use and Health: 2-year restricted use data (2021-2022). Poverty data obtained from the U.S. Census Bureau. (2024). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).* https://www.census.gov/programs-surveys/acs/data/pums.html.

[619] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* -- Texas (Tables 24 and 32).

[620] The Texas comorbid AMI and SUD rate is derived from the Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-Based Prevalence Estimates* – Texas (Tables 32); 2023 National Survey on Drug Use and Health: National Detailed Tables (6.1A and 6.10A)

[621] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates*-- Texas (Table 25).

[622] AUD severity levels are generated by applying the distribution of AUD severity to past year AUD in Texas. The Texas AUD severity rate is derived from the Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS), specifically the *National Survey on Drug Use and Health: 2-year restricted use data (2021-2022).* The Texas rate of past year AUD is obtained from SAMHSA's (2023) National Survey on Drug Use and Health: Model-based prevalence estimates – Texas (Table 25).

[623] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates*-- Texas (Table 27).

[624] Substance Abuse and Mental Health Services Administration. (2025). *2023 National Survey on Drug Use and Health: Model-based prevalence estimates* --Texas (Table 29).

[625] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[626] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimates between 1 and 9 are rounded to "<10."

	Cameron	Hidalgo	Starr	Willacy
17–20	30	100	<10	<10
21–24	300	450	20	<10
25–34	1,500	2,000	90	70
35–44	2,400	3,600	90	90
45–54	2,400	3,400	70	100
55–64	2,300	3,200	150	100
65+	5,500	10,000	300	350
Sex				
Male	13,000	21,000	700	650
Female	1,300	1,600	40	60
Race / Ethnicity				
Non-Hispanic White	4,400	7,500	150	250
African American	300	250	30	30
Asian American	250	80	<10	<10
Native American	60	100	<10	<10
Multiple Races	200	150	<10	10
Hispanic / Latino	9,500	15,000	550	400
Health Insurance				
No Health Insurance	800	1,400	80	60
Any Health Insurance	14,000	22,000	650	<10
Private Health Insurance	9,500	14,000	400	450
Public Health Insurance	10,000	18,000	500	500
Medicaid or Other Government Assistance Plans for People with Low Incomes or Disabilities[627]	14%	14%	30%	12%
Language Spoken at Home				
Spanish Spoken at Home	7,500	13,000	<10	<10
Broadband Internet Access				
Internet Access Available	13,000	20,000	550	600

Table F8: Twelve-Month Prevalence of Mental Health Conditions Among the Region's Veterans by County (2023)[628,629]

	Cameron	Hidalgo	Starr	Willacy
Total Veteran Population	**15,000**	**23,000**	**750**	**700**

[627] The Medicaid or other government assistance plans for people with low incomes or disabilities rate is a subset of those with public health insurance. These plans do not include Veteran Affairs or TRICARE coverage.

[628] The estimated population of veterans was obtained from the National Center for Veterans Analysis and Statistics (2024). *Veteran Population Projection Model 2023 (VetPop2023).* https://www.va.gov/vetdata/veteran_population.asp. To determine demographics, weights were applied to the base population. Weights are from the from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).* https://www.census.gov/programs-surveys/acs/microdata.html

[629] Veteran estimates were rounded to reflect uncertainty in the *Veteran Population Projection Model* estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimates between 1 and 9 were rounded to "<10."

	Cameron	Hidalgo	Starr	Willacy
Population in Poverty[630]	3,300	6,000	200	150
Mental Health Needs[631]				
Serious Mental Illness (SMI)	650	1,200	40	40
SMI in Poverty[632]	250	550	20	10
Major Depression	1,100	1,800	60	60
Bipolar I Disorder	200	300	10	10
Anxiety Disorders				
Generalized Anxiety Disorder	600	1,000	30	30
Panic Disorder	350	500	20	20
Social Phobia	350	600	20	20
Specific Phobia	500	800	30	30
Post-Traumatic Stress Disorder	850	1,300	40	40
Eating Disorders				
Anorexia	30	40	<10	<10
Bulimia	<10	10	<10	<10
Binge Eating	60	90	<10	<10
Estimated Number of Deaths from Suicide[633]	<10	<10	<10	<10

Table F9: Twelve-Month Substance Use Disorder Prevalence Among the Region's Veterans by County (2023)[634, 635]

	Cameron	Hidalgo	Starr	Willacy
Total Veteran Population	15,000	23,000	750	700
Substance Use Disorder (SUD) Needs[636]	**2,000**	**3,100**	**100**	**100**

[630] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data was obtained from the U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[631]Unless otherwise cited, prevalence rates were generated by The Meadows Institute. (2025). *County-level mental health prevalence estimates among Texas veterans*, 2023. See Appendix E for more information on the Meadows Institute's methodology.

[632] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[633] U.S. Department of Veterans Affairs. (2024, November). *Texas veteran suicide data sheet, 2022*. https://www.mentalhealth.va.gov/suicide_prevention/data.asp

[634] The estimated population of veterans was obtained from the National Center for Veterans Analysis and Statistics (2024). *Veteran Population Projection Model 2023 (VetPop2023).* https://www.va.gov/vetdata/veteran_population.asp. To determine demographics, weights were applied to the base population. Weights are from the from the U.S. Census Bureau. (2024, December). *American Community Survey 2019-2023 Five-Year Public Use Microdata Sample (PUMS).* https://www.census.gov/programs-surveys/acs/microdata.html

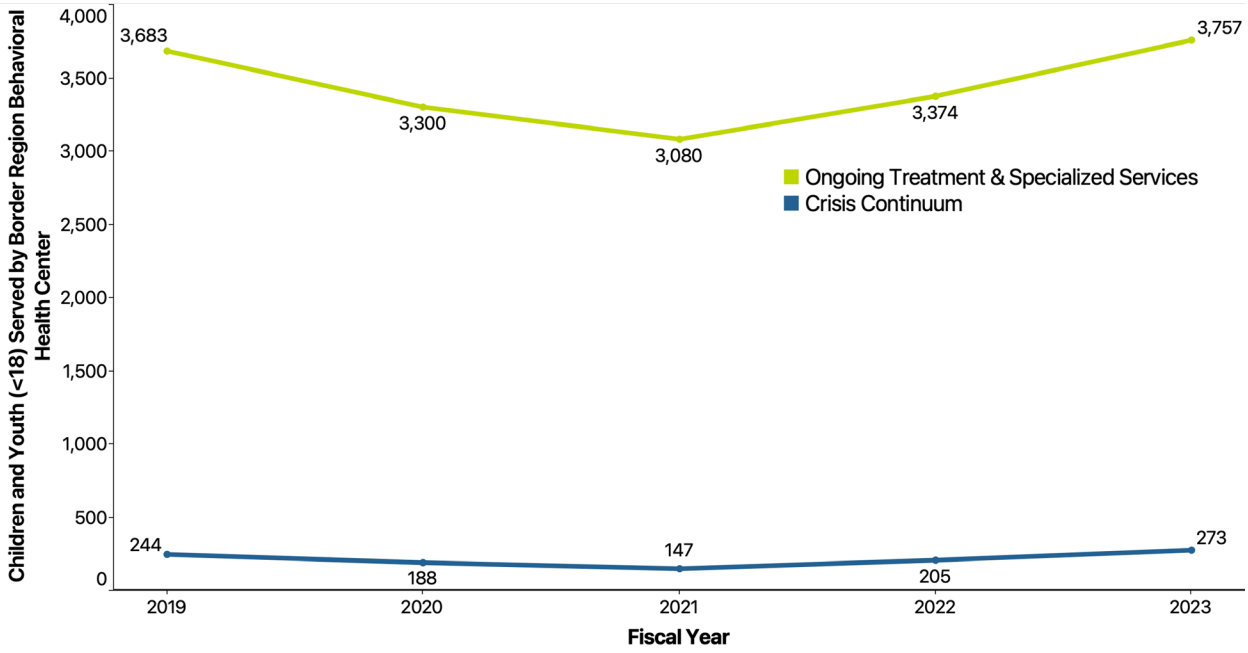
[635] Veteran estimates were rounded to reflect uncertainty in the *Veteran Population Projection Model* estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[636] Substance Abuse and Mental Health Services Administration (SAMHSA) data analysis system (DAS). (2024, September). *National Survey on Drug Use and Health: Public use data (2023).*https://datatools.samhsa.gov/das/nsduh/2023/nsduh-2023-ds0001/variable-list

	Cameron	Hidalgo	Starr	Willacy
Comorbid Mental Illness and SUD	800	1,300	40	40
Alcohol-Related SUD	**1,300**	**2,100**	**70**	**70**
Mild	800	1,200	40	40
Moderate	350	500	20	20
Severe	200	350	10	10
Drug-Related SUD	**850**	**1,300**	**40**	**40**

Supplemental Local Mental Health Authority (LMHA) Data

Figure F1: Trends in the Number of Children and Youth Served by Border Region Behavioral Health Center (FY 2019-FY 2023)[637]



[637] Unduplicated utilization data were obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.

Figure F2: Trends in the Number of Adults Served by Border Region Behavioral Health Center (FY 2019-FY 2023)[638]

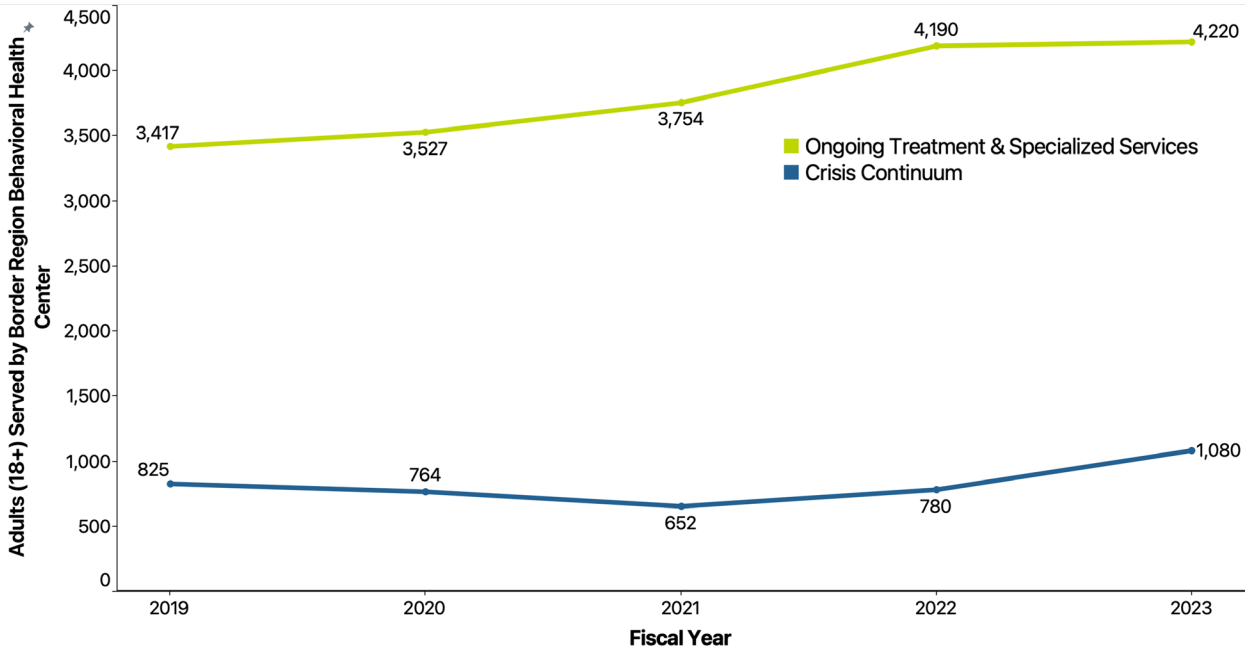


Table F10: Child and Youth Deviations at Tropical Texas Behavioral Health and Bluebonnet Trails Community Services by Level of Care (FY 2023)[639,640]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health		Bluebonnet Trails Community Services	
		LOC-R	LOC-A	LOC-R	LOC-A
Ongoing Treatment Levels	Medication Management (C1)	59	206	50	42
	Targeted Services (C2)	199	1,129	145	61
	Complex Services (C3)	1,430	69	370	51
	Intensive Family Services (C4)	94	71	56	91
	Early Onset Psychosis (CEO)	-	27	-	26
	Young Child Services (CYC)	3	1	2	1
	YES Waiver (CY)	0	284	-	309
	Transition Age Youth (CTAY)	-	0	-	0
Crisis Continuum	Residential Treatment Centers (RTC)	-	0	-	4

[638] Unduplicated utilization data were obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.
[639] Unduplicated utilization data were obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.
[640] In Fiscal Year 2023, Bluebonnet Trails Community Services served 11,693 adults residing in rural and non-major metropolitan counties—Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson—a total comparable to the 15,905 adults served by Tropical Texas.

Ideal System Category	Level of Care	Tropical Texas Behavioral Health		Bluebonnet Trails Community Services	
		LOC-R	LOC-A	LOC-R	LOC-A
	Crisis (C0)	0	0	0	0
	Transitional Services (C5)	-	1	-	52
Refusal of Services (C6)[641]		-	12	-	0
Not Eligible (C9)		16	1	14	0
Total		**1,801**	**1,801**	**637**	**637**

Table F11: Adult Deviations at Tropical Texas Behavioral Health and Bluebonnet Trails Community Services by Level of Care (FY 2023)[642,643]

Ideal System Category	Level of Care	Tropical Texas Behavioral Health		Bluebonnet Trails Community Services	
		LoC-R	LoC-A	LoC-R	LoC-A
Ongoing Treatment Levels	Medication Management (A1M)	0	0	0	0
	Medication Management & Skills Training (A1S)	2,904	2,150	658	831
	Medication Management & Therapy (A2)	2,455	150	176	308
	Psychosocial Therapy & Case Management (A3)	203	3,047	22	449
	Assertive Community Treatment (ACT) (A4)	654	126	90	42
	Early Onset Psychosis Services (AEO)	-	97	-	94
	Adult Transition Age Youth (ATAY)	-	2	-	2
Crisis Continuum	Crisis Services (A0)	0	5	0	0
	Transitional Services (A5)	-	11	-	281
Refusal of Services (A6)[644]		-	29	-	0
Waiting for All Authorized Services (A8)		-	784	-	0
Not Eligible (A9)		200	15	1,061	0
Total		**6,416**	**6,416**	**2,007**	**2,007**

[641] For those in category C6, the Uniform Assessment indicated a Recommended Level of Care (LOC- R) of LOC-C1 through LOC-C4, LOC-CYC, or LOC-CTAY; however, the person refused services.
[642] Unduplicated utilization data were obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.
[643] In Fiscal Year 2023, Bluebonnet Trails Community Services served 11,693 adults residing in rural and non-major metropolitan counties—Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson—a total comparable to the 15,905 adults served by Tropical Texas.
[644] For those in category A6, the Uniform Assessment indicated a Recommended Level of Care (LOC- R) of LOC-A1M through LOC-A4; however, the person refused services.

Table F12: Reasons for Deviations from Levels of Care at Tropical Texas Behavioral Health and Bluebonnet Trails Community Services - All Ages (FY 2023)[645,646]

Reason for Deviation	Number (%)	
	Tropical Texas Behavioral Health N=8,217	Bluebonnet Trails Community Services N=2,644
Clinical need (Determined by Clinician)	3,408 (41%)	2,094 (79%)
Continuity of care	394 (5%)	347 (13%)
Customer refused	1,640 (20%)	198 (7%)
Resource limitations	2,520 (31%)	1 (<1%)
Other	255 (3%)	4 (<1%)

Supplemental Emergency Department (ED) and Inpatient Utilization Data

We obtained hospital records from the research-use Texas Health Care Information Collection (THCIC), maintained by the Texas Department of State Health Services, Center for Health Statistics.[647] Supplemental emergency department and inpatient includes data from calendar years (CY) 2020 to 2022 because the most up-to-date datasets available (2023 and 2024) redact patient and treatment information for mental health- and substance use-related encounters.[648] As a result, we were unable to identify the region's residents in the more updated datasets. Therefore, this analysis reflects the most recent complete picture available and should be interpreted as a baseline for understanding current system capacity and trends.

[645] Unduplicated utilization data were obtained from Texas Health and Human Services Commission and represent fiscal years 2019 to 2023.

[646] In Fiscal Year 2023, Bluebonnet Trails Community Services served 11,693 adults residing in rural and non-major metropolitan counties—Bastrop, Burnet, Caldwell, Fayette, Gonzales, Guadalupe, Lee, and Williamson—a total comparable to the 15,905 adults served by Tropical Texas.

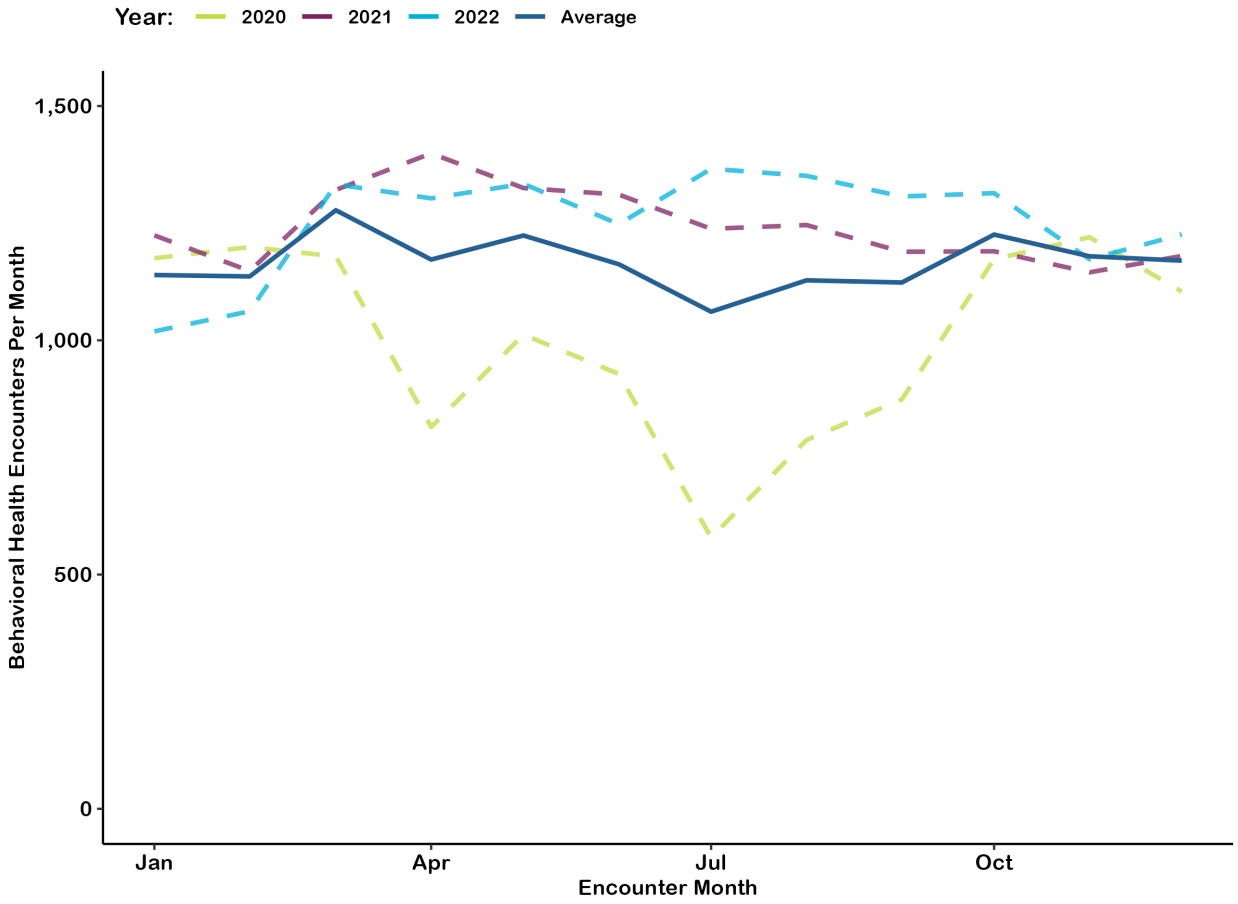
[647] The THCIC comprises discharges from inpatient, emergency department, and outpatient services for hospitals operating throughout Texas and includes patient-level information about Texas residents and non-residents discharged from Texas hospitals. Each record included details on the client's age, length of stay, county of residence, hospital or facility name, diagnoses, and primary payer type, among other patient indicators, service provided, and facility information.

[648] Although the 2023 and 2024 Texas Health Care Information Collection (THCIC) Research Data Files are available, the Meadows Institute has been working with the Texas Department of State Health Services (DSHS) to remove unnecessary redactions that eliminate the ability to assess mental health *and* SUD service capacity for inpatient and emergency encounters. DSHS redacted these data based on its interpretation of the Substance Abuse and Mental Health Services Administration's (SAMHSA) 2024 update to 42 U.S.C. § 290dd-2 and its implementing regulations (42 C.F.R. Part 2), which govern patient records related to substance use disorder (SUD) education, prevention, treatment, or rehabilitation in federally assisted programs. Included in these redactions are records' service dates, patient sex, and patient residency information, including county, ZIP code, and Census Block Group. DSHS has agreed to revise the data to remove redactions, but the Meadows Institute continues to await receipt of the 2023 and 2024 un-redacted data.

Emergency Department Utilization

Figure F3 illustrates the monthly trend in behavioral health-related ED visits across the region's EDs between 2020 and 2022. The impact of the COVID-19 pandemic is evident in the 2020 data, with a notable decline in behavioral health-related ED use during the spring and summer months. By October 2020, ED use increased to rates sustained in 2021 and 2022.

Figure F3: Trend in Primary Behavioral Health-Related Encounters at the Region's EDs by Year – All Ages (2020 – 2022)[649,650]



[649] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[650] Data in this figure is limited to patients listed as vising facilities Rio Grande Valley counties, regardless of their county of residence. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request.

