MEETING AGENDA

Criminal Justice Reform Committee (Virtual)
August 2, 2023 | 2:00 – 3:00 p.m.

Please click the link below to join the webinar:
https://us02web.zoom.us/j/83095416518

Or Telephone: Dial (for higher quality, dial a number based on your current location) US: +1 346 248 7799 or +1 253 215 8782 or +1 669 900 6833 or +1 312 626 6799 or +1 929 205 6099 or +1 301 715 8592 or 877 853 5247 (Toll Free) or 888 788 0099 (Toll Free)

Webinar ID: 830 9541 6518

I. **CALL TO ORDER**

II. **ROLL CALL**

**Members:**
- Councilmember Alyssa Garza (Chair)
- Councilmember Shane Scott
- Mayor Jane Hughson

**Staff Support:**
- City Manager Stephanie Reyes
- Assistant City Manager Chase Stapp
- Police Chief Stan Standridge
- Assistant Police Chief Bob Klett
- Assistant Police Chief Brandon Winkenwerder
- Analyst, Martha Chumchal
- Administrative Coordinator/Minute Taker Tammy Strakos

III. **MINUTES**
- Consider approval, by motion, of the July 5, 2023 meeting minutes.

IV. **PRESENTATION (OPEN TO PUBLIC)**
- Serving People In Crisis: Enhancing Mental Health In Emergency Responses *(Chief Standridge)*

V. **IDENTIFY AGENDA ITEMS FOR FUTURE MEETINGS | NEXT MEETING: 9.6.23**
Committee members may provide requests for discussion items for a future agenda in accordance with Council Committee Procedures. *No further discussion will be held related to topics proposed until they are posted on a future agenda.*

- 4.5.23 County Justice Center updates and how it affects COSM *(Hughson)*

VI. **ADJOURNMENT**
Hays County Behavioral Advisory Team Charter

May 3, 2023

Article I: Name

The name of this Committee is the Hays County Behavioral Advisory Team (BAT), and it will be referred to as the BAT.

Article II: Authority

The BAT was established on March 1, 2023, by unanimous agreement of participants at an organizational meeting. The BAT is an advisory board to local stakeholders and local government, encouraging and stewarding action plans for systemic change, and making recommendations for legislative action.

Article III: Purpose

The Hays County BAT is empowered to specifically function as a single point of advisory, accountability, planning, and resource coordination for all City of San Marcos, City of Kyle and Hays County behavioral health services. Behavioral health, for purposes of this document and the sphere of responsibility of the BAT, will encompass all individuals with co-occurring diagnoses to include mental health, substance use, and intellectual / developmental disabilities.

The BAT will communicate and present planning, financial, operational, managerial, and programmatic recommendations to the offices, groups, and governmental bodies represented on and those associated with the BAT.

In summary, the goal of the BAT is to permit the Cities of San Marcos and Kyle and Hays County to:

- Leverage all of its resources more effectively;
- Provide more empowered and coordinated representation into the functioning of the local system of care itself;
- Create leadership collaborative and interface for the Cities of San Marcos and Kyle and Hays County behavioral health services with the local hospital systems, the Local Mental Health Authority (LMHA), local community providers, and other stakeholder groups including, but not limited to: Court representative(s); magistrate representative; law enforcement; jail administrator; hospital representative(s); housing; District Attorney or his/her designee; supervision department; criminal bar representative; commissioner court representative(s); jail services (Wellpath); substance use provider; 911 Communications representative; Texas State University representative;
specialty court administrator:
- Create a body which promotes a partnership with other municipalities within and surrounding Hays County in developing a strong behavioral health care strategy for Hays County.

**Article IV: Guiding Values of the BAT**

The BAT supports the vision of the Cities of San Marcos and Kyle and Hays County to develop a system of behavioral healthcare consistent with the following values:

- A leadership collaborative is critical to the development and sustainability of a cohesive and effective system for community wellness.
- Service quality and effectiveness, not only access, should be a focus for all providers committed to improving the resilience and wellness of all citizens within Hays County.
- Behavioral health and physical health care should be integrated.
- Data must be shared among all providers in a manner that improves service quality and effectiveness.
- Adequate resources must be allocated to housing, both immediate and long-term.
- Substance Use Disorder (SUD) services should be integrated into all service delivery systems.
- Children’s services should be family-centered and systems-oriented.

To ensure these values are instilled in all systems and services:

- The BAT will partner and work closely with the Forensic Director of Health and Human Services Commission to assist in creating a road map for developing action plans.
- The BAT will be a locus for quality improvement in behavioral health in the Cities of San Marcos and Kyle and Hays County. The BAT will work with clinical operations teams and other community stakeholders to identify performance indicators that are connected to the stories and experiences of the area citizens and residents who struggle to make progress toward recovery and be able to track how well the system is doing in reducing crisis, improving integration and continuity, using its resources effectively, and working in partnership to make change.
- The BAT will be a locus for coordination of advocacy and program development for the city and county. This includes legislative advocacy, identifying major grant opportunities and other funding resources.
- The BAT will ensure that the Cities of San Marcos and Kyle and Hays County are an active partner with surrounding municipalities including the City of Buda and other counties in developing a strong behavioral healthcare system in the central Texas area.
Article VI: Deliverables from the BAT

- The BAT will meet no less than bi-monthly for the year, on a regular schedule, beginning in March 2023. The BAT will provide status reports, as well as copies of plans and recommendations, as they are developed and become available to stakeholders, funders, policy makers, and legislators.
- The BAT should be formally representative of stakeholders in the Cities of San Marcos and Kyle and Hays County with designated members representing various constituencies.
- The BAT shall be responsible for identifying designated leadership that will be accountable for leading the meetings, ensuring that the group is productive and task-focused, and for being the point of communication between the BAT and stakeholders. The leadership structure must ensure a balance between promoting broad stakeholder participation and the ability to make executive level decisions without undue influences from any particular interests.
- The BAT will be responsible for identifying workgroups, subgroup committees, and other mechanisms for getting work completed.
- Persons who are not serving on the BAT, however selected for a workgroup by the workgroup chair, must be approved by the BAT Co-Chairs prior to participating in the workgroup.
- By the end of each calendar year, the BAT will identify performance indicators and improvement targets for the behavioral health system that help the system to improve and report those indicators and targets to the stakeholders and interested parties.
- By the calendar end of each year, the BAT shall adopt a report including system needs, strides, and recommendations.
- As part of its end of year report, the BAT will identify major priorities and resource development opportunities.

Article VII: Members

Voting members:
There are sixteen voting members of the BAT who are members due to the position they hold. Refer to Appendix A: BAT Membership List.

The BAT agrees to draw on other experts or staff as necessary to conduct its duties.

Article VIII: Attendance

A quorum is no less than a simple majority of the total membership. Action may be taken by a majority of those present voting and by not less than a majority of the quorum. A quorum must include greater than 50% of designated voting members.
A voting member may select an executive level designee to attend in their stead. This designee must be empowered to make decisions on, speak for, and vote on issues on behalf of the member and represented agency.

A member may miss no more than 3 meetings per year. Additional absences will require a vote by the BAT to continue membership for the agency. Extenuating circumstances shall be approved by the BAT Co-Chair(s).

Each voting member has one vote. Designees present must vote on behalf of a voting member.

Robert’s Rules of Order, revised, govern all BAT meetings except in instances of conflict between the rules of order and the charter of the BAT or provision of law.
## Appendix A: Behavioral Advisory Team Membership List

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<thead>
<tr>
<th>Member Name</th>
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Hays County Roadmap

1. Expand crisis options through the development of a diversion center.
2. Develop strategies to address high needs utilizers and pilot a new Assertive Community Treatment (ACT) program, while also focusing on local restoration services for those who are incarcerated.
3. Explore the development of a Behavioral Health Office to coordinate county services.
4. Increase information and data sharing across the Sequential Intercept Model (SIM).
5. Enhance 911 and law enforcement response to behavioral health crises.
Resiliency – the pathway to recovery

WHAT IS RESILIENCY

Resiliency can be defined as an innate capacity that when facilitated and nurtured empowers children, to successfully meet life’s challenges with a sense of self-determination, mastery and hope.

FOUNDATIONS OF RESILIENCY

❖ The belief that all children, youth and families have strengths and are capable of overcoming challenges.
❖ Youth and families are the experts in their experiences.
❖ Youth and families have a voice and choice in services and supports.

HILL COUNTRY MHDD CENTERS

serving 19 counties, including Bandera, Blanco, Comal, Edwards, Gillespie, Hays, Kendall, Kerr, Kimble, Kinney, Llano, Mason, Medina, Menard, Real, Schleicher, Sutton, Uvalde and Val Verde Counties

BOARD OF TRUSTEES

Commissioner Donna Eccleston, Chair
Comal County

Judge Chris Schuchart, Vice-Chair
Medina County

Judge Brett Bray, Secretary
Blanco, Gillespie and Llano Counties

Judge Souli Shanklin
Edwards, Kimble, Mason, Menard, Schleicher and Sutton Counties

Mr. Wallace Whitworth
Bandera & Kendall Counties

Judge Tully Shahan
Kinney, Real and Uvalde Counties

Judge Rob Kelly
Kerr County

Judge Lewis Owens
Val Verde County

Mr. Charles Campise
Hays County

EXECUTIVE DIRECTOR

Ross C. Robinson

DIRECTOR OF MENTAL HEALTH SERVICES

Anne Taylor

CLINICAL SPECIALIST FOR CHILDREN

Teresa Thompson

FOR MORE INFORMATION CONTACT:

Hill Country MHDD Centers
819 Water Street, Suite 300
Kerrville, TX 78028
Tel: 830-792-3300
Fax: 830-792-5771
www.HillCountry.org

Mental Health Crisis? Call (877) 466-0660 Toll-Free
ELIGIBILITY FOR SERVICES

- A youth between the ages of 3-17
- Have a mental health diagnosis
- Have serious problems in daily life functioning due to psychiatric symptoms
- In addition, a child is eligible for services, if:
  - Their mental health problems put them at risk of being removed from their preferred living or childcare environment
  - The child is enrolled in a school special education program because of serious emotional problems

Hill Country MHDD Centers accepts Medicaid and Children's Health Insurance Program (CHIP). If the child has no health care coverage, fees will be assessed based on the family's income.

SERVICES AVAILABLE

The following services may be available depending upon individual need:

SKILLS TRAINING

FAMILY SKILLS TRAINING

COUNSELING

CASE MANAGEMENT

FAMILY PARTNER

PHARMACOLOGICAL MANAGEMENT

PARENT SUPPORT GROUP

MEDICATION TRAINING & SUPPORT

ENGAGEMENT ACTIVITIES

A CHILD/ADOLESCENT EXPERIENCES BIG CHANGES, SUCH AS:

- Declining school performance
- Lose of interest
- Changes in sleeping/eating patterns
- Avoiding friends/family (alone)
- Feeling life is too hard to handle
- Hearing voices
- Experiencing suicidal/homicidal thoughts

A CHILD/ADOLESCENT EXPERIENCES:

- Poor concentration and is unable to think or make up mind
- An inability to sit still or focus attention
- A need to wash, clean things, or perform certain routines hundreds of times a day
- Racing thoughts
- Persistent nightmares

A CHILD/ADOLESCENT BEHAVES IN WAYS THAT CAUSE PROBLEMS:

- Using alcohol or other drugs
- Eating excessively, purging, abusing laxatives, dieting and/or exercising obsessively
- Violating others rights/breaking the law with no regard for others
- Setting fires
- Doing things that can be life threatening
- Harming/killing animals

SOME MENTAL HEALTH WARNING SIGNS

A CHILD/ADOLESCENT IS TROUBLED BY FEELING:

- Sad and hopeless for no reason
- Very angry most of the time
- Worthless or guilty often
- Anxious or worried often
- Unable to get over a loss
- Extremely fearful
- Constantly concerned about physical problems or physical appearance
- Frightened that his or her mind either is controlled or is out of control
The Texas Toolkit
for Rightsizing
Competency Restoration Services

October 2021
About the Judicial Commission on Mental Health

The Judicial Commission on Mental Health (JCMH) was created by a joint order of the Supreme Court of Texas and the Court of Criminal Appeals of Texas. The mission of the JCMH is to engage to empower court systems through collaboration, education, and leadership, thereby improving the lives of individuals with mental health needs, intellectual and development disabilities, and substance use disorders. For more information, see www.texasjcmh.gov.

About the Texas Health and Human Services Commission

The Texas Health and Human Services (HHS) System is comprised of more than 41,000 public servants under two agencies: The Health and Human Services Commission (HHSC) and The Department of State Health Services (DSHS).

These agencies serve millions of people each month and deliver hundreds of programs and services. Additionally, the agency operates 13 state supported living centers, which provide direct services and supports to people with IDD, and 10 state hospitals, which serve people who need inpatient psychiatric care.

About Eliminate the Wait

It is time to right size competency restoration services for Texans by taking a holistic approach to this challenge. The Texas Judicial Commission on Mental Health and the Texas Health and Human Services Commission asks judges, prosecutors, defense attorneys, sheriffs and jail staff, police, and behavioral health providers to join their collaborative effort to change how Texas serves people at the intersection of mental health and criminal justice. We all have a role to play to ELIMINATE THE WAIT.

This toolkit includes a set of strategies that stakeholders can implement to help ELIMINATE THE WAIT for inpatient competency restoration services in Texas.

Project Team

JCMH Staff:
Jessica Arguijo
Molly Davis, J.D.
Kama Harris, J.D.
Michael Sipes
Kristi Taylor, J.D.
Liz Wiggins, J.D.

HHSC Staff:
Catie Bialick, M.P.A.
Jennie Simpson, Ph.D.
Suggested Citation

Bluebook Citation:

APA Citation:

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Acknowledgements

The JCMH and the HHSC would like to recognize the leadership and support of Justice Jane Bland, Supreme Court of Texas, and Judge Barbara Hervey, Texas Court of Criminal Appeals, Chairs of the JCMH; Sonja Gaines, Deputy Executive Commissioner for IDD and Behavioral Health Services; and Scott Schalchlin, Deputy Executive Commissioner for the Health and Specialty Care System. Thank you, also, to the Supreme Court of Texas, and the Court of Criminal Appeals of Texas.

The JCMH and HHSC would also like to recognize the following contributing authors and editors of this Toolkit:

Staci Biggar, J.D.
Biggar Law Firm, LLP

Virginia Brown, Ph.D.
Dell Medical School
The University of Texas at Austin

Hon. Nelda Cacciotti
Office of Judicial Staff Counsel and Special Magistration, Tarrant Co.

Kathleen Casey-Gamez, J.D.
Texas Indigent Defense Commission

Scott Ehlers, J.D.
Texas Indigent Defense Commission

Alyse Ferguson, J.D.
Collin County Mental Health Managed Counsel

Courtney Harvey, Ph.D.
Texas Health and Human Services Commission

Colleen Horton
Hogg Foundation for Mental Health

Trina Ita, M.A.
Texas Health and Human Services

Hon. David Jahn
Denton County Criminal Court No. 1

Lee Johnson, M.P.A.
Texas Council of Community Centers, Inc.

Louise Joy, J.D.
Joy & Young, LLP

Adrienne Kennedy
National Alliance on Mental Illness

Hon. Elizabeth Leonard
238th Judicial District Court

Hon. Pamela H. Liston
Rowlett Municipal Court

Chris Lopez, J.D.
Texas Health and Human Services Commission

Lucrece Pierre-Carr, M.S.S.W.
Texas Health and Human Services Commission

Lee Pierson, J.D.
Dallas County District Attorney’s Office

Britney Roshner, M.A., L.M.F.T.
Texas Health and Human Services Commission

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Lubbock County Sheriff’s Office

Simone Salloum, J.D.
Texas Health and Human Services Commission
A special thank you to the organizations who agreed to send their constituents the *Eliminate the Wait* checklists to ensure that best practices, promising practices, and great ideas were being shared throughout Texas:

- Texas Center for the Judiciary
- Texas Association of Counties
- Texas Council of Community Centers
- Texas Criminal Defense Lawyers Association
- Texas District and County Attorneys Association
- Texas Indigent Defense Commission
- Texas Justice Court Training Center
- Texas Municipal Courts Education Center
- Texas Police Chiefs Association
- Texas Sheriffs Association
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*Checklists arranged Sequential Intercept Model order.
The Texas Toolkit for Rightsizing Competency Restoration Services

The competency to stand trial process is designed to protect the rights of people who do not understand the charges against them and are unable to assist in their own defense. Like other states across the U.S., Texas faces a growing crisis in the number of people who are waiting in county jails for inpatient competency restoration services after being declared incompetent to stand trial (IST). Not only has this increased costs and overburdened state agencies and county jails but it also is taking a significant toll on the health and well-being of people waiting in Texas jails for inpatient competency restoration services. Meanwhile, resources available to the behavioral health and justice professionals serving our communities are becoming scarce.

More than 1,800 people are currently waiting in Texas jails for Competency Restoration Services.

Over the past 20 years, Texas has seen a 38% increase in people who are found incompetent to stand trial.

Nearly 70% of state hospital beds in Texas are used by the forensic population.

It is time to right size competency restoration services for Texans by taking a comprehensive and integrated approach to this challenge. The JCMH and the HHSC asks judges, prosecutors, defense attorneys, sheriffs and jail staff, police, and behavioral health providers to join their collaborative effort to change how Texas serves people at the intersection of mental health and criminal justice. We all have a role to play to **ELIMINATE THE WAIT**.

This toolkit includes a set of strategies that stakeholders can implement to help **eliminate the wait** for inpatient competency restoration services in Texas.

“We applaud this collaborative effort to raise awareness about competency-restoration services and best practices. It engages courts, law enforcement, and mental health professionals in an effort to better use state resources for people with mental health disorders or intellectual and developmental disabilities who encounter our justice system.”

Hon. Jane Bland, Justice, Supreme Court of Texas; Chair, JCMH

Hon. Barbara Hervey, Judge, Court of Criminal Appeals of Texas; Chair, JCMH

“We have a responsibility to work across systems to reduce and prevent justice involvement and connect people to care in the community. When competency restoration is needed, it should be for the purpose it was intended: to provide stabilization and legal education.”

Sonja Gaines, Deputy Executive Commissioner for HHSC Intellectual and Developmental Disability and Behavioral Health Services

Scott Schalchlin, Deputy Executive Commissioner for HHSC Health and Specialty Care System
The Causes

People with a mental illness or an intellectual or developmental disability are often arrested when diversion is appropriate and possible. The Texas Code of Criminal Procedure Art. 16.23(a) states, officers shall make a good-faith effort to divert a person who is suffering a mental health crisis or suffering from the effects of substance abuse to a proper treatment center in the law enforcement agency’s jurisdiction.¹

Competency evaluation orders are often tied to a well-intended, but inaccurate, understanding of competency restoration services. Some people view competency restoration as a way to connect a person with mental health treatment. The reality, however, is that competency restoration services have a narrow focus on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and treatment services with the goal of long-term recovery and rejoining the community.

The process does not currently operate at maximum efficiency. It can take months to over a year from the time incompetency is raised to the final disposition of the criminal case. This is, in part, due to inefficiencies in managing case flow, communicating between parties and scheduling. Sometimes a person who has been restored at a state hospital and returned to jail experiences deterioration of their mental health while waiting for their competency hearing.

The Solutions

Build a state roadmap for eliminating the wait. JCMH and HHSC are launching the Eliminate the Wait initiative to provide an actionable roadmap for reducing and eliminating the waitlist for inpatient competency restoration services.

Develop tailored resources and technical assistance. Using evidence-based strategies, JCMH and HHSC are working together to develop new trainings and educational materials focused on opportunities for diversion to treatment at all points in the criminal justice system. These will be used by judicial officials, jail staff, local mental health authorities, people who have lived experience with incompetency to stand trial, and the public.

Enhance accountability. Through pilot programs, resources, and research, JCMH and HHSC will contribute to our understanding of the public safety and fiscal implications of reducing and eliminating the wait. Millions of taxpayer dollars and thousands of public safety hours are spent each year on services related to competency restoration — from arrest to inmate housing, court proceedings to inpatient state hospital stays, and, finally, to disposition. Eliminating the wait for inpatient competency restoration services brings accountability to public safety and fiscal stewardship.

¹ The factors in Tex. Code Crim. Proc. Art. 16.23(a)(1) through (4) must also be met. Certain offenses are not eligible pursuant to Tex. Code Crim. Proc. Art. 16.23(b).
What’s My Role to Eliminate the Wait for Competency Restoration Services?

Local Mental Health and Behavioral Health Authorities, Local Intellectual and Developmental Disability Authorities, and other Behavioral Health Treatment Providers

Behavioral health treatment providers are the frontline in reducing the number of people with a mental health (MH), substance use disorder (SUD), or an intellectual and developmental disability (IDD) who become involved in the criminal justice system. These efforts include offering timely crisis response and pre-arrest diversion programs, providing quality community-based services, and establishing positive relationships with criminal justice partners to facilitate a collaborative approach. By connecting people to care outside of the criminal justice system, behavioral health treatment providers can reduce the number of people in need of competency restoration services. If a person is found incompetent to stand trial, providing alternatives to inpatient competency restoration can prevent a person from waiting in jail for an available inpatient bed.

1. Expand Crisis Response and Pre-Arrest Diversion Options

- Do I offer a range of crisis services?
  - Do I offer services that are accessible at the earliest signs of crisis, such as walk-in appointments and telehealth, if permitted?
  - Do I offer a range of services for people experiencing acute crisis, such as round-the-clock mobile crisis teams and short-term crisis stabilization services?
  - Do I offer follow up services after a crisis care episode that ensure ongoing access to care such as care coordination?

- Do I have pre-arrest diversion programs and partnerships in place in all counties in my local service area that focus on preventing criminal justice involvement of people with MH, SUD, or IDD, as described in Tex. Health & Safety Code §§ 533.0354 and 533.108?

- Do I deploy a full range of public safety responses, including partnering with emergency medical services?

- Do I provide crisis response support to law enforcement through co-response or virtual co-response?

- Have I developed a shared understanding with local law enforcement officers on the scope of their discretion and responsibilities for an emergency detention without a warrant under Tex. Health & Safety Code § 573.001?

- Do I have a range of easy access drop-off options for all counties in my local service area for people who need immediate crisis support?

