

**Texas**

**UNIFORM APPLICATION  
2011**

**STATE PLAN  
COMMUNITY MENTAL HEALTH SERVICES  
BLOCK GRANT**

OMB - Approved 08/06/2008 - Expires 08/31/2011

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**Center for Mental Health Services**

**Division of State and Community Systems Development**

## **Introduction:**

The CMHS Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant ( 45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0168.

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**FACE SHEET**  
**FISCAL YEAR/S COVERED BY THE PLAN**  
**X FY2011**

STATE NAME: Texas  
DUNS #: 80-739-1511

**I. AGENCY TO RECEIVE GRANT**

AGENCY: Department of State Health Services  
ORGANIZATIONAL UNIT: Division of Mental Health & Substance Abuse  
STREET ADDRESS: 909 W. 45th Street, Ste. 320  
CITY: Austin STATE: TX ZIP: 78751  
TELEPHONE: (512)206-5814 FAX: (512)206-5718

**II. OFFICIAL IDENTIFIED BY GOVERNOR AS RESPONSIBLE FOR ADMINISTRATION OF THE GRANT**

NAME: Michael D. Maples TITLE: Asst. Commissioner  
AGENCY: Department of State Health Services  
ORGANIZATIONAL UNIT: Mental Health and Substance Abuse  
STREET ADDRESS: 909 W. 45th Street, Ste. 320  
CITY: Austin STATE: TX ZIP CODE: 78751  
TELEPHONE: (512)206-5968 FAX: (512)206-5718

**III. STATE FISCAL YEAR**

FROM: 09/01/2010 TO: 08/31/2011

**IV. PERSON TO CONTACT WITH QUESTIONS REGARDING THE APPLICATION**

NAME: Mary Sowder TITLE: Program Specialist, Operations Services  
AGENCY: Department of State Health Services  
ORGANIZATIONAL UNIT: Mental Health & Substance Abuse  
STREET ADDRESS: 909 W. 45th Street, Ste. 320  
CITY: Austin STATE: TX ZIP: 78756  
TELEPHONE: (512)206-5814 FAX: (512)206-5718 EMAIL: mary.sowder@dshs.state.tx.us

Please respond by writing an Executive Summary of your current year's application.

# 2011 Mental Health Block Grant Application

## Executive Summary

The Community Mental Health Services Block Grant State Plan for federal fiscal year 2011 (FFY2011) provides a description of the public mental health system, the documentation of current activities, and the intended use of federal resources to support the delivery of community mental health services in Texas.

Texas health and human service agencies are consolidated into four departments under the Health and Human Services Commission, one of which is the Department of State Health Services (DSHS). DSHS is the single agency that administers public health services, mental health services, and substance abuse services. Specifically, through the Mental Health and Substance Abuse Services Division of DSHS, mental health and substance abuse services are administered throughout the state. Because DSHS is assigned responsibility for public health in Texas, the state promotes activities to accomplish integration among all the public health services. For the Mental Health and Substance Abuse Services Division, integration activities are directed at meeting the transformation goals established by the President's New Freedom Commission and the 10 goals set forth by the Substance Abuse Mental Health Services Administration (SAMHSA). Evidence of the state's efforts to address both the transformation and SAMHSA's goals can be found throughout the plan. Transformation activities are specifically delineated in Table C. SAMHSA goals are denoted with two asterisks (\*\*) and the number of the goal to which it corresponds before each applicable section. The list of SAMHSA's goals has been added to the optional section of this application for easy reference.

In Texas, resources from federal block grants primarily are directed to local mental health authorities (LMHAs) through performance-based contracts. These resources support the delivery of ongoing services to adults with serious mental illness (SMI) and children with serious emotional disturbances (SED). A smaller percentage of block grant resources are used to support special projects. An example would be the development of the Clinical Management for Behavioral Health Services (CMBHS), an integrated mental health and substance abuse client data base system. CMBHS combines substance abuse and mental health databases, establishes an electronic health record, and provides capacity to track expenditures and additional information from service providers. Federal block grant funds are also made available for a Training and Technical Assistance Center, which provides training coordination and support to consumers, youth, and families. These ongoing LMHA services and special projects that are funded via the block grant award are more specifically described in the plan.

Mental health services in Texas are in a continuing state of transformation. There are various projects aimed at improving the delivery of care, including integrating all the projects and initiatives developed through the the mental health transformation system infrastructure grant into the ongoing delivery of services; continuing to redesign the resiliency and disease management service delivery model; improving the local planning and network development processes; and fully implementing and maintaining crisis services.

Additional, more focused issues are described in the plan. Included are descriptions of efforts to address veterans, behavioral health during disasters and the continuity of care related to service access in the community and state hospitals. Information about the state's budget and the impact of national healthcare reform is included.

In addition to services being transformed, other revisions in the state system are expected in FY11 that could lead to changes affecting this plan:

- the state Mental Health Planning and Advisory Committee is revising its charge, role and activities;
- the Mental Health and Substance Abuse Division is revisiting its vision, mission and goals;
- the state Legislature will meet during the fiscal year; and
- the Patient Protection and Affordability Care Act and Health Care & Education Reconciliation Act are being debated and assessed throughout the state.

## **Attachment A. COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT FUNDING AGREEMENTS**

FISCAL YEAR 2011

I hereby certify that Texas agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

### **Section 1911:**

Subject to Section 1916, the State<sup>1</sup> will expend the grant only for the purpose of:

- i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved;
- ii. Evaluating programs and services carried out under the plan; and
- iii. Planning, administration, and educational activities related to providing services under the plan.

### **Section 1912**

(c)(1)& (2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

### **Section 1913:**

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

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<sup>21</sup>. The term State shall hereafter be understood to include Territories.

- (A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
- (B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
- (C) 24-hour-a-day emergency care services.
- (D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
- (E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

**Section 1914:**

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:

- (1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
- (2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
- (3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

- (A) the principle State agencies with respect to:
  - (i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
  - (ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
- (B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
- (C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
- (D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:

- (A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and

(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

**Section 1915:**

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.

(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

**Section 1916:**

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;

(2) to make cash payments to intended recipients of health services;

(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;

(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or

(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

**Section 1941:**

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

**Section 1942:**

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and

(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United States Code. [Audit Provision]

(c) The State will:

- (1) make copies of the reports and audits described in this section available for public inspection within the State; and
- (2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

**Section 1943:**

- (a) The State will:
  - (1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
  - (B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
  - (2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
  - (3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section
  
- (b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

---

Michael D. Maples, Assistant Commissioner  
XXXXXXXXX

Date

## CERTIFICATIONS

### 1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

- (a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
- (b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
- (c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
- (d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

### 2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free workplace in accordance with 45 CFR Part 76 by:

- (a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;
- (b) Establishing an ongoing drug-free awareness program to inform employees about--
  - (1) The dangers of drug abuse in the workplace;
  - (2) The grantee's policy of maintaining a drug-free workplace;
  - (3) Any available drug counseling, rehabilitation, and employee assistance programs; and
  - (4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
- (c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
- (d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
  - (1) Abide by the terms of the statement; and
  - (2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
- (e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central

point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

- (f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted--
  - (1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
  - (2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
- (g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management  
 Office of Grants Management  
 Office of the Assistant Secretary for Management and Budget  
 Department of Health and Human Services  
 200 Independence Avenue, S.W., Room 517-D  
 Washington, D.C. 20201

### 3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING \$100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

- (1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under-

signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

- (2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
- (3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.

### 4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

**5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE**

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children’s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children’s services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to \$1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children’s services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Assistant Commissioner	
APPLICANT ORGANIZATION Department of State Health Services		DATE SUBMITTED

## DISCLOSURE OF LOBBYING ACTIVITIES

Approved by OMB  
0348-0046

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352  
(See reverse for public burden disclosure.)

<b>1. Type of Federal Action:</b>  <input type="checkbox"/> a. contract <input type="checkbox"/> b. grant <input type="checkbox"/> c. cooperative agreement <input type="checkbox"/> d. loan <input type="checkbox"/> e. loan guarantee <input type="checkbox"/> f. loan insurance	<b>2. Status of Federal Action</b>  <input type="checkbox"/> a. bid/offer/application <input type="checkbox"/> b. initial award <input type="checkbox"/> c. post-award	<b>3. Report Type:</b>  <input type="checkbox"/> a. initial filing <input type="checkbox"/> b. material change  <b>For Material Change Only:</b> Year _____ Quarter _____  date of last report _____
<b>4. Name and Address of Reporting Entity:</b>  <div style="display: flex; justify-content: space-between;"> <span>Prime</span> <span>Subawardee</span> </div> <div style="margin-left: 150px;">Tier _____, if known:</div>  Congressional District, if known: _____		<b>5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:</b>     Congressional District, if known: _____
<b>6. Federal Department/Agency:</b>    	<b>7. Federal Program Name/Description:</b>    CFDA Number, if applicable: _____	
<b>8. Federal Action Number, if known:</b>  	<b>9. Award Amount, if known:</b>  \$ _____	
<b>10. a. Name and Address of Lobbying Entity</b> <i>(if individual, last name, first name, MI):</i>    	<b>b. Individuals Performing Services</b> <i>(including address if different from No. 10a.)</i> <i>(last name, first name, MI):</i>    	
<b>11. Information requested through this form is authorized by title 31 U.S.C. section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than \$10,000 and not more than \$100,000 for each such failure.</b>		
Signature: _____  Print Name: _____  Title: _____  Telephone No.: _____ Date: _____		Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)
<b>Federal Use Only:</b>		

## INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.
2. Identify the status of the covered Federal action.
3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.
4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.
5. If the organization filing the report in item 4 checks "subawardee", then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.
6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.
7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.
8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., "RFP-DE-90-001."
9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.
10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.  
  
(b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).
11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

According to the Paperwork Reduction Act, as amended, no persons are required to respond to a collection of information unless it displays a valid OMB Control Number. The valid OMB control number for this information collection is OMB No.0348-0046. Public reporting burden for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0046), Washington, DC 20503.

**ASSURANCES - NON-CONSTRUCTION PROGRAMS**

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

**PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.**

**Note:** Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age;
- (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is \$10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, re- gulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Assistant Commissioner	
APPLICANT ORGANIZATION Department of State Health Services		DATE SUBMITTED

Section 1941 of the Block Grant legislation stipulates that as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State Plan. States will make the mental health plan public in such a manner to facilitate comment from any person (including Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

States should describe their efforts and procedures to obtain public comment on the plan on the plan in this section.

## **Public Comments on State Block Grant Plan**

In the *Texas Register* on July 9, 2010, the Department of State Health Services (DSHS) published its intention to submit a state plan. Directions regarding how and when to obtain a draft of the plan were included in the announcement. The draft plan was made available electronically on the DSHS website and by mail upon request on July 13, 2010, and the public was given a 30-day comment period. An electronic mailbox was established specifically to receive comments on the plan. The published announcement included the electronic address as well as a physical mailing address for submission of comments. More than 2,800 stakeholders and other interested persons who regularly receive announcements of updates on the mental health webpage were directly contacted via e-mail regarding the availability of the plan and opportunity to make comments. Members of the Mental Health Planning and Advisory Committee (MHPAC) were included in this direct e-mail notification and they were furnished with individual copies of the plan.

The MHPAC also was given the opportunity to make comments and provide input at the beginning of the planning process. The mental health state block grant planner attended four MHPAC meetings prior to public posting of the application to solicit comments, ideas, and information that could be incorporated into the application prior to posting. Additionally, the planner attended a meeting after the posting to discuss and receive comments from members. The primary comments at that meeting were related to goals, targets, and action plans and prevalence data. The Goals, targets and action plans were made available to planning members through the WebBGAS on line application. MHPAC members also serve on various work groups or subcommittees and provide input on initiatives and programs that have been written into this plan.

A specific notification requesting public comment also was sent directly to Local Authority Network Advisory Committee members. The committee members were given the opportunity to comment through the electronic mail box or directly to DSHS staff.

Comments were received through the electronic mailbox and e-mails to DSHS staff. Information and suggestions obtained from the MHPAC members and other interested parties were considered and incorporated into the plan as appropriate prior to submission. Additional comments were received that expressed general concepts, recommending program changes, or requesting assistance, with no specific suggestions offered for changes to the plan. These comments were addressed directly by state staff. MHPAC members were provided with a copy of all comments and responses prior to writing their letter of support.

## II. SET-ASIDE FOR CHILDREN'S MENTAL HEALTH SERVICES REPORT

States are required to provide systems of integrated services for children with serious emotional disturbances(SED). Each year the State shall expend not less than the calculated amount for FY 1994.

### Data Reported by:

State FY   X   Federal FY \_\_\_\_\_

### State Expenditures for Mental Health Services

Calculated FY 1994	Actual FY 2009	Estimate/Actual FY 2010
<u>\$18,705,040</u>	<u>\$59,864,894</u>	<u>\$62,404,873</u>

### Waiver of Children's Mental Health Services

If there is a shortfall in children's mental health services, the state may request a waiver. A waiver may be granted if the Secretary determines that the State is providing an adequate level of comprehensive community mental health services for children with serious emotional disturbance as indicated by a comparison of the number of such children for which such services are sought with the availability of services within the State. The Secretary shall approve or deny the request for a waiver not later than 120 days after the request is made. A waiver granted by the Secretary shall be applicable only for the fiscal year in question.

Actual for FY 2009 is \$60,938,201

### III. MAINTENANCE OF EFFORT(MOE) REPORT

States are required to submit sufficient information for the Secretary to make a determination of compliance with the statutory MOE requirements. MOE information is necessary to document that the State has maintained expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

#### **MOE Exclusion**

The Secretary may exclude from the aggregate amount any State funds appropriated to the principle agency for authorized activities of a non-recurring nature and for a specific purpose. States must consider the following in order to request an exclusion from the MOE requirements:

1. The State shall request the exclusion separately from the application;
2. The request shall be signed by the State's Chief Executive Officer or by an individual authorized to apply for CMHS Block Grant on behalf of the Chief Executive Officer;
3. The State shall provide documentation that supports its position that the funds were appropriated by the State legislature for authorized activities which are of a non-recurring nature and for a specific purpose; indicates the length of time the project is expected to last in years and months; and affirms that these expenditures would be in addition to funds needed to otherwise meet the State's maintenance of effort requirement for the year for which it is applying for exclusion.

The State may not exclude funds from the MOE calculation until such time as the Administrator of SAMHSA has approved in writing the State's request for exclusion.

States are required to submit State expenditures in the following format:

#### **MOE information reported by:**

State FY   X   Federal FY \_\_\_\_\_

#### **State Expenditures for Mental Health Services**

**Actual FY                  Actual FY                  Actual/Estimate FY**

2008	2009	2010
<u>\$455,009,765</u>	<u>\$458,230,493</u>	<u>\$464,725,415</u>

## **MOE Shortfalls**

States are expected to meet the MOE requirement. If they do not meet the MOE requirement, the legislation permits relief, based on the recognition that extenuating circumstances may explain the shortfall.

These conditions are described below.

### **(1). Waiver for Extraordinary Economic Conditions**

A State may request a waiver to the MOE requirement if it can be demonstrated that the MOE deficiency was the result of extraordinary economic conditions that occurred during the SFY in question. An extraordinary economic condition is defined as a financial crisis in which the total tax revenues declined at least one and one-half percent, and either the unemployment increases by at least one percentage point, or employment declines by at least one and one-half percent. In order to demonstrate that such conditions existed, the State must provide data and reports generated by the State's management information system and/or the State's accounting system.

### **(2). Material Compliance**

If the State is unable to meet the requirements for a waiver under extraordinary economic conditions, the authorizing legislation does permit the Secretary, under certain circumstances, to make a finding that even though there was a shortfall on the MOE, the State maintained material compliance with the MOE requirement for the fiscal year in question. Therefore, the State is given an opportunity to submit information that might lead to a finding of material compliance. The relevant factors that SAMHSA considers in making a recommendation to the Secretary include: 1) whether the State maintained service levels, 2) the State's mental health expenditure history, and 3) the State's future commitment to funding mental health services.

Actual for FY 2009 should be \$461,280,493

**TABLE 1.**

**List of Planning Council**

**Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Alexander, Robert	State Employees	Vocational Rehabilitation	Area Manager, North Austin Field Office MC3038- 4900 N Lamar Austin, TX 78751- 2399 PH:5124830900 FAX:5124830905	Robert.Alexander@dars.state.tx.us
Clark, Lynn Lasky	Others(not state employees or providers)	Mental Health America of Texas	1210 San Antonio, Suite 200 Austin, TX 78701 PH:5124543706 ext.201 FAX:5124543725	lynn@mhatexas.org
Davis, Grace	State Employees	Criminal Justice	P.O. Box 4260 Austin, TX 78765 PH:5124246233 FAX:	grace.davis@tys.state.tx.us
Delgado, Frank	Consumers/Survivors/Ex-patients(C/S/X)		7229 Ferguson Rd. Apt. 1206 Dallas, TX 75228 PH:2146143313 FAX:	Frank.delgado@metrocareservices.org
Fountain, Barbara	State Employees	Mental Health	909 W. 45th Street, Building 4 Austin, TX 78751 PH:5122065800 FAX:	barbara.fountain@dshs.state.tx.us
Gay, Cliff	Consumers/Survivors/Ex-patients(C/S/X)		P.O. Box 67 Buda, TX 78610-0067 PH:5126951954 FAX:5124209987	cgay5541@ATT.net

**TABLE 1.**

**List of Planning Council**

**Members**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(if available)
Gibson, Greg	Family Members of adults with SMI		8429 Alvin High Lane Austin, TX 78729 PH:5126994938 FAX:	byrht2000@yahoo.com
Gorham, Catherine	State Employees	Social Services	101 E. 15th Street, Room 252-T Texas Workforce Commission Austin, TX 78778-0001 PH:5124750216 FAX:	catherine.gorham@twc.state.tx.us
Halligan, Mike	Consumers/Survivors/Ex-patients(C/S/X)		105 E. Jones Dr. Georgetown, TX 78628 PH:512/591-7130 FAX:	mhalligan83@hotmail.com
Hayes, Aaryce	Family Members of adults with SMI		1334 Neans Dr. Austin, TX 78758 PH:512/433-9173 FAX:	aaryce7@gmail.com
Holcomb, Valerie	Family Members of Children with SED		3923 Fry Ave. Tyler, TX 75701 PH:9035616341 FAX:	vholcomb@andrewscenter.com
Kuchta, Mollie	Family Members of adults with SMI		801 Seventh Ave. Ft. Worth, TX 76104 PH:8178913434 FAX:	Mollie.kuchta@cookchildren.org

**TABLE 1.  
Members**

**List of Planning Council**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Lewis, Kat	Others(not state employees or providers)	Advocacy Inc.	7800 Shoal Creek Blvd. Suite 171E Austin, TX 78757 PH:512/454-4816 FAX:	klewis@advocacyinc.org
Martin, Joshua	State Employees	Mental Health	909 W. 45th Street, Building 552 Austin, TX 78751 PH:5124192255 FAX:	joshua.martin@dshs.state.tx.us
Moore, Kate	State Employees	Housing	221 East 11th Austin, TX 78701-2401 PH:5129367804 FAX:5124751672	Kate.moore@tdhca.state.tx.us
Peyson, Robin	Family Members of adults with SMI	NAMI-Texas	2800 S. I-H 35 Suite 140 Austin, TX 78704 PH:512693-2000 FAX:	rpeyson@namitexas.org
Scales, Carli	Consumers/Survivors/Ex-patients(C/S/X)		1604 Taylor Amarillo, TX 79102 PH:8063739730 FAX:	carliflower@sbcglobal.net
Smith, Tikisha	State Employees	Mental Health	909 W. 45th Street, Building 4 Austin, TX 78751 PH:5122065598 FAX:5122065383	tiki.smith@dshs.state.tx.us

**TABLE 1. List of Planning Council Members**

<b>Name</b>	<b>Type of Membership</b>	<b>Agency or Organization Represented</b>	<b>Address, Phone and Fax</b>	<b>Email(If available)</b>
Smyrl, Carolyn	State Employees	Education	Divison of NCLB Program Coordination 1701 N. Congress Ave. Austin, TX 78701 PH:5124636467 FAX:	carolyn.smyrl@tea.state.tx.us
Spencer, Steve	State Employees	Criminal Justice	P.O. Box 13547 Austin, TX 78711-3547 PH:5124246699 FAX:	steve.spencer@tjpc.state.tx.us
Thyssen, Monica	Family Members of Children with SED		7800 Shoal Creek, Ste. 171-E Austin, TX 78757 PH:5124544816 FAX:5123230902	mthyssen@advocacyinc.org
Valentine, Tom	State Employees	Medicaid	4900 N. Lamar Austin, TX 78751 PH:5124246529 FAX:	tom.valentine@hhsc.state.tx.us
Wadge Switzer, Gyl	Others(not state employees or providers)	Mental Health America	1210 San Antonio, Suite 200 Austin, TX 78701 PH:5124543706 ext. 203 FAX:5124543725	gyl@mhatexas.org
Wagner, B.J.	State Employees	Criminal Justice	8610 Shoal Creek Blvd Austin, TX 78757 PH:512/406-5265 FAX:	Benniejo.wagner@tdcj.state.tx.us

**TABLE 1.  
Members**

**List of Planning Council**

Name	Type of Membership	Agency or Organization Represented	Address, Phone and Fax	Email(If available)
Watson, Brian	Consumers/Survivors/Ex-patients(C/S/X)		5813 Hugo Drive Corpus Christi, TX 78412-3467 PH:361-774-2737 FAX:	
Zamora, April	State Employees	Criminal Justice	8610 Shoal Creek Blvd Austin, TX 78757 PH:5124065435 FAX:	april.zamora@tdcj.state.tx.us

Tom Valentine, State Health and Human Services represents both Medicaid and Social Services.

**TABLE 2. Planning Council Composition by Type of Member**

Type of Membership	Number	Percentage of Total Membership
<b>TOTAL MEMBERSHIP</b>	26	
Consumers/Survivors/Ex-patients(C/S/X)	5	
Family Members of Children with SED	2	
Family Members of adults with SMI	4	
Vacancies(C/S/X and Family Members)	1	
Others(not state employees or providers)	3	
<b>TOTAL C/S/X, Family Members and Others</b>	14	53.85%
State Employees	12	
Providers	0	
Vacancies	1	
<b>TOTAL State Employees and Providers</b>	12	46.15%

Note: 1) The ratio of parents of children with SED to other members of the Council must be sufficient to provide adequate representation of such children in the deliberations of the Council, 2) State Employee and Provider members shall not exceed 50% of the total members of the Planning Council, and 3) Other representatives may include public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. 4) Totals and Percentages do not include vacancies.

State Mental Health Planning Councils are required to perform certain duties. If available, a charter or a narrative summarizing the duties of the Planning Council should be included. This section should also specify the policies and procedures for the selection of council members, their terms, the conduct of meetings, and a report of the Planning Council's efforts and related duties as mandated by law:

reviewing plans and submitting to the State any recommendations for modification

serving as an advocate for adults with serious mental illness, children with a severe emotional disturbance, and other individuals with mental illnesses or emotional problems, monitoring, reviewing, and evaluating, not less than once each year, the allocation and adequacy of mental health services within the State.

the role of the Planning Council in improving mental health services within the State.

**In addition to the duties mandated by law, States should include a brief description of the role of the Planning Council in the State's transformation activities that are described in Part C, Section II and Section III.**

## **Planning Council Charge, Role and Activities**

The Mental Health Planning and Advisory Council (MHPAC) was created as a result of the federal requirement that States and Territories engage in mental health planning to receive federal Mental Health Block Grant funds. Stakeholders, including mental health consumers, their family members, and parents of children with serious emotional or behavioral disturbances, must be involved in these efforts through membership in the planning and advisory council. Below is a copy of the MHPAC bylaws that were developed to create a planning council that meets the federal requirements.

### ***Mental Health Planning and Advisory Council Bylaws***

#### **Name**

The name of this Council shall be Mental Health Planning and Advisory Council (MHPAC).

#### **Purpose**

The MHPAC shall be responsible to the DSHS Leadership. The Council's purposes are:

- To respond to specific requests from DSHS Leadership for help and information on issues and initiatives regarding mental health services;
- To review plans and policies provided to the Council and to submit any recommendations for modifications to DSHS Leadership;
- To monitor, review, and evaluate the allocation and adequacy of mental health services within the State by reviewing the progress made in the implementation of previous plans or initiatives of the Department;
- To serve as an advocate for adults with serious mental illness, children with a severe emotional disorder, and other persons with mental illness or emotional problems; and
- To serve as the State Mental Health Planning Council as required by Public Law 102-321.

Any recommendations and results of studies conducted by MHPAC shall be addressed to DSHS Leadership.

#### ***Committee Composition***

Membership of MHPAC should include:

The mandated agency representatives from:

- Department of State Health Services (Mental Health);
- Texas Education Agency (Education)
- Department of Aging and Rehabilitation Services (Vocational Rehabilitation)
- Texas Correctional Office on Offenders with Medical or Mental Impairments (Criminal Justice)
- Texas Department of Housing and Community Affairs (Housing)
- Health and Human Services Commission (Social Services and Medicaid);

Fourteen additional positions and these could include:

- Representatives of advocacy organizations with an interest in mental health services;
- Consumers of mental health services;
- Family members of persons who are receiving (or have received) mental health services;

Of these fourteen positions:

- One shall be designated as a representative of those with "special needs". In particular, someone knowledgeable about access issues for those with additional barriers to service;
- Consumers should hold a majority of the remaining seats;
- The ratio of parents with children with a serious emotional disturbance to other members is sufficient to provide adequate representation in deliberations;
- Consideration will be given to appointments to ensure diversity in ethnic and minority representation, and geographic representation.

In addition to membership, DSHS Leadership shall ask other agencies and organizations to designate liaisons to MHPAC. These liaisons will primarily be called upon when issues related to their jurisdictions are under consideration. These agencies and organizations include:

- Texas Association of Community Health Centers
- Texas Workforce Commission
- Texas Youth Commission
- Texas Juvenile Probation Commission
- Substance Abuse Provider Organization

There will also be a liaison function to other Mental Health Advisory Groups such as:

- Transformation Working Group
- Strategic Health Partnership-Mental Health Sub-committee
- Stigma Reduction Workgroup

Where there is shared membership between MHPAC and other committees, the MHPAC Chair will designate a joint member as liaison. Where there are no shared members, DSHS Leadership will request the Chairpersons of these groups to designate a liaison.

## **Membership**

### **Terms of Appointment**

- Agency Representatives will be solicited through the appropriate Commissioner every three years or sooner if the position becomes vacant. The solicitation letter will include a statement regarding the incumbent's participation over the last term of appointment. Agency representatives may be reappointed indefinitely.
- Consumers, family members and "others" will be appointed for a 3-year term, and eligible for one reappointment.
- Members whose terms have expired may continue to serve until re-appointed or replaced.

### **Nominating Procedure**

DSHS Leadership and MHPAC members shall solicit representation from statewide family, consumer and advocacy organizations, consumers of mental health services, family members and caregivers of persons with mental illness, local PACs/NACs, and citizens with interest and expertise in mental health services. DSHS leadership shall attempt, to the extent possible, to appoint people who express an array of positions on the type of issues and problems generally under consideration.

### **Vacancies**

In the case of a vacancy created by death, resignation, or replacement of a member, the Commissioner shall appoint a citizen of the same category or solicit from the designated agency or organization an individual to serve the unexpired portion of that term.

## **Replacement**

If a member is absent without a valid reason or is unable to discharge the duties of Council membership, DSHS Leadership shall determine whether grounds for replacement exist. If so, DSHS Leadership shall appoint a citizen of the same category to serve the unexpired portion of that term.

## **Alternates**

At the Chair's discretion, alternates may be allowed to represent members who are unable to attend meetings. Arrangements for alternate attendance shall occur prior to the time of the meeting.

## **Training**

All new MHPAC appointees will be assigned a member mentor who has experience serving on MHPAC. MHPAC shall annually conduct a new member orientation session.

## **Officers**

There shall be a Chair, a Vice-Chair and Secretary of MHPAC selected by the membership, and confirmed by DSHS Leadership. The MHPAC Chair will serve as presiding officer and the Vice-Chair will serve as presiding officer in the absence of the Chair. Either the MHPAC Chair, or Vice-Chair must be a consumer.

The responsibilities of MHPAC Chair are:

- Facilitating the meetings
- Liaison with state staff
- Finalizing the meeting agenda
- Signature of relevant Mental Health Block Grant Materials
- Designating ad-hoc committees

The Vice-chair is responsible for performing the above functions as needed in the absence of the MHPAC Chair.

The responsibilities of the MHPAC Secretary are:

- Ensuring the accuracy and timeliness of minutes. Minutes will be taken and archived by designated state staff. The Secretary will work directly with the staff to ensure they are accurately drafted, and circulated timely.
- Ensuring that the MHPAC Chair is informed about items deferred, or to be followed up on, so that they are placed appropriately on future agendas.

## **Terms for Officers**

MHPAC members will elect officers annually. Officers are eligible to be re-elected as long as their term continues.

## **Committees**

The MHPAC Chair will appoint members to the following standing sub-committees:

- Peer Review/Quality Improvement
- Children's Services
- Promoting Independence

The MHPAC Chair may also establish special committees to study specific issues and make recommendations to MHPAC as a whole for its consideration. Special committees are discharged on completion of the assignment for which appointed.

The MHPAC Chair shall appoint committee chairs that shall be an MHPAC member. The subcommittees, subject to the MHPAC Chair's approval, may solicit volunteers with relevant expertise to contribute to the committee's work. Meetings may be called by the committee chair as needed to expeditiously complete the assignment.

## **Meetings**

MHPAC as a whole will meet at least quarterly. Other meeting dates for the committee or subcommittees may occur when the need arises as determined by the MHPAC Chair, *Sub-Committee* Chair or DSHS Leadership. A majority of those members present must be consumers, family members or advocates for business to be conducted.

At each meeting, there will be standing agenda items that include:

- Executive Report (which would include responses to any recommendations made);
- Legislative Update;
- Rules Update;
- Sub-Committee Reports;
- Liaison Reports;
- Old Business and ;
- New Business

The MHPAC and any of its special subcommittees shall keep written minutes of their deliberations and submit them to DSHS Leadership.

Transaction of Business—Recommendations of the Council will be adopted pursuant to a majority vote of members on a motion duly made and seconded. All council actions that rescind or amend a recommendation will also be adopted in this manner.

Resolution of Conflicts/Concerns among Membership—Any member of MHPAC with concerns about any actions, policies or procedures related to MHPAC will seek first to resolve those issues within the existing MHPAC procedures and processes.

Protocol for Visitors/Guests—The chair may invite individuals or organizations to address the Council. Individuals and organizations that have been invited to appear must wait to be called by the Chair and must limit their remarks to the time allowed by the Chair.

Visitors to Council Meetings may not participate in Council discussions unless invited to do so by the Chair. Visitors and guests may not bring forward motions, second motions or vote on council business.

## **Member Attendance at Meetings**

Members are requested to inform the Chair or the MHPAC, and Staff Liaison at least 48 hours prior to a scheduled Council meeting when the member will be unable to attend.

Upon approval by the Chair, member may arrange for another person to attend Council meetings as a "substitute". Such substitution will not be counted as an absence from that meeting for the member.

Two excused and two unexcused member absences will be allowed in any 12 month period.

The Council Chair will make the determination regarding which member absences are excused, based on member-reported extenuating circumstances, (e.g. legislature in session, member illness, etc.).

After the third member absence, of any type, the MHPAC Chair will contact the member to discuss the importance of the member's attendance. After the fifth member absence of any type or the third consecutive unexcused absence in any 12 month period, the Chair will inform DSHS Leadership in writing of the member's continued non-attendance and, where appropriate, may offer recommendations for consideration by DSHS Leadership.

The Council Chair, upon receipt of DSHS Leadership decision regarding the matter, will institute actions consistent with that decision.

### **Miscellaneous**

Central Office Staffing: DSHS Leadership will designate staff to be responsible for planning meetings, maintaining records, and various liaison activities. A representative of DSHS Leadership will attend MHPAC meetings.

Several staff liaison roles will be assigned by DSHS Leadership including:

- Block Grant Coordinator
- Adult Services
- Children's Services
- Substance Abuse

Staff liaisons will be assigned, and will attend meetings as needed.

### **Compensation**

The members of MHPAC will receive no compensation for their services except that they may receive the same per diem and transportation allowance as provided for state employees in the appropriations act that is then in effect.

### **Conflict of Interest**

Any MHPAC member with a loyalty or economic conflict of interest shall disclose such conflict or abstain from voting on or deliberating in any such action involving the matter. The MHPAC in consultation with DSHS staff reserves the right to rule on a conflict-of-interest issue involving a member on a case-by-case basis. The members shall have a duty to disclose to the DSHS Council liaison and the Council Chair when there is any conflict and the Council reserves the power, upon a majority vote, to ask a member with a conflict to remove himself or herself from participation on that issue. If the Chair of MHPAC has a conflict, the Chair shall disclose to the MHPAC Staff liaison.

Attendance by the Public: Meetings of MHPAC will be open to attendance by members of the public.

### **Amendments**

Amendments to these Bylaws shall be at the discretion of DSHS Leadership upon recommendation by the membership.

Adult - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

## **Adult – Overview of State’s Mental Health System**

The Department of State Health Services (DSHS) seeks to promote optimal health for individuals and communities while providing effective physical health, mental health, and substance abuse services to Texans. Including DSHS, four departments are under the direction of the Health and Human Services Commission (HHSC). The Executive Commissioner of HHSC reports directly to the governor. The other three departments are the Department of Aging and Disability Services (DADS), and the Department of Assistive and Rehabilitative Services (DARS), and the Department of Family and Protective Services (DFPS). The four departments facilitate opportunities for joint planning and delivery of many key human service programs such as public health, behavioral health, vocational rehabilitation, Medicaid, Texas Aid to Needy Families, and adult and child protective services.

The programs and services provided by DSHS are grouped into four broad categories--behavioral health, which consists of mental health and substance abuse services; preparedness and prevention services; community health services; and regulatory services. Within each category a broad array of diverse services is provided. Some of the services provided by DSHS benefit the general public while others address individualized needs.

The Mental Health and Substance Abuse (MHSA) Services Division is designated as the mental health and substance abuse authority for the state and oversees the public mental health service delivery system, which comprises 38 local mental health authorities (LMHAs), the NorthSTAR Program, and 10 state hospitals. Texas continues to provide accessible, effective, comprehensive, coordinated, integrated, and evidence-based treatment services to persons with psychiatric disorders, substance use disorders, or both.

In all but one area of the state, the LMHA is also a community mental health center (CMHC). Services provided by CMHCs throughout the state are delivered to adults with severe and persistent mental illness and children with severe emotional disturbance. To ensure a disease management framework for service delivery, the CMHCs follow a resiliency and disease management (RDM) model. The model utilizes empirically designed interventions to eliminate or manage symptoms and promote recovery from psychiatric disorders.

The NorthSTAR Program provides mental health and substance abuse services to indigent members and most Medicaid recipients within seven counties surrounding the Dallas area. The NorthSTAR Program consists of services that are managed by a licensed health maintenance organization (HMO) under direct contract with DSHS. Through the DSHS contract and with local oversight by the local behavioral health authority, the contracted HMO supports network development that includes a wide array of individual, group, and facility-based providers. The HMO performs functions such as utilization management, quality management, customer service, and claims adjudication. The contractually required service array includes the same resiliency and disease management services required of the CMHCs and substance abuse providers.

The state hospital system, which includes one residential treatment center that is designated specifically for youth, provides inpatient care. The state hospitals are owned by the State of Texas and operated by DSHS. Although state hospitals are operated by DSHS, each LMHA and the NorthSTAR Program receive an allocation of state hospital resources to be utilized for inpatient care for individuals from their area of authority. Cooperative agreements with designated state hospital(s) outline the roles and responsibilities for utilization management. No block grant funds are used for these inpatient services.

