Texas Behavioral Health Needs

- While the figure of “one in five” people suffering from mental illness is a sound estimate based on the latest epidemiological information, the needs vary in intensity. Inclusion of substance use disorders puts the overall needs closer to one in three.
- The subgroups with the most severe needs are generally referred to as having “serious mental illness” or “serious and persistent mental illness” for adults and “severe emotional disturbance” for children
  - **Serious Mental Illness (SMI)** – This term refers to adults and older adults whose diagnoses are seen as more severe, such as schizophrenia, severe bipolar disorder, or severe depression. A subgroup of these people is defined as having a **Serious and Persistent Mental Illness (SPMI)** that seriously impairs their ability to be self-sufficient, and has either persisted for more than a year or resulted in psychiatric hospitalization.
  - **Severe Emotional Disturbance (SED)** – In epidemiological studies, this term generally refers to children and youth ages newborn to 17 who have emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.
- **SEVERE NEEDS:** The Texas Health and Human Services Commission (HHSC), through the Department of State Health Services (DSHS), has identified about 500,000 adults and 175,000 children in Texas with the most severe mental health (MH) needs. However, the group with very severe needs is closer to 1 million adults and 500,000 children.
  - In addition, DSHS identifies nearly 1.9 million Texan adults and nearly 190,000 Texas children with substance abuse service needs. Of these, nearly 400,000 adults have severe substance use disorders.
  - Between 50% and 60% of adults with SPMI (250,000 to 300,000 total) have some level of co-occurring substance use disorders (SUD). Not all of these are severe.
  - In 2013, an estimated 499,389 adults in Texas were living with SPMI, and there were an estimated 175,137 children with SED.
  - Using 2012 population and national prevalence data, MMHPI contracted with Dr. Charles Holzer of the UT Medical Branch to carry out a prevalence analysis. His findings analyze the need somewhat more broadly, focusing on adults with severe mental illness (SMI) who are in poverty (using 200% of the Federal Poverty Level as a cut-off):
In 2012, there were 919,814 Texas adults with SMI; of these, 521,986 had incomes below 200% of the Federal Poverty Level (FPL).

In 2012, there were 539,029 youth with SED; of these, 314,478 had incomes below 200% of FPL.

Other national estimates of prevalence are consistent with this estimate.

**BROADER BEHAVIORAL HEALTH NEEDS:** Each year, just over 30 percent of adults in the U.S. experience a diagnosable mental illness (MI) or SUD. Most recent estimates range from 29.1% to 30.5%, inclusive of substance use disorders. In terms of severity (these groups are non-overlapping):

- 11.5% have **substance use disorders (SUDs) of any kind** (2.0% have severe SUDs),
- 6.3% to 8.2% have **serious conditions** (MH/SUD/co-occurring, inclusive of the SPMI and SED estimates above),
- 7.0% to 13.5% have **moderate conditions** (MH/SUD/co-occurring), and
- 10.8% to 13.8% have **mild conditions** (MH/SUD/co-occurring).

**Across a lifetime, more than half of all people experience a diagnosable MI and/or SUD (just over 50%):** anxiety disorders, 28.8%; mood disorders, 20.8%; impulse-control disorders, 24.8%; substance use disorders, 14.6%.

- Based on two surveys conducted by MMHPI in 2014, **75% of Texas voters have close friends or family members who suffer from behavioral health needs.** This is comparable to the number reporting close friends or family with cancer (73% to 76%).
- **Recovery from mental illness and substance use disorders is possible for most people, even with the most severe needs,** but it does not happen in isolation, as there must be a long-term, coordinated, sufficiently funded approach to providing effective behavioral health care services.
- **Lost productivity:** The annual cost of lost productivity in the U.S. due to mental illness is estimated at $193.2 billion.
- The consequences of limited access to community and preventive mental health services mean that Texans with behavioral health needs are inadequately served in jails, hospital emergency departments, adult and juvenile criminal justice agencies, schools, child protective services and other social service settings where services are often more costly and less effective.
- **Breakdowns by diagnosis of annual number of Texans affected:**
  - Major depressive disorder affects 6.7% of adults, or approximately 14.8 million individuals in the U.S., including an estimated 1.2 million in Texas.
  - Approximately 2.4 million American adults (1.1%), including 202,000 Texans, have schizophrenia in a given year.
  - Bipolar disorder affects approximately 5.7 million adults nationwide, including 477,000 Texans, which represents 2.6% of the adult population.
  - Approximately 2.2 million Americans, including 180,000 Texans, age 18 and older have obsessive compulsive disorder (OCD).
Panic disorder affects about six million (2.7%) American adults each year. An estimated 500,000 Texas adults are affected.

