

Texas FY2014-2015  
Combined Substance Abuse Block  
Grant (SABG) and Mental Health  
Block Grant (MHBG)  
Behavioral Health Assessment and  
Intended Use Plan

For Public Comment

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## II. Planning Steps

***Step 1. Assess the strengths and needs of the service system to address the specific populations. Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems***

### **Behavioral Health Service System**

The Department of State Health Services (DSHS) seeks to promote optimal health for individuals and communities and provide effective physical health, mental health, and substance abuse services to Texans. DSHS is one of four departments operating under the direction of the Health and Human Services Commission (HHSC), which reports directly to the governor. The other three departments are the Department of Aging and Disability Services (DADS), the Department of Assistive and Rehabilitative Services (DARS), and the Department of Family and Protective Services (DFPS). The linked structure of the HHSC facilitates 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; disease prevention and disaster preparedness services; community health services; and regulatory services. Within each category an 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 of DSHS is designated as the State Mental Health Authority (SMHA) and Single State Substance Abuse Authority (SSA) for Texas and oversees the public mental health and substance abuse service delivery system. Mental health and substance abuse services are provided in all 254 counties distributed across the state's 11 health and human services regions. Community based mental health services are primarily provided through designated Local Mental Health Authorities. One exception to this exists in a seven county area which includes Dallas in northeast Texas. In this area, the North Texas Behavioral Health Authority provides local oversight of a behavioral health "carve-out" program, referred to as NorthSTAR. The NorthSTAR program provides mental health and substance abuse services to indigent residents and most Medicaid recipients within the service area. NorthSTAR covered services are managed by a licensed health maintenance organization (HMO). The contracted HMO (ValueOptions) is responsible for network development that includes contracts with a wide array of individual, group, and facility-based providers. The HMO also performs functions such as utilization management, quality management, customer service, and claims adjudication. Substance abuse services

outside of the NorthSTAR area are competitively procured by the SSA and delivered by an array of local providers

The State uses a clinical record keeping system called Clinical Management for Behavioral Health Services (CMBHS). CMBHS is an automated, web-based software package currently used by over 200 DSHS-funded community-based service providers. CMBHS will eventually combine substance abuse and mental health databases, establish an electronic health record for both, and provide capacity to track expenditures and other data. It will also integrate information gathered from clinical activities, reporting, and reimbursement functions to provide data and statistics regarding service delivery. As development continues, this electronic health record initiative will provide opportunities for coordination between mental health and substance abuse prevention and treatment services, and between substance abuse treatment, substance abuse prevention, and other appropriate services. This will be accomplished through enhancements in functionality that will enable easier exchange of information across service systems and providers. The system is expected to facilitate improved access and outcomes, and to ensure uniform service delivery regardless of where clients enter the service system. Implementation is complete with substance abuse providers and is now being developed with mental health providers.

## ***Mental Health Service System***

### **Organization**

The SMHA has oversight responsibilities over 38 local mental health authorities (LMHAs), ten state hospitals, three community hospitals and one forensic facility. In all but one area of the state (the NorthSTAR area), the LMHA is also a community mental health center. The SMHA contracts with LMHAs and the HMO ( in the NorthSTAR area) to provide or arrange for services to adults with severe and persistent mental illness (SMI) and children with severe emotional disturbances (SED) with or without co-occurring substance use disorders. The SMHA has been delegated the operational authority by the single state agency for Medicaid, for the Medicaid mental health rehabilitation and targeted case management options for persons with SMI. Block grant funds are primarily directed to the LMHA's and the HMO through performance-based contracts. A smaller percentage of block grant resources support special projects such as a Training and Technical Assistance Center that provides training and consultation regarding best practices and recovery. Another example is the development of CMBHS which will allow for a more integrated data reporting system that includes mental health services.

State legislation requires LMHAs to develop external provider networks and to provide direct services only when other willing and able providers are not available. Most LMHA have some provider contracts, primarily for crisis services. Many also contract with individual practitioners to provide physician and counseling services. It has been more difficult to establish successful contracts for rehabilitation and other routine outpatient services. Currently, LMHAs continue to provide the vast majority of these services directly.

The DSHS funded inpatient hospital system includes ten state institutions, three community hospitals and one forensic facility. One of the state institutions is a residential treatment center that is designated specifically for youth. 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 hospitals outline the roles and responsibilities for utilization management. In FY2011, DSHS provided funding to Montgomery County to open a forensic facility which provides competency restoration for up to 94 adults. In 2012, it gave Harris County funds to establish an additional 20 competency restoration beds to serve the Houston area. No block grant funds are used for these inpatient services.

### **Texas Resilience and Recovery**

The state's Mental Health System is based on a resiliency and disease management model. It is currently being updated to incorporate new assessment tools and a more pronounced focus on recovery. To reflect this shift in focus, the system has been retitled Texas Resilience and Recovery (TRR). The TRR model relies on evidence based practices and principles of recovery to obtain the best possible consumer outcomes and maximize available dollars. A uniform assessment is provided to evaluate the needs of consumers and recommend appropriate level of care within which individual service plans are customized based on individual needs and preferences. Service packages for both adults and children have been developed to provide an appropriate array of evidence-based services for consumers in each level of care. Each level of care is described in the agency's *Utilization Management Clinical Guidelines*. This document outlines the core services for each level of care (i.e. case management, physician services, and rehabilitation). It also describes the array of add-on services available to meet individual consumer needs. The guidelines also establish eligibility and discharge criteria and define the average expected hours of service recommended for each level of care.

### **Adult Services**

The adult service array includes both ongoing packages of services and crisis services. Crisis services are available both to clients not yet enrolled in ongoing care and those enrolled in ongoing care. Crisis services include: 24-hour emergency screening and mobile crisis outreach teams, crisis respite/residential, 23 or 48 hour direct observation services and local hospitalization when needed for crisis stabilization.

Ongoing treatment begins with services such as diagnosis, evaluation, and assessment. This culminates in the development of inter-disciplinary treatment plans. Available ongoing services include patient and family education, case management, rehabilitation, counseling, and medication services including appropriate lab work. Rehabilitative services include cognitive and behavioral interventions, supported housing, supported employment, educational, and other services essential to meeting individualized goals. Flexible dollars are a part of this array of services. They are currently used primarily to address transportation barriers and housing needs. LMHAs and NorthSTAR providers

serve many people who have extensive needs and require intensive support to avoid unnecessary crises, hospitalizations, and interaction with the criminal justice system.

TRR is designed to ensure that persons who do not have high levels of need obtain the necessary services to maintain their stability. It also promotes the provision of appropriate levels of care to persons who have higher needs. Persons with frequent hospitalizations are generally recommended for the most intensive level of care (Service Package 4), Assertive Community Treatment (ACT). ACT teams provide 24/7 coordinated access to intensive rehabilitation and case management services, medication, patient/family education, supported housing and employment, and substance abuse intervention. Service Package 3 provides a step down for persons no longer in need of this level of support or for persons appropriate for intensive team-based rehabilitation services. Service Package 2 focuses on the unique needs of persons with major depression. DSHS is working to increase access to Cognitive Behavioral Therapy (CBT) for this population. CBT is an example of the use of an evidenced based best practice with this population.

DSHS partners with LMHAs to provide more oversight of the care provided to a number of individuals with higher needs. Adults 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 tracked and prioritized for the most intensive services. Individuals who have been in the hospital over a year are monitored quarterly to identify any barriers to community placement. State hospitals and LMHAs work together to resolve these issues. In FY2011, DSHS began targeted technical assistance to LMHAs and NorthSTAR area providers who have persons in their area who continue to require frequent hospitalizations. The goal of these activities is to support individual recovery, connect people with needed services and enable individuals to function outside of residential or inpatient facilities to the maximum extent of their capabilities.