Although many CMHCs are currently the primary providers of mental health services in their local service areas, the local planning and network development (LPND) initiative expands service delivery and consumer choice. The LPND initiative implements state legislation that requires LMHAs to develop a network of external service providers and to provide direct services only

when other willing providers are not available. A key goal of this project is to enable consumers to exercise greater control over the services they receive by offering them a choice of providers. The extent to which this goal can be achieved in any given service area and how quickly it can be reached depends on the circumstances, needs, and preferences of the individuals and local communities served by each LMHA.

Each LMHA is required to create a local plan for developing its provider network through a collaborative process involving providers, consumers, and local stakeholders. These biennial plans include an assessment of the availability of interested providers and a plan for procuring services for the next two-year period. The first cycle of network development began in 2008, but the results were modest. The LMHAs took a conservative approach and providers generally concluded that the terms did not provide favorable conditions for establishing services in the local areas. The second cycle of network development began in January 2010 and local plans are due in summer 2010.

Over the past year, DSHS worked with the Local Authority Network Advisory Committee (LANAC) and other stakeholders to identify barriers to network development and potential strategies for resolving them. Tools and procedures were updated based on the experience gained during first planning cycle, with a special focus on facilitating more productive communication between providers and LMHAs. Criteria were developed to guide the review and approval of local plans and performance indicators were established to evaluate the effectiveness of the LPND initiative. The LANAC, with direction from DSHS, established a workgroup to begin the process for revising the rules concerning network planning and provider development. See "Adult-New Developments and Issues" for further description of issues to be addressed by workgroup.

During the 2008-2009 biennium, the 80th Texas Legislature appropriated funds to the LMHAs and NorthSTAR to improve the response to individuals experiencing mental health and substance abuse crises. These funds helped community programs to establish accredited crisis hotlines and mobile crisis outreach teams. Other funds enabled communities to develop or expand local alternatives to incarceration or state hospitalization through local short-term inpatient hospitalization options. The most recent legislature continued support of crisis services with an appropriation to fund transitional and intensive ongoing services. Transitional services provide linkages between existing services and individuals with serious mental illness who are not receiving ongoing care. Transitional services provide opportunities to serve the homeless and persons in need of substance abuse treatment and primary health care. Intensive ongoing services for children and adults provide team-based, wrap-around services to engage high need individuals in recovery-oriented services. By expanding its capacity to provide ongoing services to individuals entering mental health services as a result of a crisis encounter, the state is helping more individuals avoid unnecessary hospitalization or incarceration.

Adult - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

## **Adult – New Developments and Issues**

Adult mental health services are benefitting from increased agency emphasis on collaboration with other human services providers, the criminal justice system, and consumers. Services are being expanded to include a Medicaid-funded substance abuse package. Through training and learning communities, adult mental health services are increasing peer services and supported employment.

Increasingly technology is being used to improve quality of services for consumers. With legislative support, a new electronic data exchange system is being developed that will ensure better continuity of care for special needs offenders. The electronic medical record (part of the Clinical Management for Behavioral Health Services, or CMBHS, initiative) is in final stages of development. Its completion will augment ongoing efforts to use the resiliency and disease management (RDM) model to evaluate the adequacy of service packages to meet consumer needs through outcome measurement.

### **Collaboration**

#### **Continuity of Care Task Force**

\*\*2. The Texas Department of State Health Services assembled the Continuity of Care Task Force to recommend ways to handle the growing problem of access to community mental health care and to state hospitals. The task force is composed of individuals with experience and expertise relevant to mental health, including law enforcement officials, members of the judiciary, local mental health clinicians and administrators, state hospital clinicians and administrators, and mental health consumers. The goals of the Continuity of Care Task Force are to:

- Examine the overall continuum of care for individuals with severe mental illness who move through local mental health authorities, state hospitals, local jails, courts, and other systems of care;
- Make and prioritize recommendations to improve efficiency, access, and quality of care for those individuals; and
- Examine barriers to discharge for individuals in state hospitals with extended lengths of stay (> 1 year) and make recommendations to resolve those barriers.

The task force has developed preliminary recommendations to address the issues of access to public mental health care and to state hospitals. After conducting five public forums across the state to discuss and obtain broad-based input, the task force met on June 18, 2010, to finalize the recommendations. The group will issue a report with the recommendations by September 30, 2010.

#### **Preadmission Screening and Resident Review (PASRR)**

\*\*2. Federal laws governing nursing facilities were revised through the *Omnibus Budget Reconciliation Act (OBRA)* of 1987, *Public Law 100-203* of 1989, and *42 Code of Federal Regulations (CFR) §§483.100-483.116*. These laws require all persons initially entering nursing facilities to have a preadmission screening and resident review (PASRR) to determine if they are mentally ill or mentally retarded. If a person is found to have mental illness or mental retardation, the screening helps determine whether nursing facility care is appropriate or whether the person should be offered community services and supports in an integrated setting, consistent with the individual's needs.

One of the goals of the department is to remove barriers to community living for persons with disabilities. In support of this goal, the Department of State Health Services is collaborating with the Health and Human Services Commission and the Department of Aging and Disabilities Services to formulate a process that meets both federal and state standards and requirements. The PASRR Workgroup has formulated a new process for screening and review prior to

admission. This process is under review by the Centers for Medicare & Medicaid Services (CMS) and by stakeholders from across the state.

The Department of State Health Services is redefining the list of specialized services that can be offered to qualified and willing mental health residents upon admission to the nursing facility. The LMHAs would provide the specialized services.

### **Local Planning and Network Development**

Over the past year, DSHS worked with the Local Authority Network Advisory Committee and other stakeholders to identify barriers to network development and potential strategies for resolving them. Tools and procedures were updated based on the experience gained during first planning cycle, with a special focus on facilitating more productive communication between providers and LMHAs. Criteria were developed to guide the review and approval of local plans, and performance indicators were established to evaluate the effectiveness of the LPND initiative. The first cycle of network development revealed a number of challenges. DSHS requires LMHAs to adhere to an evidence-based resiliency and disease management (RDM) service delivery model that is unfamiliar to private providers. DSHS is currently is conducting an extensive review of the RDM Model, working with stakeholders to ensure it reflects the best available practices and does not impose unnecessary burden on LMHAs and other service providers.

DSHS also imposes regulations and contractual requirements that are not found in the private sector, including many requirements for staff to demonstrate specific competencies. Many of these reflect state and federal mandates and the need for clear accountability. The department will continue to work with stakeholders to identify opportunities to streamline requirements and reduce the burden on LMHAs and subcontractors.

In addition to the system challenges, external providers expressed concern about the configuration of local procurement documents.

- 1) In an effort to protect critical infrastructure and avoid significant disruption of services in the case of unexpected contract termination, most LMHAs took a conservative approach and offered a limited range and volume of services for contract. Many felt the need to maintain their complete internal service capacity until external providers demonstrated competence and stability. DSHS established a stakeholder committee that developed a menu of alternative strategies for LMHAs to implement to protect critical infrastructure during transition to the external provider network.
- 2) Most LMHAs have extensive training programs to ensure staff competencies, and require providers to adhere to the same regimen. DSHS will work with the LMHAs to make training more accessible and to develop alternative ways for staff to demonstrate specific competencies required by DSHS.
- 3) Some LMHAs proposed a payment rate less than the standard Medicaid reimbursement rates. Proposed revisions to the LPND rule include two key requirements related to procurement. First, LMHAs would be required to apply equal standards to internal and external providers. Second, compensation for an external provider must be equal to the cost of an internal service provider performing the same service in accordance with the performance contract. The revisions also include an appeals process so that providers can obtain state review if they are unable to resolve procurement issues at the local level.

DSHS also established a workgroup to begin the formal rule revision process and to try and address these issues. The second cycle of network development began in January, 2010, and plans are due during the summer of 2010.

## **Service Expansion**

### **Substance Abuse Medicaid Benefit**

As a result of the 81st Texas Legislature, an appropriations rider directs the Texas Health and Human Services Commission (HHSC) to provide coverage for comprehensive substance abuse treatment services to persons who qualify for Medicaid, enabling consumers with co-occurring disorders to more easily access substance abuse services. The Texas Medicaid program currently covers very limited services for substance abuse/dependence and consists of hospital-based detoxification for adults and adolescents and outpatient (individual and group) treatment for adolescents.

In response to the rider, HHSC and DSHS have developed a comprehensive substance abuse benefit package to be implemented in the Texas Medicaid program. The expansion is scheduled for implementation on September 1, 2010. The implementation will be phased in, with the outpatient benefits beginning on September 1, 2010. Pending approval of changes to the state Medicaid plan by the Centers for Medicare & Medicaid Services, residential benefits will begin on January 1, 2011.

### **Supported Employment**

Consumers with psychiatric disabilities due to severe mental illness (SMI) often are highly employable given employment supports and the desire to work. With tailored and fidelity-based supports, many individuals are able to provide meaningful contributions to the workplace. However, consumers are often unsure about how to navigate the system to access the resources available to them, such as work incentive programs and Medicaid buy-in. Individuals with SMI and the agencies assisting them must collaborate to achieve optimal results. Consumer-agency partnerships are critical to support the employment of individuals with SMI. Local mental health authorities also play a critical role in assisting consumers returning to the workplace.

DSHS has designed a learning community process in which four LMHAs currently participate along with local representatives from the state's vocational rehabilitation agency (DARS), the workforce board and consumer members. The learning community teaches these partners how to implement or improve their evidence-based supported employment programs and coordinate services and resources. Participants have formed innovative partnerships and work closely with expert faculty. The experts continue to support and provide technical assistance to the LMHAs as they consider potential changes in the organizational structure and systems processes within their centers. The LMHAs are learning how to manage these changes as systems move closer to a recovery-based paradigm. Throughout this project, the pilot centers have the opportunity to think creatively about their operational systems and their organizational recovery orientation with respect to supporting employment for people with SMI.

### **Peer Support**

Via Hope, a training and technical assistance center, operating under contract with DSHS is engaged in efforts to train and certify consumers and family members as peer specialists. A peer specialist is someone who has lived with or has experienced mental illness and is far enough along in his or her recovery to begin providing support to other consumers. Currently, eleven local mental health authorities (LMHAs) are engaged in a peer specialist learning community. The pilot program aims to increase the availability of peer support services statewide. The aim of the learning community is to support the implementation of successful integration of peers into the mental health workforce. It is a process that will be used to increase the availability of peer support services statewide. The peer specialist movement is recovery based and represents a paradigm shift for some of the centers participating in the initiative. The learning community includes monthly support calls and two *in vivo* conferences over a nine-month period to assist the center leadership and support staff in understanding and implementing necessary organizational changes.

The peer specialist certification program that Via Hope delivers on behalf of the state provides a core curriculum based on a whole-health paradigm (the body and mind are linked and one cannot be treated without the other). The program is available to consumers who are currently providing

peer support services at their local LMHA or to consumers who are interested in becoming peer specialists. The training for certification is 40 hours, including an eight-hour whole-health module. A certification test is taken following completion of the training. Two trainings have been held in Austin, with a total of 58 peers trained. Twenty-four peers who attended the initial training have passed the certification test. Additional peers will be certified upon the completion of the trainings and administration of tests.

## **Information Technology in the Service of Quality of Care**

### **Data Exchange System for Special Needs Offenders**

\*\*7. The 80<sup>th</sup> Texas Legislature in FY 07-08 passed Senate Bill 839, which amended the Texas Health and Safety Code, Chapter 614, to include the Department of Public Safety (DPS) Bureau of Identification and Records in the data exchange process. As amended, Texas Health and Safety Code §614.017 compelled DSHS and DPS to develop a real-time identification and data exchange system for special needs offenders to replace the current 72-hour manual data exchange process. This revision is intended to ensure more expedient data exchange to support continuity of care for individuals with mental illness in the criminal justice system as well as local post-booking jail diversion activities. Full implementation of the Senate bill will be completed by September 2010.

### **Resiliency and Disease Management Redesign**

\*\*5. Resiliency and disease management (RDM) is a model of service delivery designed to better match services to mental health consumers' needs and to use limited resources more effectively. The primary goals of RDM are to ensure that consumers are receiving the services that are most beneficial to them and their recovery and to achieve the best results possible given limited funding by using evidence-based practices.

To assess the impact RDM has had on the mental health service delivery system from 2004 to 2009, DSHS, the LMHAs, advocates, and other stakeholders have combined to analyze where Texas is as a state and where it needs to go to enhance the mental health system. One significant area being studied is the method by which people are matched with services. Individuals are currently matched with service packages based on their level of need, designed to ensure that they receive appropriate services, in an adequate amount, and in the most efficient manner. DSHS is asking other states about their current practices for matching consumers to services and/or service packages. The workgroup is also examining the services that are available in each of the current service packages to ensure that consumers are getting the services they need to work toward recovery.

Another significant part of RDM being researched and analyzed is outcome measurement. DSHS currently collects information from each LMHA regarding outcomes for consumers to determine if the services being provided are effective. In order for DSHS to make informed policy decisions for the mental health service delivery system, it must collect and analyze clear and relevant data. This data is used to improve services and the lives of consumers. The RDM group will continue to have discussions with stakeholders to identify outcome measures that will provide the most accurate information about the effectiveness of services.

### **Clinical Management for Behavioral Health Services (CMBHS)**

\*\*7. CMBHS began deployment to substance abuse treatment providers in December 2009 and will complete in August 2010. CMBHS was deployed to NorthSTAR substance abuse treatment providers in August 2010. In an effort to minimize the impact on mental health providers who are using another electronic health record (EHR), DSHS is implementing a data-exchange process in addition to the web-based system. The long-term goal is to implement national standards-compliant data exchange for mental health services clients, which enables real-time and batched system interoperability between CMBHS online and EHR systems maintained by contracted providers. The timeframe for implementation is estimated to be more than 18 months. A

transitional step is to provide mental health information currently reported to the Client Assignment and Registration (CARE) system directly into CMBHS, facilitating access to a single repository for behavioral health information for both mental health and substance abuse treatment providers. This is an important step in shifting information exchange from CARE to CMBHS and is targeted to be available by December 31st, 2010. When new behavioral health data standards are adopted, the data required for submission will change.

Adult - Legislative initiatives and changes, if any.

## **Adult – Legislative Initiatives and Changes**

The Texas Legislature meets biennially, with the next regular session opening in January 2011. In 2010, the focus was on implementing legislation from the 81<sup>st</sup> Session (2009) and preparing for issues that are likely to be on the legislative agenda in 2011.

### **Update on Previous (81<sup>st</sup>) Legislative Activities**

#### **Expansion of Community Mental Health Crisis Services**

The 81<sup>st</sup> Texas Legislature appropriated \$108 million in state fiscal years (SFY) 2010 - 2011 for community mental health crisis services in three main categories:

##### **Maintenance of Crisis Services**

The 80<sup>th</sup> Texas Legislature allocated funds to support enhancement of the crisis delivery system during the 2008-2009 biennium. There was a “ramp-up” period for these services. To maintain the level of services established as of 2009, the 81<sup>st</sup> Texas Legislature allocated an additional \$26 million for the biennium.

##### **Transitional and Engagement Service Enhancement**

Statewide data indicate that approximately 63% of individuals who receive crisis services in the community are not linked to comprehensive, ongoing care. Many of these individuals have complex requirements as arising from homelessness, substance use disorders, involvement with the criminal justice system, or multiple psychiatric hospitalizations. A total of \$26 million was allocated to engage this population with a flexible array of services to ease the transition from acute crisis stabilization services to ongoing community services.

##### **Increased Capacity for Intensive Services**

The statewide service delivery system has insufficient capacity to ensure access to ongoing intensive services as people transition from acute crisis stabilization. DSHS received an additional \$29 million to increase capacity for the most intensive levels of community services to provide ongoing support for these individuals.

More information about these initiatives is found in the description of Adult-Recent Achievements.

#### **Veteran Support Services**

\*\*3. The 81st Texas Legislature approved \$1.2 million to address identified gaps in behavioral health services for veterans. Texas has the third largest population of veterans in the United States and contributes a significant number of the combatants fighting in Iraq and Afghanistan. In September 2007, approximately 1.7 million veterans were living in Texas. An additional \$5million was later directed toward veteran’s services at the request of the Governor. The majority of these funds were distributed to communities to organize locally and address the needs of veterans and their families. The combined total of \$6.2 million has allowed for training and implementation of veteran-specific services and supports described below.

##### **Cognitive Processing Therapy (CPT)**

Reports indicate one in five service members returning from Iraq or Afghanistan experience post-traumatic stress disorder (PTSD) and/or depression, and most will not be treated by the Department of Defense or Department of Veterans Affairs (VA). Rising suicide rates have underscored the need for additional community supports for these personnel.

Cognitive processing therapy (CPT) is a 12-session treatment that can significantly reduce symptoms of PTSD. It has been shown to be effective for combat as well as for sexual assault and other traumas. VA providers throughout Texas have been trained in how to use CPT. With the new funding, VA coordinators working under the oversight of Dr. Amy Williams are training local mental health authority (LMHA) staff in CPT, with a special focus on working with veterans. Over 90 LMHA staff completed the training, and two more sessions are scheduled for August and September. DSHS anticipates 191 counselors will be trained through this initiative.

### **Peer-to-Peer Services**

The stigma associated with obtaining assistance often discourages veterans from seeking appropriate mental health services. To address this issue, SB 1325 directed DSHS to implement a mental health intervention program for veterans using peer-to-peer supports. DSHS is creating a peer support program using a model that was created in Texas and has been supported by the Texas Veteran's Commission.

The "In the Zone" program uses peer-to-peer assistance groups to provide comradeship, inspiration, and support to veterans. These groups complement the formal service delivery system and are designed to make veterans more open to seeking professional assistance when appropriate.

The program has three components: *Preparing*, *Caring*, and *Sharing*. The *Preparing* component consists of the facilitator training and continuing education course, which trains volunteer veterans to implement the program in their communities. The *Caring* component connects veterans to social services, financial assistance, and other resources to help them successfully reintegrate into their families and communities. Through the final component, *Sharing*, PTSD support workshops provide veterans with peer counseling services to facilitate their recovery.

DSHS is sponsoring "In the Zone" training to communities that are ready and willing to support and implement all three components of "In the Zone." As of the end of May 2010, 73 facilitators from across the state had completed training, with five more trainings scheduled. DSHS plans to develop a train-the-trainer program to expand the state's network of peer-to-peer facilitators.

Another peer to peer approach being implemented is designed for families and called *Operation Resilient Families*. This program involves veteran family members being trained to facilitate groups that address readjustment and reintegration of families after deployment.

### **TexVet**

Many federal, state, and private entities provide a broad range of services and resources for veterans, service members, and their families in Texas. This complexity makes it difficult to gain a comprehensive understanding of service availability and utilization. It also presents significant challenges in facilitating access and coordination. TexVet, an office at Texas A&M Health Science Center, was established to address these issues. TexVet is responsible for hosting an interagency collaboration, facilitating linkages, managing an online database of resources, and conducting outreach activities.

DSHS has contracted with Texas A&M Health Science Center to enhance the database with an expanded catalog of services and programs, improved linkages for updating the information, and individualized online matching services. In addition, TexVet is conducting outreach and marketing activities to promote use of the online database. Funds are also being used to support collaboration and improve coordination, particularly between state and local providers.

### **Coordination with Criminal Justice**

Several bills from the 81<sup>st</sup> Texas Legislature focus on improving coordination between criminal justice and mental health services.

Rider 97 allocated \$7.5 million to establish a mental health facility constructed and operated by a county and a private mental health care partner. The facility seeks to reduce the number of individuals with behavioral health issues who need psychiatric hospitalization but remain in jail until space becomes available in the state system. DSHS has accepted a proposal from Montgomery County, and contract negotiations were completed in June, 2010. The 100-bed facility is scheduled to begin operations in 2011.

Rider 98 directed DSHS to provide grants for mental health deputy programs to divert individuals from unnecessary incarceration and facilitate assessments for appropriate behavioral health treatment. This enhanced diversion initiative has been implemented at MHMR Services for the Concho Valley, Heart of Texas Region MHMR, and Permian Basin Community Centers. To date, 650 individuals have been diverted by the three programs.

House Bill 1233 gave probate courts authority to order an incarcerated individual to receive psychoactive medication based on the treating psychiatrist's concern for the individual's health and safety. When such an order is made, licensed psychiatrists at the correctional facility create a continuity of care plan for the individual pending transfer to residential care or an inpatient competency restoration facility. This change in law restored the criminal court's jurisdiction when transfer is delayed so inmates who are in crisis may receive appropriate medical attention and psychiatric treatment. Several county courts and jails are now operating under these new provisions. Most of them are in large urban areas, which are more likely to have the staffing necessary to administer medication. In response to questions about specific implementation issues, the authors of this bill are preparing clarifying amendments for consideration by the 82<sup>nd</sup> Texas Legislature in 2011.

House Bill 888 clarified the length of time that a person with mental illness can be detained before being released without a mental health evaluation. It gives mental health facilities an additional four hours to perform a comprehensive evaluation or obtain a protective custody order if the 48-hour maximum custody period ends on or near a weekend, legal holiday, or before 4 p.m. on the first succeeding business day. DSHS is revising its rules to reflect this change.

House Bill 1067 amended existing law allowing authorized entities, including community mental health centers, to share non-identifying data on suicide. The purpose was to encourage prompt reporting and to reduce the occurrence of suicide. DSHS is making revisions to the existing memorandum of understanding affected by this amendment.

## **Other Legislation**

Rider 81 established psychiatric and psychotherapy services for the uninsured and underinsured populations at a designated community health center. The community health center, Lone Star Circle of Care, has partnered with the Texas A&M Health Science Center College of Medicine in Round Rock, Texas. The legislature set aside \$500,000 to hire psychiatrists and psychotherapists to train third-year medical students and provide direct care services at the clinic. During the first three quarters of 2009, 1,376 uninsured and underinsured individuals received direct psychiatric or psychotherapeutic clinical care.

## **82<sup>nd</sup> Texas Legislature**

### **Budget**

The most pressing issue facing the state is the projected budget shortfall, now estimated to be \$18 billion. Early in 2010, agencies were asked to look develop options to reduce their budgets.

DSHS identified significant savings in administrative expenses. The health and human services agencies are providing options to the state legislature regarding possible additional reductions.

DSHS is currently working with stakeholders to identify options for budget reductions while protecting client services to the greatest extent possible. In addition to providing match for federal Medicaid dollars, state general revenue funds are used to pay for supplemental services not covered in the state Medicaid plan and to provide care for medically indigent residents. Service reductions are likely to have a disproportionate impact on the state's large medically indigent population.

## **Healthcare Reform**

It is anticipated that healthcare reform will have a greater impact in Texas than in most states. Under the Patient Protection and Affordability Care Act (PPACA), states with high rates of uninsured residents and low Medicaid coverage will see the greatest increases in coverage and federal funding. Texas currently has the highest rate of uninsured residents in the nation, with 25% of the general population and 30% of non-elderly adults lacking coverage. The existing Medicaid plan extends coverage for pregnant women and newborns up to 185% of the federal poverty level and aligns with the federal minimum coverage for all other populations.

The Health and Human Services Commission (HHSC) estimates that the total caseload for Medicaid and the Children's Health Insurance Program (CHIP) will increase by 52% between 2014 and 2023 under PPACA. The cost to the state's budget during that period is projected to be \$27 billion. Until more information is available, it is difficult to assess the potential impact on mental health services.

Although Texas is challenging the legislation, implementation is moving forward. Texas has chosen not to establish its own high-risk pool, but HHSC and the Department of Insurance are taking steps to implement the requirements for expanded access to coverage and increased regulation of insurance companies. Within the state legislature, interim committees in both the Texas House and Senate are studying the implications of PPACA for Texas, the healthcare industry, and public and private insurance, and will develop recommendations for efficient implementation. It is unlikely that Texas will exercise the options for early implementation of PPACA provisions or voluntary expansion of benefits.

## **Emerging Issues**

The work of interim committees point to issues that may emerge in the 82<sup>nd</sup> Texas Legislature. Interim charges in the area of health and human services include examining the efficiency and effectiveness of prevention and early intervention programs, including those for mental health, and studying the scope and effectiveness of mental health services for abused and neglected children.

Workforce shortages are a continuing challenge for behavioral health providers in Texas. This is particularly true in the border region and underserved/rural areas of the state. Interim committee charges include developing recommendations to ensure sufficient numbers of health care professionals, with particular attention to the role of advanced practice nurses.

Health information exchange (HIE) is another key topic. Recommendations will address the state's role for facilitating HIE, including the possibility of using the Medicaid exchange as a framework for a statewide system and the feasibility of developing multiple regional health information technology exchanges in Texas. This is particularly relevant for DSHS, which is developing its own health information exchange system for behavioral health.

The House Appropriations Committee is studying cost and caseload trends in the Texas Medicaid program and making recommendations to control state expenditures. The Public Health Committee is also focusing on cost containment and quality of care in the state Medicaid program.

Veteran services issues remain a priority. Legislators are monitoring the implementation of veterans' court programs in Texas. They are also examining the link between combat stress disorders and the onset of criminal behavior.

Adult - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

## **Adult – Description of State Agency’s Leadership**

In Texas, mental health services for adults and children, substance abuse services, and public health services are co-located in the Department of State Health Services (DSHS). The organizational structure for DSHS promotes leadership for mental health issues at multiple levels.

The DSHS deputy commissioner is tasked with overseeing the integration of mental health, substance abuse, and public health services. This role includes serving as the agency's liaison to the DSHS Council, a group of nine members appointed by Governor Rick Perry. Several council members have backgrounds in mental health and substance abuse systems. To ensure that behavioral health remains a priority in the organization, the deputy commissioner is required to have a background in behavioral health.

The assistant commissioner for the Mental Health and Substance Abuse Services Division reports directly to the DSHS commissioner. The assistant commissioner is responsible for the oversight and operation of the publicly funded mental health system in Texas. He is designated by the governor to act as the single state authority for mental health. The assistant commissioner is involved in the day-to-day state level functions which ensure that mental health services are provided to the citizens of Texas. The assistant commissioner also leads the Mental Health and Substance Abuse Services Division in its mission “to serve Texans by providing leadership and oversight for mental health or substance abuse services by building resiliency, and facilitating recovery in homes and communities.”

The behavioral health services medical director reports directly to the assistant commissioner for the Mental Health and Substance Abuse Division. This position plays a vital role in shaping programs and policy and in providing clinical oversight for mental health and substance abuse services in Texas. Currently, the medical director is a psychiatrist who possesses an extensive background in working with both adults and children in the state hospital system and the community center system.

Also, a Mental Health Transformation (MHT) grant was awarded to the state. The goal is to facilitate infrastructure changes to transform the Texas mental health service system, thus improving capabilities to promote wellness, resilience, and recovery. Through the leadership of Governor Rick Perry, the Texas Transformation Working Group (TWG) was formed. This group includes 14 public agencies in addition to consumer representatives that are focused achieving the goals of the President's New Freedom Commission. The Texas TWG includes representatives from the Office of the Governor, the Texas Senate, and the Texas House of Representatives. Three commissioners from the President's New Freedom Commission serve as *ex officio* members of the TWG. DSHS manages this initiative to improve the quality and availability of mental health services for Texans.

DSHS will continue to provide leadership throughout the public mental health system and to other public and private providers of mental health services.

Child - A brief description of how the public mental health system is currently organized at the State and local levels, including the State Mental Health Agency's authority in relation to other State agencies.

**Child – Overview of State’s Mental Health System**

See “Adult-Overview of State’s Mental Health System”

Child - New developments and issues that affect mental health service delivery in the State, including structural changes such as Medicaid waivers, managed care, State Children's Health Insurance Program (SCHIP) and other contracting arrangements.

## **Child – New Developments and Issues**

### **See “Adult-New Developments and Issues”**

Additional issues that pertain to children include:

#### **Youth Empowerment Services (YES) 1915(c) Medicaid Waiver**

The state's YES waiver proposal to the federal Centers for Medicare & Medicaid Services was approved in February 2009 and implementation began shortly after with enrollment of children beginning in April 2010. This program provides home and community based services to children as an alternative to institutional care (e.g., psychiatric inpatient care) and aims to prevent or reduce out-of-home placements by all child serving agencies. The program allows for greater flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families.

The YES waiver is still being piloted in a limited geographic area (Bexar and Travis Counties) and may serve up to 300 youth aged 3 – 18 at any time. Children are determined to be financially eligible for the waiver program using the same standards to determine eligibility for Medicaid in institutions. Under these standards, parental income is not considered. This eliminates the current incentive for parents to relinquish custody to obtain access to Medicaid coverage for mental health treatment.

In addition to regular Medicaid services, waiver participants are eligible for other services as needed, including respite care; family supports; community living supports; paraprofessional services, professional services, transitional services, minor home modifications, adaptive aids and supports, supportive family-based alternatives, and non-medical transportation. Targeted case management is provided to all waiver participants. Waiver providers have been and will continue to be enrolled and contracted by DSHS. Local mental health authorities will perform administrative functions at the local level.

Additional counties may begin serving as pilot sites as early as 2012 if the waiver is determined to be cost effective after its first two years of operation.

#### **Children's Health Insurance Program (CHIP)**

Recent statistics show that in the US, approximately 9 million children and 38 million adults don't have access to affordable health insurance. Of the 9 million children, 1.5 million live in Texas. Texas continues to lead the nation with the highest rate of uninsured.

In 2009, the 81st Texas Legislature attempted to remove barriers to children's access to healthcare. Three bills to increase CHIP eligibility for certain populations passed the Legislature and two were signed into law:

HB 1630 requires children scheduled for release from the Texas Youth Commission (TYC) facilities to be assessed for CHIP and enrolled in CHIP or Medicaid after release from the TYC facility.

SB 187 allows families who have children with disabilities to buy into Medicaid on a sliding scale based on family income. Additionally, SB 865 was signed into law which creates a health insurance program for uninsured children whose parents receive child support services.

## **Telemedicine**

Due to factors that affect service delivery to children and adolescents in rural and frontier parts of Texas such as workforce shortages and vast travel distances, new models of psychiatric service delivery are needed to improve the accessibility of mental health.

Telemedicine has been shown to be an effective method of intervention across the state with the child and adolescent population. It has also been shown to be cost effective, particularly in the rural areas of the state that have greater shortages of qualified staff. Telemedicine psychiatric services are now used extensively in the western and southern portions of Texas where travel distances across counties may correspond to travel distances across states in other parts of the country. Cities in Texas implementing this technology include Laredo, El Paso, Harlingen, Lubbock, and Midland/Odessa.

Child - Legislative initiatives and changes, if any.

## **Child – Legislative Initiatives and Changes**

### **See “Adult-Legislative Initiatives”**

#### **81<sup>st</sup> Legislature**

The initiatives listed in “Adult-Legislative Initiatives” affect the system of services to both adults and children. The 81<sup>st</sup> Legislature made efforts to continue to remove barriers to children and families seeking access to both physical and mental health services in Texas. At the conclusion of the session, Texas enacted legislation that impacted all areas of a child’s well-being. The following new legislative initiatives will continue to be implemented and followed in 2011:

- SB1646 and HB3259 created the Council on Children and Families to improve high-level interagency coordination between state health, human services, education and juvenile justice agencies charged with serving children as well as to address many of the challenges encountered relating to the state’s children’s services delivery system.
- HB1630 ensures children released from Texas Youth Commission (TYC) facilities are assessed for and enrolled in Children’s Health Insurance Program (CHIP) and Medicaid to prevent youth in the juvenile justice system who qualify for Medicaid or CHIP from facing gaps in their health coverage upon discharge.
- SB187 and HB187 allow families who have children with disabilities to buy into Medicaid on a sliding scale based on family income.
- SB282 allows the Texas Department of Agriculture (TDA) to support schools using best practices in nutrition education. TDA is also authorized to assist community and faith-based organizations and early childhood education programs that provide nutrition education to children.
- SB395 creates an Early Childhood Health and Nutrition Interagency Council to assess barriers as well as best practices to improving healthy nutrition and physical activity in early childhood care settings.
- HB1409 allows increased access to influenza vaccinations for children older than age 7.
- HB1795 expanded the scope of genetic disorders screened for at birth.
- SB1824 and HB2196 created an interagency Taskforce on Children with Special Needs to improve services provided to children with chronic illnesses, intellectual or developmental disabilities, or mental illnesses. This legislation also calls for the establishment of a workgroup to recommend to the legislature how to integrate health and behavioral health services.
- HB3689 establishes a continuity of care system for juvenile offenders with mental health impairments. The intent is to ensure that the health, mental health, education, and rehabilitative needs of juveniles are addressed through coordination of these services.
- HB1232 authorizes relevant state and local agencies to collaborate and share information to facilitate early identification and treatment utilizing a system of care approach for youth at risk of being removed from their home or school due to behavior challenges.

## **Children's Health Insurance Program (CHIP)**

An estimated 750,000 Texas children are uninsured and approximately half of those are eligible for CHIP or Medicaid. During the 81<sup>st</sup> legislative session, numerous important legislative efforts were launched to help improve access to children's health insurance. There is a shortage of children's mental health providers in Texas, and many children may not be able to access health and mental health service providers. The rates of reimbursement to providers through such programs tend to be low compared to market rates and reimbursement does not automatically increase with rising inflation.

However, newly enacted legislation created a health insurance program for uninsured children whose parents receive child support services. Now non-custodial parents who are court-ordered to provide medical support for their children and who are unable to find affordable health insurance coverage can now pay a monthly health insurance premium to purchase coverage. In addition, children released from Texas Youth Commission will not incur a loss in coverage but will retain their CHIP or Medicaid coverage. Children with disabilities are now eligible to purchase Medicaid on a sliding scale based upon parental income.

Child - A description of how the State mental health agency provides leadership in coordinating mental health services within the broader system.

## **Child – Description Of State Agency’s Leadership**

### **See “Adult-Description of State Agency’s Leadership.”**

The Child and Adolescent Services Unit in the Mental Health and Substance Abuse Division of DSHS is specifically devoted to coordinating the provision of mental health services and substance abuse prevention for children and adolescents in the state. The manager of this team is a child psychiatrist and represents children’s mental health on the state’s Advisory Council for Early Childhood Education and Care. She also represents Texas as a member of the National Association of State Mental Health Program Directors, in the Children, Youth, and Families Division.

Additionally, The Mental Health Transformation-System Improvement Grant project includes a subcommittee focused on the needs of children. The Child and Adolescent Services unit manager is the co-chair of the subcommittee. The subcommittee develops interagency projects to improve coordination and delivery of mental health services to children.

Other interagency system transformation projects have provided the opportunity for mental health experts employed by the state mental health authority to lead a variety of initiatives. Examples include: mental health treatment standards for children in foster care; mental health screening for incarcerated youth, mental health screening in primary care for children and adolescents; and mental health treatment as a key component of emergency response for adults and children. Each example signifies the agency’s commitment to agencies and organizations outside the boundaries of the traditional mental health service system.

The DSHS Behavioral Health Medical Director is a licensed child psychiatrist. She also provides leadership and consultation on children’s issues for the state.

Adult - A discussion of the strengths and weaknesses of the service system.

# Adult - Service System Strengths and Weaknesses

## Strengths

The Texas public mental health system promotes the use of evidence-based practices and the harnessing of information technology to support its clinical and programmatic goals. It has the means and will to focus on those areas of the state that pose special challenges in areas of cultural competency and access to services. Most important, Texas embraces a wide range of activities that are structured to enable the transformation of the current system into one that effectively supports consumer recovery.