Approximately 7.7 million American adults, or 3.5% of the population, have PTSD. An estimated 643,000 Texas adults are affected.

Other indicators of need:

- **Homelessness.** On a single night in January 2014, there were an estimated 29,495 homeless persons living in an emergency shelter, transitional housing, or on the street in Texas. Many of these homeless adults (an estimated 3,800) are veterans. An estimated 19.5% of the 29,495 homeless adults have severe mentally illness.

- **Suicide.** Specifically within Texas, 3,032 people committed suicide in 2012. This is the second leading cause of death among young adults age 25 and 34, behind accidents, but ahead of homicide.

- **Adults with Mental Illness in the Criminal Justice System:**
  - Of the inmate population in Texas, 20% to 24% have a mental health need.
  - The odds of a person with serious mental illness being in a jail or prison versus a hospital are eight times higher in Texas, often due to a lack of access to appropriate crisis services and ongoing care.
  - **Violence.** Although as a group people with mental illness are not more (or less) violent than the general population, people with mental illness often end up in jail or prison for minor offenses when they lack access to mental health care, particularly when untreated or with co-occurring SUD. However, in the absence of necessary treatment, a subset of people with mental illness are at higher risk for violence to themselves and others. Research suggests that many of these individuals require treatment that addresses both mental illness and broader criminogenic risk factors, necessitating collaboration between the criminal justice system and health systems.

- **A 2010 study found that in Texas there were nearly eight (7.8) adults with SPMI in jail or prison for every one in a hospital on any given day.** Data was from FY 2004. The state with the highest ratio was Nevada at 9.8:1; North Dakota had the lowest ratio at 1:1. This study focused only on state psychiatric hospitals.

- **Texas spends hundreds of millions of dollars a year to provide MH and SUD services to incarcerated adults.**
  - Data provided by the Texas Department of Criminal Justice (TDCJ) shows that the Department spent in excess of $130 million in fiscal year 2011 on mental health and substance use disorder services. Our review of the FY2014 budget identified over $370 million in costs.

  - Texas Correctional Office on Offenders with Mental or Medical Impairments is a program within TDCJ that spends $21.9 million to support care coordination for offenders with special needs. Funding this biennium on an annual basis was increased nearly 50% (from $14.2 million in FY 2011).

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In Harris County, Approximately 2,200 inmates received psychotropic medications and mental health services at the Harris County jail, with a cost of $26 million in 2013. The Harris County Probation Department spent $3.7 million on direct costs for mental health treatment in the last fiscal year. Total jail costs related to mental illness in Harris County in 2013 was estimated at over $49 million.

In Dallas County, total jail costs related to mental illness in 2013 was estimated at over $47 million. The Parkland jail services program served over 19,000 people in County Fiscal Year (CFY) 2009 at a cost of $7.4 million that year. The rate of growth in the number of persons in the jail who are waiting for behavioral health placements was more than four times the rate of growth for the rest of the jail population from CFY 2008 through CFY 2010, filling an average of 395 beds per day at an annual cost of $7.1 million. Dallas County probation spent an additional $5.0 million in state funds in SFY 2009 for substance use disorder treatment and assessment services.

- The vast majority of inmates eventually return to their home communities from prisons and jails (nationally, 650,000 or more individuals each year from state prisons, and more than nine million individuals from jail).

- Children with Mental Health Needs:
  - Too few children receive needed care. According to the January 2011 Texas Education Summary, approximately 26,300 students were receiving special education services with a primary diagnosis of emotional disturbance. However, among Texas youth with a diagnosed mental illness, serious emotional disturbance, or at risk of being removed from their homes or classrooms for mental health reasons, only 18% received the mental health treatment for which they qualified.
  - Between 60% and 70% of youth in contact with the juvenile justice system meet criteria for a mental health disorder, with 60% of this group challenged by a concurrent substance use disorder.
  - As is the case for young adults, suicide is the second leading cause of death for those between the ages of 15 and 24.
  - Many needing care also risk being removed from their homes and classrooms for mental health reasons, and parents often have to relinquish their rights in order to help their children access mental health care. The expanded Youth Empowerment Services (YES) program in Texas attempts to reduce the need for out-of-home placements and hospital-based care. The YES Waiver is only operating in a few counties currently: Harris (most recent addition), Tarrant (most successful in terms of number of youth served), and Travis (longest history, but less successful due to multiple barriers).
- **Adverse childhood experiences (ACE) matter later in life.** The ACE Study findings suggest that certain mental health-related experiences are major risk factors for the leading causes of illness and death as well as poor quality of life in the United States. Progress in preventing and recovering from leading health and social problems is likely to benefit from understanding that many of these problems arise as a consequence of adverse childhood experiences.