### **Children's Services**

Services are made available for children ages 3 through 17 with a diagnosis of mental illness who exhibit serious emotional, behavioral, or mental disturbances and who 1) have a serious functional impairment, 2) are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or 3) are enrolled in a school system's special education program because of a serious emotional disturbance. A *System of Care* philosophy is employed that is child centered and family driven. Services are delivered through service packages based on the TRR model for children. This is currently under revision and new levels of care including new evidence-based practices outlined in the TRR above are planned for statewide roll-out in September of 2013. The children are matched to the service packages based on their needs and the preferences of their caregivers. Services for this population can include 1) 24-hour emergency screening and rapid crisis stabilization services; 2) community based crisis residential services or hospitalization; 3) community-based assessments, including the development of inter-disciplinary treatment plans and diagnosis and evaluation services; 4) family support services, including respite care; 5) case management services; 6) pharmacological management; and 7) counseling, skills training and development.

Children and their families have access to three levels of case management services, depending on the intensity of the service package and specific consumer needs. These include routine case management, intensive case management, and family case management. The mental health case manager works with other service providers to address additional needs of the child such as education, rehabilitation, employment and housing (for older adolescents transitioning to adulthood), criminal justice, substance abuse and physical health issues. The most intensive service packages utilize wraparound treatment planning based on the principals and philosophy of Systems of Care.

A 1915(c) Medicaid waiver entitled Youth Empowerment Services is currently being implemented and it will be reviewed to determine if it is cost effective to the state. In addition to ongoing services, this waiver allows for greater flexibility in the funding of community-based supports such as respite care, family supports, community living supports, paraprofessional services, professional services, transitional services, minor home modifications, adaptive aids and supports, supportive family-based alternatives, non-medical transportation and targeted case management.

The children's mental health system also includes initiatives aimed at the general population. A mental health promotion initiative for youth in schools is being conducted as part of a broader partnership to improve the physical and behavioral health of children and their families. The Texas School Health Network promotes an eight-part model of coordinated school health programming through a network of regional School Health Specialists located in Region Education Service Centers (ESCs) throughout the state. The School Health Specialists serve as the primary health-related resource and point of contact for school districts within their regions. Their role is to assist local school districts in the implementation of coordinated school health programs. They evaluate local school districts' needs, provide technical assistance, conduct training, and offer consultation to the school staff and local School Health Advisory Councils on a variety of health issues including tobacco and other substance use prevention, suicide prevention, and mental health awareness and promotion. Currently, the Texas School Health Network is a collaborative effort between the ESCs and several programs within the DSHS.

The Texas Children Recovering from Trauma (TCRFT) Initiative aims at a trauma-informed care transformation of children mental health services and fosters resiliency and recovery. DSHS is a Category III member of the National Child Traumatic Stress Network (NCTSN) and has two LMHAs designated as Community Treatment Service Centers of NCTSN. This initiative promotes the use of evidence-based trauma-focused treatments and best practices in the screening, assessment and treatment of childhood traumatic stress. It seeks to increase the access to trauma-focused services and expands the eligibility criteria for children mental health services at Texas Region MHMR Center and Bluebonnet Trails Community Services to include children who have witnessed or experienced traumatic events and children of military families. TCRFT provides training on trauma focused evidence-based practices including Trauma-Focused CBT and Parent Child Interaction Therapy. It will create a strategic plan for a statewide transformation to

trauma-informed care and the creation of an infrastructure that supports this transformation.

The Texas Youth Suicide Prevention Project was created through the support of a Cooperative Agreement for State-Sponsored Youth Suicide Prevention and Early Intervention. The project promotes awareness of suicide prevention and best practices in communities and schools and offers screening and referral services to youth in military families. It also provides suicide prevention training in schools, educational systems, juvenile justice systems, foster care systems, and other youth support organizations, such as those involved with mental health, gay/lesbian/bisexual/transgender and questioning youth, and substance abuse.

### **Crisis Services**

Federal block grant funds, local and state funds are used by LMHAs and the NorthSTAR program to enhance the response provided to individuals experiencing mental health and substance abuse crises. These funds support American Association of Suicidology accredited crisis hotlines statewide and mobile crisis outreach teams. They are also used for local alternatives to incarceration and state hospitalization. This includes jail diversion services, outpatient competency restoration, 23 or 48 hour observation, crisis respite, crisis stabilization units, and crisis residential services.

The crisis system also includes 90 day transitional support for persons who are not enrolled in ongoing treatment. Ninety day transitional services help assure that lower need persons are stabilized immediately after a crisis. They also provide assertive outreach to persons who are harder to engage in ongoing care including persons who are chronically homeless and persons in need of substance abuse treatment. As a part of its redesign of crisis services, DSHS was able to obtain new state dollars to fund expanded access to intensive ongoing services such as ACT for those who have been successfully engaged in care through these 90 day transitional services. Intensive ongoing services for children and youth include team-based, wrap-around services which are available in the most intensive level of care. By expanding its capacity to provide intensive ongoing services to individuals entering the mental health system as a result of a crisis, the state is working to prevent future hospitalizations or incarcerations.

### **Transformation**

The state has completed a Mental Health Transformation State Incentive Grant. The grant enabled the state 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. However, the work of Mental Health Transformation has continued primarily through recovery based initiatives from the DSHS funded program, Via Hope and research work through the Center for Social Work Research. Via Hope supports a variety of recovery based programs such as certification of peer specialists and family partners, programming to strengthen youth programs in the LMHAs, support of the seven Consumer Operated Services Programs that are consumer led, and finally the work of the Recovery Institute, which is an umbrella for a variety of recovery based programming for local mental health authorities. The focus of these recovery initiatives is to move the centers to a recovery based system of care, which

assumes that consumers can and do recover and live meaningful productive lives. Central to this project is the Person Centered Recovery Planning for which Via Hope contracts with experts from Yale University to work closely with the Divisions Quality Management Departments, Via Hope and the LMHAs. Via Hope places a high priority on peer based and consumer led services and so peers and consumers are critical to every program. The University of Texas at Austin Center for Social Work Research has been able to work closely with Via Hope to develop measures and use existing instruments to determine the effectiveness and impact of programs on the LMHAs. Via Hope is guided by an Advisory Committee that is populated by family members, consumers, members of local advocacy organizations and local mental health authorities

## ***Substance Abuse Service System***

### **Organization**

DSHS funds community based providers and state licensed treatment programs to deliver prevention and treatment services. A funding formula based on population, poverty and need determines the amount of funding allocated for each of the eleven HHSC regions in Texas, including the state's behavioral healthcare contract with the NorthSTAR program. Each region has a continuum of services provided in accordance with the block grant guidelines, direction from the Texas Legislature, and the department's strategic plan.

A Medicaid benefit has been implemented in the state for adults with Medicaid who have a substance use disorder. The benefit covers outpatient services (assessment, ambulatory detoxification, counseling, and medication assisted therapy) as well as residential services (treatment, detoxification and specialized services for women). An evaluation is under way to see if the benefit generates enough savings to the Medicaid program to offset its cost. Continuation of the benefit is contingent on achieving this result.

DSHS has a statewide implementation of a recovery oriented system of care (ROSC) initiative. ROSC's have been developed in communities to help ensure that persons affected by substance use and mental health disorders are provided a continuum of service, care and a continuous path to recovery. DSHS staff assists communities across the state with initiating and understanding the ROSC concept in their local communities. To accomplish this staff have: conducted on-site informational trainings to organize communities assisting them with the development of the initial phase of this system change approach for achieving recovery; provided telephone and email technical assistance to the local communities regarding the ROSC concept; participated in person and via teleconferencing in local ROSC community meetings; included a week long track on recovery during Texas's Behavioral Health Training Institute; and assisted with development and training of recovery coaches.