### Evidence-Based Practices

#### Ongoing Refinement of an Evidence-Based Service Model

DSHS is committed to the development and ongoing refinement of a recovery-focused and evidence-based service delivery model. Texas implemented a resiliency and disease management (RDM) evidence-based model for mental health service delivery in 2004. Since 2004, DSHS has gathered service data on this model and has conducted extensive interviews with numerous staff members from a number of community mental health centers around the state to identify how the model can be improved. The state is currently working with stakeholders to determine how to best refine the model in order to improve both the efficacy and efficiency of service delivery. Processes already identified for possible change within the model include:

- Developing of a more reliable means of measuring outcomes;
- Incorporating a satisfaction survey in the quality assessment process; and
- Incorporating revised fidelity measurements in the quality assessment process.

Because per capita funding for mental health services in Texas is among the lowest in the nation, it is essential for the state to adopt the most effective and efficient service delivery model that can be provided with the funding that has been allocated.

### Information Technology

#### A Data Storage and Analysis System

\*\*7. The implementation of the resiliency and disease management (RDM) initiative included the development of capacity to measure system performance. Texas created a data warehouse that contains data related to assessments, service assignment, service delivery, utilization management, and waiting list management. A powerful data reporting and query engine (Business Objects) is utilized to perform data analysis on multiple facets of the Texas public mental health system. This allows for monitoring of age-specific outcomes such as hospital readmissions, improved functioning, reduced criminal justice involvement, and improved school behavior. The information is collected through a uniform assessment process and is made available in the aggregate to state and local managers. Managers can access this information through the data warehouse to track every aspect of clinical and administrative information, including outcomes, services provided, and provider performance. Cases can be benchmarked and progress charted. This is a monumental advance from the previous data system that was capable of providing information on client registration only.

#### Movement Toward an Electronic Health Record

Texas is currently in the process of implementing a web-based electronic client health record system, the Clinical Management for Behavioral Health Services (CMBHS) record system. Deployment began in December 2009, and the system is being implemented across the state by region, first for substance abuse providers (completion targeted for August 2010), and then for public mental health providers. In addition to an electronic health record, CMBHS also serves as

a clinical tool which includes diagnostic and treatment plan capabilities. Ultimately, the CMBHS system will combine the electronic health recordkeeping requirements for both mental health and substance abuse treatment providers in a single system, as well as integrate cost data, service assignment data, and service outcome data.

### **Use of Technology To Improve Access to Services**

Texas has a very large rural population. In many areas travel from rural towns to primary clinics is inconvenient, expensive, and time-consuming. This poses a considerable barrier to access for thousands of Texans. To mitigate this access problem, Texas community mental health centers began limited use of telemedicine in 2002. In 2006, the state began a formal evaluation of the use of telemedicine to provide psychiatric services. Based on the outcome of this evaluation, Texas now allows Medicaid reimbursement for telemedicine-based psychiatric services delivered by community mental health centers.

### **Border Initiatives**

#### **Border Collaboration - Services to Colonias**

In November 1999, the Health and Human Services Commission (HHSC) launched the border health initiative in an effort to improve services along the Texas-Mexico border. This initiative required all state health and human service agencies to assess the degree of service activity along the border and to develop and implement a plan to improve the access and availability of services to individuals traditionally underserved and living in the colonias. These are among the most challenging areas along the border.

The agency representatives for the HHSC Colonias Initiative meet monthly to plan and provide updates of current agency activities in the colonias. Forty-six Texas counties have one or more designated colonias. Four counties and the Rio Grande Valley submitted integrated service plans to Texas HHSC for implementation between January and December 2009, with a range of service goals:

- Demonstrated cultural competence by staff providing health and human services in all interactions;
- Readily available and easily accessible health and human services;
- Continuous and current information to colonia residents regarding available health and human service agencies and how to access coordination with local food banks to remedy decreased food commodities in colonia community centers; and
- Collaboration among community- and faith based organizations and health clinics to increase access to medical services

### **Transformation**

#### **Integrated Technology for Behavioral Health System Transformation**

\*\*9. The increased use of technology to transform the mental health system is an important activity identified in the Texas Comprehensive Mental Health Plan (CMHP). The state clearly identifies the increased use of technology as key to support and catalyze transformation of the mental health system. Priority projects include the use of technology and data to assess and address behavioral health issues. The state continues to work toward goals related to enhanced information technology and data sharing:

- Electronic data sharing between the state mental health authority and criminal justice entities (Department of Public Safety, Texas Correctional Office on Offenders with Medical or Mental Impairments, Texas Department of Criminal Justice, Texas Youth Commission and the Texas Juvenile Probation Commission) to reduce involvement and/or enhance continuity of care for persons with mental illness involved in the criminal justice system.
- Refinement of the Restraint and Seclusion Reporting System, which was tested in four state hospitals with the intent to reduce and ultimately eliminate the need for restraint and

seclusion. The system was found to be effective and is not used in all state hospitals to report seclusion and restraint.

- Development and implementation of data standards to allow data sharing, care coordination, and technology planning at state agencies involved in managing and delivering health and social services.

### **Integration of Mental Health and Substance Abuse Services**

\*\*1. The creation of the Texas Department of State Health Services (DSHS) brought together public health, mental health, and substance abuse services into a single agency. Mental health and substance abuse services are further integrated administratively in a single operational division with shared leadership. This integration contributes to improved capacity of both mental health and substance abuse providers to serve the needs of persons with co-occurring disorders at all levels of the operation and is reinforced by cross-training agency-wide.

The following examples indicate how the combined Mental Health and Substance Abuse Services (MHSA) Division has integrated the disciplines in an effort to improve the continuity of care and services:

- The Outreach, Screening, and Referral (OSAR) substance abuse program provides mental health related services by screening for mental health issues during routine substance abuse screenings, and by providing mental health materials at substance abuse prevention centers. OSAR staff members are trained to provide motivational interviewing during crisis screenings and assessments.
- The local mental health authorities (LMHAs) have offered training in trauma-informed care for substance abuse treatment providers. As part of the crisis redesign initiative, some mobile crisis outreach teams now include licensed chemical dependency counselor staff. DSHS also holds statewide conference calls addressing the need for co-occurring treatment in the community mental health service delivery system and in substance abuse treatment settings.
- DSHS will continue to use a behavioral health framework in its substance abuse prevention programs which allows for efficient, cost-effective, and culturally-appropriate prevention services for substance abuse and other mental health related disorders. The behavioral health framework will promote prevention of substance abuse and related mental health disorders. It will enhance the state's ability to provide a comprehensive continuum of services that promotes individual, family, and community health. Services are designed to prevent substance abuse, promote mental health, support resilience, foster recovery, promote treatment, and prevent relapse.
- The annual DSHS Summer Institute will provide a comprehensive prevention track, including the basic 40-hour course to be credentialed as a certified prevention specialist, prevention ethics, a coalition track, and a leadership management track. In SFY 2010, DSHS expects to provide training to 1,200 professionals in the fields of mental health and substance abuse, as well as to other professionals working in related areas. In the past, the institute has focused on substance abuse. However, it now provides professionals with a wider variety of information on both substance abuse and mental health topics.
- The Clinical Management for Behavioral Health Services (CMBHS) web-based database is an information technology system that integrates mental health and substance abuse services. Benefits to the use of CMBHS for both mental health and substance abuse providers include:
  - 1) More streamlined intake, admission, assessment, diagnosis, treatment plan development, treatment, and discharge processes;
  - 2) A reduction in the amount time it takes staff to perform administrative tasks and gather basic client information during the intake and admission process;
  - 3) A single screening process that assesses a person's need for MH or SA treatment, or both, eliminating the need to conduct separate screening interviews;
  - 4) Creation of a single client record that can be shared between DSHS-funded MH services providers, SA service providers, and any other authorized users, ensuring

- access to important treatment history and eliminating the need to create and maintain multiple client records that are often difficult to access; and
- 5) Ready access to previous admission and treatment history, enabling clinicians to better avoid repeating ineffective treatment regimens.

### **Primary Care and Behavioral Health Integration**

\*\*8. This program is a federally qualified health center (FQHC) "incubator program." DSHS has set aside funds to offer contracts under the Primary Care and Behavioral Health Integration Program (PCBHIP). These funds are to be used to support planning and partnership development between local mental health authorities (LMHAs) and FQHCs or FQHC "look-alikes" that conform to FQHC requirements but don't receive federal Section 330 grant funds. The long-term goals of this project are to improve LMHA consumer access to primary healthcare services and make specialized mental services available to consumers of FQHCs and vice versa; as well as increase the chances of success of the FQHC's success in applying for federal funds to support integrated care.

These contracts will pay for several categories of expenses incurred by FQHC and LMHA staff working on integration. These include:

- expenses for travel to off-site trainings and conferences;
- on-site training, technical assistance, and consultation;
- staff time and travel to inter-agency meetings; and
- salary for a PCBHIP coordinator

### **Mental Health Transformation Project**

The population of Texas is growing and expanding in diversity. Texas has recognized that ensuring equitable, culturally competent access to quality mental health and substance abuse services will continue to require greater effort and increased interagency collaboration and coordination.

Texas is using the funding from the Mental Health Transformation State Incentive Grant to build a foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the needs of mental health consumers across the life span. The Mental Health Transformation (MHT) project is guided by the Transformation Working Group (TWG), a partnership of government agencies and consumer representatives.

The Department of State Health Services has leveraged existing interagency initiatives involving criminal justice, juvenile justice, rehabilitation services, and early intervention, fueled by urgent need and the energy to drive transformation. DSHS has also worked with academic research partners to incorporate in practice the results and lessons learned from research.

Through the MHT Project the state continues to move the existing system toward a transformed service delivery system. Fourteen agencies, consumers, and representatives of the state legislature have formed the TWG. The TWG has outlined a number of strategies to address workforce concerns: collaboration with universities and licensing/credentialing bodies to address professional training and curriculum requirements, credentialing of peer specialists, and the use of new technologies to promote distance-learning initiatives. The TWG representatives have worked diligently to build consensus across agencies and have supported the development of new partnerships to advance the improvement of mental health services.

The Mental Health Transformation Project has initiated a number of transformative activities. Among these are:

#### **Community Collaboratives**

To be successful, transformative activities must occur at both the state and local levels. Policy, infrastructure, and program changes solely at the state level will not result in improved access or outcomes at the local level without community-level, consumer-focused implementation. The

MHT Project funds community-based collaboratives, representing the diversity of Texas, to demonstrate transformative efforts within Texas regions and to serve as partners in testing new programs and infrastructure developed by both state and local-level organizations.

#### Training and Technical Assistance Center (Via Hope)

Via Hope is a training and technical assistance resource for mental health consumers, their family members, youth consumers, and professionals funded by a combination of Mental Health Transformation and Mental Health Block Grant funds. It provides mental health consumers and family members with information and education that assists with their recovery, and enables them to better navigate the public and private mental health care systems. Via Hope also operates a certified peer specialist training program. The center is operated by Mental Health America of Texas and NAMI Texas.

#### Supported Employment

Supported employment is a well-defined approach to helping people with mental illnesses find and keep competitive employment within their communities. The Department of State Health Services, in partnership with other agencies, is working to improve supported employment programs across Texas.

#### Integrated Care

Persons with mental illness die an average of 25 years earlier than the rest of the population. To increase this population's longevity, the MHT Project has allocated resources to advance the integration of physical and mental health care at the local level with an initial focus on the MHT community collaboratives. Within each collaborative, the local mental health authority (LMHA) is working in partnership with federally qualified health centers (FQHCs) and other organizations to develop and implement plans that accelerate integrated care between health care providers.

Resources made available to local communities include funding assistance through the Department of State Health Services Primary Care Office, the Mental Health Transformation Project, and an online health assessment tool which is still in the beginning stages of implementation.

In addition to the health assessment, the MHT Project is also providing resources to assist clinics and care sites in modifying workflow processes and coordinating care with other organizations within the community to advance treatment for frequently occurring conditions such as diabetes, cardiovascular disease, smoking, alcoholism, substance abuse, obesity, and depression.

#### Continuity of Care

As individuals move between systems of care, such as the state's psychiatric hospitals, community-based services, and other environments, it is essential that key components of any health condition or current service plan be appropriately and securely communicated so that appropriate treatment can be delivered. The Texas transformation effort focuses on several key activities, including a DSHS Task Force on Continuity of Care, the implementation of technology solutions to support the continuity of care between the criminal justice and public mental health delivery systems, and the development of behavioral health data standards to enhance continuity of care between and among local behavioral health care providers as part of the Clinical Management for Behavioral Health Services electronic health record system.

#### Veterans Programs

In December 2008, a TWG subgroup on veterans developed a report, *Behavioral Health Services for Returning Veterans and Their Families*, which identified behavioral health needs – and gaps in services – of veterans returning to Texas from Operation Enduring Freedom in Afghanistan and Operation Iraqi Freedom.

The 81st Texas Legislature allocated funding to DSHS to help bridge those gaps by implementing initiatives to expand training for veteran peer support, enhance mental health services, and

improve access to information about services available to veterans, service members, and their families.

TexVet: Partners Across Texas is the collaborative effort of federal, state, and local organizations that focuses on bringing military members and those who care about them a wealth of resources. TexVet serves as a forum for interagency collaboration and provides information directly to veterans and family members, including its web-based resource directory.

## **Challenges**

The Department of State Health Services (DSHS) is responsible for meeting the mental health treatment needs of both the Medicaid-eligible and medically indigent populations who have been diagnosed with a severe mental illness (adults) or serious emotional disturbance (children and adolescents). The primary challenge and greatest concern for Texas is the ability to address the growing number of consumers in need of ongoing mental health services. The demand for mental health services is far greater than DSHS's ability to contract or provide funding for these services. Waiting lists for treatment services exist at several local mental health authorities (LMHAs) and are growing longer. Although some LMHAs do not have waiting lists, their efforts to serve as many individuals as possible strain their resources and compromise the frequency, intensity, and quality of services that are provided.

There are a number of factors that make the delivery of public mental health services challenging in the State of Texas:

### **Increasing Population**

The population of Texas is estimated to have increased by 17.7% between 2000 and 2009. This represents a total increase of 3,686,515 according to the Texas state demographer. The total increase in the Texas population exceeds the current total populations of Arkansas and Vermont combined<sup>1</sup>. The rapid expansion of the Texas population creates a strain on the ability of the Texas mental health system to deliver quality services in sufficient volume to meet the needs of the designated priority population.

### **Largest Number of Uninsured Individuals**

Texas has the highest number of uninsured adults and children of the 50 states. The Texas Medical Association estimates that 30% of adults and 22% of children are uninsured. The total number of uninsured Texans exceeds 5,700,000 – which is larger than the combined populations of the neighboring states of Oklahoma and New Mexico<sup>2</sup>. The Texas public mental health system must serve as the “safety net” for uninsured adults with a severe mental illness and children with serious emotional disturbance. The large percentage of uninsured individuals means that Texas faces a greater challenge in meeting the needs of the uninsured than do other states. Furthermore, because the lack of insurance coverage serves as a disincentive for people to seek health care during the early stages of an illness; people seeking help are often much sicker than their insured counterparts.

### **Low Per-Capita Funding for Services**

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<sup>1</sup> The U.S. Census Bureau estimates that the 2009 population of Arkansas was 2,289,450 and the population of Vermont was 621,760.

<sup>2</sup> The U.S. Census Bureau estimates that the 2009 population of New Mexico was 2,009,671 and the population of Oklahoma was 3,678,050.

The overall per capita funding for mental health services in Texas is still among the lowest in the nation.<sup>3</sup> While funding for services has improved over the past three years, overall per capita funding for mental health services in Texas remains low. The recent legislative appropriations for improvements to the public mental health service delivery system have substantially expanded capacity and improved access to crisis, transitional, and intensive services. However, these enhancements have also highlighted the need to improve the less intensive ongoing services which are the services utilized by the vast majority of consumers in the Texas public mental health system.

### **Effects of the Economic Downturn**

The economic downturn that began in 2008 has had two significant impacts on the Texas public mental health system:

First, the number of people seeking services increased. For SFY 2007 the total number of people served by the Texas public mental health system was 243,377; during SFY 2008 the number increased to 263,863; and for SFY 2009 the number of people served reached 284,253. This represents a 16.8% increase in service demand from 2007-2009. Although it is difficult to determine exactly how much of the increase in service demand is due to the economic downturn, the increase in demand clearly exceeds the normally expected increase in demand attributable to population growth.

Second, due to declining tax revenues Texas is estimating an \$18 billion budget shortfall entering SFY 2011. Currently Texas state agencies are being asked to plan for budget reductions of around 14.5%. The state has implemented a hiring freeze that is increasingly placing stress on DSHS as employees retire or move elsewhere. If these proposed budget cuts are implemented, the continuation of services at the current level will prove to be a significant challenge.

### **Large Frontier and Rural Regions**

Texas has the nation's largest rural population with more than 3.5 million people residing in rural and frontier areas of the state. Access to services for this large population is complicated by the sheer physical size of the state, which covers 266,807 square miles. For thousands of Texans residing in the rural and frontier areas, the distance to services is a significant barrier to treatment. Moreover, because many individuals served by the public mental health system do not have transportation, the problem of access is further compounded. For staff providing services, the time required to travel great distances to serve only one or two consumers greatly increases the cost of delivering services. The Texas system has responded to this challenge through the establishment of satellite clinics in many small towns throughout the state and, more recently, through the use of telemedicine for the provision of psychiatric services. Although these initiatives have helped to partially reduce the burden of accessing services, travel distances continue to pose an ongoing challenge to service delivery.

### **Workforce Shortages**

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<sup>3</sup> Lutterman, T., Berhane, A., Phelan, B., Shaw, R., & Rana, V. (2009). *Funding and characteristics of state mental health agencies, 2007*. HHS Pub. No. (SMA) 09-4424. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Texas has historically been challenged by workforce shortages, especially in rural and frontier areas. The aging of the provider population, the difficulty in recruiting into mental health professions, funding issues, and the volume of staff needed to meet the increases in service demand all contribute to workforce shortages. The shortages are especially acute in rural areas. Although the Texas rural population is very large, the general trend toward urbanization continues. Because most professionals tend to prefer the conveniences associated with urban living, there is a dearth of licensed mental health professionals in many rural and frontier areas of Texas.

DSHS recently conducted a survey of the community health centers (CMHC's) to determine the number of licensed counseling professionals (licensed psychologists, licensed clinical social workers, licensed professional counselors, and licensed marriage and family therapists) who are delivering direct services to consumers. The survey indicated that only 333 licensed professionals were directly delivering services<sup>4</sup>, and 60% of these professionals were located in Houston, San Antonio, and Fort Worth. In rural areas, it was not uncommon for a single licensed professional to be serving six or more counties.

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<sup>4</sup> The survey covered 240 of the 254 counties in Texas. Excluded from the survey were the seven counties in Texas that are served through a managed behavioral healthcare organization (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall) as well as seven additional rural counties that were omitted because there was no response to the survey.

Adult - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

## **Adult – Unmet Service Needs**

The number of adults in Texas receiving DSHS-funded community mental health services has increased from 73,731 to 81,551 in the past four years. The demand for services continues to exceed supply. Texas is currently working to address these needs needs:

### **Rising Demand**

A lack of resources exists to support non-Medicaid funded services relative to the needs of the state's population. Texas leads the nation in the number of uninsured individuals. Information based on the 2007-2008 Census Bureau and the 2008 Current Population Survey as well as statistics from the Urban Institute and Kaiser Commission on Medicaid and the Uninsured reveal that 73.4% of the Texas non-elderly adult population is uninsured. DSHS funds local mental health authorities (LMHAs) to provide services to this indigent population, but as the population grows, so do waiting lists. The number of people waiting for ongoing community mental health services has increased from 1,394 to 5,422 in the past four years. According to the Census Bureau, the population of Texas will continue to increase in the years to come.

Decreased access to ongoing mental health services has also led to an increased need for front door crisis services. The number of people that received a front door crisis service increased from 1,997 to 5,265 over the past four years. This has put more strain on the LMHAs to provide services to these high need individuals. In return, this increases the numbers of people waiting to get into ongoing community services.

These facts point to a potentially large number of adults with serious mental illness who currently are not receiving, and in the future may be unlikely to receive, the care and supports they need. The growing population (most of which is currently uninsured), current funding levels, and budgetary constraints continue to limit the number of individuals who can access care.

### **Workforce Shortage**

In May 2008, The Hogg Foundation released a study entitled *Health Care in Texas: Critical Workforce Shortages in Mental Health*. The study determined that Texas faces a critical shortage of mental health professionals. Most counties in Texas are under-resourced, and these shortages are most prevalent in disadvantaged urban areas and rural and border regions. Compounding the problem is a shortage in mental health professionals who are racially, culturally, and linguistically competent. These problems reduce access to effective treatment, most notably in rural and border areas and in some cities. Existing supply gaps in mental health providers are likely to increase in the future. Leaders of state agencies and community health care organizations report extensive problems in recruiting and retaining mental health workers today. An aging workforce is beginning to retire, further exacerbating shortages. Under current policies regarding practice and delivery of mental health services, projected growth in mental health professions will not be sufficient to meet the growing demand for services in Texas.

The supply gap in mental health providers is likely to become even wider in the near future as the aging workforce begins to retire and fewer people enter mental health professions. With current workforce aging trends and a projected increase in demand over the next five years, the need for recruitment and retention of mental health professionals is crucial. Below is more information regarding mental health professionals in the mental health service system in Texas.

### **Licensed Professional of the Healing Arts (LPHA)**

DSHS recently surveyed all LMHAs to gather information on LPHA shortages. LPHAs include licensed professionals such as licensed clinical social workers, licensed professional counselors, licensed marriage and family therapists, physician assistants and advanced nurse practitioners with psychiatric backgrounds, and psychiatrists. Information included the number of LPHAs employed by each center, the amount of time spent on direct services versus the amount of time spent on administrative activities, and salary information. When analyzed in the context of the number of consumers needing counseling services, of the number of available LPHAs within the mental health system is significantly lacking. This is a barrier to providing evidence-based practices such as cognitive behavioral therapy.

### **Psychiatrists**

In October 2009, 173 of 256 counties in Texas were designated as whole county Mental Health Professional Shortage Areas (MHPSAs) due to a shortage in psychiatrists. Four counties had a partial county or low income mental health MHPSA designation.

### **Peer Specialists**

Nationally and within the state, there is a growing movement to utilize consumers of mental health services to provide support and assistance to persons in treatment. These are individuals who are in recovery or are family members of a person with mental illness or severe emotional disturbance. Certified peer specialists typically provide peer supports as an employee of, or contractor to, a provider of mental health services. Peer supports are consumer-centered services with a rehabilitation and recovery focus. They are intended to help consumers cope with and manage psychiatric symptoms. Peer supports help consumers identify and use community resources and increase their community living skills. Peer specialist activities are intended to help a consumer achieve the identified goals or objectives in his or her individualized treatment plan. Peer specialists may work individually with consumers or in a group setting. It is a profession that is encouraged and supported throughout the state.

DSHS recently surveyed all LMHAs to determine how many peer specialists are currently providing services and found that approximately 61 peers are employed across all of the CMHCs statewide. Peer specialists who were on volunteer status were not included in the total. Peers employed in Texas can provide services such as skills training, psychosocial rehabilitation, supported employment, and supported housing. They can also act as a social support for the consumers receiving mental health services and assist them in the process of recovery. The survey found the following barriers to hiring peer specialists: "difficulty finding people with the skills necessary to perform the required duties," and "the stress of being a consumer of services and provider of support for others; the stress of both can be too much, causing a large amount of absences and an increased need for supervision and support." An initiative to train and certify more peer specialists statewide is currently in place. Texas is still in the beginning stages of developing this resource and looks forward to further expanding on the opportunity to involve peers more fully in the service delivery system.

## **Evidence-Based Practices**

In addition to meeting the rising demand for services and overcoming workforce shortages, Texas is struggling to remain current with all of the research and fidelity to evidence-based practices. DSHS provides a wide service array; however, some of the evidence-based practices, that is, cognitive behavioral therapy (CBT), supported employment, and supported housing, have been implemented sporadically because of high provider turnover, the lack of licensed professionals to provide services such as CBT, and limited funding.

Statewide, psychosocial rehabilitation services are heavily based on evidence-based practices yet require improvement. These practices include skills training, co-occurring psychiatric and

substance abuse disorders services, supported employment, permanent supportive housing, and peer support. Research shows that these practices are effective when implemented correctly. Due to a lack of resources, Texas has been unable to implement these practices to full fidelity.

### **Texas-Mexico Border**

Please refer to the “Adult-Rural Area Services” section for more information.

Adult - A statement of the State's priorities and plans to address unmet needs.

## **Adult – Plans to Address Unmet Needs**

As noted in the section titled “Adult - Unmet Service Needs”, the demand for community mental health services currently exceeds the availability of those services. The Department of State Health Services (DSHS) is engaged in continuous initiatives and strategies to increase services to meet population and prevalence increases, improve access and efficiencies, and address workforce shortages. \*\*10. The DSHS MHSA Division has worked hard to educate the Texas Legislature around the benefits of mental health and substance abuse prevention and treatment, and how a focus on these issues reduces the rates of both incarceration and hospitalization. Despite tight budget constraints, DSHS successfully articulated its needs to the Texas Legislature for the past few and has received additional funding to address some of these unmet needs:

### **Plans To Address Rising Demand**

#### **Crisis Services Redesign**

\*\*3. In 2007 the Texas Legislature appropriated \$82 million to enhance the mental health crisis services throughout Texas. These funds were used to develop new capacity in various areas of the state to address the short term needs of individuals experiencing a mental health crisis. The following table illustrates many of the enhancements made to the Texas crisis service delivery system.

	SFY 2007	SFY 2008
AAS Accredited Hotlines	1	38
Mobile Crisis Outreach Teams	4	38
Extended Observation Units	3	6
Crisis Residential Facilities	10	13
Crisis Respite Facilities	4	14

In addition to these enhancements, Hill Country MHMR Center developed a 16-bed crisis stabilization unit that serves an area comprising 19 largely rural Texas counties. A portion of the crisis funding was utilized to assist with transportation costs for individuals in crisis and to provide training for mental health deputies who frequently respond to individuals in the community who are experiencing a mental health crisis.

#### **Increased Capacity for Transitional and Intensive Ongoing Services**

In 2009 the Texas Legislature appropriated \$55 million to the Department of State Health Services (DSHS) for the purpose of funding the implementation of expanded transitional and intensive ongoing services, with funds to be distributed evenly between state fiscal years 2010 and 2011 (SFY 2010-2011) for the following:

- Provide transitional services for individuals who have received mental health or substance abuse crisis services in Texas but are not members of the DSHS priority population. This enhancement provides up to 90 days of services to help these individuals make a successful transition back into the community.
- Provide up to 90 days of engagement activities to individuals who are difficult to engage in traditional services.
- Provide transitional services to a number of people who are waiting to be served in a traditional service package.
- Provide increased capacity for the provision of the more intensive services.

## **Training and Technical Assistance Center**

Please refer to “Adult-Resources for Providers” section for more information.

### **Plans to Address Workforce Shortages**

By creating opportunities to recruit and retain mental health professionals, Texas can improve the services that are being delivered.

#### **Physician Education Loan Repayment Program**

One resource available in Texas to expand the workforce is the Physician Education Loan Repayment Program. The purpose of the program is to recruit and retain qualified physicians to provide primary health care in areas of Texas that are medically underserved and for certain state agencies. The CMHCs are an approved practice site for these physicians. The eligibility requirements are below:

Physicians must:

- have full physician license with no restrictions from the Texas Medical Board;
- provide care to Medicaid and CHIP enrollees;
- not have concurrent service obligation;
- have eligible outstanding student loans;
- be board eligible in Years 1 – 3 and board certified in a primary care specialty by Year 4;
- and provide four consecutive years of services in a HPSA in Texas.

#### *Approved Specialties*

Family Practice	General Pediatrics
Osteopathic Family Practice	Psychiatry (including Child)
Obstetrics/Gynecology	Emergency Medicine*
General Internal Medicine	General Surgery*

#### *Approved Practice Site*

- Federally designated [Primary Care Health Professional Shortage Areas \(HPSA's\)](#), or [Mental Health Professional Shortage Areas \(MHPSA\)](#) for psychiatrists, in Texas;
- Federally funded Community Health Centers;
- Texas Health and Human Services Commission;
- Texas Department of Criminal Justice;
- Texas Youth Commission; and
- Texas Department of State Health Services

#### **Psychiatric Residency Rotations**

The 81st Texas Legislature appropriated funds in 2009 to establish psychiatric residency rotations in the state mental hospitals. Residency training has proven to be a successful tool in recruiting new employees who develop relationships with the organizations where they perform their clinical rotations and who wish to continue their experience beyond academic study. The ultimate purpose is to attract psychiatric physicians to work in all areas of the public mental health

field. This program is not administered by the state but rather through contracts with medical schools.

Residency rotations will enhance the ability of the public mental system to recruit qualified psychiatric physicians to work in the public mental health sector. DSHS expects to benefit greatly from the public sector-academic linkages that will inevitably follow residency and training programs from academic research centers into public mental health facilities. Having psychiatric residents in the state hospitals is also expected to improve the quality of care by motivating staff psychiatrists to further enhance their psychiatric knowledge so that they can mentor and inspire their trainees.

Service delivery began in September 2009. To date, 1,376 uninsured and underinsured individuals received direct psychiatric or psychotherapy clinical care. The most prevalent primary diagnosis is mood disorder (47.5%), followed by anxiety (26.9%). A substance abuse primary diagnosis is present in 8.1% of cases.

### **Licensed Professionals of the Healing Arts**

The workforce shortage in the Texas mental health system is an ongoing challenge. The survey conducted on LPHA availability within the community mental health system is being used to inform decision-making around the types of services that will be made available to consumers in the future.

## **Efforts to Support Evidence-Based Practices**

### **Supported Employment and Peer Support**

To expand on the usage of evidence-based practices, DSHS has started two new pilot projects. The first one involves the implementation of evidence-based supported employment, and the second project is the training and credentialing of peer specialists. Both projects have been conducted using various grant funding opportunities. Two groups of centers are currently in the pilot processes. The goal is to take lessons learned from the pilot projects and share these lessons with all CMHCs so that they have the knowledge and information to implement the practices as well. Please refer to section titled "New Developments—Adult" for more information.

### **Cognitive Behavioral Therapy (CBT) Training**

To enhance efforts to create an evidence-based mental health system, the Department of State Health Services (DSHS) embarked on the initiative, Expanding the Effectiveness of Cognitive Therapy (EXPECT), funded through a grant from the National Institute of Mental Health and the Substance Abuse and Mental Health Services Administration. This project builds on a previous grant, in which a stakeholder committee ranked and selected cognitive therapy (Beck, Rush, Shaw & Emery, 1979) as a cognitive behavioral treatment model for adoption by DSHS and created an implementation plan. CBT has an extensive track record of efficacy for the treatment of major depressive disorder (MDD). CBT has been found to be effective in reducing residual symptoms following medication treatment, reducing the risk of relapse and recurrence of depression, remediating chronic forms of MDD, and treating individuals who did not respond to an antidepressant trial. The EXPECT study had two aims. One was to see if masters' level therapists could be trained to provide cognitive therapy (CT), and the second aim was to see if the consumers receiving the service had reductions in depressive symptoms. The study found that adults with depression receiving CT in publicly-funded clinics improved. This finding occurred in clients who had severe depression, indicators of numerous functional impairments, and significant comorbidity. This is a promising practice for consumers with MDD.

### **Cognitive Processing Therapy (CPT) Training**

\*\*2. DSHS received funding through the 81<sup>st</sup> Texas Legislature to provide training on CPT to mental health staff. This training provides staff with the knowledge to successfully treat people with a history of trauma, including veterans returning from war. So far 91 professional therapists have been trained in CPT, and 20 more will be trained in August and again in September. The training sessions include two days of classroom training, followed by telephone consultations during which the therapists discuss with the CPT trainer at least two active cases.

### **United States - Mexico Border and Services to the Colonias**

**Please refer to the “Adult-Rural Area Services” section for more information on Services to the Colonias.**

Adult - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

## **Adult – Recent Significant Achievements**

The integration of mental health services with primary care public health is a central objective of the reorganization of services in Texas that led to the co-location of mental health and public health state agencies in DSHS. A recent initiative linking federal qualified health centers (FQHCs) and local mental health authorities (LMHAs) are providing an important next step toward this goal. Other significant achievements focus on regulating boarding homes, continuing the mental health transformation projects, and enhancing the state's ability to respond to disasters.

### **Federal Qualified Health Center (FQHC) Primary Care and Behavioral Health Integration Program (PCBHIP)**

The Department of State Health Services Federal Qualified Health Center (FQHC) Program set aside funds to offer contracts to supplement the current Primary Care and Behavioral Health Integration Program (PCBHIP). An FQHC is a type of provider defined by Medicare and Medicaid statutes. The designation includes all organizations receiving grants under Section 330 of the Public Health Service Act, certain tribal organizations, and FQHC look-alikes. Currently, six FQHCs in Texas are partnered with a local mental health authority (LMHA).

In addition to the benefit of grant funding, other positive aspects of the program include enhanced Medicare and Medicaid reimbursement, medical malpractice coverage through the Federal Tort Claims Act, eligibility to purchase medications at a reduced cost, and eligibility for various other federal grants and programs. PCBHIP funds are used to support planning and partnership development between the LMHAs and FQHCs.

The FQHC applies for three funded phases. These phases include project planning, project development, and project implementation. The FQHC has a main goal of improving client access to primary care services. The chances of a successful application for federal funds increase when the FQHC shows significant focus toward this goal. The contract pays for expenses incurred by staff working on integration. These expenses include travel to off-site training and conferences, on-site training and technical assistance, staff time and travel to interagency meetings, and a coordinator's salary.

### **Boarding Home Standards**

\*\*5. There is a lack of appropriate and affordable housing in Texas, particularly for individuals with severe and persistent mental illness and co-occurring disorders. In some areas, boarding homes have developed to address this lack of housing. Regulatory agencies, in an effort to develop standards and rules for such housing, must strike a delicate balance between ensuring safe housing and not contributing to increased homelessness.

Boarding homes, by definition, provide services, including communal meals, light housework, meal preparation, transportation, grocery shopping, money management, or laundry services to three or more persons residing who are unrelated to the owner or proprietor. Boarding homes are distinguishable from assisted living facilities, which are currently licensed in Texas by the Department of Aging and Disability Services (DADS).

In the 80<sup>th</sup> Texas Legislature (2007), the Health and Human Services Commission contracted with Health Management Associates to prepare a report outlining the current methods for regulating boarding houses. The report highlighted issues for legislative consideration in regards to boarding homes, particularly the care and treatment of the aged, disabled, and mentally ill.

The report also gave recommendations for strengthening housing options, strengthening enforcement and monitoring, and better education regarding boarding houses.

As a result of this report, in the 81<sup>st</sup> Texas Legislature, HB 216 was enacted for the purpose of defining and developing *Texas Register* (administrative law) model standards for the operation of a boarding home. A statewide workgroup was formed to develop model standards that municipalities and counties may choose to utilize should they desire to license boarding homes within their boundaries. The workgroup consists of the Health and Human Services Commission, the Department of Aging and Disabilities, the Department of Family and Protective Services, and the Department of State Health Services.

The *Texas Register* model standards are divided into seven sections. These standards include construction and remodeling, sanitary and related conditions, reporting and investigation of injuries, assistance with self-administering medications, requirements for in-service education of the facilities' staff, criminal history record checks, and assessment and periodic monitoring.

The standards have been presented to the public and feedback was received from statewide stakeholders and advocates. Revisions to the standards were made based on the feedback, and have been offered again for further comment. After the standards become part of the *Texas Register*, the municipality or county may set reasonable fees for issuing, renewing and inspecting facilities. The municipality or county may also impose fines, access records, and conduct inspections.