- **Veterans:** There are nearly **1.6 million veterans residing in Texas**, ranking just behind California. **Texas is home to 186,000 uninsured veterans and family members, the most of any state.** The needs of America’s growing number of veterans and active-duty members of the armed forces, as well as their families, have grown dramatically and become better understood.

- **Comorbid Physical Health and Mental Health Needs:** People with mental illnesses die on average 25 years younger than the rest of the population nationally (and over four years sooner in Texas). U.S. adults with serious mental illness (SMI) are dying on average at age 53 of largely preventable causes. In Texas, studies show that adults with SPMI die at age 49.5 on average. This average life expectancy is comparable to that of sub-Saharan Africa and the poorest nations in the world. Through the 1115 waiver, Texas is testing new programs where people get physical and mental health care in the same place.

  - Focusing on adults with SMI, the factors underlying this trend, as described in a 2006 study by the National Association of State Mental Health Directors (NASMHPD), are largely preventable conditions that are not well treated in the population to a large degree because of poorly treated mental health needs:
    - Rates of respiratory disease are five times higher,
    - Rates of diabetes, cardiovascular disease, and infectious diseases are 3.4 times higher, and
    - Rates of stroke among people under age 50 is higher.

  - Whatever happens in the future with health care reform, “bending the cost curve” for overall health care will require effective strategies for addressing comorbid behavioral health costs within a better integrated delivery system.
Level of Need Currently Met

- **People served:**
  - Of those with the most severe MH needs (SPMI/SED), DSHS served just under one-third of adults and just over one-quarter of children in the community (156,642 or 31.4% of adults and 42,086 or 26.9% of children were served in DSHS-funded community mental health services in FY 2013).
  - DSHS-funded substance use disorder services reach only a fraction of people with severe needs (less than one in eight) (and it is not clear that services go to those most in need).
    - DSHS provided SUD services to 54,914 adults (3% of estimated need) and 6,928 children (4% of estimated need) in FY 2013.
    - The criminal justice system serves tens of thousands more. The criminal justice system is the single largest source of referral to the public substance use disorder treatment system, with probation and parole treatment admissions representing the highest proportion of these referrals.
  - Through the Medicaid program, HHSC served 164,787 adults with SMI in 2013 (the risk category that is somewhat broader than SPMI). Overall, 250,711 adults with Medicaid received behavioral health care at some level in 2013 (238,430 mental health and 26,686 substance abuse, with some overlap between the two groups) and 311,767 children (under age 21) received behavioral health care of some sort (306,809 mental health and 9,738 substance abuse, with some overlap between the two groups). These data come from special analyses requested by MMHPI and HHSC, and such data is not readily available to decision-makers within HHSC. The disconnect between HHSC and DSHS on this issue is dramatic and quite unlike most other large states.
  - Increases in funding in FY 2014 and FY 2015 increased numbers served:
    - The Texas legislature appropriated an additional $368 million/biennium to DSHS for mental health and substance abuse services for FY14-15. This represents a 16.3% increase over the FY12-13.
    - DSHS received a 26% increase in community MH funding for the 2014-15 biennium (18% funding increase for adults, 25% for crisis, 58% for children). This included Community Mental Health Waiting List funds ($48.2 million for the biennium) that were distributed to Local Mental Health Authorities based on the number of individuals waiting for services. It also included Mental Health Surge/Underserved funds ($43 million for the biennium) that were appropriated to expand or improve community mental health services to address the needs of those who are underserved due to resource limitations and the anticipated “surge” in demand due to increased public awareness and population growth.
    - Waitlists were essentially eliminated. According to DSHS, the adult waitlist was reduced from 5,321 in February 2013 to 361 in August 2014; the child waitlist was reduced from 194 in February 2013 to 7 in August 2014.
DSHS reports that, for children, the “surge” and “waitlist” funding increased monthly service capacity by 980 (to 14,370 using that funding, out of an overall capacity, inclusive of Medicaid, of approximately 21,000 a month). DSHS also reports that, for adults, the “surge” and “waitlist” funding increased monthly service capacity by 5,579 (to 57,392 using that funding, out of an overall capacity, inclusive of Medicaid, of approximately 89,000 a month). The way in which DSHS tracks use of the “surge” and “waitlist” funds as compared to overall service levels is not entirely clear.

As of March 2014, 1,435 adults had been moved into the appropriate level of care using “underserved” funds.