An independent peer review process called the Peer Review Quality Improvement Process is conducted each October. By contract, funded providers are required to participate in this process. A committee of provider representatives uses the state's electronic data system, CMBHS, to conduct a review of client records and assess the quality of care being provided across the state. Results of the peer review are presented to the Substance Abuse Clinical Director and the Substance Abuse Policy Committee.

This information is used to identify technical assistance needs and make recommendations for system improvements.

All contracted prevention, intervention, and treatment providers are required by state administrative rules and performance contracts to protect client/participant-identifying information and records from unauthorized disclosure. Quality Management staff monitors compliance through desk reviews (using CMBHS), onsite reviews, and complaint investigations. Confidentiality is also monitored during the annual peer reviews. Remedies may include technical assistance, increased monitoring, or requirements to implement improvement or corrective action plans.

The State does not fund any programs utilizing or recognized as Charitable Choice with block grant funds. However, the State does include Charitable Choice requirements in its substance abuse performance contracts and has a complaint process in place for all participants and clients receiving services. The requirements follow the regulations outlined in 42 U.S.C. 300x-65 and 42, C.F.R. part 54 (42 C.F.R. 54.8(c) (4) and 54.8(b), Charitable Choice Provisions and Regulations. The contract provisions require providers to inform clients of their choice options for treatment and offer alternatives prior to admission. These requirements are described further as follows: A faith-based provider must ensure that recipients are advised of provider's religious character, recipient's freedom not to engage in religious activities, and recipient's right to receive services from an alternate provider. If the client objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith based provider must have made advance arrangements with the alternate provider, which includes access and transportation to the nearby provider.

### **Prevention Services**

In June 2012, the State of Texas developed the Texas Behavioral Health Strategic Plan (TBHSP) as a result of the recommendations made by a federal expert team that conducted the May 2010 review of Texas' prevention and Synar programs. The TBHSP is in line with the federal direction and will help Texas create a coordinated data-driven substance abuse prevention system. The data collected and reviewed for the Strategic Plan supports the determination of the state's prevention priorities which include alcohol, marijuana, and prescription drugs. The TBHSP was used as a guide to develop the program scopes of work for prevention services to be procured through the Request for Proposals (RFP) for Behavioral Health Prevention Services which was issued November 5, 2012. The new funding cycle will begin September 1, 2013. It is anticipated that the number of programs and the scopes of work within some of the prevention program types funded in FY2014 will change the current state's service delivery system. The changes will be a result of the procured services that will reflect the service needs in Texas as determined by the TBHSP.

The state's prevention service system includes programs that target Universal Direct, Selective, Indicated, and Universal Indirect Prevention populations. The entities represent non-profit, public and private, and governmental entities across the state. The services are delivered within school and community sites within the eleven Health and

HHSC—regions. All programs are structured according to the Strategic Prevention Framework and incorporate all six of the Center for Substance Abuse Prevention (CSAP) strategies to ensure a comprehensive continuum of prevention services. One of the core strategies includes the prevention education/skills training component which is driven by an evidence-based curriculum that has been approved through the National Registry of Evidence-based Programs and Practices and has been proven effective with specific target groups in school and community sites. Family focused activities provide an opportunity for the youth and their parents, grandparents, guardians, siblings, to meet together to improve the family unit as a whole. Programs that include family-focused curriculum or activities provide adults with learning opportunities and the development of skills that teach them about the behavior of their children and how to manage their actions through positive reinforcement and participation in their lives. This allows for the youth and the adults to bond and learn more about the harmful effects of any form of alcohol, tobacco, and other illicit drug use. Alternative Activities provide an opportunity for youth and their families to participate in skill building activities that promote bonding with the youth and their parents. These activities are designed to include a goal and objective to create awareness of the health consequences of substances of substance use/abuse and to reinforce prevention education lessons for youth program participants. Parents and youth that participate in some of the school or community programs may need assistance with a referral to other support services. Referrals for these participants and family members are initiated through the problem identification and referral prevention strategy. In addition, there is an opportunity for the youth and adults to participate in presentations that are directed at the prevention or alcohol, tobacco, and other drug specific topics. The community-based process strategy encourages collaborative partnerships to maximize community resources and address service gaps. Many of the programs participate in coalition work that promotes partnerships with a variety of stakeholders that include of community leaders and school administrators in support of policy or social changes within their environment.

DSHS funds community coalitions which focus on establishing or changing laws, policies, and social norms within the community through the implementation of environmental evidence-based strategies throughout the 11 regions of the state. The coalitions begin their work by conducting a needs assessment to identify the targeted county, zip code, or neighborhood area, or community. The coalitions will then assess capacity and mobilize coalition members and key stakeholder to begin meeting to discuss the needs assessment data and establish the goals and priorities for their communities. The data that is collected determines the direction in which the members will contribute their time and effort in establishing written policy, attitude, and behavioral change. Both youth and adults are impacted through various community coalition activities within the eleven regions and primarily within specific zip code areas and neighborhood. This community work impacts the total population as policies, ordinances, city priorities, school policies are implemented. Much of this work is conducted through several task force meetings that require the ability to bring key representatives from different sectors of the community to work to achieve specific goals within their local jurisdictions. The written agreements are established with these key representatives to ensure that the collaborative efforts are continued throughout the year and that specific policies are

achieved to change the attitudes, behaviors, and knowledge of the individuals residing within their area. In order to publicize their efforts, the coalitions initiate media contacts for media awareness activities such as billboards, television, radio, and editorial news prints with a no use message.

There are 11 Prevention Resource Centers (PRCs) that function as regional clearinghouses to deliver messages and information on the harmful effects of alcohol, tobacco and other drug (ATOD) use. The PRCs also serve as the prevention training liaison and coordinate prevention trainings in their respective region. The PRCs are designed to serve the general population in the regions where they are located. Some of the entities that are served by the PRC's include schools, communities, prevention providers, LMHA, churches, professional associations, colleges and universities, and other interested groups. The PRCs also play a key role in conducting Synar activities to ensure compliance with State and Federal regulations to limit minors' access to tobacco products. The PRCs conduct retail merchant education to educate them on the requirements and training that is necessary for their employees and the people they serve. Information on minors and tobacco is provided through presentations to the parents of the youth who are enrolled in school or at a community center. These parents are able to receive information on the impact that tobacco may have not only on their children but their own health as well. Adults receive brochures and videos to preview in order to learn more about the dangers of tobacco, spitless tobacco and second hand smoking. Each PRC has a Tobacco Prevention Specialist and they are required to conduct on-site voluntary compliance checks to reduce the sale of tobacco products to minors throughout the region. In addition to the voluntary compliance checks, the PRCs conduct on-site follow-up visits to any retailers in their region that were not in compliance during a voluntary compliance check and/or received a citation for non-compliance with the Texas Tobacco Laws.

Additional tobacco prevention, including SYNAR activities, is a key area of focus. The tobacco program promotes coordinated efforts to establish smoke-free policies and social norms, assist tobacco users to quit, and prevent initiation of tobacco use. This approach combines educational, clinical, regulatory, economic, and social strategies to reduce the personal and societal burden of tobacco-related deaths and illnesses. The use of media campaigns, cessation programs, and the implementation of smoke free ordinances are examples of the tobacco prevention efforts in the state. In addition, specific tobacco-related activities are incorporated into ongoing prevention services, such as information presentation and dissemination. Tobacco program staff is responsible for the annual SYNAR survey.