### **Mental Health Transformation**

\*\* 3. As a result of the 2009 Texas legislative session, Transformation Working Group (TWG) agencies were charged with engaging a broad range of activities. Based in part on a 2008 report produced by a TWG subgroup on veteran's needs, the Texas legislature allocated \$1.2 million and later expanded it to \$6.2 million to support the mental health of servicemen, veterans, and families. Activities undertaken through this work include enhanced cognitive processing therapy training for mental health professionals, incentive funding for local mental health authorities to enhance services to veterans, including coordinating services with partner agencies, and a competitive round of funding to provide additional services. In addition, a contract is in place with TexVet: Partners Across Texas (TexVet), a partnership between TWG agencies, higher education, and the private sector to better connect veterans and their families with existing services, builds virtual communities supporting veterans' needs, and serves as a forum for coordinating programs across service providers.

\*\*7&9. Data and information services have been an important focus of activities in 2010. See section titled "Adults-New Developments and Issues" regarding Senate Bill 839 and CMBHS.

The state mental health authority has been engaged in technology planning activities associated with the Office of the National Coordinator (ONC) for Health Information Technology's Health Information Exchange (HIE) Cooperative Agreement between ONC and state governments. The goal of the collaboration is to support health information exchange and address issues such as privacy and security, technology, consumer engagement and provider adoption, and governance issues. The agency is participating in the development and implementation of a pilot HIE project between select regional health information organizations (RHIO's) and the Texas Health and Human Services Commission. The state mental health authority is also partnering with a RHIO, the Integrated Care Collaboration, on an application for the Beacon Community program, with the goal of advancing integrated physical and behavioral health care.

There have been a number of policy changes and programmatic research that have contributed to the transformation of the mental health delivery system in Texas. These include:

- An interagency school health workgroup produced a report analyzing and making recommendations about coordinating and resource school-based mental health programs
- Via Hope developed a peer training program manual
- The Texas legislature created a work group on the integration of health and behavioral health, which is scheduled to release a report later this year.
- The legislature created a task force on children with special needs.
- Work effort has been put forward on improving health information exchange.

## **Disaster Mental Health Response**

The Department of State Health Services (DSHS) is the lead agency for disaster behavioral health and, in that capacity, established the Disaster Mental Health Services (DMHS), a full-time disaster mental health program. During Hurricane Ike, the DMHS was called upon extensively to respond not only to the affected area but also across the state as the scope of the response broadened. Local mental health providers in the hardest hit areas suffered structural damage to their facilities and were short-staffed, as many employees had evacuated the area in anticipation of the storm. To ensure that the communities' behavioral health needs were met, the DMHS team coordinated the efforts of other providers from across the state to respond with much-needed resources. Response efforts began on September 7, 2008.

DMHS established the Texas P.R.I.D.E. (People Recovering In Spite of Devastating Events) Crisis Counseling Program (CCP) to extend, expand, and enhance service delivery at the local level during and after federally declared disasters. This program was funded by the Federal Emergency Management Agency (FEMA) under the authority of the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1974, and was contingent upon the award of a CCP grant.

As a result of the overwhelming devastation caused by Hurricane Ike, DSHS applied for and received grant funding in the amount of \$8.5 million to administer and manage a CCP in the impacted counties. Five of the contracted LMHAs – The Gulf Coast MHMR Center, the MHMRA of Harris County, Spindletop MHMR, Tri-County MHMR, and The Burke Center – hosted teams for the Texas P.R.I.D.E. CCP in response to Hurricane Ike. The teams worked with DSHS Texas P.R.I.D.E. staff to ensure that the survivors of Hurricane Ike received the care needed to cope with and overcome the emotional stress caused by Hurricane Ike.

These teams made a concerted effort to hire crisis counselors and outreach workers from each provider's respective community so that team members, in many cases survivors themselves, could easily relate to other survivors. This was also beneficial in that most staff were already knowledgeable of recovery programs and social service systems within their catchment areas, expediting the referral process and empowering survivors to regain confidence and rebuild their lives.

By August 31, 2009, the Texas P.R.I.D.E. CCP had provided in-depth individual crisis counseling services, which included stress management, emotional support, and referral services to local resources, to 19,609 Hurricane Ike survivors. Additionally, Texas P.R.I.D.E. CCP staff members had reached an estimated 603,972 individuals by way of group services, brief encounters, and the distribution of informative materials.

Another highlight and accomplishment during the past year was the development of the Texas P.R.I.D.E. quarterly newsletter. These newsletters featured survivor success stories, program activities in the schools, and staff reflections on their work in the community. These stories put a human face on the impact of the disaster as well as the progress made over the past 12 months as communities rebuild. Like other disasters, Hurricane Ike provided an opportunity to demonstrate the resiliency of the human spirit.

The Department of State Health Services has also secured a Social Services Block Grant (SSBG) that is intended to fund activities designed to deter, reduce or eliminate the negative impact (i.e. psychological impact, environmental damage, structural damage, disruption of infrastructure, etc) of hurricanes on Texas counties. The social services funded under SSBG include but are not limited to assistance to health and mental health centers, development of local recovery-oriented systems of care, and assistance for education centers and training services. DSHS is working closely with the mental health and substance abuse providers in the impacted areas to ensure that the required funding is available and utilized for services that fall within the SSBG program goals. SSBG funds can be used to serve the victims through September, 2010.

### **Disaster Training**

Disaster Behavioral Health Branch (DBHS) has set out to provide mental health and mental retardation centers, substance abuse providers and public health regions with the training opportunity at no cost to the participants. The training is intended to ensure a consistent and uniform continuum of disaster behavioral health instruction for Hurricanes Dolly and Ike for local mental health, substance abuse providers, and public health regions. The training prepares provider staff to recognize and identify appropriate intervention strategies. Survivors referred by other community agencies to their local MHSA providers for follow-up mental health and substance abuse services benefit from the enhanced knowledge and skill sets of MHSA staff. The subject matter covered by the training varies from children's reactions to trauma to suicide prevention to resilience-building techniques among response behavioral health personnel. The number of mental health and substance abuse staff that plan to attend the training is close to 600 people.

Adult - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

## **Adult – State’s Vision for the Future**

Texas is committed to a multidimensional for the future of mental health services in the state. At the highest level of the Health and Human Services Enterprise System, there is a commitment for all Texas Health and Human Service agencies to integrate systems of health. A key aspect of this ideal is to ensure that statewide mental health needs are addressed.

At the agency level, the Texas Department of State Health Services’ (DSHS) vision is “A Healthy Texas.” DSHS envisions the melding of physical and behavioral health systems to eliminate healthcare “silos” and instead focus upon all aspects that enhance individual well-being.

The Mental Health and Substance Abuse (MHSA) Division supports the overall agency vision by identifying and implementing efficient, cost-effective administrative and service delivery strategies which result in the provision of essential mental health and substance abuse services that meet the needs of all Texans.

To accomplish this goal, the division will implement the following service delivery strategies:

- develop and implement a statewide strategic plan consistent with state and federal guidance, local systems of care and client needs;
- operate a statewide service delivery system that incorporates evidence-based practices and holds providers accountable for quality services and fiscal responsibility;
- research and identify service improvements consistent with the strategic plan to improve client services, maximize use of resources and leverage funding streams;
- integrate mental health and substance abuse functions into a behavioral health system;
- incorporate data-driven decision support into program design, implementation and management activities;
- support ability of local communities to manage and deliver integrated mental health and substance abuse services, and;
- partner with other DSHS divisions to incorporate behavioral health into a seamless system of total health care for Texans.

In summary, the vision for mental health services is that all individuals in need of services will be able to obtain them. These services will be effective and delivered in the home or community of the individual in need and they will be culturally and linguistically appropriate to the individual. As a part of the overall vision Texas will continue moving toward a recovery-oriented system of care.

Child - A discussion of the strengths and weaknesses of the service system.

## **Child – Service System’s Strengths and Weaknesses**

See “Adult-Service System’s Strengths and Weaknesses”

### **Strengths**

In addition to the strengths of the adult service system, the children’s mental health service system in the Texas includes among its strengths:

#### **Integration of Mental Health with Substance Abuse Services**

\*\*1. The Co-Occurring Psychiatric and Substance Use Disorder (COPSD) agency rules require specific age-defined competencies in providing COPSD services to children and youth. DSHS has been involved with a SAMHSA policy academy grant since 2003 which impacts, at the systems level, services to persons with co-occurring psychiatric and substance use disorders. In particular, attention has been focused on keeping at-risk youth and those in the early stages of problem behavior out of the juvenile justice and child protective services systems. DSHS continues to work with the Education Services Centers to prevent and/or remediate disciplinary issues resulting from emotional, social, psychological, and substance use issues to produce better life outcomes.

The DSHS Children’s Cross-Functional Team continues to serve as the primary policy-making group to address issues related to child and adolescent behavioral health services. Having members representing mental health and substance abuse issues maintains the cross-functionality with the focus on youth. During SFY10, a request for proposal was designed and released resulting in 33 organizations being chosen to provide COPSD services across the 11 health service regions beginning in SFY11 over a 5-year period. The hope was to fund at least two sites in each of the 11 regions; however regions 1, 5 and 9 have only have one site each.

#### **Integration of Mental Health and Other Services**

\*\* 8.&10. Using a public health framework, DSHS identifies opportunities to address mental health as a component of physical health, through health promotion, prevention, and intervention activities. Several projects involving shared resources and knowledge (e.g., Adolescent Mental Health in Primary Care, and Mental Health Assessment in Foster Care) continue from previous years. Plans to develop an integrated pediatric and mental health program at various pilot sites throughout the state continue through the Services Uniting Pediatrics and Psychiatry Outreaching to Texas (SUPPORT) program. It is designed to identify mental health needs early while making more efficient use of a very limited number of child psychiatrists in Texas. This is an agency-wide endeavor to further define methods of service integration between physical and behavioral health. These projects are designed either to facilitate access to other needed services for children with serious emotional disturbance, or to bring mental health expertise to other settings to provide prevention and early intervention services to citizens of Texas, expanding the definition of "public mental health."

In association with the Texas Youth Suicide Project (TYSP), a number of suicide prevention activities have occurred. There are 19 statewide agencies/groups and 16 local community coalitions across the state. By training coalition members locally, the project is adhering to the essential public health functions of informing, educating, and empowering people about health issues.

The training contract for high school web-based suicide prevention was signed in mid-February, 2010 with Via Hope. Kognito, the original developer of the At-Risk Gatekeeper Training simulation for university faculty, will be involved in the process of making the process work for the younger population of high school students. Work began in February to design and inform how the tool should look and work in Texas. A focus group brought together a broad spectrum of

stakeholders, including those with experience in the suicide prevention and education fields. Stakeholders included classroom teachers, school administrators, and other community leaders. The Title V funding for this project will expire at the end of FFY10 and from that point the project will be self-sustaining.

Webinars will be presented for people to learn about current and planned mental health initiatives in Texas with the primary focus on the upcoming roll out of an online, interactive Gatekeeper Training Simulation to be made freely available to more than 40,000 public high school teachers and administrators in the state. Since inception of the grant, activities have included working with the Suicide Prevention Council, development of a website and toolkit, QPR booklets and cards, General awareness, Media outreach, and Information and Technical assistance.

### **Information Systems and Outcome Measurement**

The implementation of the resiliency and disease management (RDM) initiative included the capacity to measure services in terms of key client outcomes. The Mental Retardation and Behavioral Health Outpatient Warehouse allows the monitoring of age-specific outcomes, such as hospital readmissions, improved functioning, improved criminal justice involvement, and improved school behavior. This information is collected through a uniform assessment and is made available in the aggregate to state and local managers. State and local managers can use this information to track every aspect of clinical and administrative information, including outcomes, services provided, and provider performance. Cases can be benchmarked, and progress charted. This is a monumental advance from the previous data system that was only capable of providing information on client registration.

### **Service Delivery System Model Flexibility**

Beginning in 2009, and continuing through 2010 and into 2011, the Mental Health and Substance Abuse Services Division of the Department of State Health Services has been in the process of reviewing and revising the resiliency and disease management (RDM) service system model. The process has involved not only DSHS staff, but also a wide array of internal and external stakeholders. All aspects of the children's RDM are being reviewed, researched and vetted, including the service packages and the sorting instrument (currently known as the Texas Recommended Assessment Guidelines). The State has been consulting with developers to investigate the adaption and validation of an instrument that could assist in assessing, sorting, treatment planning, and measuring clinical outcomes.

## **Challenges**

### **Workforce Shortages**

In addition to what is stated in the adult section, there may be fewer resources available to meet the needs of children and adolescents.<sup>1</sup> Funding for health and mental health needs is a constant challenge. Additionally, the work force shortages outlined from the adult section affect the children's services. Specifically, there are not enough child psychiatrists to meet service needs, even in large metropolitan areas. There is an equal challenge regarding the availability of licensed practitioners of the healing arts (LPHAs) across the state and rural areas are experiencing the greatest shortage.

A study that was published in *Texas Medicine* in March of 2010 had the following findings about child and adolescent psychiatrists:

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<sup>1</sup> *The Texas Challenge in the Twenty-First Century: Implications of Population Change for the Future of Texas* found at: <http://txsdc.utsa.edu/pubsrep/pubs/txchal.php>

This study was conducted to determine how the current shortage of Texas child and adolescent psychiatrists (CAPs) impacts the delivery of mental health care services to indigent Texas youth. First, Texas Medical Board data detailed how many counties had CAPs and how many did not. Second, statewide Medicaid data revealed the number of prescriptions for psychotropics written for Medicaid youth by CAPs and non-CAPS. Third, Local Mental Health Authority (LMHA) encounter data of youth seen by a CAP were analyzed. Fourth, state census data gave the location and characteristics of youth by county. Eighty percent of counties in Texas, predominantly rural, do not have a CAP. Non-CAPs wrote 66% of psychotropic medication prescriptions written for Medicaid youth. Those in nonmetropolitan areas were more likely to see a non-CAP than were Medicaid youth in metropolitan areas. For youth seen by an LMHA, those in rural poor counties were less likely to see a CAP than were those in urban counties. The shortage of CAPs in Texas results in an unequal distribution of psychiatric care for those receiving Medicaid prescriptions or services through LMHAs, especially in rural areas.

Child - An analysis of the unmet service needs and critical gaps within the current system, and identification of the source of data which was used to identify them.

## **Child – Unmet Service Needs**

### **Unmet Service Need: Penetration Rate, Prevalence, and Rate of Uninsured**

The population of children and adolescents with serious emotional disturbance (SED) is generally characterized by two criteria:

- Psychiatric diagnosis, and
- Significant functional impairment.

Of the 162,130 children estimated to have a serious emotional disturbance in 2008 (for estimate methodology, see *Federal Register*, Volume 63, Number 137, July 17, 1998, pp. 38661-38665; Friedman et al., 1996<sup>1</sup>), only 38,302 or 23.6% received DSHS-funded community mental health services in SFY2008, including NorthSTAR.

Poverty remains a major unmet need in Texas today and is one of the significant risk factors for SED. Studies have shown that children and adolescents who are identified as living in poverty, specifically long-term poverty, have a two-fold risk of SED. According to the most recent available data released in late 2008 and based on 2007 information, the Kaiser Foundation<sup>2</sup> indicates the percentage of children under the age of 18 that are living in poverty is greater in Texas (29%) than in the nation as a whole (23%). Based on the actual numbers, 11% of the children living in poverty in the United States reside in Texas.

Long-term poverty additionally affects the mental health of children. Given the high rate of children without insurance, higher poverty rates in Texas, and the finding that poverty doubles the risk, the incidence of serious emotional disturbance among Texas children may in fact be higher than the estimated 5.4%. Additionally, according to the *Transforming Juvenile Justice in Texas* report (2007), 38% of youths involved in the Texas juvenile justice system were identified with mental health problems. The facts suggest that it is likely that large numbers of Texas children with serious emotional disturbances are not receiving treatment.

The need throughout Texas is for increased access to intensive community supports including respite care, wrap-around services, case management and short-term residential treatment in order to keep and appropriately treat children in the community and decrease the incidence of families having to relinquish parental rights of children with serious mental health issues. The Yes Waiver pilot has been approved to address these concerns as detailed in the “Children’s New Developments and Issues” section.

### **Critical Gaps: Workplace Shortage**

In 2010, there remains a critical workforce shortage among mental health professionals and providers in the state of Texas. In particular, rural areas, the panhandle, and border counties lack an adequate supply of skilled mental health professionals. Data on children’s specialists is available only regarding psychiatrists, but it is a safe assumption that only a subset of the available professional workforce in all listed professions has been thoroughly trained to meet the

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<sup>1</sup> Friedman, R. M., Katz-Levey, J. W., Manderschied, R. W., & Sondheimer, D. L. (1996). Prevalence of serious emotional disturbance in children and adolescents. In R. W. Manderscheid & M. A. Sonnenschein (Eds.), *Mental health, United States, 1996* (pp. 71–88). Rockville, MD: Center for Mental Health Services.

<sup>2</sup><http://www.statehealthfacts.org/profileind.jsp?ind=10&cat=1&rgn=45>

unique needs of children and adolescents. The acute workforce shortage is likely to be more severe when considering the specialty care of children and adolescents.

According to the Texas Medical Board, as of May 2009, 230 child psychiatrists were distributed across 34 of the state's 254 counties. Only seven of the 34 counties lie west of the I-35 corridor, and most psychiatrists are in urban areas. Harris County had 54 child psychiatrists, the most of any county. However, only a very small number of child psychiatrists practice in the rural areas. Fully 85% of child psychiatrists in Texas practice in three major geographical areas which include 13 counties:

- Dallas/Ft.Worth metroplex (4 counties),
- Houston to Galveston (2 counties), and
- the Waco/Austin/San Antonio I-35 corridor (7 counties)

The remaining 15% of child psychiatrists were spread among the remaining 241 counties in the state. Most counties and large geographical regions have no child psychiatrists at all.

Child - A statement of the State's priorities and plans to address unmet needs.

## **Child - Plans to Address Unmet Needs**

### **Mental Health Transformation**

The demand for mental health services in Texas exceeds the available workforce in state and federally funded public mental health systems. The Texas Transformation Work Group (TWG), a group made possible through the Mental Health State Incentive Grant includes agency and consumer representatives critical to achieving the goals of the New Freedom Commission. In establishing projects and activities, the TWG has established committees, including a committee devoted to the unique needs of children. As a result of the work done by the TWG and forwarded to the Texas Legislature, the 81<sup>st</sup> Texas Legislature passed legislation requiring increased coordination between state agencies to more efficiently and economically meet the needs of children and adolescents in Texas:

- SB1824 and HB2196 create an interagency Taskforce on Children with Special Needs to improve services provided to children with chronic illnesses, intellectual or developmental disabilities, or mental illnesses. This legislation also calls for the establishment of a workgroup to recommend to Legislature how to integrate health and behavioral health services
- SB1646 and HB3259 create the Council on Children and Families to improve high-level interagency coordination between state health, human services, education and juvenile justice agencies charged with serving children as well as address many of the challenges encountered relating to the state's children's services delivery system.
- HB1630 ensures children released from Texas Youth Commission (TYC) facilities are assessed for and enrolled in Children's Health Insurance Program (CHIP) and Medicaid to prevent youth in the juvenile justice system who qualify for Medicaid or CHIP from facing gaps in their health coverage upon discharge.
- HB3689 establishes a continuity of care system for juvenile offenders with mental health impairments that ensures the health, mental health, education and rehabilitative needs are not only met but met by coordinating these services
- Financing Consultation looks for the best use of funding streams, or "braided funding," to make recommendations for transforming the existing state mental health financing system into a more integrated approach capable of producing improved outcomes for children and youth with serious emotional disturbances (whose service needs and costs are shared among multiple agencies) and for infants and children to prevent any further penetration into any systems. An example is HB1232, which authorizes relevant state and local agencies to collaborate and share information to facilitate early identification and treatment utilizing systems of care approach for youth at risk of being removed from their home or school due to behavior challenges. Under HB1232, Bexar County (San Antonio area) has worked to create a county-wide collaboration between the LMHA, the local school districts, and local police agencies to create the "Bexar Cares" project. This project uses blended funding from several sources in Bexar County, to redirect youth offenders with mental health problems from the justice system into the mental health system for treatment.

An essential task of the Mental Health System Transformation project is to continue working on ways to expand system capacity by integrating all needed services into coherent, accessible models of care, and to ensure all public purchasers of mental health services are of service types demonstrated to support recovery.

## **Crisis Services Redesign**

Crisis services funding has been made available through the state for the past two fiscal years. The funding has been used to develop services including mobile outreach, crisis walk-in services; children's outpatient services and residential services; and for specially trained mental health law enforcement officers. A large portion of the funding was spent on statewide hotline training and certification, and evaluation and agency support.

Crisis funding was awarded to 14 local mental health centers for two-year projects to establish or enhance psychiatric emergency service centers or for other facilities. This provides alternatives to sending mentally ill patients to hospitals or jails. In this way individuals can be treated efficiently in more appropriate settings. Additional funding was awarded to five mental health entities for two-year projects to provide outpatient treatment to individuals found incompetent to stand trial. These projects are currently in their second year.

Program research indicates promising and effective approaches to treating children and adolescents in crisis. Most experts agree it is important to provide services to children as close to home as possible in the least restrictive setting. It is also imperative to include families in the intervention.

Types of interventions described as effective for children are not substantially different from services identified for adults. Specific recommendations include: availability of assessment and emergency observation; crisis respite; and mobile crisis outreach. Although the recommended interventions for children are consistent with services recommended for adults, children's services should be provided by clinicians who are trained and have demonstrated competency in children's mental health. Assessments for children must be developmentally appropriate and services should be provided in an environment appropriate for children.

Additionally, emphasis is placed on parent training and support. A child's crisis effectively translates into a family's crisis, and the family's lack of adequate resources (emotional, experiential, physical, financial, and social) to effectively and safely manage the child's behavior, emotions and/or symptoms during the crisis episode. An important goal of crisis intervention is to provide tools to increase the parent's ability to manage the child in the home environment. Therefore, this aspect of outpatient crisis service for children differs markedly from typical adult outpatient services. Children's outpatient crisis services are designed to be flexible, multi-faceted, and immediately accessible for children and adolescents at high risk for hospitalization or out-of-home placement. Services provided *in vivo* or other settings and primarily in the home, are designed to be family-focused, intensive, and time-limited.

## **Local Planning and Network Development (LPND) Process**

The Local Planning and Network Development (LPND) initiative implements legislation that requires local mental health authorities (LMHAs) to develop a network of external service providers, and to provide direct services only when other willing providers are not available. A key goal of this project is to provide consumers greater control over their services by offering them a choice of providers. The extent to which this goal can be achieved in any given service area and how quickly it can be reached will depend on the circumstances, needs, and preferences of the local communities served by each LMHA.

LMHAs are required to develop local plans for developing provider networks through a collaborative process involving providers, consumers, and local stakeholders. These biennial plans include an assessment of the availability of interested providers and a plan for procuring services over the next two years. The first cycle of network development began in 2008, but the results were modest. LMHAs took a conservative approach, and providers generally concluded

that the terms being offered did not provide favorable conditions for establishing services in the local area.

Over the past year, DSHS has worked with the Local Authority Network Advisory Committee and other stakeholders to identify barriers to network development and potential strategies for resolving them. Tools and procedures were updated based on the experience gained during first planning cycle, with a special focus on facilitating more productive communication between providers and LMHAs. Criteria were developed to guide the review and approval of local plans, and a set of performance indicators was established to evaluate the effectiveness of the LPND initiative. DSHS also established a workgroup to begin the formal rule revision process.

The second cycle of network development began in January 2010, and plans are due this summer.

### **Behavioral Health Framework for Prevention**

\*\*1. The behavioral health framework for substance abuse prevention and mental health promotion will outline a system that will provide efficient, cost effective and culturally sensitive behavioral health prevention services across the state. These services will be evidence-based models performed through a comprehensive system that matches services to the needs of individuals and local communities. Both substance abuse and mental health fields have the same vision of healthy functioning individuals and families resulting from interventions. This framework is an ordered set of steps along a continuum to promote individual, family, and community health, prevent mental and behavioral disorders, support resilience, foster recovery, promote treatment, and prevent relapse. This is based on the National Institute of Medicine model that recognizes the importance of a whole spectrum of interventions from universal strategies of preventing or delaying the onset of substance abuse and mental disorders to the treatment of disorders.

Providers across the state will no longer operate in isolation having prevention services for both mental health and substance becoming more effective through integration. They will replicate and adapt evidence-based programs that directly address the challenges of substance abuse and mental health. These evidence-based programs prevent substance abuse and mental health problems; promote mental health and prevent related challenges in a community by reducing the risk and increasing the protective factor. This prevention framework will provide a system to promote mental health and the prevention of substance abuse and mental illness, as well as support many aspects of healthy behavior and healthy living.

### **Youth Empowerment Services (YES) Waiver**

The state's YES waiver proposal to the federal Centers for Medicare & Medicaid Services was approved in February 2009 and implementation began shortly after with enrollment of children beginning in April 2010. This program provides home and community based services to children as an alternative to institutional care (e.g., psychiatric inpatient care) and aims to prevent or reduce out-of-home placements by all child serving agencies. The program allows for greater flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families.

The YES waiver is still being piloted in a limited geographic area (Bexar and Travis Counties) and may serve up to 300 youth aged 3 – 18 at any time. Children are determined to be financially eligible for the waiver program using the same standards to determine eligibility for Medicaid in institutions. Under these standards, parental income is not considered. This eliminates the current incentive for parents to relinquish custody to obtain access to Medicaid coverage for mental health treatment.

In addition to regular Medicaid services, waiver participants are eligible for other services as needed, including respite care; family supports; community living supports; paraprofessional services, professional services, transitional services, minor home modifications, adaptive aids and supports, supportive family-based alternatives, and non-medical transportation. Targeted case management is provided to all waiver participants. Waiver providers have been and will continue to be enrolled and contracted by DSHS. Local mental health authorities will perform administrative functions at the local level.

Additional counties may begin serving as pilot sites as early as 2012 if the waiver is determined to be cost effective after its first two years of operation.

### **Expanded Evidence-Based Practices**

Global conflicts have brought increased focus to issues related to surviving trauma. In 2009 DSHS added Trauma-Focused Cognitive Behavioral Therapy (T-F CBT) to the list of approved resiliency disease management treatment protocols available to children's therapists at the local mental health authorities. This evidence-based treatment is appropriate for children ages 3-17, and involves the primary caregiver integrally in the treatment process. DSHS contracted with subject matter expert Dr. Susana Rivera of "Serving the Needs of Children and Adolescents" (SCAN, in Laredo) to offer regional trainings across the state to the children's therapists of the LMHA's. The initial phase of training was on line at no charge, from the National Child Traumatic Stress Network (<http://tfcbt.musc.edu/>). The second phase of training was two days *in vivo* training with Dr. Rivera, followed by a period of 8-12 supervision/consultation conference calls to solidify participants' comprehension of the model.

DSHS will continue to identify new evidence-based treatment protocols that can be implemented in Texas, especially combining both online and *in vivo* training resources to stretch our training dollars.

Child - A brief summary of recent significant achievements that reflect progress towards the development of a comprehensive community-based mental health system of care.

## **Child – Recent Significant Achievements**

### **See “Adult-Recent Significant Achievements”**

Additional achievements that pertain to children include:

#### **Youth Empowerment Services (YES) Waiver -1915(c) Medicaid Waiver**

As previously discussed, the state’s YES waiver proposal to the federal Centers for Medicare & Medicaid Services was approved in February 2009 and implementation began shortly after with enrollment of children beginning in April 2010. This program provides home and community based services to children as an alternative to institutional care (e.g., psychiatric inpatient care) and aims to prevent or reduce out-of-home placements by all child serving agencies. The program allows for greater flexibility in the funding of intensive community-based services and supports for children with serious emotional disturbances (SED) and their families.

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Additional counties may begin serving as pilot sites as early as 2012 if the waiver is determined to be cost effective after its first two years of operation.

#### **Mental Health System Transformation**

Texas has entered the last year of the five-year Substance Abuse and Mental Health Services Administration (SAMHSA) Mental Health Transformation State Incentive Grant. Through the Mental Health Transformation efforts the Children and Adolescent Workgroup was established and charged with developing goals, objectives, and action plans that would:

- Assess and address the current situation in Texas regarding availability, linkages with the community, and financing for school based mental health services.
- Build on current initiatives related to: 1.) early childhood intervention, 2.) SAMHSA supported systems of care projects, and 3.) the Texas Integrated Funding Initiatives related to the objective of building a population based, early intervention approach for children and adolescents.
- Identify evidence-based practices for children and adolescents used by TWG agencies and develop a coordinated, uniform approach to their delivery.
- Support TWG initiatives related to community collaborative and returning veterans and their families.

The Children and Adolescent Workgroup was able to assess staff perceptions of behavioral health needs and resources in Texas public schools with The Texas School-Based Behavioral Health Survey Report and Recommendations survey.

## **Texas Models for Change**

The Mental Health/Juvenile Justice Action Network, a multi-agency team headed by the Texas Juvenile Probation Commission, works with other states and national experts to improve the response to youth with mental health needs within the juvenile justice system

## **Physical and Behavioral Health Services for Children in Foster Care**

Maintaining the health and well-being of children who have been placed in care outside their home in the absence of an appropriate non-custodial parent or relative can be challenging. Previous reviews indicated that for various reasons, children placed in foster care do not always receive the best and most appropriate healthcare. Together, the Health and Human Services Commission (HHSC), the Department of Family and Protective Services (DFPS), the Department of State Health Services (DSHS) and other state agencies have worked collaboratively to improve the health of children in foster care.

This collaboration resulted in the development of STAR Health, a comprehensive health care program for children in foster care. STAR Health provides services for more than 27,000 children and youth. Services are coordinated, comprehensive, easy to find, and uninterrupted when the child is required to move. Benefits of the STAR Health program include:

- A health passport for each child in foster care, containing a summary of his or her medical information. The health passport is an electronic health information system for the medical information of children in foster care that follows each child wherever he or she goes. The passport travels with each child even when the child leaves state care. By providing a consolidated format to view basic medical information about a child, health care outcomes can be improved;
- Each child has a medical home, meaning a doctor (or other primary care provider (PCP) or PCP team) to oversee care
- Speedy enrollment for immediate healthcare benefits
- Promotes coordination of physical and behavioral health
- Promotes preventive care to keep children healthier
- Improves access to healthcare through a network of providers (doctors, nurses, hospitals, clinics, psychiatrists, therapists, etc.)
- Health passport puts more health history and medical records at the fingertips of medical consenters, doctors, and other healthcare providers
- Gives caregivers and caseworkers 7-day, 24-hour nursing and behavioral health help-lines
- Medical advisory committees monitor healthcare provider performance
- Recruits providers with a history of treating children who have been abused or neglected

DSHS worked with DFPS and HHSC to create a “best practices” guide to ensure the proper use of psychotropic medications for children in foster care, the *Psychotropic Medication Utilization Parameters for Foster Children*.

A panel of child and adolescent psychiatrists, psychologists, guideline development specialists, and other mental health experts developed the guide. These guidelines are a resource for physicians and clinicians who care for children diagnosed with a mental health disorder. They provide recommendations for the appropriate use of psychotropic medications for foster children and highlight seven red flags that indicate a need for further review of a patient’s case. Today children in DFPS care are prescribed fewer psychotropic medications because of these guidelines. In fact, use of these psychotropic medications by children in foster care continues to decline. Although these guidelines were developed for children in foster care, they are a valuable when treating any child with a mental health disorder.



Child - A brief description of the comprehensive community-based public mental health system that the State envisions for the future.

## **Child – State’s Vision for the Future**

### **See “Adult-Vision for the Future.”**

In addition, the service delivery system for public mental health services for children is based on the following vision and values:

#### **Vision**

Emotional wellness for youth, families, and communities in Texas.

#### **Mission**

To provide quality family-focused, community-based mental health services and supports to children and their families.

#### **Values**

- Services and supports for children and their families will be individualized based on family-identified strengths, needs, preferred services and supports, and outcomes.
- Services and supports will be flexible and will fit the children and families.
- Children and families will have access to an array of mental health treatment services and supports provided through local mental health authority provider networks, as well as access to informal and natural supports preferred by the children and families.
- Families will be included as full partners in all aspects of the treatment of their own children. Families will be included at state and local levels of planning, policy development, service delivery, and evaluation.
- There will be an increasing commitment to the development of a service delivery system that is sensitive and responsive to cultural diversity.

Adult - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

## **Adult – Establishment of System of Care**

The legal and regulatory provisions establishing a comprehensive system of care exist in state statute. The provisions are best described through excerpts from the enabling legislation. Many sections of state law could be included; however, the following excerpts of the provisions demonstrate the numerous responsibilities of the Health and Human Services Commission (HHSC), the Department of State Health Services (DSHS) and local mental health authorities (LMHAs) in the comprehensive system of care for adults with serious mental illness, and children with serious emotional disturbance.

A comprehensive system of services is provided for in the Texas Government Code, Title 4, Subtitle I, Chapter 531, Health and Human Services Commission:

### Section 531.003 GOALS

The commission's goals are to:

- (1) Maximize federal funds through the efficient use of available state and local resources;
- (2) Provide a system that delivers prompt, comprehensive, effective services to the people of this state by:
  - (A) Improving access to health and human services at the local level; and
  - (B) Eliminating architectural, communications, programmatic, and transportation barriers;
- (3) Promote the health of the people of this state by:
  - (A) Reducing the incidence of disease and disabling conditions;
  - (B) Increasing the availability of health care services;
  - (C) Improving the quality of health care services;
  - (D) Addressing the high incidence of certain illnesses and conditions of minority populations;
  - (E) Increasing the availability of trained health care professionals;
  - (F) Improving knowledge of health care needs;
  - (G) Reducing infant death and disease;
  - (H) Reducing the impact of mental disorders in adults;
  - (I) Reducing the impact of emotional disturbances in children;
  - (J) Increasing participation in nutrition programs;
  - (K) Increasing nutritional education; and
  - (L) Reducing substance abuse;
- (4) Foster the development of responsible, productive, and self-sufficient citizens by:
  - (A) Improving workforce skills;
  - (B) Increasing employment, earnings, and benefits;
  - (C) Increasing housing opportunities;
  - (D) Increasing child-care and other dependent-care services;
  - (E) Improving education and vocational training to meet specific career goals;
  - (F) Reducing school dropouts;
  - (G) Reducing teen pregnancy;
  - (H) Improving parental effectiveness;
  - (I) Increasing support services for people with disabilities;
  - (J) Increasing services to help people with disabilities maintain or increase their independence;
  - (K) Improving access to work sites, accommodations, transportation, and other public places and activities covered by the federal Americans with Disabilities Act of 1990 (42 U.S.C. Section 12101 et seq.); and
  - (L) Improving services to juvenile offenders;

- (5) Provide needed resources and services to the people of this state when they cannot provide or care for themselves by:
  - (A) Increasing support services for adults and their families during periods of unemployment, financial need, or homelessness;
  - (B) Reducing extended dependency on basic support services; and
  - (C) Increasing the availability and diversity of long-term care provided to support people with chronic conditions in settings that focus on community-based services with options ranging from their own homes to total-care facilities;
- (6) Protect the physical and emotional safety of all the people of this state by:
  - (A) Reducing abuse, neglect, and exploitation of elderly people and adults with disabilities;
  - (B) Reducing child abuse and neglect;
  - (C) Reducing family violence;
  - (D) Increasing services to truants and runaways, children at risk of truancy or running away, and their families;
  - (E) Reducing crime and juvenile delinquency;
  - (F) Reducing community health risks; and
  - (G) Improving regulation of human services providers; and
- (7) Improve the coordination and delivery of children's services.