2. Promote Alternatives to Inpatient Competency Restoration

- Do I offer outpatient competency restoration (OCR) and/or jail-based competency restoration (JBCR) to provide an alternative to inpatient competency restoration services? If not, have I explored these options?

- Do I have a process in place for actively monitoring persons under a Code of Criminal Procedure 46B commitment order based on Form Z, the Forensic Clearinghouse Waitlist Template?

3. Provide Services that Reduce Justice-Involvement and Ensure Continuity of Care

- If a person has been identified to be incarcerated through the continuity of care query (CCQ), do I have an outreach plan in place with my jail?

- Do I offer contracted jail-based treatment services?

- Are my staff educated on justice-responsive programs and interventions, such as cognitive behavioral treatment targeted to criminogenic risk, motivational interviewing, forensic intensive case management, and critical time intervention?

- Are my staff educated on criminogenic risk and need factors that contribute to recidivism?
4. Lead Through Partnership

☐ Do I coordinate, communicate, and collaborate with criminal justice partners?

☐ Do I have representation from criminal justice partners on my advisory board, including police departments, sheriffs’ offices, and courts?

☐ Do I, or staff, participate in local planning boards and workgroups focused on issues at the intersection of behavioral health and criminal justice?

☐ Are criminal justice partners educated on diversion programs available through my organization, including the crisis hotline, mobile crisis response, mental health deputies, co-responder teams, and other like programs?

☐ If I provide OCR and/or JBCR services, do I provide education to defense attorneys, prosecutors, and judges on these programs as alternatives to inpatient competency restoration?

☐ Do I actively promote my organization’s diversion programs with criminal justice partners?

☐ Do I offer training to criminal justice partners on Mental Health First Aid?

☐ Are policies, procedures, and/or processes in place for diversion programs that clarify and outline the roles, responsibilities, and actions of my staff and those of our criminal justice partners?

☐ Do I or my leadership team have a direct connection or relationship with each of my criminal justice partners, including law enforcement, jail administration, and the judiciary for each county in my service area?

☐ Do I understand the challenges experienced by criminal justice partners in working with my organization as well as in utilizing my crisis and diversion programs?

Additional Resources:

- Principles of Community-based Behavioral Health Services for Justice-involved Individuals: A Research-based Guide | SAMHSA Publications and Digital Products
- Tailoring Crisis Response and Pre-Arrest Diversion Models for Rural Communities | SAMHSA Publications and Digital Products
- Forensic Assertive Community Treatment (FACT): A Service Delivery Model for Individuals with Serious Mental Illness Involved with the Criminal Justice System | SAMHSA
- How to Successfully Implement a Mobile Crisis Team | Council of State Governments Justice Center
- Building a Comprehensive and Coordinated Crisis System | Council of State Governments Justice Center
- Justice and Mental Health Collaboration Program Implementation Science Checklist Series | Council of State Governments Justice Center
- Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies | National Association of State Mental Health Program Directors
- Data Collection Across the Sequential Intercept Model: Essential Measures | SAMHSA

This document is not intended to expand the requirements in the Statement of Work of the LMHA/LBHA’s Performance Agreement with HHSC.

1 Tex. Health & Safety Code Section 573.001 provides peace officers with broad discretion to make a warrantless apprehension of a person with mental illness, regardless of age, when the officer has reason to believe and does believe that because of the mental illness “there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained.” This belief may be based on information provided by a credible person, the apprehended person’s conduct; or the circumstances under which the apprehended person is found. If a warrantless apprehension is made, peace officers must:

Transport the individual to the nearest appropriate inpatient mental health facility or a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available OR Transfer the apprehended person to emergency medical services personnel of an emergency medical services provider in accordance with a memorandum of understanding executed under Texas Health & Safety Code 573.005 for transport to the nearest appropriate mental health facility or, if one is not available, to a mental health facility deemed suitable by the local mental health authority.

Pursuant to Texas Health & Safety Code Section 573.002, give notice of detention to the facility using Notification of Emergency Detention form; without notice, the facility may not hold the person involuntarily.

2 When a person is processed into correctional institutions, facility personnel run a CCQ and receive an alert which identifies if the individual has a history of receiving mental health services from state-funded mental health programs.
What’s My Role to Eliminate the Wait for Competency Restoration Services?

Police officers are the gatekeepers of the criminal justice system. Texas law has granted peace officers discretion in diverting people with a mental illness (MI), substance use disorder (SUD), or an intellectual or developmental disability (IDD) from the criminal justice system without arrest, when appropriate. By doing this, peace officers help ensure that criminal justice system resources are focused on people who truly pose a threat to public safety, thus decreasing the number of people who enter the criminal justice system and reducing demand for inpatient competency restoration services.

1. Plan for a Pre-Arrest Diversion and Crisis Response
   - Have I identified pre-arrest diversion and crisis response models that will work for my agency and community (e.g., Crisis Intervention Team training; law enforcement and mental health co-response; clinician and officer remote evaluation programs; or other interdisciplinary mobile crisis response teams) and developed policies and procedures to support the implementation of these models?
   - Do I have a single representative (ideally senior level) that is responsible for overseeing and managing pre-arrest diversion and/or crisis response programs?
   - Are policies and procedures in place for crisis responses that clarify and outline the roles, responsibilities, and actions of my staff and those of our behavioral health partners?
   - Do I have inter-agency memoranda of understanding, policies, procedures, and/or agreements to help guide referrals from my agency to local behavioral health providers?
   - Do I collect data to help improve pre-arrest and crisis response programs?

2. Create a Culture of Diversion First
   - Do I communicate to my officers the importance of diverting people with MI, SUD, or IDD, when appropriate, from the criminal justice system and connecting them to treatment?
   - Do I have an agency policy for interactions with people who have MI, SUD or IDD?
   - Per Tex. Code Crim. Proc. Art.16.23(a), are my officers aware that they must make a good-faith effort to divert a person (1) suffering a mental health crisis or (2) suffering from the effects of substance abuse to a proper treatment center in the agency’s jurisdiction if:
     1) there is an available and appropriate treatment center in the department’s jurisdiction to which the agency may divert the person;
     2) it is reasonable to divert the person;
     3) the offense that the person is accused of is a misdemeanor, other than a misdemeanor involving violence; and
     4) the mental health crisis or substance abuse is suspected to be the reason the person committed the alleged offense.
   - Per Tex. Code Crim. Pro. Art. 14.035, are my officers aware of the alternative to arrest release locations for an individual with IDD?
   - Are my officers aware of the scope of their discretion and responsibilities for an emergency detention without a warrant under Tex. Health & Safety Code § 573.001?
   - Do I actively work across my organization and with local partners to troubleshoot and address barriers to diversion?
3. Lead Through Partnerships

- Does my agency coordinate, communicate, and collaborate with behavioral health partners?

- Do I or my staff participate in local planning boards and workgroups focused on issues at the intersection of behavioral health and criminal justice?

- Am I aware of diversion programs available through my Local Mental Health Authority (LMHA), Local Behavioral Health Authority (LBHA), and Local Intellectual and Developmental Disability Authority (LIDDA), including crisis hotlines, mobile crisis response, mental health deputies, co-responder teams, and other similar programs?

- Have I developed relationships with a broad range of behavioral health partners, including service providers, advocates, substance use treatment providers, housing officials, hospital and emergency room administrators, and other criminal justice personnel?

- Have I explored options at the point of 911 call-taking and dispatch to support pre-arrest diversion and improve behavioral health crisis response?

- Do I receive training from my LMHA, LBHA, or LIDDA on Mental Health First Aid, a national program to teach the skills to respond to the signs of mental illness and substance use?

- Do I or my leadership team have a direct connection or relationship with my LMHA, LBHA, or LIDDA leadership and other local behavioral health experts?

- Do I understand the challenges experienced by behavioral health treatment providers in working with my agency?

Additional Resources:

- Request Technical Assistance through the Council for State Governments Justice Center: Law Enforcement-Mental Health Learning Site Program
- Police-Mental Health Collaboration (PMHC) Toolkit | Bureau of Justice Assistance
- Mental Health | International Association of Chiefs of Police
- Law Enforcement Mental Health Support Center | Council of State Governments Justice Center
- Police Mental Health Collaboration Self-Assessment Tool | Council of State Governments Justice Center
- Sharing Behavioral Health Information within Police-Mental Health Collaborations | Council of State Governments Justice Center
- Police-Mental Health Collaborations: A Framework for Implementing Effective Law Enforcement | Council of State Governments Justice Center
- Responses for People Who Have Mental Health Needs | Council of State Governments Justice Center
- Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies | National Association of State Mental Health Program Directors
- Data Collection Across the Sequential Intercept Model: Essential Measures | Substance Abuse and Mental Health Services Administration

Tex. Health & Safety Code Section 573.001 provides peace officers with broad discretion to make a warrantless apprehension of a person with mental illness, regardless of age, when the officer has reason to believe and does believe that because of the mental illness “there is a substantial risk of serious harm to the person or to others unless the person is immediately restrained.” This belief may be based on information provided by a credible person, the apprehended person’s conduct; or the circumstances under which the apprehended person is found. If a warrantless apprehension is made, peace officers must:

- Transport the individual to the nearest appropriate inpatient mental health facility or a mental health facility deemed suitable by the local mental health authority, if an appropriate inpatient mental health facility is not available
- Transfer the apprehended person to emergency medical services personnel of an emergency medical services provider in accordance with a memorandum of understanding executed under Texas Health & Safety Code 573.005 for transport to the nearest appropriate mental health facility or, if one is not available, to a mental health facility deemed suitable by the local mental health authority.

Give notice of detention to the facility using Notification of Emergency Detention form; without notice, the facility may not hold the person involuntarily.
ELIMINATE the WAIT

What’s My Role to Eliminate the Wait for Competency Restoration Services?

SHERIFFS AND JAIL ADMINISTRATORS

Sheriffs and jail administrators play a critical role in improving the competency restoration process. When appropriate, they can reduce further involvement with the criminal justice system and the need for competency restoration services through jail diversion; early identification of people with a mental illness (MI), substance use disorder (SUD), or intellectual and developmental disability (IDD); and timely interventions, like connection to treatment. Provision of behavioral health services and medications while a person is incarcerated may increase the likelihood that a person’s symptoms improve and reduce the potential for mental health deterioration that may lead to findings that they are incompetent to stand trial.

1. Identify MI, SUD, and IDD and Provide Treatment and Services in Jail Settings

☐ Am I in compliance with state and federal laws to provide medical care to inmates, including mental health treatment?
  ☐ Do I provide access to 24/7 telemental health? Tex. Gov’t Code § 511.009(a)(19).
  ☐ Do I provide their prescription MH medications as required by law? Tex. Gov’t Code § 511.009(d).
  ☐ Do I provide mandatory prescription review by qualified professional asap? Tex. Gov’t Code § 511.009(d); 37 Tex. Admin. Code Ch. 273.2(12).

☐ Am I aware that the Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) may be able to provide independently contracted correctional mental health care in my jail, in addition to crisis screenings and assessments already provided?

☐ Am I, and are my staff, familiar with Code of Criminal Procedure (CCP) Article 16.23 and the good faith effort required to divert individuals suffering from MI, IDD, or SUD?

☐ Am I familiar with the statutory requirements under the CCP Article 16.22 (requirements first enacted under the Sandra Bland Act)?
  ☐ Do I have a policy on prescriptions in jail that is shared with defense attorneys to assist in getting timely information to provide medication?
  ☐ Am I aware that I am responsible for the medical records of a defendant while that defendant is confined in my jail? If so, do I have appropriate procedures surrounding the collection and maintenance of the 16.22 reports, as now required under CCP 16.22 (b-1)?

☐ Do I have a process in place to facilitate court-ordered medications?
  ☐ Do I ensure my medical contracts encompass providing court-ordered medications and requesting orders for medication when needed?

☐ Do I have standard operating procedures in place delineating the process for providing timely written or electronic notice to a magistrate of credible information that may establish reasonable cause to believe that a person has a MI or IDD? Tex. Code Crim. Proc. art. 16.22(a)(1).

☐ Do my correctional staff conduct the mandatory Continuity of Care Query1 (CCQ) for every person at booking and do I have a process in place for notifying my LMHA, LBHA, or LIDDA if there is a match?

☐ Do my correctional staff provide MI, SUD, and suicide screenings for every person at booking? 37 Tex. Admin. Code § 273.5

☐ Do I have a standard operating procedure in place to screen individuals for mental illness after booking if a mental illness is later suspected?

2. Provide Care and Coordination with Courts and State Hospitals for People Found Incompetent to Stand Trial

☐ Do I work with my LMHA or LBHA to monitor people on CCP 46B commitments?

☐ Have I discussed operating a Jail-Based Competency Restoration program with my LMHA/LBHA?

☐ Do I ensure that once a person is returned to my jail after restoration at a state hospital, I continue to provide medication prescribed by the state hospital and mental health services to prevent deterioration prior to an appearance in court per CCP 46B.0825?
3. Lead Through Partnerships

- Does my agency coordinate, communicate, and collaborate with mental health partners, including judges, the state, and defense attorneys?
- Do I or my staff participate in local planning boards and workgroups focused on issues at the intersection of mental health and criminal justice?
- Am I aware of diversion programs available through my LMHA/LBHA, including crisis hotlines, mobile crisis response, mental health deputies, co-responder teams, and other similar programs?
- Do I receive training from my LMHA/LBHA on Mental Health First Aid, a national program to teach the skills to respond to the signs of mental illness and substance use?
- Do I, or my leadership team, have a direct connection or relationship with my LMHA/LBHA leadership and other qualified local mental health experts?
- Do I, or my leadership team, have a direct connection with the courts and/or mental health court liaisons?
- Do I understand the challenges experienced by behavioral health treatment providers in working with my agency?
- Have I developed a relationship with the qualified mental health experts used by magistrates in my community for 16.22 evaluations?
- Do I accept and disclose information about defendants with MH/IDD challenges, to serve the purposes of continuity of care and services as permitted by Health & Safety Code §614.017?

Additional Resources:

- Request Technical Assistance from the National Institute of Corrections on providing mental health care in jails.
- Managing Mental Illness in Jails: Sheriffs are Finding Promising New Approaches | Police Education and Research Forum
- Jails: Inadventent Health Care Providers, How County Correctional Facilities are Playing a Role in the Safety Net | Pew Charitable Trusts
- Mentally Ill Persons in Corrections | National Institute of Corrections
- Resources for Interactions between Law Enforcement and Individuals with Mental Health Issues | NATIONAL SHERIFFS' ASSOCIATION
- Standards of Care: Mental Health in Our Jails and Prisons...Now What? | Justice Clearinghouse
- Data Collection Across the Sequential Intercept Model: Essential Measures | SAMSHA
- Just and Well: Rethink How States Approach Competency to Stand Trial | The Council of State Governments Justice Center

1When a person is processed into correctional institutions, facility personnel run a TLETS CCQ and receive an alert that identifies if the individual has a history of receiving mental health services or IDD services from state-funded mental health/IDD programs. An exact or probable match from the CCQ serves as credible information.
Judges play an essential role in helping eliminate the wait for competency restoration (CR) services. By leading and facilitating the collaboration of parties, courts can connect people with the appropriate mental health treatment and services. Furthermore, Judges ensure the legal system is more just, compassionate, and fair by promoting practices that help those with mental illness (MI) and Intellectual and Developmental Disabilities (IDD) receive the necessary treatment to prevent recidivism, thus balancing community needs and judicial economy.

1. Identify and Meet Mental Health and IDD Needs at the Earliest Point
   □ Do I receive timely notice of credible information from jail administration that may establish reasonable cause to believe that an individual is a person with MI or IDD? Tex. Code Crim. Proc. (CCP) art. 16.22(a)(1).
   □ Do I (or the Magistrate Judge) order the 16.22 Interview if reasonable cause is found (from the jail admin or from an alternative source)?
   □ Have I, or has my county, developed a process for effective and efficient ordering, collecting, distributing, and consideration of 16.22 requests, interviews, and reports?
   □ Is this process written in a procedure manual for others to follow in the future?
   □ Do I (or the magistrate judge) appoint an attorney (if applicable) as soon as possible?
   □ If MI or IDD is evident, am I appointing someone with training and experience on mental health (MH) and IDD and related legal issues?
   □ Am I in communication with my Sheriff about the issues that arise in my court if the jail does not ensure individuals in custody:
     □ Have access to 24/7 telemental health and telehealth? Tex. Gov’t Code § 511.009(a)(19).
     □ Are being provided their prescription MH medications as required by law? Tex. Gov’t Code § 511.009(d).
   □ Have I considered utilizing a MH liaison position in the courts to connect with the jails and treatment providers, and to coordinate between courts with criminal jurisdiction and those with probate jurisdiction over civil commitments?
   □ Does my Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) have a MH liaison already? Is my court able to communicate with this person effectively and quickly regarding specific cases and dockets?
   □ Have I developed a specialty court as required under Tex. Gov’t Code § 125.005?

2. Create a Culture of Diversion First
   □ Are the 16.22 Reports and risk assessments being used for decisions about bail, appointment of counsel, treatment, specialty courts, & community supervision conditions? CCP art. 16.22(c)(3) - (5).
   □ On misdemeanor cases, am I considering treatment or diversion alternatives first, and using competency evaluations only as a last resort when alternatives are not available or appropriate?
   □ Are diversion alternatives being considered for individuals when appropriate?
   □ Have I considered outpatient or inpatient MH treatment instead of competency restoration? Has the option for Outpatient Competency Restoration (OCR) been discussed with Defense and State?
   □ If the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person, have I considered CCP art. 16.22(c)(5) to release the defendant (D) on bail with charges pending, enter an order transferring D to the appropriate court for court-ordered outpatient mental health services under Tex. Health & Safety Code ch. 574? CCP art. 16.22(c)(5); HSC 574.0345.

3. Consider Alternatives to State Hospital if CR is Necessary
   □ Am I aware that competency restoration services (CRS) are not comprehensive mental health treatment?
     □ The goal of CR is to return the client to a competent state that would allow resumption of the adjudication process. While symptoms of mental illness may be reduced during the client’s time in CR services, CR is not a substitute for comprehensive MH treatment.
   □ Have I considered Outpatient Competency Restoration or Jail-Based Competency Restoration in lieu of inpatient CR? CCP art. 46B.071.
   □ I am aware if OCR and JBCR is available in my community. If not available, am I aware of what I can do to advocate for the creation of one or both in my community?
   □ Upon an indication of restoration, have I approved funding for the defendant to be re-evaluated after stabilization to see if D is still incompetent CCP art. 46B.0755?
4. Create Efficient Court Policies for People who Receive Inpatient CR Services at the State Hospital (SH)

☐ Have I assigned one point-of-contact between my Court and the SH?

☐ Have I sent a letter annually to the SH notifying them of my point-of-contact, who should receive all communication (name, email address, fax, and phone)?

☐ Have I established an efficient process for communicating with the SH using email?

☐ Does my Court coordinate with the probate court to have medication proceedings when applicable, and start medication orders immediately, while the person awaits transport to SH? See Health & Safety Code § 574.106 (MI); § 592.156 (IDD); CCP art. 46B.086.

☐ If D is on court ordered medications, have I ordered a check for evidence of immediate restoration under CCP art. 46B.0755?

☐ Do I schedule status conferences periodically, as needed, while the client is at SH? Do I urge the Defense and State Attorneys to continue to work on the case while waiting for the individual to return from SH?

☐ Do I coordinate bench warrants to and from the SH?

☐ To prevent decompensation, does my court set cases preferentially when an individual has been restored to competency under CCP 46B.084 and returned to my county? CCP art. 32A.01.

☐ Does the point-of-contact communicate with my coordinator to set the person on a docket quickly upon returning from the SH or other CR program?

5. Leading through Partnerships

☐ Has my Court gathered key stakeholders to meet regularly to improve communication regarding diversion?

☐ Has my community planned and established co-located services?

☐ Are the agencies and individuals listed in Health & Safety Code § 614.017 Exchange of Information accepting and disclosing information about defendants with mental health/IDD challenges, including jails, LMHAs, attorneys, judges, probation, TDCJ, and others?

6. Education and Awareness

☐ Do I require training for the defense bar on best practices for clients with MH/IDD including identification, interaction, protections in Texas law, and diversion options? Have I considered partnering with JCMH, or other appropriate attorney educator to create needed training?

☐ Do I foster an open dialog about the common misunderstandings associated with Competency Restoration Services (CRS)?

☐ Many times, requests for competency evaluations are attributable to a well-intended, but inaccurate, understanding of CRS. Some view CR as a method for connecting individuals to mental health treatment.

☐ The reality, however, is that CRS are narrowly focused on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and services with the goal of long-term recovery and a positive place in the community.

☐ Does my Court utilize a list of attorneys with specialized knowledge in MH or IDD for complex cases?

☐ Do I have a separate fee schedule to pay attorneys with specialized MH/IDD knowledge more for handling these types of cases?

☐ Is my referral process to a mental health court in written form and shared with referral sources?

☐ Who are the referral sources (e.g., prosecutors, defense attorneys, judges)? Are they familiar with identification of individuals with mental illnesses and understand potential judicial responses?

☐ Are all the judges and attorneys in my community aware of the diversion options?

☐ Is my policy of preferential settings for cases in which an individual has been restored to competency and returned to the county written for lawyers to know and abide by the procedures? CCP art. 32A.01

Additional Resources:

What’s My Role to Eliminate the Wait for Competency Restoration Services?

**PROSECUTORS**

Prosecutors play a critical role in helping to eliminate the wait for competency restoration (CR) services. If appropriate, diversion and connection to treatment is ideal to reduce further penetration into the criminal justice system and the need for CR services. Provision of mental health (MH) services and medications while a person is incarcerated may increase the likelihood that the person’s symptoms improve, reducing the likelihood that the person is found incompetent to stand trial (IST), or leading to the immediate restoration of a person previously found incompetent to stand trial.

1. **Identify and Meet Mental Health and IDD Needs at the Earliest Point**
   - Does Magistrate Judge order a 16.22 Interview if reasonable cause is found? Does the Magistrate Judge send me a copy of the Collection of Information Report (16.22 Report) in a timely manner?
   - Is there a mechanism in place for the 16.22 reports to be maintained and then sent to the trial court and defense attorney once they are assigned? CCP art. 16.22(b-1).
   - Do I suspect MH or IDD issues while reviewing discovery? Have I noted this in the file? Have I brought this to the attention of the defense attorney? Do I take this into account when deciding the disposition of the case and alternatives offered?
   - Do I participate and attend collaborative meetings with key personnel to review cases and address MH and IDD issues early in the process?