Figure F4: Seasonal Trends in the Rate of Primary Behavioral Health Diagnoses Across All ED Encounters at the Region's Facilities by Year – All Ages; 2020 – 2022)[651,652]

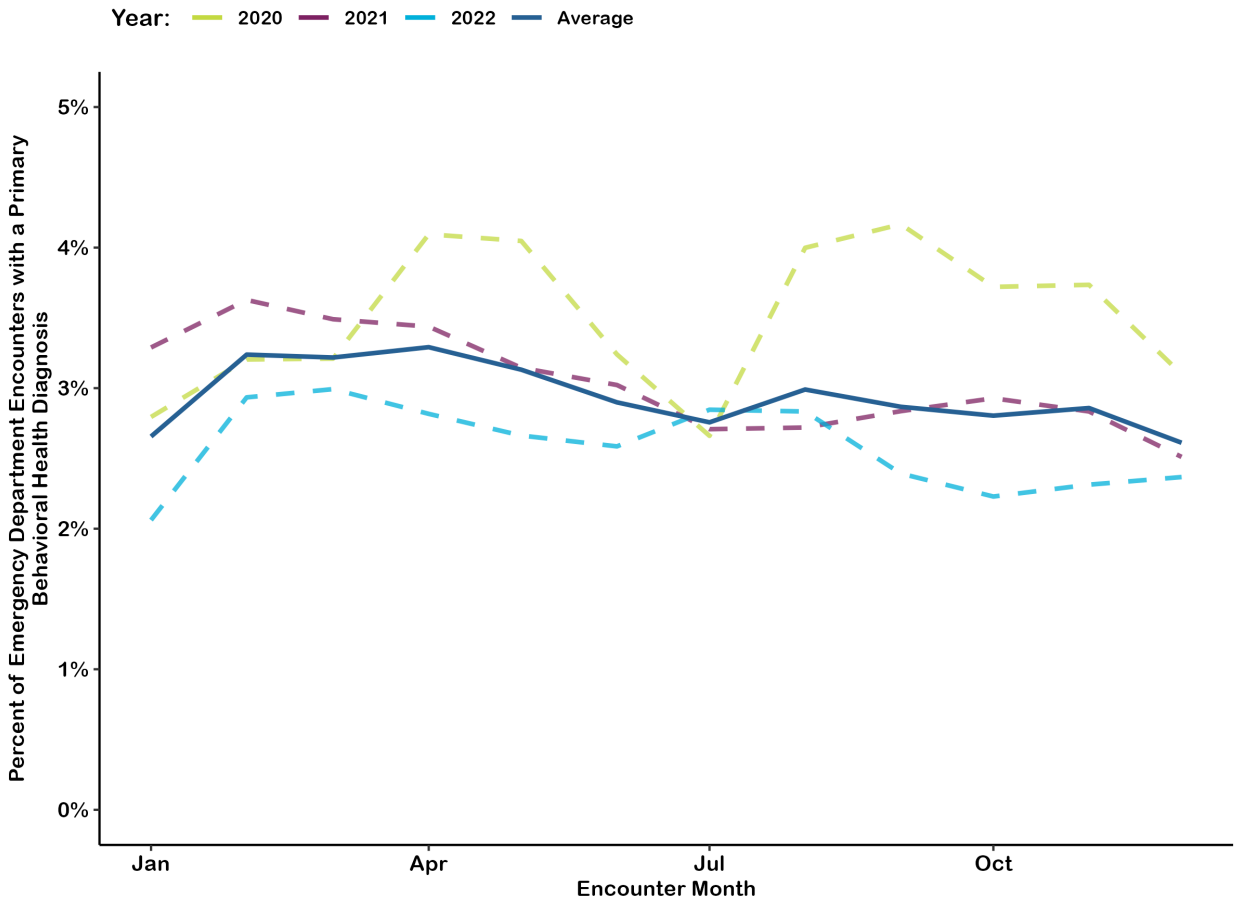


Table F13 highlights trends in behavioral health-related ED utilization by children and youth region residents, and non-region residents who used the region's facilities. Between 2020 and 2022, behavioral health-related ED encounters by the region's children and youth increased by 39%, from 1,326 encounters in 2020 to 1,840 in 2022. No single ED dominated patient visits, with South Texas Health System facilities in McAllen and Edinburg and Doctors Hospital at Renaissance, each accounting for 12% to 15% of all visits during this period.

Despite the overall increase in utilization, the larger facilities saw static or declining numbers of behavioral health-related visits, while smaller EDs experienced most of the growth. Additionally, more children and youth from outside the region sought care at the region's EDs (87 behavioral health-related encounters recorded between 2020 and 2022) than

[651] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.
[652] Data in this figure is limited to patients listed as visiting RGV facilities regardless of their county of residence. Behavioral health encounters were identified by a primary psychiatric or substance use-related diagnosis code.

children/youth region residents seeking care elsewhere (54 encounters during the same time frame).

Table F13: Primary Behavioral Health-Related Emergency Department Encounters by Resident Status and Facility – Children and Youth (<18) (2020–2022)[653,654]

	Facility County	2020	2021	2022	Total
Rio Grande Valley Residents					
Encounters Within Rio Grande Valley					
South Texas Health System – McAllen	Hidalgo	240	262	219	721
South Texas Health System – Edinburg	Hidalgo	207	196	220	623
Doctors Hospital-Renaissance	Hidalgo	191	185	189	565
Valley Baptist Medical Center - Harlingen	Cameron	147	103	114	364
Valley Regional Medical Center	Cameron	77	95	109	281
Valley Baptist Medical Center-Brownsville	Cameron	80	69	65	214
Rio Grande Regional Hospital	Hidalgo	66	50	82	198
South Texas Health System ER Monte Cristo	Hidalgo	10	83	86	179
Other Facilities		308	596	756	1,660
Within Rio Grande Valley Total		**1,326**	**1,639**	**1,840**	**4,805**
Encounters Outside of Rio Grande Valley[655]					
Nueces County Facilities (2020 – 2022 Total)		20			
Harris County Facilities (2020 – 2022 Total)		14			
Other Facilities (2020 – 2022 Total)		20			
Outside of Rio Grande Valley Total		**17**	**22**	**15**	**54**
Statewide Total		**1,343**	**1,661**	**1,855**	**4,859**
Non-Rio Grande Valley Residents[656]					
Valley Baptist Medical Center – Harlingen (2020 – 2022 Total)	Hidalgo	13			
Doctors Hospital-Renaissance (2020 – 2022 Total)	Cameron	12			
South Texas Health System – McAllen (2020 – 2022 Total)	Hidalgo	12			

[653] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[654] Data in this table is limited to children and youth (<18) patients listed as residents of the Rio Grande Valley counties or residents from other counties visiting facilities located in the Rio Grande Valley counties. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request. All values between 1 and 9 are labeled as "<10" to protect confidentiality and may result in totals differing between tables.

[655] Behavioral health-related emergency department encounters in counties outside the Rio Grande Valley were pooled between 2020 and 2022 due to their small number of annual encounters.

[656] Behavioral health-related emergency department encounters by non-residents to Rio Grande Valley facilities were pooled between 2020 and 2022 due to their small number of annual encounters.

	Facility County	2020	2021	2022	Total
South Texas Health System – Edinburg (2020 – 2022 Total)	Cameron	11			
Other Facilities (2020 – 2022 Total)		39			
Non-Resident Encounter Total		**24**	**32**	**31**	**87**

Table F14 outlines adult behavioral health-related ED utilization trends by the region's residents and non-residents. Between 2020 and 2022, behavioral health-related ED visits by the region's adults statewide increased by 23%, from 10,335 encounters in 2020 to 12,745 in 2022. The most frequently utilized facilities for the region's adult residents were South Texas Health System's McAllen facility, Doctors Hospital at Renaissance, and Valley Baptist Medical Center in Harlingen, each accounting for 8% to 13% of total utilization.

Similar to the trends observed in children and youth, the overall increase in adult behavioral health-related ED utilization was concentrated in smaller EDs across the region rather than the larger, most utilized facilities. In addition, the region's adults infrequently sought behavioral health treatment outside the region. Most out-of-region visits were made to facilities in Harris and Bexar counties, with some additional visits to counties like Nueces and Travis. Adults not in the region accounted for just 3% of total adult behavioral health-related ED visits in the region. These non-resident encounters were distributed across various the region's facilities, indicating limited external demand for the region's behavioral health-related services.

Table F14: Primary Behavioral Health-Related Emergency Department Encounters by Resident Status and Facility – Adults (18+) (2020–2022)[657,658]

	Facility County	2020	2021	2022	Total
Rio Grande Valley Residents					
Encounters Within Rio Grande Valley					
South Texas Health System - McAllen	Hidalgo	1,488	1,642	1,572	4,702
Doctors Hospital-Renaissance	Hidalgo	1,041	999	1,085	3,125
Valley Baptist Medical Center - Harlingen	Cameron	1,416	844	823	3,083
Valley Baptist Medical Center - Brownsville	Cameron	972	710	760	2,442
Valley Regional Medical Center	Cameron	805	782	776	2,363
South Texas Health System - Edinburg	Hidalgo	710	700	823	2,233
Rio Grande Regional Hospital	Hidalgo	744	582	574	1,900

[657] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[658] Data in this table is limited to adult (18+) patients listed as residents of the Rio Grande Valley counties or residents from other counties visiting facilities located in the Rio Grande Valley counties. Record counts include behavioral health-related encounters identified by a primary psychiatric or substance use-related diagnosis code within the following Clinical Classifications Software Refined (CCSR) categories: MBD001-MBD011, MBD013, MBD013, MBD017-MBD034. We modified these CCSR categories so that each ICD-10 code is assigned only one CCSR category. A full list of ICD-10 codes are available upon request. All values between 1 and 9 are labeled as "<10" to protect confidentiality and may result in totals differing between tables.

	Facility County	2020	2021	2022	Total
Knapp Medical Center	Hidalgo	642	590	628	1,860
Other Facilities		2,517	5,909	5,704	14,130
Within Rio Grande Valley Total		**10,335**	**12,758**	**12,745**	**35,838**
Encounters Outside of Rio Grande Valley					
Harris County Facilities		40	64	65	169
Bexar County Facilities		53	38	55	146
Nueces County Facilities		31	23	36	90
Travis County Facilities		16	30	30	76
Other Facilities		144	202	189	535
Outside of Rio Grande Valley Total		**284**	**357**	**375**	**1,016**
Statewide Total		**10,619**	**13,115**	**13,120**	**36,854**
Non-Rio Grande Valley Residents					
South Texas Health System – McAllen	Hidalgo	73	90	80	243
Valley Regional Medical Center	Cameron	46	53	45	144
Valley Baptist Medical Center - Brownsville	Cameron	41	31	25	97
Doctors Hospital-Renaissance	Hidalgo	31	29	30	90
Valley Baptist Medical Center - Harlingen	Cameron	35	35	17	87
Other Facilities		134	249	223	606
Non-Resident Encounter Total		**360**	**487**	**420**	**1,267**

Table F15: Primary Behavioral Health Emergency Department Encounters by Resident Status and Facility – All Ages (2020–2022)[659,660]

	Facility County	2020	2021	2022	Total
Rio Grande Valley Residents					
Encounters Within Rio Grande Valley					
South Texas Health System	Hidalgo	1,728	1,904	1,791	5,423
Doctors Hospital-Renaissance	Hidalgo	1,232	1,184	1,274	3,690
Valley Baptist Medical Center	Cameron	1,563	947	937	3,447
South Texas Health System	Hidalgo	917	896	1,043	2,856
Valley Baptist Medical Center - Brownsville	Cameron	1,052	779	825	2,656
Valley Regional Medical Center - Harlingen	Cameron	882	877	885	2,644
Rio Grande Regional Hospital	Hidalgo	810	632	656	2,098
Knapp Medical Center	Hidalgo	700	629	697	2,026
Other Facilities		2,777	6,549	6,477	15,803
Within Rio Grande Valley Total		**11,661**	**14,397**	**14,585**	**40,643**
Encounters Outside of Rio Grande Valley					
Harris County Facilities		44	71	68	183
Bexar County Facilities		55	40	56	151

[659] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[660] Behavioral health encounters were identified by primary psychiatric or substance use-related diagnosis codes.

	Facility County	2020	2021	2022	Total
Nueces County Facilities		38	31	41	110
Travis County Facilities		17	30	31	78
Other Facilities		147	207	194	548
Outside of Rio Grande Valley Total		301	379	390	1,070
Statewide Total		**11,962**	**14,776**	**14,975**	**41,713**
Non-Rio Grande Valley Residents					
South Texas Health System	Hidalgo	75	96	84	255
Valley Regional Medical Center	Cameron	47	58	48	153
Doctors Hospital-Renaissance	Hidalgo	35	36	31	102
Valley Baptist Medical Center - Brownsville	Cameron	42	31	25	98
Valley Baptist Medical Center - Harlingen	Cameron	41	39	20	100
Other Facilities		144	259	243	646
Non-Resident Encounter Total		**384**	**519**	**451**	**1,354**

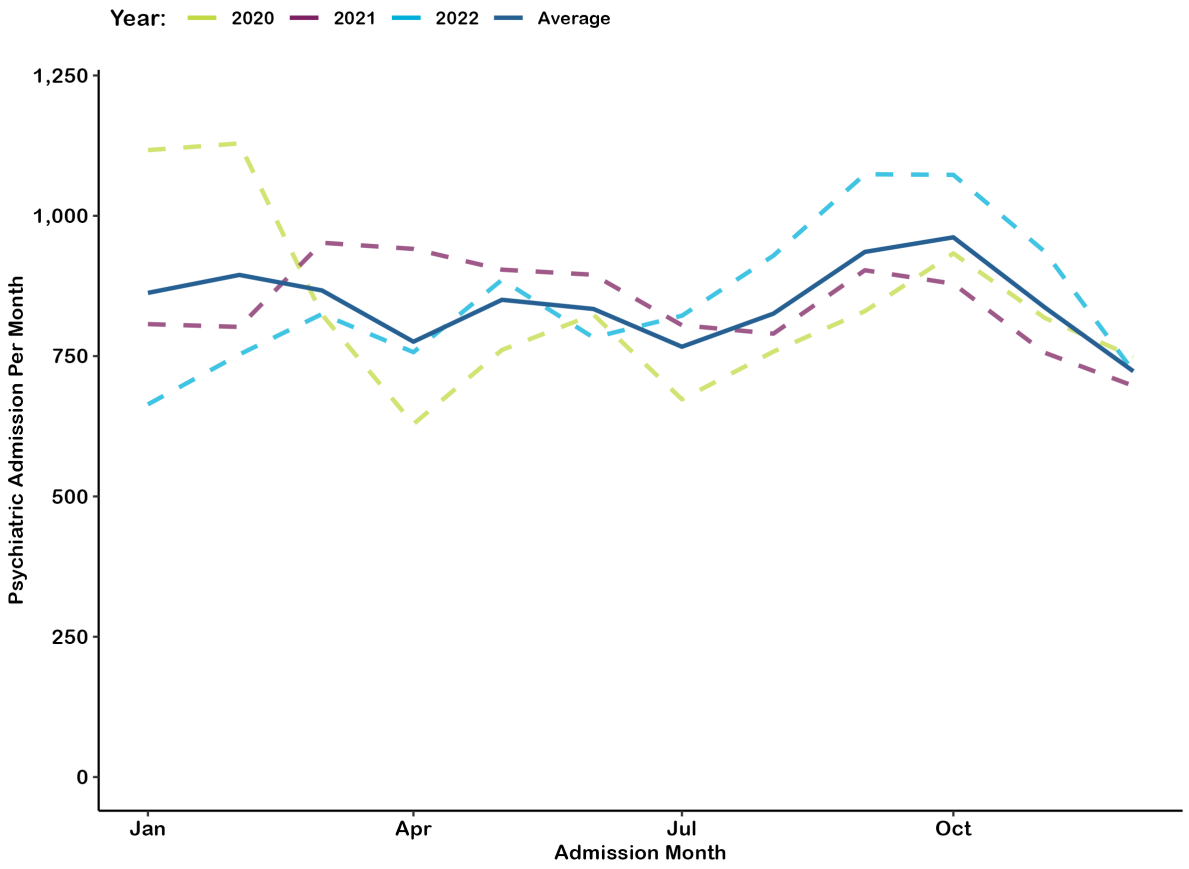
Table F16: Primary Behavioral Health Emergency Department Encounters of Transition Age Youth and Young Adult (17-25) Regional Residents by County of Residence (2020 – 2022)[661]

	Entire Region	County of Residence			
		Cameron	Hidalgo	Starr	Willacy
Encounters within region	8,258	2,141	5,708	333	76
Encounters outside region	<295	90	179	16	<10
Total	**<8,553**	**2,231**	**5,887**	**349**	**<86**

[661] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

Inpatient Psychiatric Utilization

Figure F5: Monthly Trend in Admissions to the Region's Hospitals' Psychiatric Beds at the Region's Facilities by Year – All Ages (2020 – 2022)[662,663]



[662] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[663] Data in this figure is limited to patients who visited facilities in Rio Grande Valley counties, regardless of their county of residence. Record counts include psychiatric specialty encounters identified using the THCIC billing data. Due to billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled as "<10" to protect confidentiality.

Figure F6: Seasonal Trends in Inpatient Admissions to the Region's Psychiatric Beds by Year and Facility – All Ages (2020 – 2022)[664,665]

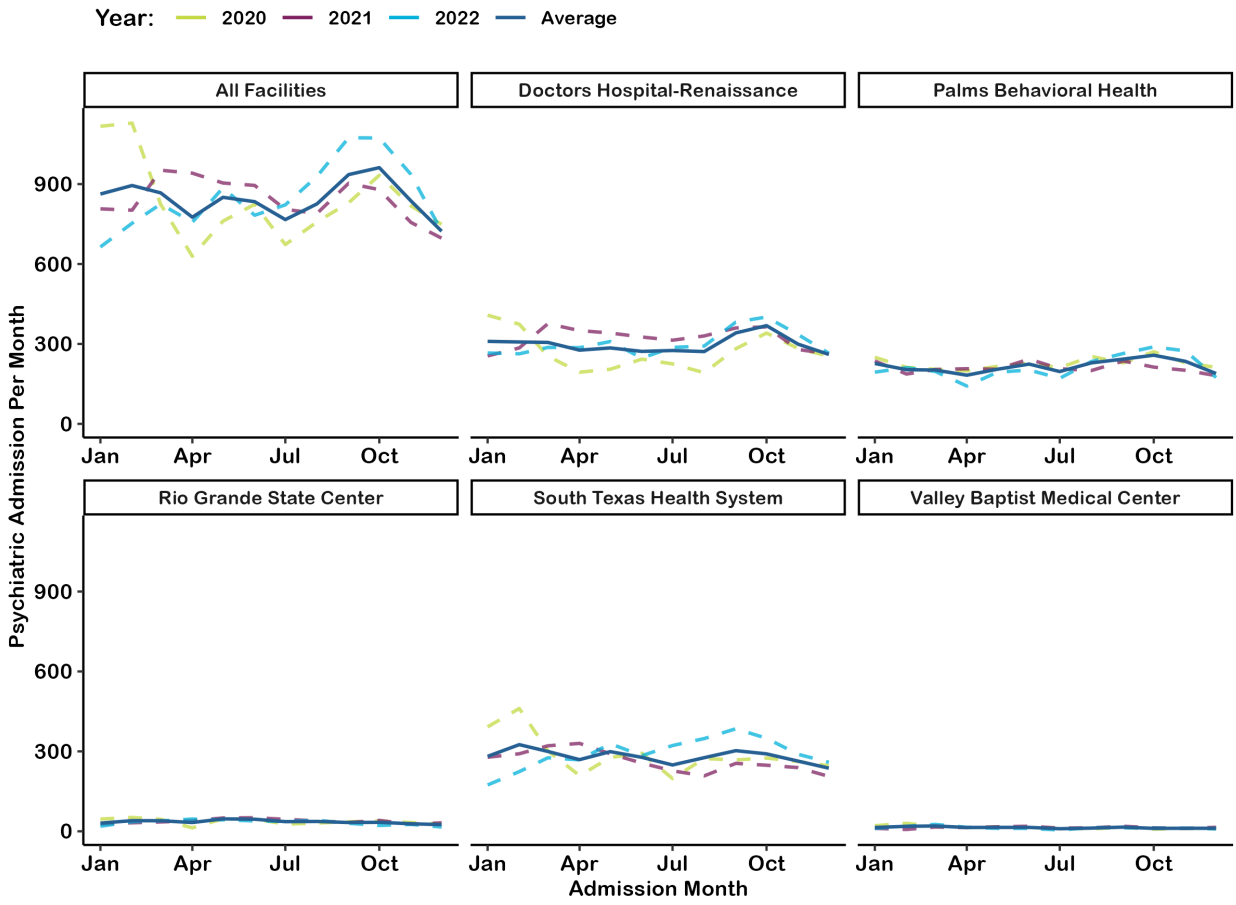


Figure F7 illustrates the average travel time for the region's residents from their home zip code to psychiatric beds within the region and outside the region. Starr County residents needed to travel the longest for admission to the region's psychiatric beds, averaging one hour longer than other residents in the region. However, they also had the shortest travel time to beds outside the region, averaging 4.2 hours. In the region's other counties, travel times to psychiatric beds were relatively brief, averaging approximately 30 to 45 minutes. When admissions occurred outside the region, the average travel time to a psychiatric bed was five hours.

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[664] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[665] Data in this figure is limited to patients listed as RGV residents or non-residents who visited facilities in the RGV counties. Psychiatric specialty encounters were identified using THCIC billing data. Due to billing data quality concerns, admissions to Doctors Hospital at Renaissance's acute unit for a primary psychiatric or substance-use diagnosis are counted as a psychiatric specialty encounter. All state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

Figure F7: Average Travel Time from the Region's Residents' Home Zip Code to Inpatient Care Location by County of Residence and Facility Location – All Ages (2020 – 2022)[666,667,668]

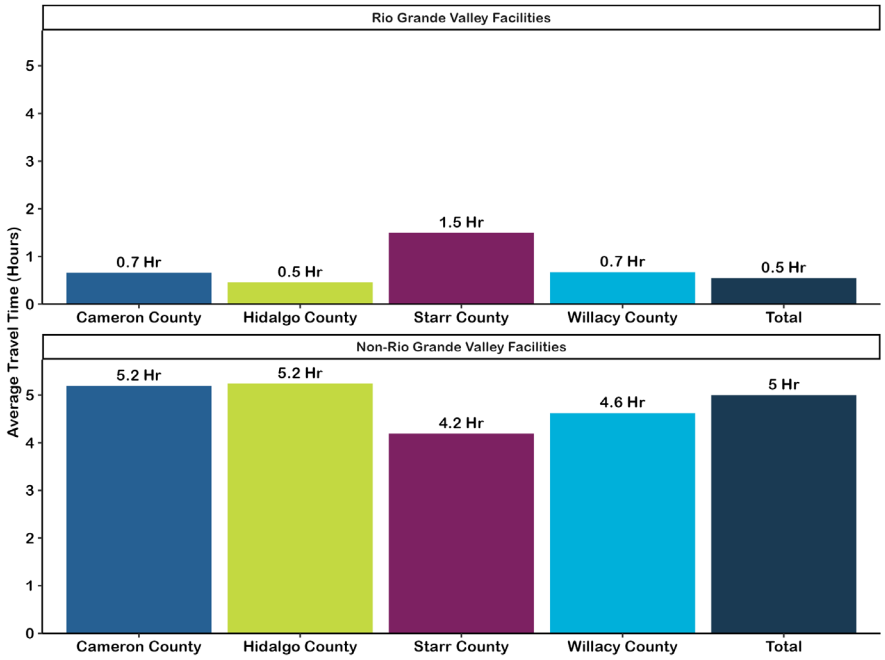

Table F17 highlights trends in psychiatric bed utilization for children and youth in the region. Among the region's residents, pediatric psychiatric bed admissions statewide rose by 18%, from fewer than 2,822 admissions in 2020 to 3,341 in 2022. This rise was primarily driven by Doctors Hospital-Renaissance, which accounted for 44% of statewide admissions.

The Rio Grande State Center, the region's state hospital, lacks pediatric beds and, therefore, rarely admits children and youth. The region's children and youth resident admissions to state hospitals outside the region were also rare, with less than 20 cases between 2020 and 2022. Non-state hospital admissions outside the region were uncommon and primarily occurred in Bexar County facilities (46 admissions between 2020 and 2022).