The Department of State Health Services (DSHS) is an agency of the Health and Human Services Commission. Health and Safety Code, Title 7, Chapter 533, POWERS AND DUTIES addresses community mental health services, and establishes the Commission's powers and responsibilities. The following excerpts describe the roles of DSHS and Local Mental Health Authorities (LMHAs) in the operation of a comprehensive, community-based system of care for adults with serious mental illness, and children with serious emotional disturbance.

§ 533.033. DETERMINATION OF REQUIRED RANGE OF MENTAL HEALTH SERVICES

(a) Consistent with the purposes and policies of this subtitle, the commissioner biennially shall determine:

- (1) The types of mental health services that can be most economically and effectively provided at the community level for persons exhibiting various forms of mental disability;

§ 533.034. AUTHORITY TO CONTRACT FOR COMMUNITY-BASED SERVICES (a) The department may cooperate, negotiate, and contract with local agencies, hospitals, private organizations and foundations, community centers, physicians, and other persons to plan, develop, and provide community-based mental health services.

§ 533.0345. STATE AGENCY SERVICES STANDARDS

(a) The department by rule shall develop model program standards for mental health and mental retardation services for use by each state agency that provides or pays for mental health or mental retardation services. The department shall provide the model standards to each agency that provides mental health or mental retardation services as identified by the Health and Human Services Commission.

§ 533.035. LOCAL MENTAL HEALTH AUTHORITIES

(a) The commissioner shall designate a local mental health authority in one or more local service areas. The board may delegate to the local authorities the board's authority and responsibility for the planning, policy development, coordination, including coordination with criminal justice entities, resource allocation, and resource development for and oversight of mental health services in the most appropriate and available setting to meet individual needs in that service area.

§ 533.03521. LOCAL NETWORK DEVELOPMENT PLAN CREATION AND APPROVAL

(a) A Local Mental Health Authority shall develop a local network development plan regarding the configuration and development of the local mental health authority's provider network. The plan must reflect local needs and priorities and maximize consumer choice and access to qualified service providers.

(b) The Local Mental Health Authority shall submit the local network development plan to the Department of State Health Services for approval.

§ 533.035

(e) Subject to Section § 533.0358, in assembling a network of service providers, a local mental health authority may serve as a provider of services only as a provider of last resort and only if the local authority demonstrates to the department in the local authority's local network development plan that:

- 1) the local authority has made every reasonable attempt to solicit the development of an available and appropriate provider base that is sufficient to meet the needs of consumers in its service area; and
- (2) there is not a willing provider of the relevant services in the local authority's service area or in the county where the provision of the services is needed.

§ 533.0352. DISEASE MANAGEMENT PRACTICES OF LOCAL MENTAL HEALTH AUTHORITIES.

(a) A Local Mental Health Authority shall ensure the provision of assessment services, crisis services, and intensive and comprehensive services using disease management practices for adults with bipolar disorder, schizophrenia, or clinically severe depression and for children with serious emotional illnesses. The Local Mental Health Authority shall ensure that individuals are engaged with treatment services that are:

- (1) Ongoing and matched to the needs of the individual in type, duration, and intensity;
- (2) Focused on a process of recovery designed to allow the individual to progress through levels of service;
- (3) Guided by evidence-based protocols and a strength-based paradigm of service; and
- (4) Monitored by a system that holds the local authority accountable for specific outcomes, while allowing flexibility to maximize local resources.

Adult - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

## **Adult – Available Services**

The array of services available to adults include mental health services, services for dually diagnosed individuals (co-occurring psychiatric and substance use disorders), suicide prevention, and medical and dental services.

### **Mental Health Services**

#### **Resiliency and Disease Management (RDM)**

Please see the "Adult - New Developments" section for further details regarding resiliency and disease management (RDM). RDM continues to be the cornerstone of the service delivery system in Texas. A uniform assessment is provided to assess the needs of consumers, recommend appropriate services based on identified needs, and monitor individual outcomes. The result of the assessment is an authorized level of care (LOC) that corresponds to a service package. Service packages for both children and adults have been developed to ensure the provision of evidence-based services to those individuals who would most benefit from those services. The service packages are described in *Utilization Management Clinical Guidelines*. These guidelines identify the services available and the intensity of service provision for each package, as well as guide decisions on eligibility and appropriate discharge from a service package.

#### **Psychiatric Rehabilitation Services**

Services comprise an array of age-appropriate, individualized, and medically necessary services. These services provide training and instruction designed to ameliorate mental and functional disabilities that negatively affect community integration and tenure, employment, and the individual's ability to function in non-work, role appropriate settings. The goal of rehabilitation services is to reduce an individual's disability from severe mental illness or serious emotional disturbance, and to restore and maintain the individual's best possible functioning level in the community.

Rehabilitation services are delivered in both individual and group formats. Rehabilitation services are intended for natural settings such as the individual's home, school, or work place, but when appropriate can be provided in traditional service settings. Providers are required to work collaboratively with the individual in developing a personal treatment plan to ensure the services provided reflect the individual's self-proclaimed recovery goals and cultural context of the individual.

#### **Medication Training And Support**

Curriculum-based training and guidance provide an initial orientation for the individual in understanding the nature of their mental illness and the important role of medications in ensuring symptom reduction and increased tenure in the community.

#### **Psychosocial Rehabilitation Service**

Psychosocial rehabilitation services are social, educational, vocational, behavioral, and cognitive interventions to improve an individual's potential for social relationships, occupational or educational achievement, and living skills development. This service is provided by members of a therapeutic team. They are responsible for delivering rehabilitative case management which encourages the individual to learn and practice skills for self-advocacy. The long term goal is for the individual to acquire the necessary skills to be able to function independently of a case

manager. When appropriate, the provision of services will address the impact of co-occurring disorders upon the individual's ability to decrease symptomatology, increase community tenure, and realize their recovery goals.

### **Skills Training and Development**

Skills training is a supportive intervention that focuses on the improvement of communication skills, appropriate interpersonal behaviors, and other skills necessary for independent living, and when appropriate, functioning effectively with family and peers.

### **Crisis Intervention Services**

Intensive one-to-one community-based guidance and instruction are delivered to an individual in order to control acute symptoms that place the individual at immediate risk of hospitalization, incarceration, or placement in a more restrictive treatment setting. This service focuses on behavioral skills training for stress and symptom management, problem solving, and reality orientation. This will assist the individual to identify and manage their symptoms of mental illness. Supportive counseling and training is given to the individual so as to allow adaptation and coping skills with stressors. Included in the assessment is the level of dangerousness and, when appropriate, coordination of emergency services is available.

### **Day Program for Acute Needs**

Intensive site-based group services provide individuals with methods to control symptoms and prevent hospitalization, incarceration, or placement in a more restrictive treatment setting, reducing time spent in hospitals or restrictive treatment settings. This service focuses on intensive, medically-orientated, multidisciplinary interventions such as behavior skills training, crisis management and nursing services designed to stabilize acute psychiatric symptoms, reducing the probability of relapse.

### **Supported Employment**

\*\*6. Although supported employment is a required service in each LMHA, this service area proves to be one of the more difficult challenges to address due to funding and economic restraints. Despite the financial adversities, LMHAs have the capacity to provide individualized assistance in choosing and obtaining employment in integrated work sites in regular community jobs. Services are not time-limited and include a maintenance phase. Long-term support provides assistance for individuals to keep employment. Job loss or other need for increase in service intensity is accommodated. Goals around employment are addressed by promoting the behavioral health of individuals, families, and communities affected by the economic downturn, the employment of people with mental and substance use disorders, and policies for employers that support behavioral health in the workplace.

Service standards and the fidelity instrument address the following evidence-based principles:

- Individualized job search activities
- Rapid job search
- Competitive employment is the goal
- Long-term support is provided

In addition to services provided within the mental health system, consumers have access to additional state services.

### **Supported Housing**

**\*\*5.** Housing services are in short supply and in great demand. This is one of the areas in which funding and service provision fall extremely short in the state. LMHAs are given the task of addressing the housing issues of their consumers but their results vary across the state given local financial resources. They do provide assistance in obtaining and maintaining regular housing in the community of the consumers' choice, and some are able to provide supportive housing services. Supportive housing services are designed to assist consumers with severe and persistent mental illness to choose, obtain, and retain regular integrated housing.

Services consist of:

- Individualized assistance in finding and moving into regular, integrated, housing that is habitable;
- Temporary rental assistance;
- Intensive in-home rehabilitation services; and
- Coordination activities that facilitate access to resources or services that support or assist the consumer in achieving their housing goal.

Supportive housing service programs provide temporary rental assistance until long-term housing programs are accessed (e.g., Section 8, tenant-based rental assistance vouchers, etc.). Some LMHAs apply for Section 811 housing grants which are sometimes offered through the federal Department of Housing and Urban Development and provide financial assistance to non-profit organizations for the development of supportive housing projects. These projects are designed to house people with disabilities and to provide supportive services on a long-term basis with the help of community collaboration. Short-term rental assistance recipients are provided with assistance in developing plans to pay rent without support of the mental health system. Some long-term strategies include applying for Section 8 public housing, and increasing personal income. Housing assistance alone without supports and services cannot be counted as supported housing.

The supported housing program includes services and supports. Services include:

- Case management activities;
- In-home rehabilitation services; and
- Assistance in locating, moving into and maintaining regular integrated housing.

Regular housing is defined as normal, ordinary living arrangements typical of the general population. Integration is achieved when individuals with serious mental illness choose ordinary, typical and habitable housing units that are located among non-disabled individuals. Supported housing is primarily an intensive program based upon identified consumer housing needs. As needs, goals, and preferences are addressed, there are changes in the intensity and scope of services provided. Texas strives to provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience to accessing affective programs that sustain recovery.

#### Assertive Community Treatment

Local mental health authorities (LMHAs) ensure the provision of assertive community treatment (ACT) team services for adult individuals with the diagnosis of bi-polar disorder or schizophrenia that have difficulty maintaining a life outside the hospital. The team includes intensive rehabilitative services, nursing for medication monitoring and patient/family education, staff specializing in supported housing, supported employment, and substance abuse intervention. Team members for urban ACT meet on a regular, daily basis and rural ACT members consult with the team three times per week to discuss the needs of consumers in ACT services. Face-to-face contact is frequent with consumers, being daily in most cases. Team members are available for crisis needs 24 hours a day, 7 days a week.

Individuals who have been hospitalized three times in 180 days or with four or more hospitalizations in two years are considered to be part of the "Promoting Independence"

population, defined in response to the Olmstead lawsuit. These individuals are prioritized for the most intensive services. Also, the names of individuals who have been hospitalized twice in 120 days are forwarded to LMHAs who are encouraged to provide intensive intervention to avoid further hospitalization. In addition, individuals who have been in the hospital over a year are monitored quarterly to identify any barriers to placement and to ensure the LMHA and the hospital conduct special staffing to address those issues.

#### **Case Management Services**

Case management services assist an individual in gaining, coordinating and retaining access to necessary care and services appropriate to the individual's needs and self-proclaimed recovery goals. The role of the case manager is to serve as a single point of contact for the individual when service needs arise. This includes assistance in identifying, locating, coordinating, and advocating for services and supports when necessary. The goal of case management is to support the individual with the least disruption to daily activities.

The successful evaluation of current needs and the appropriate delivery of services to the individual rely on the abilities of the case manager to be culturally competent and experienced in serving those with special needs. These groups include, but are not limited to, traditional ethnic minorities, locally significant minorities, linguistic minorities, including those individuals who are deaf and hard of hearing, homeless people and people who have been involved with the criminal justice system. By providing culturally and individually based services, the need for crisis intervention is reduced, as is the need for more intensive and restrictive services.

#### **Educational Services**

Please see "Adult – Plans to Address Unmet Needs" section. Educational services are supported by LMHAs as a part of a person's treatment plan. These services may include skills training and supports related to mental illness, medication training, rehabilitation training, or educational related skills training. These services are garnered through a community referral or with funds from the LMHAs flexible funding accounts.

Input collected by MHPAC and other shareholders was used to develop a request for proposals (RFP) that was released in SFY 09 and awarded in early SFY09 for a Training and Technical Assistance Center (TTAC) now referred to as Via Hope. DSHS continues to move toward quality consumer and family-driven services. As an integral part of the ongoing process to develop evidence-based, consumer and family operated services those services must be made a part of the statewide mental health system. Through the RFP process DSHS procured one TTAC to provide services for consumers, the family members of consumers, and stakeholders using evidence-based practices. A primary goal of the TTAC is to support and develop a select, diverse array of locally-based consumer and family-operated organizations, and turn them into viable service providers. The TTAC will provide training coordination, technical assistance, networking and leadership development, and technical assistance. The TTAC will provide support to consumers, and families in transforming mental health in Texas.

#### **Support Services**

Please see "Adult – New Developments and Strengths and Weaknesses Section" for more details. DSHS provides state funding for consumer peer support. These activities are provided between and among clients who have common issues and needs that are client-motivated, initiated, and/or managed and that allow a client to live as independently as possible. A contractor may, upon approval by DSHS, expend up to \$50,000 to provide outreach through peer-facilitated services, e.g., drop in centers, peer counseling, peer support groups, peer-led education groups, and Texas Implementation of Medication Algorithms (TIMA) and Patient and Family Education Program (PFEP) unpaid volunteer peer facilitators. This service does not include paid peer providers as provided for under Rehabilitative Services

Respite services are also available to provide for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the client's usual living situation. Community-based respite services are provided by respite staff at the client's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.

Another support service provided by DSHS is crisis flexible benefits. These benefits are non-clinical supports that reduce the crisis situation, reduce symptomatology and enhance an individual's ability to remain in the home or community. Benefits in adult mental health services include spot rental, partial rental subsidies, utilities, emergency food, house wares, clothing, transportation assistance, and residential services.

### **Services for Dually-Diagnosed Individuals** **Co-Occurring-Psychiatric and Substance Abuse Services**

Services for persons with Co-Occurring Psychiatric and Substance Use Disorders (COPSD) are available throughout the state. DSHS currently funds 23 local MHMR centers and/or substance abuse providers to provide specialized services for persons with COPSD in all regions in Texas. COPSD specialists provide these adjunctive services to mental health and substance abuse treatment programs. Their efforts enhance the regions' continuum of care for individuals with COPSD.

The state is currently in the last year of the Co-Occurring State Incentive Grant (COSIG) which was implemented to increase co-occurring capacity by building on existing services, ensuring competencies through training, and by conducting an evaluation of the state's current practice for serving clients with co-occurring disorders. Six contractors are actively providing services to clients with co-occurring disorders under this grant.

DSHS has built on existing services for individuals with co-occurring disorders through a voucher arrangement that funds additional community supports not included in the contractor's service array. Voucher funds supplement existing funding for the treatment of qualified clients. Allowable community supports are for childcare, housing, transportation, temporary food, education, vocational assistance, clothing, medical care, prescriptions, and peer mentoring. The voucher arrangement requires contractors to network and link to community resources that serve persons with COPSD. Funds in the voucher system may not be used to purchase services from the contractor's own agency.

Through the COSIG grant DSHS has developed a COPSD program self-rating fidelity instrument. The development stage of the COPSD fidelity instrument began with consultation from experts in the field who have developed and validated the Dual Diagnosis Capability in Addictions Treatment (DDCAT) fidelity scale. The DDCAT produces scores on seven fundamental dimensions that assess a program's capability to treat clients with co-occurring disorders. The fidelity instrument is now being piloted, tested, and should be available for use in 2009. DSHS is also developing a fidelity instrument for adolescents. The COPSD fidelity instrument will be available as a self-assessment instrument to all mental health and substance abuse contractors and will be instructive to both DSHS and providers regarding readiness for integrated treatment for individuals with co-occurring disorders.

DSHS also provides training to mental health service providers and providers of COPSD to help providers identify individuals in need of COPSD services and to develop and maintain evidence-based services. DSHS, with the assistance of Texas Health and Human Services Information Management, produced and distributed an *Introduction to COPSD CD-ROM* as a technical assistance tool for LMHAs and COPSD providers.

### **Suicide Prevention Framework**

DSHS continues to lead the state in both proactive and reactive suicide prevention services.

- The Texas Suicide Prevention Council was formed by statewide associations and organization joined by local suicide prevention coalitions who all agree to support one or more goals of the Texas State Plan for Suicide Prevention. DSHS was awarded a Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention authorized under the Garrett Lee Smith Memorial Act. As one of the key activities of this grant (Texas Youth Suicide Prevention Project), Mental Health America of Texas (MHAT) partners with DSHS on the council which currently consists of 16 local coalitions and 19 members representing statewide organizations.
- As one of the key activities of the Texas Youth Suicide Prevention (TYSP) Project (MHAT) held a two-day symposium in Austin, Texas on suicide prevention in June 2010. Presenters included national and state experts in suicide prevention and evidence based practices. To ensure the attendance of those who need this information the most, there were no costs to attend the symposium. More than 400 individuals attended.
- DSHS established an Injury and Violence Prevention (IVP) work group which pulled every division into a collaborative effort to examine where, when, and how injury and violence prevention is being conducted with the agency. Collaborative partnerships among all divisions are working to improve injury (which includes suicidal behavior) and violence prevention for all ages. Initially convened in November 2009, the work group is conducting an assessment and developing a report on the status and impact of injury and violence across the lifespan in Texas, including best practices in prevention of this public health concern. The assessment/report will serve as the foundation for planning and implementation to be conducted over the next biennium. The report was finalized in July of 2010 and builds on the federal assessment conducted in December 2008 by a technical assistance team sponsored by the State and Territorial Injury Prevention Directors Association. The team made recommendation on implementing an effective injury and violence prevention program within DSHS.
- A subcommittee of the state hospital Clinical Oversight Committee focuses on reducing suicides in the inpatient population. Guidelines for a new suicide assessment have been implemented. Suicide protocols have been approved and instituted. Screens have been added to the electronic medical record for the suicide assessment. In the third quarter of FY09, the hospital implemented the Joint Commission system tracer that addresses all aspects of suicide prevention including the environment, staff training, patient assessment and treatment interventions was initiated.
- DSHS continues to provide oversight and other resources to support Texas Youth Suicide Prevention Project (TYSP). The TYSP project is funded through the SAMHSA Garrett Lee Smith Memorial State/Tribal Youth Suicide Prevention and Early Intervention Grant Program. The project involves collaborative efforts between Mental Health America of Texas (MHAT), DSHS, the Texas Suicide Prevention Council, and the Center for Health Care Services (CHCS). MHAT has been involved in a wide range of activities to enhance public awareness across Texas and has trained health and community representatives to identify and refer at-risk youth across the state. As of June 2010, over 6,402 individuals were trained – 3,703 in school settings and 3,329 in community settings. MHAT is developing a nonproprietary gatekeeper training curriculum (called ASK) which will be available toward the end of the grant in 2012 at no charge. MHAT maintains a website, [www.TexasSuicidePrevention.org](http://www.TexasSuicidePrevention.org) that contains a wealth of information on suicide prevention and resources including the Texas Suicide Prevention and Postvention Toolkit. CHCS in San Antonio implemented a community-based youth suicide prevention program serving high risk youth and families in the military.

Screenings and referral services for youths of military families at the Fort Sam Houston Independent School District and Brooke Army Medical Center Pediatric and Adolescent Clinic were offered through this program.

- All LMHAs operate or contract with a crisis hotline that is accredited by the American Association of Suicidology (AAS). In addition, all centers have at least one Mobile Crisis Outreach Team (MCOT). DSHS contracted with the AAS to provide crisis hotline training for crisis hotline and MCOT staff. The training included a "Train-the-Trainer" component to ensure that LMHA staff could provide future training in their local service area. LMHAs continue to provide training in their local service area to their employees. In addition to the crisis hotline training, individuals who completed the training were given the opportunity to receive their crisis worker certification through AAS. This process involved taking an individual crisis worker certification examination.
- Suicide prevention coordinators have been identified within each state hospital and community center in Texas. A survey has been created (for the hospitals) in order to establish a baseline for suicide prevention efforts within each hospital and to identify unmet needs in this area.
- Web-based suicide prevention gatekeeper training is being developed for public high school teachers and other personnel. This will enable early identification and intervention of at risk high school students at no cost for public school districts. See "Child – Service System's Strengths and Weaknesses".

### **Medical and Dental Services**

Each LMHA is required to address the health issues of their consumers throughout the treatment planning process. Currently, there are no medical or dental services provided onsite at local community mental health centers. LMHAs provide case management services to consumers in order to link and refer them to appropriate medical providers in their community.

Some LMHAs have established strong relationships with the federally qualified health centers in their local service area. These partnerships have not only assisted in meeting the medical and dental needs of consumers but in some cases have served as a mechanism to discharge a. Additional initiatives have been implemented with the intention of more closely integrating physical and behavioral health. Current projects include behavioral health screening in primary care, an establishment of a medical home, and standards of care for physical and behavioral health for children in foster care. The closer integration of mental and physical health through the Department of State Health Services (DSHS) is expected to result in additional projects intended to provide improved access to physical health care for the people served by the public mental health system.

There are resources available that provide low cost dental services for persons that are indigent or on Medicaid. These services are available through the dental schools and an independent program, *Texas Dentists for Healthy Smiles*. Both of these resources have long waiting lists and are limited programs. Generally, by the time persons request assistance or are able to access services, they have major dental problems requiring numerous extractions, antibiotics and dentures.

Adult - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

## **Adult – Estimate of Prevalence**

### **Priority Population**

State law requires DSHS to identify its adult mental health priority population and the minimum array of services necessary to address the needs of this priority adult population. The legislation also requires services to be offered first to those in the most need, and for state dollars to be used only for services provided to the priority population.

DSHS's priority population for adult mental health services consists of adults who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, or other severely disabling mental disorders that require crisis resolution or ongoing and long-term support and treatment. Although the priority population is unchanged, the target population has changed in response to the requirements of state law HB 2292. The target population includes only those priority population individuals diagnosed with schizophrenia, bipolar disorder, or clinically severe depression. Those priority population members with other diagnoses may be placed into ongoing service if clinically justified. Everyone in need of crisis intervention will continue to have access to Crisis Services.

### **The Prevalence of Mental Illness among Adults**

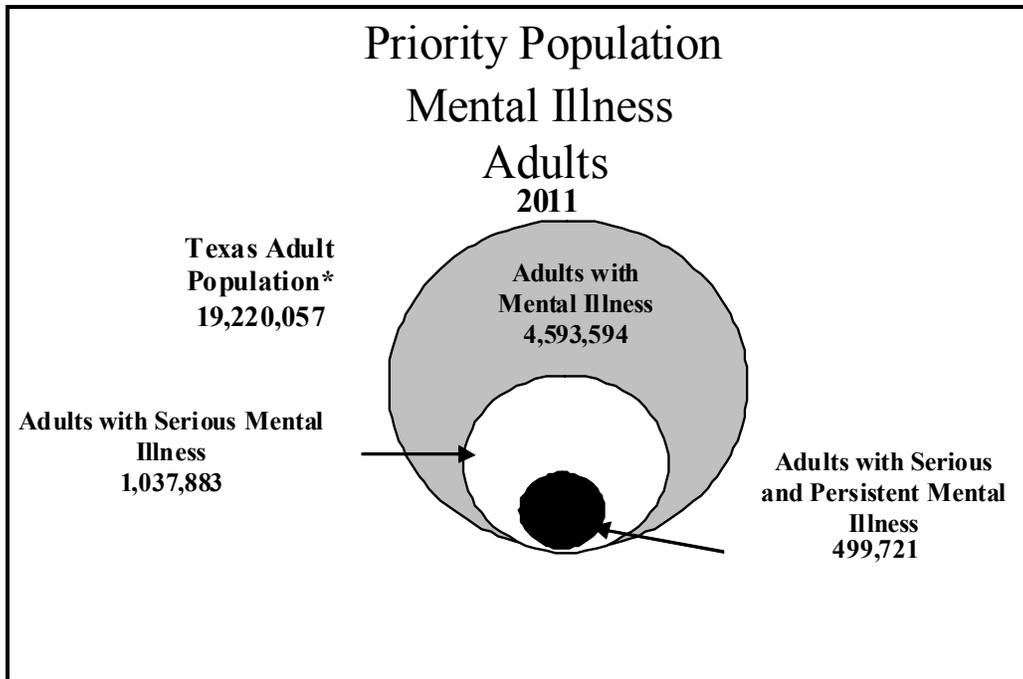
Mental illness does not exempt any group of individuals -- it occurs in all age, race, ethnicity, gender and socioeconomic groupings. Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for the adult population (source: U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, 1999). Approximately 22-23% of the adult population has some diagnosable mental disorder. Those with severe and persistent mental illness represent approximately 2.6% of the adult population.

The Center for Mental Health Services (CMHS) within the Substance Abuse and Mental Health Services Administration (SAMHSA) requires the use of a specific methodology for estimating the number of adults with serious mental illness (SMI) for purposes of the Mental Health Block Grant. The methodology is defined in the *Federal Register*, Volume 64, Number 121, Thursday, June 24, 1999, Notices, pages 33890 – 33897. This calculation methodology is based on a 95% confidence level. It is estimated that 5.4% of the adult population has a serious mental illness during a given year. The methodology also further defines the lower and upper limits of the 5.4% point estimate based on the 95% confidence level.

<b>Estimated Adult Population - 2011*</b>	<b>Point Estimate of SMI Prevalence</b>	<b>95% Confidence Level</b>	
		<b>Lower Limit</b>	<b>Upper Limit</b>
19,220,057	1,037,883	698,841	1,376,925

\* Source: Texas Population Projections for 2011, Texas Health and Human Services Commission, version February 2009.

The priority population prevalence projections in the chart below represent the number of individuals who are estimated to meet the priority population definition for mental health services in the Texas public mental health system.



\* Source: Texas Population Projections for 2011, Texas Health and Human Services Commission, version February 2009.

There are many more adults in need of services than are currently served in the public mental health system. In SFY2009, 150,057 (or 32.12%) of the 467,226 adults with serious and persistent mental illness were served by DSHS-funded community mental health centers including NorthSTAR (for estimate methodology, see *Federal Register*, Volume 64, Number 121, June 24, 1999, pp. 33890-33897; National Advisory Mental Health Council 1993<sup>1</sup>; Kessler et al., 1996<sup>2</sup>).

<sup>1</sup> National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry*, 150, 1447-1465.

<sup>2</sup> Kessler, R. C., Berglund, P. A., Zhao, S., Leaf, P. J., Kouzis, A. C., Bruce, M. L., Friedman, R. M., Grossier, R. C., Kennedy, C., Narrow, W. E., Kuehnel, T. G., Laska, E. M., Manderscheid, R. W., Rosenheck, R. A., Santoni, T. W., & Schneier, M. (1996). The 12-month prevalence and correlates of serious mental illness, In Manderscheid, R. W., & Sonnenschein, M. A. (Eds.), *Mental health, United States, 1996* (DHHS Publication No. (SMA) 96-3098, pp. 59-70). Washington, DC: U.S. Government Printing Office.

Adult - Quantitative targets to be achieved in the implementation of the system of care described under Criterion 1

## **Adult – Quantitative Targets**

N/A – Quantitative Targets are included as part of the measures discussed in the Goals, Target, and Action Plans Section.

Adult - Describe State's outreach to and services for individuals who are homeless

## **Adult – Outreach to Homeless**

### **PATH (Projects for Assistance in Transition from Homelessness)**

Outreach and services for persons who are homeless in Texas and have a mental illness, including co-occurring substance use disorder (which may include a co-occurring substance use disorder) are available through blended funding from the federally funded PATH program, state general revenue, and local matching funds. PATH activities include outreach to identify and link the individual and families with mainstream mental health and substance abuse services, case management, primary health services, job training, supported employment, and relevant housing and services. PATH activities can occur where the person is found, including homes, jails, streets, shelters, and public areas.

DSHS selects Texas PATH sites through an application process and consideration of poverty and density indices as well as geographic areas with the greatest need. Currently, DSHS contracts with 16 not-for-profit and governmental entities to operate PATH programs in their respective regions.

Approximately 16,000 homeless persons, including children and adults, receive PATH services each year. According to FY 2009 Texas PATH report data, 45% had a co-occurring substance use and 69% were literally homeless. Twenty-five percent of the persons enrolled in PATH were a result of targeted outreach. Over half of PATH enrolled individuals received some type of community mental health services.

Adult - Describes how community-based services will be provided to individuals in rural areas

## **Adult – Rural Area Services**

There are 254 counties within the State of Texas. Each is classified as urban, urban/rural, rural or frontier. Although a majority of Texans live in urban areas, over one half of the counties in the state are considered rural. According to the U.S. Bureau of the Census and the Office of Management and Budget, 196 of the 254 counties are non-metropolitan. Approximately three million people, or 13% of the population, live outside metropolitan areas.

Local Mental Health Authorities (LMHAs) are responsible for the provision of community mental health services to all 254 counties in Texas. Approximately 77% of Texas' 254 counties are in urban/rural, rural or frontier areas. Rural priority population members are in need of the same services as those who live in urban areas. Listed below are many of the common challenges that service providers face in the rural and frontier counties, as well as some of the more unique ones:

- Lack of access to affordable health care
- Lack of transportation
- Lack of housing resources
- Little or no economic development
- Limited fiscal resources
- The out migration of younger population
- Increased need for geriatric services
- Isolation
- Increased substance abuse (alcohol, prescriptions, and illegal drugs)
- Domestic Violence
- Lack of trained professionals

LMHAs providing services to rural areas are challenged daily to meet the complex needs of the individuals they serve with the limited resources at their disposal. As such, it is imperative that attention be given to improving access to quality health and human services, strengthening families, strengthening and supporting economic development, developing partnerships with state, local and tribal governments, and supporting a rural voice in local, state and federal policy making.

To address the needs of rural communities, the Office of Rural Community Affairs is the state agency that was created to ensure a continuing focus on rural issues, monitor governmental actions affecting rural Texas, research problems and recommend solutions, and to coordinate rural programs among state agencies.

Since its inception, the agency has worked to strengthen rural communities, assisting with economic development and healthcare. This is done by serving as the central source for rural programs, services, and activities so governmental resources are efficiently delivered with the best possible results for the state's rural residents.

Texas provides services through the Office of Rural Community Affairs (ORCA). On the national level, services are provided by the Office of Rural Health (SORH), designated by the US Department of Health and Human Services Health Resources and Services Administration (HRSA). These agencies are dedicated to serving the healthcare needs and interests of rural Texas communities.

The state level Office of Rural Health Division facilitates and coordinates the use of available resources to assist rural Texans to enhance quality of life, achieve sustained economic growth, and strengthen local healthcare infrastructure and systems of care to meet the needs, challenges, and priorities of rural Texas. To this end, SORH works closely with many local, state, and federal partners to:

- Develop, support, and coordinate programs and services that enhance the ability of rural Texas communities, improving access to equitable, high quality health services across the continuum of care that meets local needs;
- Inform, guide, and facilitate efforts in rural health policy design, service planning, resource allocation, and program implementation;
- Enhance the communities' capacity to plan and direct intervention on key health domains which have the greatest impact on the health status of local citizens;
- Reduce the pervasive, harmful and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral healthcare systems.

\*\*3. In addition, substance abuse prevention and intervention funds through the SAMHSA Block Grant provide "Rural Border Intervention" Programs (RBIs) serving 20 rural border counties. A limited amount of these funds provide evidence-based curriculum training in Substance Abuse prevention to adult/parents, and information and referral services that include mental health. RBI personnel also encourage substance abuse and mental health screening and treatment, and make referrals for those adults needing those services in these rural areas. Adults receiving services through the RBI are also provided with short term motivational interviewing which focuses on change behavior and improving quality of life as it relates to behavioral health services. The counties serviced are: Dimmit, Edwards, Frio, Kinney, LaSalle, Maverick, Real Uvalde, Val Verde, Zavala, Brewster, Culberson, Hudspeth, Jeff Davis, Presidio, Brooks, Duval, Jim Hogg, Starr, and Zapata.

In February 2010, a hurricane disaster Social Services Block Grant (SSBG) became available to DSHS MHSA. This grant allowed the department to provide funding for an additional three 3 rural counties in the rural Texas-Mexico border to expand the Rural Border Intervention Program. The Rural Intervention Program was expanded in Region 11 which includes Hidalgo, Cameron and Willacy counties). These are three of the poorest and most remote rural counties in Texas. These funds are available through September 30, 2010 and are being utilized to augment the RBI services (noted above). These funds will also be utilized to develop and implement programming related to border violence and disaster prevention. The State of Texas clearly notes the connection between the experiences related to border violence, drug trafficking and MHSA intervention and treatment needs.

The State of Texas Department of State Health Services currently certifies Community Health Workers/*Promotores*. These workers serve as indigenous outreach workers and are part of the communities they serve. This model is very useful in the rural areas of Texas. Currently, two Rural Border Intervention programs employ *Promotoras* who provide services underserved communities to provide information and education. These *Promotoras* have additional training in Behavioral Health and are able to identify some mental health concerns and make appropriate referrals for families and their children. Additionally, many rural communities are served via a special initiative by Texas A&M University (TAMU). TAMU has established community centers in a variety rural Border areas, specifically, the *Colonias*, where there are many unmet needs and high levels of poverty. These community centers also operate with the support of *Promotoras* and provide a venue where many community providers collaborate and provide education, and conduct intakes related to behavioral health concerns of individuals in their communities. Currently TAMU, the Department of State Health Services Mental Health and Substance Abuse Division, the Rio Grande Valley Council on Drug and Alcohol Abuse in Pharr, Texas are working on a joint SSBG funded project to train Promotoras/Community Health Workers on a newly developed curriculum related to Border Violence and Disaster Prevention. The goal is for the Promotoras to train families in rural Colonia communities how to better identify issues related to trauma and how to protect themselves and their children against drug use and drug related violence. This new curriculum and training plan will be "rolled out" in August, 2010. Texas A&M has 42 centers in Texas Border *Colonias* with approximately 40 based in primarily rural counties.



Adult - Describes how community-based services are provided to older adults

## **Adult – Older Adults**

### **Demographic Trends**

As in all parts of the nation, the growing elderly population in Texas is placing increased demands on health care, long term care, and other services. However, aging in Texas is tempered by relatively rapid growth in young, largely non-Caucasian populations. Consequently, the population of Texas overall is likely to remain somewhat younger than other parts of the nation.

Statistics indicate the population aged sixty-five and older will be the segment of the population with the greatest proportional changes over the next ten years. This is attributable, in part, to the aging “Baby-Boom” generation--the cohort population born between 1946 and 1964. Demographers estimate that the sixty-five and older cohort in 2000 was 9.9 percent. By 2020, this age group is anticipated to grow to 12.3 percent of the population. Due to the large and expanding population of Texas overall, this growth represents a large number of individuals who may seek services from local mental health authorities.

### **Services Provided**

Depression is one of the conditions most commonly associated with suicide in older adults, according to the Centers for Disease Control. Studies by the National Institute for Mental Health show that many elderly individuals and health professionals may mistakenly think that persistent depression is a “normal” and acceptable response to the serious medical illnesses and the social and financial hardships that often accompany aging. This belief may contribute to low rates of diagnosis and treatment of depression in older adults.

According to the National Institute for Mental Health, combining psychotherapy with antidepressant medication appears to provide the most benefit for older adults. This approach has proven more effective than psychotherapy or medication alone.

In FY09, DSHS’s public mental health system provided psychotherapy, medication and other services to approximately 9,610 individuals aged sixty and older with serious mental illness. This is a 41% increase in numbers served as compared to FY06. Mental health services provided include Cognitive Behavior Therapy, Inpatient Acute services, Medication Management, Case Management, Psychosocial Rehabilitation and Skills Training and Supports.