- **DSHS funding for substance abuse treatment was up 11.4%**. This included:
  - Substance Abuse Capacity Expansion funds ($4.9 million for the biennium). DSHS used this to increase monthly service levels to 9,306 in SFY 2014, an increase of 1,183 from a year prior.
  - Substance Abuse Treatment Rate Increase funds ($10.7 million for the biennium) that were designated to increase treatment rates for substance abuse services. The rate increase has been fully implemented
  - Substance Abuse Services for Department of Family and Protective Services (DFPS) Clients ($10 million for the biennium) were used to increase treatment and intervention services to DFPS clients, including specialized services to fathers.
  - Oxford House Expansion funds ($1.1 million for the biennium), providing funds to start-up specialized housing for individuals who have completed substance abuse treatment programs. As of May 2014, there were an additional 27 houses and 421 residents.

- **Spending on state-purchased hospital beds was up 43%** ($45.7 million for biennium).

- **Increases in spending for state-operated hospital beds in the current biennium did not cover needed** increases in operating costs (only a 2.7% increase in operating funds) or current, critical capital improvement needs (only $30 million of $77 million in critical needs were provided). This also included:
  - Victory Field construction ($4 million for the biennium),
  - Psychiatric Residency stipends ($2 million for the biennium),
  - Psychiatric Nursing Assistants pay increase ($14.7 million for the biennium), and
  - State Hospital Patient Safety programs ($1.3 million for the biennium).

- **Other new funds included**: Residential Treatment Center (RTC) Project funding ($2 million for the biennium), that allowed 13 children to receive treatment and avoid parental relinquishment.
- Mental Health First Aid funding ($5 million for the biennium) for educators in school systems across the state to promotes early identification and intervention for behavioral health issues.
- YES Waiver Expansion funds ($24.0 million for the biennium) to expand access to these supports to Harris, Brazoria, Fort Bend, Galveston, Cameron, Hidalgo, and Willacy counties.
- Specialized Inpatient and Forensic Projects, including: (1) Harris County Psychiatric Center added beds ($2.4 million for the biennium); (2) Harris County Jail Diversion Program has implemented ($10 million for the biennium); and the (3) Jail-Based Competency Restoration pilot begun ($3 million for the biennium).
- Veterans Mental Health Program expanded ($4 million for the biennium).
- Health Community Collaborative Projects ($25 million for the biennium) for homeless people with mental illness. Bexar, Harris, Tarrant, Dallas, and Travis counties were awarded funds, matched by private dollars.
- A Public Awareness Campaign was implemented ($1.6 million for the biennium).
- Supportive Housing funds ($24 million/biennium), serving over 1466 individuals received services, including 40 people who transitioned to the community from state mental hospitals.

- More broadly, only one in three people nationally with a diagnosable condition receives treatment. The most recent national studies show that the proportion of people receiving care varies by severity as follows:
  - 37.1 percent to 40.5 percent of those with serious needs received treatment (63 percent in specialty care settings),
  - 26.3 percent to 37.2 percent of those with moderate conditions received treatment (51 percent in specialty care settings),
  - 11.3 percent to 23 percent of those with mild conditions received treatment (46 percent in specialty care settings), and
  - Of those with no diagnosable need, 6.2 percent to 14.5 percent nonetheless received treatment (42 percent in specialty care settings).

- Mental Health Workforce Shortages: Over two-thirds of Texas counties have shortages of mental health professionals, particularly psychiatrists and culturally/linguistically diverse mental health professionals. In response, Texas is expanding the use of physician extenders (nurse practitioners, etc. – though Texas physicians have limited the scope of practice more narrowly than other states), certified peer specialists, promotores (community health workers in rural areas), telemedicine, and workforce recruitment. HB1023 required a report in 2014 to propose policy recommendations for addressing the mental health workforce shortage in Texas. DSHS distributed a document describing the shortage and some related background information to stakeholders in mid-February, 2014. Stakeholders used this draft
as an aid in drafting policy recommendations. Recommendations were synthesized in a report to the Legislature September 1, 2014.