2. **Work Toward Diversion First**
   - Have I reviewed the case and determined if a case should be filed and, if so, at what charging level? Did I consider MH issues or IDD during this process?
   - Have I considered a defendant’s 16.22 report and risk assessments in my decisions about bail, jail diversions, treatment, and community supervision conditions? Tex. Code Crim. Proc. (CCP) art. 16.22(c)(1) - (5).
   - Can I agree to a reasonable bond amount and appropriate bond conditions? Or for a non-violent offense/prior, a PR Bond? CCP art. 17.032; 17.03.
   - If I am recommending that a defendant is released on personal bond, have I consulted with the defense attorney to determine what, if any, conditions are reasonable, helpful, and doable in this person’s circumstances?

- Am I aware that competency restoration services (CRS) are not comprehensive mental health treatment?
  - CRS are narrowly focused on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and services with the goal of long-term recovery and a positive place in the community.
  - During negotiations and discussions with the defense attorney, am I open to options other than a competency evaluation? For example:
    - Can I agree to inpatient or outpatient mental health treatment instead of sending the defendant to the state hospital (SH) for inpatient competency restoration?
    - If the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person, can I agree to using CCP 16.22(c)(5) to leave charges pending in criminal court and divert the defendant to the appropriate civil court for court-ordered outpatient mental health services under Tex. Health & Safety Code ch. 574? CCP art. 16.22(c)(5); HSC 574.0345.
    - Is this a case suitable for a straight dismissal under CCP art. 46B.004(e)?

- Have I considered the possibility of dismissal with:
  - a treatment plan;
  - a referral to outpatient mental health services;
  - a referral to an assisted outpatient treatment program (with or without civil/probate court supervision); or
  - a transfer to appropriate court to commence civil commitment proceedings? CCP art. 46B.151; Tex. Health and Safety Code ch. 571, 574.
3. Consider Alternatives to State Hospital if Competency Restoration is Needed

- Have I considered Outpatient Competency Restoration (OCR) or Jail-Based Competency Restoration (JBCR) as an alternative to inpatient and/or SH competency restoration? CCP art. 46B.071.
- I am aware if OCR and JBCR is available in my community? If not available, what can I do to advocate for either or both in my community?

4. Continue to Work on Cases when the Defendant Must Wait for Inpatient CR Services at the SH

- Am I continuing to communicate with the defense attorney while the defendant awaits transfer to the SH?
- Have I considered what evidence might fall under the Michael Morton Act specific to MH or IDD cases and produced all evidence that is material to any matter involved in the action? Have I subpoenaed relevant medical, psychological, or education records of the defendant?
- Have I considered what constitutes Brady in mental health and IDD cases and produced all evidence to the defense that is in possession of the State and tends to negate the defendant’s guilt or mitigate their punishment? Have I reviewed the defendant’s previous cases for information, records, or orders that should be produced to the defense?
- Am I working with the court and defense counsel to obtain a fast court setting upon the defendant’s return from SH or another CR program to prevent decompensation? Have I requested a preferential case setting under CCP art. 32A.01?
- Am I advocating that the defendant receive mental health treatment in custody while awaiting transfer to or after returning from SH?
- If necessary, have I filed an application with the probate or other appropriate court to order the administration of medications in custody to help prevent deterioration (or coordinated with the county attorney to file the application)? Health & Safety Code § 574.106 (MI) or § 592.156 (IDD); CCP art. 46B.086.
- If the Defendant is on court ordered medications, have I requested another competency evaluation after stabilization or a check for evidence of immediate restoration under CCP art. 46B.0755?
- Is this case one where the defendant is unlikely to restore per 46B.071(b)? Have I considered proceeding under Health & Safety Code subchapters E or F (civil commitment with charges pending or dismissed)?
5. Create Education and Awareness

☐ Have I been trained on best practices for cases where a D has MI/IDD including identification, interaction, protections in Texas law, and diversion options? Consider working with JCMH or other appropriate attorney educator for needed training.

☐ Does my office actively discuss educational resources, community resources, and court practices and procedures for individuals with MI or IDD?

☐ Am I communicating with my office about my successes in diversion techniques for individuals with MI or IDD?

6. Lead Through Partnerships

☐ Am I regularly engaging with the LMHA, LBHAs, LIDDAs, other prosecutor’s offices, the defense bar and/or public defenders or managed counsel offices, pretrial services, probation, and the courts to meet formally and regularly to improve communication, policies, and procedures regarding mental health / IDD diversion?

☐ Are the agencies and individuals listed in Health & Safety Code § 614.017, Exchange of Information, accepting and disclosing information about defendants with mental health/IDD challenges, including jails, LMHAs, LBHAs, LIDDAs, attorneys, judges, probation, the Texas Department of Criminal Justice, and

Additional Resources:

What's My Role to Eliminate the Wait for Competency Restoration Services?

**Defensive Attorneys**

*Defensive Attorneys can help eliminate the wait for competency restoration (CR) services. With best practices and current policies, defensive attorneys advocate for their clients to receive mental health treatment, find an amicable resolution to the case, and prevent their clients from languishing in jail waiting for inpatient CR services. By focusing on these goals for their individual clients, defensive attorneys contribute to the overall effect of reducing the total number of people on the competency restoration waitlist.*

1. Identify and Meet Mental Health (MH) and Intellectual and Developmental Disabilities (IDD) Needs at the Earliest Point

- Is the Magistrate Judge ordering a 16.22 Interview if reasonable cause is found?
- If I believe my client needs a 16.22 interview, am I asking the Magistrate to order one?
- Am I receiving a copy of the Collection of Information Report (16.22 Report) in a timely manner?
- Am I meeting with my client as soon as possible?
- At this meeting, am I asking my client about their MH and IDD history?
- To the greatest extent possible, am I exploring with my client the risks and benefits of all possible options, to include making a choice about whether the client wants to address their MH issues as a part of this criminal process or not?
- If necessary, am I re-visiting a client to re-evaluate their mental state if circumstances change?
- Am I asking my clients if they are receiving their prescription medications in jail? *Tex. Gov't Code § 511.009(d).*
- If my client is not receiving their medication, am I communicating with the jail, magistrate, and trial court about this issue?
- Have I established communication with the jail MH liaison to get updates about my client and relay information for the client’s benefit?
- Do I ensure that my client and/or their family knows how to provide proof of client's valid prescription to the jail?
- Am I considering poverty, cultural differences, and language differences when determining whether to raise issues related to MH, IDD or competency?
- Have I investigated whether my client was ever previously found incompetent to stand trial and the subsequent procedural history?

2. Work Toward Diversion First

- Am I knowledgeable about local MH & IDD resources?
- Have I established a contact within my LMHA, LBHA, and/or LIDDA?
- Am I working closely with my LMHA/LBHA/LIDDA or mental health jail/court liaison to discuss alternatives to incarceration available in my community?
- If my client has not been charged with or previously convicted of a violent offense, have I advocated for my client’s release on a MH personal bond? *CCP art. 17.032; 17.03.*
- During bond hearings, do I use my client’s 16.22 report and risk assessments to advocate for my client on decisions about bail, diversion, treatment, and possible community supervision conditions? *Tex. Code Crim. Proc. (CCP) art. 16.22(c)(1) - (5).*
- If my client is being released on personal bond, have I made arrangements to ensure that the client has the transportation and other supports necessary to adhere to bond conditions?
- Am I aware that competency restoration services (CRS) are not comprehensive MH treatment?
- CRS are narrowly focused on stabilization, symptom management, and required legal education. This is not the same as providing access to a fully developed treatment plan and services with the goal of long-term recovery and a positive place in the community.
- If my client wants to pursue MH treatment as part of their criminal court process, am I zealously advocating for it?
- Have I made sure the prosecutor understands the distinction between CRS and comprehensive MH treatment?
- Have I advocated for the court and prosecutor to consider outpatient or inpatient MH treatment instead of competency restoration for my client?
ELIMINATE the WAIT

3. Consider Alternatives to State Hospital if CR is Necessary

☐ Have I considered, or asked the Court to consider Outpatient Competency Restoration (OCR) or Jail-Based Competency Restoration (JBCR)? CCP art. 46B.071.

☐ I am aware if OCR and JBCR is available in my community? If not available, what can I do to advocate for either or both in my community?

☐ Do I work with my LMHA/LBHA ahead of the competency hearing to create an OCR plan before the hearing? CCP art. 46B.072.

☐ Have I specifically made the request for OCR or JBCR on the record?

☐ Have I specifically requested these alternatives in my motion and proposed order?

4. Continue to Advocate for Individuals Who Must Wait for Inpatient CR at the State Hospital (SH)

☐ Am I continuing to communicate with my client while they are awaiting transfer to SH to determine if they may have stabilized while waiting in jail (with appropriate MH treatment) to see if incompetency is still an issue in the case? See TEX. DISCIPLINARY RULES OF PRO. CONDUCT, R. 1.16 Clients with Diminished Capacity.

☐ If stabilization has occurred before transfer, have I requested another competency evaluation or a check for evidence of immediate restoration under CCP art. 46B.0755?

☐ Am I advocating for mental health treatment for my client while they are awaiting transfer to SH or other CR program?

☐ Am I continuing to communicate with my client once they go to the SH? See TEX. DISCIPLINARY RULES OF PRO. CONDUCT, R. 1.16, Clients with Diminished Capacity.

☐ Am I continuing to progress this case and communicate with the prosecutor while waiting for my client to return from the SH?

☐ Am I communicating with the SH regarding the direct release of my client? Do I work with my LMHA, LBHA, prosecutor, and court to make a plan to set PR bond and have my client released from SH to community living arrangement?

☐ If strategically appropriate, and I believe my client is competent, am I working with my court to obtain a fast court setting upon my client’s return from SH, or other CR program? Have I requested a preferential setting under CCP art. 32A.01? If necessary, have I filed a motion for a speedy trial under art. 32A.01?

☐ If the offense charged does not involve an act, attempt, or threat of serious bodily injury to another person, have I used the 16.22 report to advocate for CCP 16.22(c)(5) diversion, which leaves charges pending in criminal court and diverts the defendant to the appropriate civil to the appropriate court for court-ordered outpatient MH services under Tex. Health & Safety Code ch. 574? CCP art. 16.22(c)(5); HSC 574.0345.

☐ Have I tried negotiating for a dismissal with:
  ☐ a treatment plan;
  ☐ a referral to outpatient MH services;
  ☐ a referral to an assisted outpatient treatment program (with or without civil/probate court supervision); or
  ☐ a transfer to appropriate court to commence civil commitment proceedings? CCP art. 46B.151; Tex. Health & Safety Code ch. 571, 574.

☐ Am I only using CR when it is necessary and the best resolution for my client that does not cause unnecessary delay or harm to my client? ABA STANDARDS RELATING TO COMPETENCE TO STAND TRIAL § 7-4.2(e) (1989).

☐ Have I considered using Ake v. Oklahoma, 470 U.S. 68, 71 (1985), (possibly ex parte with a sealed motion) for appointment of an expert for psychological assessments instead of going down the CR path to achieve the same goals, evaluations, or evidence?

☐ If necessary, am I requesting funding from the court for psychological evaluations (rather than competency evaluations) for decisions about trial, sentencing, and community supervision?

☐ Am I meeting my burden of proof (BOP) / holding the state to their BOP?
  ☐ Typically, there is a presumption that the defendant is competent, and defense must prove incompetency by a preponderance of the evidence. CCP 46B. 003(b); Dusky v. U.S., 362 U.S. 402 (1960).

☐ If client has a previous, unvacated Incompetent to Stand Trial (IST) finding, was committed for restoration, and was found not likely to be restored, then client is presumed incompetent, and state must prove competency Beyond a Reasonable Doubt. Manning v. State, 730 S.W.2d 744 (Tex. Crim. App 1987).

☐ If the prosecution agrees to dismiss my client’s case, have I communicated this with my client and assisted with a discharge plan or transportation upon release? Have I made the prosecution and the court aware of the need to communicate and coordinate with the client, so they are not abruptly released without understanding what happened or transportation or plan?
5. Leading Through Partnerships

□ Am I regularly engaging with the LMHA, Prosecutor’s offices, other defense bar and/or public defenders or managed counsel offices, pretrial services, probation, and the courts to meet regularly to improve communication, policies, and procedures regarding mental health/IDD diversion?

□ Are the agencies and individuals listed in Health & Safety Code § 614.017, Exchange of Information, accepting and disclosing available information about defendants with MH/IDD challenges, including jails, LMHAs, LBHAs, LIDDAs, attorneys, judges, probation, the Texas Department of Criminal Justice, and others?

□ Am I monitoring my client’s cumulative period (in custody, SH, inpatient CR, JBCR) to see if they have reached their maximum period of confinement under CCP art. 46B.0095?

□ Am I working to make sure my client continues to receive their prescription medications while in custody after returning from SH? Tex. Gov’t Code § 511.009(d).

6. Education & Awareness

□ Have I been trained on best practices for clients with MH/IDD including identification, interaction, protections in Texas law, and diversion options? Consider attending JCMH, or other appropriate attorney educator CLEs for needed training.

□ Does my defense bar, public defender office (PDO), or managed assigned counsel program (MAC) actively discuss education resources, community resources, and court practices and procedures to benefit clients with mental illness or IDD?

□ Am I communicating with my defense bar, Public Defenders Office, or Managed Assigned Counsel about my successes in diversion techniques for clients with mental illness or IDD?

Additional Resources:

- CMHS National Gains Center, Practical Advice on Jail Diversion: Ten Years of Learnings on Jail Diversion from the CMHS National GAINS Center (2007).
  [http://www.pacenterofexcellence.pitt.edu/documents/PracticalAdviceOnJailDiversion.pdf](http://www.pacenterofexcellence.pitt.edu/documents/PracticalAdviceOnJailDiversion.pdf)
- Alyse Ferguson, Chief Attorney, Collin County Mental Health Managed Counsel, Practical Ideas for Counties to Streamline Competency Restoration and Save Money (2020)
What is Health and Human Services doing to Eliminate the Wait for Competency Restoration Services?

While a full array of community-based services can reduce the need for inpatient care, the Texas Health and Human Services Commission’s (HHSC) State Hospital System (SHS) is a critical component of the behavioral health continuum of care, providing inpatient psychiatric care to adults in nine of its state psychiatric hospitals. The state hospitals serve people with various mental health (MH) needs, including forensic patients who have been determined to be incompetent to stand trial or acquitted as not guilty by reason of insanity, and civil patients who are at risk of harming themselves or others or at risk of significant deterioration. HHSC is working to transform and modernize the delivery of inpatient psychiatric care and services at the state hospitals through several major initiatives, including expanding state hospital capacity and renovating and replacing the state hospital infrastructure. In addition, HHSC has prioritized efforts to transform the delivery of inpatient psychiatric forensic care and services by implementing strategies that achieve treatment and operational efficiencies and change.

State Hospital System Initiatives

The SHS is implementing initiatives that will improve the efficiency and quality of the delivery of forensic services within the SHS while enhancing collaboration with external stakeholders. As described below, these initiatives use a variety of strategies that have direct and/or indirect impacts on the SHS’s waitlist and/or forensic patient lengths of stay.

Collaboration and Coordination

Waitlist and Admissions Management

Collaborating with stakeholders across the behavioral health and justice continuum of care to actively manage the forensic waitlist to:

- identify individuals committed to the SHS who may benefit from alternative dispositions [e.g. individuals with neurocognitive disorders (dementia), Intellectual and Developmental Disabilities (IDD) diagnoses, medical comorbidities, or found not likely to restore within the foreseeable future], and
- educate, coordinate and provide technical assistance, including the evaluation of cases, to jail staff, district attorneys, defense counsel, and the judiciary, as needed.

Jail In-Reach Learning Collaborative

Educating and collaborating with external stakeholder community-based teams to support active forensic waitlist monitoring of individuals awaiting in jail for state hospital admission and court-ordered competency restoration through:

- clinical consultation services that may assist with psychiatric stabilization,
- trial competency re-evaluations in the event of immediate restoration while awaiting state hospital transfer,
- legal education on options for alternative case dispositions, and
- enhanced continuity of care following an individual's restoration to competency and return to jail to prevent clinical decompensation and unnecessary rehospitalization.

Our Partners: Local mental Health Authorities, Local Behavioral Health Authorities, judges, prosecutors, defense attorneys, sheriffs, jail administrators, jail psychiatric providers, and the Judicial Commission on Mental Health’s Community Diversion Coordinators across 13 counties.
Enhancing the Delivery, Quality, and Efficiency of Competency Restoration Services

Competency Restoration Curriculum Standardization

The SHS is developing a simplified and standardized competency restoration curriculum for use at all state hospitals to improve treatment efficiencies and patient movement through the competency restoration process.

Outpatient Management Plan Quality Improvement Initiative

The outpatient management plan (OMP) is a document presented to the court that is used to prescribe the services, supports and requirements a patient must adhere to when transitioning from the SHS to the community. The SHS has developed a simplified and standardized OMP to improve the quality of the plans so that a greater number are approved by the court on the first submission.

Trial Competency Examination Quality Improvement Initiative

To enhance how trial competency evaluations (TCE) are conducted in the SHS, this initiative includes:

- developing and implementing a standard report form that allows for the SHS to extract necessary forensic data found in the TCEs,
- developing an enhanced pool of qualified forensic evaluators in the SHS by implementing an evaluator registry, and
- implementing a TCE peer review process to improve the quality of TCEs completed in the SHS.

State Hospital System Forensic Treatment Data Enhancement

The SHS has been implementing mechanisms for reporting and collecting accurate forensic-related data, including data from a standardized clinical screening of competency, to help make data-informed decisions and develop data-informed interventions for the continuous quality improvement efforts in the delivery of forensic treatment services.

Additional Resources:

Outpatient Management Plans: Creating a Statewide Approach for Successful Not Guilty by Reason of Insanity (NGRI) Transitions to Community Living (webinar)

HHSC Contact:

Felix Torres, MD, MBA, DFAPA
Chief of Forensic Medicine, State Hospital System
Email: Felix.Torres@hhs.texas.gov
Next Steps

Over the next year, the JCMH and the HHSC will:

- Develop additional resources to support the Eliminate the Wait Campaign.

- Offer Sequential Intercept Model Mapping to communities who seek to better understand how individuals with mental and substance use disorders come into contact with and move through the criminal justice system, with the goal of identifying resources and gaps in services at each intercept and developing local strategic action plans.

- Offer targeted technical assistance to stakeholders who seek support in implementing the Eliminate the Wait checklists.

For more information on how to get involved, visit http://texasjcmh.gov/ & contact forensicdirector@hhs.texas.gov.
Acknowledgements

This report was prepared by the Texas Behavioral Health and Justice Technical Assistance Center (TA Center) on behalf of Texas Health and Human Services Commission (HHSC). The workshop was convened by Judge Daniel O’Brien, Hays County Court-at-Law, #3 and organized by Kaimi Mattila, LCSW, Mental Health Court Administrator. The planning committee members included:

Chief Stan Standridge, San Marcos Police Department; Amy Lowrie, Hill Country MHDD; Sergeant Steve Cunningham, Hays County Sheriff’s Office; Jeffrey Weatherford, Criminal Court District Attorney; Commissioner Walt Smith, Hays County Commissioner; Nichole Mueller, MH Coordinator, WellPath, Hays County Jail; Mark Jones, Precinct 2 County Commissioner; Judge Benjamin Moore, Hays County Judge; Mark Kennedy, General Council; Julie Villalpando, Captain, Hays County Jail; Juan Saenz, Captain, Hays County Jail; Jennifer Scott, Executive Assistant to Commissioner Jones; Donald Lee, San Marcos Police Department; Paula Countryman, Baylor Scott and White; Pam Howard, Ascension Seton Kyle; James Swisher, Hays County EMS; Blythe Long, Emergency Department Manager Baylor Scott and White

The planning committee members played a critical in making the Hays County SIM Mapping Workshop a reality. They convened stakeholders, helped to identify priorities for the workshop, reviewed this report, and provided feedback prior to its publication.

The facilitators for this workshop were Jennie M. Simpson, PhD, Associate Commissioner and State Forensic Director, HHSC and Catherine Bialick, MPAff, Senior Advisor, Office of Forensic Coordination, HHSC. The report was authored by Emily Dirksmeyer, LMSW; Catherine Bialick, MPAff; Matthew Lovitt, MSW; and Jennie M. Simpson, PhD.

About the Texas Behavioral Health and Justice Technical Assistance Center and Texas SIM Mapping Initiative

The TA Center provides specialized technical assistance for behavioral health and justice partners to improve forensic services and reduce and prevent justice involvement for people with mental illnesses (MI), substance use disorders (SUD), and/or intellectual and developmental disabilities (IDD). Established in 2022, the TA Center is supported by HHSC and provides free training, guidance, and strategic planning support both in person and virtually on a variety of behavioral health and justice topics to support local agencies and communities in working collectively across systems to improve outcomes for people with MI, SUD and/or IDD.

The TA Center, on behalf of HHSC, has adopted the SIM as a strategic planning tool for the state and communities across Texas. The TA Center hosts SIM Mapping Workshops to bring together community leaders, government agencies, and systems to identify
strategies for diverting people with MI, SUD and/or IDD, when appropriate, away from the justice system into treatment. The goal of the Texas SIM Mapping Initiative is to ensure that all counties have access to the SIM and SIM Mapping Workshops.

**Recommended Citation**

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Appendix H: SIM Mapping Workshop Participant List

List of Acronyms
Introduction

The Sequential Intercept Model (SIM), developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D.,\(^1\) has been used as a focal point for states and communities to assess available opportunities, determine gaps in services, and plan for community change. These activities are best accomplished by a team of stakeholders that cross over multiple systems, including mental health, substance use, law enforcement, jails, pretrial services, courts, community corrections, housing, health, and social services. They should also include the participation of people with lived experience, family members, and community leaders.

The SIM is a strategic planning tool that maps how people with behavioral health needs encounter and move through the criminal justice system within a community. Through a SIM Mapping workshop, facilitators and participants identify opportunities to link people with MI, SUD, and/or IDD to services and prevent further penetration into the criminal justice system.