DSHS’s public substance abuse treatment system during the same year provided treatment for approximately 603 individuals aged sixty and older with substance abuse diagnoses. This is a 15% increase in numbers served as compared to FY06. Substance abuse treatment services include Detoxification, Co-occurring Psychiatric and Substance Disorder services, HIV Services, Residential and Outpatient Services, and Methadone Maintenance.

### **Next Steps**

DSHS has recently started production of a web page linked to the primary DSHS website that provides information to local mental health authorities about working with older adults. This page will provide links to research by the National Institute for Mental Health and the Surgeon General's Office regarding diagnosis, physiological factors, treatment compliance, increased risk of side effects, polypharmacy, comorbidity, life stages, unique barriers and specialized treatment for older adults.

DSHS is also planning a workshop at the 2011 Community Mental Health and Substance Abuse Behavioral Health Institute entitled, “Mental Health Issues in the Older Population,” which will cover the latest research and best practices. Additionally, DSHS periodically distributes literature to local mental health authorities and other stakeholders detailing the latest research and recommendations from SAMHSA. DSHS has shared SAMHSA’s recent

publications which have addressed substance abuse treatment and co-occurring substance abuse and mental illness in the elderly population.

DSHS would like to train mental health practitioners in "Cognitive Behavioral Therapy for Late Life Depression." Currently however, shortages in professional staff as well as budget cuts hinder this expansion.

Adult - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

## **Adult – Resources for Providers**

### **Financial Resources**

The estimated SFY10 operating budget called for the expenditure of over \$550 million for community mental health services. This included general revenue, federal funds, and other funds. Of the general revenue funds, Rider 65 (81<sup>st</sup> legislative session) appropriated \$55 million dollars (\$55,000,000) to the Department of State Health Services (DSHS) to expand transitional and intensive ongoing services. These funds were distributed evenly between SFY10 and SFY 11 and were allocated to community mental health crisis services. In addition to these amounts, community center operating budgets included local funds as well as revenues generated from federal, state and other sources. These additional revenues do not appear in DSHS' operating budget because they are directed to the local mental health authorities (LMHAs), increasing those community centers' funding. Although trends have been to increase available financial resources over the last several biennia, the Texas' per capita expenditure remains among the lowest in the nation.

### **Staffing and Training**

The LMHAs are responsible for the training and competency of provider (employee or contracted) staff. DSHS supports the effort by offering specialty trainings on current topics through the use of outside developers/contractors to maintain the focus on evidence based research and practices. This is an effort to continue helping the LMHA staff to successfully deliver quality services, and to increase effectiveness without the need to rely on the state for annual trainings on evidence-based practices.

Staff delivering community mental health services are required to demonstrate the appropriate competencies, licenses, and certifications for their positions. LMHAs are responsible for ensuring that staff members have all the appropriate competencies for the positions they fill, and must implement a process to ensure the competency of staff. The process must define competency-based expectations for each position. This includes critical competencies (such as first-aid and cardiopulmonary resuscitation) and specialty competencies (such as prevention and management of aggressive behavior, suicide/homicide, etc.).

Staff members must also demonstrate competencies required for their positions before contact with consumers. These competencies must be periodically reviewed throughout their employment tenure or association with the LMHA or provider. Each LMHA must implement a credentialing and re-credentialing process for its entire licensed staff and its qualified mental health professional-community services (QMHP-CS) staff. This includes a process for staff to appeal decisions, provision of necessary QMHP-CS supervision, and implementation of a peer review process. These processes must comply with all applicable rules and state laws (e.g., Medical Practice Act, Nursing Practice Act, Vocational Nurse Act, Dental Practice Act, and Pharmacy Practice Act).

### **Evidence-Based Supported Employment**

In order to assist LMHAs in implementing evidence based practices, DSHS provided training on evidence-based supported employment (EBSE) to all LMHAs. This training was based on the individual placement and support (IPS) model of EBSE developed by Dartmouth Psychiatric Research Institute. This model was selected because it has consistently proven to be more effective than traditional approaches in helping consumers gain competitive employment. Numerous studies done on IPS report 40%-58% of people in supported employment obtained competitive employment compared to 21% in traditional programs. Key principles of the IPS model include finding consumers competitive jobs in a timely manner, integrating supported

employment with other mental health services, individualizing employment goals, and having zero-exclusion criteria for eligibility. Research on these principles shows a strong correlation between finding and maintaining employment for consumers, which is a key ingredient in recovery. For more information on this initiative please see the “New Developments-Adult” section of this mental health block grant application.

### **Cognitive Processing Therapy**

\*\* 2&3. Over the past several years, Texas has prioritized initiatives supporting veteran's needs. In order to target the needs of veterans and consumers who have a history of trauma, DSHS has started providing training to LMHAs and community therapists on cognitive processing therapy (CPT). Research on CPT has demonstrated its effectiveness in treating consumers with post-traumatic stress disorder (PTSD), a common diagnosis among veterans and many consumers utilizing community mental health services in Texas. Thus far, 91 LMHA staff have been trained in CPT; however, two additional trainings will be held for LMHA staff and community therapists. The trainings are projected to result in 100 additional people being trained in CPT.

Additionally, DSHS has made some funding available to LMHAs to provide peer and family training programs, including “In The Zone, “ which is a peer-to-peer support group for veterans.

### **Cognitive Behavioral Therapy**

Cognitive behavioral therapy (CBT) is a widely accepted evidence-based practice. In order to improve delivery of this service DSHS has partnered with Monica Basco, Ph.D., of the University of Texas, to offer clinicians at LMHAs the opportunity to become certified CBT trainers. At this time, two cohorts have completed the training. These certified trainers have returned to their centers and trained their colleagues in service delivery skills and best practices related to CBT.

### **Mental Health and Substance Abuse Training and Technical Assistance Center-Via Hope**

Substantial emphasis has been placed on the implementation of Via Hope, a consumer training and technical assistance center. It provides mental health consumers and family members with information and education that assists with their recovery and enables them to better navigate the public and private mental health care systems. Via Hope provides a certified peer specialist training program; during 2010, 58 peers were trained in providing peer services during week-long training in Austin. Via Hope also provides online training resources and an information database for consumers and mental health professionals. Please refer to the “Adult-New Developments-” section of this application for more information on the peer initiative.

### **Mental Health Transformation**

Information on Mental Health Transformation activities is also included in the section entitled “Adult - Recent Significant Achievements”. The Mental Health Transformation grant has been used to launch three learning communities-one focused on peer specialists, one focused on supported employment and another focused on integrated care. These training programs are designed to inform health care providers and service coordinators about emerging trends, resources, and activities that support the New Freedom Commission goals.

The integrated care learning community is working to advance the integration of physical and behavioral health care. Six federally qualified health centers (FQHCs) have received financial support from the state's Primary Care Office to support planning activities in conjunction with local mental health authorities. Other partners are working together using Mental Health Transformation funds to advance integrated care. In addition to considering different models of coordinating service delivery, the organizations can leverage a state-provided web-based health assessment tool which is still in the beginning stages of implementation.

Other resources for providers include the following: training to school-based professionals through school health specialists in the Education Service Center program, which is partially funded by MHSA and managed through the DSHS School Health Program; funding for mental health training for staff in various regions of Texas, including those served by the promotoras (community-based health care workers); and online training for providers enrolled in the Texas Health Steps Program.

Finally, to help train the next generation of mental health professionals, MHSA has also sponsored a variety of MHSA internships, providing training opportunities for students enrolled in higher education.

Adult - Provides for training of providers of emergency health services regarding mental health;

## **Adult – Emergency Service Provider Training**

The training of emergency service providers for mental health crises is the delegated responsibility of local mental health authorities (LMHAs). The performance contract and the DSHS community mental health standards require LMHAs to provide or arrange for crisis services. LMHAs work directly with emergency room staff and have established protocols to provide screening for inpatient admission.

In many communities, the LMHA provides mobile crisis teams that receive specialized training and accreditation. All LMHAs must have agreements with law enforcement agencies which address training of officers and include protocols for handling psychiatric crises. Several communities have mental health deputy units that work closely with the LMHAs to provide the most appropriate response to psychiatric crises and divert consumers from entering jails.

Additionally, Texas has been a national leader in the development of mental health disaster assistance services, which involve training of clinicians, public health, mental health and substance abuse providers, and first responders in the event of natural and man-made disasters. The Disaster Behavioral Health Services (DBHS) team is charged with coordinating disaster behavioral health preparedness, response, and recovery efforts for Texas during and after a state or federally declared emergency. This coordination includes guidance, technical assistance, and collaboration with decision makers at all levels of government.

In addition, DBHS is tasked with coordinating the DSHS disaster behavioral health activities during the emergency response and recovery phase of a disaster. To this end, DSHS establishes FEMA crisis counseling teams to provide stress management and crisis counseling to first responders and any individual or group affected by the event.

The Disaster Behavioral Health Services Team offers the following services:

### **Crisis Counseling Program**

During and after a state or federally declared emergency, DBHS provides a comprehensive and coordinated disaster behavioral health response. During a federally declared disaster, DBHS works with local mental health, substance abuse, voluntary agencies, and local community resources in the development, submission, and management of FEMA-funded Crisis Counseling Programs (CCP).

To assist those impacted by the disaster with their recovery, the community-based CCP provides direct services to alleviate or decrease psychological distress and adverse emotional reactions as a result of the disaster. This goal is achieved through crisis counseling services to any individual, family, group, or community that experienced a catastrophic event.

CCP services include:

- Outreach
- Screening and assessment
- Counseling
- Information and referral
- Public education

### **Stress Management**

Stress management provides education and information on traumatic stress including both the psychological and physical symptoms frequently identified after a traumatic event. It also provides education and training in healthy stress management techniques to improve individual and group coping skills.

### **Education and Training**

This training program includes information for DSHS mental health, substance abuse, and public health components on the purpose, requirements, goals, scope of services, rules, and regulations of a CCP grant. DSHS participates in the Texas Division of Emergency Management (TDEM) staff training programs for disaster response personnel to raise awareness about disaster survivor issues and needs.

### **Emergency Management**

Emergency management provides consultation and technical assistance to DSHS public health departments, mental health and substance abuse groups, and government agencies during a local, state, or federally declared disaster. Staff work in conjunction with TDEM, state hospitals, community mental health centers, regional public health departments, substance abuse providers, and local governments to provide or assist with basic emergency disaster mental health management activities. The team assists DSHS mental health, substance abuse, and public health groups in preparing for, responding to, and recovering from facility or community-based disasters that impact the physical and emotional well-being of mental health and substance abuse consumers and staff. Through technical assistance, the program assists local and state mental health, substance abuse, and public health facilities to obtain federal resources in preparation for, responding to, and recovering from federally declared disasters.

### **Critical Incident Stress Management (CISM)**

The CISM function is to alleviate or decrease psychological suffering as a result of the event and mitigates the long-term effects that acute stress may have on individuals, families, responders, and the community. CISM provides organizational consultation, diffusions, debriefings, one-on-one crisis counseling, follow-up, and referrals to any individual or group that has experienced a traumatic or catastrophic event. Services are provided to emergency service personnel, rescuers, organizations (i.e. schools, non-profit organizations, businesses), and other groups or individuals. Services are assessed and prioritized based on suitability to the situation as well as resource availability.

CISM service provision is coordinated with the DSHS CISM Network, Department of Public Safety – Psychological Services Bureau, Voluntary Organizations Active in Disaster, and the Attorney General - Crime Victim Services Division.

Adult - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

## **Adult – Grant Expenditure Manner**

Community Mental Health Block Grant funds are allocated to the following:

**Community Mental Health Centers** -- Community Mental Health Block Grant funds are used primarily to fund services through local mental health authorities (LMHAs) and are distributed with other state funds according to a funding formula based on historical funding, poverty rates, and other relevant demographic data.

**NorthSTAR** – NorthSTAR is the Medicaid managed care behavioral health carve-out that also serves the non-Medicaid eligible population in the Dallas service area. In this capacity, the Medicaid managed care organization is delegated by the local behavioral health authority some of the LMHA functions as required by the Texas Department of Insurance. It differs from the rest of the system in a number of ways, but funds are allocated in similar fashion. Block grant funds are combined with all sources mentioned above and are paid out primarily in the form of a “per member, per month” capitation payment.

**Innovations/System Changes**– DSHS holds allocations to LMHAs constant in order to maintain basic client services. However, some innovations or system changes that would support the basic services are also funded with Mental Health Block Grant dollars. DSHS consults its staff, providers, and Mental Health Planning and Advisory Council (MHPAC) to determine priority projects. In 2010 projects funded included funding of co-occurring treatment services; the continued development of an electronic health record that will integrate mental health with substance abuse services, and the training and technical assistance project (TTAC) mentioned in previous sections.

**Table C. MHBG Funding for Transformation Activities**

**State: Texas**

	Column 1	Column 2	
	Is MHBG funding used to support this goal? If yes, please check	If yes, please provide the <i>actual or estimated</i> amount of MHBG funding that will be used to support this transformation goal in FY2011	
		Actual	Estimated
GOAL 1: Americans Understand that Mental Health Is Essential to Overall Health	<input checked="" type="checkbox"/>		1,610,453
GOAL 2: Mental Health Care is Consumer and Family Driven	<input checked="" type="checkbox"/>		2,254,635
GOAL 3: Disparities in Mental Health Services are Eliminated	<input checked="" type="checkbox"/>		805,227
GOAL 4: Early Mental Health Screening, Assessment, and Referral to Services are Common Practice	<input checked="" type="checkbox"/>		805,227
GOAL 5: Excellent Mental Health Care Is Delivered and Programs are Evaluated*	<input checked="" type="checkbox"/>		24,156,802
GOAL 6: Technology Is Used to Access Mental Health Care and Information	<input checked="" type="checkbox"/>		2,576,725
<b>Total MHBG Funds</b>	N/A	0	32,209,070.00

\*Goal 5 of the Final Report of the President's New Freedom Commission on Mental Health states: Excellent Mental Health Care is Delivered and Research is Accelerated. However, Section XX of the MHBG statute provides that research ... Therefore, States are asked to report expected MHBG expenditures related to program evaluation, rather than research.

For each mental health transformation goal provided in Table C, briefly describe transformation activities that are supported by the MHBG. You may combine goals in a single description if appropriate. If your State's transformation activities are described elsewhere in this application, you may simply refer to that section(s).

**32. Table C – Description of Transformation Activities**  
**Calculation of Funding for Transformation Activities**

To obtain estimates regarding the amount of MHBG funding that is applied toward each of the Freedom Commission goals; the Texas Department of State Health Services (DSHS) utilized the figure of \$32,209,069.00, which is the amount of the block grant award in FFY 2010. All activities are targeted toward transformation, and DSHS categorized them by Freedom Commission goal (see below), with some activities applied to more than one goal. DSHS assigned a percentage to each goal, taking into consideration the time and MHBG money spent on local provider costs, special funded projects, state office personnel, and operating costs. This provided an approximate percentage to apply to each of the goals. The percentage was applied to the total award amount to obtain an unduplicated estimate of how much is spent on each goal.

**Descriptions of Transformation Activities**

The activities noted below are supported fully or in part by the Mental Health Block Grant. Many of the activities address more than one goal. Column 1 describes the activities relative to each goal. Column 2 describes where the activity is described in the application. Although funds for adult and children’s activities are not separated in Table C, the activities are indicated as adult (A), child(C), or both.

	<b>Column 1</b>	<b>Column 2</b>
	Transformation Activities that are supported by the MHBG	Description of the Activity can be found in the application in section:
<b>Goal 1: Americans Understand that Mental Health is Essential to Overall Health</b>	Behavioral Health Framework for Prevention A,C	A-Strengths and Weaknesses C-Available Services
	Provision of services for co-occurring psychiatric and substance abuse disorders and physical health A,C	A & C-Available Services
	Disaster Mental Health Services (DMHS) A,C	A-Emergency Service Provider Training
	Texas Implementation of Medication Algorithms (TIMA) A,	A -Available Services
	Comprehensive Health Care for Children in Foster Care C	C-System of Strengths and Weaknesses and Recent Significant Achievements
	Suicide Prevention Framework- A & C	A -Available Services
<b>Goal 2: Mental Health Care is Consumer and Family Driven</b>	Resiliency and Disease Management Initiative for adults and children A,C	A&C-Available Services Address A&C-Available Services
	Training and Technical Assistance Center (TTAC) A,C	A&C-Plans to Address Unmet Needs
	NorthSTAR A,C	A-Overview of Mental Health System

	<p>Local Planning and Network Development (LPND)</p> <p>Texas Implementation of Medication Algorithms (TIMA) A</p> <p>Texas Transformation Workgroups for Adults and Children A,C</p> <p>Behavioral Health Framework for Prevention A,C</p> <p>Money Follows the Person A</p> <p>Children with Special Health Care Needs (CSHCN) Services C</p> <p>Texas Integrated Funding Initiative (TIFI) C</p> <p>Preadmission, Screening and Resident Review (PASRR)</p> <p>Supported Employment and Peer Support</p> <p>Border Collaboration-Services to Colonias</p>	<p>A-Overview of Mental Health System</p> <p>A-Available Services</p> <p>A&amp;C-Recent Significant Achievements</p> <p>A-Strengths and Weaknesses C-Plans to Address Unmet Needs</p> <p>A-Plans to Address Unmet Needs</p> <p>C-Available Services</p> <p>C-Grant Expenditure Manner</p> <p>A-New Developments and Issues</p> <p>A-New Developments and Issues</p> <p>A-Service System Strengths and Weaknesses</p>
<p><b>Goal 3:</b> Disparities in Mental Health Services are Eliminated</p>	<p>Jail Diversion –A,C</p> <p>Resiliency and Disease Management Initiative for adults and children A,C</p> <p>Crisis Service A,C</p> <p>Behavioral Health Framework for Prevention A,C</p> <p>Telemedicine A,C</p> <p>State-agency-level data sharing A</p> <p>Child with Special Health Care Needs (CSHCN) C</p> <p>Youth Empowerment Services (YES) 1915-C- Medicaid Waiver C</p> <p>Texas Integrated Funding</p>	<p>A-Update on Legislative Issues C-Plans to address unmet needs</p> <p>A&amp;C-Available Services</p> <p>A&amp;C-Available Services</p> <p>A-Strengths and Weaknesses C-Plans to Address Unmet Needs</p> <p>A &amp; C-Pans to Address Unmet Needs</p> <p>A-Recent Significant Achievements</p> <p>C-Available Services</p> <p>C-New Developments and Issues</p> <p>C-Grant Expenditure Manner</p>

	<p>Initiative (TIFI) C</p> <p>Education Service Center Project, C</p> <p>Provision of services for co-occurring psychiatric and substance abuse disorders A,C</p> <p>Border Collaboration-Services to Colonias</p>	<p>C-Available Services</p> <p>A &amp; C-Available Services</p> <p>A-Service System Strengths and Weaknesses</p>
<p><b>Goal 4:</b> Early Mental Health Screening, Assessment, and Referral to Services are Common Practice</p>	<p>Resiliency and Disease Management Initiative for adults and children A&amp;C</p> <p>Education Service Center Project, C</p> <p>Suicide Prevention Framework, A&amp;C</p>	<p>A&amp;C-Available Services</p> <p>C-Available Services</p> <p>A&amp;C Available Services</p>
<p><b>Goal 5:</b> Excellent Mental Health Care is Delivered and Research is Accelerated</p>	<p>Resiliency and Disease Management Initiative for adults and children A&amp;C</p> <p>Behavioral Health Framework for Prevention A,C</p> <p>Texas Implementation of Medication Algorithms (TIMA) A</p> <p>Texas Transformation Workgroups for Adults and Children A,C</p> <p>Training in evidence-based practices</p> <p>Training and Technical Assistance Center (TTAC) A&amp;C</p> <p>Provision of services for co-occurring psychiatric and substance abuse disorders A,C</p>	<p>A&amp;C-Recent Significant Achievements</p> <p>A-Strengths and Weaknesses</p> <p>A-Strengths and Weaknesses</p> <p>C-Plans to Address Unmet Needs</p> <p>A-Available Services</p> <p>A-Recent Significant Achievements</p> <p>C-Plans to Address Unmet Needs</p> <p>A-Resources for Providers</p> <p>A&amp;C-Available Services</p> <p>A &amp; C-Available Services</p>
<p><b>Goal 6:</b> Technology is Used to Access Mental Health Care and Information</p>	<p>The Clinical Management for Behavioral Health Services (CMBHS)</p> <p>Resiliency and Disease</p>	<p>A&amp;C-Recent Significant Achievements</p> <p>A&amp;C-Available Services</p>

	Management A,C Telemedicine A,C State-agency-level data sharing A Children's Co-Occurring Policy Academy C	C-Strengths and Weaknesses A&C-Service System Strengths and Weaknesses A&C Service System Strengths and Weaknesses C-Grant Expenditure Manner
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## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	207,186	225,482	233,469	251,765
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Increase access to services for adults with mental illness

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Number of persons served (adults)

**Measure:** Unduplicated count of adults served per year

**Sources of Information:** The state database of persons served by the community system. The Client Assignment and Registration System (CARE). Service data for the NorthSTAR region is maintained in a separate data warehouse. URS Table 2A

**Special Issues:** None

**Significance:** This measure provides the actual number of adults who receive services.

**Action Plan:** Improved crisis services and engagement of other agencies through the Transformation initiative should expand the reach of mental health services.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	8.95	8.49	7.40	8
Numerator	1,197	1,055	--	--
Denominator	13,379	12,428	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Reduce the rate of readmission to state hospitals within 30 days after discharge

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Decreased rate of readmissions to state psychiatric hospitals within 30 days

**Measure:** Numerator: Number of adult readmissions to state hospitals within last 30 days  
Denominator: Number of adult discharges from state hospitals during the fiscal year

**Sources of Information:** State hospital admission and discharge data in CARE - URS Table 20A

**Special Issues:** None

**Significance:** This measure provides information regarding the rate at which discharges from state hospitals result in readmissions within 30 days. This measure provides an indication of continuity of care and the capacity of community-based systems of care.

**Action Plan:** Ongoing evidence-based treatment is intended to result in fewer hospitalizations.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	20.77	20.03	15.60	16.80
Numerator	2,779	2,489	--	--
Denominator	13,379	12,428	--	--

Table Descriptors:

- Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community
- Target:** Reduce the rate of readmission to state hospitals within 180 days after discharge
- Population:** Adults with Serious Mental Illness (SMI)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased rate of readmission to state psychiatric hospitals within 180 days
- Measure:** Numerator: Number of adult readmissions to state hospitals within last 180 days  
Denominator: Number of adult discharges from state hospitals during the fiscal year
- Sources of Information:** State hospital admission and discharge data in CARE - URS Table 20A
- Special Issues:** None
- Significance:** This measure provides information regarding the rate at which discharges from state result in readmissions within 180 days. This measure provides an indication of continuity of care and the capacity of community-based systems of care.
- Action Plan:** Ongoing evidence-based treatment is intended to result in fewer hospitalizations.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	6	6	6
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:** To maintain/expand the use of evidence-based practices

**Target:** To offer statewide:  
 Supported Housing  
 Supported Employment  
 Assertive Community Treatment (ACT)  
 Integrated Treatment of Co-Occurring Disorders (MH/SA)  
 Illness Self-Management  
 Medication Management

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
 3:Children's Services

**Indicator:** Number of Evidence Based Practices (EBPs) offered

**Measure:** Total number of programs described in URS Tables 16 and 17

**Sources of Information:** Service assignment data in CARE as reported in URS Tables 16 and 17

**Special Issues:** None

**Significance:** Evidence-based practices have been demonstrated to produce positive outcomes.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	2.71	2.25	1.92	2.20
Numerator	4,939	4,468	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

- Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community
- Target:** Adult target population members will receive services that are evidence-based
- Population:** Adults with Serious Mental Illness (SMI)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Adults receiving evidence-based practices - Supported Housing
- Measure:** Numerator: Total number of adults receiving supported housing services  
Denominator: Total unduplicated number of adults with SMI served by the SMHA
- Sources of Information:** Service assignment data in CARE as reported on URS Table 16
- Special Issues:** None
- Significance:** This evidence-based practice has been demonstrated to produce positive outcomes.
- Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Supported Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	1.20	.94	.98	1
Numerator	2,187	1,876	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

**Goal:** To provide employment services to people with serious mental illness

**Target:** Adult target population members will receive services that are evidence-based

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Adults receiving evidence-based practices - Supported Employment

**Measure:** Numerator: Number of adults receiving supported employment services  
Denominator: Total unduplicated number of adults with SMI served by the SMHA

**Sources of Information:** Service assignment data in CARE as reported on URS Table 16

**Special Issues:** None

**Significance:** This evidence-based practice has been demonstrated to produce positive outcomes.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Assertive Community Treatment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	1.81	1.50	1.51	1.50
Numerator	3,304	2,983	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adult target population members will receive services that are evidence-based

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Adults receiving evidence-based practices - Assertive Community Treatment (ACT)

**Measure:** Numerator: Number of adults receiving ACT  
Denominator: Total unduplicated number of adults with SMI served by the SMHA

**Sources of Information:** Service assignment data in CARE as reported on URS Table 16

**Special Issues:** None

**Significance:** This evidence-based practice has been demonstrated to produce positive outcomes.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Family Psychoeducation (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:** ]

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Integrated Treatment of Co-Occurring Disorders(MISA) (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	5.82	6.38	6.78	6.20
Numerator	10,600	12,691	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adult target population members will receive services that are evidence-based

**Population:** Adults with Serious Mental Illness (SMI) and Substance Abuse Disorders

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Adults receiving evidence-based practices - Integrated Treatment of Co-Occurring Disorders

**Measure:** Numerator: Number of adults receiving integrated MH/SA services  
Denominator: Total unduplicated number of adults with SMI served by the SMHA

**Sources of Information:** Service assignment data in CARE as reported on URS Table 17

**Special Issues:** None

**Significance:** Many persons with serious mental illness have co-occurring substance disorders. Integrated treatment is crucial for recovery. This evidence-based practice has been demonstrated to produce positive outcomes.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Illness Self-Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	58.53	63.35	54.99	58
Numerator	106,542	125,950	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

- Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community
- Target:** Adult target population members will receive services that are evidence-based
- Population:** Adults with Serious Mental Illness (SMI)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Adults receiving evidence-based practices - Illness Self-Management
- Measure:** Numerator: Number of adults receiving illness self-management  
Denominator: Total unduplicated number of adults with SMI served by the SMHA
- Sources of Information:** Service assignment data in CARE as reported on URS Table 17
- Special Issues:** None
- Significance:** This evidence-based practice has been demonstrated to produce positive outcomes.
- Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Adults with SMI Receiving Medication Management (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	52.61	50.46	50.02	53
Numerator	95,773	100,315	--	--
Denominator	182,042	198,810	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adult target population members will receive services that are evidence-based

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Adults receiving evidence-based practices - Medication Management

**Measure:** Numerator: Number of adults receiving medication management  
Denominator: Total unduplicated number of adults with SMI served by the SMHA

**Sources of Information:** Service assignment data in CARE as reported on URS Table 17

**Special Issues:** None

**Significance:** This evidence-based practice has been demonstrated to produce positive outcomes.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	84.84	84.20	84.20	85
Numerator	459	389	--	--
Denominator	541	462	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adult consumers surveyed will report satisfaction with the services they received

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of adult consumers reporting positively about outcomes

**Measure:** Numerator: Number of adult consumers reporting positively about outcomes  
Denominator: Number of adults responding to the outcomes question on the survey

**Sources of Information:** Texas Adult Mental Health Consumer Survey - URS Table 11

**Special Issues:** The Texas Adult Mental Health Consumer Survey is a 28-item survey based on national standards for measuring satisfaction, access, quality, participation in treatment, and outcomes of services. 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.

**Significance:** Perceptions of the effectiveness of services are important for service design and selection. Reports of positive outcomes reinforce clinical judgments, indicate an aspect of consumer satisfaction, and are associated with long-term compliance with treatment and better service outcomes.

**Action Plan:** Ongoing evidence-based treatment is expected to improve the quality of service, and that should result in improved satisfaction. The Texas Adult Mental Health Consumer survey data collection will continue on an annual basis.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increase/Retained Employment (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	18.07	16.08	14.38	16.25
Numerator	26,229	24,902	--	--
Denominator	145,188	154,852	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adult consumers of mental health services will be employed

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems

**Indicator:** Percent of adult clients who are competitively employed

**Measure:** Numerator: Number of adults who report being employed.  
Denominator: Number of adults who report being employed plus the number unemployed plus the number not in labor force.  
NOTE: This measure excludes persons whose employment status was "not available."

**Sources of Information:** The community assessment portion of the Mental Health Adult Uniform Assessment asks about consumers' current employment status. The most recent assessment of each adult is used to compute the measure. URS Table 4

**Special Issues:** None

**Significance:** Mental illness frequently causes unemployment and reduces employability. One of the most successful outcomes of treatment is the ability to maintain employment.

**Action Plan:** Community data will remain a part of the Uniform Assessment for Resiliency and Disease Management.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	71.43	73.08	73.08	65
Numerator	30	19	--	--
Denominator	42	26	--	--

Table Descriptors:

- Goal:** To reduce criminal justice involvement of adults with serious mental illness
- Target:** Adults with serious mental illness who have been involved with the criminal justice system will avoid additional arrest after treatment
- Population:** Adults with Serious Mental Illness (SMI)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of adult consumers arrested in year 1 who were not rearrested in year 2
- Measure:** Numerator: Number of adults arrested in T1 who were not rearrested in T2 (new and continuing clients combined)  
Denominator: Number of adults arrested in T1 (new and continuing clients combined)
- Sources of Information:** Texas Adult Mental Health Consumer Survey - URS Table 19A
- Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.
- Significance:** Reducing criminal justice involvement is a goal of mental health treatment, and an indicator of success.
- Action Plan:** All Local Mental Health Authorities (LMHAs) are required to maintain Jail Diversion plans. The Texas Adult Mental Health Consumer survey data collection will continue on an annual basis.

## ADULT - GOALS TARGETS AND ACTION PLANS

Transformation Activities:

**Name of Performance Indicator:** Adult - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	3.38	3.34	3.46	3.16
Numerator	4,942	5,219	--	--
Denominator	146,401	156,171	--	--

Table Descriptors:

**Goal:** To increase housing stability for adults receiving services

**Target:** Decrease the percent of adults reporting to be homeless

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of adults who are homeless

**Measure:** Numerator: Those adults reporting they are homeless  
Denominator: All adults reporting housing situation excluding (minus) "not available"

**Sources of Information:** Living situation data in CARE - URS Table 15

**Special Issues:** None

**Significance:** Housing stability is an indicator of recovery as well as a contributor.

**Action Plan:** Community data will remain a part of the Uniform Assessment for Resiliency and Disease Management.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Increased Social Supports/Social Connectedness  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	60.75	61.50	61.50	63
Numerator	322	278	--	--
Denominator	530	452	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adults with serious mental illness will report a feeling of social connectedness

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of adult consumers reporting positively about social connectedness

**Measure:** Numerator: Number of adults reporting positively about social connectedness  
Denominator: Number of adults responding to social connectedness question on the survey

**Sources of Information:** Texas Adult Mental Health Consumer Survey - URS Table 9

**Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target based on 2009 survey data.

**Significance:** Mental illness can create a sense of isolation. Recovery involves reclaiming a sense of connectedness.

**Action Plan:** The Texas Adult Mental Health Consumer survey data collection will continue on an annual basis.

**ADULT - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Adult - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	57.22	59.82	59.82	57
Numerator	305	271	--	--
Denominator	533	453	--	--

Table Descriptors:

**Goal:** To increase the abilities of persons with mental illness to lead successful lives in their community

**Target:** Adults with serious mental illness will report an improvement in functioning

**Population:** Adults with Serious Mental Illness (SMI)

**Criterion:**  
 1:Comprehensive Community-Based Mental Health Service Systems  
 3:Children's Services  
 4:Targeted Services to Rural and Homeless Populations

**Indicator:** Percent of adults reporting positively about functioning

**Measure:**  
 Numerator: Number of adults reporting positively about functioning  
 Denominator: Number of adults responding to level of functioning question on the survey

**Sources of Information:** Texas Adult Mental Health Consumer Survey - URS Table 9

**Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target based on 2009 survey data.

**Significance:** Self-perception of functioning is an indicator of recovery.

**Action Plan:** The Texas Adult Mental Health Consumer survey data collection will continue on an annual basis.

Child - Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness.

**Child – Establishment of System Of Care**

**See “Adult Establishment of System of Care**

Child - Describes available services and resources in a comprehensive system of care, including services for individuals with both mental illness and substance abuse. The description of the services in the comprehensive system of care to be provided with Federal, State, and other public and private resources to enable such individuals to function outside of inpatient or residential institutions to the maximum extent of their capabilities shall include:

Health, mental health, and rehabilitation services;  
Employment services;  
Housing services;  
Educational services;  
Substance abuse services;  
Medical and dental services;  
Support services;  
Services provided by local school systems under the Individuals with Disabilities Education Act;  
Case management services;  
Services for persons with co-occurring (substance abuse/mental health) disorders; and  
Other activities leading to reduction of hospitalization.

## **Child – Available Services**

DSHS recognizes that children with serious emotional disturbances, their families and caregivers require a range of age-appropriate mental health services and supports at various levels of intensity. As a result, all services and supports within the state's delivery of services are interrelated and the effectiveness of any one is related to the availability and effectiveness of all other services and supports. The goal is to provide an appropriate balance between the *less restrictive services* (those provided within the community), and the *more restrictive services* (those provided within the residential setting). In an effort to facilitate this balance, emphasis must be placed on the service system's capacity to provide intensive, non-residential services in the least restrictive setting to prevent an over-reliance on residential services.

Mental health services and supports for children are provided through the same local organizational structure as those provided within adult services. Children and adolescents, who meet eligibility criteria for services and are covered by Medicaid, are entered into services directly following eligibility screening. Children and adolescents, who meet eligibility criteria for services but do not have Medicaid coverage, may be placed on a waiting list for services. If there are no other funding sources to pay for a child's treatment service, the LMHA treating the child funds the services from block grant and general revenue funds. Major initiatives and issues specific to children's mental health are described in this section.

### **Health Services**

Each LMHA is required to address the health issues of its consumers throughout the treatment planning process. Services to address the health needs of consumers are generally not on site and are obtained through community referrals. Also, see "Medical and Dental" section below.

### **Mental Health Services**

DSHS provides children's mental health services and supports for the 254 counties of Texas. Block grant resources are utilized exclusively for the provision and support of comprehensive community mental health services. The service delivery system for public mental health services for children is based on a vision to provide quality family-focused, community-based mental health services and supports to children and their families. Services and supports provided will be flexible to fit the needs of children and families and are provided through local mental health authority provider networks. Families are included as full partners in all aspects of their child's treatment, including all levels of planning at the state and local level, policy development, service delivery, and evaluation.

Although children's mental health care needs differ from those of adults, there are certain aspects of service management that are common to both services, and these have been described in previous sections of this document. Below are the similar services and how they are adapted to focus on children and their families.