The Coordinated Training Services (CTS) entity works collaboratively with the PRC-to coordinate regional training on ATOD. The CTS coordinates trainings for prevention providers on required evidenced based prevention curricula. They also coordinate the state's required Substance Abuse Prevention Skills Training (SAPST), the 15-hour Prevention Training, 15- Hour Prevention Continuing Education, and various other trainings based on the training needs identified by the provider field and the state office. Some of these include training on the Strategic Prevention Framework, Coalition

Building and Mobilization, Cultural Competency, Risk and Protective Factors, Strengthening Families, Adolescent Development, and Prevention across the Lifespan.

The Department of State Health Services supervises and funds the Texas Alliance of the Partnership for a Drug-Free America. The Texas Partnership is an alliance of the Partnership for a Drug-Free America, a nonprofit organization that unites parents, renowned scientists and communications professionals to help families raise healthy children. DSHS' involvement and funding make the Texas Partnership unique. DSHS has used the Texas Partnership to generate millions of dollars in advertising and media exposure to encourage Texas youths to make wise choices about alcohol and other drugs. The Texas Partnership reviews, localizes and distributes public service announcements provided by the national organization to newspapers and television and radio stations statewide. The Texas Partnership also generates creative work tailored to address concerns identified by DSHS. The Texas Partnership has designed book covers and posters that were distributed to Texas students, set up kiosks with anti-drug information in malls and developed a billboard campaign targeting marijuana use to name a few. In addition, the Texas Partnership has won numerous national awards for its work. The Partnership also runs a state wide information and referral hot line.

### **Intervention Services**

Outreach, Screening, Assessment, and Referral (OSAR) programs are located in every region to provide referral to treatment and other appropriate services. The OSARs help consumers move through the continuum of care and link to community-based support services after treatment. To guide referrals, they use severity guidelines mapped to specific levels of care and identify priority populations at the time of assessment. They maintain residential treatment waiting lists, maintain communication with individuals waiting for treatment, and refer them to an appropriate level of care as soon as space becomes available. OSARs monitor residential capacity using reports from funded treatment contractors to assist in waiting list management. HIV early intervention and outreach programs maintain service agreements with treatment providers and the regional OSARs to ensure that, once identified, Intravenous Drug Users (IDUs) are prioritized for DSHS funded treatment services.

Specialized female services include Pregnant Post-Partum Intervention programs that provide outreach, screening, and referral to treatment services, education on the effects of alcohol, tobacco and other drugs on the fetus, case management, and parenting education. Pregnant Post-Partum Intervention programs operate in perinatal clinics, Women, Infants and Children (WIC) sites, DFPS offices, domestic violence shelters, and schools and classrooms for teen mothers.

HIV Early Intervention programs provide testing and case management services for persons who are HIV positive or diagnosed with AIDS and have substance abuse issues. They also provide substance abusers at risk with intensive risk reduction messages.

The Rural Border Intervention Program (RBI) is a specific initiative targeting residents of 22 rural Texas-Mexico border counties. See below- "Other Population-Rural"

## Treatment Services

Treatment services for adults and youth engage the client and the family in recovery efforts from outreach through treatment and continuing care. Treatment addresses the client's psychosocial and familial needs in conjunction with the substance abuse or dependency. Treatment approaches are research-based, holistic in design, and emphasize coordination of care across the continuum. Evidence based Motivational Enhancement Therapy (MET) is required in all substance abuse treatment settings. Service modalities include residential and ambulatory detoxification (for adults), intensive and supportive residential, and outpatient programs with varying intensities to meet client needs and preferences. Services include family, group, and individual counseling, as well as educational presentations and other support services.

Youth between the ages 13-17 who meet DSM-IV-R and soon to be DSM-V criteria for substance abuse or dependence are eligible for treatment services. Young adults aged 18-21 may be admitted to a youth treatment program when the screening process indicates the individual's needs, experiences, and behavior are similar to those of youth clients. The DSHS Client Placement Guidelines are based on assessed severity: intensive residential treatment for high severity, supportive residential treatment for moderate severity, and outpatient treatment for lower severity. Youth outpatient treatment providers use the Cannabis Youth Treatment Series, Motivational Enhancement Therapy, Cognitive Behavioral Therapy, and Family Support Network treatment models. Adolescent services include in-home and school-based counseling when appropriate, and psychiatric consultation if deemed necessary.

All treatment programs are required to establish formal agreements with available substance abuse, mental health, health care, and social service providers to address the multi-dimensional needs of individual clients and to facilitate referrals for family members needing services. Treatment programs provide case management and refer clients to ancillary services to help clients meet their treatment goals. They also conduct follow-up with clients leaving treatment, as well as individuals on their waiting list, to ensure successful linkage with referral destinations.

Treatment programs are required to screen for HIV/TB/STDs and Hepatitis, as well as provide or make referrals for testing and treatment for these diseases. HIV outreach services and early intervention services are in nine of the eleven - regions of the state. The outreach teams target substance abusers, particularly IDUs, and provide communicable disease information, testing, and risk reduction interventions. They also refer clients to treatment and facilitate admission. There is one residential substance abuse treatment that provides specialized services for persons who are HIV positive and/or who have been diagnosed with AIDS. A statewide training contractor provides training on TB, HIV, hepatitis and other communicable diseases for substance abuse service providers.

Specialized female services promote individual, familial, and economic self-sufficiency for pregnant and parenting women, including women whose children are in foster care. The continuum of care for this population includes detoxification, specialized residential

for women, residential services for women and their dependent children, and outpatient services. Treatment is designed to promote stable recovery from addiction, reduce the number of infants born drug- or alcohol-dependent or affected, and improve family functioning, academic success and employment. Specialized services that contribute to the successful attainment of these goals include gender-specific and trauma informed counseling that addresses issues of abuse and neglect, childcare, transportation, parenting education and reproductive health care. The use of the trauma informed treatment model, *Seeking Safety* is required in all specialized female services.

Pharmacotherapy services, referred to as opioid replacement therapy, is an adult treatment strategy that provides a client with the choice to use methadone or buprenorphine to facilitate higher functioning and to relieve symptoms associated with addiction to opiates or other narcotics. These services are specifically targeted to opioid injecting drug users (IDUs). DSHS has worked to reduce the stigma associated with opioid replacement therapy, encourage the development of new clinical strategies, and promote individualized treatment planning. Particular attention is given to ensuring this treatment population has access to a continuum of services and is not restricted from full participation in mainstream treatment settings. The State of Texas continues to prohibit the distribution of clean needles and syringes along with needle exchange programs. This, along with the federal laws and regulations prohibiting the use of federal dollars for the purchase of these items for use in HIV prevention programming are clearly stated in all provider contracts.

## ***Other Target Populations***

### **Co-occurring Psychiatric and Substance Abuse Disorders (COPSD)**

COPSD programs provide adjunct services to adult and adolescent clients with active psychiatric and substance use disorders who are receiving services in existing mental health and substance abuse residential and outpatient treatment programs. These services target clients who require crisis resolution and/or specialized support in treatment as a result of their co-occurring diagnoses. COPSD services address both disorders and employ engagement, stabilization, and coordination strategies to help clients benefit from treatment. There are currently thirty two substance abuse providers of which twelve are in LMHA's, providing COPSD services in every region of the state. Blended funding from mental health and substance abuse is used to support this program.

In addition to these specially funded COPSD programs, both mental health and substance abuse providers are required to screen clients for co-occurring disorders and make appropriate referrals. Texas Administrative Code Rules and DSHS contracts require competency in this area. Training is made available to help providers identify individuals in need of COPSD services and develop, maintain, and enhance access to evidence based services.