The SIM Mapping Workshop has three primary objectives:

1. Development of a comprehensive picture of how people with MI and co-occurring substance use disorders move through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections/Community Support.
2. Identification of gaps and opportunities at each intercept for people in the target population.
3. Development of strategic priorities for activities designed to improve system and service level responses for people in the target population.

In 2022, Judge Daniel O’Brien requested a SIM Mapping Workshop be conducted for Hays County to help foster behavioral health and justice collaborations and improve

diversion efforts for people with MI, SUD and/or IDD. The SIM Mapping Workshop was divided into three sessions: 1) Introductions and Overview of the SIM; 2) Developing the Local Map; and 3) Action Planning. See Appendix A for detailed workshop agenda.

This report reflects information provided during the SIM Mapping Workshop by participating Hays County stakeholders and may not be a comprehensive list of services available in the county. All gaps and opportunities identified reflect the opinions of participating stakeholders, not HHSC.
As part of the mapping activity, facilitators worked with workshop participants to identify services, key stakeholders, gaps and opportunities at each intercept. This process is important due to the ever-changing nature of the criminal justice and behavioral health services systems. The opportunities and gaps identified provide contextual information for understanding the local map. The catalogue below was developed during the workshop by participants and can be used by policymakers and systems planners to improve public safety and public health outcomes for people with MI, SUD, and/or IDD by addressing the gaps and leveraging opportunities in the service system. See Appendix B for a more in-depth overview of Hays County services across each intercept.

### Overview of Gaps and Opportunities

#### Crisis Call Lines

**Gaps**

- The Hill Country MHDD 10-digit crisis line phone number can be difficult to quickly recall for law enforcement, courts, and social service providers.

- Stakeholders expressed confusion on which help/crisis lines to call for which purposes (e.g., Hill County MHDD 10-digit crisis line, 9-8-8, 2-1-1, 9-1-1, etc.).

**Opportunities**

- Hays County can implement a public awareness campaign on the rollout of the new three-digit National Suicide Prevention Lifeline phone number, 9-8-8.
• Hill Country MHDD can work with local stakeholders to ensure that they understand how utilize crisis lines that are available to Hays County.
• Hays County can conduct a public education campaign on how to identify signs or symptoms of a mental health crisis.

**9-1-1/Dispatch**

**Gaps**
• Dispatch call takers screen calls to identify individuals that might be experiencing a mental health crisis but lack training to identify signs or symptoms of a mental health crisis when the caller does not explicitly disclose their mental health status.

**Opportunities**
• Hill Country MHDD can provide Mental Health First Aid and Trauma-Informed Care training to dispatchers in Hays County to improve their ability to identify and respond to mental health crisis calls.
• Hays County and Hill Country MHDD can explore co-locating a mental health professional in the dispatch call center to support mental health crisis call diversion.

**Crisis Services**

**Gaps**
• Hays County lacks an alternative to the emergency department or county jail as a law enforcement drop-off point for people experiencing a mental health crisis.
• Hays County lacks local options for inpatient psychiatric care.
• The Hill Country MHDD Mobile Crisis Outreach Team experiences challenges responding to mental health crisis calls in a timely fashion due to coverage area and other capacity constraints.

**Opportunities**
• San Marcos PD, Kyle PD, Buda PD, and the Hays County Sheriff’s Office may consider requiring more officers to obtain 40-hour mental health certification to help deescalate and divert people experiencing a crisis from the emergency department or jail.
• Hays County can explore opportunities for a mental health crisis diversion center as an alternative to the emergency department or jail.
Healthcare

Gaps

- Hays County residents who are uninsured or underinsured have limited access to detox, inpatient, or outpatient substance use treatment in Hays County.
- The Outreach, Screening, and Referral (OSAR) office for referrals to detox, inpatient, or outpatient substance use treatment is only open on Mondays and operates on an appointment and stand-by basis.
- Hays County lacks a dedicated facility to provide supervised withdrawal for people who are acutely intoxicated.
- Emergency Departments often struggle with providing timely medical clearance prior to inpatient psychiatric hospitalization.

Opportunities

- Hays County can explore opportunities to streamline medical clearance processes in the community, including establishing a community-based paramedic program to provide non-emergent care in the community and medical clearance prior to inpatient psychiatric hospitalization.
- Hays County can explore building a diversion center or sobering center to provide a centralized drop-off point for law enforcement for people experiencing a mental health crisis and those in need of supervised withdrawal from substances.
- Hays County may consider modifying its existing contract with the OSAR office operated by Bluebonnet Trails in Hays County to expand the capacity for substance use treatment referrals for people who are uninsured or underinsured.

Law Enforcement and First Responders

Gaps

- Law enforcement in Hays County lack diversion options for people who may be appropriate to drop-off at a mental health crisis facility in lieu of an emergency department or incarceration.
- Not all law enforcement offices from the Kyle, Buda, San Marcos, Texas State University PDs, and the Hays County Sheriff’s Office have received the full 40-hour mental health training.
• Law enforcement in Hays County lack specialized training on how to respond to people with IDD.

**Opportunities**

• The Mental Health Deputy program may consider conducting “well checks” on people or locations that are flagged for recent or frequent interaction with law enforcement due to mental health crisis.

• Hays County can explore opportunities for a mental health crisis diversion center as an alternative to the emergency department or jail.

• Hill Country MHDD can coordinate with community partners to provide training to law enforcement on responding to individuals with IDD.

• Hays County may consider establishing a multi-disciplinary crisis response team that pairs law enforcement with a mental health clinician and paramedic.

**Housing**

**Gaps**

• Hays County lacks adequate affordable, permanent supportive, transitional, and congregate housing options.

• Hays County lacks housing options for people who are justice-involved.

**Opportunities**

• Hays County can consider conducting a housing assessment to identify the critical housing needs, strategies to meet the county’s housing needs, and identify funding opportunities.

**Peer Support**

**Gaps**

• Counseling services are not available to all those who may benefit in Hays County.

**Opportunities**

• Hill Country MHDD, Hays-Caldwell Women’s Center (HCWC), and other local agencies and non-profits in Hays County may consider employing Peer Specialists to serve people experiencing mental health concerns who may not qualify for counseling services.

• Cenikor may consider seeking additional funding to expand existing or establish new peer-led programs in Hays County.
Data Collection and Information Sharing

Gaps

- Information about people with mental health needs is often not shared between law enforcement and Hill Country MHDD when needed for care coordination.
- Hays County and Hill Country MHDD do not collect or report data on the location of frequent mental health calls or crisis response encounters.
- Law enforcement agencies across Hays County track mental health (MH) crisis calls but lack common definitions, making analyzing trends county-wide difficult.

Opportunities

- Providing training on HIPAA-compliant information sharing between mental health providers and law enforcement for care coordination may increase efficiencies during mental health related calls for service.
- Stakeholders can develop a uniform data collection and reporting strategy to promote data sharing and enable county-wide analyses.
- Hill Country MCOT can collect and report data on frequent crisis response locations.

Overview of Gaps and Opportunities

Booking

Gaps

- The Texas Law Enforcement Telecommunication System Continuity of Care Query (TLETS CCQ) is run at jail booking, but there is limited utilization of that information by Hill Country MHDD and WellPath for service provision and continuity of care.
• The jail conducts universal screenings for MI and SUD and usually sees those that have screened positive for SUD or MI within seven days, however the time between the initial screening and more in-depth assessments, or to be seen by a psychiatrist for those that screen positive, can be prolonged.

Opportunities
• Identify opportunities for Hill Country MHDD and WellPath to utilize the TLETS CCQ to inform treatment, reentry planning and continuity of care for people positively identified through the query.

Jail Medical

Gaps
• High demand for WellPath behavioral health services in the Hays County Jail can mean that people do not receive a mental health assessment until after magistration. All MH referrals are triaged based on the level of need and for those determined to be low priority, the wait for an assessment and psychiatric referral can exceed three to four weeks.
• Court Ordered Medications (COMs) are not included in the Hays County Jail contract with WellPath, and the WellPath psychiatrist will not prescribe involuntary medications.
• The Hays County Jail contracts with WellPath for psychiatric care for 6-8 hours per week, which may mean that people with less acute behavioral health needs must wait multiple weeks for a psychiatry appointment. This also means that WellPath has limited capacity to provide mental health treatment and counseling services inside the jail beyond initial assessments and crisis care.
• Hays County Jail staff do not have the ability to “flag” incidents that occur in the jail as mental health related.
• Substance use disorder treatment is not currently available inside the jail.

Opportunities
• WellPath and Hays County may consider novel employee recruitment initiatives to ensure adequate staffing for timely access to mental health services in the Hays County Jail.
• Hays County can explore opportunities to support WellPath’s efforts to hire and retain qualified staff.
• Hays County may explore opportunities to provide court ordered medications (COMs) to individuals in the Hays County Jail.
• Hays County Sheriff’s Office and WellPath may explore ways to “flag” mental health related incidents that occur in jail.
• Hays County Jail may consider exploring substance use treatment and services that could be offered inside the jail for individuals with SUD and co-occurring disorders.

Competence to Stand Trial

Gaps

• Individuals found incompetent to stand trial (IST) are waiting in county jails for extended periods of time for inpatient competency restoration services.
• Hill Country MHDD has successfully partnered with Travis County to refer individuals found IST to Integral Care’s outpatient competency restoration program, but referrals have been limited.
• Jail-based competency restoration is not currently available in the Hays County Jail.

Opportunities

• Hill Country MHDD and Hays County stakeholders can work with HHSC to provide training on competence to stand trial processes, quality competency evaluations, use of medication reimbursement (pursuant to General Appropriations Act, S.B. 1, Article V, Sec. 35(b), 87th Texas Legislature, Regular Session), active waitlist management, and court-ordered medications.
• Hill Country MHDD and Hays County stakeholders can identify additional opportunities for training and education for judges and prosecutors on alternatives to inpatient competency restoration for people found IST, including strategies to increase referrals to Integral care’s OCR program and dismissing charges and transferring cases to a court with probate jurisdiction for a civil commitment.
• Hays County leadership may engage other counties with JBCR programs to assess if a similar program would be appropriate for Hays County.
• Hays County is a participant in HHSC’s Jail In-Reach Learning Collaborative, and additional judicial stakeholders and jail medical can be included in this effort.

Pretrial Services

Gaps

• Hays County does not operate a specialized mental health pretrial diversion program.
**Opportunities**

- Specialized caseloads for people with MI can be considered at the pretrial stage.
- Hays County may consider ways to promote early appointment of specialized counsel for people with known or acute behavioral health concerns.
- Hays County can increase continuity of care with Hill Country MHDD to provide pretrial mental health services if a specialized caseload is created.

**Courts (Including Specialty Courts)**

**Gaps**

- Defense attorneys do not receive training on the process by which the criminal court can dismiss charges and transfer the person to the appropriate court for a civil commitment.
- Defense attorneys have varying degrees of experience working with people with mental health conditions.
- Resource limitations prevent Hays County from providing comprehensive services and support to people engaged with the Mental Health Court or the Felony Drug Court.
- Hays County has underutilized court-ordered outpatient mental health services as an avenue to treatment for people with behavioral health conditions in the probate court.

**Opportunities**

- Hays County can consider establishing a protocol to discuss advanced psychiatric directives with the Mental Health Court participants.
- Hays County can consider providing dedicated court-appointed attorneys that specialize in mental health.
- Hays County may consider ways to provide training opportunities on utilizing probate courts rather than the criminal courts as an avenue to treatment.

**Data Collection and Information Sharing**

**Gaps**

- Hays County specialty courts have not established a uniform or unified data collection and reporting strategy.
- Key Hays County court stakeholders and elected officials are not provided data on how many people in pretrial are awaiting a competency evaluation in Hays County Jail.
Hays County courts have not developed a streamlined process for reviewing CCP Art. 16.22 reports provided by WellPath mental health staff.

**Opportunities**

- Hays County may consider establishing a centralized data collection and reporting office to facilitate data sharing between mental health and criminal justice entities in Hays County.
- Hays County may consider expanding the established regular meeting for jail medical, correctional staff, and court personnel to include Hill Country MHDD and Hays County ADAs in order to share information on inmates with known behavioral health concerns.
- Hays County may consider developing process for utilizing CCP Art. 16.22 reports to inform decisions.

**Overview of Gaps and Opportunities**

**Jail Continuity of Care**

**Gaps**

- Hays County Jail may release people with behavioral health conditions with limited or no psychiatric medications.
- Hays County Jail may release people with behavioral health conditions after 5pm on weekdays or on weekends.
- There is no reentry planning provided to people with MI to support continuity care planning.

**Opportunities**
• Hays County Jail may explore opportunities to coordinate releases with WellPath and ensure individuals are released with a prescription or extended supply of psychiatric medications.

• Hays County can explore working with Hill Country MHDD to embed care coordinators in the Hays County Jail to provide reentry planning and coordination for people returning to their community with ongoing behavioral health needs.

**Community Reentry**

**Gaps**

- There is a lack of reentry support provided to people released from the Hays County Jail. Housing, transportation, healthcare, job, and other supports help reduce recidivism if made available consistently upon release.
- People exiting the Hays County Jail often wait up to 30 days for a follow-up appointment with a mental health provider at Hill Country MHDD.

**Opportunities**

- Hill Country MHDD and Hays County may consider the utilization of Peer Support Specialists to support reentry planning and provide interim support prior to a follow-up appointment with Hill Country MHDD.
- Hays County may consider developing a referral system and referral resources to improve access to community-based services upon reentry.

**Probation and Parole**

**Gaps**

- The limited amount of medication provided to people released from jail often does not last long enough for them to be seen by a new psychiatric provider, which may result in mental health-related probation violations.
- There are limited long-term housing options for individuals with prior justice involvement.
- Hays County Adult Probation only has specialized caseloads for people with mental health conditions with felony offenses.
- There is limited access to the Adult Probation specialized caseload.

**Opportunities**

- Hays County Adult Probation may consider expanding specialized caseloads to serve people with mental health conditions with misdemeanor offenses.
- Hays County Adult Probation may consider providing additional mental health training to probation officers.
The priorities for change were determined through a voting process. Following completion of the SIM Mapping exercise, the workshop participants defined specific areas of activity that could be mobilized to address the challenges and opportunities identified in the group discussion about the cross-systems map. Once priorities were identified participants voted for top priorities. The voting took place on September 15, 2022. The top five priorities are highlighted in bold text below.

<table>
<thead>
<tr>
<th>Rank</th>
<th>Priority</th>
<th>Total Votes</th>
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<tbody>
<tr>
<td>1</td>
<td>Expand crisis options through the development of a diversion campus.</td>
<td>28</td>
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<tr>
<td>2</td>
<td>Develop strategies to address frequent utilizers and pilot new ACT team program.</td>
<td>21</td>
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<tr>
<td>3</td>
<td>Explore the development of a Behavioral Health Office to coordinate county services.</td>
<td>16</td>
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<tr>
<td>4</td>
<td>Increase information and data sharing across the SIM.</td>
<td>13</td>
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<td>5</td>
<td>Enhance 911 and law enforcement response to behavioral health crises.</td>
<td>12</td>
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<tr>
<td>6</td>
<td>Enhance reentry planning for individuals returning to the community.</td>
<td>11</td>
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<tr>
<td>7</td>
<td>Explore the development of a jail-based competency restoration program.</td>
<td>8</td>
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<td>8</td>
<td>Support planning for the public defender office, pretrial services, mental health court, and court appointed attorneys.</td>
<td>6</td>
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<tr>
<td>9</td>
<td>Establish a behavioral health and justice leadership team.</td>
<td>1</td>
</tr>
<tr>
<td>Rank</td>
<td>Priority</td>
<td>Total Votes</td>
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<tr>
<td>10</td>
<td>Expand jail in-reach efforts.</td>
<td>1</td>
</tr>
<tr>
<td>11</td>
<td>Improve early identification of people with mental health needs (e.g., CCP Art. 16.22)</td>
<td>1</td>
</tr>
<tr>
<td>12</td>
<td>Increase opportunities to engage families and peers across the SIM.</td>
<td>1</td>
</tr>
<tr>
<td>13</td>
<td>Enhance community-based preventative services.</td>
<td>1</td>
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Strategic Action Plans

Stakeholders spent the second day of the workshop developing action plans for the top five priorities for change. This section includes action plans developed by Hays County stakeholder workgroups as well as additional considerations from HHSC staff on resources and best practices that could help to inform implementation of each action plan.

The following publications informed the additional considerations offered in this report:

- [All Texas Access Report](#), Texas Health and Human Services Commission
- [A Guide to Understanding the Mental Health System and Services in Texas](#), Hogg Foundation
- [Texas Statewide Behavioral Health Strategic Plan Update](#), Texas Statewide Behavioral Health Coordinating Council
- [Texas Strategic Plan for Diversion, Community Integration and Forensic Services](#), Texas Statewide Behavioral Health Coordinating Council
- [The Joint Committee on Access and Forensic Services (JCAFS): 2020 Annual Report](#), Texas Health and Human Services Commission
- Texas SIM Summit Final Report, Policy Research Associates
- SAMHSA’s publication, [Principles for Community-Based Behavioral Health Services for Justice-Involved Individuals](#) provides a foundational framework for providing services to people with MI and SUD who are justice-involved.

Finally, there are two overarching issues that should be considered across all action plans outlined below.

The first is equity and access. While the focus of the SIM Mapping Workshop is on people with behavioral health needs, disparities in healthcare access and criminal justice involvement can also be addressed to ensure comprehensive system change.
The second is trauma. It is estimated that 90 percent of people who are justice-involved have experienced traumatic events at some point in their life. It is critical that both the healthcare and criminal justice systems be trauma-informed and that there be trauma screening and trauma-specific treatment available for this population. A trauma-informed approach incorporates three key elements:

- Realizing the prevalence of trauma;
- Recognizing how trauma affects all people involved with the program, organization, or system, including its own workforce; and
- Responding by putting this knowledge into practice Trauma-Informed Care in Behavioral Health Services.

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## Priority Area One: Expand Crisis Options Through the Development of a Diversion Center

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| **Identify Funding Sources and Key Stakeholders** | - Identify additional stakeholders to support Diversion Center planning and funding, including: Hays County Commissioners; San Marcos PD; Hays County Sheriff’s Office; Hays District Judges; Hays Court at Law Judges; Substance Use provider/ non-profits; Hill Country MHDD; county hospitals; public defenders; probation; parole; city government; county judges/ Justice of the Peace  
- Gather data to reflect current crisis service and incarceration trends to inform Diversion Center planning efforts/community needs.  
- Present data to county stakeholders and behavioral health leadership to develop support for local diversion center planning efforts | Diversion Center Planning Committee  
Led by County Commissioner and San Marcos Police Department | 30 days |
| **Identify a Location/Building and Consider the Diversion Center Operational Structure** | - Identify hours of operation based on county data collected (e.g., crisis hotline data and 911 dispatch data):  
  - Consider 4PM-12AM as a starting point;  
  - Consider building/space opportunities:  
    - Learn from existing diversion centers in other counties;  
    - Consider existing medical and mental health treatment buildings or structures in Hays County that may be converted into a diversion center;  
  - Determine initial clinical/medical services and other supports that will be available at the Diversion Center. Consider:  
    - Low-barrier drop off center elements;  
    - On site security;  
    - Onsite medical evaluation;  
    - MH/SUD referrals;  
    - Case management;  
    - Counseling;  
    - Medication management.  
- Identify staff needed to run facility:  
  - Hill County;  
  - Security staff;  
  - Ascension Seton;  
  - Cenikor. | Diversion Center Planning Committee | 90 days |
| **Identify Center Eligibility Requirements/ Scope** | - Gather data from hospitals and police departments to identify existing community needs.  
- Assess frequent utilizer data across Hays County.  
- Consider specialized services to be offered at the Diversion Center: detox, treatment and medication management for individuals with Substance Use Disorder (SUD) and Serious Mental Illness (SMI). | Diversion Center Planning Committee | 120 days |
**Additional Considerations**

**Conduct a comprehensive needs assessment** by analyzing existing data to make a case for the development of a diversion center. Where data doesn’t exist, stakeholders can discuss plans to collect and track additional measures. Data gathered to inform the development of the Harris County Diversion Center and other Mental Health Drop-Off Facilities include:

- MCOT dispatch data
- Number of crisis line calls
- Number of emergency department hospitalizations for psychiatric reasons
- Daily jail population
- Percent of people in jail who have serious mental health issue
- Percent of people in jail with low-level misdemeanors
- Percent of people in jail with low-level misdemeanors who screened positive for MI
- Number of jail bookings for a specific period
- Number of jail bookings for low-level misdemeanors during that same period
- Number of jail bookings for people who screened positive for MI during that same period
- Average length of stay for this population
- Average cost to house people with mental health issues in jail

**Learn from other communities** and consider reviewing the following publications for diversion center implementation best practices:

- **Implementing a Mental Health Diversion Program, A Guide for Policy Makers and Practitioners**, developed by Justice System Partners, provides practical guidance from Harris County for planning a crisis diversion center including,

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laid out in four phases: (1) information gathering; (2) planning; (3) implementation and monitoring; (4) evaluation and sustainability.  

- **A Community Guide for Development of a Crisis Diversion Facility**, by Health Management Associates (HMA), outlines key considerations for planning and managing a crisis diversion facility. The guide outlines potential services; roles and responsibilities across local stakeholders; the role of data in informing planning and ongoing program improvement; and funding strategies. HMA also produced a companion document which provides case studies of communities in Arizona, South Dakota, Tennessee and San Antonio.

- **Blueprint for Success: The Bexar County Model, How to Set Up a Jail Diversion Program in Your Community** was produced by the National Association of Counties, in partnership with Bexar County, on setting up jail diversion programs. This provides an overview of the diversion center, steps taken for enlisting community support, funding, etc.

- **Roadmap to the Ideal Crisis System, National Council for Behavioral Health** has a section titled, Elements of the Continuum, Crisis Center or Crisis Hub (Pg. 88), which describes the role a crisis center can play within the local crisis system. The section provides an overview of services you may want to consider, and shares examples of crisis hubs in states across the country.

**Define the diversion centers goals and determine program eligibility to meet those goals.** Questions to consider: Who is the target population? At which contact point will diversion be most impactful in addressing gaps in the community and meeting community goals? Who is eligible for services?