DSHS requires all local mental health authorities (LMHA) and NorthSTAR to provide the following core services:

- **Crisis hotline:** available 24 hours a day, seven days a week to provide information, support, and referrals for children experiencing a psychiatric crisis.
- **Screenings:** face-to-face or telephone contact with a LMHA staff member to gather information to determine if there is a need for a detailed mental health assessment.
- **Assessment:** a licensed professional meets with the child and family face-to-face to assess the child's mental health, emotional and behavioral issues, and other aspects of their daily life to determine if the child is eligible to receive services from the LMHA. A child must meet the definition criteria of "priority population":

- Between the ages of 3-17
  - Have a diagnosis of mental illness and exhibiting serious emotional disturbance, behavioral or mental disorders who
  - Have a serious functional impairment; or
  - Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
  - Are enrolled in a school system's special education program because of a serious emotional disturbance.
- **Crisis Intervention Services:** Interventions in response to a crisis in order to reduce symptoms of severe and persistent mental illness or emotional disturbance and to prevent admission of a child/adolescent to a more restrictive environment. Shall be provided in accordance with 25 Texas Administrative Code (TAC), Chapter 419, Subchapter L, *MH Rehabilitative Services*.
  - **Psychiatric Diagnostic Interview Examination:** A face-to-face interview with the child/adolescent and family to evaluate the child/adolescent's psychiatric diagnosis and treatment needs provided by a licensed professional practicing within the scope of their license. This service must be provided and documented as described in the most current version of 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards*.
  - **Pharmacological Management:** A service provided to a child/adolescent by a physician or other prescribing professional, in accordance with Texas Implementation of Medication Algorithms (TIMA) when applicable, to the consumer to determine symptom remission and the medication regimen needed.
  - **Safety Monitoring:** Ongoing observation of a child/adolescent to ensure the child/adolescent's safety. An appropriate staff person must be continuously present in the child/adolescent's immediate vicinity. Provide ongoing monitoring of the child/adolescent's mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.
  - **Crisis Transportation:** Transporting child/adolescents receiving crisis services or crisis follow-up and relapse prevention services from one location to another. Transportation is provided in accordance with state laws and regulations by law enforcement personnel, or, when appropriate, by ambulance or qualified staff.
  - **Crisis Flexible Benefits:** Non-clinical supports that reduce the crisis situation, reduce symptomatology, and enhance the ability of the child/adolescent to remain in the home. Examples in children's/adolescent's mental health services include home safety modifications, child care to allow the family to participate in treatment activities, and transportation assistance.
  - **Respite Services:** Services provided for temporary, short-term, periodic relief for primary caregivers. Program-based respite services are provided at temporary residential placement outside the child/adolescent's usual living situation. Community-based respite services are provided by respite staff at the child/adolescent's usual living situation. Respite includes both planned respite and crisis respite to assist in resolving a crisis situation.
  - **Extended Observation:** Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Child/adolescents are provided appropriate and coordinated transfer to a higher LOC when needed.
  - **Children's Crisis Residential Services:** Twenty-four hour, usually short-term residential services provided to a child/adolescent demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting. This service may use crisis beds in a residential treatment center or crisis respite beds.
  - **Crisis Stabilization Unit:** Short term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised treatment environment that is licensed under and complies with a crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and

Title 25, TAC, Part 1, Chapter 411, Subchapter M, *Standards of Care and Treatment in Crisis Stabilization Units*.

- **Family Partner:** Experienced parents or primary caregivers of a child/adolescent with a serious emotional disturbance. Family partners are active members of the intensive case management/wraparound team process providing peer mentoring and support to the primary caregivers; introducing the family to the treatment process; modeling self-advocacy skills; providing information, referral and non-clinical skills training; assisting in the identification of natural/non-traditional and community support systems; and documenting the provision of all family partner services, including both face-to-face and non face-to-face activities.
- **Engagement Activity:** Face-to-face activities with the child/adolescent or collaterals (in accordance with confidentiality requirements) in order to develop treatment alliance and rapport with the child/adolescent or collaterals and includes activities such as motivational interviewing, providing an explanation of services recommended, education on service value, education on adherence to the recommended SP and its importance in recovery, and short term planned activities designed to develop a therapeutic alliance and strengthen rapport. This service shall not be provided in a group.
- **Inpatient Hospitalization Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff provide intensive interventions designed to relieve acute psychiatric symptomatology and restore child/adolescent's ability to function in a less restrictive setting. The hospital must be contracting with or operated by Contractor.
- **Crisis Follow-up and Relapse Prevention:** Supported services provided to children/adolescents who are not in imminent danger of harm to self or others but require additional assistance to avoid reoccurrence of the crisis event. The service is provided to ameliorate the situation that gave rise to the crisis event, ensure stability, and prevent future crisis events. This service includes ongoing assessment to determine crisis status and needs, provides time-limited (up to 30 days) brief, solution-focused interventions to children/adolescents and families and focuses on providing guidance and developing problem-solving techniques to enable the child/adolescent to adapt and cope with the situation and stressors that prompted the crisis event.
- **Skills Training and Development Services:** Training provided to a child/adolescent and the primary caregiver or Legally Authorized Representative (LAR) that addresses the serious emotional disturbance and symptom-related problems that interfere with the child/adolescent's functioning, provides opportunities for the child/adolescent to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the child/adolescent's community integration and increases his or her community tenure. This service includes treatment planning to facilitate resiliency. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.
- **Medication Training and Support:** Instruction and guidance based on curricula promulgated by DSHS. The curricula include the Patient/Family Education Program Guidelines as referenced in TAC and other materials that have been formally reviewed and approved by DSHS. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.
- **Routine Case Management:** Primarily site-based services that assist a child/adolescent, or caregiver in gaining and coordinating access to necessary care and services appropriate to the child/adolescent's needs. Routine case management activities must be provided in accordance with 25 TAC, Part 1, Chapter 412, Subchapter I, *MH Case Management Services*. Contractor shall not subcontract for the delivery of these services.
- **Intensive Case Management:** Activities to assist a child/adolescent and their caregiver gain and coordinate access to necessary care and services appropriate to the child/adolescent's needs. Wraparound planning is used to develop the case management plan. Intensive case management activities shall be provided in accordance with 25 TAC, Part 1, Chapter 412,

Subchapter I, *MH Case Management Services*. Contractor shall not subcontract for the delivery of these services.

- **Wraparound planning:** is a means of planning treatment that focuses on the child and family strengths. The family and child identify participants who would be the most helpful in serving on the wraparound team. The goal of the team is to identify services and supports that best fit the needs of child and family that are reflective of their values and preferences. Supports are both informal and natural and available within the community.
- **Family Case Management:** Activities to assist the child/adolescent's family members in accessing and coordinating necessary care and services appropriate to the family members' needs. The need for family case management must be documented in the child/adolescent's case management plan.
- **Counseling:** Child/adolescent, family, and group therapy focused on the reduction or elimination of a child/adolescent's symptoms of emotional disturbance and increasing the child/adolescent's ability to perform activities of daily living. Counseling shall be provided by an LPHA, practicing within the scope of their own license or by a child/adolescent with a master's degree in a human services field pursuing licensure under the direct supervision of a LPHA. This service includes treatment planning to enhance recovery and resiliency.
- **Parent Support Group:** Routinely scheduled support and informational meetings for the child/adolescent's primary caregiver(s).
- **Medication Training and Support:** Instruction and guidance based on curricula promulgated by DSHS. The curricula include the Patient/Family Education Program Guidelines as referenced in TAC and other materials that have been formally reviewed and approved by DSHS. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.
- **Skills Training and Development:** Training provided in a group format to a child/adolescent and/or the primary caregiver or LAR that addresses the serious emotional disturbance and symptom-related problems that interfere with the child/adolescent's functioning, provides opportunities for the child/adolescent to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the child/adolescent's community integration and increases his or her community tenure. This service includes treatment planning to facilitate resiliency. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.
- **Family Training:** Training provided to the child/adolescent's primary caregivers to assist the caregivers in coping and managing with the child/adolescent's emotional disturbance. This includes instruction on basic parenting skills and other forms of guidance that cannot be considered rehabilitative skills training.
- **Flexible Funds:** Funds utilized for non-clinical supports that augment the service plan to reduce symptomatology and maintain quality of life and family integration.
- **Flexible Community Supports:** Non-clinical supports that assist child/adolescent with community integration, reducing symptomatology, and maintaining quality of life.

### **Rehabilitation Services for Children**

Rehabilitation services are an array of age appropriate, individualized, and medically necessary services. These services provide training and instruction designed to ameliorate mental and functional disabilities that negatively affect community integration and tenure; school and employment; and the child or adolescent's ability to function in non-school or non-work role settings. The goal of rehabilitation services is to reduce the child or adolescent's disability from serious emotional disorder, and to restore and maintain his or best possible functioning level in the community.

Rehabilitation services are delivered in both individual and group formats. Rehabilitation services are intended for natural settings such as the individual's home, school, or work place, but when appropriate can be provided in traditional service settings. Providers are required to work

collaboratively with the child or adolescent and the family/caregiver to develop a personal treatment plan. The goal of the plan is to ensure that the services provided reflect the individual child or adolescent's self-proclaimed recovery goals and reflects the cultural context of the child or adolescent.

The specific rehabilitation services are as follows and are described above:

- Medication Training and Support:
- Skills Training and Development
- Family Case Management
- Crisis Intervention Services

## **Employment Services**

The Division for Rehabilitation Services (DRS) a division of the Department of Assistive and Rehabilitative Services (DARS) has established an interagency letter of agreement with the Texas Education Agency for the coordination of transition planning services for those students who receive special education services in Texas. The letter of agreement serves as framework for the implementation of local interagency collaborative efforts to provide transition planning services to students with disabilities who are transitioning from high school into the adult world of work.

DRS recognizes the importance of providing timely transition planning services for students with disabilities as the students prepare to exit the high school setting. The agency provides technical assistance and consultation services to education officials and provides timely and appropriate transition planning services to eligible students. Each public high school in Texas has a vocational rehabilitation (VR) counselor assigned to provide transition planning services.

DRS remains committed to the continued maintenance of a collaborative working relationship with public education in Texas. The DRS assigns a representative to work in conjunction with the TEA's Special Education Division, Texas School for the Deaf, Educational Service Centers (ESC), and Independent School Districts (ISD) at the high school level in an effort to provide Texas youth with a wide variety of VR services. These services strengthen the connections between school, student, parents, and community to promote a smooth transition to adult life. In addition to working with consumers and parents on their special education rights and responsibilities, DRS provide educational support by working with the education team to contribute as needed to the individualized education plan (IEP).

The Transition VR counselors provide an array of transition planning services that include:

- Actively seeking and identifying students with disabilities enrolled in regular and special education
- Providing transition planning services to students with disabilities and their families
- Completing the individualized plan for employment (IPE) prior to the time the eligible student completes/leaves high school
- Coordinating transition planning activities with the individualized education program
- Providing appropriate vocational assessments that focus on career interests, aptitudes and preferences that are based on the individual's abilities
- Linking students with no impediment to employment (ineligible) to TWC or other appropriate community resources
- Providing outreach activities that enable transition students, parents, education personnel, and others to actively plan for and assist the transition student to prepare for life after leaving high school
- May form collaborative relationships with others working to promote transition from school to work in the community

In each of its five regions, DRS provides a regional transition planning specialist to work with VR counselors to develop greater interagency cooperation between DRS, local school districts, and other community organizations that provide transition planning services to students with disabilities. In an effort to better meet the needs of students, the VR counselor is available for parents at nights and on weekends when necessary. The VR counselors are assigned only to the schools. It is their objective to know the students determined eligible for DRS services. The VR counselors also work in classrooms to present a VR Curriculum for students interested in participating in VR. In addition, they develop partnerships with schools and communities to help students with disabilities make a smooth transition to adulthood and work. This partnership assists students in the development of independent work skills while in school and connect students to community and real work experience. The partnership also assists students and families to gain understanding of what students need to know to transition effectively into the community. The partnership reinforces the IEP through the IPE as the Individuals with Disabilities Education Act (IDEA) directs.

### **Housing Services**

Housing needs are met through family case management (FCM). FCM activities provide assistance to the client's family members to gain and coordinate access to the necessary care and services appropriate to the family members' needs.

In addition, another state agency provides housing assistance. The Texas Department of Housing and Community Affairs (TDHCA) provides services that address a broad spectrum of housing and community development issues, including low-interest mortgage financing, emergency food or shelter, rental subsidy, energy assistance, weatherization, economic development, and the provision of basic public infrastructure for small rural communities. TDHCA is a valuable financial and educational resource for individuals and communities attempting to deal with problems of housing, poverty, public facility needs, energy assistance, and economic development. TDHCA assists the public with federal grant funds for housing and community development.

### **Educational Services**

Appropriately trained LMHA staff members provide face-to-face training with the family or caregivers of a child. This is to initiate and maintain the child's plan of care, broaden the family's knowledge of the emotional/behavioral disorder, treatment, and monitoring of symptoms and side effects of medication, as well as to monitor symptom remission.

In addition, DSHS has implemented coordinated school health (CSH), which is a systemic approach to advancing student academic performance by promoting, practicing, and coordinating school health education and services for the benefit and well-being of students. Its goal is to establish healthy behaviors designed to last for a student's lifetime. CSH consists of eight health-related areas which encompass all aspects of the school environment and are linked together to function as a unified, effective system to the benefit of the entire school community:

- Health Education
- Healthy & Safe School Environment
- Counseling & Mental Health Services
- Parent & Community Involvement
- Staff Wellness Promotion
- Health Services
- Physical Education
- Nutrition Services

All Texas school districts are required by law to implement a coordinated school health program in grades K-8.

### **DSHS Education Service Centers (ESC) Project**

The project is a broad partnership to improve the physical and behavioral health of children and their families. The DSHS ESC Project provides a blueprint for similar program coordination initiatives across the agency. The partnership includes DSHS divisions of Prevention and Preparedness, Family and Community Health Services, and Community Mental Health and Substance Abuse in collaboration with the Texas Education Agency. The purpose is to coordinate financial and technical assistance, support, and quality assurance to the 20 regional Education Service Centers. This supportive effort enables the ESC to effectively promote a coordinated approach to improving physical and behavioral health in Texas schools. The ESC Project is a collaborative effort that advances an evidence-based, holistic approach to children's physical and behavioral health and assists the Education Service Centers to improve learning and academic achievement. The DSHS ESC Project provides a blueprint for similar program coordination initiatives across the agency.

### **Substance Abuse Services**

Mental Health and Substance Abuse Services are integrated at the administrative level through a single operational division and shared leadership. This integration contributes to improved capacity of both mental health and substance abuse providers on the local level to serve the needs of persons with co-occurring disorders, or to refer the person to the most appropriate treatment. The Outreach, Screening, and Referral (OSAR) substance abuse programs screen for mental health issues during regular substance abuse screening, and by provide mental health materials at their substance abuse prevention centers. LMHAs also use the OSAR to obtain referral services for persons who enter the mental health system and need substance abuse services.

The LMHAs are offered training in trauma-informed treatment which is provided for substance abuse treatment providers. As part of the crisis redesign initiative, some mobile crisis outreach teams (MCOTs) include licensed chemical dependency counselors. DSHS has held statewide conference calls addressing the need for co-occurring treatment in the community mental health service delivery system and in substance abuse treatment settings.

With the implementation of the Clinical Management for Behavioral Health Services (CMBHS), a single process to assess a person's need for mental health and/or substance abuse treatment will eliminate the need to conduct separate screening interviews. CMBHS creates a single client record that can be shared between DSHS-funded mental health and substance abuse service providers. The ability to share information ensures access to important treatment history and eliminates the need to create and maintain multiple client records that are often difficult to access between providers. Because clinicians who use CMBHS will have access to previous admissions and treatment, they may be aware of treatments that have been most effective in the past and may avoid prescribing ineffective treatment regimens.

DSHS uses a behavioral health framework in its substance abuse prevention programs, which allows for efficient, cost-effective, and culturally-appropriate prevention services for substance abuse and other mental health related disorders. This system enhances the state's ability to provide a comprehensive continuum of services. The programs promote individual, family, and community health. Services are designed to prevent substance abuse, promote mental health, support resilience, foster recovery, promote treatment, and prevent relapse.

### **Medical and Dental Services**

There are several programs in other divisions of the DSHS that specifically address the health care needs of children and adolescents and other programs that address health care needs of both children and adults. Children with mental health needs are referred to these services in their local communities and local mental health programs receive referrals from these programs. At the state level, Mental Health and Substance Abuse Division staff collaborates with these other divisions in order to develop a more effective and comprehensive service delivery system.

### **Children with Special Health Care Needs (CSHCN)**

The program has worked to improve the lives of children with special health care needs since 1993. Through federal Title V block grant and state funds, CSHCN provides health benefits to qualified children with special health care needs and their families, and individuals of all ages with cystic fibrosis. Title V programs, including the CSHCN Services Program, recognize the importance of the family as the focus of planning and delivery of services while promoting family choice and collaboration between parents and professionals. The CSHCN program strives to deliver services that honor and respect cultural beliefs, traditions, values, interpersonal styles, attitudes and behaviors.

The CSHCN Services Program helps clients with:

- Medical, dental and mental health care
- Drugs
- Special therapies
- Case management
- Family support services
- Travel to health care visits
- Insurance premiums

As part of its mission, the program promotes the “medical home.” A medical home is not a clinic or a hospital; it is a partnership between a child, the child's family, and the place where the child gets primary health care. At a medical home, the child's family and health care experts are a team. They work together to find and obtain all the services the child and family need, including non-medical services. In other words, "medical home" is a name for a special kind of health care. The key elements of the medical home are based on recognized standards of child and adolescent health care. They are documented in policies and best-practice guidelines by recognized professional organizations, such as the American Academy of Pediatrics (AAP) and the American Academy of Family Physicians (AAFP).

The medical home is designed to provide health care that is:

- **Accessible** in providing health care in the community at times that best serve the community's families; as well as accepting Medicaid, Children's Health Insurance Program (CHIP), Children with Special Health Care Needs (CSHCN) Services Program, and private insurance.
- **Family-centered** as it sees the family as the expert in the child's care; and offers a safe place for families and professionals to discuss health care issues as partners.
- **Continuous** by ensuring a child sees the same doctor over time; and provides help with the transition to adult or specialty care.
- **Comprehensive** by providing a full range of preventative, primary and specialized care; working together with specialists and other service providers; and sharing information about insurance and other resources with the family.
- **Coordinated** by having the doctor, family, and child develop a plan of care as a team; and offering support and links to schools and community-based services.
- **Compassionate** by showing concern for child and family.

- **Culturally Competent** by acknowledging and respecting every family's cultural and religious beliefs.

### **Adolescent Health Program**

The mission of the program is to protect and promote the health of adolescents in the state of Texas. The program maintains a comprehensive and holistic view of adolescent health and well being. Instead of looking at single behaviors (teen pregnancy, substance use/abuse, violence, delinquency, suicide, depression, unintentional injuries, and school failure), the Adolescent Health Program looks at overlap between behaviors, their underlying common causes, and successful interventions. Interventions must be built around researched risk and resiliency factors and also maintain a collaborative, multi-disciplinary approach that includes families, schools, churches, communities, and agencies that serve teens, as partners in adolescent health.

The Adolescent Health Program provides information on adolescent health through consultation, technical assistance, and educational presentations to agencies (local and state, public and private). The program coordinator also responds to inquiries concerning adolescent health services from medical professionals, legislators, other agencies and the public. A core service of the program coordinators is to provide technical assistance/training to health care providers as they assess the needs, and develop, implement and evaluate health programs that serve adolescents.

### **Case Management for Children and Pregnant Women (CPW)**

CPW provides services to children from birth through 20 years of age who have a health condition/health risk, and to high-risk pregnant women of all ages. The purpose is to encourage the use of cost-effective health and health-related care. Together, the case manager and family assess the medical, social, educational and other medically necessary service needs of eligible recipients.

### **Newborn Screening Case Management**

The program has the goal of decreasing the morbidity and mortality of infants born in Texas through customer-oriented, high quality newborn screening, follow-up case management, and outreach education. To assist in reaching this goal, the Texas Newborn Screening Program has created an ombudsman position. The function of the ombudsman is to assist families, the public, health care providers, community organizations, and government agencies to resolve issues, such as obtaining benefits, and to find service programs related to the newborn screening program.

### **Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) and Texas Health Steps (THSteps)**

EPSDT is Medicaid's comprehensive and preventive child health service for individuals younger than 21 years old. EPSDT was defined by federal law as part of the Omnibus Budget Reconciliation Act of 1989 and includes periodic screening, vision, dental, and hearing preventive services. In addition, Section 1905(r)(5) of the Social Security Act requires that any medically necessary healthcare service listed in the act be provided to EPSDT clients even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan. These additional services are available through the Comprehensive Care Program (CCP). In Texas, EPSDT is known as the THSteps Program. THSteps is for children from birth through age 20 who have Medicaid. THSteps provides regular medical and dental checkups and case management services to babies, children, teens, and young adults at no cost. A number of training modules to educate physicians and health care workers on how to screen and refer children to mental health services have been developed, including modules on Pediatric

Depression: When to Refer, Developmental Screening, Mental Health and Behavioral Disorders, Mental Health Screening, Using Developmental Screening Tools, Adolescent Health Screening and Identifying Children and Teens with High-Risk Behavior.

### **The Oral Health Group (OHG)**

Located at the Department of State Health Services (DSHS), the OHG serves to encourage the residents of the State of Texas to improve and maintain good oral health. The OHG works collaboratively with various partners across the state in order to identify the oral health needs of Texans and to identify resources to meet these needs.

As a result of *Oral Health in America: A Report of the Surgeon General* and the subsequent release of *A National Call to Action to Promote Oral Health*, the awareness of the link between oral health and overall health of individuals has come to light. OHG has staff located in Austin, Lubbock, Tyler, Houston, San Antonio, and El Paso. These dental public health professionals serve the residents of Texas by providing preventive dental services for low-income, underserved, pre-school, and school-aged children in collaboration with many of the partners listed above.

### **First Dental Home Initiative**

This legislatively supported dental initiative is designed to improve the oral health of children 6 – 35 months of age enrolled in Medicaid/Texas Health Steps (THSteps). Materials for the initiative were developed collaboratively by pediatric and general dentists. The goal of the initiative is to begin preventive dental services with very young children to decrease the occurrence of early childhood caries and to provide simple and consistent oral health messages to parents and caregivers of very young children.

### **Oral Evaluation and Fluoride Varnish in the Medical Home Training**

While this program is not direct care to children, they do benefit from this training program. The program educates Texas Health Steps physicians, physician assistants, and advanced nurse practitioners on a dental initiative aimed at improving the oral health of children enrolled in Medicaid from 6 through 35 months of age. This does not take the place of a dental checkup. Medical providers work hand-in-hand with dentists to encourage the establishment of a dental home.

### **Support Services**

DSHS provides funds to be used for non-clinical supports to children and families in an effort to augment the wrap around service plan, reduce symptomatology, and maintain quality of life and family integration. Strengths and needs are identified by youth and families during a family-driven planning process. Non-clinical supports must be:

- Included as strategies in the client's case management plan;
- Based on the preference of the client and family and focus on the outcomes they choose;
- Monitored for effectiveness by the case manager and adjusted based on effectiveness;
- Available through General Revenue funding; and
- Not readily available through other sources (e.g., other agencies, volunteers).

Flexible community supports may include mentors, respite care, family aides, therapeutic child-oriented activities, initial independent living supports, transportation services, tutoring, temporary child care, child care consultation, initial job development/placement activities, and other supports that enhance the child's resiliency and improve the child and family's quality of life. Many support needs can be addressed through existing community services or through the development of

natural supports, but flexible funds for support services allow the child or family access to these crucial supports when necessary.

### **Education (Services Provided by Local School Districts under IDEA)**

Educational services are available for children through their local school districts, with oversight provided by The Texas Education Agency (TEA). Some students participate in work/study programs. Transition plans for special education students can address both employment and housing as they transition from the child mental health system to the adult mental health system.

DSHS is engaged in extensive efforts to ensure that children in the priority population have access to a complete range of federal, state, public, and private resources, including those available through school districts under the Individuals with Disabilities Education Act (IDEA). LMHA personnel often attend transition and Admission, Review, and Dismissal (ARD) meetings for children who are in special education due to serious emotional disturbances to ensure the parent has support in requesting needed services and supports. Children who receive special education services due to serious emotional disturbances are included in the DSHS defined child priority population.

### **Case Management**

Routine case management services are those that are appropriate to a child/adolescent's individual needs and self-proclaimed recovery goals. A case manager serves as a single point of contact for the child/adolescent and his or her parent or caregiver when service needs arise or assistance in identifying, locating, coordinating, or advocating for services and supports become necessary to the child's needs.

Intensive case management services are provided for children with greater needs. The case manager monitors the provision of the services and supports identified in the child/adolescent's individualized plan. The case manager is required to utilize the wraparound planning process to ensure adequate integration of services and natural supports across service providers and community resources. The wraparound planning process also ensures family voice and choice as well as a culturally competent approach in assisting the child and his or her family. A significant benefit to the wraparound planning process is the assistance provided by the family partner. Family partners are the experienced parents or primary caregivers of a child or adolescent with a serious emotional disturbance. Family partners are active members of the intensive case management/wraparound team process providing peer mentoring and support to the primary caregivers; engaging the family in the treatment process; modeling self-advocacy skills; providing information, referral, and non-clinical skills training; maintaining engagement; assisting in the identification of natural/non-traditional and community support systems; and documenting the provision of all family partner services, including both face-to-face and non face-to-face activities.

### **Services for Youth with Co-Occurring Mental Health and Substance Abuse Disorders**

LMHAs have served children with co-occurring mental health and substance abuse disorders for many years. Rules outline the required competencies for mental health providers who serve children with substance use/abuse disorders. A dedicated position continues to be funded by DSHS to guide system level projects and services for this population. In addition, DSHS provides technical assistance to LMHAs regarding substance abuse assessment and treatment, and COPSD services. DSHS contracts with treatment programs in each region of the state to serve adolescents. Each region provides access to a continuum of care.

Additional substance abuse services for youth are available to address mental health issues; including three research-based programs:

- Adolescent Support,
- Family Support In-Home and Office Visits,
- Psychiatrist Consultation and Family Counseling. The added treatment models are: Motivational Enhancement Therapy (MET) Cognitive Behavioral Therapy (CBT), and Family Support Network (FSN).

### **Adolescent Support Services**

Providers will offer adolescent support services, which shall include wraparound services among other services as needed. These include engaging and linking the family to needed services, including community support groups, appearances at drug court, truancy courts and schools, phone contacts, appointment reminders, appointment follow-ups, and help with transportation.

### **Family Support: In-home and Office Visits**

Through appropriate in-home or office visits providers assess the family environment; individualize the treatment process; develop a family commitment to recovery; encourage a three-way therapeutic alliance: family, client, and provider; and translate the lessons the parents and clients are learning into specific changes in the family functioning. Provider staff will visit the client's home for the purpose of family substance abuse counseling (in-home visits), as needed.

### **Psychiatric Consultation**

Substance abuse providers may obtain appointments or refer clients for appointments for psychiatric evaluation and medication and possible referral to Co-Occurring Psychiatric and Substance Use Disorders (COPSD) services.

### **Family Counseling: Individual Sessions and Group Sessions with Clients and Family**

Providers counsel clients and their families using one or more of the following research based adolescent development and therapy approaches (treatment models) in group or individual sessions, as appropriate:

- **Motivational Enhancement Therapy (MET)** is a systematic intervention for evoking change in problematic alcohol, tobacco, and substance use. It is based on principles of motivational psychology and is designed to produce rapid, internally motivated change. This intervention employs motivational strategies to mobilize the client's own change resources.
- **Cognitive Behavioral Therapy (CBT)** is a short-term, focused approach to assist substance-dependent individuals become abstinent from substances. The underlying assumption is that learning processes play an important role in the development and continuation of substance abuse and dependence. These same learning processes can be used to help individuals reduce their substance use. CBT attempts to help patients recognize the situations in which they are most likely to use substances, avoid these situations when appropriate, and cope more effectively with a range of problems and problematic behaviors associated with substance abuse.
- **Trauma Focused Cognitive Behavioral Therapy(T-FCBT)** is a psychotherapeutic intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It targets symptoms of posttraumatic stress disorder (PTSD), which often co-occurs with depression and behavior problems. The intervention also addresses issues commonly

experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use.

- **Activities that Lead to the Reduction of Hospitalization**

In addition to the intensive case management activities outlined above, the YES 1915(c) Medicaid waiver is designed to reduce Medicaid psychiatric hospital expenses for children with SED by providing community-based services. The goals of the waiver are:

- Reducing out-of-home placements and inpatient psychiatric treatment by all child-serving agencies;
- Providing a more complete continuum of community-based services and supports;
- Ensuring families have access to parent partners and other flexible non-traditional support services as identified in a family-centered planning process;
- Preventing entry into the foster care system and relinquishment of parental custody; and
- Improving the clinical and functional outcomes of children and adolescents.

Child - An estimate of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children

## **Child – Estimate of Prevalence**

### **Priority Population**

State law requires DSHS to identify the child priority population and the minimum array of services necessary to address the needs of children and families in this priority population. The legislation also requires services be offered to those most in need and state dollars be used only for services provided to the child priority population.

The DSHS mental health priority population for children is defined as children and adolescents ages 3 -17 years with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disorders and who:

- Have a serious functional impairment; or
- Are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
- Are enrolled in a school system’s special education program because of a serious emotional disturbance.

Children and adolescents do not meet the priority population criteria if they have a single diagnosis of autism, pervasive developmental disorder, mental retardation, or substance abuse. DSHS funding is targeted to provide services that meet the needs of this priority population. LMHAs desiring to offer services to individuals other than those in the priority population may do so using other funds.

### **Prevalence of Mental Illness among Children and Adolescents**

Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for children and adolescents (source: U.S. Department of Health and Human Services. *Mental Health: A Report of the Surgeon General*, 1999). Approximately 20% of children and adolescents have some type of mental disorder. Those children and adolescents who are defined with serious emotional disturbance (SED) represent approximately 5% to 9% of the child and adolescent population. The prevalence estimates of SED in these studies are based on children and adolescents ages 9 to 17 (estimates for children under the age of 9 were not provided).

Several methodologies exist for estimating the prevalence of SED in children and adolescents. In the table below, two scenarios are depicted. The first scenario applies an upper and lower limit percentage for prevalence of youth with Global Assessment of Functioning (GAF) scores of 50 or below. The second scenario is for youth with GAF scores of 60 or below. (The lower GAF score indicates limited level of functioning [LOF] for the child or adolescent.)

<b>Estimated Population of Children (age 9 - 17) - 2011*</b>	<b>LOF* = 50 GAF Score</b>		<b>LOF* = 60 GAF Score</b>	
	<b>Lower Limit</b>	<b>Upper Limit</b>	<b>Lower Limit</b>	<b>Upper Limit</b>
	<b>7%</b>	<b>9%</b>	<b>11%</b>	<b>13%</b>
3,127,802	218,946	281,502	344,058	406,614

\* Source: Texas Population Projections for 2011, Texas Health and Human Services Commission, version February 2009.

The priority population prevalence projections in the chart below represent the number of children who are estimated to meet the priority population definition for mental health services in the Texas public mental health system.

# Priority Population Mental Illness Children 2011

**Texas Child  
Population\*  
[under 18]  
6,663,942**



**Priority Population  
156,390**

\* Source: Texas Population Projections for 2011, Texas Health and Human Services Commission, version February 2009.

There are many more children in need of services than are currently served in the public mental health system. In FY2009, 40,575 (or 26.22%) of the estimated 154,724 children with SED were served by DSHS-funded community mental health centers including NorthSTAR (for estimate methodology, see *Federal Register*, Volume 64, Number 121, June 24, 1999, pp. 33890-33897; National Advisory Mental Health Council 1993<sup>1</sup>;

<sup>1</sup> National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry*, 150, 1447–1465.

Child - Quantitative targets to be achieved in the implementation  
of the system of care  
described under Criterion 1

## **Child – Quantitative Targets**

N/A – Quantitative Targets are included as part of the measures discussed in the Goals, Target, and Action Plans Section.

Child - Provides for a system of integrated services appropriate for the multiple needs of children without expending the grant under Section 1911 for the fiscal year involved for any services under such system other than comprehensive community mental health services. Examples of integrated services include:

Social services;  
Educational services, including services provided under the Individuals with Disabilities Education Act;  
Juvenile justice services;  
Substance abuse services; and  
Health and mental health services.

## **Child – System of Integrated Services**

The needs of children with serious emotional disturbances are complex and represented across agencies. To meet the needs of children and their families, the approach to service delivery must be an integrated interagency approach. Services and supports for the child priority population can be categorized by:

- Social Services
- Educational Services
- Juvenile Justice Services
- Substance Abuse Services
- Health Services
- Mental Health Services
- Vocational Services
- Operational Services

In Texas, no single agency is responsible for the overall coordination of children's services. Lead responsibility for services falls to a number of different state agencies. Each agency is responsible for portions of service delivery that are consistent with the agency's primary mission. The majority of agencies have case managers, probation or parole officers, and school personnel responsible for the coordination of services provided by these agencies, and ensuring the needs of children are met.

The Health and Human Services Commission is responsible for oversight and provision of the Children's Health Insurance Program (CHIP), the Texas Integrated Funding Initiative (TIFI), detailed under "Child – Grant Expenditure Manner" and the Children's Policy Council (which assists health and human services agencies to develop, implement, and administer family support policies and related long-term care and health programs for children with disabilities).

**Social Services:** As it relates to a majority of social services in Texas, the lead agency for this area is the Texas Department of Family and Protective Services (DFPS). Services provided include: protective services; financial assistance; home aide services; respite care; shelter care; foster care; and adoption. The Texas Temporary Assistance for Needy Families (TANF) program is managed by the Health and Human Services Commission.

**Education Services:** The lead agency for public education services in Texas is the Texas Education Agency (TEA). Public education services include: assessment and planning; resource rooms; self-contained special education; special schools; dropout prevention; in-school GED; student support programs; homebound instruction; residential schools; alternative programs; transition planning; and services related to the Individuals with Disabilities Education Act (IDEA). In collaboration with the Education Service Centers, the DSHS Substance Abuse and Mental Health Community Services Division's, Child and Adolescent Services Unit continues to explore ways to have a greater interface between Texas schools and the public mental health system; detailed under "Child – Available Services".

IDEA ensures that children with disabilities have access to a free and appropriate public education. DSHS is engaged in extensive efforts to ensure children in the priority population have access to a complete range of federal, state, public, and private resources. These include resources through school districts. LMHA or provider personnel often attend transition meetings for children who receive special education due to serious emotional disturbance. Their participation ensures the parent has support in planning for needed services. Children in special education due to serious emotional disturbance are part of the DSHS defined child priority population.

**Juvenile Justice Services:** The Texas Juvenile Probation Commission (TJPC) is the lead agency for juvenile justice services in Texas. Services include: prevention; early intervention;

assessment and disposition; local detention; sentencing; probation; training schools; parole; aftercare and mental health treatment.

**Substance Abuse Services:** The Texas Department of State Health Services, (DSHS) is the lead agency in the provision of prevention; substance abuse intervention; HIV intervention; pregnant-postpartum intervention; outreach, screening, assessment and referral; day treatment; ambulatory and residential detoxification; residential treatment for adults, youth, females, and HIV positive individuals; outpatient treatment for adults and youth; the Texas State Incentive Program (TSIP); Strategic Prevention Framework (preventing underage and college-age binge drinking); and Tobacco Prevention and Control (to reduce the health effects and economic toll of tobacco).

**Health Services:** The lead agency for health services in Texas is the Department of State Health Services (DSHS). Health services include: health education and prevention; screening and assessment; primary care; acute care; and long-term care.

Other state agencies are responsible for critical aspects of service delivery, and are not under the umbrella of the Health and Human Services Commission. These include:

- Texas Workforce Commission (workforce development programs)
- Texas Education Agency (public schools)
- Texas Youth Commission and Texas Juvenile Justice Commission (juvenile justice)
- Texas Correctional Office on Offenders with Medical or Mental Impairments (correctional institution)

**Mental Health Services:** DSHS is the lead agency for mental health services and substance abuse services in Texas. The children's mental health services and supports are detailed under "Children – Available Services". The geographic area covered by DSHS for the provision of children mental health services and supports is the entire state of Texas. Block grant resources are used exclusively for the provision and support of comprehensive community mental health services. As noted previously, DSHS provides service coordination (case management) for the children served through the LMHAs. Routine case management services and intensive case management services are detailed under "Children – Available Services." The service coordinators examine the needs of the child and family, and do not limit to mental health needs. A plan is developed with the child and family that meets the identified needs. The service coordinators make referrals to the appropriate agencies for meeting non-mental health needs, ensuring the delivery of services, monitoring services for effectiveness, and advocating for the change or modification of services as needed.