### **Homeless**

Outreach and services are made available through a blended funding program for adults who are homeless and have a serious mental illness, including those with a co-occurring substance use disorders. This funding includes the federally funded Project for

Assistance in Transition from Homelessness (PATH) program, state general revenue, and local matching funds. PATH activities include outreach to locate homeless populations in need of services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health and substance abuse services, case management services, primary health services, job training, supported employment, relevant housing services. Outreach and services occur where the person is currently residing, including homes, tent cities, bridges, streets, shelters, and other public areas.

The state also has a contract with Oxford House for the provision of residential assistance in five metropolitan areas. Through a revolving loan fund, Oxford House locates housing for persons who successfully complete DSHS-funded substance abuse treatment programs, who may or may not have a job, and who risk return to a former environment where their newly won sobriety/drug-free status may be compromised. DSHS' objective is to assist an individual to move into drug free, self-supporting housing for a period of time until he/she gains employment and is able to transition into more permanent housing. The DSHS contract supports six of the almost 70 Oxford Houses currently operating throughout Texas.

### **Rural**

Living in a rural area does not preclude a person from receiving mental health or substance abuse services, but service availability may be reduced outside of major population centers. In two specific mental health services, adaptations to the delivery system have been made to accommodate the unique issues in the rural areas. The ACT program has both urban and rural models. The rural model uses a lower staff-to-client ratio to compensate for the added travel time necessary to reach clients. Likewise, in order to maximize mobile crisis response in rural areas, adjustments have been made to the expectations for Mobile Crisis Outreach Teams. Rural MCOT teams are not required to employ an LPHA and have reduced hours where they must be fully staffed (56 hours/week vs. 72 hours/week).

To better reach individuals living in rural areas, some providers have established telemedicine and telehealth services to increase access to psychiatric services, substance abuse screening, assessment, and group education. In 2011, new legislation was implemented to expand the use of these services in Texas. This expansion allows for certified and licensed providers acting within the scope of their license to provide telehealth services. The HHSC Medicaid Division engaged stakeholders, via the Telemedicine and Telehealth Advisory Committee, in the development of rules to govern this expansion. Under the new rules, non-medical providers (LPC, LMFT, LCSW and LPs) will be allowed to provide Medicaid billable telehealth services, beginning in May of 2013.

DSHS has updated its data collection system to align with contracted providers' data systems in preparation for the expanded telemedicine benefit. This will eliminate duplicative reporting, which could discourage broader participation. To further encourage use, DSHS has publicized the expanded Medicaid benefit through its broadcast message system. The availability Medicaid reimbursement will be an added incentive for

increased use of advanced telecommunication methods, particularly for the rural and underserved areas of Texas.

The Rural Border Intervention Program (RBI) is a specific initiative targeting residents of twenty two rural Texas-Mexico border counties. The purpose of the RBI is to develop and implement a comprehensive behavioral health model that promotes and embraces culturally competent prevention, intervention, and treatment for youth and adults in rural border communities, including Colonias. These unique programs have a three-fold approach which includes 1) primary prevention for youth using evidence-based curricula, 2) substance abuse and mental health screening and short term intervention services using motivational interviewing, and 3) a community-wide approach that promotes local community action and establishes linkages with existing services and resources. Several of the RBI projects provide some of their services through the use of Community Health Workers, or Promotores. These indigenous outreach workers, Community Health Workers, come from the communities they serve. Promotoras provide information and education and are able to identify some mental health and substance abuse concerns and make appropriate referrals for children and their families. The RBI program also works to create strong alliances among agencies and organizations to leverage existing resources, strengthen the local workforce and infrastructure, and increase access to health and social services in the rural border areas.

#### **Underserved Racial/Ethnic, LGBTQ, Disabled and Older Adults**

DSHS contracts and rules require both mental health and substance abuse contractors to provide culturally, linguistically, and developmentally appropriate services that are non-discriminatory (including physical disabilities) for clients, families and/or significant others. Additionally, the contracts and rules require training for staff in cultural and sensitivity concerns. The MHSA division also has an internal Cultural Competency Workgroup made up of members from the mental health, substance abuse and prevention units. They are tasked with designing, implementing, and evaluating culturally and linguistically competent delivery systems that respond to growing diversity and disparities.

There are a limited number of providers that target specific underserved racial, ethnic, LGBTQ, disabled and older populations in their communities. These providers have developed programs that are based on the needs of their local communities. Specific initiatives at the state level that target and serve higher proportions of these populations include the RBI and the HIV Outreach, Early Intervention and HIV Residential Treatment Programs and the Texas Youth Suicide Prevention Project. An initiative is continuing from the last FY to better capture the persons who are currently in services who identify as LGBTQ in a sensitive way during the assessment process of both mental health and substance use disorder treatment.

DSHS has an interagency agreement with the DARS to make available interpreter services for the deaf and hard of hearing.

There is one adult mental health residential facility that specifically provides long term mental health care for older adults. Also, two initiatives in the state are working to help

persons including older adults who have mental illness and/or substance abuse disorders move from nursing facilities to receiving specialized services in the community. In order to enhance efforts to serve older adults, DSHS has mental health program specialist in who is also a gerontologist.

### **Military and Families**

Veterans and their family members are served in the ongoing mental health and substance abuse service system. Additionally, there are several specific initiatives that originated from the work of the Mental Health Transformation Workgroup (TWG) that target this population. First, mental health professionals are being trained to provide Cognitive Processing Therapy, which is evidence based therapy for Post-Traumatic Stress Disorder (PTSD), and growing numbers of LMHAs offer this service. Veteran peer services have been developed using the “Bring Everyone in the Zone” program, and family-to-family peer services have been developed through “Operation Resilient Families.” In addition, a contract is in place with TexVet: a partnership between TWG agencies, higher education, and the private sector. TexVet works to better connect veterans and their families with existing services, build virtual communities supporting veterans’ needs, and serve as a forum for coordinating programs across service providers.

DSHS has implemented a Jail Diversion and Trauma Recovery initiative for veterans. This involves creating trauma informed jail diversion services for veterans suffering from PTSD. The initiative is being piloted in the San Antonio area, which has many military installations. The Texas Children Recovering from Trauma Initiative increases access to trauma-focused treatments to children of military families ages 3 to 17 and provides treatment to this population in fourteen counties in Texas within two LMHAs. It creates community partnerships with military and veterans organizations to ensure referral process and address the needs of the population in the serving area.

### **Criminal Justice**

Mental health services for adults and juveniles involved with the criminal justice system are provided statewide using the Texas Resilience and Recovery (TRR) model. Most LMHAs in the more populated regions have contracts with Texas Correctional Office on Offenders with Mental and Medical Impairment to provide staff to work with individuals on parole and probation and support other re-entry initiatives. The larger urban areas also have outpatient competency restoration programs for individuals who have been found incompetent to stand trial.

Through State Hospitals, DSHS directly provides inpatient services for forensic patients on competency restoration and Not Guilty by Reason of Insanity commitments. The contracted beds provided in the Montgomery County Forensic Facility and Harris County added to this capacity. In addition to the ongoing efforts of numerous LMHAs, four counties receive specific funding to provide mental health deputy training and staff in order to divert individuals with mental illness from the criminal justice system. LMHAs and providers in the NorthSTAR program link people with the TRR levels of care. In addition, they may receive transportation to the court or probation or parole office. These services frequently place special emphasis on readiness for court, understanding rules of probation, parole, or outpatient commitment, and prevention of recidivism.

Substance abuse services for adults and juveniles involved with the criminal justice system are also provided statewide. Local providers work with city, county, state and federal corrections systems to address the substance abuse issues of persons in the criminal justice system. A contract with the Texas Department of Criminal Justice provides outpatient treatment for adult probationers through the Treatment Alternative to Incarceration Program, and a contract with Texas Juvenile Justice Department provides intensive residential and moderate treatment services for youth within the institutional settings.