- Initially, the Harris County Diversion Center determined that the diversion center would be voluntary, and that diversion was appropriate for individuals who:

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- Committed low-level, non-violent crimes;
- Appear to have a MI or have a documented history of MI;
- Have a mental health need contributing to their offending conduct;
- Do not pose a public safety threat;
- Are 18 and over;
- Do not appear to be in mental health crisis and do not meet the criteria for Emergency Detention Order (not likely to harm self or others); and
- Have no open warrants or detainers.

- Harris County stakeholders also agreed on disqualifiers, including individuals charged with the following offenses: domestic violence offenses, assault, terroristic threat weapons offenses (e.g. discharging a firearm, deadly conduct), driving while intoxicated, burglary of a motor vehicle, and any offense where public safety could be compromised.  

**Workgroup Members:**

David Glicker, Civil Attorney; Ron Stretcher, Meadows; Michael Fugerty, Military Veterans Peer Network, Hill Country MHDD; Carrie Bartomolucci, Hill County MHDD; Natalie Werman, Cenikor; Stan Standridge, San Marcos Police Department; D’Anna Belvins, Cristus Santa Rosa; Alison Boleware, Hogg Foundation

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Priority Two: Develop Strategies to Address Frequent Utilizers and Pilot New Assertive Community Treatment Program

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| Establish a Frequent Utilizer Planning Committee and Begin Data Exploration | • Convene a comprehensive group of stakeholders to discuss frequent utilizers in Hays County. Stakeholders could include Hill Country MHDD, Hays County law enforcement, Hays County Jail, Hays County Courts, housing service providers and others who frequently engage with this population in Hays County  
• Explore data from participating stakeholders to begin to identify the frequent utilizer population and understand their characteristics and patterns of service utilization. Data to explore:  
  o 911 data;  
  o Crisis line data;  
  o Arrests and jail bookings;  
  o Homeless shelter data;  
  o ER and hospital visits;  
  o MCOT data.  
• Take time to understand each agency’s definition of frequent utilizers, both in terms of system contacts and costs.  
• Start to combine data to understand how individuals touch multiple systems.  
• Consider the development of case examples to supplement descriptive data described above and better illustrate the stories and challenges presented by this population | Frequent Utilizer Planning committee       | 30-60 days |
| Explore the Development of an Assertive Community Treatment (ACT) Program | • One evidence-based program that can help address the needs of frequent utilizers is ACT. In developing a new program, stakeholders first proposed the development of a planning committee, including: Hill County MHDD, the District Attorney’s Office, Hays County law enforcement, Hays County first responders, Hays County Commissioners; Substance use providers/ non-profits; housing and employment stakeholders; county hospitals.  
• Set a regular meeting date and time for the planning group.  
• Determine program services and eligibility.  
• Based on this information, identify individuals from the analysis above that might be a good fit for a pilot ACT program.  
• Learn from Other Community ACT Programs.  
• Explore funding opportunities:  
  o County Commissioners;  
  o ARPA funds;  
  o Grant opportunities;  
  o Existing LMHA crisis services funding. | Frequent Utilizer Planning Committee       | 90 Days    |
## Additional Considerations

**Develop data sharing protocols to identify and engage people who frequently encounter law enforcement, emergency departments, crisis services, and the jail.** Explore model programs:

- That National Association of Counties (NACo) launched the [Familiar Faces Initiative](https://familiarfaces.naco.org/) (formally known as Data Driven Justice Initiative) to improve outcomes and lower incarceration rates for people who frequently cycle through jails, homeless shelters, emergency departments and other local crisis services. Through the Familiar Faces Initiative, the NACo empowers communities to share data and integrate care options between health and justice systems so they can intervene earlier, improve outcomes and reduce incarceration and hospitalization rates. NACo has a number of resources to support data sharing, including:

  - The [Familiar Faces Initiative Playbook](https://familiarfaces.naco.org/) is designed to help guide the development of a multi-system strategy to successfully divert familiar faces, when appropriate, away from the criminal justice and emergency health systems and toward community-based treatment and services.
  
  - The [Data-Driven Justice Playbook](https://familiarfaces.naco.org/) is designed to help guide the development of a multi-system strategy to successfully divert frequent utilizers, when appropriate, away from the criminal justice and emergency health systems and toward community-based treatment and services.

  - [Issue Briefs](https://familiarfaces.naco.org/) for key stakeholders, including behavioral health and social service providers, criminal justice coordinators, courts, probation, elected officials, law enforcement, corrections, and IT and

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data analysts on the role they can each play in support local Familiar Faces efforts.

- **Data sharing examples, implementation resources, and case studies** that can support Hays County data efforts. Workshop participants requested examples of data sharing agreements. Below are a few made public by the Familiar Faces Initiative:
  - Data Use Agreement: An Example from King County, Wash.
  - Information Sharing MOU: An Example from Gila County, Ariz.
  - Confidentiality Agreement: An Example from Johnson County, Kan.
  - Business Associate Agreement: An Example from Johnson County, Kan.
  - Sample Business Associate Agreement Provisions
  - Using an MOU to Formalize Goals and Establish Data Sharing: An Example from Codington County, S.D.

- The **National Center for Complex Health and Social Needs** has resources to support leadership in developing programs that focus on complex care populations, analyzing data to inform decision making, and exploring business and legal needs.

- **Frequent Users Systems Engagement** (FUSE) is an initiative through the Corporation for Supportive Housing and another model for identifying frequent users of jails, shelters, hospitals and/or other crisis public services by linking data networks to identify those in need and quickly linking them to supportive housing. CSH FUSE has been formally evaluated and shows reductions in the use of expensive crisis services and improvements in housing retention. More than 30 communities implementing FUSE are seeing positive results.11

**Pilot an Assertive Community Treatment (ACT) Team targeting Hays County frequent utilizers.** Review national and State best practices on the development and implementation of an ACT team.

- **SAMHSAs Evidence Based Practices Toolkit, Building Your Program**, provides guidance on how to develop and structure an assertive community treatment

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model. The toolkit identifies the following key principles of a high-fidelity ACT program:12

- ACT is a service delivery model not a case management program
- The primary goal of ACT is recovery through community treatment and habilitation
- ACT is characterized by: a team approach, in vivo services, a small caseload, time-unlimited services, shared caseloads, flexible service delivery, a fixed point of responsibility and 24/7 crisis availability
- ACT is for people with the most challenging and persistent problems
- Programs that adhere most closely to the ACT model are more likely to get the best outcomes.

- **SAMHSA’s Forensic Assertive Community Treatment** (FACT) brief provides an overview of the FACT model for individuals with serious mental illness who are involved with the criminal justice system. This model is designed to serve individuals who are high utilizers across behavioral health and justice systems. This brief identifies the key components of FACT and recommended eligibility criteria for individuals to receive services. Recommended criteria include:13
  - Eligibility criteria for ACT are met
  - Current or recent involvement with the criminal justice system, including a history of failure to comply with criminal justice system supervision
  - Medium to high criminogenic risk and need
  - SMI; may also include co-occurring substance use disorders
  - Functional impairment, including the inability to manage activities of daily living

- **The University of North Carolina Center for Excellence in Community Mental Health** has a number of resources to support planning and implementation of ACT). Resources include networking opportunities with ACT teams from across the country and tools for assertive engagement, assessment and

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**Explore other national best practice models to address the needs of frequent utilizers in Hays County.**

- In Sonoma, California, the Accessing Coordinated Care and Empowering Self Sufficiency (ACCESS) program aims to coordinate across agencies to more effectively serve clients with complex needs. This program integrated anonymized utilization records from health, mental health, substance use, housing, criminal justice and human services systems on residents from 2014 to 2018 and defined high utilizers as any person whose utilization across systems was in the top 1\% of any given year. This information was used to guide service type and delivery for the target frequent utilizer population identified and coordinate services across providers to prevent duplication in service deliver.\footnote{Data Driven Justice: A Playbook for Developing a System of Diversion for Frequent Utilizers. National Association of Counties. (n.d.). Retrieved 21 November 2022, from \url{https://craftmediabucket.s3.amazonaws.com/uploads/DDJPlaybook.pdf}.}

- In Boone County, MO, the Corporation for Supportive Housing (CSH) worked to reduce imprisonment or jail time among the county’s homeless residents who were often among some of the highest utilizers of behavioral health and justice resources. CSH, in collaboration with the University of Chicago, developed a web-based data integration tool that matches lists from county jail administration data to local homeless data. Merging these data sets allowed service providers to accurately focus resources on the highest utilizers across those two systems.

  - **Brief Intervention Programs:** Brief crisis focused residential care can act as a step down from a crisis diversion center
- **Substance Use Focused Crisis Stabilization:** Can serve as an outpatient or inpatient facility to serve as a walk in clinic for individuals with SU or as a drop off location for law enforcement.

- **Post Crisis Follow Up:** Second responder teams that provide community outreach and engagement with individuals challenged by chronic behavioral health needs.

**Workgroup Members:**

Rebekah Falke, Christus Trinity Santa Rosa (CSR); Lina Muniz, CSR; Martin Rodriguez, Buda PD; Nate Waters, Kyle PD; Steve Cunningham, Hays County Sheriff’s Office; Erin Barker, Hays County Sheriff’s Office; Kendra Marstellar, Texas State PD; Jeff Hohl, Neighborhood Defender Service; Ed Kuny, NAMI; Ashley Seltz, Hays County DA; Jeff Weatherford, Hays County DA
Priority Three: Explore the Development of a Behavioral Health Office to Coordinate County Services

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| Identify Funding Sources | • Conduct assessment of existing county funding resources  
  o Explore County Commissioner funding  
  o Consider resource limits  
  o Consider community BH data to support the development of Behavioral Health Office and identify the potential cost savings | County BH Office Action Planning Committee | 30 days |
| Establish Information Sharing Policy and Protocols to Assist in Connection to BH Services | • Establish Information sharing criteria between the new County BH Office and Community BH and Justice Stakeholders  
  o Agency/partner agreements (ROIs and MOUs)  
  o Identify single point of contact at each agency  
  • Explore information sharing tools  
  o UniteUs- learn about data sharing capabilities  
  o Learn from agencies currently using UniteUs software | County BH Office Action Planning Committee | 60 days |
| Develop Training and Education Offered by the Behavioral Health Office | • Research best practice approaches  
  • Assess county coordinator models in other similarly sized counties implemented in other communities  
  • Develop education and training materials based on research and community needs assessments conducted | County BH Office Action Planning Committee | 60 days |
| Establish Quality Control Process | • Establish clear outcome measures to monitor the BH Office’s activities  
  • Identify manpower/staff to monitor and maintain county coordination activities  
  o Consider working with Texas State University | County BH Office Action Planning Committee | 90 days |
| Maintain Multi-disciplinary Relationships and Coordination | • Identify opportunities to present progress and provide updates across county stakeholder groups  
  o Present on data gathered, training and education resources developed and key outcomes or intended outcomes from the coordinator position | County BH Office Action Planning Committee | Ongoing |
| Regular Communication with County Leadership | • Encourage BH Leadership Committee to engage with state/federal partners to increase legislative presence  
  • Establish regular coordination meetings between the BH Office and key county Stakeholder groups across SIM Intercepts | County BH Office Action Planning Committee | Ongoing |

Additional Considerations

Explore strategic planning best practices to help identify a vision, mission and goals for the Behavioral Health Office.
• The Office of New York State Comptroller developed a Local Government Management Guide on Strategic Planning that highlights the five basic elements of strategic planning: mission, vision, goals, objectives and strategies. These elements should all be considered as the development of the Hays County Behavioral Health Office is explored. In order to effectively identify these five elements, all strategic planning should be guided by four key questions: 17
  o Where are we currently?
  o Where do we want to be in the future?
  o How do we get there?
  o How do we gauge progress?

• Consider key components of effective behavioral health and justice system collaboration:
  o Develop joint projects across Hays County BH and justice providers.
  o Explore blended funding opportunities to support BH Office projects.
  o Ensure information is being shared across relevant stakeholder groups.
  o Provide cross-training across BH and Justice stakeholder groups.

Review strategies to assess county level behavioral health and justice collaborations and to monitor the quality of behavioral health service delivery in Hays County.

• Wayne State University’s Center for Behavioral Health and Justice created the SIMPLE (Sequential Intercept Model Practices Leadership, and Expertise) Scorecard as a tool to assess county-level BH and justice collaborations. Counties were analyzed on a 36 point scale for best, promising and evidence-based practices across intercepts, leadership and expertise. This model could be built upon to evaluate the activities of the Hays County Behavioral Health Office and their success at increasing county level BH and justice coordination.

Explore tools the office could use to help establish a new standard of care for Hays County residents, enable identification and prediction of social care needs, track trends in referrals, enrollment, and availability of mental health services.

health services, and leverage meaningful outcome data and analytics to further drive community investment.

- Tools identified by workshop participants included UniteUs and FindHelp.org.
- The National Center for Complex Health and Social Needs and the National Association of Counties has tools and resources to assist counties in developing health programs and services. The Complex Care Startup Toolkit supports communities in developing a comprehensive program for people with complex needs.

Learn from communities with behavioral health coordinating offices.

- The Panhandle Behavioral Health Alliance is a coordinating office developed to improve mental health service delivery in the 26 counties of northwest Texas. The target of this coordinating office to improve access and alignment of local behavioral health systems. PBHA is tasked to convene as a policy-making body to improve the planning, coordination, oversight and implementation required to create sustained and effective system change leading to optimal positive impact for our region. Hays County stakeholders can coordinate with PBHA to learn more about the development and effective collaborative strategies to inform the development of the BH office in Hays County.

- Fort Bend County Behavioral Health Services (BHS) was established by the Fort Bend County Council of Judges in October 2010. The department was restructured in December of 2018 to report to Fort Bend County Commissioners Court. The department was created to assist in addressing the needs of those with mental illness who come into contact with the justice system. Over the years, Behavioral Health Services has expanded to begin to address those in the community who are high-risk of involvement in the justice system. Working collaboratively with the justice system, health and human services, behavioral health providers, county offices, schools, and the community, BHS continues to increase the awareness of the needs of Fort Bend County’s most vulnerable populations and guide systems to work collaboratively to better address those.

- The Office of Care Coordination in Orange County, California engages across the county working with cities and community-based organizations to strengthen regional capacity and multi-city, multi-sector investments to prevent and address homelessness. They accomplish this by coordinating with public and private BH resources in the County and promoting integration of services within the community to target improving the county-wide response to homelessness.
Workgroup Members

Michelle Zaumeyer, Hill County MHDD; Melissa Rodriguez, HCWC; Tucker Furlow, Hays County DA’s Office; Samantha Vanderberg, Hays County Veterans Services; Debbie Inglesbee, Commissioner’s Court
# Priority Four: Improve Information and Data Sharing Across the SIM

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| Develop Data Taskforce | • Identify a city official or other sponsor to organize regular meetings focused on data collection, sharing, and analysis across Hays County for behavioral health and justice stakeholders.  
• Coordinate with other workgroups that have identified data collection and analysis as an action step.  
• Plan for Taskforce meetings. Identify:  
  o Key participants  
  o Location  
  o Time and Date  
  o Frequency | Jail, WellPath, County Clerk, District and County Court, County Attorney | 60 days |
| Learn from Other Communities | • Research national data initiatives and connect with Texas counties who are leading efforts to improve data collection and data sharing. | Jail, WellPath, County Clerk, District and County Court, County Attorney | 90 days |
| Assess Data Availability | • Assess availability of baseline data across the SIM  
  o Use the community impact measures spreadsheet from the SIM Mapping Workshop to guide data collection (see Appendix C).  
• Consult with County stakeholders to identify gaps in information. | Jail, WellPath, County Clerk, District and County Court, County Attorney | 90 days |
| Examine Existing Data Sharing Practices | • Explore existing data collection and data sharing practices across key agencies.  
• Assign a lead agency to collect and analyze data  
• Examine existing tools to promote community awareness of existing resources and data sharing practices  
• Ensure that an examination of the current CCP Art. 16.22 process is part of this conversation. | Jail, WellPath, County Clerk, District and County Court, County Attorney | 90 days |
| Analyze Data | • Use initial analysis to help build a case for what data is needed and advocate for necessary funding to build out their Hays County data strategy. | Jail, WellPath, County Clerk, District and County Court, County Attorney | 90 days |

## Additional Considerations

Clarify goals for data sharing and data integration for Hays County and develop potential use cases to guide planning efforts. Information sharing across behavioral health and criminal justice systems is critical to reducing the number of people with MI, SUD, and IDD in jails. Tracking aggregate trends can help key
decision makers develop policy and funding strategies to support people with MI, SUD, and IDD in the community. At the point of service, the availability of information related to the person’s treatment history and condition can enhance safety, improve the individual’s health and support recovery outcomes. Consider convening a work group to clarify data sharing goals for the community. Examples of goals might include:

- Track key criminal justice and behavioral health trends across Hays County to inform policy, planning, and funding.
- Identify people cycling through jails, emergency rooms, and crisis services and develop new plans for engaging them in care in the community.
- Improve continuity of care for people who are justice-involved upon return to the community.
- Support 911 dispatchers and law enforcement in identifying people who might need mental health support and be eligible for diversion based on previous contacts with the public mental health system.

Assess the availability of baseline data across the SIM. A few key resources can help guide this assessment, including:

- The Community Impact Measures collected in preparation for the SIM Mapping Workshop. See Appendix C for more detail.
- SAMHSA’s manual, Data Collection Across the Sequential Intercept Model: Essential Measures, recommends data elements organized around each of the six SIM intercepts. Each section lists data points and measures that are essential to addressing how people with MI and SUD flow through that intercept. The sections also cover common challenges with data collection and ways to overcome them, along with practical examples of how information is being used in the field.\(^\text{18}\)

Learn from national efforts and other Texas communities.

- In 2016, the U.S. Department of Justice’s Bureau of Justice Assistance (BJA) launched an online toolkit in partnership with the Council of State Governments (CSG) Justice Center that supports law enforcement agencies around the country in planning and implementing effective public-safety

responses to people who have MI. One key component is the identification of four key outcomes of Police-Mental Health Collaboration effectiveness:

- Increased connections to resources;
- Reduced repeat encounters with law enforcement;
- Minimized arrests; and
- Reduced use of force encounters with people who have mental health needs.

- Texas counties have joined national data initiatives like the Stepping Up Initiative to reduce the number of people with MI in jail. In early 2019, Lubbock County became one of 15 counties nationwide nominated as a Stepping Up Innovator County. Lubbock County has implemented strategies to accurately identify people in jails who have SMI; collect and share data on people to better connect them to treatment and services; and use this information to inform local policies and practices. The four key measures of the Stepping Up initiative are:
  - Number of bookings;
  - Average length of stay;
  - Connections to treatment and services; and
  - Recidivism for the general population and for people identified as having SMI to provide a point of comparison. This can be used to determine whether disparities between these populations exist in each of these areas.

Review national and state data sharing guidelines.

- Information Sharing in Criminal Justice-Mental Health Collaborations: Working with HIPAA and Other Privacy Laws, is a report from the Council of State Governments Justice Center's Criminal Justice and Mental Health Consensus Project that was developed to help criminal justice officials work with health professionals to better use both systems information, when appropriate, to reduce criminal justice involvement among people with MI and to provide better links to treatment. The guide explains the federal legal framework and how it relates to state laws. It describes how HIPAA and 42

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Code of Federal Regulations (CFR) Part 2 may affect exchanges among behavioral health care; law enforcement; courts; jails and prisons; and probation and parole professionals. It reviews the circumstances under which protected health information can be released and received and offers answers to scenario-based frequently asked questions.\(^{21}\)

- **Point-of-Service Information Sharing Between Criminal Justice and Behavioral Health Partners: Addressing Common Misconceptions**, compiles strategies presented at the 2018 Best Practices Implementation Academy convened by SAMSHA’s GAINS Center to enable appropriate information sharing between healthcare and criminal justice agencies.\(^{22}\)

- See **Appendix** D for some relevant Texas and federal privacy and information sharing provisions.

**Workgroup Members**

Cindi Carter, District Court; Judge O’Brien; Julissa Villalpando, Hays County Jail Captain; Ben Moore, Magistrate Judge; Marie Herrera, ARCIC; Juan Saenz, Hays County Jail Captain; Nichole Mueller McNorris, WellPath; Amy Lowrie, Clinic Director, Hill Country MHDD

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Priority Five: Enhance 911 and Law Enforcement Response to Behavioral Health Crises

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| Establish Data Collection Points | • Assess existing MH crisis line and 911 dispatch call data. Consider the following data points:  
  o Identify MH Calls;  
  o Identify MH Jailings;  
  o Response: Police, EMS or other;  
  o Frequency of MH Unit Calls;  
  o Time spent per unit responding to MH calls.  
  • Form a workgroup to establish best practice data collection methods at 911 dispatch:  
  o Coordinate with data task force to collect information on existing practices;  
  o Establish workgroup priorities;  
  o Identify who to invite. | Meadows  
  911 dispatch, San Marcos Police Department; Hays County Sheriff's Office; Wellpath; Jail Constables/Marshalls | 30 days |
| Improve Regular Training and Education Opportunities for 911 Dispatch and Law Enforcement | • Identify goals for dispatch and law enforcement trainings  
  • Identify where gaps in stakeholder knowledge exists  
  • Streamline mental health questions asked by dispatchers and law enforcement:  
  o Consider adding an option at 911 for MH response in addition to police EMS or Fire.  
  • Consider training options for 911 dispatch staff, including:  
  o Mental Health First Aid;  
  o Applied Suicide Intervention Skills Training;  
  o Assess Support Know: Suicide Prevention Training; and  
  o Counseling on Access to Lethal Means.  
  • Further train 911 dispatch staff on criteria used to identify a MH need and dispatch a MH Unit. | 911 dispatch, San Marcos Police Department; Hays County Sheriff's Office; Wellpath; Jail Constables/Marshalls | 90 days |
| Identify Opportunities to Increase First Responders Available to Address MH Crisis in Hays County | • Identify opportunities to increase the number of available MH trained first responders. Consider:  
  o Increasing the number of CIT Trained officers across Hays County;  
  o Opportunities for ride-along/constable assistance;  
  o Embedding clinicians on MH response teams (explore co-responder models).  
  • Identify key partners:  
  o Establish contracts between local law enforcement and Hill Country MHDD. | 911 dispatch, San Marcos Police Department; Hays County Sheriffs Office; Wellpath; Jail Constables/Marshalls | 120 days |

Additional Considerations

**Develop a standardized script** for dispatch and first responders in Hays County to assess for a behavioral health crisis. Some resources that have been developed to guide call-taker best practices include:
• **Crisis Intervention Techniques and Call Handling Procedures for Public Safety Telecommunicators**\(^{23}\) provides an overview of what signs and symptoms might indicate a behavioral health crisis and provides some suggestions for effectively responding to individuals with behavioral health needs.