**Vocational and Operational Services are also addressed by the following agencies:**

**Texas Workforce Commission:** The state government agency is the lead agency charged with overseeing and providing workforce development services to employers and job seekers of Texas. Services include: recruiting, retention, training and retraining, outplacement services, career development information, job search resources, training programs, and unemployment benefits. Targeted populations receive intensive assistance to overcome barriers to employment.

**Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI):** The mission of TCOOMMI is to provide a formal structure for criminal justice, health and human service, and other affected organizations to communicate and coordinate on policy, legislative, and programmatic issues affecting offenders with special needs. The special needs category includes offenders with serious mental illnesses, mental retardation, terminal or serious medical conditions, physical disabilities, and those who are elderly.

TCOOMMI legislative directives include:

- Determine the status of offenders with special needs in the state criminal justice system;
- Identify needed services for offenders with special needs;

- Develop a plan for meeting the treatment, rehabilitative, and educational needs of offenders with special needs that includes a case management system and the development of community-based alternatives to incarceration;
- Cooperate in coordinating procedures of represented agencies for the orderly provision of services for offenders with special needs;
- Evaluate programs in this state and outside this state for offenders with special needs and recommend to the directors of state programs methods of improving the programs;
- Collect and disseminate information about available programs to judicial officers, law enforcement officers, probation and parole officers, providers of social services or treatment, and the public;
- Provide technical assistance to represented agencies and organizations in the development of appropriate training programs;
- Apply for and receive money made available by the federal or state government, or by any other public or private source to be used by the council to perform its duties;
- Distribute to political subdivisions, private organizations, or other persons money appropriated by the legislature to be used for the development, operation, or evaluation of programs for offenders with special needs;
- Develop and implement programs to demonstrate a cooperative system to identify, evaluate, and manage outside of incarceration offenders with special needs; and
- Monitor, coordinate and implement a continuity of care system for offenders with special needs.

TCOOMMI wraparound services for juvenile probationers are:

- Designed as a family-based, multi-service approach to meet the mental health needs of juvenile offenders
- Targeted for youth in the Texas juvenile justice system, ages 10-18, who have been assessed with severe emotional disturbances
- Present in 19 statewide mental health programs that provide wraparound case management philosophy and flexible programming
- Comprised of the following service components :
  - Assessments for service referral;
  - Service coordination and planning;
  - Medication and monitoring;
  - Individual and/or group therapy and skills training;
  - In-home services such as multi-systemic therapy or functional family therapy;
  - Family focused support services;
  - Benefit eligibility services;
  - Transitional services

TCOOMMI Wraparound services for TYC youth on parole include:

- Juvenile services, including a Continuity of Care system, are provided to TYC youth
- Services are targeted for youth released on parole who have a serious mental illness that requires post release treatment
- The following mental health services:
  - Individualized assessments
  - Service coordination
  - Medication monitoring
  - Advocacy services
  - Transitional services to other treatment programs
  - Benefit eligibility

Child - Establishes defined geographic area for the provision of the services of such system.

## **Child – Geographic Area Definition**

DSHS contracts for children's mental health and support services with 38 local mental health authorities (LMHAs) and NorthSTAR, a behavioral health organization. These entities have responsibility for the entire state of Texas and the 254 counties. Block grant resources are used exclusively for the provision and support of comprehensive community mental health services.

Child - Describe State's outreach to and services for individuals who are homeless

## **Child – Outreach to Homeless**

### **PATH (Projects for Assistance in Transition from Homelessness)- Families and Youth**

Crisis, poverty, and chronic disabilities continue to be observed as the principle causes of homelessness in Texas. Affordable housing remains daunting for many. Many children and families lack access to primary and behavioral health care, putting them at increased risk for a variety of social, medical, and behavioral problems.

For households that earn less than \$20,000 per year, 62% of renters pay more than 35% of their income for rent. Texas has less than one subsidized unit for every five families in need. In Texas, 12% of the homeless population ranges in age from 12-24 years are mostly females with children, and only 49% have a high school diploma.

- Over half have been homeless for 2 to 9 years, and most report their first episode of homelessness in their teens.
- 40% have a history of sexual abuse;
- 25% report problems with alcohol;
- 46% report mental health problems;
- 33% spent time in juvenile detention prior to age 18.
- Almost 90% of family homelessness is due to a financial crisis.

Statistics for homeless youth under age 20 are even more startling:

- 33% start drinking before age 15;
- 72% report school suspension;
- 32% report expulsion;
- 60% were in foster care.
- One in 25 Texas families is likely to have a child run away each year (approximately 121,421 children annually).
- Homeless youth reported having been in foster care and their homelessness occurred in the first 6 to 12 months upon release from foster care.

DSHS receives federal PATH funds to serve individuals who are homeless and who have severe and persistent mental illnesses. These funds provide outreach, engagement, case management, and support services. PATH service providers conduct outreach on the streets, at homeless shelters that serve families, at child-runaway shelters, and in domestic violence shelters.

These service providers assess each family and/or child for the need for mental health and substance abuse services and supports. If the family and/or child is determined to be in need of mental health intervention and substance abuse services, then the family and/or child is referred to the local community service providers for mental health treatment and to appropriate substance abuse providers. Additional service coordination may occur in conjunction with Child Protective Services.

Child - Describes how community-based services will be provided to individuals in rural areas

## **Child – Rural Area Services**

### **Geographic and Demographic Challenges**

Service providers in Texas are faced with challenges as a result of the geographic and demographic complexity of the state and its citizens. The issues and strategies to address these concerns are common across all service providers.

Although rural service delivery presents a common problem among all service providers, certain demographic realities indicate that provision of services to children are disproportionately affected by these factors. Significant numbers of individuals in Texas live below the poverty level. In 2007, approximately 17% of the total population lived below the poverty level; however 25% of all children under the age of 18 were living in poverty. Approximately 1.42 million, or 21% of all children under age 18 were uninsured in Texas, and 60% of the uninsured were Hispanic. Many of the children living in poverty live in the rural areas of Texas. With increased numbers of children living in poverty, many of whom do not speak English, additional strategies are needed to address the needs of rural children.

### **Addressing Barriers to Service Delivery in Rural Texas**

Transportation is a serious issue in the delivery of services and supports to children and families in rural areas. Families may not have cars, and there is often limited access to public transportation systems outside of urban areas. Clinics may be located great distances from children and families, and travel time may be excessive. There are providers whose service areas cover approximately 30,000 square miles. The provision of emergency services can be especially problematic in rural and frontier areas. Strategies to address these needs include providing services in the home/school, maintaining outlying clinics, using volunteers, providing stipends for family members/friends to transport the children and families, providing taxi vouchers, and telemedicine. For crisis related services, strategies include having cooperative agreements with local sheriffs' offices, establishing agreements with local physicians and community hospitals, and using ambulances to transport.

Recruitment and retention of competent child-trained professionals in rural and frontier areas is extremely difficult. Local mental health authorities (LMHAs) and service providers have tried various approaches including providing licensure support, paying higher salaries, recruiting new graduates, offering opportunities for advancement and recruiting from specialty agencies.

The State of Texas Department of State Health Services (DSHS) currently certifies community health workers/promotoras throughout the state. These workers serve as indigenous outreach workers and are part of the communities they serve. This model is very useful in the rural areas of Texas. Currently, two rural border intervention programs employ promotoras who travel to underserved communities to provide information and education. These promotoras have additional training in behavioral health, and are able to identify some mental health concerns and make appropriate referrals for families and their children. In addition, many rural communities are served by a special initiative by Texas A&M University (TAMU), which has built 42 community centers in a number of the Texas/Mexico border rural areas. The program specifically targets colonias, where there are many unmet needs and high levels of poverty. These community centers also operate with the support of promotoras (employed by Texas A&M) and provide a venue where many community providers can make presentations, do intakes, etc., related to behavioral health concerns. Currently the DSHS MHSA is involved in a joint project with TAMU and the Rio Grande Valley Council on Drug and Alcohol Abuse (in Region 11), which is funded through SSBG federal monies, in developing a new promotora training for Border families on Border Violence and Disaster Prevention. This will allow the promotoras and TAMU community centers to identify more issues related to trauma and issues related to preventing drug use. This

program was rolled out in August 2010. Texas A&M has 42 centers in Texas border colonias with approximately 40 based in primarily rural counties.

### **Services and Supports in Rural Areas**

The required array of children's mental health services and supports is available in both urban and rural areas. Services in rural areas are generally limited to traditional children's mental health services. With some exceptions, rural areas have not had the capacity to redirect resources to provide some of the more innovative services and supports.

Mental Health Block Grant funds support the provision of innovative services including wraparound planning, in-home crisis intervention, and an intensive school-based program to prevent children from being placed outside the home. Rural areas are included in every initiative supported by DSHS' Children's Mental Health Services. In some cases, requirements are modified to work in rural areas.

Clinical models, services of a family partner (family member of a child with serious emotional disturbance who provides support to the family), wraparound planning, and flexible community supports are provided. Because of the vast differences across the state, adaptations must be made to address both urban and rural needs. At the same time, it is essential that the basic integrity of a model (the elements that make the model successful) be maintained.

Performance targets for children in rural areas are adjusted by a population density factor to compensate for difficulties inherent in service delivery in rural areas. In some instances, rural LMHAs may contract for particular services or join with a neighboring LMHA to have a population base for sustainability of a service.

Child - Describes financial resources, staffing and training for mental health services providers necessary for the plan;

## **Child – Resources for Providers**

### **Funding**

Funds are made available specifically for children's community mental health services. The funding streams for the funds are: state general revenue, mental health block grant dollars, Texas Aid to Needy Families (TANF) dollars, Social Services Block Grant, and Medicaid. Approximately 8% of the available resources are mental health block grant dollars.

Mental health block grant funds support innovative services, such as: wraparound planning, in-home crisis intervention and intensive school-based service. Mental health block grant funds are used to support the resiliency and disease management initiative. These are examples of current resources for innovative services being redirected.

DSHS has aggressively pursued the enrollment of children eligible for Medicaid and the Children's Health Insurance Program (CHIP) after eligibility for the CHIP program was expanded. This has resulted in increased funding for the provision of services to children. Because no additional state financial resources have been obtained, this has been a key strategy enabling DSHS to maintain essential services.

In addition to these funds, LMHAs acquire funds from other sources which also serve the child priority population. These funds come from contracts with other child-serving agencies including entities such as: Department of Family and Protective Services (DFPS); the Texas Juvenile Probation Commission (TJPC); DSHS Substance Abuse contracts; the Texas Correctional Office on Offenders with Medical and Mental Impairments (TCCOOMI); and the Texas Integrated Funding Initiative (TIFI). In addition, LMHAs can and do receive funding from foundations, grants, and local sources.

### **Staffing and Training**

#### **Staffing**

Staff who deliver children community mental health services are required to demonstrate the appropriate competencies, licenses and certifications for their positions. LMHAs are responsible for ensuring staff has the appropriate competencies for the positions they fill. Each LMHA must implement a process to ensure a process that defines competency-based expectations for each position. All staff must demonstrate all required competencies for their positions before contact with consumers and periodically throughout their tenure of employment or association with the LMHA or provider. Each LMHA must implement a credentialing and re-credentialing process for its entire licensed staff and qualified mental health professionals. These processes must comply with all applicable rules and state laws (e.g., Medical Practice Act, Nursing Practice Act, Vocational Nurse Act, Dental Practice Act, and Pharmacy Practice Act) and rules.

In addition to competencies that deliver community mental health services, staff must ensure the delivery of services to children or adolescents are age and developmentally appropriate. Staff delivering services to consumers with co-occurring disorders must demonstrate competencies specific to children and youth.

Required competencies also include: critical competencies for positions in which staff perform high risk and low frequency tasks such as first aid, cardiopulmonary resuscitation, and seizure assessment; and specialty competencies for positions in which staff perform specialized services and tasks such as suicide/homicide precautions; screening and crisis intervention; safe management of verbally and physically aggressive behavior.

## Training

Having properly trained staff is the responsibility of the LMHAs. DSHS supports the effort by training on current topics and providing the trainings throughout the state. The redesign of the DSHS Mental Health and Substance Abuse Division created an opportunity for subject matter experts to train on topics of interests to the mental health and substance abuse community. The objective being to allow in house professionals an opportunity to bring some program expectations directly to the field through trainings in an effort to continue to help successfully deliver quality services and increase effectiveness. The division continues to provide some specialty trainings through the use of outside developers/contractors in order maintain the focus on evidenced-based research and practices. Through the continued use of provider-based learning system of trainers, the unit ensures funded programs have a sustained training force of professionals without the need to rely on the state for annual trainings on evidenced-based practices.

Mental Health and Substance Abuse Training and Technical Assistance  
Courses currently available include:

- Assessment and Treatment Planning in Substance Abuse
- Barkley Defiant Child
- Client Placement and Severity Rating
- Clinical Supervision
- Clinical Management for Behavioral Health System
- Cognitive Behavioral Therapy
- Co-occurring Psychiatric and Substance Use Disorders Competencies (Online Training)
- Cultural Sensitivity Training
- Mental Retardation and Behavioral Health Outpatient Warehouse (MBOW) Training
- Motivational Interviewing
- Patient and Family Education Program (PFEP) - Adult
- Prevention Measures Training
- Psychosocial Rehabilitation Training/Adult Skills
- Sole Source Contract Training
- Suicide Prevention Training (described in detail in previous sections)
  - 1. The Education Service Center (ESC) Project: A collaborative effort with Coordinated School Health that advances an evidence-based, holistic approach to children's physical and behavioral health and assists ESC's in being successful in improving learning and academic achievement.
  - 2. The Texas Youth Suicide Prevention Project (TYSP): The focus of TYSP is to: 1) provide information to the public about youth suicide, risk factors, and prevention; 2) train health, school and community representatives to identify and refer youth who are at risk of suicide; and 3) screen youth in military families and refer those at risk.
  - 3. The high school web-based suicide prevention training through the Via Hope Program of Mental Health America of Texas: The web based interactive virtual simulation will address suicide prevention and related mental health issues. The training will be used to enhance Texas public high school staff and other high school educators
- Texas Recommended Assessment Guidelines (TRAG )Training (Online Training in FY10)
- Trauma-Focused Cognitive Behavioral Therapy
- Trauma Informed Service
- What Every Non-Profit Board Member Needs to Know
- Wrap Around Training
- Youth Empowerment Services

In the NorthSTAR area, the NorthSTAR behavioral health organization (BHO) and DSHS provider relations staff coordinates with MHA staff on general and NorthSTAR specific training issues. This may include direct training and technical assistance to NorthSTAR providers, as well as assisting with the resolution to complaints or appeals.

Child - Provides for training of providers of emergency health services regarding mental health;

## **42. Child Emergency Service Provider Training**

See “Adult-Emergency Service Provider Training”

Child - Describes the manner in which the State intends to expend the grant under Section 1911 for the fiscal years involved

## **Child – Grant Expenditure Manner**

**See “Adult-Grant Expenditure Manner”**

**Child-Innovations/System Changes–** DSHS holds allocations to LMHAs constant in order to maintain basic client services for children. Funds for those basic services are distributed to community centers to implement the Texas Integrated Funding Initiative and pilot project Bexar Cares outlined below. In addition, innovations or system changes that support the basic children services include the South Texas Family Support Conference and the Education Service Centers-described in “Child-Available Services”.

### **Texas Integrated Funding Initiative (TIFI)**

TIFI is a legislatively driven statewide initiative that supports the development of a community infrastructure called Systems of Care (SOC). The SOC addresses vulnerable children and youth with complex mental health needs that require services from multiple agencies and integrates federal, state, and local funds and other resources. TIFI funded communities focus on the families’ unique strengths and develop a family driven, culturally competent, community-based SOC which results in children and youth with serious emotional disturbances being able to remain in their homes and communities. Lessons learned and the promising practices from those communities serve as a feedback loop into state policy and practices. These practices have also informed the development work for a successful Medicaid application for a 1915(c) waiver implemented in the SFY 2009-2010, as well as informing activities of mental health transformation in Texas.

Six communities have received TIFI funding since 2001 to demonstrate a SOC approach with wraparound service delivery models. Three of the six TIFI communities have successfully applied for and received SAMHSA SOC grants. There are currently two communities contracted as TIFI sites. These contracts are being negotiated for extension while a request for proposal is being developed for in 2011. The TIFI Consortium oversees TIFI and reflects a unique combination of 50% family member representation and youth and 50% state agency representation from six child serving agencies.

### **BexarCares**

The BexarCares pilot project mandated by HB 1232 of the 81<sup>st</sup> Texas Legislature, uses blended funding from the Texas Department of State Health Services (DSHS), Bexar County school districts, Bexar County Juvenile Justice and the Texas Department of Family and Protective Services (DFPS). The intent of the pilot is as follows:

The project implements consistent cross-system identification, screening, assessment, intervention and information sharing practices to support realization of a local integrated system of care for children with behavioral health problems who also are involved with DFPS child protective services, juvenile probation, or school disciplinary processes.

The target population is children and youth from kindergarten through eighth grade who are at risk of placement in an alternative setting for behavior management, in accordance with Texas Education Agency standards or local school district policy, or intervention by juvenile justice or DFPS child protective services.



**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Increased Access to Services (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	51,284	54,227	56,001	58,994
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:** To increase the abilities of children with mental illness to lead successful lives in their community

**Target:** Increase access to services for children with serious emotional disturbance

**Population:** Children with Serious Emotional Disturbance (SED)

**Criterion:** 2:Mental Health System Data Epidemiology  
3:Children's Services

**Indicator:** Number of persons served (children)

**Measure:** Unduplicated count of children and adolescents served per year

**Sources of Information:** The state database of persons served by the community system. The Client Assignment and Registration System (CARE). Service data for the NorthSTAR region is maintained in a separate data warehouse. URS Table 2A

**Special Issues:** None

**Significance:** This measure provides the actual number of children and adolescents who receive services.

**Action Plan:** Improved crisis services and engagement of other agencies through the Transformation initiative should expand the reach of mental health services.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 30 days  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	5.24	5.87	5.40	5.30
Numerator	89	94	--	--
Denominator	1,697	1,602	--	--

Table Descriptors:

- Goal:** To increase the abilities of children with mental illness to lead successful lives in their community
- Target:** Reduce the rate of readmission to state hospitals within 30 days after discharge
- Population:** Children with Serious Emotional Disturbance (SED)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased rate of readmission to state psychiatric hospitals within 30 days
- Measure:** Numerator: Number of child readmissions to state hospitals within last 30 days  
Denominator: Number of child discharges from state hospitals during the fiscal year
- Sources of Information:** State hospital admission and discharge data in CARE - URS Table 20A
- Special Issues:** None
- Significance:** This measure provides information regarding the rate at which discharges from state hospitals result in readmissions within 30 days. This measure provides an indication of continuity of care and the capacity of community-based systems of care.
- Action Plan:** Ongoing evidence-based treatment is intended to result in fewer hospitalizations.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Reduced Utilization of Psychiatric Inpatient Beds - 180 days  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	12.96	14.48	10.90	12.30
Numerator	220	232	--	--
Denominator	1,697	1,602	--	--

Table Descriptors:

- Goal:** To increase the abilities of children with mental illness to lead successful lives in their community
- Target:** Reduce the rate of readmission to state hospitals within 180 days after discharge
- Population:** Children with Serious Emotional Disturbance (SED)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Decreased rate of readmission to state psychiatric hospitals within 180 days
- Measure:** Numerator: Number of child readmissions to state hospitals within 180 days  
Denominator: Number of child discharges from state hospitals during the fiscal year
- Sources of Information:** State hospital admission and discharge data in CARE - URS Table 20A
- Special Issues:** None
- Significance:** This measure provides information regarding the rate at which discharges from state hospitals result in readmissions within 180 days. This measure provides an indication of continuity of care and the capacity of community-based systems of care.
- Action Plan:** Ongoing evidence-based treatment is intended to result in fewer hospitalizations.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Number of Practices (Number)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	1	1	1
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

- Goal:** To build resiliency for children with serious emotional disturbances
- Target:** Children with serious emotional disturbances will be served in evidence-based services
- Population:** Children with Serious Emotional Disturbance (SED)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Number of Evidence Based Practices (EBPs) offered
- Measure:** Total number of programs described in URS Tables 16
- Sources of Information:** Service assignment data in CARE as reported in URS Tables 16
- Special Issues:** None
- Significance:** Evidence-based practices have been demonstrated to produce positive outcomes.
- Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Therapeutic Foster Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Multi-Systemic Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	.35	.29	.10	.32
Numerator	153	138	--	--
Denominator	43,424	47,187	--	--

Table Descriptors:

**Goal:** To increase the abilities of children with mental illness to lead successful lives in their community

**Target:** Provide Multi-Systemic Therapy (MST) to more children with serious emotional disturbance

**Population:** Children with Serious Emotional Disturbance (SED)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Children receiving evidence based practices - Multi-Systemic Therapy

**Measure:** Numerator: Children receiving evidence based practices - multi-systemic therapy  
Denominator: Total unduplicated number of children with SED served by the SMHA

**Sources of Information:** Service assignment data in CARE as reported on URS Table 16

**Special Issues:** The cost of this service requires, in practical terms, that its provision be limited to urban areas where the economy of scale is large enough to achieve a positive cost-benefit ratio. This service is not offered statewide.

**Significance:** Outcomes associated with MST will be achieved by more children.

**Action Plan:** Evidence-based practices remain the framework by which Resiliency and Disease Management operates.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**  **Indicator Data Not Applicable:**

**Name of Performance Indicator:** Evidence Based - Children with SED Receiving Family Functional Therapy (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	N/A	N/A	N/A
Numerator	N/A	N/A	--	--
Denominator	N/A	N/A	--	--

Table Descriptors:

**Goal:**

**Target:**

**Population:**

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:**

**Measure:**

**Sources of Information:**

**Special Issues:**

**Significance:**

**Action Plan:**

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Client Perception of Care (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	78.46	77.31	77.31	80
Numerator	419	293	--	--
Denominator	534	379	--	--

Table Descriptors:

**Goal:** To increase the abilities of children with mental illness to lead successful lives in their community

**Target:** Parents surveyed will report satisfaction with the services they received

**Population:** Children with Serious Emotional Disturbance (SED)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of families reporting positively about outcomes

**Measure:** Numerator: Number of families reporting positively about outcomes  
Denominator: Number of families responding to the outcomes question on the survey

**Sources of Information:** Texas Youth Services Survey for Families (YSSF) - URS Table 11

**Special Issues:** The Texas YSSF is a 21-item survey based on national standards for measuring consumer satisfaction with services, access to services, cultural sensitivity, outcomes of services, and participation in treatment. 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.

**Significance:** Perceptions of the effectiveness of services are important for service design and selection. Reports of positive outcomes reinforce clinical judgments, indicate an aspect of consumer satisfaction, and are associated with long-term compliance with treatment and better service outcomes.

**Action Plan:** Ongoing evidence-based treatment is expected to improve the quality of service, and that should result in improved satisfaction. The Texas YSSF survey data collection will continue on an annual basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Return to/Stay in School (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	33.51	26.96	26.96	33
Numerator	130	79	--	--
Denominator	388	293	--	--

Table Descriptors:

**Goal:** To increase the abilities of children with mental illness to lead successful lives in their community

**Target:** Increase the number of reports of improved school attendance

**Population:** Children with Serious Emotional Disturbance (SED).

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of parents reporting improvement in child's school attendance

**Measure:** Numerator: Number of parents reporting improvement in child's school attendance (both new and continuing clients)  
Denominator: Total responses (excluding Not Available) (new and continuing clients combined)

**Sources of Information:** Texas Youth Services Survey for Families (YSSF) - URS Table 19B

**Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.

**Significance:** Improved school attendance is a positive treatment outcome.

**Action Plan:** The Texas YSSF survey data collection will continue on an annual basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Decreased Criminal Justice Involvement (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	42.86	53.57	53.57	44
Numerator	15	15	--	--
Denominator	35	28	--	--

Table Descriptors:

- Goal:** To reduce juvenile justice involvement of children with serious emotional disturbance
- Target:** Children with serious emotional disturbance who had been arrested will avoid additional arrests after treatment
- Population:** Children with Serious Emotional Disturbance (SED)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services
- Indicator:** Percent of children/youth consumers arrested in year 1 who were not rearrested in year 2
- Measure:** Numerator: Number of children arrested in T1 who were not rearrested in T2 (new and continuing clients combined)  
Denominator : Number of children arrested in T1 (new and continuing clients combined)
- Sources of Information:** Texas Youth Services Survey for Families (YSSF) - URS Table 19A
- Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.
- Significance:** Reducing juvenile justice contact is a goal of mental health treatment, and an indicator of success.
- Action Plan:** All Local Mental Health Authorities (LMHAs) are required to maintain Jail Diversion plans. The Texas YSSF survey data collection will continue on an annual basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Stability in Housing (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	N/A	.16	.14	.16
Numerator	N/A	63	--	--
Denominator	N/A	38,291	--	--

Table Descriptors:

**Goal:** To increase housing stability for children receiving services

**Target:** Decrease the percent of children reporting to be homeless

**Population:** Children with Serious Emotional Disturbance (SED)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent of children who are homeless

**Measure:** Numerator: Number of children reported as homeless  
Denominator: All children reporting housing situation excluding (minus) "not available"

**Sources of Information:** Living situation data in CARE - URS Table 15

**Special Issues:** None

**Significance:** Housing stability is an indicator of recovery as well as a contributor.

**Action Plan:** Community data will remain a part of the Uniform Assessment for Resiliency and Disease Management.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Increased Social Supports/Social Connectedness  
(Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	72	73.32	73.32	77
Numerator	378	272	--	--
Denominator	525	371	--	--

Table Descriptors:

**Goal:** To increase the abilities of children with mental illness to lead successful lives in their community

**Target:** Children with serious emotional disturbance will report a feeling of social connectedness

**Population:** Children with Serious Emotional Disturbance (SED)

**Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services

**Indicator:** Percent reporting positively about social connectedness

**Measure:** Numerator: Number of families/children reporting positively about social connectedness  
Denominator: Number of families/children responding to social connectedness question on the survey

**Sources of Information:** Texas Youth Services Survey for Families (YSSF) - URS Table 9

**Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.

**Significance:** Mental illness can create a sense of isolation. Recovery involves reclaiming a sense of social connectedness.

**Action Plan:** The Texas YSSF survey data collection will continue on an annual basis.

**CHILD - GOALS TARGETS AND ACTION PLANS**

**Transformation Activities:**

**Name of Performance Indicator:** Child - Improved Level of Functioning (Percentage)

(1)	(2)	(3)	(4)	(5)
Fiscal Year	FY 2008 Actual	FY 2009 Actual	FY 2010 Projected	FY 2011 Target
Performance Indicator	53.18	53.17	53.17	57
Numerator	284	201	--	--
Denominator	534	378	--	--

Table Descriptors:

- Goal:** To increase the abilities of children with serious emotional disturbance to lead successful lives in their community
- Target:** An improvement in functioning is reported for children with serious emotional disturbance
- Population:** Children with Serious Emotional Disturbance (SED)
- Criterion:** 1:Comprehensive Community-Based Mental Health Service Systems  
3:Children's Services  
4:Targeted Services to Rural and Homeless Populations
- Indicator:** Percent of families reporting positively about functioning
- Measure:** Numerator: Number of families of children reporting positively about functioning  
Denominator: Number of families of children responding to level of functioning question on the survey
- Sources of Information:** Texas Youth Services Survey for Families (YSSF) - URS Table 9
- Special Issues:** 2010 survey data not yet available. 2010 projection and 2011 target set on 2009 survey data.
- Significance:** Self-perception of functioning is an indicator of recovery.
- Action Plan:** The Texas YSSF survey data collection will continue on an annual basis.

Upload Planning Council Letter for the Plan

August 31, 2010

Barbara Orlando  
Grants Management Specialist  
Substance Abuse and Mental Health Services Administration  
Division of Grants Management, OPS  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 29857

Dear Ms. Orlando:

As required under federal law and the Center for Mental Health Services, the Texas Federal Mental Health Block Grant application for State fiscal year (FY) 2011 is enclosed for your review and approval. This document fulfills the written requirement that each state develop a comprehensive community mental health system for adults with serious mental illness and children with serious emotional disturbance.

The MHPAC was provided an opportunity to review and comment on the draft of the Mental Health Block Grant Application. Members of the MHPAC provided comments or recommendations to the plan. The document reflects the Department of State Health Service's incorporation of comments and or recommendations into the plan. The Mental Health Block Grant Application was also made available for comment through the state website and SAMHSA's WEBGAS process. We will work with DSHS to identify even more ways to solicit additional public input in the future.

The planning council understands and tries to perform its advocacy, monitoring, and advisory functions, to the best of its ability, and are continuing to work with DSHS to be more functional. In an attempt to change our self-assessment, we have had two trainings by NAMHPAC, one to provide a basic understanding of the MHPAC and the federal mental health block grant to new members and the second devoted to strategic planning. We are currently revising our by-laws and rearranging our structure to hopefully, create a more credible, appreciated, functional, advisory group for the state.

The MHPAC membership has several concerns about the mental health system in Texas. We are a few short months away from our legislative

session with warnings concerning significant budget shortfalls with the possibility of losing approximately 15% of our state human services funding.

Other potential losses include a significant number of public hospital beds to forensic consumers, therefore, making it difficult to serve non-forensic consumers requiring hospitalization. To add to our concerns, during the last legislative session, a 100 bed forensic unit was approved for construction to be operated by private industry, but under the jurisdiction of the public mental health system. The structure will be built using public dollars, funds that could have been used in and for the public system. Other issues include continuity of care for people involved in the criminal justice system and long term mental hospital service recipients and those difficult to serve in the community.

Texas is a Transformation grant recipient state and would like to become a consumer and family driven system as described by the President's New Freedom Commission. We have found this is easier declared than done. DSHS is in the early stages of creating and funding VIA HOPE, as a network management entity to fund consumer and family member organizations and to establish a network of such organizations. DSHS, through the Transformation Work Group, is beginning to consider economic development issues for consumers using supported employment endeavors, IDA's, Medicaid Work Incentives, and collaborative efforts with the Department of Assistive and Rehabilitation Services. The MHPAC is supporting those efforts and will assist in promoting them.

The MHPAC continues to expand membership with a focus on the increased involvement of stakeholders representing the geographic and demographic make-up of Texas, as well as increased collaboration with state agencies other than DSHS who also have an investment in behavioral health services.

We thank you for your ongoing support.

Sincerely,

  
/s/ Mike Halligan, Co-Chair



OPTIONAL- Applicants may use this page to attach any additional documentation they wish to support or clarify their application. If there are multiple files, you must Zip or otherwise merge them into one file.



OFFICE OF THE GOVERNOR

RICK PERRY  
GOVERNOR

November 3, 2008

Barbara Orlando, M.S.  
Grants Management Specialist  
Formula Grant Team  
Substance Abuse and Mental Health Services Administration  
Office of Program Services, Division of Grants Management  
1 Choke Cherry Road, Room 7-1091  
Rockville, Maryland 20850

Dear Ms. Orlando:

I hereby delegate authority to the Assistant Commissioner, Mental Health and Substance Abuse Services division, Texas Department of State Health Services (DSHS) to sign documents for the Block Grant uniform application and to perform similar acts relevant to the administration of the Mental Health Block Grant.

This designation is valid for the full length of my term as Governor of the State of Texas unless modified by my office.

If you have questions or need clarification concerning the administration of the Mental Health Block Grant in Texas, please contact Mike Maples at (512) 206-5968.

Sincerely,

A handwritten signature in black ink that reads "Rick Perry".  
Rick Perry  
Governor

RP:dfp

cc: David L. Lakey, M.D., Commissioner, DSHS  
Mr. Mike Maples, Assistant Commissioner, Mental Health and Substance Abuse Services,  
DSHS  
Ms. Rasheda Q. Stevenson-Parks, MSPH, Federal Project Officer, Center for Mental Health  
Services

# SAMHSA's 10 Strategic Initiatives

The Substance Abuse and Mental Health Services Administration's (SAMHSA) mission is to reduce the impact of substance abuse and mental illness on America's communities. SAMHSA, in collaboration with other Federal agencies, States, Tribes, local organizations, and individuals including consumers and the recovery community, has demonstrated again and again in research and practice - prevention works, treatment is effective, and people recover from mental and substance use disorders. Behavioral health is an essential part of health service systems and community-wide strategies that work to improve health status and lower costs for families, businesses, and governments. Through continued improvement in the delivery and financing of prevention, treatment, and recovery support services SAMHSA with its partners can advance and protect the Nation's health. In order to achieve this goal SAMHSA has identified 10 Strategic Initiatives to focus the Agency's work on improving lives and capitalizing on emerging opportunities. The 10 Initiatives are described below with the Agency lead identified.

## 1. Prevention of Substance Abuse and Mental Illness

(Fran Harding, Director, Center for Substance Abuse Prevention)

Create prevention prepared communities where individuals, families, schools, workplaces, and communities take action to promote emotional health and prevent and reduce mental illness, substance abuse including tobacco, and suicide across the lifespan.

## 2. Trauma and Justice

(Larke Huang, Senior Advisor to the Administrator)

Reduce the pervasive, harmful, and costly health impact of violence and trauma by integrating trauma-informed approaches throughout health and behavioral healthcare systems and to divert people with substance use and mental disorders from criminal and juvenile justice systems into trauma-informed treatment and recovery.

## 3. Military Families – Active, Guard, Reserve, and Veteran

(Kathryn Power, Director, Center for Mental Health Services)

Support of our service men and women and their families and communities by leading efforts to ensure needed behavioral health services are accessible and outcomes are successful.

## 4. Health Reform

(John O'Brien, Senior Advisor for Health Finance)

Broaden health coverage and the use of evidence based practices to increase access to appropriate and high quality care, and to reduce disparities that currently exist between the availability of services for substance use and mental disorders and other medical conditions.

## 5. Housing and Homelessness

(Kathryn Power, Director, Center for Mental Health Services)

Provide housing and reduce the barriers that homeless persons with mental and substance use disorders and their families experience to accessing effective programs that sustain recovery.

## **6. Jobs and Economy**

(Larke Huang, Senior Advisor to the Administrator)

Promote the behavioral health of individuals, families, and communities affected by the economic downturn; the employment of people with mental and substance use disorders, and policies for employers that support behavioral health in the workplace.

## **7. Health Information Technology for Behavioral Health Providers**

(Westley Clark, Director, Center for Substance Abuse Treatment)

Ensure the behavioral health provider network, including prevention specialists and consumer providers, fully participates with the general health care delivery system in the adoption of health information technology.

## **8. Behavioral Health Workforce – In Primary and Specialty Care Settings**

(Westley Clark, Director, Center for Substance Abuse Treatment)

Provide a coordinated approach to address workforce development issues affecting the behavioral health and general health service delivery community to promote the integration of services and the training and use of behavioral health screening, brief intervention and referral for treatment in primary care settings.

## **9. Data, Outcomes, and Quality – Demonstrating Results**

(Pete Delany, Director, Office of Applied Studies)

Realize an integrated data strategy that informs policy, measures program impact, and results in improved quality of services and outcomes for individuals, families, and communities.

## **10. Public Awareness and Support**

(Mark Weber, Director, Office of Communications)

Increase understanding of mental and substance use disorder prevention and treatment services to achieve the full potential of prevention and help people recognize and seek assistance for these health conditions with the same urgency as any other health condition.