A notable share of admissions to the region's facilities involved non-region residents, representing 12% (1,282 of 10,480) of child and youth psychiatric bed admissions. Palms Behavioral Health had the highest number of non-resident admissions (465 of 1,282; 36%),

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[666] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[667] Data in this figure is limited to patients listed as residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to observed billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnoses are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters.

[668] Travel time between patient's home zip codes and facility location extracted via Rodrigo Azuero Melo & David Zarruk (2022). *gmapsdistance: Distance and Travel Time Between Two Points from Google Maps*. R package version 4.0.0. https://CRAN.R-project.org/package=gmapsdistance.

though admissions were relatively evenly distributed across the facilities in the region that offer pediatric psychiatric beds (e.g., Doctors Hospital – Renaissance, South Texas Health System, and Palms Behavioral Health).

Table F17: Inpatient Psychiatric Unit Admissions by Resident Status and Facility – Children and Youth (<18) (2020–2022)[669,670]

	Average Length of Stay (Days)	2020	2021	2022	Total
Rio Grande Valley Residents					
Admission Within Rio Grande Valley					
Doctors Hospital-Renaissance	4.6	1,100	1,454	1,536	4,090
South Texas Health System	5.3	1,116	1,061	1,135	3,312
Palms Behavioral Health	6.3	560	595	631	1,786
Rio Grande State Center	17.9	<10	0	0	<10
Within Rio Grande Valley Total	**6.5**	**<2,786**	**3,110**	**3,302**	**<9,198**
Admissions Outside of Rio Grande Valley[671]					
Non-State Hospitals Admission	11.7	26	40	39	105
Bexar County Facilities (Total)	7.8	46			
Nueces County Facilities (Total)	5.4	16			
Harris County Facilities (Total)	14.4	13			
Other Facilities (Total)	19.8	30			
State Hospital Admissions	216.5	<10	<10	0	<20
Austin State Hospital (Total)	111.5	<10			
Terrell State Hospital (Total)	426.4	<10			
Outside of Rio Grande Valley	**17.4**	**<36**	**<50**	**39**	**<125**
Statewide Total	**6.8**	**<2,822**	**<3,160**	**3,341**	**<9,323**
Non-Rio Grande Valley Residents					
Palms Behavioral Health	7.0	134	202	129	465
Doctors Hospital-Renaissance	5.3	137	211	105	453
South Texas Health System	5.7	117	139	108	364
Non-Resident Admissions Total	**6.0**	**388**	**552**	**342**	**1,282**

[669] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[670] Data in this table is limited to children and youth (<18) patients listed as residents of the Rio Grande Valley counties or residents from other counties visiting facilities in the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to problematic billing data at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as psychiatric specialty encounters. Further, all state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

[671] Psychiatric admissions to individual counties or state hospitals outside the Rio Grande Valley were pooled between 2020 and 2022 due to their small number of annual admissions.

Table F18 shows trends in psychiatric bed utilization among adults in the region. Between 2020 and 2022, psychiatric bed admissions among the region's adults remained relatively stable over time. South Texas Health System and Doctors Hospital-Renaissance were the primary facilities serving this population and jointly treated two-thirds of adult patients admitted to psychiatric beds statewide. Between 2020 and 2022, less than one in five (19% of adult psychiatric bed admissions, or 3,748 patients) psychiatric admissions to the region's facilities were non-region residents. Over half of these non-resident admissions (56%) occurred at Palms Behavioral Health.

The region's facilities, including state hospitals, met most of the region's adult psychiatric bed needs. The Rio Grande State Center, the region's state hospital, 97% of the region's residents' state hospital admissions were to the Rio Grande State Center. Expectedly, the length of stay (LoS) at state hospitals is substantially longer than the average LoS at non-state facilities. Among the region's resident adults, the average LoS was only slightly higher among adults treated within the region (7.3 days) than those treated outside the region (7.8 days). Non-resident stays at the region's Rio Grande State Center had the longest average LoS, with patients staying two to three times longer than the region's residents treated at the Rio Grande State Center.

Table F18: Inpatient Psychiatric Unit Admissions by Resident Status and Facility – Adults (18+) (2020–2022)[672,673]

	Average Length of Stay (Days)	2020	2021	2022	Total
Rio Grande Valley Residents					
Admissions Within Rio Grande Valley					
South Texas Health System	5.3	1,936	1,750	1,860	5,546
Doctors Hospital-Renaissance	4.8	1,755	1,953	1,834	5,542
Palms Behavioral Health	5.7	1,194	1,118	1,110	3,422
Rio Grande State Center	30.8	420	414	365	1,199
Valley Baptist Medical Center	9.9	169	160	153	482
Within Rio Grande Valley Total	**7.3**	**5,474**	**5,395**	**5,322**	**16,191**
Admissions Outside of Rio Grande Valley[674]					
Non-State Hospitals Admission	9.1	138	121	146	405

[672] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[673] Data in this table is limited to adult (18+) patients listed as residents of the Rio Grande Valley counties or residents from other counties visiting facilities in the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified by a THCIC according to billing data. Due to billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are reported as "<10" to protect confidentiality.

[674] Psychiatric admissions to individual counties or state hospitals outside the Rio Grande Valley were pooled between 2020 and 2022 due to their small number of annual admissions.

	Average Length of Stay (Days)	2020	2021	2022	Total
Bexar County Facilities (Total)	10.5	175			
Harris County Facilities (Total)	8.5	92			
Nueces County Facilities (Total)	5.2	37			
Other Facilities (Total)	8.6	101			
State Hospital Admissions	182.7	17	13	<10	<40
San Antonio State Hospital (Total)	196.7	19			
North Texas State Hospital - Vernon (Total)	155.9	<10			
Austin State Hospital (Total)	266.2	<10			
Other State Hospitals (Total)	91.2	<10			
Outside of Rio Grande Valley	**22.5**	**155**	**134**	**<156**	**<445**
Statewide Total	**7.7**	**5,629**	**5,529**	**<5,478**	**<16,636**
Non-Rio Grande Valley Residents					
Palms Behavioral Health	6.5	827	605	676	2,108
South Texas Health System	6.2	287	200	404	891
Doctors Hospital-Renaissance	5.1	263	225	145	633
Rio Grande State Center	66.6	20	37	29	86
Valley Baptist Medical Center	13.4	<10	<10	<10	<30
Non-Resident Admissions Total	**7.6**	**<1,407**	**<1,077**	**<1,264**	**<3,748**

Table F19: Inpatient Psychiatric Unit Admissions by Resident Status and Facility – All Ages (2020–2022)[675,676]

	Average Length of Stay (Days)	2020	2021	2022	Total
Rio Grande Valley Residents					
Admission Within Rio Grande Valley					
Doctors Hospital-Renaissance	4.7	2,855	3,407	3,370	9,632
South Texas Health System	5.3	3,052	2,811	2,995	8,858
Palms Behavioral Health	5.9	1,754	1,713	1,741	5,208
Rio Grande State Center	30.8	421	414	365	1,200
Valley Baptist Medical Center	9.9	169	160	153	482
Within Rio Grande Valley Total	**6.5**	**8,251**	**8,505**	**8,624**	**25,380**
Admissions Outside of Rio Grande Valley					
Non-State Hospitals Admission	9.6	164	161	185	510
State Hospital Admissions	185.4	19	14	<10	<43

[675] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[676] Data in this table is limited to patients listed as RGV residents or non-residents who visited facilities in the RGV counties. Psychiatric specialty encounters were identified using THCIC billing data. Due to billing data quality concerns, admissions to Doctors Hospital at Renaissance's acute unit for a primary psychiatric or substance-use diagnosis are counted as a psychiatric specialty encounter. All state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

	Average Length of Stay (Days)	2020	2021	2022	Total
Outside of Rio Grande Valley	**21.5**	**183**	**175**	**189**	**<553**
Statewide Total	**6.8**	**8,434**	**8,680**	**8,813**	**<25,933**
Non-Rio Grande Valley Residents					
Palms Behavioral Health	6.6	961	807	805	2,573
South Texas Health System	6.0	404	339	512	1,255
Doctors Hospital-Renaissance	5.2	400	436	250	1,086
Rio Grande State Center	66.6	20	37	29	86
Valley Baptist Medical Center	13.4	<10	<10	<10	<30
Non-Resident Admissions Total	**7.2**	**1,794**	**1,626**	**1,601**	**<5,030**

Table F20: Admissions to Psychiatric Beds by County of Residence and Age Among Transition Age Youth and Young Adult (17-25) Regional Residents – Statewide (2020 – 2022)[677,678]

	Entire Region	County of Residence			
		Cameron	Hidalgo	Starr	Willacy
Admissions within region	5,688	1,455	3,977	215	41
Admissions outside region	<133	31	65	27	<10
Total	**<5,821**	**1,486**	**4,042**	**242**	**<51**

Table F21: Regional Resident Admissions to State Hospitals by Hospital – All Ages (2020 – 2022)[679,680]

Hospital	Hospital County	2020	2021	2022	Total
Rio Grande State Center	Cameron	421	414	365	1,200
San Antonio State Hospital	Bexar	12	<10	<10	<32
North Texas State Hospital-Vernon	Wilbarger	<10	<10	0	<20
Austin State Hospital	Travis	<10	<10	0	<20

[677] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[678] Data in this table is limited to patients listed as residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified using THCIC billing codes. Due to data quality concerns at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as psychiatric specialty encounters. Further, all state hospital admissions are considered psychiatric specialty encounters. All values between 1 and 9 are labeled as "<10" to protect confidentiality.

[679] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[680] Data in this figure is limited to patients listed as residents of the Rio Grande Valley counties. Psychiatric specialty encounters were identified using THCIC billing codes. Due to billing data quality concerns, admissions to Doctors Hospital at Renaissance's acute unit for a primary psychiatric or substance-use diagnosis are counted as a psychiatric specialty encounter. All state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

Hospital	Hospital County	2020	2021	2022	Total
Rusk State Hospital	Cherokee	0	<10	0	<10
North Texas State Hospital	Wichita	<10	0	0	<10
Terrell State Hospital	Kaufman	<10	0	0	<10
Total		**<473**	**<454**	**<375**	**<1,302**

Table F22: Capacity and Average Daily Census of Psychiatric Units in the Region's Hospitals – All Ages (2020–2022)[681,682,683]

	2020	2021	2022
Doctors Hospital-Renaissance			
Capacity	87	87	87
Average Daily Census (ADC)	40.0	49.6	45.7
ADC as % of Capacity	46%	57%	53%
South Texas Health System			
Capacity	124	124	124
Average Daily Census (ADC)	48.3	44.5	52.2
ADC as % of Capacity	39%	36%	42%
Palms Behavioral Health			
Capacity	94	94	94
Average Daily Census (ADC)	46.2	38.0	41.9
ADC as % of Capacity	49%	40%	45%
Rio Grande State Hospital			
Capacity	55	55	55
Average Daily Census (ADC)	33.2	45.9	39.5
ADC as % of Capacity	60%	83%	72%
Valley Baptist Medical Center			
Capacity	12	12	12
Average Daily Census (ADC)	5.1	4.2	4.3
ADC as % of Capacity	43%	35%	36%

Figure F8 highlights the distribution of counties where the region's residents were admitted to psychiatric beds between 2020 and 2022. While 98% of admissions (or 25,380 of <25,933) occurred within Hidalgo and Cameron counties, the region's residents were admitted to 27 counties outside the region for psychiatric care. Bexar, Harris, and Nueces counties were the

[681] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[682] Data in this figure is limited to patients listed as visiting facilities in Rio Grande Valley counties, regardless of their county of residence. Psychiatric specialty encounters were identified using THCIC billing data. Due to billing data quality concerns, admissions to Doctors Hospital at Renaissance's acute unit for a primary psychiatric or substance-use diagnosis are counted as a psychiatric specialty encounter. All state hospital admissions are considered psychiatric specialty encounters.

[683] Daily census was calculated the number of patients in a facility's psychiatric unit at the end of a day.

primary destinations for these non-region admissions, collectively accounting for 73% of all out-of-region psychiatric bed admissions. A few admissions occurred in regions distant from the region, including the Dallas-Fort Worth metroplex, Texas Panhandle, and El Paso areas.[684]

Figure F8: Location of the Region's Residents Admissions to Psychiatric Beds by Hospital County – All Ages (2020–2022)[685,686]

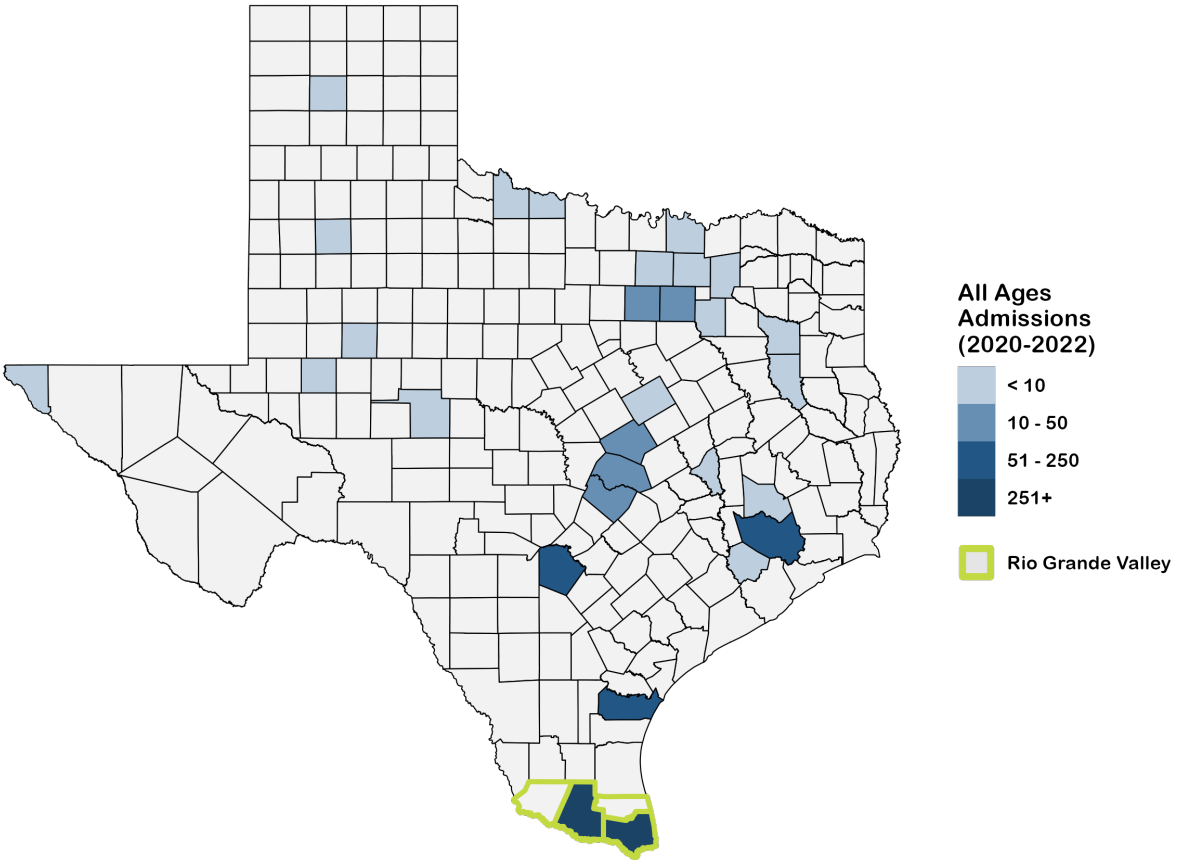

Table F23 presents the top five primary diagnoses for which the region's residents were admitted to between 2020 and 2022. Depressive disorders were the most common diagnosis, accounting for 53% of all resident admissions in the region, followed by bipolar and related disorders (19%) and schizophrenia spectrum and other psychotic disorders (17%).

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[684] In out-of-region admissions outside of Bexar, Harris, and Nueces counties, 23% (34 of 149) of admissions had a patient ZIP code that did not correspond to RGV ZIP codes. Although all admission records stated these patients' county of residency was within the RGV, some discretion is advised when considering these 34 records.

[685] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[686] Data in this figure is limited to patients who are residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified using the THCIC billing data. Due to billing data issues at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis are counted as a psychiatric specialty encounter. Further, all state hospital admissions are considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

While depressive disorders were the leading diagnosis for all resident admissions, bipolar and related disorders were the second most common reason for local admissions (~20% of total admissions were for bipolar disorder). In contrast, schizophrenia spectrum and other psychotic disorders were more common for non-local admissions, representing three in ten non-local admissions.

Table F23: Top 5 Primary Diagnoses for the Region's Resident Admissions to Local and Non-Local Psychiatric Beds – All Ages (2020 – 2022)[687,688]

Rank	All Admissions to Inpatient Psychiatric Beds	Admissions to the Region's Beds	Admissions to Beds Outside the Region
	N < 25,936	N = 25,380	N < 556
1	Depressive disorders (13,626)	Depressive disorders (13,453)	Depressive disorders (173)
2	Bipolar and related disorders (4,913)	Bipolar and related disorders (4,790)	Schizophrenia spectrum and other psychotic disorders (165)
3	Schizophrenia spectrum and other psychotic disorders (4,548)	Schizophrenia spectrum and other psychotic disorders (4,383)	Bipolar and related disorders (123)
4	Disruptive, impulse-control and conduct disorders (927)	Disruptive, impulse-control and conduct disorders (924)	Other specified and unspecified mood disorders (27)
5	Trauma- and stressor-related disorders (452)	Trauma- and stressor-related disorders (443)	Alcohol-related disorders (12)

Transfers to Psychiatric Beds

Figure F9 illustrates the top facilities receiving transfers of the region's residents to psychiatric beds from EDs or inpatient facilities between 2020 and 2022. Transfers accounted for nearly 20% of total psychiatric bed admissions, with over 99% directed to facilities within the region. Palms Behavioral Health received the largest share of transfers, at 31%, followed by Doctors Hospital-Renaissance with 28%, and South Texas Health System's McAllen facility at 27%.

[687] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[688] Data in this figure is limited to patient residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified using the THCIC billing data. Due to observed billing data quality concerns at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis and all state hospital admissions were considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

Figure F9: Top Facilities Destination Facilities in Transfers to Psychiatric Beds Among the Region's Residents – All Ages (2020–2022)[689,690]

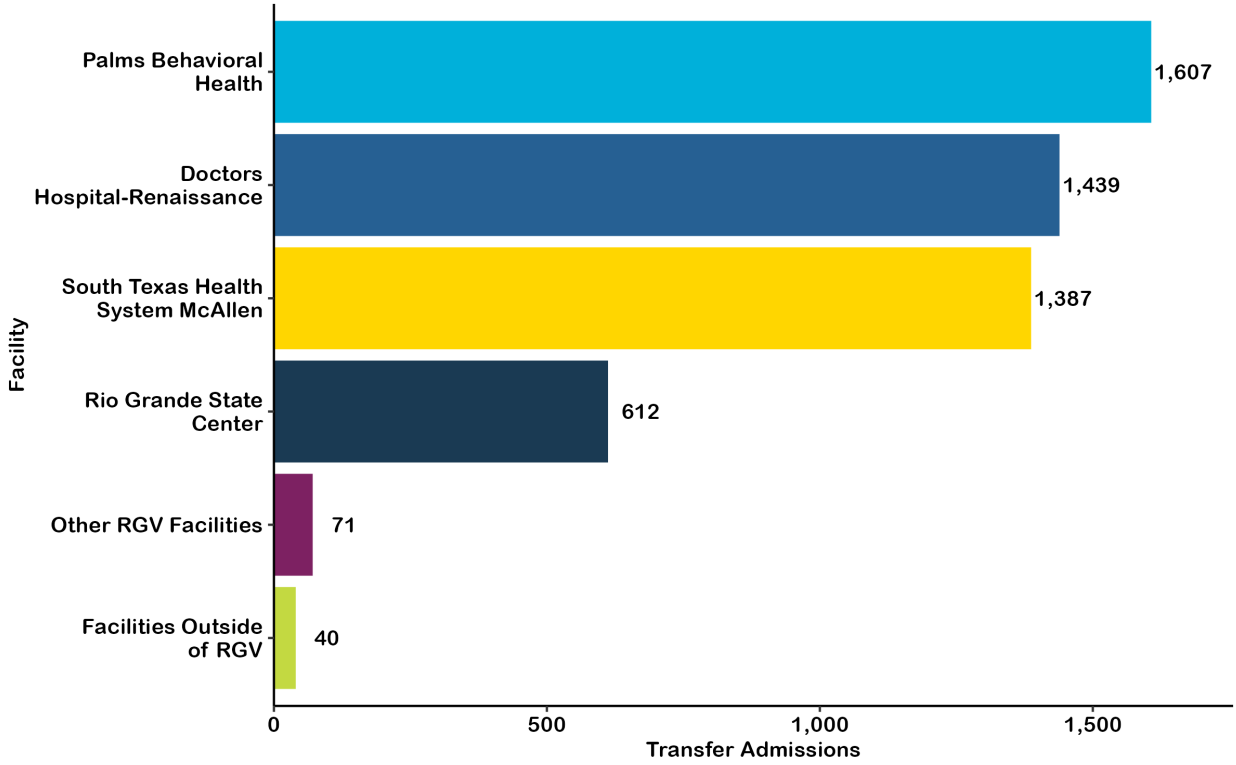

Table F24 details the most frequent transfer routes for the region's 3,873 residents who were transferred to psychiatric beds between 2020 and 2022. EDs were the primary source of transfers, accounting for 4,471 admissions from 28 of the region's EDs - an average of 53 transfers per ED per year).[691]

Transfers from inpatient facilities[692] to psychiatric beds at separate facilities were less frequent, comprising fewer than 776 admissions from 17 of the region's inpatient facilities (an average of 15 transfers from inpatient units annually). More than half of these inpatient transfer referrals were made to South Texas Health System McAllen and Doctors Hospital Renaissance (55% of

[689] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[690] Data in this figure is limited to patient residents of the Rio Grande Valley counties. Transfers were determined by matching a patient's unique identifier on their discharge date from an emergency department with an admission to a psychiatric unit on the same or the next day. Psychiatric units were identified from THCIC billing codes. Due to data quality concerns at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis and all state hospital admissions were considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

[691] No single pair of hospitals exceeded 5% of total ED-to-inpatient transfers, but transfers from Valley Regional Medical Center and Valley Baptist Medical Center – Brownsville to Palms Behavioral Health were the most commonly observed transfers.

[692] For this analysis, the transferred patient may have been assigned to a non-psychiatric bed but was transferred to a psychiatric inpatient bed in a different facility.

inpatient transfers). Less than ten total patient transfers outside the region's counties were made annually.