- An overwhelming majority of Texas counties are designated as Mental Health Professional Shortage Areas (MHPSAs). There are three different types of MHPSA designations, each with its own designation requirements: Geographic Area, Population Groups, and Facilities. As of November 2013, 207 of 254 (81.5%) Texas counties had whole or partial county Health Professional Shortage Areas (HPSAs) for mental health, and 241 counties had whole or partial county designation or at least one site-designated HPSA. Over 80% of these counties are rural counties.
- For psychiatrists, 10.5% (2.8 million) Texans live in counties with no psychiatrists; 20.7% (5.5 million) live in MHPSA shortage areas (ratio of 30,000:1); 99.4% of Texans live in counties with ratios higher than optimal recommendations (ratio of 4,000:1).
- For the broader set of core mental health professionals (such as clinical psychologists, psychiatric nurses, clinical social workers, licensed professional counselors, and marriage and family therapists), 23.3% of the 2013 Texas population lived in 199 different counties with mental health workforce shortages.
- In 2009, 102 Texas counties did not have a psychologist, 48 counties did not have a licensed professional counselor, and 46 counties did not have a single licensed social worker.
- The large size of Texas poses great difficulties for rural residents seeking access to mental health care services. Of the 254 counties in Texas, 177 (70%) are rural counties. Rural Texas is home to over three million people. Approximately 15% of Texans live in rural areas, while only 10% of primary care physicians practice in rural areas. For many rural area Texans, it is not uncommon to travel 50 miles or more to see a doctor.
- Culturally competent and linguistically diverse mental health professionals are also enormously difficult to access in Texas. In Texas, 65.5% of all psychiatrists are white, only 5.3% are African American, and 9.7% are Hispanic.
- By 2020, national predictions estimate a shortage of more than 100,000 doctors and 300,000 nurses. This problem is particularly acute for mental health services, which account for the most severe health professional shortages in Texas.

- **Evidence-based Practices:** There are hundreds of evidence-based practices available for mental health (MH) and substance use disorder (SUD) treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP). The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment, rating each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention (it includes many “promising” approaches).
- **Successful best practice promotion requires understanding of the real world limitations of each specific best practice.** This process is sometimes called “using
practice-based evidence” to inform implementation and is a core feature of continuous quality improvement.

- **One major issue is that the literature prioritizes randomized clinical trials (RCTs) that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings.** This “efficacy-effectiveness gap” was clearly defined in the 1999 U.S. Surgeon General’s report on mental health services in America and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships. Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships. Because of this, practitioners must in many cases extrapolate from the existing research evidence.

- **Quality improvement is the key to change in health care more broadly and MH/SUD care in particular.** The 2001 Institute of Medicine’s (IOM) landmark publication, “Crossing the Quality Chasm,” fundamentally changed the national dialogue regarding the design of health care systems and shaped an emerging consensus nationally in the last decade of the need for a major shift in operational priorities and health care delivery organization commitment to ongoing quality improvement. The premise of the report is that the health care industry must move from a traditional command and control model to a continuous quality improvement model. Recently the IOM argued convincingly that these quality gaps cost the U.S. upwards of $750 billion in poor, inefficient, wasteful, and ineffective care. In 2006, the Quality Chasm series focused its attention on mental health (MH) and substance use disorders (SUD), documenting severe system level quality gaps and describing a framework for improving them. The report goes on to note that the challenges facing MH/SUD systems are in many ways more severe than those facing the broader health system.

- **Some of the biggest concerns about best practices involve application of practices to individuals and families from diverse cultural and linguistic backgrounds.** There are inherent limitations in the research base with regard to diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their

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communities and the situations they encounter on a daily basis. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across culture. Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that best practices be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major best practices. There is also increasing recognition of best practices for refugee and immigrant communities.

- **It is also therefore critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care.** The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Cultural and Linguistically Appropriate Services (CLAS) Standards in Health and Healthcare were adopted in 2001 by the U.S. Department of Health and Human Services’ (HHS) Office of Minority Health (OMH) with the goals of “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available, but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African American, Asian American / Pacific Islander, Hispanic / Latino, and Native American / American Indian groups is also available, as well as guidance for multicultural applications.

- **Peer-Delivered Services:** President George W. Bush’s 2002 New Freedom Commission shifted the national dialogue firmly to the goal of recovery – the ability of people with mental illness to improve their health and wellness, live self-directed lives, and reach their potential. This is a core value of the Texas system, and Texas leads in many areas promoting self-directed care for people with SPMI, peer-delivered services (for adults with MH and/or SUD, parents of children with SED, and youth), and recovery-oriented systems of care (ROSC). By the middle of 2014, all local mental health authorities (LMHAs), six state psychiatric hospitals, and the Veteran’s Administration Heart of Texas Healthcare Network utilized certified peer support specialists. Since the certification process began in 2010, over 633 certified peer specialists have been trained in Texas. Of those 574 passed the certification exam and there are presently 408 certified peer specialists with active certification. For families dealing with children who have serious emotional disorders (SED),
another type of peer services has emerged. Family Partners, who are parents that have been through the experience of supporting a child with SED are also being trained and certified by Via Hope. To date, there have been 138 Family Partners trained and 135 certified, of whom 99 remain actively certified.