Other initiatives related to the Criminal Justice system include coordination with specialized courts throughout the state. DSHS staff provides technical assistance related to policy and assist with the development of specialized drug, mental health, and veteran courts.

**COMMENTS:**

## **Step 2. Identify the Unmet service needs and critical gaps within the current system**

### **Unmet Needs and Services Gaps**

In order to identify the unmet service needs and critical gaps within the current system two approaches were taken. First, the state used the prevalence formulas for adults with serious and persistent mental illness and children with serious emotional disturbances that have been historically reported. Secondly, the state used prevalence estimates epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the state level. These pieces of data were used to determine priorities #1-9 in Step 3 of this document.

### **Data sources and methodology used to determine needs and gaps for required and other populations identified by the State as a priority (#1-9 in Step 3).**

#### **Estimates for Adult Mental Health Treatment Needs in Texas**

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. The Center for Mental Health Services (CMHS) within the U.S. 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). The methodology is defined in the *Federal Register*, Volume 64, Number 121, Thursday, June 24, 1999, Notices, pages 33890 – 33897. It is estimated that 5.4% of the adult population has a serious mental illness during a given year. Those with severe and persistent mental illness represent approximately 2.6% of the adult population. The number of adults who were estimated to meet the priority population for mental health services in the Texas public mental health system is shown in a Venn diagram on page 1, Attachment A. There are many more adults in need of services than are currently served. In FY2012, 155,770 (or 31.4%) of the 496,390 adults with serious and persistent mental illness were served by DSHS-funded community mental health centers and including the NorthSTAR program (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>).

### **Estimates for Child Mental Health Treatment Needs in Texas**

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). The number of children who were estimated to meet the priority population for mental health services in the Texas public mental health system is shown in a Venn diagram on page 2 of Attachment A. There are many more children in need of services than are currently served. In FY2012, 47,034 (or 26.7%) of the 175,937 children with SED were served by DSHS-funded community mental health centers including the NorthSTAR program (for estimate methodology, see *Federal Register*, Volume 64, Number 121, June 24, 1999, pp. 33890-33897; National Advisory Mental Health Council 1993; Kessler et al., 1996).

### **Estimates for Adult Substance Abuse Treatment Needs in Texas**

The sub-state estimates from the multi-year 2005-2010 National Survey on Drug Use and Health (NSDUH) were used to assess the adult substance abuse treatment needs in Texas. The substance abuse treatment needs for adults with chemical dependency were estimated by multiplying the 2012 adult population aged 18 and older by the NSDUH's percentage of those needing treatment for an illicit drug or alcohol problem if they met the diagnostic criteria for dependence on, or abuse of, illicit drugs or alcohol, or received treatment for an illicit drug or alcohol problem at a specialty facility in the past 12 months. The number of chemically dependent adults who were also poor was based on the NSDUH's percentage of those needing treatment for an illicit drug or alcohol problem and meeting medical indigence criteria in the past 12 months.

The NSDUH, conducted annually by the Office of Applied Studies (OAS) at the Substance Abuse and Mental Health Services Administration (SAMHSA), uses in-person interviews to collect data from which drug and alcohol use incidence and prevalence estimates are developed. Survey data are also collected periodically on special topics of interest such as serious mental illness, criminal behaviors, substance abuse treatment, and attitudes about drugs. The 2012 estimates for adult substance abuse treatment needs were based on a total sample of 14,331 Texans aged 18 and over in the 2005-2010 NSDUH data. The percentages of adults needing treatment by gender, age category, and racial/ethnic group for the state as a whole and for 11 sub-state planning areas were requested and obtained from the OAS in September, 2012.

As one of the eight large states sampled in NSDUH, the direct survey-weighted estimates were available for Texas. The direct design-based estimates for these eight states had relatively small standard errors, so that these estimates were assumed to be the "true values" for the purpose of validating the modeled estimates. To develop a good relative summary measure, the absolute value of the difference between the modeled estimate and the direct-weighted estimate for each of the eight states was divided by the direct-weighted estimate and averaged across the eight states to obtain an overall estimate of

relative bias for each of the substance use measures. The overall standard errors of percentages were 0.31% for needing treatment prevalence and 0.23% for needing treatment and medical indigence prevalence based on the 2005-2010 NSDUH data in Texas.

The number of adults who were estimated to meet the priority population for substance services in the Texas public substance abuse system is shown in a Venn diagram on page 3 of Attachment A. There are many more adults in need of services than are currently served. In FY2012, 32,857 (or 3.73%) of the 881,434 adults with chemical dependence and medical indigence were served by DSHS-funded substance abuse providers including the NorthSTAR program.

### **Estimates for Youth Substance Abuse Treatment Needs in Texas**

The statewide Texas School Survey of Substance Use among Students (TSS) has been conducted biennially since 1988 and used to assess youth treatment needs in Texas. Youth substance abuse treatment needs were calculated by using the prevalence rates from TSS and the youth population aged 12 to 17 in Texas. Since the sampling design of TSS (a multi-stage cluster approach) is not based on regional strata, the method of census-based synthetic estimation is applied to measure the youth treatment needs in 11 sub-state planning areas. The basic logic of this form of synthetic estimation is extrapolation from estimated rates of demographic groups at the state level to the same demographic groups at the small area (e.g., county) levels of analysis. The synthetic estimate for the county is then calculated as the weighted average of the statewide rates for each demographic group (the weights being the relative size of each demographic group within the county). In addition, since the TSS results can be generalized only to in-school students, the fact that school dropouts may have a higher prevalence of substance use is taken into account when estimating the treatment needs of youth population in Texas.

Youth are considered to be in need of treatment if they were chemically dependent. Based on TSS questions, a proxy parameter of chemical dependence is derived. Chemical dependence is defined as using a substance (except tobacco) daily, or more than once per week and having had any of the following problems during the past school year: attended class high; gotten into trouble with teachers or police due to substance use; had difficulties with friends or dates due to substances; or driven while high on substances.

The 2012 TSS data was used to estimate the youth substance abuse treatment needs in 2012. This survey included a sample of 87,293 Texas students in grades seven through twelve. Students were randomly selected from school districts throughout the State using a multi-stage probability design. Stage one was the selection of districts; stage two, the selection of classes within the sampled districts; and stage three, the selection of classes within the sampled schools. School districts along the Texas-Mexico border were over-sampled to allow statistically-valid comparison to the rest of the State. The survey asks students about the use of tobacco, alcohol, inhalants, and illicit drugs. Other questions pertain to the behavioral and demographic correlates of substance abuse, including risk and protective factors, sources of information about substance-related problems, and

perceptions of peer values and attitudes. The TSS is a joint project of DSHS and the Public Policy Research Institute at Texas A&M University.

*The TSS is compatible with the National Monitoring the Future Survey. To ensure the quality of the statewide survey data, a number of internal checks were put into place to guide the process. First, a quality control analyst oversaw the implementation of all pre- and post-analysis quality control procedures, from the initial mailing to the production of the final report. Also, the litho-coding is used to confirm that data from every survey instrument read was associated with the correct school district. Programming checks were also incorporated into the data analysis program by cross-analysis for data consistency. Exaggerated responses, such as those claiming to use a false drug or extremely high levels of drug and alcohol use, were identified and dropped from the analyses. If students failed to report both their grade level and age, the data were dropped from the analyses as well.*

Weights were applied to the final TSS estimates so that the samples of students in each campus, district, and stratum reflected their proportions in the actual district, campus, and stratum populations. The 95 percent confidence interval for estimates regarding the Texas secondary school population as a whole in the 2010 survey was at most plus or minus 1.8% for lifetime alcohol use. Actual confidence intervals on most substances were smaller.