Table F24: Transfers of the Region's Residents from the facilities to Psychiatric Beds by Year – All Ages (2020 – 2022)[693,694]

Origin Facility (County)	Destination Facility (County)	2020	2021	2022	Total
Emergency Department Origin					
Valley Regional Medical Center (Cameron)	Palms Behavioral Health (Cameron)	90	51	76	217
Valley Baptist Medical Center-Brownsville (Cameron)	Palms Behavioral Health (Cameron)	71	41	73	185
Mission Regional Medical Center (Hidalgo)	Doctors Hospital-Renaissance (Hidalgo)	58	54	53	165
Valley Baptist Medical Center – Harlingen (Cameron)	Palms Behavioral Health (Cameron)	56	44	63	163
Valley Baptist Medical Center – Brownsville (Cameron)	South Texas Health System McAllen (Hidalgo)	29	30	95	154
Other transfers to facilities in region		931	1,211	1,405	3,547
Other transfers to facilities outside of the region		<10	<10	20	<40
Total		**1,245**	**1,441**	**1,785**	**4,471**
Inpatient Origin					
South Texas Health System Edinburg (Hidalgo)	South Texas Health System McAllen (Hidalgo)	53	51	28	132
South Texas Health System McAllen (Hidalgo)	Doctors Hospital-Renaissance (Hidalgo)	12	11	17	40
Rio Grande Regional Hospital (Hidalgo)	Doctors Hospital-Renaissance (Hidalgo)	13	11	15	39
South Texas Health System Edinburg (Hidalgo)	Doctors Hospital-Renaissance (Hidalgo)	10	13	12	35
Valley Baptist Medical Center – Harlingen (Cameron)	Palms Behavioral Health (Cameron)	11	<10	12	<33
Other transfers to facilities in the region		125	127	155	407
Other transfers to facilities outside of the region		<10	<10	<10	<30

[693] Texas Department of State Health Services, Center for Health Statistics. (2020-2022). T*exas Hospital Inpatient and Emergency Department Discharge Research Data Files*. Austin, Texas: 2020-2022.

[694] Data in this figure is limited to patient residents of the Rio Grande Valley counties. Record counts include psychiatric specialty encounters identified using the THCIC billing data. Due to observed billing data quality concerns at Doctors Hospital at Renaissance, admissions to the hospital's acute unit for a primary psychiatric or substance-use-related diagnosis and all state hospital admissions were considered psychiatric specialty encounters. Values between 1 and 9 are labeled "<10" to protect confidentiality.

Appendix G: Changes in Behavioral Health Care Utilization During the COVID-19 Pandemic

The onset of the COVID-19 pandemic in the first quarter of 2020 quickly altered the health care utilization landscape. Emergency departments (ED) in many locations were overwhelmed and understaffed, leading to many EDs diverting patients to different facilities for care.[695] Research conducted early in the pandemic suggests that overall ED visits declined by as much as sixty percent (60%) in April 2020 and never reached projected volume calculations based on historical data.[696] Rates of hospitalization declined substantially during the first months of the pandemic, suggesting delayed routine, elective, and emergency care in the United States.[697]

This summary describes the impact of the COVID-19 pandemic on ED visits and inpatient hospitalizations for mental health and substance use disorders (SUD) in Texas. ***In summary, we identified a statistically significant decline in ED visits immediately following the COVID-19 emergency declaration in March 2020. Inpatient admissions for behavioral health care did not immediately decline; however, a significant reduction in inpatient care utilization was identified during the third quarter (summer/fall) of 2020 and persisted for the remainder of the calendar year. For ED and inpatient hospitalizations, the number of visits slowly increased over time but did not approach projected volume rates.*** The reduced rate of behavioral health care utilization should be considered when projections or capacity assessments are conducted using data from 2020.

Approach

We investigated the impact of COVID-19 on Texas ED visits and inpatient admissions for behavioral health reasons using a subset of facilities from the Texas Health Care Information Collection (THCIC).[698,699]

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[695] Jeffery, M. M., D'Onofrio, G., Paek, H., Platts-Mills, T. F., Soares, W. E., 3rd, Hoppe, J. A., Genes, N., Nath, B., & Melnick, E. R. (2020). Trends in emergency department visits and hospital admissions in health care systems in 5 states in the first months of the COVID-19 pandemic in the US. *JAMA Internal Medicine*, *180*(10), 1328–1333. 10.1001/jamainternmed.2020.3288

[696] Heist, T., Schwartz, K., & Butler, S. (2021, February 18). Trends in overall and non-COVID-19 hospital admissions. Kaiser Family Foundation. https://www.kff.org/health-costs/issue-brief/trends-in-overall-and-non-covid-19-hospital-admissions/

[697] Birkmeyer, J. D., Barnato, A., Birkmeyer, N., Bessler, R., & Skinner, J. (2020). The impact of the COVID-19 pandemic on hospital admissions In the United States. *Health affairs (Project Hope)*, *39*(11), 2010–2017. 10.1377/hlthaff.2020.00980

[698] Texas Hospital Inpatient and Emergency Department Discharge Research Data File, [2016-2020]. Texas Department of State Health Services, Center for Health Statistics, Austin, Texas.

[699] For ED, 128 hospitals were analyzed, representing 75% of total behavioral health visits from 2019-2020. For inpatient admissions, 79 hospitals were analyzed, representing 78% of total behavioral health admissions from 2019-2020. Facilities with small averages of weekly admissions were not included in the analyses due to large fluctuations in percentage change estimates.

Changes in Behavioral Health Care Utilization Overall

Trends in the weekly average number of encounters for behavioral health reasons are shown in Figure G1. Statistically significant declines in all behavioral health care utilization were identified after the onset of the COVID-19 pandemic (March 15, 2020). As shown in Table G1, the average number of weekly ED visits for behavioral health reasons declined from 36.3 encounters pre-pandemic to 31.1 encounters after the onset of the pandemic—a statistically significant decline. For inpatient encounters, the average number of weekly visits declined from 43.7 pre-pandemic to 38.6 after the onset of the pandemic.

Figure G1. Trends in the Weekly Average Number of Behavioral Health Emergency Department Visits and Inpatient Admissions, by Year (2016–2020)

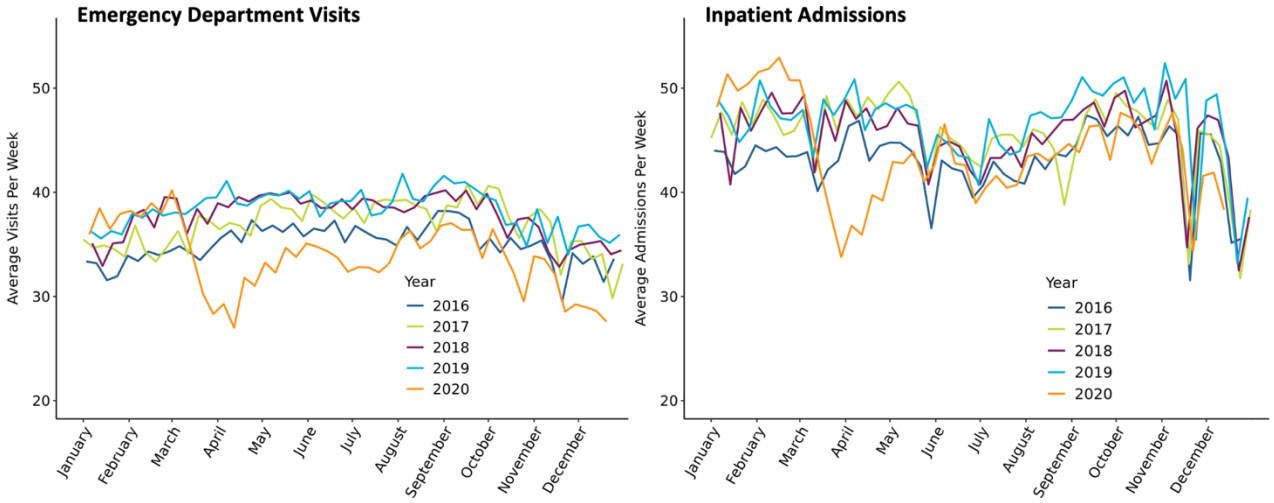

Table G1. Weekly Encounters for Behavioral Health Reasons (2016–2020) by Time Period[700]

	Emergency Department Visits		Inpatient Admissions	
	Pre-COVID-19	COVID-19	Pre-COVID-19	COVID-19
Average Number of Encounters Per Week (Standard Error)	37.0* (0.26)	32.8* (0.52)	45.4* (0.25)	42.2* (0.60)

*Denotes a significant difference ($p<0.001$) between the average number of pre-COVID-19 and COVID-19 values using a Student's t-test.

Table G2 includes the results of the regression discontinuity analyses by four different bandwidths.[701] Overall, the models identified a rapid, statistically significant decline in behavioral health ED visits after the onset of the COVID-19 emergency declaration. This significant reduction persisted through the end of 2020.

[700] Pre-COVID-19 period refers to January 3, 2016, through March 14, 2020. COVID-19. The COVID-19 period refers to March 15, 2020, through December 31, 2020.

[701] Four different bandwidths were used to explore changes before and after the COVID-19 pandemic declaration date.

For inpatient encounters, the results show no significant difference in the rate of inpatient behavioral health admissions in March/April 2020 compared to February/March 2020 (Table G2). However, the rate of inpatient care utilization between 16- and 40- weeks after the onset of the pandemic resulted in a significant reduction of inpatient care utilization when compared to utilization rates during the same pre-COVID-19 period.

Table G2. Results of Regression Discontinuity Analysis Examining Changes in ED visits and Inpatient Admissions Over Time

Weeks Before/After COVID-19 Pandemic Declaration Date	Coefficient	Standard Error	*p*-Value
	Emergency Department Visits		
6.21 weeks	-0.464	0.179	0.009
16 weeks	-0.478	0.051	<0.001
28 weeks	-0.418	0.032	<0.001
41 weeks[702]	-0.354	0.024	<0.001
	Inpatient Admissions		
4.33 weeks	-0.330	0.295	0.264
16 weeks	-0.443	0.068	<0.001
28 weeks	-0.475	0.043	<0.001
40 weeks	-0.365	0.034	<0.001

Summary

The COVID-19 pandemic had a substantial effect on overall behavioral healthcare utilization. This impact on ED visits was immediate, and the rates of both ED visits and inpatient admissions were significantly lower throughout 2020 than expected, given prior years' utilization patterns.

[702] We truncated the inpatient dataset to include only 40 weeks and the emergency department dataset to include 41 weeks, which removed the final weeks in 2020 that had an artificially lower encounter rates due to patients not being discharged until after the end of calendar year 2020.

Appendix H: Nonmedical Drivers of Health

Meaningfully impacting access to services requires a thorough understanding of a community's population characteristics. These contextual issues are often referred to as non-medical drivers of health (NMDOH), which Texas Health and Human Service (HHSC) defines as "the conditions in the places where people live, learn, work and play that affect a wide range of health risks and outcomes".[703,704] Analysis of several years of public spending on health, education, and other social services shows that investments in these areas have a statistically significant impact on the health outcomes and health factors of communities.[705]

While these contextual factors – these non-medical drivers of health – exist in all communities, we identified several of note for this report's four-county region:

- Income, specifically poverty.
- Housing, including colonias.
- International border community.
- Broadband access.
- Transportation.

Income

While the effects living in poverty are well-known, it bears repeating that people living in poverty have an increased risk of mental illness, chronic disease, and lower life expectancy in addition to facing barriers to accessing health care.[706] In 2022, approximately 650,000 children, youth, and adults in the region lived in poverty—reflecting a regional poverty rate of 51%, significantly higher than the state average of 30%. This included 410,000 people in Hidalgo County, 195,000 in Cameron County, 31,500 in Starr County, and 8,600 in Willacy County.[707]

Additionally, about 5% of adults living in the region (roughly 46,000 adults) have a serious mental illness (SMI). Among these adults with SMI, nearly two-thirds (67%) also live in poverty – twenty percentage points higher than the statewide average (48%).

Adults who are racial/ethnic minorities in working-class low-income families are more likely to be uninsured. In 2022, about 52% of the region's adults living in poverty (below 200% of the federal poverty level) had health insurance, compared to 63% of adults across all income levels. Additionally, insurance coverage was also lower among African American and Hispanic/Latino

[703] Texas Health and Human Services, (n.d.), *Non-Medical Drivers of Health*
[704] Texas Health and Human Services, (2023), *MCS NMDOH Action Plan*
[705] McCullough, J. M., & Leider, J. P., (2019), The Importance of Health and Social Services Spending to Health Outcomes in Texas, 2010–2016, *Southern Medical Journal*, *112*(2), 91–97
[706] Office of Disease Prevention and Health Promotion. (n.d.). *Poverty—Healthy People 2030.* Retrieved February 10, 2025, from https://odphp.health.gov/healthypeople/priority-areas/social-determinants-health/literature-summaries/poverty
[707] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data was obtained from the U.S. Census Bureau. (2023, December). *American Community Survey 2018-2022 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

adults (60%) than among Non-Hispanic White adults (87%). Across the United States, estimates are that 80.9% of the uninsured people under 65 years old have incomes below 400% of federal poverty level.[708] In 2025, four times the federal poverty level is $62,600 for a family of one and ranges to $128,600 for a family of four.[709] These incidence rates include the average incomes listed for the counties in this report. Uninsured rates in the area are nearly twice as much as the entire state, and income levels prevent many residents from paying out-of-pocket for health care.

Table H1: Health Insurance Coverage Among the Region's Adults (2022)[710,711]

	Total Population	Any Health Insurance
Adult Population (18+)	**970,000**	**610,000**
Population in Poverty[712]	460,000	240,000
Race/Ethnicity		
African American	5,000	3,000
Asian American	9,500	8,000
Hispanic / Latino	870,000	530,000
Multiple Races	2,600	2,100
Native American	800	700
Non-Hispanic White	80,000	70,000

Housing

Access to stable, quality, and affordable housing is a critical non-medical driver of health, influencing both physical and mental well-being.[713] Three interconnected factors influence this NMDOH: conditions inside the home, neighborhood conditions, and housing affordability.[714] Overcrowding and substandard housing can increase the spread of infectious diseases, while a lack of safe, affordable housing can force people into temporary or unstable living

[708] Tolbert, J., Cervantes, S., Bell, C., & Published, A. D. (2024, December 18). Key Facts about the Uninsured Population. *KFF*. https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/

[709] American Council on Aging. (n.d.). *Federal Poverty Guidelines / Levels for 2025 & Their Relevance to Medicaid Eligibility*. Retrieved February 11, 2025, from https://www.medicaidplanningassistance.org/federal-poverty-guidelines/

[710] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[711] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[712] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region. Poverty data was obtained from the U.S. Census Bureau. (2023, December). *American Community Survey 2018-2022 Five-Year Public Use Microdata Sample (PUMS)*. https://www.census.gov/programs-surveys/acs/microdata.html

[713] American Academy of Family Physicians. (2014). *Poverty and health: The family medicine perspective (position paper).* American Family Physician. Retrieved from https://www.aafp.org/pubs/afp/issues/2014/0415/p634.html

[714] Robert Wood Johnson Foundation. (May 20111). *Housing and Health*. https://www.rwjf.org/content/rwjf-web/us/en/insights/our-research/2011/05/housing-and-health.html

arrangements, leading to disruptions in medical care, employment, and education. The constant uncertainty and exposure to unsafe environments can worsen existing mental health conditions or contribute to new ones, particularly among vulnerable populations such as low-income families, older adults, and people with disabilities.[715]

Homeless Services

People with mental illness and substance use disorders who are also experiencing homelessness live in communities across the country, including South Texas. Their characteristics vary from person to person, as do their reasons for chronic homelessness, which are complex and multifaceted. Homelessness is often the result of a combination of factors, including shortage of affordable housing, lack of access to health care and supportive services, and high rates of poverty and unemployment. In addition, systemic inequities resulting from the effects of discrimination in housing that have contributed to displacement, as well as the denial of socioeconomic opportunities among people of color, continue to perpetuate disparities in critical areas like housing affordability and homelessness.[716]

There is a well-documented correlation between behavioral health diagnoses and homelessness; unhoused people are significantly more likely to have mental health or substance use conditions than their housed counterparts. Current prevalence of mental health disorders among people experiencing homelessness in the United States is 67%.[717] In many cases, untreated or undertreated behavioral health needs contribute to housing instability, while homelessness itself can exacerbate mental health challenges. Therefore, addressing homelessness requires a multidimensional approach that addresses both the immediate needs of people experiencing homelessness and the underlying causes of homelessness, while providing the necessary behavioral health supports for people to thrive and reach their full potential.

How Many People in the Region Are Unhoused?

Annually, communities across the country participate in the United States Department of Housing and Urban Development (HUD) required Point-in-Time (PIT) count. This count includes the numbers of people who are sheltered in an emergency shelter or transitional housing program on a single night in January. Communities also conduct a count of people living unsheltered on the streets, in vehicles, and in other places not meant for human habitation. The table below shows the total number of people experiencing homelessness in the region during the PIT counts for 2021-2024. In 2021, the unsheltered PIT count was canceled due to the COVID-19 pandemic; numbers for that year only reflect people in shelters. Beginning in 2022, Cameron and Willacy counties created the Cameron and Willacy Counties Homeless

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[715] Health Affairs. (n.d.). *Housing and health: An overview of the literature*. Health Affairs. https://www.healthaffairs.org/content/briefs/housing-and-health-overview-literature

[716] National Alliance to End Homelessness. (n.d.). What Causes Homelessness? Retrieved from https://endhomelessness.org/homelessness-in-america/what-causes-homelessness/

[717] Barry, R., Anderson, J., Tran, L., Bahji, A., Dimitropoulos, G., Ghosh, S. M., Kirkham, J., & Seitz, D. P. (2024). Prevalence of mental health disorders among individuals experiencing homelessness: A systematic review and meta-analysis. *JAMA Psychiatry*. https://doi.org/10.1001/jamapsychiatry.2024.0426

Coalition and began reporting their numbers together. Starr County has not completed any PIT counts.

Table H2: Number of Unhoused People Identified during Annual PIT Count

Number of UnhousedPeople identified during Annual Point-in-Time (PIT) Count				
Total	**2021**	**2022**	**2023**	**2024**
Cameron and Willacy	61 (Cameron County only)	354	402	777
Hidalgo	36	448	353	189
Starr	N/A	N/A	N/A	N/A

During the PIT count, people are also asked to self-disclose information about their behavioral health, HIV/AIDS status, and domestic violence history. This information is used to identify specialty housing programs that have certain eligibility requirements, such as Housing Opportunities for People with AIDS (HOPWA), a federal program that helps low-income people living with HIV/AIDS find housing and support services. Self-reported SMI and SUD remained relatively stable in the last few years in Cameron and Willacy counties. Notably, there was a significant increase in people who reported fleeing domestic violence.

Table H3: Cameron/Willacy Counties PIT Count Special Population Totals[718]

Cameron/Willacy Counties PIT Count Special Population Totals				
	2021 (Cameron County)	**2022**	**2023**	**2024**
Adults SMI	13	50	52	50
Adults SUD	6	35	33	42
Adults HIV/AIDS	0	6	4	2
Adults Domestic Violence	6	42	43	70

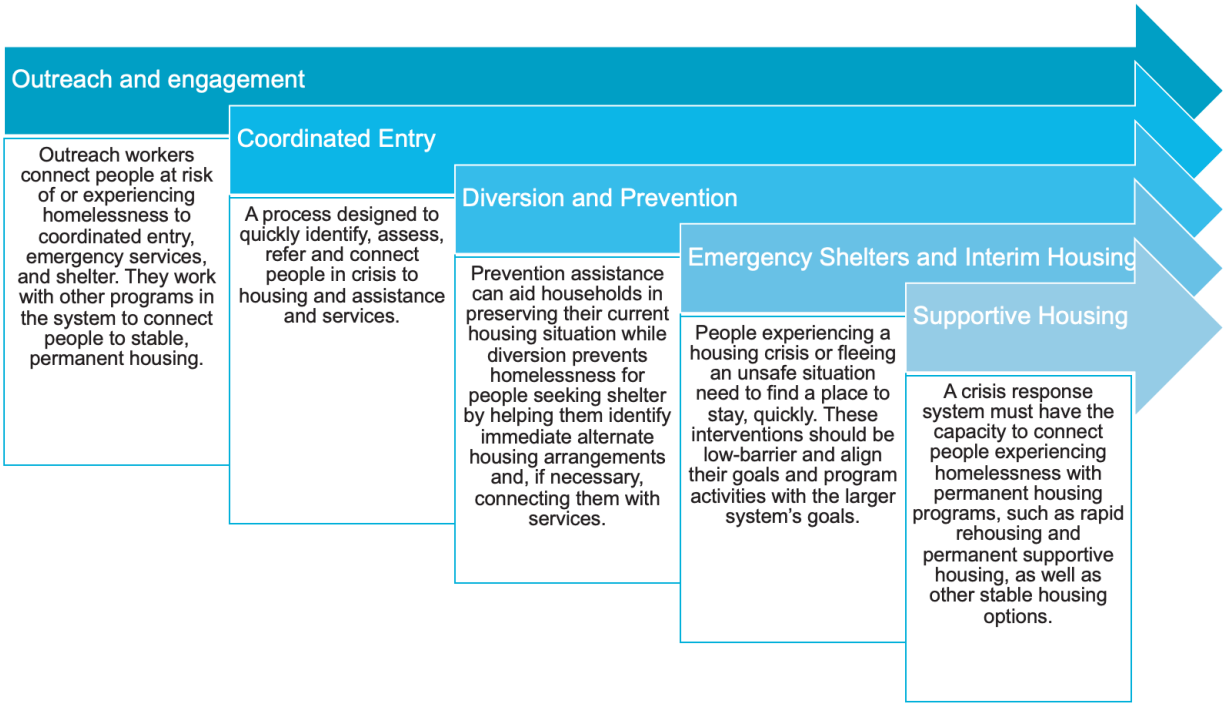
Table H4: Hidalgo County PIT Count Special Population Totals

Hidalgo County PIT Count Special Population Totals				
	2021	**2022**	**2023**	**2024**
Adults SMI	6	12	35	8
Adults SUD	2	11	37	10
Adults HIV/AIDS	0	0	1	1
Adults DV	9	9	15	17

[718] Texas Homeless Network. (2024, May). *Final Cameron and Willacy Homeless Coalition 2024 PIT Report*. Retrieved from https://www.thn.org/wp-content/uploads/2024/05/Final-Cameron-and-Willacy-Homeless-Coalition-2024-PIT-Report.pdf

What Services are Available in the Region?

To effectively decrease homelessness, communities need a robust homeless response system that includes a continuum of resources and programs to help quickly connect people experiencing homelessness to services and housing, with as few barriers as possible, while also diverting people from homelessness whenever possible. The National Alliance to End Homelessness includes the following interventions in a homeless response system:[719]



Supportive housing is an evidence-based practice that combines affordable housing and supportive services to help people with mental health and substance use conditions live more stable, productive lives. Residents in supportive housing may live in their homes if they meet the requirements of tenancy, while having access to robust support services that are person-centered, and safe, secure housing with the same rights and responsibilities as other community members. The two most common types of supportive housing are permanent supportive housing and rapid rehousing.

Permanent Supportive Housing (PSH)

Long-term rental subsidies, typically vouchers, partnered with robust support services for the most vulnerable people experiencing chronic homelessness.

Rapid Rehousing (RRH)

Short-term rental subsidies and support services with the goal of helping people obtain housing quickly, increase self-sufficiency, and stay housed. Rental assistance varies but usually lasts 4-6 months.

[719] National Alliance to End Homeless (NAEH). Crisis Response (2024). https://endhomelessness.org/resources/toolkits-and-training-materials/crisis-response/

The following table identifies agencies in the region providing homeless and housing services and the types of programs they manage.