• Review **Call-Taker and Dispatcher Protocols** in the Bureau of Justice Assistance’s **Police-Mental Health Collaboration Toolkit**. The Call-Taker Dispatcher Protocol highlights that when a call taker suspects that the request for service involves a person with mental illness the following immediate next steps should be considered:\(^{24}\)
  
  o Gather descriptive information on the person’s behavior;
  o Identify if the individual appears to pose a danger to themselves or others;
  o Identify if the person possesses or has access to weapons; and,
  o Ask the caller about the person’s history of mental health or SUD treatment, violence or victimization.

• The Council of State Governments Justice Center released a brief titled **Tips for Successfully Implementing a 911 Dispatch Diversion Program**, which outlines four tips for successfully implementing 911 dispatch diversion in a community:\(^{25}\)
  
  o Determine which approach to 911 dispatch diversion is a good fit;
  o Identify which calls will be eligible for diversion;
  o Provide training for all dispatchers and clinicians; and,
  o Use data to assess the programs performance and make improvements.


Learn from other communities that have begun to implement dispatch and crisis call diversion strategies:

- **Austin Police Department** partnered with Austin-Travis County Integral Care to develop the Mental Health Crisis Call Diversion program. Since the program's launch in 2019, Austin 911 operators have successfully diverted thousands of calls to crisis clinicians.\(^{26}\) In 2021, 82% of calls with a mental health crisis component were diverted, meaning clinicians were able to help the caller without the need to send a police officer.\(^{27}\)

- In 2015, the **Harris Center** launched the Crisis Call Diversion program in collaboration with the Houston Police Department (HPD), Houston Fire Department (HFD), Houston Emergency Center to decrease the volume of non-emergency mental health-related calls for service for both HPD patrol and HFD emergency medical services.\(^{28}\) Between March 2016 and March 2021 the CCD program diverted almost 7,500 calls from law enforcement response, saving more than $2 million in resources for the police department.\(^{29}\)

- Since a soft launch during January 2022, **Williamson County** residents calling 911 are offered help from emergency medical responders, police, firefighters, and now, mental health professionals. Bluebonnet Trails Community Services (BTCS) entered a strategic partnership with Williamson County Emergency Services embedding mental health clinicians in the Emergency Operations Center. Beyond the primary goal of connecting more people to critical crisis care when they need it most, a secondary goal of the program is to reduce unnecessary hospitalizations, arrests, and utilization of law enforcement and EMS resources. Since the program’s inception 40% of all calls have resulted in diversions from jail; 46% resulted in a mental health assist alongside a first responder in the field; and, 14% resulted in support and information shared by the mental health professional triaging the call.\(^{30}\)

- **Yavapai County, Arizona** has sought to improve community services by introducing a co-response model and 911 deflection services. The deflection

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\(^{27}\) *Combined Transportation, Emergency, and Communications Center Crisis Call Diversion Program Cost Analysis*. Austin Integral Care. (2020).


\(^{30}\) Data provided by Bluebonnet Trails Community Services
program identifies people who call into 911 reporting a mental health-related crisis and dispatches a mobile crisis intervention team in lieu of law enforcement. To help 911 staff prepare for the new team, a series of trainings, dispatch protocols, and screening tools were developed. These services are available 24/7, and regular communication among local dispatch agencies, patrol officers, and crisis services helps the program run smoothly.

- **In Dane County, Wisconsin** representatives from the dispatch center were involved in the planning for the Community Alternative Response Emergency Services (CARES) community responder team from the beginning. Law enforcement, Journey Health employees (the provider who run the CARES team along with the Madison Fire Department), the fire department, and dispatchers collaborated to develop the workflows and questions that dispatchers now use to determine which team to send to a call. They were able to establish protocols for using standard call screening questions to determine if a call could be routed to the CARES team. For example, any call where the person identified weapons on the scene, stated that someone was exhibiting assaultive or threatening behavior, or indicated that there was a need for medical services was disqualified for the community responders. However, if none of these situations were presented, but the caller was suicidal or needed a welfare check, then the CARES team could respond.  

**Explore regular training and education opportunities for 911 dispatch and law enforcement** that are centered around working with individuals experiencing a behavioral health crisis.

- Work with Hill Country MHDD to explore existing MH trainings offered in Hays County:
  - Mental Health First Aid,
  - Applied Suicide Intervention Skills Training,
  - Assess Support Know: Suicide Prevention Training, and
  - Counseling on Access to Lethal Means.

- Identify opportunities for law enforcement and dispatch to engage in 988 implementation strategies and stay informed around 988 planning in Hays County. The Council of State Governments Justice Center released a brief titled *How to Use 988 to Respond to Behavioral Health Crisis Calls*, which

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outlines what every community should know about 988 as well as tips to prepare for successful 988 Implementation.\(^{32}\)

**Explore the use of remote technologies** to further support law enforcement responding to individuals experiencing a mental health crisis.

- Examine plans, trainings, and other resources developed for similar Texas programs. The Harris County Sheriff’s Office developed a *Telehealth Implementation Guide*, which outlines:\(^{33}\)
  - Reasons for telehealth for patrol;
  - Benefits of telehealth for patrol;
  - Frequently Asked Questions;
  - Details on the Harris County pilot program;
  - Comparison tables which include outcome data from the pilot program; and
  - Other resources.

- Consider opportunities for law enforcement to use existing tools such as a duty phone to support MH calls and remote assessments.

**Workgroup Members**

Dan Royston, San Marcos PD; Arroya McGhee Enyard, Wellpath; Stacy Johnston, Hays County Sheriff’s Office 911; Joyce Bender, San Marcos PD; Debbie Ingalbe, County Court; Wes Mau, District Attorney; Jim Swisher, EMS; Layla Fry, Meadows; Daryl Perez

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Priority Six: Establish the Hays County Behavioral Health Leadership Team

<table>
<thead>
<tr>
<th>Objective</th>
<th>Action Steps</th>
<th>Who</th>
<th>When</th>
</tr>
</thead>
</table>
| Establish Behavioral Health Leadership Team to Inform Public Policy Regarding Mental Health Services | • Establish a 12-member leadership team representing leadership from each intercept.  
• Create subcommittees to carry out priority action plans developed. | Chief Standridge, Judge O’Brien, Debbie Gonzales - Ingalsbe, Wes Mau, Amy Lowrie, and Thomas McKinney | 30 Days |

Additional Considerations:

Hays County stakeholders identified the importance of developing a team of Hays County Behavioral Health and Justice system leaders to lead policy, planning and coordination efforts for Hays County. Additionally, this leadership team will oversee implementation of SIM action plans and workgroups across the county.

Learn from both national and local leadership team best practice models.

- Criminal Justice Coordinating Councils (CJCCs) bring together stakeholders to explore and respond to issues in the criminal justice system. Many CJCCs use data and structured planning to address issues in the justice system, including issues related to mental health and substance use. These councils are intended to be permanent, rather than to address a problem or set of problems within a set time frame. Successful CJCCs need buy-in from key members of the justice and behavioral health systems and those in positions of authority. 34
  - The Harris County CJCC was created by Order of Harris County Commissioners Court dated July 14, 2009. The Council works collectively to manage systemic challenges facing Harris County’s criminal justice system and strengthen the overall well-being of their communities by developing and recommending policies and practices that improve public safety; promote fairness, equity, accountability; and reduce unnecessary incarceration and criminal justice involvement in Harris County. The Council collects and evaluates local criminal justice data to identify systemic issues and facilitates collaboration between agencies, experts, and community

service providers to improve Harris County's criminal justice system in accordance with best practices.

- Explore successful Texas Leadership Teams.
  - The Dallas County BHLT was developed in 2011 and is made up of five advocates, 13 county/city organizations, 6 residential facilities, 16 outpatient providers and three payers/funders. The leadership team also has developed sub-committees to target specific community needs including an Adult Clinical Operations Team, a Behavioral Health Steering Committee, and a Crisis Services Project.
  - Texoma BHLT serves as the community’s hub for mental health and wellness. The team is comprised of Behavioral Health Hospitals; city, county, and state representatives; consumers; patients, and families; school districts; community college; private liberal arts college; Emergency Departments; funders; judicial and law enforcement; managed care/insurance; mental health service providers (including the area’s local mental health authority); the region’s veterans hospital located in the service area, and workforce leaders.

**Clarify goals for data sharing and data integration for Hays County and assess the availability of baseline data across the SIM** to guide all planning efforts. Tracking aggregate trends can help key decision makers develop policy and funding strategies to support people with MI, SUD, and or IDD in the community.

Consider convening a data sub-group to clarify data sharing goals for the community.

- Examples of goals might include:
  - Track key criminal justice and behavioral health trends across Hays County to inform policy, planning, and funding.
  - Identify people cycling through jails, emergency rooms, and crisis services and develop new plans for engaging them in care in the community.
  - Improve continuity of care for people who are justice-involved upon return to the community.
  - Support 911 dispatchers and law enforcement in identifying people who might need mental health support and be eligible for diversion based on previous contacts with the public mental health system.
Quick Fixes

While most priorities identified during a Sequential Intercept Model Mapping Workshop require significant planning and resources to implement, quick fixes are priorities that can be implemented with only minimal investment of time, and if any, financial investment. Yet quick fixes can have a significant impact on the trajectories of people with MI, SUD and/or IDD in the justice system.

- Reconvene SIM Workshop BH and Justice stakeholders on a regular basis to support the implementation of the action plans developed during the SIM Mapping Workshop.
- Standardize mental health coding protocols across dispatch and LE departments in Hays County.
- Develop a centralized list of all behavioral health resources available in Hays County that can be easily accessed by community members, first responders, and crisis mental health providers, building on resource lists already utilized by local hospitals, law enforcement and the Hill Country MHDD.
- Distribute updated data on individuals awaiting competency restoration in Hays County across justice stakeholders and analyze competency restoration waitlist data to provide relevant decision makers with updates on waitlist trends in Hays County.
- Partner with Hill Country MHDD to ensure MHFA training is made widely available to 911 dispatcher, law enforcement, and court personnel (DAs, judges, prosecutors).
Parking Lot

Some gaps identified during the SIM Mapping Workshop are too large or in-depth to address during the workshop. Others may be opportunities to explore in the near term but were not selected as a priority.

- Increase access to community resources for Hays County residents who lack adequate funding for behavioral health care.
- Explore ways to expand access to the TLETS Continuity of Care Query to law enforcement and the courts in Hays County.
- Increase the quality of competency evaluations in Hays County.
Appendices

Appendix A: Hays County Workshop Agenda

Sequential Intercept Model Mapping Workshop

Hays County

September 15, 2022 - September 16, 2022

Hays County Office of Emergency Services
810 S. Stagecoach Trail #1200, Conference Room 1202, San Marcos, TX 78666

AGENDA – Day 1

<table>
<thead>
<tr>
<th>TIME</th>
<th>MODULE TITLE</th>
<th>TOPICS / EXERCISES</th>
</tr>
</thead>
<tbody>
<tr>
<td>8:15</td>
<td>Registration</td>
<td>Coffee and snacks to be provided</td>
</tr>
<tr>
<td>8:30</td>
<td>Opening Remarks</td>
<td>Welcome, Judge Daniel O’Brien, Hays County Court-at-Law, #3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Opening Remarks- Tod Citron, Hill Country MHDD Chief Executive Officer</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Welcome and Introductions, Jennie M. Simpson, PhD, Associate Commissioner</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and State Forensic Director, Texas Health and Human Services</td>
</tr>
<tr>
<td>8:45</td>
<td>Workshop Overview and Keys to Success</td>
<td>Overview of the Workshop</td>
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<td></td>
<td>Texas Data Trends</td>
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<tr>
<td></td>
<td></td>
<td>Community Polling</td>
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<tr>
<td>9:15</td>
<td>Presentation of Intercepts 0, 1</td>
<td>Overview of Intercepts 0 and 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hays County Data Review</td>
</tr>
<tr>
<td>9:45</td>
<td>Break</td>
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</tr>
<tr>
<td>10:00</td>
<td>Map Intercepts 0, 1</td>
<td>Map Intercepts 0 and 1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Examine Gaps and Opportunities</td>
</tr>
<tr>
<td>11:35</td>
<td>Lunch</td>
<td>Lunch to be provided</td>
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<tr>
<td>12:30</td>
<td>Presentation of Intercepts 2, 3</td>
<td>Overview of Intercepts 2 and 3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hays County Data Review</td>
</tr>
<tr>
<td>12:50</td>
<td>Map Intercepts 2, 3</td>
<td>Map Intercepts 2 and 3</td>
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<tr>
<td></td>
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<td>Examine Gaps and Opportunities</td>
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<td>1:50</td>
<td>Presentation of Intercepts 4, 5</td>
<td>Overview of Intercepts 4 and 5</td>
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<td>Hays County Data Review</td>
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<td>2:10</td>
<td>Break</td>
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<td>2:20</td>
<td>Map Intercepts 4, 5</td>
<td>Map Intercepts 4 and 5</td>
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<td></td>
<td>Examine Gaps and Opportunities</td>
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<tr>
<td>3:00</td>
<td>Summarize Opportunities, Gaps &amp;</td>
<td>Identify potential, promising areas for modification within the existing system</td>
</tr>
<tr>
<td></td>
<td>Establish Priorities</td>
<td>Establish a List of Top 5 Priorities</td>
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**AGENDA – Day 2**

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<td>Registration</td>
<td>Coffee and snacks to be provided</td>
</tr>
<tr>
<td>8:30</td>
<td>Welcome</td>
<td>Opening Remarks, Chief Stan Standridge, San Marcos Police Department</td>
</tr>
<tr>
<td>8:45</td>
<td>Preview &amp; Review</td>
<td>Preview of Day #2 Review Day #1 Accomplishments</td>
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<tr>
<td>9:15</td>
<td>Action Planning</td>
<td>Group Work</td>
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<tr>
<td>10:30</td>
<td>Break</td>
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<tr>
<td>10:45</td>
<td>Finalize the Action Plan</td>
<td>Group Work</td>
</tr>
<tr>
<td>11:30</td>
<td>Workgroup Report Outs</td>
<td>Each Group will Report Out on Action Plans</td>
</tr>
<tr>
<td>12:00</td>
<td>Next Steps &amp; Summary</td>
<td>Finalize Date of Next Task Force Meeting Discuss Next Steps for Hays County Report Share Technical Assistance Opportunities Complete Evaluation Form</td>
</tr>
<tr>
<td>12:20</td>
<td>Closing Remarks</td>
<td>Closing Remarks, Commissioner Walt Smith, Hays County Commissioner’s Court, Precinct 4</td>
</tr>
<tr>
<td>12:30</td>
<td>Adjourn</td>
<td></td>
</tr>
</tbody>
</table>
Appendix B: Overview of Hays County Resources

Intercept 0 and Intercept 1

Intercept 0 encompasses the early intervention points for people with a MI, SUD, and/or IDD prior to possible arrest by law enforcement. It captures systems and services designed to connect people with treatment before a crisis begins or at the earliest possible stage of system interaction.

Intercept 1 encompasses initial contact with law enforcement and other emergency service responses. Law enforcement officers have considerable discretion in responding to a situation in the community involving a person with MI, SUD, and/or IDD who may be engaging in criminal conduct, experiencing a mental health crisis, or both. Intercept 1 captures systems and programs that are designed to divert people away from the justice system and toward treatment when safe and feasible.

Crisis Call Lines

The Hill Country MHDD crisis calls are routed to contractor Avail Solutions, Inc. (Avail). The Avail Crisis Line is available 24 hours per day, 7 days a week. It serves anyone experiencing a behavioral health crisis. Avail triages calls, dispatching Hill Country’s Mobile Crisis Outreach Team (MCOT) when deemed appropriate. For people not experiencing a mental health crisis, Avail can refer callers to the appropriate Hill Country provider of MI, SUD, or IDD services.

In addition to the Hill Country MHDD crisis hotline, Hays County residents have access to the 988 Suicide & Crisis Lifeline, the Hays-Caldwell Women’s Center (HCWC) Crisis Hotline, and other national crisis hotline providers. NSPL is a network of local crisis centers that provides free and confidential emotional support to people in suicidal crisis or emotional distress 24 hours a day, 7 days a week. HCWC provides confidential crisis and information line for victims of abuse 24 hours a day, 7 days a week.

Texas State University students can call the Texas State University Counseling Center Monday through Friday, from 8am to 5pm, to speak with a crisis counselor.
or make a crisis appointment. The Central Texas affiliate of the National Alliance on Mental Illness (NAMI Central Texas) operates a warm line during normal business hours for people seeking mental health information and resources. Telephone numbers for crisis hotline options in Hays County are as follows:

- Hill Country MHDD: 877-466-0660
- 988 Suicide & Crisis Lifeline: 9-8-8
- Hays-Caldwell Women’s Center (HCWC): 512-396-4357
- National Domestic Violence Hotline: 800-799-7233
- The Trevor Project Crisis and Suicide Prevention Lifeline: 866-488-7386
- NAMI Central Texas: 512-420-9810
- Texas State Counseling Center: 512-245-2208

9-1-1 Dispatch

The Combined Emergency Communications Center (CECC) and Public Safety Answering Point (PSAP) provides 9-1-1 call-taking and dispatch services for San Marcos, Buda, and Kyle Police Departments, the Hays County Sheriff’s Office, the five County Constables Offices, San Marcos-Hays County EMS, North and South Hays Fire Department, Kyle Fire Department, Buda Fire and EMS, Wimberly Fire and EMS, and Chisholm Trail Fire and Rescue.

Dispatchers are Texas Commission on Law Enforcement (TCOLE)-Certified telecommunicators, which grants them access to the Texas Law Enforcement Telecommunications System (TLETS). Although dispatchers are not able to directly activate MCOT, they do have the ability to activate a Mental Health Deputy (MHD). Dispatchers “flag” locations from which they frequently receive mental health-related calls.

Crisis Services

Crisis services in Hays County are provided by Hill Country MHDD and can be accessed through the crisis line operated by Avail. If a person in crisis contacts Avail and they determine an MCOT response is appropriate, MCOT is dispatched to the call. Walk-in crisis services are available at Hill Country MHDD locations during regular office hours.

In addition to MCOT and walk-in crisis services, Hill Country MHDD operates the Scheib Center crisis respite center and the Linda J. Werlein Crisis Stabilization Unit (CSU). The Scheib Center crisis respite center serves youth between the ages of 13 and 17 who are at low risk of harm to self or others. The Linda J. Werlein CSU
serves adults who are experiencing a mental health crisis and whose symptoms interfere with their ability to remain safely in the community.

People in need of voluntary or involuntary inpatient psychiatric hospitalization can access hospital-based services in surrounding counties—Travis, Kerr, and Bexar.

**Healthcare**

Public primary care services can be accessed at CommuniCare Health Centers San Marcos. CommuniCare San Marcos is a Federally Qualified Health Center (FQHC). FQHCs can provide preventive health, dental, mental health, substance use, hospital, and specialty care on a sliding scale.

Emergency medical and hospital-based care in Hays County is provided at Baylor, Scott, & White Medical Center in Buda, Ascension Seton in Kyle, and Cristus Santa Rosa in San Marcos.

Substance use services can be accessed at Cenikor in San Marcos, NOVA Recovery Center in Wimberly, and Right Step in Wimberly. Cenikor provides outpatient prevention and mutual support services for youth and young adults. NOVA Recovery Center provides detox, 90-day inpatient, intensive outpatient, aftercare, and sober living. Right Step provides inpatient, outpatient, and aftercare. NOVA and Right Step are private pay facilities. Bluebonnet Trails operates the Outreach, Screening, and Referral (OSAR) program that provides public access to detox, inpatient, and outpatient substance use services to people in Hays County. OSAR-contracted facilities may be located outside of Hays County.

**Law Enforcement and First Responders**

Multiple law enforcement agencies serve Hays County, including the Hays County Sheriff’s Office, San Marcos Police Department (PD), Kyle PD, Buda PD, and Texas State University PD. Emergency Medical Services are provided through San Marcos-Hays County EMS, Kyle Fire and EMS, Buda Fire and EMS, and Wimberly Fire and EMS. Law enforcement and other first responders are routed through 9-1-1 dispatch.

The Hays County Sheriff’s Office has a dedicated Mental Health Deputy program to respond to emergency calls involving people believed to be experiencing a mental health crisis. Mental Health Deputies (MHD) are licensed peace officers and have completed the required TCOLE Mental Health Certification course and a 12-week field training program. MHDs have the authority to file Emergency Detention Orders (EDO) for inpatient care, divert people in crisis to community-based mental health services, and assist Hill County MHDD MCOT to ensure the safety of the scene when responding to a person in crisis. Currently, the Hays County Sheriff’s Office employs
1 mental health sergeant, 4 mental health deputies, and 2 outreach liaisons that are available 24 hours a day.

Texas State University PD provides law enforcement services in and around the university campus.

**Housing**

Housing services are most effectively provided on a continuum that may include emergency shelter, rapid re-housing, permanent supportive housing and transitional housing options. Southside Community Center in San Marcos operates a 30- to 90-day transitional shelter for people experiencing homelessness who proactively work toward independence. Oxford House operates a network of sober living homes for people with substance use concerns who abstain from substance use while a resident. Currently, there are no emergency or temporary congregate shelters for people experiencing homelessness in Hays County.

The Greater San Marcos Youth Council is private, non-profit that operates a Children’s Shelter to provide residential services to children and youth who have been victims of abuse and neglect. The Hays-Caldwell Women’s Center (HCWC) operates the McCoy Family Shelter, a secure facility for women, men, and families who are victims of violence and abuse. Residents of the McCoy Family Shelter have access to individual and group counseling provided by HCWC.

**Peer Support**

Cenikor San Marcos is a Recovery Support Service (RSS) provider that incorporates peer support services into the program’s prevention and intervention services. Hill County MHDD adult mental and behavioral health programs employ Peer Support Specialists. NAMI Central Texas provides peer and family support services to residents of Hays County.