The number of youth who were estimated to meet the priority population for substance use disorder services in the Texas public substance abuse system is shown in a Venn diagram on page 4 of Attachment A. There are many more youth in need of services than are currently served. In FY2012, 4,672 (or 6.08%) of the 76,822 youth with chemical dependence and medical indigence were served by DSHS-funded substance abuse providers including the NorthSTAR program.

### **Prevention and Promotion Needs in Texas**

The State's epidemiological profiles including substance abuse consumption and consequences data for adults and youth, which are shown on pages 5-6 of Attachment A, are used to guide programming decisions in substance abuse prevention needs, and prevention providers are expected to identify and serve these populations appropriately. Survey data such as TSS, Texas Behavioral Risk Factor Surveillance System (BRFSS), and NSDUH for Texas are used to show the scope of substance use behaviors among different age groups, ethnic groups, and geographic areas. Consequences data such as alcohol or/and illicit drug abuse or dependence, substance-related deaths, and substance-related arrests are also used to show the negative impact of substance use in various demographic groups.

The number of adults and youth who were served in DSHS-funded substance abuse prevention programs from 2008 to 2012 is shown on page 7 of Attachment A. A simple linear regression over time formula was used to project the number of adults and youth who may need prevention services in 2013-2015. The need for services is indicated in the three service categories shown in Attachment A. They include: Youth Prevention for

Universal populations (YPU); Youth Prevention for Selected populations (YPS) and Youth Prevention for Indicated populations (YPI).

The Texas Epidemiological Workgroup (TEW) was established in 2004 as part of the state prevention framework funded through the State Prevention Framework State Incentive Grant (SPF SIG). This workgroup served as the State's Epidemiological Outcomes Workgroup (SEOW), but is no longer actively functioning. However, a contact list of the representatives from various state entities such as Texas Health and Human Services Commission, Texas Education Agency, Texas Department of Public Safety, Texas Department of Transportation, Texas Alcoholic Beverage Commission, Texas Standing Tall, and State Universities has been kept. Periodical email contacts and phone calls are made to request necessary information regarding the consequences and consumption of substance abuse and related intervening factors in the state. This information along with statewide survey data has helped guide prevention planning in Texas.

DSHS-funded providers incorporated the Strategic Prevention Framework (SPF) within their funding application to demonstrate the priorities that are needed in their local communities. In order to determine the needs within the local communities and schools, the entities used the TSS and local data to demonstrate the current trends regarding alcohol, tobacco, marijuana, ecstasy, etc. Providers were able to select an approved curriculum that had been determined effective with a similar target population within their catchment area. They also coordinated with regional coalitions who have been funded for several years and have gathered information for their local county area. The community coalitions also utilized the SPF process within their initial funding application to implement the appropriate environmental strategies within their catchment area. The prevention resource centers were required to collaborate with the regional coalitions and providers to review the data that was already established for their area as well as review any other medical data or national data as well in order to address their local needs.

For mental health promotion, data from the BRFSS was used to identify potential gaps in mental health services among adults. The selected measures that indicate persons at risk for poor mental health or have a depressive disorder are included. Data from the Texas Youth Risk Behavior Survey (YRBS) was used to guide youth mental health services. These prevalence data is shown on page 8 of Attachment A. Also, the DSHS death statistics along with YRBS suicide-related prevalence were used to examine gaps and needs related to suicide prevention. These measures are found on pages 9-10 of Attachment A.

## ***Additional Data sources and methodology used to determine needs and gaps for enhancements identified by the State as a priority.***

### **Comparative Analysis of Good and Modern Service System**

For the 2012-13 block grant planning the State undertook a considerable task of comparing the current service system to SAMHSA's continuum of services identified in the "Good and Modern System Brief." Information from that analysis was used again to inform the 2014-15 block grant plan. In addition to the work that was previously completed, annual plans that were required from each of the Local Mental Health Authorities for FY 14, included additional analysis of local service systems compared to the Good and Modern continuum. The state has chosen to address the gaps in housing and recovery services, both identified in the analysis.

### **Comprehensive Analysis of Public Behavioral Health System**

A Public Consulting Group (PCG) conducted a comprehensive analysis of the public behavioral health system in Texas, as required by DSHS Rider 71, General Appropriations Act, 82nd Texas Legislature. PCG's efforts focused on two major components: (1) a comprehensive study of the current public behavioral health system in Texas and (2) short and long term recommendations for the Texas behavioral health system. Recommendations from the analysis can be found at: <http://www.publicconsultinggroup.com/client/txdshs/documents/PCG%20Draft%20Options%20for%20System%20Reform.pdf>. Recommendations from this report were used to inform the FY 14-15 Plan as well as the state legislature.

### **Crisis Point: Mental Health Workforce Shortages in Texas**

In the document, *Crisis Point: Mental Health Workforce Shortages in Texas*, March 2011, Hogg Foundation, workforce shortages are clearly delineated, [http://www.hogg.utexas.edu/uploads/documents/Mental\\_Health\\_Crisis\\_final\\_032111.pdf](http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf). The statistics show that as of March 2009, 173 out of 254 counties in Texas and two partial counties were designated as Health Professional Shortage Areas (HPSAs) for mental health. While the actual number of psychiatrists and social workers, counselors has risen between 2002 and 2010, none have risen to levels to keep up with the state's population growth. The number of licensed chemical dependency counselors and marriage and family counselors has steadily declined. Additionally, the workforce is aging. The median age for psychiatrists, licensed chemical dependency counselors and social workers is respectively 54, 52, and 51. This analysis was used again to inform the FY 2014-15 Plan.

### **Texas Behavioral Health Strategic Plan (TBHSP)**

In June 2012, a statewide prevention plan was prepared for the state as part of a technical assistance plan that had been developed in conjunction with The Center for Substance Abuse Prevention (CSAP). The TBHSP is in line with federal direction and will help Texas create a coordinated data-driven substance abuse prevention system. The data collected and reviewed for the Strategic Plan supports the determination of the state's prevention priorities which include alcohol, marijuana, and prescription drugs. The TBHSP was used as a guide to develop the program scopes of work for prevention

services to be procured through the Request for Proposals (RFP) for Behavioral Health Prevention Services. [Behavioral Health Strategic Plan \(Online; MS Word\)](#)

### **Return on Investment (ROI)**

DSHS used return on investment data to evaluate program effectiveness and efficiency and to plan for housing services. The need for housing services in both DSHS-funded community mental health and substance abuse services had been documented in the analysis of the Good and Modern system and the ongoing review of gaps in services. One ROI study showed the system cost savings of supported housing in the form of rental assistance to persons with serious mental illness who are also homeless. Cost savings include those achieved by offsetting psychiatric hospitalization, crisis services, criminal justice system costs, as well as homeless shelter costs and inpatient hospital costs. Another ROI study showed the system cost savings of establishing more Oxford Houses in Texas, evidenced-based supportive, residential settings for individuals in recovery for substance abuse. Cost-savings include those achieved from a reduction in treatment relapse, general hospitalization, and unemployment. Importantly, both ROI studies were used to support exception item funding requests in the 83<sup>rd</sup> Texas Legislative Session, which were funded.