Table H5: Regional Homeless Services Agencies

Agency	County Served	Program Type
Border Region Behavioral Health	Starr	Outreach and Engagement
Endeavors	Cameron Hidalgo Starr Willacy	Homeless Prevention Rapid Rehousing
Friendship of Women	Cameron Accepts referrals from outside of county	Emergency Shelter for Domestic Violence and Sexual Assault Survivors Rapid Rehousing Homelessness Prevention Transitional Housing
Good Neighbor Settlement House	Cameron	Street Outreach Rapid Rehousing Respite Shetler for Asylum Seekers
Loaves & Fishes of the Rio Grande Valley	Cameron Willacy	Emergency Shelter Homeless Prevention Rapid Rehousing
The Enrique San Pedro Ozanam Center, Inc.	Cameron	Emergency Shelter Homeless Prevention Transitional Housing Rapid Rehousing
Salvation Army	Hidalgo	Emergency Shelter Homeless Prevention Rapid Rehousing
Tropical Texas Behavioral Health	Cameron Hidalgo Willacy	Outreach and Engagement Transitional Housing Supportive Housing

The four counties in this assessment—Cameron, Willacy, Hidalgo, and Starr—are part of the Texas Balance of State Continuum of Care. While Cameron and Willacy counties formed a Homeless Coalition in 2022, Hidalgo County's coalition only recently reconvened, and Starr County lacks a local planning body, limiting coordination efforts.

Beyond insufficiently coordinated efforts, regional stakeholders identified the following key challenges in the region's homeless response system:

- Stakeholders noted an increase in elderly people experiencing homelessness, many of whom are uninsured and awaiting disability benefits. Despite that increased need, few service providers have staff trained in the expedited SOAR process for SSI/SSDI

applications, delaying regional access to critical support. Tropical Texas was one of the few agencies who reported having staff who are SOAR trained.

- A significant gap exists in the availability of permanent supportive housing, with no known programs providing long-term housing and supportive services for people experiencing chronic homelessness. Rapid re-housing programs exist but do not meet the needs of those requiring long-term stability.
- Shelters report growing mental health and substance use needs among residents, with slow response times from regional LMHAs, often leading to emergency service interventions. While some shelters have secured grant funding for on-site behavioral health support, broader solutions are needed.

New Housing Opportunities

Communities in the region have seen the need to increase permanent supportive housing and affordable housing opportunities and are acting accordingly:

- In November 2024, **Hidalgo County** celebrated the grand opening of a newly renovated affordable housing complex, Weslaco Village Apartments. The units serve low-income families. The renovation added six additional units to the building for a total of fifty affordable housing units. The majority of the families who qualify for the units are single female heads of households with children under the age of 18.
- **Cameron County** will soon have 50 new units of permanent supportive housing for Friendship of Women clients.
- The Housing Authority of the **City of Brownsville** received $56.4 million in Housing Tax Credits from the Texas Department of Housing and Community Affairs. Through these tax credits, they are planning to renovate Buena Vida, the city's oldest public housing site, creating 82 units of senior housing, 80 units of multi-family dwellings, and 50 units of permanent supportive housing for survivors of domestic violence and sexual assault. The project is expected to be completed in December 2026.
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Colonias

"Colonia," a neighborhood or community in Spanish, represents a unique and significant regional non-medical driver of health. There are 1,266 colonias across the report's four counties: 172 in Cameron County, 846 in Hidalgo County, 232 in Starr County, and 16 in Willacy County. Hidalgo County has the largest concentration, with 66% of the colonias. These communities are home to approximately 188,455 people, accounting for 14% of the region's population.[720]

While colonias are often defined by a lack of basic infrastructure – like clean water, drainage, and paved roads – their isolation also creates serious barriers to mental health care. Residents, many of whom are U.S. citizens and veterans, face limited access to government benefits and healthcare services. Nearly 70% of adults in colonias lack a high school diploma, compounding

[720] Kyne, D. (2023). A Bird's-Eye View of Colonias Hosting Forgotten Americans and Their Community Resilience in the Rio Grande Valley. *Geographies*, *3*, 459–476. https://doi.org/https://doi.org/10.3390/ geographies3030024

economic and health challenges.[721] Though these tight-knit communities offer social support, the chronic stress of poverty, limited resources, and restricted access to care contributes to poor mental health outcomes. With nearly 500,000 people living in Texas colonias[722] – half under 18[723] – addressing these barriers is critical to improving community well-being.

International Border Community

Living in an international border region presents unique behavioral health challenges for people and families. In Texas border communities, a combination of economic hardship, limited access to healthcare, high rates of uninsured residents, and social stressors contribute to unmet mental health needs.

Immigration dynamics add another layer of complexity. People and families who have recently migrated, as well as those in mixed-status households, often face heightened levels of stress, including fears around family separation, economic insecurity, and social isolation.[724] These experiences can increase the risk of depression, anxiety, and trauma-related disorders.[725] Additionally, confusion and fear surrounding policies may discourage some eligible people from seeking services, further deepening disparities in access to care.

Cultural disconnection, loss of traditional support networks, and language barriers can make it harder for families to find services that feel safe and responsive to their needs.[726] Behavioral health providers in these communities are often stretched thin, managing high demand while also navigating their own exposure to secondary trauma.[727] Similarly, law enforcement officers working near the border may experience moral distress and occupational stress related to

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[721] Texas Department of Housing and Community Affairs. (n.d.). *Background on the Colonias*. Retrieved September 25, 2024, from https://www.tdhca.state.tx.us/oci/background.htm

[722] Texas A&M. (2020, October 19). *Improving Lives Of Texans Along The Border*. https://stories.tamu.edu/news/2020/10/19/improving-lives-of-texans-along-the-border/ Texas A&M, (2020, October 19), *Improving Lives Of Texans Along The Border*

[723] Texas A&M, (2020, October 19), *Improving Lives Of Texans Along The Border*

[724] Garcini, L. M., Galvan, T., & Klonoff, E. (2017). Mental Disorders Among Undocumented Mexican Immigrants in High-Risk Neighborhoods: Prevalence, Comorbidity, and Vulnerabilities. *Journal of Consulting and Clinical Psychology*, *85*(10), 927–936. https://doi.org/doi:%2010.1037/ccp0000237 Garcini, L. M. et al., (2017), Mental Disorders Among Undocumented Mexican Immigrants in High-Risk Neighborhoods: Prevalence, Comorbidity, and Vulnerabilities, *Journal of Consulting and Clinical Psychology*, *85*(10), 927–936

[725] Garcini, L. M. et al., (2017), Mental Disorders Among Undocumented Mexican Immigrants in High-Risk Neighborhoods: Prevalence, Comorbidity, and Vulnerabilities, *Journal of Consulting and Clinical Psychology*, *85*(10), 927–936

[726] Cervantes, R. C., Fisher, D. G., Padilla, A. M., & Napper, L. E. (2016). The Hispanic Stress Inventory Version 2: Improving the Assessment of Acculturation Stress. *Psychological Assessment*, *28*(5), 509–522. https://doi.org/10.1037/pas0000200

[727] Olcoń, K., & Gulbas, L. E. (2021). "Their needs are higher than what I can do": Moral distress in providers working with Latino immigrant families. *Qualitative Social Work: Research and Practice*, *20*(4), 967–983. https://doi.org/10.1177/1473325020919804

enforcement and public safety challenges, adding to the region's complex behavioral health landscape.[728]

Improving mental health outcomes in border communities requires regional collaboration, culturally and linguistically responsive care, and expanded access to community-based services. By addressing these needs holistically, the region can build a more equitable, resilient behavioral health system that supports the well-being of all who live and work there.

Telehealth Utilization and Broadband Access

The FCC recognizes that broadband access and adoption are significant non-medical drivers of health, finding there is a significant correlation between increasing broadband access and improved health outcomes and that internet adoption appeared to have an even greater correlation to improved health outcomes.[729] Digital divides restrict telehealth usage, limiting vital healthcare services and contributing to health disparities.

Texas has experienced a 77% increase in the number of mental health telemedicine patients, and in rural areas there was an increase as high as 160%. Additionally, Texans using telemedicine had two to three more mental health visits per year than mental health patients not using telemedicine.[730] As telehealth increasingly becomes an alternate way of accessing healthcare, reliable broadband has become an important factor influencing health outcomes.

Across the nation and Texas, approximately 90% of people have access to the internet.[731] However, a lack of access disproportionately affects populations that are considered racial and ethnic minorities, older adults, people living on tribal lands, and those with lower education and income levels.[732] These challenges are especially pronounced in rural communities, where geographic and economic barriers often prevent access to high-speed internet, even for those who are willing and able to pay. In the region, Starr County faces significant challenges; approximately 30% of adult residents lack any internet access, ranking them among the lowest counties in Texas.[733]

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[728] Papazoglou, K., & Chopko, B. (2017). The Role of Moral Suffering (Moral Distress and Moral Injury) in Police Compassion Fatigue and PTSD: An Unexplored Topic. *Frontiers in Psychology*, *8*, 1999. https://doi.org/10.3389/fpsyg.2017.01999

[729] Federal Communications Commission. (n.d.). *Studies and Data Analytics on Broadband and Health*. Retrieved February 10, 2025, from https://www.fcc.gov/health/sdoh/studies-and-data-analytics

[730] Kellett, A. (2024, May 17). Telemedicine use by Texas Medicaid patients grew statewide even pre-COVID, especially in rural areas. *Vital Record*. https://vitalrecord.tamu.edu/telemedicine-use-by-texas-medicaid-patients-grew-statewide-even-pre-covid-especially-in-rural-areas/

[731] U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[732] Community Tech Network. (n.d.). *The state of digital equity in Texas*. Community Tech Network. https://communitytechnetwork.org/blog/the-state-of-digital-equity-in-texas/

[733] Community Tech Network. (n.d.). *The state of digital equity in Texas*. Community Tech Network. U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

Table H6: Internet Access in the Region by County (2022)[734,735]

	Total Population		Internet Access	
	Children/ Youth	Adults	Children/ Youth	Adults
State of Texas	**5,200,000**	**22,500,000**	**4,950,000**	**20,200,000**
Rio Grande Valley	**300,000**	**970,000**	**260,000**	**820,000**
Cameron County	85,000	300,000	75,000	250,000
Hidalgo County	190,000	610,000	170,000	520,000
Starr County	13,000	45,000	11,000	32,000
Willacy County	3,500	15,000	2,800	11,000

Table H7: Fixed Broadband Comparison for Counties[736]

Fixed Broadband Comparison						
Location	**0.2/0.2***	**10/1**	**25/3**	**100/20**	**250/25**	**1000/100**
Cameron	100%	100%	100%	100%	93.37%	44.61%
Hidalgo	100%	100%	100%	100%	92.6%	21.55%
Starr	100%	100%	100%	100%	88.77	12.57%
Willacy	100%	100%	100%	100%	94.26%	86.29%

*Upload/Download Speed Mbps

Table H8: Mobile Broadband Comparison for Counties

Mobile Broadband Comparison				
Location	**3G (0.2/0.5)**	**4G (5/1)**	**5G (7/1)**	**5G (35/3)**
Cameron	NA	74.56%	83.58%	80.01%
Hidalgo	NA	99.98%	95.83%	89.09%
Starr	NA	99.98%	95.4%	80.26%
Willacy	NA	76.92%	71.85%	61.38%

The tables above indicate the number of households that are eligible to connect to broadband service. Still, the ability to connect and the ability to use the service are two different things.

[734] We extracted internet availability data for the region and Texas residents from the U.S. Census Bureau 2018-2022 American Community Survey (ACS). The ACS is the standard source used across the country to obtain household and demographic data. Local data was not used in this section due to quality concerns, such as how the data was obtained or the adequacy of sample size. U.S. Census Bureau. (2024, December). American Community Survey 2019-2023 5-year estimates. https://www.census.gov/data/developers/data-sets/acs-5year.2023.html

[735] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts, and percentages may not always add up to 100%. Estimated values between 1 and 9 are rounded to "<10."

[736] *FCC National Broadband Map*. (n.d.). FCC National Broadband Map. Retrieved February 4, 2025, from https://broadbandmap.fcc.gov

This phenomenon is called "access versus adoption."[737] Adoption of the service requires equipment (computer and/or tablet and cables, plus the appropriate connection equipment) and the knowledge to use the service once installed, not to mention a subscription to the service itself which often competes with necessities of the household. The Rio Grande Valley Broadband Coalition indicates the most common barriers to adoption are the high cost of subscription, language barriers, and unreliable service, especially when families are managing budgets.[738]

Table H9: Digital Opportunity[739]

Share of Household Internet Adoption							
Location	**Age 60+**	**Limited English Proficiency**	**Disabled**	**Low-income**	**Racial/Ethnic Minorites**	**Veterans**	**Total**
Cameron	36%	29%	38%	32%	40%	52%	43%
Hidalgo	44%	41%	45%	40%	55%	61%	55%
Starr	35%	41%	39%	41%	49%	49%	51%
Willacy	37%	21%	41%	40%	47%	59%	36%
Texas Statewide	**61%**	**51%**	**60%**	**52%**	**66%**	**72%**	**69%**

Efforts Addressing Telehealth Utilization and Broadband Access

The 87th Legislative session established the Broadband Development Office (BDO) to expand broadband access in Texas using a statewide plan the BDO developed.[740] While building their plan, the BDO hosted listening sessions, conducted surveys with analysis of the results, and collected staff recommendations.[741] According to stakeholders, notably, the BDO was not familiar with the term "colonias" or the existence of these communities, so their plan excludes these communities.

Philanthropic efforts to bolster regional access include the following:

- **Methodist Healthcare Ministries Digital Equity Grant:** In December 2023, Methodist Healthcare Ministries (MHM) of South Texas pledged over $21 million over three years to support digital equity in all counties they serve; they estimate that about $5 million is

[737] Texas Digital Opportunity Hub. (n.d.). *Internet Adoption Dashboard*. Retrieved February 5, 2025, from https://digitalopportunityfortexas.com/data/internet-adoption

[738] RGV Broadband Coalition. (2025). *RGV Broadband and Digital Opportunity-Plan Updated Feb. 2025*. https://connecthumanity.fund/wp-content/uploads/2025/02/RGV-Broadband-and-Digital-Opportunity-Plan-Updated-Feb-2025.pdf

[739] Texas Digital Opportunity Hub, (n.d.), *Internet Adoption Dashboard* Texas Digital Opportunity Hub, (n.d.), *Internet Adoption Dashboard*

[740] Broadband Development Office. (n.d.). *Texas Broadband Plan*. Retrieved April 22, 2025, from https://comptroller.texas.gov/programs/broadband/about/what/plan.php Broadband Development Office, (n.d.), *Texas Broadband Plan*

[741] Broadband Development Office, (n.d.), *Texas Broadband Plan*

going to support the work in the four counties covered in this report. These organizations include the City of Pharr, Community Council of South-Central Texas, MHP Salud, South Texas Rural Health Services.[742] This funding will help community organizations increase access to digital resources and training.

Tropical Texas reports they received a two-year MHM technology grant totaling $1 million ($500,000 per year). Through this funding, they served 7,424 people, expanding digital access and resources. They conducted 4,406 computer lab sessions at their SUDS residential and veterans drop-in centers. On an average day, 893 clients and their families accessed digital resources through these access points, increasing digital inclusion and support for populations with limited access.

- **Valley Baptist Legacy Foundation Connect Humanity Grant:** VBLF has pledged nearly $400,000 to Connect Humanity, who is working with the Rio Grande Valley Broadband Coalition to expand broadband access and adoption.[743]

Spotlight: Rio Grande Valley Broadband Coalition

This coalition is a partnership of local governments addressing gaps in connectivity, including internet providers, schools, healthcare institutions, small businesses, and nonprofits. Their goal is to bridge the digital divide by ensuring all residents and small businesses have access to high-speed, affordable, and reliable internet, enabling economic growth, educational advancement, and civic participation throughout the region. In February 2025, they released the RGV Broadband and Digital Opportunity Plan. The RGV Broadband and Digital Opportunity Plan will ensure healthcare providers have necessary internet speed and capacity, and patients have reliable connectivity.[744] They designed their plan to align with the Texas Digital Opportunity Plan (TDOP) and the Texas BEAD 5-Year Action Plan and Initial Proposal Volumes I and II.

Transportation

Transportation is fundamental to accessing health care, as well as an important non-medical driver of health that disproportionately impacts people with chronic health conditions.[745] Medicaid recipients are eligible for nonemergency medical transportation,[746] including gas funds plus meals and lodging to stay overnight to receive covered healthcare services. Medicaid covered transportation includes city buses, taxis, or commercial transit.

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[742] Methodist Healthcare Ministries. (2023). *Methodist Healthcare Ministries awards more than $21 million to advance digital equity across South Texas*. Retrieved from https://www.mhm.org/methodist-healthcare-ministries-awards-more-than-21-million-to-advance-digital-equity-across-south-texas/

[743] Taylor, S. (2024, March 21). Valley Baptist Legacy Foundation invests in digital equity for South Texas. *Rio Grande Guardian*. https://riograndeguardian.com/valley-baptist-legacy-foundation-invests-in-digital-equity-for-south-texas/

[744] RGV Broadband Coalition, (2025), *RGV Broadband and Digital Opportunity-Plan Updated Feb. 2025*

[745] Starbird, L. E., DiMaina, C., Sun, C. A., & Han, H. R. (2019). A systematic review of interventions to minimize transportation barriers among people with chronic diseases. *Journal of community health*, *44*(2), 400–411. https://doi.org/10.1007/s10900-018-0572-3

[746] Texas Health and Human Services. (n.d.). *Nonemergency Medical Transportation Program*. Retrieved February 24, 2025, from https://www.hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/nonemergency-medical-transportation-program

Annually, approximately 3.6 million Americans delay or miss medical care due to a transportation barrier.[747] While several regional services aim to connect both urban and rural areas in Cameron, Hidalgo, Starr, and Willacy counties, community stakeholders overwhelmingly reported transportation as a barrier in their communities, especially in more rural parts of the region. The region has these services available for public transportation: Brownsville Metro, Jag Express, Metro McAllen, Valley Metro, and Vaquero Express.

Despite efforts of local organizations, like Topical Texas who offer transportation services, community stakeholders report that transportation challenges, along with increased roadwork and construction, impact one's ability to make it to medical appointments. These roadblocks and delays not only hinder patients from accessing timely care but also create difficulties for clinical staff who travel to meet with patients in the community or provide transportation services. As traffic congestion and construction projects extend travel times, they add an additional layer of complexity, limiting both patient and provider mobility.

In 2021, the Lower Rio Grande Valley Development Council (LRGVDC) released the Five-Year Regional Public Transportation Plan and our stakeholder insights regarding gaps, needs, and barriers aligned with the findings of the LRGVDC's comprehensive assessment. In the plan, LRGVDC outlined 24 recommendations around public transportation. Most notably, the organization pointed to the need for lower-cost transportation but also that many systems already offer low-cost alternatives for fares; however, people still struggle with fares even at a low cost.[748] The report also identifies youth, veterans, and seniors ages 65 and older as "ride dependent" populations. It further noted that Cameron County has the largest percentage of households with no vehicles, while Willacy County had the lowest percentage.

[747] Wallace, R., Hughes-Cromwick, P., Mull, H., & Khasnabis, S. (2005). Access to health care and nonemergency medical transportation: Two missing links. *Transportation Research Record, 1924*(1), 76–84. https://doi.org/10.1177/0361198105192400110

[748] Lower Rio Grande Valley Development Council. (2021). *LRGVDC Coordination Plan 2022*. https://www.lrgvdc.org/downloads/transportation/LRGVDC%20Coordination%20Plan%202022.pdf

Appendix I: Faith Communities

The following table summarizes faith and mental health initiatives. While the models can certainly overlap, this framework might be useful if regional leaders consider supplementing and strengthening current efforts.

Table I1. Faith and Mental Health Initiatives

Model	Goal / Approach	Examples
Educate Faith Communities to Increase Mental Health Literacy and Awareness	Uses educational and training methods to increase understanding of mental illness, reduce stigma, and increase capacity to refer for services.	San Antonio's Wellness Center for Families of Faith and the city's Mental Health Action Team provide mental health education.[749]
Equip Congregations for Mental Health Ministry	Trains congregation members in the provision of community-based support to people with mental health conditions and / or their families.	Grace Alliance and Fresh Hope[750] provide support group manuals and training. The Mental Health Chaplaincy of Seattle[751] provides training in companionship.
Engage Faith Communities as Partners to Improve Mental Health System Access and Performance	Works collaboratively with congregations to improve system access and mental health outcomes.	The Memphis Model[752] establishes covenants between a health system and congregations, who work together to decrease hospital readmissions and improve mental health services access. Bridges to Care and Recovery in St. Louis[753] train congregations in mental health ministry and provides referral pathways and financial support for accessing mental health services.

[749] City of San Antonio. (n.d.). *STRATEGIC ENGAGEMENT OF SAN ANTONIO'S FAITH-BASED INITIATIVE*. Retrieved June 13, 2025, from https://www.sanantonio.gov/portals/0/Files/HumanServices/FaithBased/Resources/Structure-Infographic.pdf#view=Fit

[750] Grace Alliance. (n.d.). *Mental Health Grace Alliance*. Mental Health Grace Alliance. Retrieved June 13, 2025, from https://mentalhealthgracealliance.org

[751] Mental Health Chaplaincy. (n.d.). *MENTAL HEALTH CHAPLAINCY*. MENTAL HEALTH CHAPLAINCY. Retrieved June 13, 2025, from https://www.mentalhealthchaplaincy.net/

[752] Methodist Le Bonheur Healthcare. (n.d.). *Congregational Health Network—Methodist Le Bonheur Healthcare*. Retrieved June 13, 2025, from http://www.methodisthealth.org/faith-and-health/Faith-Community-Relations/Congregational-Health-Network

[753] Behavioral Health Network. (2023, June 6). *St. Louis Behavioral Health Planning & Coordination*. https://bhnstl.org/

Model	Goal / Approach	Examples
Establish System-Level Efforts to Promote Faith and Mental Health Collaboration	Leaders develop a community-wide coalition or collaborative that systematically disseminates mental health education, training, and ministry throughout a geographic region.	The Interfaith Mental Health Coalition in Chicago[754] organizes mental health conferences and other mental health training and education events and develop mental health advocacy capacities among collaborating partners. Pathways to Promise[755] works with national faith groups and other leaders to disseminate mental health education and ministry resources.
Embed Mental Health Services in Faith Communities	Mental health services are delivered in the congregation setting to increase access to faith-friendly approaches to mental health.	West Texas Counseling and Guidance[756] co-locates mental health services and support groups in area congregations. Using "task-shifting" methods, Houston's Hope and Healing Center & Institute[757] embeds mental health support services and interventions within congregations. It also provides a wide array of mental health treatments and interventions at the center.