- **Organization of Public Mental Health Services in Texas:** Public funding and services in Texas are channeled through a number of state agencies, contributing to a fragmented and poorly-integrated system.
  - The Department of State Health Services (DSHS) is the public state mental health authority, whose budget comes from state general (59%), federal (25%), and local (16%) funds.
  - Local mental health authorities (LMHAs) contract with DSHS and operate as providers of last resort. The unique NorthSTAR program serves both Medicaid-eligible and medically indigent members in a capitated managed care system that contracts with providers in the Dallas area and manage utilization.
  - Other agencies through which funding is channeled include:
    - The Health and Human Services Commission (HHSC) oversees Medicaid State Plan services and the Children’s Health Insurance Program (CHIP).
    - The Department of Family and Protective Services (DFPS) operates the child protective services delivery system, which includes mental health and substance use services.
    - The Department of Aging and Disability Services (DADS) provides long-term services and supports to aging Texans and persons with intellectual / developmental disabilities.
    - The Department of Assistive and Rehabilitative Services (DARS) provides early intervention services for children and vocational services for people with disabilities.
    - The Texas Department of Criminal Justice (TDCJ) provides behavioral health services to people in state jails and prisons and private correctional facilities, and the Texas Juvenile Justice Department (TJJD) provides a continuum of mental health services to youth.
    - The Texas Education Agency and local school districts provide mental health services to students, though budget cuts have made it more difficult to provide these services.
    - The Department of Housing and Community Affairs (DHCA) develops and operates affordable housing programs, to which people with serious mental illnesses have access.
    - The Texas Veterans Commission acts as an advocate for Texas veterans attempting to secure earned benefits and funds grants (in collaboration with DSHS) that support specific programs and services for mental health problems.
• **Hospital / Acute Care Capacity:**
  
  The current capacity of the state-operated hospital system is 2,463 beds across 11 facilities (see map below), with approximately 893 beds designated for the **forensic population**. However, because DSHS is under a court order to accommodate all forensic patients, the beds assigned to the forensic population at any given time greatly exceed the designated number (approximately **50% of beds were filled with forensic cases in January 2014**). Of the 2,465 beds:
  
  o 204 are segregated to provide acute services for children and adolescents.
  o 116 beds are designated as residential beds for individuals who no longer need hospital-level care but have no appropriate community alternatives available.
  o **Note that in the figure below, the Kerrville labels are switched between the crisis stabilization units and the Kerrville State Hospital.**

  ![Diagram of Texas Behavioral Health Landscape](https://example.com/diagram.png)

  - DSHS currently purchases an additional 456 beds outside of the state hospitals.
  - **DSHS funds 944 additional crisis beds statewide:** 456 Crisis Residential beds, 127 Crisis Respite beds, 60 Extended Observation beds, 32 Crisis Stabilization Unit beds, and 259 Rapid Crisis Stabilization beds.
  - **Over one-quarter of the 1115 Waiver BH projects reviewed (54 of 202) are expanding crisis supports.**
  - Other 3rd party payors bought approximately 1936 additional inpatient psychiatric beds in 2013.
  - **The HB 3793 Advisory Group is trying to define the unmet need:**
    
    o **Initial HB 3793 Estimates of Unmet Need:** 879 more beds are needed to match national averages and 17 beds per year are needed to keep pace with current utilization trends. In 2020, this would equate to 3,056 total state-funded beds. Currently, there are approximately 11 state-funded hospital beds per 100,000 people, including state hospital beds and state-funded community beds. The national average for psychiatric hospital beds is 14 per 100,000. To achieve this
number, Texas would need an additional 879 hospital beds currently. Pending further analysis, the HB 3793 Initial Plan defines a goal of 14 beds per 100,000 as “a reasonable reference point to assess the acute and long-term needs of the population within the current statutory framework.” Adding 879 hospital beds to the DSHS-funded system would cost $176.5 million.

- **In a December 2014 report from CannonDesign**, DSHS was advised that it needed to increase inpatient beds by 570 (272 State-operated and 298 Community-operated) to address existing latent demand. Over the next 10 years, DSHS was advised that it would need a total of 600 more State-operated beds and 1135 more Community-operated inpatient beds.