**Special Populations**

Services across the SIM intercepts can be specialized to support the unique needs of special populations, including children and adolescents. Hill Country MHDD provides mental health services and support to children and adolescents who reside in their catchment area. The Youth Empowerment Services (YES) Waiver program provides a variety of in-home and alternative community services, including animal-assisted and art therapy, family supports, paraprofessional services, respite care, and community livings supports.
Data Collection and Information Sharing

Baseline data across the intercepts was collected when planning for the Hays County SIM Mapping Workshop. In Hays County, data collection is performed independently by each service provider, agency, and/or program. Data sharing is done on an as need basis.

Intercept 2 and Intercept 3

After a person has been arrested, they move to Intercept 2 of the model. At Intercept 2, a person is detained and faces an initial hearing presided over by a judge or magistrate. This is the first opportunity for judicial involvement, including interventions such as intake screening, early assessment, appointment of counsel and pretrial release of those with MI, SUD, and/or IDD.

During Intercept 3 of the model, people with MI, SUD, and/or IDD not yet diverted at earlier intercepts may be held in pretrial detention at a local jail while awaiting the disposition of their criminal cases.

Booking

In Hays County, a person is brought to the Hays Jail by the arresting law enforcement officer. Upon booking, jail medical staff screen every person brought to the jail for behavioral health concerns using the Screening Form for Suicide and Medical and Mental Impairments provided by the Texas Commission on Jail Standards (TCJS) and run a Continuity of Care Query (CCQ) in the Texas Law Enforcement Telecommunications System (TLETS) to determine if they have accessed public mental health services within the past three years. The screening tool collects information on the presence and severity of feelings of hopelessness and history of suicidal ideations and attempts. If the CCQ produces an exact or probable match, jail staff notify the magistrate who may request an assessment of the person to verify the presence of MI or IDD.
**Jail Medical**

People who are booked into the Hays County Jail can access medical and behavioral health care from the jail’s medical provider, WellPath. A nurse conducts the health screen at booking and logs the medical and psychiatric medications the person indicates they are taking, as well as their medical and mental health history. If a behavioral health concern is indicated during the intake assessment, the medical provider refers the person to the WellPath behavioral health provider for a thorough behavioral health assessment.

WellPath provides behavioral health assessment and psychiatric care. WellPath does not provide counseling or ongoing MH services and will not do forced medications as a component of court ordered medications (COMs). WellPath may contact Hill Country MHDD if they are notified by an inmate that they receive services from Hill Country MHDD. Hill Country MHDD may contact WellPath if they are notified that a client has been booked into the Hays County Jail.

**Competence to Stand Trial**

Competence to stand trial is the legally determined capacity of a criminal defendant to proceed with criminal adjudication. A criminal defendant may not be subjected to trial if they lack the capacity to understand the proceedings against them and to consult with counsel with a reasonable degree of rational understanding (CCP Art. 46B.003). Texas procedures related to competency are generally found in Chapter 46B of the CCP. Chapter 46B applies to a defendant charged with a felony or with a misdemeanor punishable by confinement (CCP Art. 46B.002). Hays County Jail currently houses individuals waiting to receive competency restoration services.

**Pretrial Services**

Pretrial services describe a larger process that encompasses the use of a risk assessment and makes recommendations regarding bonds and pretrial supervision. Hays County is currently in the process of establishing a pretrial services program for people with behavioral health concerns but does not currently operate a pretrial program.

**Courts (Including Specialty Court Dockets)**

The Hays County Courts at Law oversee misdemeanor criminal cases. District Courts oversee felony criminal cases. Specialty court dockets, which are state-mandated for counties of certain population levels, are established to reduce recidivism through therapeutic and interdisciplinary approaches that address underlying mental health and SUD without jeopardizing public safety. Hays County
operates a Misdemeanor Veteran Treatment Court, a Misdemeanor Mental Health Court, and a Felony Drug Court.

**Data Collection and Information Sharing**

Data sharing between jails, courts, and behavioral health providers can improve coordination and continuity of care for justice-involved people with behavioral health conditions. Currently, Hays County does not have a coordinated data collection and information sharing system.

** Intercept 4 and Intercept 5**

At Intercept 4 of the model, people plan for and transition from jail or prison into the community. Supportive reentry establishes strong protective factors for justice-involved people with MI, SUD, and/or IDD re-entering a community.

People under correctional supervision are usually on probation or parole as part of their sentence, as part of the step-down process from prison, or as part of other requirements by state statutes. The last intercept of the model aims to combine justice system monitoring with person-focused service coordination to establish a safe and healthy post-criminal justice system lifestyle.

**Jail Health Reentry Services**

WellPath provides mental health services to people in the Hays County jail. Community reentry planning is limited prior to jail release.

**Community Reentry**

In collaboration with the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Hill Country MHDD provides a 90-day continuity of care program for people exiting the justice system who meet certain criteria. Continuity of care services include case management, life skills training, psychiatric services, medication management, benefits coordination, and referral to
community-based services such as counseling, group therapy, substance use services, and housing and employment support.

**Probation and Parole**

Adult probation services are provided by Hays County Adult Probation. The Texas Department of Criminal Justice (TDCJ) Parole Division operates the Region 4 District Parole Office in Travis County, which covers Hays County.

Adult probation services are provided by the Caldwell, Comal and Hays Counties Community Supervision and Corrections Department.

The Texas Risk Assessment System (TRAS) is used to determine specialized service needs for people entering the community on probation and parole and to identify persons who are appropriate for specialized caseloads.

The Texas Juvenile Justice Department (TJJD) oversees the Hays County Juvenile Probation Department.
### Appendix C: Community Impact Measures

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<td>Mental health crisis line calls, count (#)</td>
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<td>Crisis Lines</td>
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<td>Emergency department admissions for psychiatric reasons, count (#)</td>
<td>Intercept 0</td>
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<td>Emergency department admissions for psychiatric reasons, average length of stay (hours)</td>
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<td>Mobile crisis outreach team face-to-face episodes, treated-in-place (% of episodes)</td>
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<td>Mobile crisis outreach team calls, repeat calls (% of calls)</td>
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<tr>
<td>8</td>
<td>Crisis center admissions, transported by law enforcement (% of all admissions)</td>
<td>Intercept 0</td>
<td>Crisis Center</td>
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<td>9</td>
<td>Crisis center admission, law enforcement wait time (average)</td>
<td>Intercept 0</td>
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<td>10</td>
<td>Law enforcement officers trained in specialized responses (e.g., Crisis Intervention Team), percent of sworn (%)</td>
<td>Intercept 1</td>
<td>Law Enforcement</td>
</tr>
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<td>Mental health crisis calls handled by law enforcement (trained and untrained), count (#)</td>
<td>Intercept 1</td>
<td>Law Enforcement</td>
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<td>12</td>
<td>Mental health crisis calls handled by trained law enforcement officers, percent (%)</td>
<td>Intercept 1</td>
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<td>13</td>
<td>Daily Jail Population</td>
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<td>14</td>
<td>Proportion of people in jail with low-level misdemeanors</td>
<td>Intercept 2</td>
<td>Jail (Pretrial)</td>
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<tr>
<td>15</td>
<td>Proportion of people in jail with low-level misdemeanors who have a serious mental health issue</td>
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<td>16</td>
<td>Jail bookings, count (#)</td>
<td>Intercept 2</td>
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<td>17</td>
<td>number of jail bookings for low-level misdemeanors</td>
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<td>Jail mental health screenings, count (#)</td>
<td>Intercept 2</td>
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<td>19</td>
<td>Jail mental health screenings, percent screening positive (%)</td>
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<td>Jail (Pretrial)</td>
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<td>20</td>
<td>Jail substance use screenings, count (#)</td>
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<td>Jail substance use screenings, percent screening positive (%)</td>
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<td>Jail (Pretrial)</td>
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<td>22</td>
<td>Pretrial release rate of all arrestees, percent released (%)</td>
<td>Intercept 2</td>
<td>Pretrial Release</td>
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<tr>
<td>23</td>
<td>Pretrial release rate of all arrestees with mental disorders, percent released (%)</td>
<td>Intercept 2</td>
<td>Pretrial Release</td>
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<tr>
<td>24</td>
<td>average length of stay for this population</td>
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<td>Jail (Pretrial)</td>
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<td>average cost per day to house someone in jail</td>
<td>Intercept 2</td>
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<td>26</td>
<td>average cost per day to house people with mental health issues in jail</td>
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<td>Jail (Pretrial)</td>
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<td>27</td>
<td>average cost per day to house someone with psychotropic medication</td>
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<td>28</td>
<td>mapping data to see geographic catchment area</td>
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<td>Jail (Pretrial)</td>
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<td>29</td>
<td>jail bookings and conviction by charge</td>
<td>Intercept 2</td>
<td>Jail (Pretrial)</td>
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<td>Caseload rate of the court system, misdemeanor, and felony cases (#)</td>
<td>Intercept 3</td>
<td>Case Processing</td>
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<td>31</td>
<td>Misdemeanor and felony cases where the defendant is evaluated for adjudicative competence, percent of criminal cases (%)</td>
<td>Intercept 3</td>
<td>Case Processing</td>
</tr>
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<td>32</td>
<td>Jail sentenced population, average length of stay (days)</td>
<td>Intercept 3</td>
<td>Incarceration</td>
</tr>
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<td>33</td>
<td>Jail sentenced population with mental disorders, average length of stay (days)</td>
<td>Intercept 3</td>
<td>Incarceration</td>
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<td>34</td>
<td>Individuals with mental or substance use disorders receiving reentry coordination prior to jail release, count (#)</td>
<td>Intercept 4</td>
<td>Reentry</td>
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<td>35</td>
<td>Individuals with mental or substance use disorders receiving benefit coordination prior to jail release, count (#)</td>
<td>Intercept 4</td>
<td>Reentry</td>
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<td>Individuals with mental disorders receiving a short-term psychotropic medication fill or a prescription upon jail release, count (#)</td>
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<td>Reentry</td>
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<td>Probationers with mental disorders on a specialized mental health caseload, percent of probationers with mental disorders (#)</td>
<td>Intercept 5</td>
<td>Community Corrections</td>
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<td>38</td>
<td>Probation revocation rate of all probationers, percent (%)</td>
<td>Intercept 5</td>
<td>Community Corrections</td>
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<td>39</td>
<td>Probation revocation rate of probationers with mental disorders, percent (%)</td>
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<td>Community Corrections</td>
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<td>40</td>
<td>Criminal justice and behavioral health coordinating body meetings, count (#)</td>
<td>Cross-Intercept</td>
<td>Coordination</td>
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</tbody>
</table>
Appendix D: Texas and Federal Privacy and Information Sharing Provisions

Mental Health Record Protections

Health and Safety Code Chapter 533:

Section 533.009. EXCHANGE OF PATIENT RECORDS.

(a) HHSC facilities, local mental health authorities, community centers, other designated providers, and subcontractors of mental health services are component parts of one service delivery system within which patient records may be exchanged without the patient's consent.

Health and Safety Code Chapter 611:

Section 611.004 AUTHORIZED DISCLOSURE OF CONFIDENTIAL INFORMATION OTHER THAN IN JUDICIAL OR ADMINISTRATIVE PROCEEDING.

(a) A professional may disclose confidential information only:

1. to a governmental agency if the disclosure is required or authorized by law;
2. to medical, mental health, or law enforcement personnel if the professional determines that there is a probability of imminent physical injury by the patient to the patient or others, or there is a probability of immediate mental or emotional injury to the patient;
3. to qualified personnel for management audits, financial audits, program evaluations, or research, in accordance with Subsection (b);
4. to a person who has the written consent of the patient, or a parent if the patient is a minor, or a guardian if the patient has been adjudicated as incompetent to manage the patient's personal affairs;
5. to the patient's personal representative if the patient is deceased;
6. to individuals, corporations, or governmental agencies involved in paying or collecting fees for mental or emotional health services provided by a professional;
7. to other professionals and personnel under the professionals' direction who participate in the diagnosis, evaluation, or treatment of the patient;
8. in an official legislative inquiry relating to a state hospital or state school as provided by Subsection (c);
(9) to designated persons or personnel of a correctional facility in which a person is detained if the disclosure is for the sole purpose of providing treatment and health care to the person in custody;

(10) to an employee or agent of the professional who requires mental health care information to provide mental health care services or in complying with statutory, licensing, or accreditation requirements, if the professional has taken appropriate action to ensure that the employee or agent:

(A) will not use or disclose the information for any other purposes;

and

(B) will take appropriate steps to protect the information; or

(11) to satisfy a request for medical records of a deceased or incompetent person pursuant to Section 74.051(e), Civil Practice and Remedies Code.

(a-1) No civil, criminal, or administrative cause of action exists against a person described by Section 611.001(2)(A) or (B) for the disclosure of confidential information in accordance with Subsection (a)(2). A cause of action brought against the person for the disclosure of the confidential information must be dismissed with prejudice.

(b) Personnel who receive confidential information under Subsection (a)(3) may not directly or indirectly identify or otherwise disclose the identity of a patient in a report or in any other manner.

(c) The exception in Subsection (a)(8) applies only to records created by the state hospital or state school or by the employees of the hospital or school. Information or records that identify a patient may be released only with the patient's proper consent.

(d) A person who receives information from confidential communications or records may not disclose the information except to the extent that disclosure is consistent with the authorized purposes for which the person first obtained the information. This subsection does not apply to a person listed in Subsection (a)(4) or (a)(5) who is acting on the patient's behalf.

Health and Safety Code Chapter 614

Section 614.017 EXCHANGE OF INFORMATION.

(a) An agency shall:

(1) accept information relating to a special needs offender or a juvenile with a mental impairment that is sent to the agency to serve the purposes of continuity of care and services regardless of whether other state law makes that information confidential; and
(2) disclose information relating to a special needs offender or a juvenile with a mental impairment, including information about the offender's or juvenile's identity, needs, treatment, social, criminal, and vocational history, supervision status and compliance with conditions of supervision, and medical and mental health history, if the disclosure serves the purposes of continuity of care and services.

(b) Information obtained under this section may not be used as evidence in any juvenile or criminal proceeding, unless obtained and introduced by other lawful evidentiary means.

(c) In this section:

(1) "Agency" includes any of the following entities and individuals, a person with an agency relationship with one of the following entities or individuals, and a person who contracts with one or more of the following entities or individuals:

   (A) the Texas Department of Criminal Justice and the Correctional Managed Health Care Committee;
   (B) the Board of Pardons and Paroles;
   (C) the Department of State Health Services;
   (D) the Texas Juvenile Justice Department;
   (E) the Department of Assistive and Rehabilitative Services;
   (F) the Texas Education Agency;
   (G) the Commission on Jail Standards;
   (H) the Department of Aging and Disability Services;
   (I) the Texas School for the Blind and Visually Impaired;
   (J) community supervision and corrections departments and local juvenile probation departments;
   (K) personal bond pretrial release offices established under Article 17.42, Code of Criminal Procedure;
   (L) local jails regulated by the Commission on Jail Standards;
   (M) a municipal or county health department;
   (N) a hospital district;
   (O) a judge of this state with jurisdiction over juvenile or criminal cases;
(P) an attorney who is appointed or retained to represent a special needs offender or a juvenile with a mental impairment;
(Q) the Health and Human Services Commission;
(R) the Department of Information Resources;
(S) the bureau of identification and records of the Department of Public Safety, for the sole purpose of providing real-time, contemporaneous identification of individuals in the Department of State Health Services client data base; and
(T) the Department of Family and Protective Services.

**SUD Records Protections:**

**42 CFR Part 2.** CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS

**42 CFR Part 2 Subpart C.** DISCLOSURES WITH PATIENT CONSENT

**42 CFR Part 2 Subpart D.** DISCLOSURES WITHOUT PATIENT CONSENT

**42 CFR Part 2 Subpart E.** COURT ORDERS AUTHORIZING DISCLOSURE AND USE
Appendix E: Resources for Law Enforcement During a Behavioral Health Crisis

Resources for Law Enforcement During Behavioral Health Crises

March 2022

Commitment Status: Voluntary

Immediate medical attention needed?

Yes

Transport to ER

Hospital will facilitate placement or activate BTCS Crisis Team

No

Call 512-701-1982 for assessment and placement assistance or transport to the Diversion Center

Commitment Status: Involuntary

Immediate medical attention needed?

Yes

Transport to ER

Hospital will facilitate placement or activate BTCS crisis team

No

Law Enforcement to write emergency detention and transport, if needed

Imminent Risk? 
Danger to self/others, severe deterioration, psychosis, or inadvertent risk

Yes

No

Provide person/family with BTCS Crisis Hotline: 800-841-1255
BTCS Care Coordination Line: 833-359-0106

Send Referral for Follow Up to Wilco_LE_Referrals@bbnails.org or fax to 512-686-6847

At any point during this process, please call the crisis team for consultation 24/7.
BTCS Crisis Team Consult Line 512-701-1982

Bluebonnet Trails Community Services
Appendix F: Acute Mental Health Crisis Transport Algorithm

Acute Mental Health Crisis Transport

History
- Mental / psychiatric illness / behavioral health medications
- Suicidal / homicidal with or without actual act or plan
- Situational crisis

Signs and Symptoms
- Anxiety, agitation, or confusion
- Affect change or hallucinations
- Delusional thoughts / bizarre behavior
- Expression of suicidal / homicidal thoughts
- Depression

Differential
- Altered mental status
- Alcohol intoxication
- Toxins / substance abuse
- Medication withdrawal syndromes
- Bipolar
- Schizophrenia

---

Is the scene safe?
- Yes
- Call for help / additional resources. Stage until the scene is safe

Universal Patient Care protocol.
Basic evaluation of the patient including vital signs, blood glucose measurement, and an appropriate body survey.

Vital sign range:
- Heart rate between 60 to 110 bpm
- Systolic BP between 110 to 160 mmHg
- Pulse oximetry > 92% on room air
- Blood glucose > 70 and < 300 mg/dL
- Axillary – Between 96.8 to 100.4 F

Meets all vital sign criteria

Cooperative and non-violent?
- Yes
- No

Is the patient awake, alert, and can ambulate without difficulty?
- Yes
- No

Behavior not caused by an acute medical condition? Examples include hypoxia, BGL, HTN emergencies, and head injury.
- Yes
- No

Denies any acute injury? No acute injuries noted?
- Yes
- No

Denies pregnancy?
- Yes
- No

Denies overdose with any medication? ***
- Yes
- No

Patient preference: If "The Plaza" or CMC, proceed to CMC emergency department.

If no preference, requests UMC, or requests Sunrise Canyon, notify the Sunrise Canyon crisis worker at 800-790-1227. Do not release this phone number.

Transport to the emergency department and notify the receiving hospital.

---

* If the patient requires supplemental oxygen for an acute or chronic condition, transport the patient directly to the emergency department.

** If the patient has consumed alcoholic beverages in the last 8 hours and/or presents with signs of clinical intoxication (example: unable to stand unassisted or slurred speech), transport the patient to the emergency department for medical clearance.

*** If there is any chance the patient may have taken "too many medications", the patient should be taken to an Emergency Center. Be sure to ask specifically about Tylenol and aspirin.
Appendix G: CCP 16.22 Forms and Process Charts

During the Hays County SIM Mapping Workshop participants identified opportunities to enhance and better leverage 16.22 processes to identify people with mental illness and connect them to care. Below is an overview of 16.22, as defined by the Texas Code of Criminal Procedure, as well as some process charts that could be helpful to stakeholders who seek to enhance their CCP 16.22 Procedures.

Applicable Forms for Tex. CCP § 16.22 Process

1. **Police interaction / detention of defendant**
   - Consider if diversion under CCP 16.23 applies to situation

2. **If not, & interaction becomes an arrest, Police take defendant to jail**

3. **Jailer completes Screening Form**
   - If Jailer gets a “yes” answer or has any other credible information, then continue
   - 16.22(1)(A) 15.17(e-1)

4. **Jailer fills out Magistrate Notification Form 16.22(a)(1)**
   - Within 12 hours, provides form as notification to Magistrate

5. **Magistrate:**
   - Reviews notification form
   - Reviews charges / criminal history
   - Meets with Defendant
   - Communicates with LMHA/LIDDA/MH Provider

6. **If Magistrate determines there is reasonable cause to believe the Defendant has MI or is a person with IDD, then continue.**
   - 16.22(b)(1)

   **Note:** The determination of reasonable cause to believe can arise from jailer notification or from Magistrate’s own observations

7. **Magistrate conducts 15.17 hearing (magistration)**
   - Consider if CCP 17.032 is applicable
   - Set terms & conditions of bond
   - Enter bond terms and conditions into TCIC per CCP art. 17.50

8. **Magistrate shall** order MH Provider to conduct 16.22 interview.
   - 16.22(a)(1)

   - LHMA / LIDDA / MH Provider returns 16.22 report (TCDMMP form) to Magistrate

9. **Magistrate must give notice of 16.22 report to all stakeholders**
   - Stakeholders include:
     - Defense Counsel
     - State’s Attorney
     - Trial Court
     - Sheriff (or holder of medical records of D)
     - Personal bond office / director pretrial supervision dept.

10. **Within 96 hours if defendant in custody; 30 days if defendant out of custody**
    - 16.22(b)(1)(1)(A)

11. **LMHA/LIDDA/MH Provider interviews defendant and makes report**

---

*Not required if:
  * D no longer in custody OR
  * D had 16.22 interview & report done within year prior to arrest date, and a court elects to use that report 16.22(a)(2)*
16.22 Process

- **Take to Jail. Jailer Completes Screening Form**
  - 16.22(a)(1) & 15.17(a-1)
  - NO

- **A “yes” answer to MH/IDD question -OR- any other credible info**
  - Jailer Notifies Magistrate 16.22(a)(1)

- **Proceed as a non-MH case**
  - NO

- **Magistrate**
  - Reviews notification form
  - Reviews charges/ criminal history
  - Meets with Defendant
  - Communicates with LMHA/LIDDA/MH Provider (County Specific Notes)

- **Magistrate determines if there is reasonable cause to believe D has MI or IDD**
  - YES

- **Magistrate shall Order MH Provider to conduct 16.22 interview. 16.22(a)(1)**

- **Magistrate conducts 15.17 hearing**
  - Consider if CCP 17.032 is applicable
  - Set terms & conditions of bond
  - Enter bond terms into TCIC per CCP art. 17.50

- ** возможные направления линий связи**

- **Continue to Next Page**

- **Possible Diversion Locations**
  - County Specific Notes

- **Divert under 16.23?**
  - YES
  - Police Interaction
  - Start
Clerk required to document the number of 16.22 reports completed on Judicial Monthly Court Activity Report. See VCA § 16.22(a) & Tex. Admin Code Ch. 171.