[754] Interfaith Mental Health Coalition. (n.d.). *Get Involved with the Coalition!* Retrieved June 13, 2025, from https://interfaithmhc.org/
[755] Pathways to Promise. (n.d.). *Mental Health Resource*. Pathways to Promise. Retrieved June 13, 2025, from https://www.pathways2promise.org
[756] West Texas Counseling & Guidance. (n.d.). *Directory Listings*. Retrieved June 13, 2025, from https://www.sanangelocounseling.org/directoryListings/index
[757] Hope and Healing Center and Institute. (n.d.). *About Us*. Retrieved June 13, 2025, from https://hopeandhealingcenter.org/about-us/

Appendix J: Integrated Behavioral Health Models

Primary Care Behavioral Health Model

Current literature has been focused on a clear definition for Primary Care Behavioral Health Model (PCBH) as the model struggled in the past with a clear and operationalized definition making research difficult.[758] In 2018, PCBH was defined as:

> A team-based primary care approach to managing behavioral health problems and bio-psychosocially influenced health conditions. The model's main goal is to enhance the primary care team's ability to manage and treat such problems/conditions, with resulting improvements in primary care services for the entire clinic population. The model incorporates into the primary care team a behavioral health consultant (BHC), sometimes referred to as a behavioral health clinician, to extend and support the primary care provider (PCP) and team. The BHC works as a generalist and an educator who provides high volume services that are accessible, team-based, and a routine part of primary care.[759]

PCBH employs a Behavioral Health Consultant (BHC) in the primary care practice and the BHC works alongside the doctors (PCPs) in that practice. The BHC sees most of the patients within the practice and is seen as providing routine care.[760] Initially the patient may be seen by both the PCP and the BHC, but eventually the PCP will take over all necessary care and consult with the BHC as needed.[761] BHCs must be a Licensed Clinical Social Workers (LCSW), Licensed Marriage and Family Therapists (LMFT), or Licensed Professional Counselors (LPC) to practice within Texas.

The lack of a clear definition has delayed research into the application, goals, and efficacy of PCBH.[762] Despite this delay, the American Psychological Association recognizes the model as aligning and delivering the objectives of the "Quadruple Aim."[763] Specifically, PCBH:

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[758] Jeffrey T. Reiter, Anne C. Dobmeyer, & Christopher L. Hunter. (2018). The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition. *Journal of Clinical Psychology in Medical Settings*, *25*, 109–126. https://doi.org/https://doi.org/10.1007/s10880-017-9531-x Jeffrey T. Reiter et al., (2018), The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition, *Journal of Clinical Psychology in Medical Settings*, *25*, 109–126

[759] Jeffrey T. Reiter et al., (2018), The Primary Care Behavioral Health (PCBH) Model: An Overview and Operational Definition, *Journal of Clinical Psychology in Medical Settings*, *25*, 109–126

[760] Hunter, C. L., Funderburk, J. S., Polaha, J., Bauman, D., Goodie, J. L., & Hunter, C. M. (2018b). Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action. *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156. https://doi.org/10.1007/s10880-017-9512-0 Hunter, C. L. et al., (2018b), Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action, *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156

[761] Hunter, C. L. et al., (2018b), Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action, *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156

[762] Hunter, C. L. et al., (2018b), Primary Care Behavioral Health (PCBH) Model Research: Current State of the Science and a Call to Action, *Journal of Clinical Psychology in Medical Settings*, *25*(2), 127–156

[763] Bodenheimer, T., & Sinsky, C. (2014). From Triple to Quadruple Aim: Care of the Patient Requires Care of the Provider. *Annals of Family Medicine*, *12*(6), 573. https://doi.org/10.1370/afm.1713

- Improves the patient/family experience.
- Improves patient outcomes.
- Provides cost-effective care.
- Improves provider experience of care.
- Supports a range of population health needs.
- Improves care for population which are considered marginalized.
- Increases screening of perinatal mood and anxiety disorders.[764]

Collaborative Care Model

The Collaborative Care Model (CoCM) is an extensively evidenced-based model for behavioral health integration in primary care and pediatric settings. CoCM has been shown to be effective for various behavioral health problems across diverse populations and treatment settings. Furthermore, CoCM is the integrated behavioral health model with the strongest evidence-base to effectively address the needs of our mental health care system.[765, 766, 767, 768]

CoCM is a systematic and evidence-based approach[769] to delivering mental health services effectively and efficiently in primary care and pediatric settings at a population level. In CoCM, a team of professionals, including a primary care provider or pediatrician, consulting psychiatrist and a behavioral health care manager (BHCM), work together to coordinate care and ensure access to the best treatment available for a patient's needs. CoCM is particularly adept at detecting common behavioral health problems like depression because it incorporates another proven approach: universal screening and measurement-informed care (MIC). After implementation of CoCM, every medical visit includes screening for common behavioral health disorders (e.g., depression or anxiety), like routine measurement of common physical health markers like blood sugar and cholesterol. When a need is detected, the CoCM team implements a measurement-guided care plan based on evidence-based practice guidelines and follows each patient to defined treatment targets.[770]

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[764] APA Office of Health and Health Care FInancing's Integrated Primary Care Advisory Group, (n.d.), *Behavioral Health Integration Fact Sheet*

[765] Behavioral Health Care When Americans Need It: Ensuring Parity and Care Integration, U.S. Senate, 7 (2022) (testimony of Anna D. H. Ratzliff).

[766] Covino, N. A. (2019). Developing the behavioral health workforce: Lessons from the states. Administration and Policy in Mental Health and Mental Health Services Research, 46(6), 689–695. https://doi.org/10.1007/s10488- 019-00963-w

[767] Lauerer, J. A., Marenakos, K. G., Gaffney, K., Ketron, C., & Huncik, K. (2018). Integrating behavioral health in the pediatric medical home. *Journal of Child and Adolescent Psychiatric Nursing, 31*(1), 39–42. https://doi.org/10.1111/jcap.1219

[768] Kepley, H.O., & Streeter, R. A. (2018). Closing behavioral health workforce gaps: A HRSA program expanding direct mental health service access in underserved areas. *American Journal of Preventive Medicine*, *54*(6), S190–S191. https://doi.org/10.1016/j.amepre.2018.03.006

[769] Centers for Medicare & Medicaid Services. (2019, May). *Behavioral health integration services*. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[770] American Psychiatric Association. (2016). Dissemination of Integrated Care within Adult Primary Care Settings—The Collaborative Care Model. Academy of Psychosomatic Medicine.

Evidence-based Principles

CoCM has five primary evidence-based principles or pillars.

Patient-centered Team Care

CoCM is patient-centered, meaning that all care delivered through the model is done, to the greatest extent possible, with the patient's interests, preferences, and schedule in mind. All three core members of the CoCM team work together to achieve this goal.

Population-based Care

CoCM leverages a care team to screen an entire patient population and influence the care of far more patients than they would be able to see working on their own, allowing a whole population of patients to be carefully managed and enter treatment more quickly and preventing patients from falling through the cracks.

Measurement-based Treatment to Target

When outcomes are tracked in the CoCM treatment registry, the CoCM treatment team is responsible for ensuring that patients' outcome scores improve according to evidence-based metrics, such as response or remission.

Evidence-based Care

CoCM is itself evidence-based, and additionally, the model incorporates other evidence-based treatments, including medication prescribing guidelines (that may include the use of treatment algorithms) and brief interventions such as cognitive behavioral therapy, problem solving therapy, or motivational interviewing.

Accountable Care

In CoCM, the clinical team is incentivized to provide high-value care, as opposed to high-volume care. The team may regularly be presented with data on their patients' treatment progress, providing the opportunity for clinicians to continuously improve their treatment strategies.

Collaborative Care Model Clinical Workflow

CoCM presents an innovative approach to integrating behavioral health services within primary care settings, aiming to improve early identification of behavioral health needs and access to treatment. A broad-based overview of a CoCM program clinical workflow is as follows.

After adopting universal behavioral health screening, a practice must define the target population and diagnostic scope for its CoCM program. For example, a practice may define its target population age, and its diagnostic scope as depression, anxiety, and ADHD. Patients in the target population who screen positive for conditions within the diagnostic scope or display concerning signs/symptoms are considered for referral to the CoCM program.

Typically, the PCP will inform the patient (and their guardian if under 18 years of age) of the program and offer them enrollment. For billing purposes, the PCP informs the patient and guardian that, depending on their health insurance, they may receive a monthly bill for CoCM services (i.e., cost sharing). This discussion between the PCP patient (as developmentally appropriate), and guardian is considered the "consent process." Verbal consent must be documented in the medical record. Uninsured patients should also be informed that they may receive a bill for CoCM services (though they may not be required to pay the bill due to sliding scale payment arrangements). If the patient is ultimately enrolled in CoCM, the PCP will connect them with the program's BHCM.

The BHCM connects with the patient via warm handoff in person, by telephone, or through secure messaging to schedule an intake visit. During this visit, the BHCM conducts a full behavioral health evaluation that explores current symptoms in addition to a comprehensive history of diagnoses, treatments (including medication and psychotherapy), higher acuity care, and comorbid medical problems. In this evaluation, the BHCM also administers evidence-based assessments, such as the Patient Health Questionnaire-9, Patient Health Questionnaire-9 Modified for Adolescents (PHQ-A) and the Generalized Anxiety Disorder-7 (GAD-7). The BHCM may, with permission, speak to relevant collaborators, including school. The BHCM writes a draft report of the findings from the intake evaluation and enters demographic data, visit data, and assessment results into the patient registry.

During weekly case reviews with the psychiatric consultant, the BHCM reviews the treatment registry broadly, with each patient considered for detailed discussion. The BHCM and psychiatric consultant typically discuss new patients and those with acute events; patients who are not responding to treatment or following up as scheduled with the BHCM are also prioritized. The BHCM, with help from the psychiatric consultant, develops a personalized treatment plan, which may include parent/family training, medication recommendations, brief psychotherapy, and/or psychosocial interventions for new patients. This plan is then described in the BHCM's report, which is preliminarily discussed with the patient and sent to the PCP. The PCP then reviews the patient's treatment plan with recommendations from the rest of the CoCM team.

If the psychiatric consultant recommends medications and the PCP agrees, the PCP will write prescriptions and schedule a visit with the patient and guardian to discuss the recommended medications further. The PCP is always welcome to ask follow-up questions of the CoCM team. Due to this bidirectional collaboration, CoCM provides valuable real-time education opportunities for PCPs, rendering them more knowledgeable about relevant psychopharmacology during future patient encounters. When the CoCM team recommends

specific psychotherapy, these services are typically delivered by the BHCM directly. The BHCM most commonly provides brief behavioral health interventions, such as motivational interviewing or behavioral activation, though other modalities or psychosocial interventions may be used as indicated. In some cases, patients can be referred to community providers (while still being followed in CoCM) if they require more extensive therapy, long-term therapy, or additional interventions for which the BHCM is not adequately trained.

After the CoCM intake visit and initial recommendations, patients are followed closely by the BHCM. Typically, patients interact with the BHCM and potentially their guardians, a minimum of two times per month while in active treatment. During each interaction between the patient, guardian, and BHCM, the BHCM administers evidence-based assessments, and adds follow-up results to the treatment registry. The goal for each target symptom is remission, which is defined differently for each instrument. With the PHQ, for example, remission is defined as a score of less than five. Patient treatment response is also tracked, which is typically defined as a reduction from the baseline score of 50% or more with the PHQ. Of note, the choice of instruments is discretionary for each CoCM program. The BHCM and psychiatric consultant update treatment plans for existing CoCM patients during case review sessions based on clinical progress. All treatment plan updates, including updated medication recommendations, are sent to the PCP. Each patient is considered for review weekly in case review sessions with the psychiatric consultant (and is reviewed at least monthly). The BHCM also remains in close contact with the patient's guardian, if a minor, to discuss treatment recommendations and proposed changes. Additionally, the BHCM may remain in ongoing communication with school representatives or teachers, if indicated and permissible. On average, patients remain in the active treatment phase of the program for three to six months.

A patient moves from active treatment into the relapse prevention phase of the CoCM program when they achieve symptom response or remission. At this point, the patient's frequency of interaction with the BHCM typically decreases to approximately once per month, and the clinical focus shifts to creating a plan to mitigate future worsening of symptoms. This relapse prevention plan integrates the patient’s goals, medication recommendations (if applicable), and guidance on the use of key therapy skills interventions. After successful maintenance in relapse prevention for two to three months, patients are typically discharged from CoCM and back to the care by their PCP entirely. Patients can re-enroll in CoCM if clinically necessary.

Figure J1: Collaborative Care Model for Adults

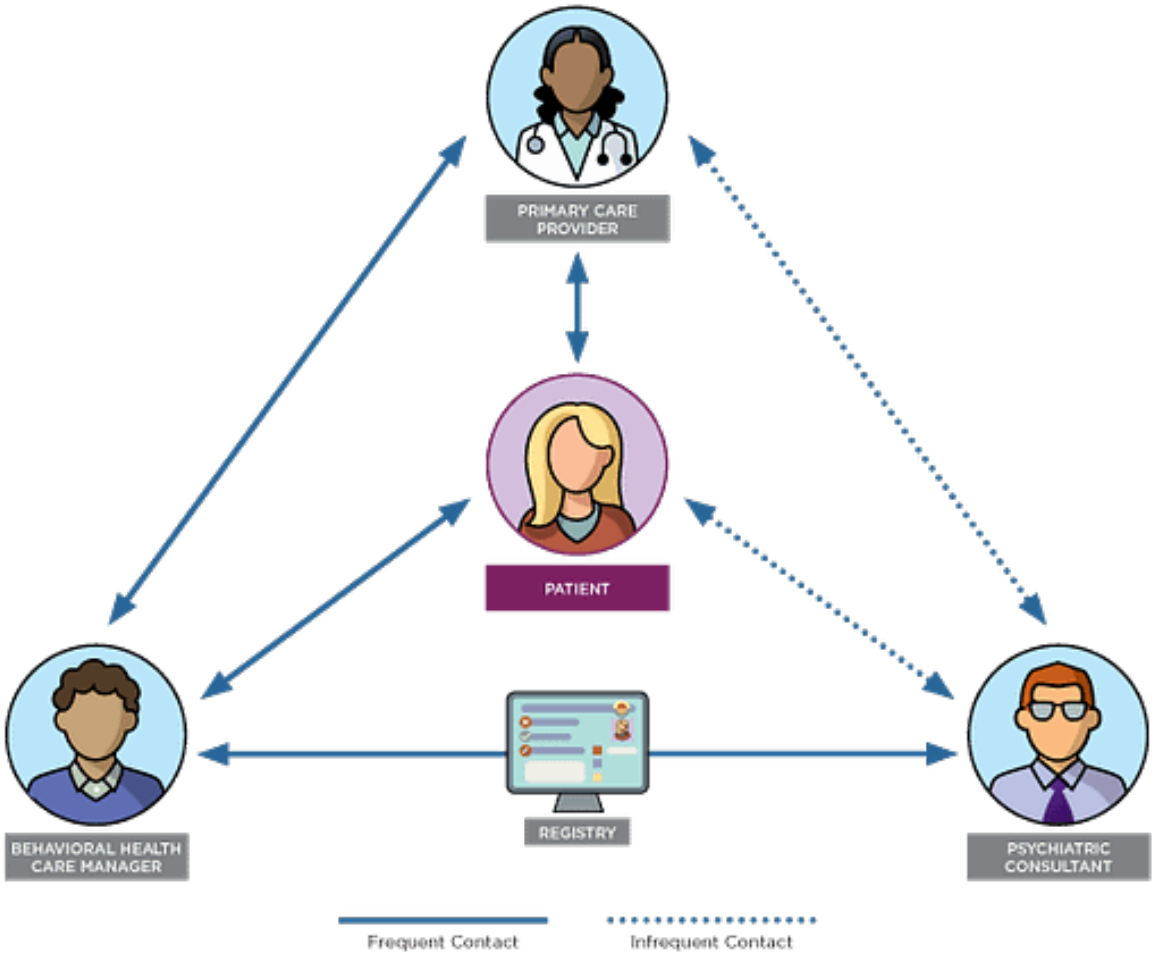
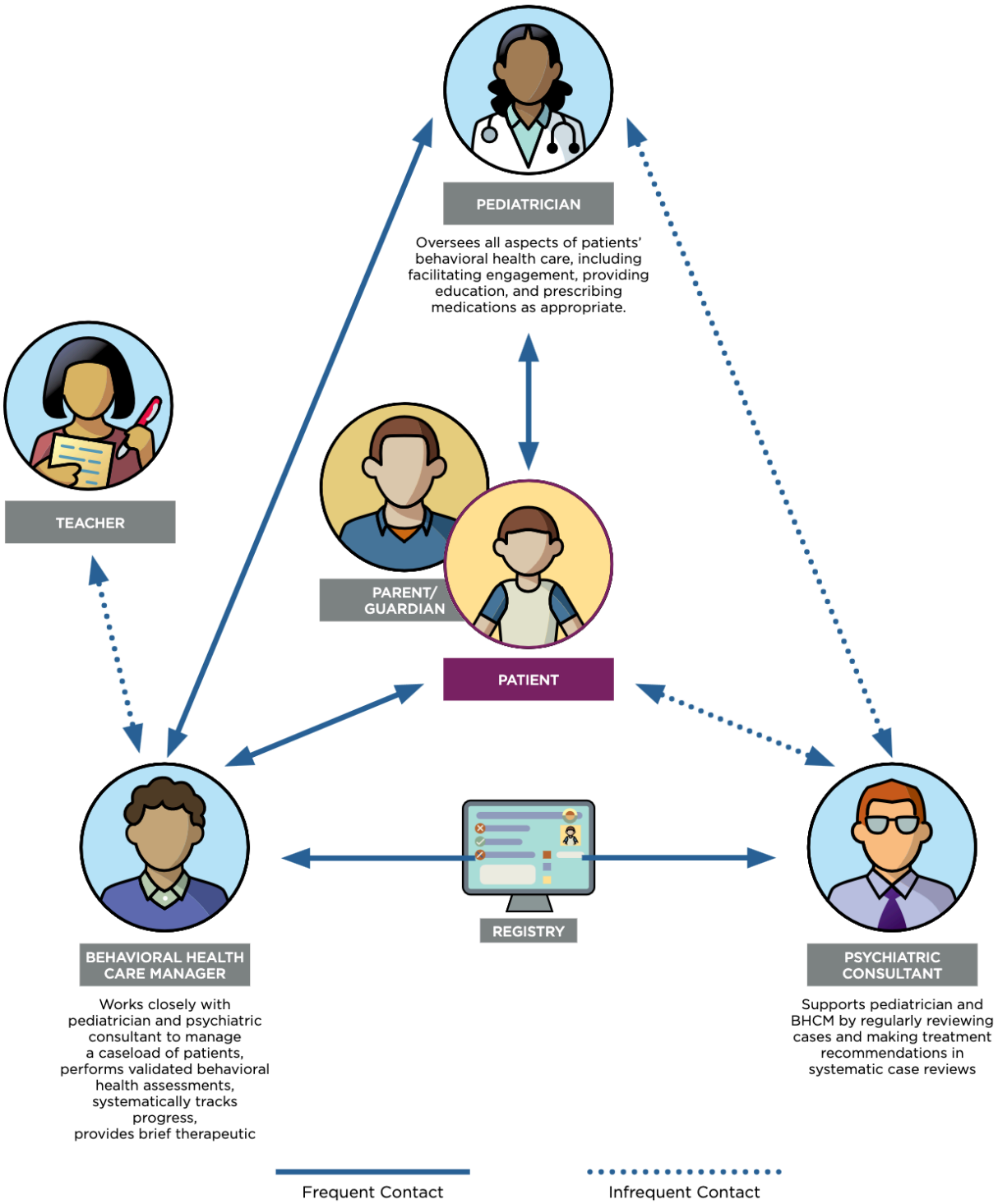


Figure J2: Collaborative Care Model for Youth



Collaborative Care Model Billing Basics

The Collaborative Care Model (CoCM) is the only integrated behavioral health model to have designated billing codes. CoCM billing codes are time-based and reported as the total amount of time the Behavioral Health Care Manager (BHCM), in collaboration with the Psychiatric Consultant (PC), working under the direction of the Primary Care Physician (PCP), spends engaging in clinical activities over the course of a calendar month.

CoCM services are reimbursed by Medicare, more than half state Medicaid agencies, and most private payers. CoCM billing codes are paid under the medical benefits, not the behavioral health carve-out, despite using behavioral health diagnosis. Prior to CoCM services starting, the PCP must obtain consent and inform the patient that cost-sharing may apply. Most payers follow similar cost sharing to other non-preventive PCP services, and if a copay applies, only one monthly charge is due.

CoCM services are billed monthly once the time threshold has been met. CoCM billing codes are billed with the PCP (treating provider) as the billing provider. All services delivered by the BHCM working in collaboration with the PC are billed incident to. Other separate and distinct Evaluation and Management (E/M) and psychotherapy services may be billed in addition to CoCM.

Some common reasons why CoCM codes are not paid include codes are not included in the provider fee schedule, prior authorization requirement, or the claim was forwarded to the behavioral health carve-out in error.

Additionally, if CoCM criteria is not met, 99484 for 20 minutes of general Behavioral Health Integration (BHI) services may be billed.

Table J1: Collaborative Care Model Billing Codes

Collaborative Care Model Billing Codes	
Code	**Description**
99492	First 70 minutes of CoCM services rendered in the first calendar month (36-85 minutes).
99493	First 60 minutes of CoCM services rendered in any subsequent month (31-75 minutes).
99494	Each additional 30 minutes of CoCM services rendered in any calendar month (16-30 minutes), after the total time for the primary code has been met. *Effective 7/1/24, Medicare reimburses up to 4 units, per month. Stipulations and limitations vary by payer and may change over time.*
GG214	30 minutes of CoCM services rendered in any calendar month (16-30 minutes).

G0512	Minimum 70 minutes during initial month and minimum 60 minutes during subsequent months of CoCM services in FQHC/RHC settings.

Appendix K: Complex Care Best Practice

Multisystemic Therapy

Multisystemic Therapy (MST) is a well-established, evidence-based practice for youth ages 12-17 with severe behavioral problems related to willful misconduct and delinquency and has proven outcomes and cost benefits when implemented with fidelity.[771,772] MST has a large body of evidence and has been the focus of 74 studies and $75 million in research, appearing in over 140 peer-reviewed journals and studied across 57,000 families.

At its core, MST assumes that problems are multi-determined, and to be effective, treatment must have an impact on multiple systems, such as a youth's family and peer group.[773] Accordingly, MST is designed to increase family functioning by helping parents improve how they monitor their children, as well as reducing familial conflict and improving communication, among other factors.

Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and reducing association with "deviant" peers, primarily through parental mediation.[774] MST also reduces delinquent and antisocial behavior by addressing the core causes of such conduct and expanding the focus of treatment beyond the youth to include the network of systems responsible for caring for them, which includes their family, peers, schools, and neighborhoods. MST has been proven effective and has reduced rearrest by 54% over 14 years and violent felony arrests by 75% over 22 years.[775]

MST has low caseloads and varies in frequency, duration, and intensity levels. The average length of treatment is between three and five months, and therapists and provider agencies are held accountable for achieving positive outcomes.[776] MST has been successfully adapted and researched for specific subpopulation groups such as youth in the child welfare system (MST-Child Abuse and Neglect), youth with substance use disorders (MST-SUD), youth transitioning

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[771] Huey, S. J., Henggeler, S. W., Brondino, M. J., & Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. *Journal of Consulting and Clinical Psychology*, *68*(3), 451–467.