- **However, Texas relies too much on hospital care currently, as opposed to community-based care.** As a state, the percentage of the population utilizing community behavioral health services in Texas (12%) is very low compared with the U.S. (21%), while utilization of Texas state hospitals (0.55%) is 8% higher than the national average (0.51%) indicating the need for more accessible community-based services. While hospital care is needed in acute psychiatric situations, community-based services provide the treatment and support necessary for people to recover and have a stable life in the community.
• **Publicly-funded Community Mental Health Capacity:** Texas currently funds services through 39 community centers. Funding flows through 38 local authorities (37 local mental health authorities or LMHAs and one local behavioral health authority or LBHA) across the state. Each LMHA has responsibility to conduct oversight and provide needed services to a minimum number of people within a specific geographic area.
• **Publicly-funded Substance Abuse Treatment Capacity:** Texas currently funds 80 substance abuse treatment providers (SATP) across the state. Unlike LMHAs, SATPs are responsible for serving specific numbers of people, regardless of geographic area. However, access is organized across 10 Outreach, Screening, Assessment, and Referral Centers (OSARs) organized by region, as shown in the map below (see this link for detail on each contracted OSAR: http://www.dshs.state.tx.us/sa/OSAR/).
• **Medicaid Managed Care Programs:** The Texas Medicaid program finances managed care statewide through four programs: STAR, STAR+PLUS, STARHealth and NorthSTAR. The NorthSTAR model is a carve-out model in the seven-county Dallas service area for all behavioral services for all Medicaid beneficiaries and persons who qualify for indigent care services. The STARHealth program is a statewide program for children in foster care and includes all Medicaid covered behavioral health services. The STAR program is a Medicaid managed care program designed for pregnant women and poor children, while STAR+PLUS is designed for people with dual eligibility (Medicaid and Medicare) and adults with disabilities (SSI). Both STAR and STAR+PLUS currently include all standard behavioral health services and, starting in September 2014, SB 58 expands these benefits to also include the specialty mental health services designed for persons with SPMI, known as Medicaid Rehabilitative Services (Rehabilitation) and Targeted Case Management (TCM). The map below shows current vendors.
• **1115 Transformation Waiver:** The Texas Health Care Transformation and Quality Improvement Program (authorized under a federal 1115 transformation waiver, which is how many refer to the program) funds an increasing array of services. It allows the state to expand Medicaid managed care while preserving federal hospital funding previously received as upper payment limit (UPL) payments. Under the waiver, two funding pools replace the UPL payment methodology: (1) the Uncompensated Care Pool helps offset the costs to hospitals for treating people who are uninsured and (2) the Delivery System Reform Incentive Pool (DSRIP) funds programs and strategies that enhance access to health care, quality of care, and cost-effectiveness. Payments will be based on performance outcomes and not simply on delivering a service. Eligibility for DSRIP payments requires participation in a regional health care partnership (RHP). Texas has designated 20 RHPs and has identified an “anchor entity” for each to coordinate efforts to develop and implement regional plans. Each partnership is comprised of participating entities that can provide public funds known as intergovernmental transfers (IGT). LMHAs use local governmental funds and state general revenue funding as IGT and will be eligible for the DSRIP federal funding. A current map of RHPs is below.
• **Comment on Preceding Maps:** A comparison of the prior maps demonstrates the fragmented nature of the provision of care for MH/SA as each agency designs its own approach to regionalization based on its own priorities.

• **Medicare and Private Insurance:** Medicare and private coverage and reimbursement for services is limited, despite recent improvements in access to coverage and benefit plan design (e.g., the Mental Health Parity and Addiction Equity Act). This will be changing, but is still in process.

• **Veterans Services.** The Veterans Administration (VA) provides MH and SUD services for eligible veterans (not all veterans) for the first five years post-deployment and for any service-related conditions. The nationwide service system in which services are provided consists of 22 Veterans Integrated Services Networks or VISNs. Texas is served by three multi-state VISNs. VISN 16 serves east Texas, including Houston; VISN 17 serves south, central and north Texas along the IH35 corridor and is totally contained in Texas with the exception of two counties in Oklahoma; and, VISN 18 serves west Texas.
  
  – **The VA focuses on best practice treatments for PTSD.** This link (http://www.ptsd.va.gov/professional/treatment/overview/overview-treatment-research.asp) from the VA National Center for PTSD summarizes the literature on effective treatments for PTSD. It also links to the VA/DoD PTSD Clinical Practice Guideline (2010). In summary, effective treatments include:
    
    o Exposure-based Treatments, in which subjects re-experience the trauma leading to PTSD to reduce symptom strength and develop ways to cope.
    
    o Cognitive Approaches, including Cognitive Processing Therapy (CPT), which challenges and modifies maladaptive beliefs related to the trauma.
    
    o Eye Movement Desensitization and Reprocessing (EMDR), in which the person engages in virtual exposure to a trauma while simultaneously performing saccadic eye movements.
  
  – Locations for VA treatment in Texas include all VA medical centers (VAMCs) and community-based outpatient clinics, as well as satellite sites in Texas through telehealth linkages. Services available are summarized at this link (http://www.ptsd.va.gov/public/treatment/therapy-med/va-ptsd-treatment-programs.asp).