### **MH & SA Data Sources for the Needs Assessments Report in Texas**

1. 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
2. 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.
3. 2012 Population Projections for Texas, Texas State Data Center and Texas Health and Human Services Commission, Nov. 2012 version (migration growth scenario = 1.0).
4. 2008-2012 Consumer Analysis Data Warehouse (CADW), DSHS.
5. 2008-2012 NorthSTAR Data Warehouse, DSHS.
6. 2008-2010 Behavioral Health Integrated Provider System (BHIPS), DSHS.
7. 2010-2012 Clinical Management for Behavioral Health Services (CMBHS), DSHS.
8. 2009-2010 National Survey on Drug Use and Health for Texas, OAS/SAMHSA.
9. 2010 and 2011 Texas Behavioral Risk Factor Surveillance System (BRFSS), DSHS.
10. 2004-2009 and 2010 Texas Death Data, DSHS.
11. 2011 Texas Arrest Data, Uniform Crime Reporting, Texas Department of Public Safety.

12. 2012 Texas School Survey of Substance Use Among Students in Grades 7-12, DSHS.
13. 2011 Texas Youth Risk Behavior Survey (YRBS), DSHS.
14. Federal Register, Volume 64, Number 121, Thursday, June 24, 1999, Notices, pages 33890-33897.
15. Federal Register, Volume 63, Number 137, Friday, July 17, 1998, Notices, pages 33661-38665.
16. 2005-2010 National Survey on Drug Use and Health for Texas (a special request of treatment needs parameters by sub-state), OAS/SAMHSA, September 2012.
17. "Secondary School Completion and Dropouts in Texas Public Schools 2010-2011," Texas Education Agency, July 2012 (dropout rates were used to adjust the prevalence rates among in-school youths).
18. *Crisis Point: Mental Health Workforce Shortages in Texas*, March 2011, Hogg Foundation.
19. 2012 DSHS Client Assignment and Registration (CARE) system.

**COMMENTS:**

## Steps 3 and 4. Priority Area and Annual Performance Indicators

**Table 2: State Agency Planned FY 2014 Expenditures**

Priorities Populations/Areas	Goal	Indicators/Strategies
<b>1. Adults with Serious Mental Illness</b>	Deliver Texas Resilience and Recovery (TRR) services to persons with SMI throughout the State	<ul style="list-style-type: none"> <li>• Increase the number of eligible persons served with SMI</li> <li>• Implement ANSA (assessment) in all LMHA's</li> <li>• Eliminate 2013 waiting list for persons with SMI</li> <li>• Enhance services to the underserved SMI population</li> <li>• Increase crisis services</li> </ul>
<b>2. Children and Adolescents with Serious Emotional Disorders</b>	Deliver Texas Resilience and Recovery (TRR) Services to children with serious emotional disorders	<ul style="list-style-type: none"> <li>• Increase the number of eligible children served with SED</li> <li>• Implement CANS (assessment) in all LMHA's</li> <li>• Eliminate 2013 waiting list for children/ adolescents with SED</li> <li>• Enhance services to the underserved SED population</li> <li>• Increase crisis services</li> </ul>
<b>3. Injecting Drug Users</b>	Deliver specialized treatment services to injecting drug users throughout the state	<ul style="list-style-type: none"> <li>• Maintain Medication Assisted Treatment (MAT) for injecting drug users across the state</li> </ul>
<b>4. Pregnant Women and women with dependent children</b>	Deliver specialized treatment services for pregnant women and women with dependent children	<ul style="list-style-type: none"> <li>• Provide specialized services for pregnant women on demand</li> <li>• Provide women with dependent children specialized services</li> </ul>

Priorities Populations/Areas	Goal	Indicators/Strategies
<b>5. Individuals at risk of or infected with HIV/TB</b>	Provide outreach, early intervention and treatment services for persons at risk of or infected with Human Immunodeficiency Virus (HIV)/Tuberculosis(TB)	<ul style="list-style-type: none"> <li>• Provide Early Intervention Services for persons infected with HIV/TB</li> <li>• Provide Outreach Services for persons at risk for HIV/TB</li> <li>• Provide Residential Substance Abuse Services for persons infected with HIV</li> </ul>
<b>6. Children and Adolescents at risk of Substance Use and Mental Health disorders</b>	Provide prevention and promotion for children and adolescents at risk for substance use and mental health disorders	<ul style="list-style-type: none"> <li>• Provide evidence based substance abuse prevention services to Universal, Selective, and Indicated Populations, focusing on alcohol, marijuana, and prescription drugs.</li> <li>• Train educators in Education Service Centers on Mental, Emotional and Social Well Being awareness, suicide prevention, bullying prevention, and substance use.</li> <li>• Increase the number of Coalitions providing population based services</li> </ul>
<b>7. Adults with Substance Use Disorders</b>	Deliver Treatment Services to adults with (SUD)	<ul style="list-style-type: none"> <li>• Provide services to eligible adults with (SUD)</li> <li>• Provide services to eligible adults with SUD who were on 2013 waiting list</li> <li>• Increase the reimbursement rate of services for services to adults with SUD</li> </ul>
<b>8. Person with Co-Occurring Psychiatric and Substance Use Disorders (COPSD)</b>	Deliver coordinated and integrated services for individuals with COPSD	<ul style="list-style-type: none"> <li>• Provide specialized services to eligible individuals with COPSD</li> </ul>

Priorities Populations/Areas	Goal	Indicators/Strategies
<b>9.Recovery Support</b>	Promote recovery, resiliency and community integration through the delivery of peers support and recovery based activities	<ul style="list-style-type: none"> <li>• Expand and Support Recovery Oriented Systems of Care (ROSCS)</li> <li>• Expand Housing Opportunities for Persons with SUD and MHD</li> <li>• Increase Number of Peer Specialists</li> <li>• Increase number of Family Partners</li> <li>• Develop and fund Recovery Centers</li> <li>• Increase Recovery Based Performance Outcomes</li> <li>• Continue Person Centered Recovery Planning</li> <li>• Expand Housing Options</li> </ul>
<b>10.Integration of Behavioral Health</b>	Increase the level of service integration between mental health, substance abuse and physical health services	<ul style="list-style-type: none"> <li>• Develop plan via SAMHSA T.A. for integration of MH and SA</li> <li>• Complete and implement short term plan for integration with infectious and chronic diseases</li> <li>• Complete and Implement Peer Curricula for Co-Occurring Disorders</li> <li>• Secure and renew community agreements to reflect community collaborative efforts that facilitate referrals for S.A., MH, and support services.</li> </ul>
<b>11. Workforce Development</b>	Enhance the capacity of the behavioral workforce in the state	<ul style="list-style-type: none"> <li>• Provide Training to current workforce</li> <li>• Train and Certify Family Partners</li> <li>• Train and Certify Peer Specialists</li> <li>• Train and Certify Recovery Coaches</li> <li>• Make available Certified Prevention Specialist Training</li> <li>• Increase use telemedicine/telehealth opportunities</li> <li>• Provide access to training on outreach and enrollment</li> </ul>

### III. Intended Use of Block Grant Dollars for Block Grant Activities

Table 2: State Agency Planned FY 2014 Expenditures

Activity	SABG	MHBG
1. Substance Abuse Prevention* and Treatment	\$ 86,649,748	
<b>Subtotal</b>		
a. Pregnant Women & Women with Dependent Children*	15,996,876	
b. All Other	70,652,872	
2. Substance Abuse Primary Prevention	33,326,826	
3. Tuberculosis Services	-	
4. HIV Early Intervention	6,665,365	
5. State Hospitals		
6. Other 24 Hour Care		
7. Ambulatory/Community Non-24 Hour Care		30,198,501
8. Mental Health Primary Prevention		250,000
9. Mental Health Evidenced-based Prevention & Treatment**		1,691,583
10. Administration	6,665,365	1,691,583
<b>11. Total</b>	<b>\$ 133,307,304</b>	<b>\$ 33,831,667</b>
<i>*Prevention other than Primary Prevention</i>		
<i>**Subject to approval of Presidential budget – 5% Mental Health Prevention Set-Aside</i>		

**COMMENTS:**