[772] Henggeler, S. W., Cunningham, P. B., Pickrel, S. G., Schoenwald, S. K., & Brondino, Michael J. (1996). Multisystemic therapy: An effective violence prevention approach for serious juvenile offenders—ScienceDirect. *Journal of Adolescence*, *19*(1), 47–61. https://doi.org/https://doi.org/10.1006/jado.1996.0005

[773] *MST Payment Options for Harris County Juvenile Probation Department—MMHPI - Meadows Mental Health Policy Institute*. (n.d.). Https://Mmhpi.Org/. Retrieved June 13, 2025, from https://mmhpi.org/project/multisystemic-therapy-payment-options/

[774] Huey, Stanley J., Henggeler, S. W., Rowland, M. D., Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., & Edwards, J. (2004). Multisystemic Therapy Effects on Attempted Suicide by Youths Presenting Psychiatric Emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, *43*(2), 183–190. https://doi.org/10.1097/00004583-200402000-00014

[775] MST Services. (n.d.). *MST State Success Story Guide*. Retrieved June 13, 2025, from https://info.mstservices.com/mst_state_success_story_guide MST Services, (n.d.), *MST State Success Story Guide*

[776] MST Services, (n.d.), *MST State Success Story Guide*

out of residential care (MST-Family Integrated Transitions), and youth with co-occurring serious behavior issues and psychiatric concerns (MST-Psychiatric).

Coordinated Specialty Care

Early detection of psychosis is important since people who experience psychoses typically do not receive care and treatment until five years after the onset of symptoms.[777] The CSC team provides community education activities and develops strategic partnerships with key entities in the community, which are critical elements of the program. The team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person experiencing early psychosis and actively engages their family in supporting recovery. CSC provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management, as well as other less common evidence-based approaches that are known to help people with serious mental illnesses retain or recover a meaningful life in the community such as Supported Education and Supported Employment.

A 2016 study by Kane and colleagues on the multisite Recovery After an Initial Schizophrenia Episode (RAISE) study — conducted in 34 clinics across 21 states — showed that study participants had a better quality of life and were more involved in work and school, especially when they received CSC within the first 17 months of the onset of psychosis.[778] CSC was better than care-as-usual at helping people remain on a normal developmental path. Researchers have also compared the costs of CSC to care-as-usual and found that CSC was less expensive per unit of improvement in quality of life.[779]

While CSC, like standard clinical protocols for diseases such as cancer or heart disease, has proven positive outcomes, its implementation faces challenges. Despite CSC being and evidenced-based model of care, some services, particularly those crucial to the CSC model like intensive case management and navigation, are only covered by Medicaid. This creates barriers for families with commercial insurance or the ability to pay out of pocket, hindering their access to comprehensive care.

Dialectical Behavior Therapy

Dialectical Behavior Therapy (DBT) is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and

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[777] Wang, P. S., Berglund, P. A., Olfson, M., & Kessler, R. C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health services research*, *39*(2), 393–415. https://doi.org/10.1111/j.1475-6773.2004.00234.x

[778] Kane, J. M. et al. (2016). Comprehensive Versus Usual Community Care for First-Episode Psychosis: 2-Year Outcomes From the NIMH RAISE Early Treatment Program. *American Journal of Psychiatry*, *173*(4), 362–372. https://doi.org/10.1176/appi.ajp.2015.15050632

[779] Rosenheck, R., Leslie, D., Sint, K., Lin, H., Robinson, D. G., Schooler, N. R., Mueser, K. T., Penn, D. L., Addington, J., Brunette, M. F., Correll, C. U., Estroff, S. E., Marcy, P., Robinson, J., Severe, J., Rupp, A., Schoenbaum, M., & Kane, J. M. (2016). Cost-Effectiveness of Comprehensive, Integrated Care for First Episode Psychosis in the NIMH RAISE Early Treatment Program. *Schizophrenia Bulletin*, *42*(4), 896–906. https://doi.org/10.1093/schbul/sbv224

behaviors. DBT is well supported for adults and adolescents (DBT-A)[780,781,782] and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to coach their adolescents in developing skills and improve their own skills for interacting with their adolescent. Therapy sessions usually occur twice a week. DBT strategies include both acceptance-oriented (validation) and more change-oriented (problem-solving) approaches. DBT proposes that comprehensive treatment needs to help children and youth develop new skills, address motivational obstacles to implementing these skills, and generalize what they learn to their daily lives. It also needs to keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed through four different modes that support treatment delivery: group skills training, individual psychotherapy, telephone coaching between sessions, and a therapist consultation team meeting. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

Specific adaptations of the original DBT model have been developed for eating disorders. To implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

[780] Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal youth receiving DBT. Cognitive & Behavioral Practice, 7, 183–187.
[781] Rathus, J. H. & Miller, A. L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. Suicide and Life-Threatening Behavior, 32, 146-157.
[782] Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. Child and Adolescent Mental Health, 7(3), 121–127.

Appendix L: Local Mental Health Authorities' Levels of Care

Based on the Texas Resilience and Recovery (TRR) Utilization Management Guidelines for Mental Health Services below is a table summarizing the Levels of Care (LOC), their descriptions, and the services provided at each level. These levels of care are designed to provide a continuum of services that match the person's needs, promoting recovery and stability. Each level includes specific services aimed at addressing the person's functional impairments and supporting their journey toward recovery.

Table L1: Local Menal Health Authority Levels of Care

LMHA Levels of Care		
Level of Care (LOC)	**Description**	**Services**
LOC-0: Crisis Services	Immediate, short-term services for people in acute mental health crises.	24/7 crisis intervention
		Immediate stabilization
		Referral to appropriate follow-up care
LOC-1M: Medication Management	Basic services focusing on medication management for people with minimal functional impairments.	Psychiatric evaluation
		Medication prescription and monitoring
		Medication education
LOC-1S: Skills Training	Services aimed at developing basic skills for people with minimal functional impairments.	Life skills training
		Social skills development
		Support for daily living activities
LOC-2: Basic Services	Services for people with mild to moderate functional impairments.	Medication management
		Skills training
		Supportive counseling
LOC-3: Moderate Services	Services for people with moderate to severe functional impairments.	Intensive medication management
		Intensive skills training
		Individual and group therapy
LOC-4: Intensive Services	Comprehensive services for people with severe functional impairments.	Comprehensive psychiatric care
		Intensive therapy (individual and group)-
		Case management
		Rehabilitation services

LMHA Levels of Care		
LOC-5: Transitional Services	Short-term services to assist people in maintaining stability and transitioning to appropriate care.	Transitional housing support
		Community integration services
		Short-term therapy and case management
LOC-EO: Early Onset Services	Specialized services for children and adolescents with early onset mental health conditions.	Developmentally appropriate therapy
		Family and school-based interventions
		Medication management for youth
		Support for family members
LOC TAY: Transition-Age Youth Services	Services tailored to young adults (ages 16-25) as they transition to adulthood and independence.	Transitional support
		Independent living skills training
		Vocational and educational support
		Mental health therapy
		Medication management

Appendix M: Clinic and Home-Based Interventions

Table M1: Intervention Descriptions

Clinic and Home-Based Interventions	
Intervention	**Description**
Mood Disorders	
Cogitative Behavioral Therapy (CBT)	CBT is a structured, time-limited, and evidence-based form of psychotherapy that focuses on the relationship between thoughts, feelings, and behaviors. CBT includes psychoeducation, identification of physical signs of anxiety, cognitive restructuring, and coping skills. In younger children, protocols rely more on parent training and behavioral strategies due to limited cognitive development.
Dialectical Behavioral Therapy (DBT)	DBT is an evidence-based form of cognitive behavioral therapy for people who experience trouble managing their emotions, thoughts, and behaviors. DBT is well supported for adults and adolescents (DBT-A),[783, 784, 785] and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to coach their adolescents in developing skills and improve their own skills for interacting with their adolescent.
Parenting Interventions	
Positive Parenting Program (Triple P)	An evidence-based parenting intervention designed to prevent and address emotional, behavioral, and developmental problems in children. Triple P offers five levels of support, ranging from general advice and print materials to intensive, multi-session programs for families experiencing significant challenges. It draws on social learning, cognitive-behavioral, and developmental theories, aiming to enhance parenting skills, increase confidence, and reduce child behavior problems.[786]

[783] Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal adolescents receiving dialectical behavior therapy. *Cognitive and Behavioral Practice*, *7*(2), 183–187. https://doi.org/10.1016/S1077-7229(00)80029-2

[784] Rathus, J. H., & Miller, A. L. (2002). Dialectical behavior therapy adapted for suicidal adolescents. *Suicide & Life-Threatening Behavior*, *32*(2), 146–157. https://doi.org/10.1521/suli.32.2.146.24399

[785] Eric W. Turpin & David Gage Stewart. (2002). Effectiveness of a Dialectical Behaviour Therapy Program for Incarcerated Female Juvenile Offenders. *Child and Adolescent Mental Health*, *7*(3), 121–127. https://doi.org/10.1111/1475-3588.00022

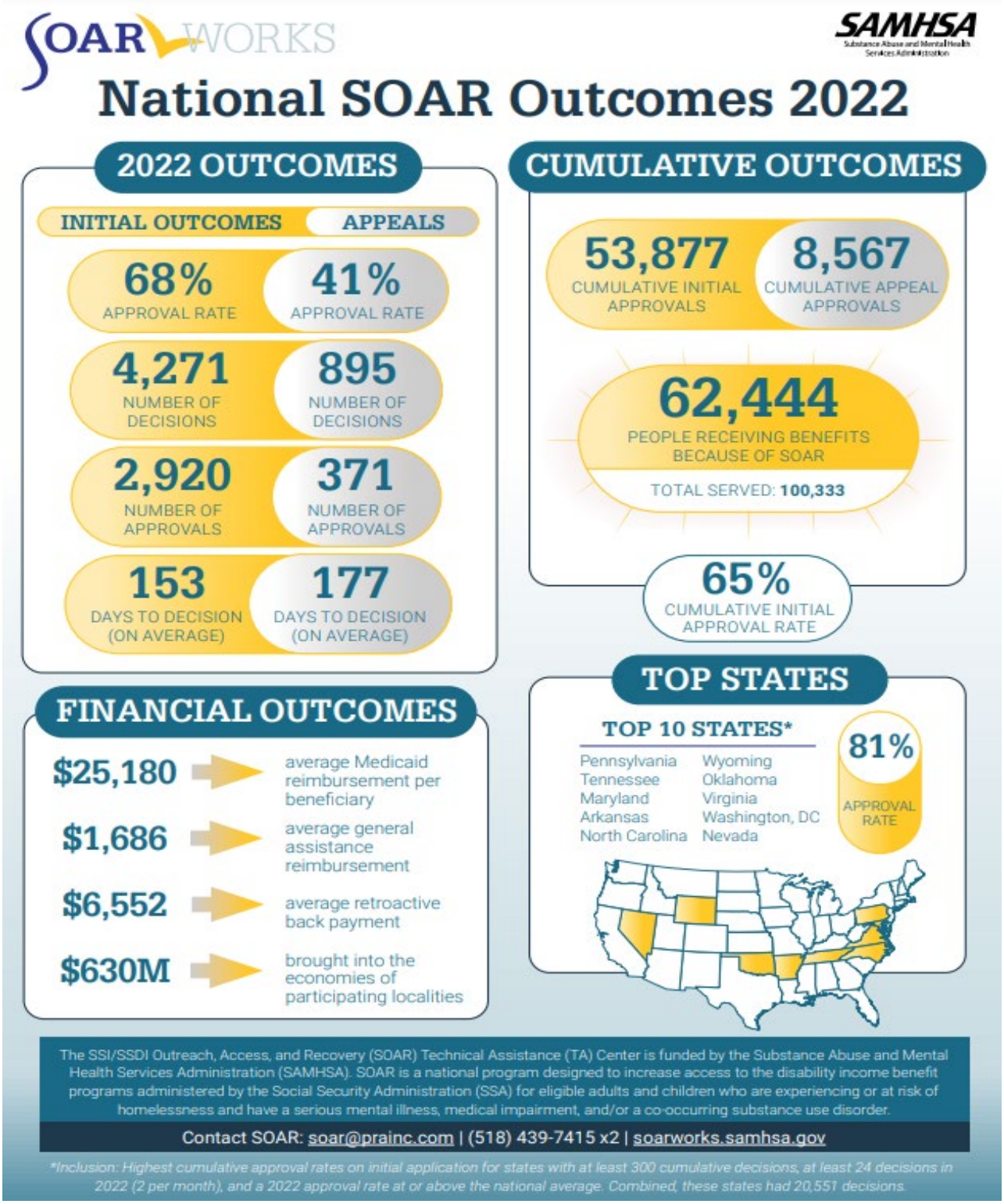
[786] Sanders, M. R., Markie-Dadds, C., Tully, L. A., & Bor, W. (2000). The triple P-positive parenting program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology*, *68*(4), 624–640.

Clinic and Home-Based Interventions	
Parent-Child Interaction Therapy (PCIT)	An evidence-based intervention for children ages 3 to 6 with oppositional or disruptive behavior disorders. PCIT strengthens the parent-child relationship by coaching parents in real time on effective behavior management strategies. Through structured play and targeted communication techniques, parents learn to provide consistent discipline, reinforce positive behaviors, and respond appropriately to challenging ones. A therapist guides parents through education, skill-building, and live coaching sessions with their child to promote lasting change.[787]
Parent Management Training (PMTO)	An evidence-based intervention that aims to promote social skills and prevent or reduce moderate-to-severe conduct problems in children and youth. PMTO focuses on strengthening parenting practices through structured training and may also include classroom behavior management and peer-related interventions to support consistent behavior change across settings.
Suicide Prevention and Crisis Intervention	
Collaborative Assessment and Management of Suicidality (CAMS)	An evidence-based, suicide-specific therapeutic framework designed to assess and reduce suicidal risk. CAMS emphasizes a collaborative, client-centered approach where the person and clinician work together to understand the drivers of suicidality and develop a treatment plan targeting those issues. It is adaptable across care settings and can be used alongside other therapeutic approaches.
Trauma Focused Interventions	
Trauma-Focused Cognitive Behavioral Therapy (Ages 3–18)	An evidence-based treatment for children and youth ages three to 18 and their caregivers, TF-CBT addresses symptoms related to trauma, including anxiety, depression, and low self-esteem. It is typically delivered in outpatient settings through individual, family, or group sessions. TF-CBT helps families process and recover from traumatic experiences such as abuse, traumatic loss, domestic violence, community violence, natural disasters, or war-related trauma.
Child-Parent Psychotherapy (Ages 0–5)	An evidence-based intervention for children ages zero to five who have experienced trauma or are facing mental health, attachment, or behavioral challenges. Rooted in attachment theory and integrating multiple psychological frameworks, CPP involves joint therapeutic sessions with the child and caregiver. The primary goal is to strengthen the caregiver-child relationship to support the child's emotional and developmental recovery. Treatment addresses maladaptive beliefs, relational patterns, and external stressors, including cultural, socioeconomic, and immigration-related

[787] Chaffin, M., Silovsky, J. F., Funderburk, B., Valle, L. A., Brestan, E. V., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. L. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, *72*(3), 500–510. https://doi.org/10.1037/0022-006X.72.3.500

Clinic and Home-Based Interventions	
	factors. For trauma-exposed children, CPP includes developing a shared narrative to process the traumatic experience and manage triggers
Family Based Interventions	
Family Therapy	A type of counseling that helps family members improve communication, resolve conflicts, and strengthen their relationships. It views the family as a system where each member's behavior affects the whole group, and it works to address issues by understanding and changing patterns within the family dynamic. Family therapy often involves multiple family members in sessions and aims to promote healthier interactions and support among them.
Functional Family Therapy	A short-term family therapy intervention and juvenile diversion program. It serves children and youth aged 11 to 18 who are at risk of substance abuse, along with their families. FFT addresses a broad range of behavioral problems, including violence, drug use and abuse, conduct disorder, and family conflict.

Appendix N: National SOAR Outcomes (2022)[788]



[788] Substance Abuse and Mental Health Service Administration. (n.d.). *2022 National SOAR Outcomes | SOAR Works!* Retrieved May 5, 2025, from https://soarworks.samhsa.gov/article/2022-national-soar-outcomes

Appendix O: Crisis Care Best Practice: Youth Crisis Outreach Teams

Youth Crisis Outreach Teams (YCOT) is a home and community-based crisis intervention model that works across family systems to provide rapid crisis response and stabilization services in settings, such as schools, with the goal of helping people stabilize and connect with ongoing services to prevent reoccurrence.

The YCOT model aims to prevent emergency room use and the disruptive, out-of-home placement and care for children and youth, it also aims to treat emerging concerns rapidly before a situation escalates further or becomes unsafe. Creating a response model that is based on what the child, youth, or family consider urgent must be the basis of any YCOT model. Extending this family-centered approach to include peers and siblings empowers YCOTs to help anyone in the family who needs connections to appropriate supports and ongoing services. This strategy strengthens the whole family unit and helps to equip the family with the skills they need to avoid future crises. The approach requires creative problem solving, caregiver skill building, and strong referral pathways to community services.

Relationships with child-serving community partners are also critical to the model's success. YCOTs must invest heavily in building relationships with schools, which are often where children and youth experience crises. Moreover, how schools handle these crises has a substantial influence on outcomes. In Connecticut, almost half (45% in 2023) of child and youth mobile team deployments are in schools.[789] This is critical because schools are often hesitant to trust outside parties in crisis situations, and thus choose to respond on their own or bring students to the hospital where they often wait for hours to be seen and are sent home with little in the way of services. For schools to feel comfortable using YCOTs, they must provide rapid response by being able to anticipate what to expect when a team is deployed and receive follow-up support from the team after a crisis event. Building school relationships is time consuming and requires deliberate effort but will greatly increase the success of the model.

Crisis mobile teams are considered by SAMHSA, among other experts, an essential component of the crisis continuum of mental health care. These teams provide rapid crisis response and stabilization services at home or in community settings, with the goal of helping a person stabilize and connect with ongoing services to prevent reoccurrence. Mobile crisis teams are interdisciplinary in nature, making them uniquely equipped to deal not only with clinical presentations, but external factors as well. Mobile outreach services for all ages include crisis de-escalation and stabilization, screening and assessment, safety planning, and care management focused on connections to long-term mental health services.

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[789] Seng, K., Theriault, K., Casiano, Y., Randall, K., Clinger, H., Camerota, S., & Vanderploeg, J. (n.d.). *This report was prepared by the Mobile Crisis Performance Improvement Center (PIC):*. https://www.mobilecrisisempsct.org/wp-content/uploads/2019/09/Mobile-Crisis-PIC-July-2019-Report.pdf

Efficacy of Youth Crisis Outreach Teams

While difficult to track, the holistic, whole-family approach used by YCOTs helps strengthen families, which benefits all children and youth in a home. The use of YCOTs is increasing nationally, with important lessons learned from other states[790] and localities based on their experiences that are worth mentioning:

- YCOT response should be face-to-face in most instances. For example, Connecticut has a face-to-face response rate of 85%.[791] Teams often respond to a crisis reported for one reason, but when they meet the family, they realize there are other, often more significant, concerns than what led to the initial call.
- Successful teams provide acute phase stabilization as well as ongoing stabilization; remaining connected to families for at least eight weeks and making warm connections for ongoing, community-based services; helping families more effectively tap into positive relationships and support systems.
-

Table O1: Youth Crisis Outreach Team Benefits

YCOT Benefits At-A-Glance
Hospital diversion[792]
Decreased juvenile justice involvement[793]
Decreased entry to foster care and disruptions to placement[794]
Decreased truancy and missed school[795]

Recommended Commitments and Best Practices for YCOTs:

- Design YCOT programming and protocols around the needs of children, youth, and families - not as an extension of existing crisis response strategies. One way to do this is to hire or reassign dedicated YCOT staff knowledgeable and experienced in working with children, families, and child-serving systems like schools, child welfare, and juvenile justice.
- Meet urgency with urgency. Train crisis hotline staff on how YCOT is distinct from other crisis services. In YCOT, the caller's judgment determines the need rather than a standard screening or assessment process.

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[790] Examples include Connecticut, Nevada, New Jersey, Ohio, Oklahoma, and Washington.
[791] Response rate was obtained from our conversations with administrators who oversee the Connecticut program.
[792] Jeffrey J. Vanderploeg, Kellie G. Randall, Sarah Becker, & Kayla Theriault. (2023). *Mobile Response for Children, Youth, and Families: Best Practice Data Elements and Quality Improvement Approaches: The Child Health and Development Institute of Connecticut*. https://www.chdi.org/index.php/publications/resources/mobile-response-children-youth-and-families-best-practice-data-elements-and-quality-improvement-approaches
[793] *WISe Quality Management Plan, CANS 5+ Quarterly Report for Quarter 1, 2023 King*. (2023, May 18). https://fortress.wa.gov/hca/wisebhasreports/KingCounty.html *WISe Quality Management Plan, CANS 5+ Quarterly Report for Quarter 1, 2023 King*, (2023, May 18)
[794] *WISe Quality Management Plan, CANS 5+ Quarterly Report for Quarter 1, 2023 King*, (2023, May 18) Jeffrey J. Vanderploeg et al., (2023), *Mobile Response for Children, Youth, and Families: Best Practice Data Elements and Quality Improvement Approaches: The Child Health and Development Institute of Connecticut*

- Heavily lean upon Certified Family Partners (CFPs) who are dedicated to YCOT and can play a critical role in ensuring parents and caregivers have the knowledge and support they need to better respond to their child's future needs.
- Consider ways YCOT can help curb future out-of-home placements. Related strategies may involve introducing certain families to YCOT in non-crisis situations. For example, reaching out to families recommended by DFPS or working with local hospitals to facilitate an introduction following an emergency room visit for a mental health need so the family is knowledgeable enough to use YCOT if they need it in the future.
- Take advantage of the seasonal nature of youth crisis needs by anticipating and planning for lower volume times (summer and the early part of school semesters) and conducting outreach to community partners during these periods. These community relationships are key to maximizing YCOT referrals and require targeted outreach.
- Develop clear protocols and trainings to ensure the YCOT team is prepared and well-equipped to modify their support strategies for youth with developmental disabilities; collect the data needed to monitor, and track outcomes overtime; and systematically obtain family input on which aspects of YCOT are most and least helpful.
- Dedicate a partial or full YCOT position to community outreach, working with a broad range of community partners, including mental health, to ensure that youth and families receive warm connections to appropriate ongoing services prior to the end of YCOT.