  – **Barriers to care exist at many levels:**
    
    o Gaps in access to / quality of services were widely noted across multiple reports.
    
    o Insufficient workforce capacity and lack of sufficient training in evidence-based practices for PTSD and Traumatic Brain Injury (TBI) in particular are common issues, as are limitations in ongoing quality improvement efforts and infrastructure within the Department of Defense (DoD), Veterans Administration (VA), and community-based systems.
Backlogs of over 700,000 cases seeking to access VA services have been noted, as has the general reluctance among veterans and service members to seek MH and SUD treatment.

This includes a general mistrust of DoD and VA programs, related to broader concerns about stigma.

Nearly two-thirds of active duty service members surveyed strongly agreed that they would “be seen as weak” (65 percent) and be treated differently by their unit leadership (63 percent) if they received mental health care.

**Outreach:**

- The VA works with LMHAs across Texas to conduct outreach to help veterans be aware of and access VA services for which they are eligible, and serve those not eligible for the VA using LMHA funds.
- The Texas Veterans Commission (TVC) represents Texas before the VA and acts as an advocate for Texas veterans attempting to secure earned benefits.

**Research:** There are two major research centers for veteran needs in Texas:

- StrongStar is the South Texas Research Organizational Network Guiding Studies on Trauma and Resilience, a research consortium funded by DoD and VA specifically focusing on PTSD. It is under the leadership of the University of Texas Health Science Center at San Antonio. Last summer they received a $45 million five-year grant from DoD/VA.
- The Veterans Integrated Service Network (VISN) 17 Center of Excellence (COE) for Research on Returning War Veterans in Waco is part of the VA. They are located at the VA medical center in Waco and are affiliated with Texas A&M Health Science Center, the University of Texas, and Baylor University, plus other universities nationally. They do a lot of PTSD work, but have a more general mission.

**Additional Supports:** The Fund for Veterans’ Assistance (FVA) uses a combination of state funds, lottery ticket proceeds, and private donations to award three categories of grants to eligible organizations that provide direct services to veterans and their families. First, FVA general assistance grants reimburse charitable organizations, local government agencies, and veterans service organizations (VSO) for providing direct support services to veterans and their families. Second, Housing4TexasHeroes grants support nonprofit or local government organizations that provide temporary and permanent housing assistance for veterans and their families. Third, in 2013, the TVC partnered with the Department of State Health Services (DSHS) to create the Veterans Mental Health Grant program to fund projects providing direct counseling and mental health services to Veterans and their families. These grants are awarded once a year. The program’s first Veterans Mental Health Grants were awarded in May 2014. The 12 grants, totaling $1.75 million, began July 2014. Since 2009, the FVA
program has awarded nearly $40 million in 207 grants to 118 non-profit and local government entities.

- **Select innovative services:**
  
  1. To mobilize and organize community resources, the **Community Blueprint Initiative** has brought together a coalition of leading nonprofit organizations serving veterans and their families to develop an online tool to help local community leaders assess and improve support available in their community. The Blueprint focuses on organizing local resources; providing information to community leaders on the challenges faced by returning veterans, service members, and their families; and offering advice on best practice approaches. Behavioral health is one of eight key areas addressed.
  
  2. **Warrior Gateway**, a web portal and search platform that provides returning veterans access to information about local community resources and helps fill gaps in access to a variety of needed services, including MH care and SUD services.
  
  3. Online communities for veterans (**VetsPrevail** – see www.vetsprevail.com) and active duty armed forces (**WarriorsPrevail** – see www.warriorsprevail.com) provide anonymous, easily accessible entry into support and care that uses peer outreach by specially trained veterans to overcome stigma and provide 24-hour-a-day, seven-day-a-week online peer support.
  
  4. **Give an Hour** (www.givenanhour.org) is a nonprofit organization founded in September 2005 with the mission to develop national networks of volunteers capable of responding to both acute and chronic mental health conditions. As of Spring 2011, Give an Hour had developed a network of more than 5,000 mental health professionals willing to donate at least an hour of their time each week to provide free mental health services to military service members/veterans.
  
  5. **Services for PTSD and depression** – Despite gaps in access to and quality of care, a number of successful initiatives exist. The DoD Center of Excellence for Psychological Health and Traumatic Brain Injury (TBI) promotes improved care and provides training based on emerging clinical practice guidelines. VA Centers have been training their counselors in evidence-based therapies for PTSD. The VA’s national depression collaborative care program is noted as a successful program in treating persistent depression. Other successful programs include RESPECT-Mil program, an example of a multifaceted model in a military setting, based on the RESPECT program, designed to decrease stigma and improve access to care by providing behavioral health care within the primary care setting.