Appendix P: Behavioral Health Solutions of South Texas

Table P1: Recovery Support Service Descriptions

Recovery Support Services	
Recovery United	The recovery support service program provides peer support to adults wanting to initiate or maintain their recovery from substance use. Service providers consist of recovery coaches and people with lived experience. Available services include individual, group meetings, and wellness activities.
Awareness and Drug Risk Education Services (P.A.D.R.E.S)	The P.A.D.R.E.S program offers community-based intervention services, brief case management, and evidence-based education to both mothers and fathers. The program seeks to reduce the impact of substance use within families and improve access to community resources. Services are available both in-person and virtually, depending on the location.
Naloxone Distribution HUB	The program provides free naloxone, a life-saving medication that can reverse opioid overdoses, to community members. Through a comprehensive, one-hour training session, participants learn how to recognize the signs of an overdose, administer naloxone safely, and take essential steps to support those in need during an emergency.
Fueling Hope & Empowering Hope	The outpatient treatment program is designed to improve access to treatment for adults (18+) in Cameron and Hidalgo Counties. The program offers a comprehensive 12-week schedule, including 6 individual and 24 group sessions, utilizing a Cognitive Behavioral Therapy curriculum with Motivational Interviewing techniques.
Rural Border Intervention Program (R.B.I.) Empowering Communities	The R.B.I. program offers prevention and intervention services to youth, adults, and families in rural border areas at risk for substance use and mental health disorders. The program provides awareness, education, and access to community resources to support the needs of people in the community.
Caring for Mommies - Pregnant, Parenting Intervention Program (PPI)	The program provides support for mothers with current or past substance use, as well as other risk factors such as domestic violence, mental health issues, teen pregnancy, CPS involvement, and financial distress.
Monarch	This outpatient treatment service is for youth (13-17). Services are available to youth with substance use disorder. The program consists of a 12-week outpatient schedule of 6 individual and 24 group sessions.

Appendix Q: Juvenile Justice Department Program Registry

The following is a list of programs and services listed in the Texas Juvenile Justice Department's program registry for each department in the region. The registry lists the type of programs and services offered and includes a description of the components of each program or service, expected lengths of stay, and average number of youth served per year.

Table Q1: Cameron County Juvenile Department Program Registry

Cameron County Juvenile Department – Program Registry				
Program	**Provider Type**	**Curriculum**	**Expected Length of Stay (LOS)**	**Average # Youth Served per Year**
Border Children Justice Project	In-house (I)	Other	365	31
Building Trades Project/Cadets for Vets Vocational Program	I	Other	180	55
General Equivalency Diploma (GED) Program	Other (O)	Provider developed	180	25
Juvenile Justice Alternative Education Program	C	Other	180	90
Mental Health Services	C	Provider developed	24	350
Parenting Classes & Family Engagement Services	O	Provider developed	285	300
Prevention & Intervention Mentor Program	I	Purchased Curriculum - Copyrighted	365	35
Project Phoenix Vocational Program	O	Provider developed	60	110
Qualified Mental Health Provider Mental Health Program	C	Provider developed	180	40
Re-entry Aftercare Management Program	I	Department developed	120	36
School Collaborative Program	I	Other	720	320
Sex Offender Treatment	C	Provider developed	730	30
Special Needs Diversionary Program – Mental Health	LMHA (M)	Provider developed	180	60
Substance Abuse Counseling	C	Provider developed	180	270
Victim of Sexual Abuse Counseling	C	Other	10	200

Table Q2: Hidalgo County Juvenile Department Program Registry

Hidalgo County Juvenile Department – Program Registry				
Program	**Provider Type**	**Curriculum**	**Expected LOS**	**Average # Youth Served per Year**
After-care Transitional Program	I	Department developed	180	24
Bluebonnet Counseling Services	C	Provider developed	180	60
Community Service Restitution Program	I	Department developed	90	500
Family Empowerment Program for Parent	I	Purchased Curriculum - Copyrighted	98	250
Family Empowerment Program for Siblings	I	Purchased Curriculum - Copyrighted	98	250
Hidalgo County Juvenile Drug Court Program	P	Provider developed	365	30
Hidalgo County Lifelines Girls Juvenile Mental Health Court Program	P	Provider developed	365	30
Internal Anger Management Skills Group	I	Other	60	80
Internal Mental Health Unit	I	Department developed	120	180
Internal Substance Abuse Treatment Program	I	Purchased Curriculum - Copyrighted	126	180
Internal Substance Use Intervention Program	I	Purchased Curriculum - Copyrighted	120	75
Juvenile Court Conference Committee Volunteer Program	I	Provider developed	90	900
Redirect Empower Divert 180 Life Skills Program	I	Department developed	180	100
Sex Offender - Post Adjudication Facility	C	Provider developed	180	10
Sex Offender Program	C	Provider developed	180	40
Sex Offender Program	P	Provider developed	360	40
Special Needs Diversionary Program	M	Other	180	15
Tropical Texas Behavioral Health Mental Health Program	O	Provider developed	90	60

Table Q3: Starr County Juvenile Department Program Registry

Starr County Juvenile Department – Program Registry				
Program	**Provider Type**	**Curriculum**	**Expected LOS**	**Average # Youth Served per Year**
M & M Counseling Services	O	Other	90	5
South Texas Council On Alcohol And Drug Abuse Counseling Services	O	Provider developed	90	30
Stars At Risk Program	O	Provider developed	60	10

Table Q4: Willacy County Juvenile Department Program Registry

Willacy County Juvenile Department – Program Registry				
Program	**Provider Type**	**Curriculum**	**Expected LOS**	**Average # Youth Served per Year**
Cognitive Behavioral Treatment	C	Other	60	38
Community Service Program	I	Department developed	365	30
Family Preservation Program	C	Department developed	120	7
Sex Offender Counseling	C	Provider developed	730	2
Why Try Program - Cognitive Behavioral Therapy/Treatment	I	Purchased Curriculum - Copyrighted	120	80

Appendix R: School Partnerships

Community Partners Supporting the Region's School Districts
The following list includes existing community partnerships mentioned in stakeholder interviews.

Table R1: Agencies, Services, and Areas Served

Agency	Services	Area Served
Behavior Health Solutions	Mental health and substance use services	All counties in the region with outpatient services available in Harlingen, Pharr, and Weslaco
Bluebonnet Counseling and Assessment Center	Professional counseling and behavioral health support in a private practice setting	Edinburg
Border Region Behavioral Health Center	Mental health and substance use treatment	Webb, Jim Hogg, Starr, and Zapata counties, located in Laredo
Buckner Family and Youth Success Program	Child, adolescent, and family support services	Cameron, Brooks, Hidalgo, Willacy
Cameron County Probation Office	Juvenile justice and intervention programs	Cameron County
Child Bereavement Center	Grief and bereavement counseling for children and families	Cameron, Hidalgo, Starr, Willacy counties, located in Harlingen and McAllen
Counseling Center of South TX	Mental health counseling services in a private practice setting	Edinburg
Doctor's Hospital at Renaissance (DHR) Health Behavioral Hospital	Medical and behavioral health services	All counties in the region, located in Edinburg
Department of Public Safety	Community and school safety outreach programs	All counties in the region
Homeland Security	Safety and crisis intervention in partnership with the Texas School Safety Center	All counties in the region
HOPE Family Clinic	Health and mental health services for families	Cameron, Hidalgo, Starr, Willacy counties, located in McAllen
District Attorney's Office	Juvenile first offender programs	Cameron, Hidalgo, Starr, Willacy

Agency	Services	Area Served
Loaves and Fishes	Basic needs assistance, including food and shelter	Cameron, Willacy with locations in Harlingen and Raymondville
Mesquite Treatment Center	Youth residential substance use treatment and rehabilitation services	Serves all counties, located in Harlingen
Mission Police Department	Law enforcement support and crisis intervention (mental health units)	Mission
Palms Behavior Center	Inpatient and outpatient behavioral health treatment	All counties in the region, located in Harlingen
South Texas Health System Behavioral	Behavioral and mental health services	Cameron, Hidalgo, Starr, Willacy, located in Edinburg,
Su Clinica	Community health and wellness services	Cameron, Willacy with locations in Brownsville, Harlingen, Raymondville, and Santa Rosa
Tropical Texas	Healthcare and behavioral health services	Hidalgo, Cameron, Willacy, with locations in Brownsville, Harlingen, Weslaco, Edinburg
UTRGV	University-based mental health programs and research initiatives	Cameron, Hidalgo, Willacy

Appendix S: Regional TCHATT Programs

Please note that TCHATT[796] does not use county information when tabulating data. Instead, it uses Regional ESC, District, and HRI identification. For the tables below, the Meadows Institute divided the districts into the county they primarily serve. Charter schools are represented in their own table, as they can span multiple counties.

Table S1: TCHATT Programs in Cameron County

Cameron County			
School District	**# of Campuses**	**Student Population**	**TCHATT Status**
Brownsville ISD	52	36,140	Active
Harlingen CISD	31	16,462	Active
La Feria ISD	6	2,124	Planned
Los Fresnos CISD	14	10,357	Active
Point Isabel ISD	5	1,391	Active
Rio Hondo ISD	4	1,002	Active
San Benito CISD	22	9,033	Active, 1 Pending
Santa Maria ISD	6	512	Active
Santa Rosa ISD	4	874	Active
South Texas ISD	9	4,639	Active
Total	**153**	**82,534**	

Table S2: TCHATT Programs in Hidalgo County

Hidalgo County			
School District	**# of Campuses**	**Student Population**	**TCHATT Status**
Donna ISD	19	12,230	Active
Edcouch-Elsa ISD	10	3,765	Active
Hidalgo ISD	7	2,918	Active
La Joya ISD	37	22,942	Active
La Villa ISD	3	512	Active
McAllen ISD	31	19,842	Active
Mercedes ISD	12	4,106	Active
Mission CISD	23	13,765	Active
Monte Alto ISD	4	819	3 Active, 1 Onboarding
Pharr-San Juan-Alamo ISD	45	29,613	Declined
Progreso ISD	6	1,339	Active
Sharyland ISD	14	9,844	Active
Valley View ISD	7	3,444	Active
Weslaco ISD	21	16,250	20 Active, 1 Planned
Total	**239**	**141,389**	

Table S3: TCHATT Programs in Starr County

Starr County

[796] *Texas Child Health Access Through Telemedicine (TCHATT) – TCMHCC,* (n.d.)

School District	# of Campuses	Student Population	TCHATT Status
Rio Grande City Grulla ISD	16	9,316	Planned
Roma ISD	10	6,019	Active
San Isidro ISD	2	153	Planned
Total	**28**	**15,488**	

Table S4: TCHATT Programs in Willacy County

Willacy County			
School District	**# of Campuses**	**Student Population**	**TCHATT Status**
Lasara ISD	2	343	Active (1 campus declined)
Lyford CISD	3	1,396	Active
Raymondville ISD	6	1,963	Active
San Perlita ISD	3	187	Planned
Total	**14**	**3,889**	

Table S5: TCHATT Programs in Regional Charter Campuses

Charter Campuses*			
School District	**# of Campuses**	**Student Population**	**TCHATT Status**
Brillante Academy	1	354	Planned
Excellence In Leadership Academy (Hidalgo County)	1	183	Active
Harmony Schools	5	3,015	Active
Horizon Montessori Public Schools (Hidalgo County)	3	948	Planned
IDEA Public Schools*	51*	35,099*	Active
Jubilee Academies	5	2,586	Active
Premier High School of Brownsville (Cameron County)	6	628	Active, 1 Planned
Raul Yzaguirre School for Success (BRYSS Academy) (Cameron County)	2	582	Active
Triumph Public High Schools – Rio Grande Valley	6	457	Active
UTRGV Mathematics and Science Academy (Brownsville or Edinburg TX)**	2	Unknown	Unknown
Vanguard Academy	6	6,814	Active
Total	**88**	**50,666**	

*Where possible, an attempt was made to count the charter campuses only within the region. However, district address and Regional ESC are often the addresses of the main offices, and a district can have multiple campuses. Public charters sometimes span multiple counties, so their overall student enrollment is reflected in their TEA-assigned county to prevent duplication.

**The status of the two UTRGV schools was unknown at the time this table was created.

Appendix T: Supplemental Information on Regional Veterans

County and Community Veteran Organizations

Cameron, Hidalgo, Starr, and Willacy counties employ a Veteran County Service Officer to assist veterans, their dependents, and survivors in filing federal and state benefits. Hidalgo and Cameron counties also provide a Veterans Court for veterans involved in the justice system.

Veteran County Service Officers

Veteran County Service Officers (VCSO) are county-funded officials responsible for assisting veterans, their dependents, and survivors with navigating and obtaining benefits from the Department of Veterans Affairs and the State of Texas. They are trained and certified to provide services through the Texas Veterans Commission (TVC) and, depending on the population size of the county, may have additional staff or funding to provide additional services.

In general, a VCSO will help veterans, their dependents, and survivors:

- File claims for disability compensation, aid and attendance, dependency and indemnity compensation, and pensions.
- Obtain military records, discharge documents, and medals.
- File appeals for VA compensation and benefits.
- Request to upgrade military discharges.
- Complete burial benefit claims.
- Provide additional information on state benefits and federal benefits.

VCSOs are in a unique position that grants them access to protected state funding through TVC (Veteran County Service Officer Grants). Counties may also apply for TVC grant funds to expand services. In Hidalgo County, for example, the VCSO office was awarded a second TVC grant to support the Patriot Support Center, which provides veterans with access to group and peer support counseling. Altogether, Cameron, Hidalgo, and Willacy counties received $750,000 in TVC grants this year for veteran financial assistance and peer support services (Starr did not receive a TVC grant).

Veteran Treatment Courts

Veteran Treatment Courts (VTC) provide the region with an opportunity to reduce recidivism among justice-involved veterans by providing resources such as support services (employment, education, health), and mental health and substance use treatment rather than traditional incarceration. VTCs are voluntary and can serve justice involved veteran for misdemeanor or felony offenses, depending on presiding judge and district attorney's approval.

As such, veterans must first apply to the VTC, and the courts must consent to the veteran's participation. Both the court and the veteran have the option to drop out of the VTC and proceed through the criminal justice system at any time.

Eligibility for VTCs[797] include the person:

- Is a veteran or current member of the armed forces.
- Has suffered a brain injury or mental illness (including PTSD military sexual trauma); and
  - That occurred or resulted from military service, and
  - Affected the veterans criminal conduct.
- Is appropriate for the VTC and, considering circumstances of conduct, personal and social background, and criminal history, can be effectively rehabilitated.

Rio Grande Valley's two VTCs are in Cameron and Hidalgo:

- The Honorable David A. Sanchez presides over the 444th District Court – Veterans Treatment Count Program and serves justice-involved veterans in **Cameron and Willacy** counties. The Cameron County VTC is a misdemeanor only court and, in 2024, received a $105,600 grant from the Office of the Governor, Criminal Justice Division, to support court activities.
- In **Hidalgo County**, the Honorable Israel Ramon Jr. recently retired, and the Honorable Orlando Esquivel now presides over the Hidalgo County Treatment court. The Hidalgo VTC is also a misdemeanor only court and serves justice-involved veterans in Hidalgo County. In 2024, the Hidalgo County VTC received a $98,313.56 grant from the Office of the Governor, Criminal Justice Division, to support court activities.

Both Cameron and Hidalgo VTCs have LPCs assigned to provide mental health services to veteran participants and, if needed, the VTC's may utilize mental health providers from the Tropical Texas Veterans Center. As part of the VTC programming, veterans must also submit to drug testing and, if they test positive, may be removed from the VTC or referred to substance use facilities for up to six months before continuing.

Cameron and Hidalgo VTCs have a rolling enrollment, so the number of veterans involved at any given point in time may change. The table below provides details on the VTCs efforts in 2024.

Table T1: Veteran Treatment Court Statistics 2024

Veteran Treatment Court Statistics				
County	**Name of Court**	**Veterans Served**	**Number of Veterans Successfully Completed**	**Number of Veterans Unsuccessfully Completed**
Cameron	Cameron County Veterans Treatment Court	22	7	4

[797] Texas Legislature. (n.d.). *Texas Government Code Section 124*. Retrieved from https://statutes.capitol.texas.gov/Docs/GV/htm/GV.124.htm#124

Veteran Treatment Court Statistics				
County	**Name of Court**	**Veterans Served**	**Number of Veterans Successfully Completed**	**Number of Veterans Unsuccessfully Completed**
Hidalgo	Hidalgo County Veterans Treatment Court	9	11	3

Community Veteran Service Organizations and Coalitions

The region also supports many other veteran service organizations. Staple organizations like the Veterans of Foreign Wars (10 posts),[798] the American Legion (13 posts)[799] and the Disabled Veterans of America have multiple locations throughout the area, while additional community programs, like those funded by TVC FVA, provide niche and wraparound services.

There are also multiple veteran coalitions across the region, with Cameron and Hidalgo counties being the central focus area. From longstanding Cameron County Veterans Coalition started in 2011 and hosted by United Way of Southern Cameron County to the newest coalitions hosted by CVSOs, there are a lot of well-intentioned community members dedicated to and actively working on improving the lives of the region's veterans and their families.

However, stakeholders shared concerns about the unwillingness of these organizations to work together or even refer to each other's services when one coalition does not have what they need, ultimately to the detriment of the veterans and families they are trying to serve. At the time of this assessment, there is no unified veteran's collaborative in the region and no person or organization has been identified as the region's "veteran champion" – a member of the community who is ubiquitously trusted and can help the veteran serving community align with a direction and purpose.

[798] Veterans of Foreign Wars, (n.d.), *Find a Post* Veterans of Foreign Wars, (n.d.), *Find a Post* Veterans of Foreign Wars, (n.d.), *Find a Post* Veterans of Foreign Wars, (n.d.), *Find a Post*

[799] American Legion Post Locator. Veterans of Foreign Wars, (n.d.), *Find a Post*

Appendix U: The El Paso Behavioral Health Consortium

The El Paso Behavioral Health Consortium (Consortium) offers a structure that has been successful in spearheading change through the coordinated efforts of a diverse group of engaged community leaders, members, and service providers. The Consortium was established in 2012 to examine the El Paso community behavioral health system in preparation for future service needs and funding trends.[800] The Consortium envisions an accessible, person-centered behavioral health system of care in the El Paso region. The Consortium includes three leadership councils, described below, that meet regularly and are dedicated to a specific population, policy, and program goals – the Justice Leadership Council, the Family Leadership Council, and the Integration Leadership Council. Each council has diverse membership representing a spectrum of providers, law enforcement entities, schools, local elected officials, nonprofits, and many more, and each has established goals, objectives, and strategic plans. Additionally, these councils have created workgroups to address specific topics.

Consortium Leadership Councils:

- Family Leadership Council: The Family Leadership Council works with child, adolescent and family health organizations, other child-serving agencies and natural support systems to transform El Paso County into a model community for child and family behavioral health services and support.
- Judicial Leadership Council: The Justice Leadership Council works with Justice System leaders and stakeholders as they transform the current system to support person-centered, recovery-oriented care and treat as many people as possible in health care settings instead of within the criminal justice system.
- Integration Leadership Council: The Integration Leadership Council works with healthcare providers to increase access to recovery-oriented behavioral healthcare by increasing the number of available providers and by integrating behavioral health and recovery supports into primary care settings.

[800] Paso del Norte Health Foundation. (n.d.*). Health priorities, initiatives & programs: El Paso Behavioral Health Consortium*. https://pdnhf.org/what_we_do/initiatives/el-paso-behavioral-health-consortium

Appendix V: Data Sharing Legal Environment

We briefly cover a few important and high-level points about HIPAA and 42 CFR Part 2 as well as a few recent federal regulatory changes because of the COVID-19 pandemic. We encourage the region's stakeholders to review federal law and Texas state restrictions in more detail, depending on the goals of the data sharing collaborative.

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- On issues of legality, see: Legal Issues for IDS Use: Finding a Way Forward (2017).[801]

HIPAA

The following information is from the *Legal Issues for IDS Use: Finding a Way Forward* (2017).

- HIPAA establishes a minimum standard for protecting protected health information. If a state law provides more protection, then the state law applies. This will often be the case when mental health records are involved.
- HIPAA only applies to "covered entities," defined as a "health plan" (e.g., insurance companies, Medicaid agencies, Medicare); "health providers," such as hospitals and licensed health professionals; and "health care clearinghouses," which are entities that standardize health information for functions such as billing. HIPAA does not apply to courts and other entities that may produce or hold health-related information.
- A question always worth considering is whether it is essential to use information that identifies the person for the functions of the integrated data system (IDS), or whether de-identified information will suffice (or be the only type of information that is politically possible to use in an IDS). HIPAA provides specific information on the "de-identification" of protected health information. In addition, HIPAA provides for creation of a "limited data set" (similar but not identical to a "de-identified data set") as an alternative to the use of protected health information.

42 CFR Part 2

This following information is from the *Legal Issues for IDS Use: Finding a Way Forward* (2017).

- Despite the stringent nature of the regulations, they do provide for the use of covered information for research without the person's consent if the director of the federally assisted program finds certain conditions are met.
- As with FERPA, there is crossover with HIPAA in some circumstances (42 CFR).[802]
- Many state laws on SUDs track (or in some cases may exceed) protections in 42 CFR. In thinking about an IDS, it will be important to look at state law as well as the federal regulations.

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[801] Petrila, J., Cohn, B., Pritchett, W., Stiles, P., Stodden, V., Vagle, J., & Humowiecki, M. (n.d.). *Legal issues for IDS use: Finding a way forward*. Actionable Intelligence for Social Policy, University of Pennsylvania. https://www.aisp.upenn.edu/resource-article/legal-issues-for-ids-use-finding-a-way-forward/

[802] Kamoie, B., & Borzi, P. (2001). Behavioral health issue brief series: A crosswalk between the final HIPAA privacy rule and existing federal substance abuse confidentiality requirements. The George Washington University School of Public Health and Services.

Recent Federal Changes

In response to the changing landscape of providing care during the COVID-19 pandemic, there have been changes at the federal level related to 42 CFR Part 2.

42 CFR Part 2: CARES Act (2020)

''Once a patient gives prior written consent, the contents of a record may be used or disclosed by a covered entity, business associate, or a [Part 2 program] for purposes of treatment, payment, and health care operations as permitted by the HIPAA regulations."[803] This change more closely aligns 42 CFR Part 2 with HIPAA.

[803] CARES Act, no. H.R. 748, H.R. 748 – 96 (2020). https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf

Appendix W: Hope Squad Program

HOPE SQUAD

Our Program

Hope Squad is an evidence-based, peer-to-peer suicide prevention program built around the **power of connection**.

- Hope Squads ***use key prevention strategies*** to reduce the risk of suicide
- Hope Squad members ***are nominated by their peers*** to learn about mental health from a trained advisor and ***perform intentional outreach*** to struggling peers

Why Choose Hope Squad?

Hope Squad provides everything you need to launch and implement a successful program

Peer-to-Peer Approach

Hope Squad's peer-to-peer approach empowers members to intentionally reach out to peers and become instruments of change.

Comprehensive Training

Advisors can choose from multiple expert-led training options to set their Hope Squads up for success.

Accessible Support & Community

A dedicated Customer Success team, technical support, and an online advisor community provide comprehensive support.

Content & Resources

Our curriculum and activities are designed to educate members and provide opportunities for ongoing skill-building.

Flexible Implementation

Hope Squad's programming is adaptable to fit your community's needs—our on-demand materials can be delivered how and when works best.

> **I have never seen a program change the culture of our schools the way Hope Squad has.** The power of peer-to-peer and education about mental illness has opened doors and saved lives.
>
> Dr. Holly Ferguson, Superintendent of Prosper Independent School District, Prosper, TX

SPRC APPROVED PROGRAM Best Practices Registry

Hope Squad is on the Suicide Prevention Resource Center's Best Practice Registry

This verifies that our programming has been reviewed by experts to ensure it aligns with the most current guidance on preventing suicide and that it has demonstrated effectiveness in preventing suicide or directly addresses the factors that impact suicide prevention.

Learn more about bringing Hope Squad to your school at hopesquad.com