- **County / District Clerk**
  - County Specific Notes

- **Trial Court**
  - County Specific Notes

- **Prosecutor**
  - County Specific Notes

- **Defense Attorney**
  - County Specific Notes

- **Sheriff (jail records)**
  - County Specific Notes

- **Personal bond office / Pretrial**
  - County Specific Notes

**Flowchart:**
- Magistrate Receives Report from MH Provider
- Magistrate gives report to stakeholders
  - 16.22(b-1)
Court Receives 16.22 Written Report

16.22(c)(1)
17.032 PR Bond

Special MH Related Conditions

Outpatient Competency Restoration (OCR)

Jail Based Competency Restoration (JBCR)

State Hospital Competency Restoration (CR) Services (waitlist)

Monitor D while on Bond

CR Successful

CR Failed

Consider Transfer to Civil Court for Commitment (with or without dismissal)

Proceed with Criminal Case

Proceed with Civil Court for Commitment (with or without dismissal)

D fails to comply with court-ordered outpatient services

D complies with court-ordered outpatient services

State moves & Court Orders criminal case dismissed

Order transferring D to appropriate court for court-ordered OUTPATIENT MH services (regardless of competency status)

State files Application for Court-Ordered Outpatient MH Services (Health & Safety Code 574).

Note: When considering starting (c)(2), remember that competency restoration is not comprehensive MH treatment. Try (c)(5) instead.
## Appendix H: SIM Mapping Workshop Participant List

<table>
<thead>
<tr>
<th>Name</th>
<th>Agency/Title</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alison Mohr Boleware</td>
<td>Hogg Foundation</td>
</tr>
<tr>
<td>Amy Lowrie</td>
<td>Hill Country MHDD</td>
</tr>
<tr>
<td>Aroya McGhee Enyard</td>
<td>Wellpath – Hays County</td>
</tr>
<tr>
<td>Ashley Seitz</td>
<td>ACDA</td>
</tr>
<tr>
<td>Baleigh Stibbens</td>
<td>Ascension Seton/LMSW</td>
</tr>
<tr>
<td>Carolie Bartolomwcei</td>
<td>MCMDO Care Navigator</td>
</tr>
<tr>
<td>Chris Johnson</td>
<td>CCL #2</td>
</tr>
<tr>
<td>Cindi Carter</td>
<td>District Courts Hays Co.</td>
</tr>
<tr>
<td>Dan O’Brien</td>
<td>Hays CCC 3 Judge</td>
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<tr>
<td>Dan Royston</td>
<td>SMPD</td>
</tr>
<tr>
<td>David Glickler</td>
<td>Attorney</td>
</tr>
<tr>
<td>Debbie Ingalsbe</td>
<td>Hays County</td>
</tr>
<tr>
<td>Deborah Villalpando</td>
<td>Southside Community Center</td>
</tr>
<tr>
<td>Ed Kum</td>
<td>Scheib</td>
</tr>
<tr>
<td>Elaine Cardenas</td>
<td>Hays County</td>
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<tr>
<td>Eric Dobbs</td>
<td>Hays County Attorney</td>
</tr>
<tr>
<td>Erin Barker</td>
<td>HCSO</td>
</tr>
<tr>
<td>James Swisher</td>
<td>SMHC EMS</td>
</tr>
<tr>
<td>Jason Anika</td>
<td>Hays Adult Probation</td>
</tr>
<tr>
<td>Jeff Hohl</td>
<td>NDS – Supervising Attorney</td>
</tr>
<tr>
<td>Jeffrey Weatherford</td>
<td>Hays DA</td>
</tr>
<tr>
<td>John Saenz</td>
<td>HCSO</td>
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<tr>
<td>Joyce Bender</td>
<td>San Marcos Police MHU</td>
</tr>
<tr>
<td>Julie Villalpando</td>
<td>HCSO - Captain</td>
</tr>
<tr>
<td>Kendra Marsteller</td>
<td>TXST UPD</td>
</tr>
<tr>
<td>Kristi Taylor</td>
<td>ED JCMH</td>
</tr>
<tr>
<td>Name</td>
<td>Organization</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------------------------</td>
</tr>
<tr>
<td>Layla Fry</td>
<td>Director of Youth Justice; Meadows Mental Health Policy Institute</td>
</tr>
<tr>
<td>Lina Muniz</td>
<td>CSR CN RN</td>
</tr>
<tr>
<td>Marie Herrea</td>
<td>ARCIL</td>
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<tr>
<td>Martin Rodriguez</td>
<td>Buda PD</td>
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<td>Mary Beth Roper</td>
<td>Scheib</td>
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<td>Matt Burns</td>
<td>District County Courts</td>
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<tr>
<td>Meenu Walters</td>
<td>NDS</td>
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<tr>
<td>Men Moore</td>
<td>Hays County Mag.</td>
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<td>Michael Fogiry</td>
<td>Hill Country MHDD</td>
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<td>Michael Kerr</td>
<td>Ascension Seton</td>
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<tr>
<td>Michelle Harper</td>
<td>United Way</td>
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<td>Michelle Zaumeyer</td>
<td>Hill Country MHDD</td>
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<tr>
<td>Natalie Weimer</td>
<td>Cenikor</td>
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<tr>
<td>Nate Waters</td>
<td>Kyle PD</td>
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<tr>
<td>Nichole Mueller McMorris</td>
<td>Wellpath – Mental Health Coordinator</td>
</tr>
<tr>
<td>Peter Arellano</td>
<td>UT/Program Director</td>
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<tr>
<td>Rebekah Falke</td>
<td>Christus Santa Rosa Hospital</td>
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<tr>
<td>Ron Stretcher</td>
<td>MMHPI</td>
</tr>
<tr>
<td>Samantha Vanderberg</td>
<td>VAC</td>
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<tr>
<td>Sarah Blevins</td>
<td>ED Director Christus Health</td>
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<tr>
<td>Sarah Kramer</td>
<td>Austin Oaks</td>
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<tr>
<td>Shelley MacAllister</td>
<td>Unite Us Community Engagement Mgr.</td>
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<tr>
<td>Stacy Johnston</td>
<td>HCSO</td>
</tr>
<tr>
<td>Stan Stondridge</td>
<td>Chief; SMPD</td>
</tr>
<tr>
<td>Steve Cunningham</td>
<td>Hays County Sheriff’s Office</td>
</tr>
<tr>
<td>Tod Citron</td>
<td>CEO HCMHDDC</td>
</tr>
<tr>
<td>Tucker Furlow</td>
<td>ACAA ADA</td>
</tr>
<tr>
<td>Wesley Mau</td>
<td>Hays County CDA</td>
</tr>
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</table>
List of Acronyms

Include a list of all acronyms that appear in the report. Add each new entry in its own row of this table.

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
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<tbody>
<tr>
<td>ACT</td>
<td>Assertive Community Treatment</td>
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<tr>
<td>ARPA</td>
<td>American Rescue Plan Act</td>
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<tr>
<td>BHLT</td>
<td>Behavioral Health Leadership Team</td>
</tr>
<tr>
<td>BJA</td>
<td>Bureau of Justice Assistance</td>
</tr>
<tr>
<td>CARR</td>
<td>City and Rural Ride Service</td>
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<tr>
<td>CCP</td>
<td>Code of Criminal Procedure</td>
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<td>CCQ</td>
<td>Continuity of Care Query</td>
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<td>CIT</td>
<td>Crisis Intervention Team</td>
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<td>CJCC</td>
<td>Criminal Justice Coordinating Council</td>
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<td>CSG</td>
<td>Council of State Governments</td>
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<td>CSH</td>
<td>Corporation of Supportive Housing</td>
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<td>COMs</td>
<td>Court Ordered Medications</td>
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<td>CRCG</td>
<td>Community Resource Coordination Group</td>
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<td>DDJ</td>
<td>Data-Driven Justice</td>
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<td>DOJ</td>
<td>Department of Justice</td>
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<tr>
<td>ECHO</td>
<td>Ending Community Homelessness Organization</td>
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<td>Acronym</td>
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<tr>
<td>ED</td>
<td>Emergency Department</td>
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<td>EMS</td>
<td>Emergency Medical Services</td>
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<td>ER</td>
<td>Emergency Room</td>
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<tr>
<td>FUSE</td>
<td>Frequent User System Engagement</td>
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<tr>
<td>FQHC</td>
<td>Federally Qualified Health Center</td>
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<tr>
<td>HCWC</td>
<td>Hays-Caldwell Women’s Center</td>
</tr>
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<td>HHSC</td>
<td>Health and Human Services Commission</td>
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<td>HIPAA</td>
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<td>HMA</td>
<td>Health Management Associates</td>
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<tr>
<td>IDD</td>
<td>Intellectual and Developmental Disability</td>
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<td>ISD</td>
<td>Independent School District</td>
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<tr>
<td>IST</td>
<td>Incompetent to Stand Trial</td>
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<tr>
<td>JCAFS</td>
<td>Joint Committee on Access and Forensic Services</td>
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<td>JSO</td>
<td>Juvenile Supervision Officer</td>
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<td>LE</td>
<td>Law Enforcement</td>
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<td>LIDDA</td>
<td>Local Intellectual and Develop</td>
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<td>LMHA</td>
<td>Local Mental Health Authority</td>
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<td>LPC</td>
<td>Licensed Professional Counselor</td>
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<td>MAT</td>
<td>Medication-Assisted Treatment</td>
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<td>MCOT</td>
<td>Mobil Crisis Response Team</td>
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<td>My Health My Resources Concho Valley</td>
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<td>MI</td>
<td>Mental Illness</td>
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<td>MOU</td>
<td>Memorandum of Understanding</td>
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<td>NCMHJJ</td>
<td>National Center for Mental Health and Juvenile Justice</td>
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<tr>
<td>NCYOJ</td>
<td>The National Center for Youth Opportunity and Justice</td>
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<tr>
<td>NTBHA</td>
<td>North Texas Behavioral Health Authority</td>
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<tr>
<td>OCR</td>
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<td>OPC</td>
<td>Order of Protective Custody</td>
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<td>OSAR</td>
<td>Outreach Screening and Referral</td>
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<td>OSFD</td>
<td>Office of the State Forensic Director</td>
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<td>OTP</td>
<td>Opioid Treatment Program</td>
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<td>PBHA</td>
<td>Panhandle Behavioral Health Alliance</td>
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<td>PD</td>
<td>Police Department</td>
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<td>PRA</td>
<td>Policy Research Associates</td>
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<td>QMHP</td>
<td>Qualified Mental Health Professional</td>
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<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>ROI</td>
<td>Release of Information</td>
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<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
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<td>SIM</td>
<td>Sequential Intercept Model</td>
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<tr>
<td>SMI</td>
<td>Serious Mental Illness</td>
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<td>SOAR</td>
<td>SSI/SSDI Outreach, Access, and Recovery</td>
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<td>SUD</td>
<td>Substance Use Disorder</td>
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<td>TA</td>
<td>Technical Assistance</td>
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<tr>
<td>TCJS</td>
<td>Texas Commission on Jail Standards</td>
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<tr>
<td>TCOLE</td>
<td>Texas Commission on Law Enforcement</td>
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<tr>
<td>TCOOMMI</td>
<td>Texas Correctional Office on Offenders with Medical or Mental Impairments</td>
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<tr>
<td>TDCJ</td>
<td>Texas Department of Criminal Justice</td>
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<tr>
<td>TLETS</td>
<td>Texas Law Enforcement Telecommunication System</td>
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<tr>
<td>THDSN</td>
<td>The Texas Homeless Data Sharing Network</td>
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<td>TJJD</td>
<td>Texas Juvenile Justice Department</td>
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<tr>
<td>TRAS</td>
<td>Texas Risk Assessment System</td>
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<tr>
<td>YES</td>
<td>Youth Empowerment Services</td>
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</table>
Community stakeholders can consider the following next steps to reduce justice involvement for people with mental illness (MI), substance use disorders (SUD), and/or intellectual and developmental disabilities (IDD). For more information and resources review the Hays County SIM Report.

### Hays County Roadmap

<table>
<thead>
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<th>Invest in Strategic Priorities</th>
<th>Support Local Planning, Partnership and Education</th>
<th>Build Upon Existing Efforts</th>
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| 1. Expand crisis options through the development of a diversion center. | **1. Coordinate**  
- Strengthen behavioral health and justice partnerships through regular convening of a leadership team.  
- Establish subcommittees dedicated to implementing the action plans developed during the SIM Workshop. | Build on alternatives to inpatient competency restoration explored through HHSC's Jail in-Reach Learning Collaborative. |
| 2. Develop strategies to address frequent utilizers and pilot a new Assertive Community Treatment program. | **2. Partner**  
- Identify opportunities to strengthen relationships with new stakeholders (e.g. housing partners, IDD services, jail mental health providers).  
- Learn from other similar sized counties implementing best practice models. | Leverage recommendations from the SIM Mapping Workshop and the Meadows Mental Health Policy Institute MH Assessment to increase available MH services in the jail. |
| 3. Explore the development of a Behavioral Health Office to coordinate county services. | **3. Train**  
- Train stakeholder groups on identifying, responding and effectively treating people with MI, SUD, and IDD. | Explore the opportunity to expand Hays treatment courts to serve individuals pretrial. |
| 4. Increase information and data sharing across the SIM. | | Expand specialized probation caseloads to serve more individuals with BH needs. |
| 5. Enhance 911 and law enforcement response to behavioral health crises. | | |

See the Strategic Action Plans on pg. 19 of the Hays County SIM Report for additional details.
Hays County Gaps, Opportunities and Best Practices

Intercepts 0&1
Community Services, Crisis Services & Law Enforcement

Selected Gaps:
- Mental health (MH) training for 911 dispatch and law enforcement
- Alternatives for diversion from emergency rooms and jail
- Information sharing across stakeholder groups
- Substance use disorder (SUD) treatment options
- Housing options for justice involved individuals

Opportunities:
- Develop a uniform data collection and reporting strategy across stakeholders
- Explore developing a MH crisis diversion center
- Conduct housing assessment to identify community needs
- Provide MH training to 911 dispatchers and law enforcement
- Expand contract capacity for SUD treatment

Intercepts 2&3
Initial Detention, Jails, & Courts

Selected Gaps:
- Wait times for MH assessments and psychiatric referrals
- Wait times for inpatient competency restoration services
- Use of alternatives to inpatient competency restoration
- Pretrial diversion programs
- Ability to flag MH related incidents in jail

Opportunities:
- Increase MH service capacity in jail
- Educate courts on alternatives to competency restoration and waitlist management best practices
- Establish specialized pretrial MH caseloads
- Increase data collection and sharing between MH and criminal justice entities

Intercepts 4&5
Reentry & Community Corrections

Selected Gaps:
- Capacity on specialized probation and parole caseloads
- Case-management and reentry planning in jail prior to a release
- Wait times to access community mental health services upon reentry
- Limited affordable housing for people with criminal records

Opportunities:
- Provide adult probation officers with additional MH training
- Utilize peers to support community reentry programs
- Embed mental health providers in the jail to support care coordination
- Develop a jail-based referral system for improved access to community services

Best Practices at Each Intercept

Intercept 0 & 1
- MH training for LE and 911 dispatch
- Police coding of MH Calls
- Police referrals to treatment
- MH and SUD diversion centers

Intercept 2 & 3
- Consistent screening for MI, SUD and IDD
- Pretrial Supervision and Diversion Programs
- Active forensic waitlist monitoring
- Jail-based SUD and MH services

Intercept 4 & 5
- Robust reentry planning (psych medications, benefits coordination, peer-support)
- Specialized MI, IDD and SUD caseloads
- Jail in-Reach transition planning
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1. Introduction

Having mental health needs is common. National statistics estimate 18 percent of all Americans 18 and older — almost one in five adults — struggle with mental health problems every year (Mental Health America, 2018).

At some point, most people experience life events or changes that impact their mental health leading to negative changes in behavior, feelings, relationships and job performance. This could be a sign additional support or mental health services are needed. Early identification and treatment increases resilience and the possibility of a quick recovery.

Your friend or family member is more than their mental health needs and their quality of life is important. They are a part of a family, a co-worker, and an important member of the community.

This guide helps you navigate adult mental health services in Texas and was developed by the Intellectual and Developmental Disabilities and Behavioral Health Services Section of the Texas Health and Human Services Commission.

What if My Friend or Family Member is an Immediate Danger to Themselves or Others?

If your friend or family member is in crisis:

- Call the crisis hotline at your local mental health authority or local behavioral health authority; or
- Call 911

How Do I Know if My Friend or Family Member Needs Crisis Services?

A person is in urgent need of mental health crisis services if they:

- Are an immediate danger to themselves or others
- Are at risk of serious mental or physical deterioration
- Believe they are a danger to themselves or others
2. Reaching Out for Local Help — Who to Contact

Texas Health and Human Services contracts with 37 Local Mental Health Authorities (LMHA) and two Local Behavioral Health Authorities (LBHA) to deliver mental health services in communities across Texas. There are several ways to locate the LMHA/LBHA in your area:

- Online: apps.hhs.texas.gov/contact/search.cfm
  - This site will allow you to locate the center by entering your county, city or ZIP code.
  - You can also call the referral line of the LMHA/LBHA in your area for confidential help 24/7.
- Phone: Call 2-1-1 and ask for the LMHA/LBHA in your area.

Once you have identified your LMHA/LBHA, give them a call.

Do You Qualify for Mental Health Services? Introducing The Texas Resilience and Recovery Model

In Texas, the service delivery system for community-based mental health services is the Texas Resilience and Recovery (TRR) model. The TRR model acknowledges that people experiencing mental health issues are on a continuum of mental health and have natural supports and strengths which should be built upon to foster recovery. The modern framework of the TRR system uses an intensity-based approach to service delivery.

If a person is experiencing disruption in their daily life because of their mental illness, they might qualify for mental health services. A licensed clinician will meet with them to determine their mental health diagnosis and treatment needs.

The Screening and Assessment Process

For a person to qualify for TRR Mental Health Services, they:

- Must be a Texas resident (the person doesn’t need to prove they are a Texas resident; their statement is sufficient)
- Must meet financial criteria
- Must qualify for mental health services as determined by a uniform assessment. More information on levels of care can be found at Utilization Management Guidelines and Manual webpage.

The Adult Needs and Strengths Assessment is completed at the initial visit and periodically through treatment. The questions are the same ones asked during
intake, where someone from the treatment/recovery team will complete this assessment. The assessment identifies which services best meet ongoing needs and helps track the progress toward recovery goals.
3. Your First Appointment

What Do I Need to Bring?

If this is an intake appointment (to enroll you, or your friend, or family member in services for the first time or to re-enroll after a long break), bring the following with you to the appointment:

- Photo ID
- Proof of income (most current pay stub)
- Most current Medicaid card (if applicable)
- Proof of residence for last 30 days (utility bill or rental agreement)
- Name, address and phone number of any physician who has treated the person enrolling
- A list of all medications the person is taking or has taken
- A list that includes dates of any psychiatric hospitalizations for the person enrolling

Paying for Services

Local mental health and behavioral health authorities complete a financial assessment for people seeking and receiving mental health services. Providers will first try to pay for services with federal Medicare or Medicaid funds, or bill a third-party resource such as private health insurance. A person might be asked to contribute to the cost of their own care, depending on their financial situation. People are charged for services based on their ability to pay.

Uniform Assessment

Your friend or family member will meet with a clinician who will complete a uniform assessment to recommend appropriate services through a level of care. The uniform assessment includes a tool called the “Adult Needs and Strengths Assessment (ANSA).” The ANSA is detailed and might ask questions that make your friend or family member uncomfortable or embarrassed. These questions are important to ask. The answers help identify which services are most likely to meet their needs. The information provided is kept confidential within the limits of the law.

Clients are reassessed periodically to keep track of any changes that might have happened throughout their treatment/recovery plan. This also helps track their strengths and progress they have made toward their recovery.
Assigning a Level of Care — Responding to the Level of Need

The TRR adult mental health system has created levels of care (LOC) that respond to the person’s identified needs. Everyone is unique, and so are their mental health needs. Some have intense and/or complex needs where a more intense level of care with a variety of complex services are more appropriate. However, when a person begins to build up resilience and has less complex needs, they will require a less intense level of care.

To learn more, visit the Utilization Management Guidelines and Manual webpage.

Person-Centered Recovery Planning

After an appropriate LOC is identified for you or your loved one, the person-centered planning (PCRP) begins where the person in services is in the driver’s seat of their own recovery. PCRP uses a collaborative process in developing the recovery plan between the person, the treatment provider and person’s natural supports. The goal of PCRP is to help the person achieve their goals along the journey to recovery.
4. Available Services

Medication Management

- **Medication Training and Support:** This service offers information about medications and their possible side effects. This service is available in Levels of Care (LOC) 1M, 1S, 2, 3, 4 and 5. To learn more, visit the [Medication Management](#) webpage.
- **Pharmacological Management:** This service, provided by a physician or other prescribing professional, deals with the management of psychoactive drugs to treat the signs and symptoms of mental illness. This is available in all service levels. This service is available in all LOCs.

To learn more, visit the [Adult Services Array](#) webpage.

Crisis Services

- **Crisis Follow-up and Relapse Prevention:** Services provided to people who are not an imminent danger of harm to themselves or others, but need help to avoid recurrence of the crisis event. This services helps:
  - Improve the person’s reaction to the situation that led to the crisis event.
  - Ensure stability.
  - Prevent future crisis events.

Ongoing assessments determine crisis status and needs. They also provide up to 30 days of brief, solution-focused interventions to the person and their families. It helps in developing problem-solving techniques to help the person adapt and cope with the situation and stressors that led to the crisis event. The following services are available in all LOCs. To learn more, visit the [Crisis Units](#) webpage.

- **Crisis Intervention:** Interventions in response to a crisis can be used to reduce symptoms of serious mental illness or emotional disturbance and to prevent admission to a more restrictive environment.
- **Crisis Residential Treatment:** Short-term, residential treatment close to home is provided for people with some risk of harm to themselves or others. These people might have fairly severe functional impairment and require direct supervision and care, but not hospitalization.
- **Crisis Stabilization Unit:** This service provides a short-term residential treatment to reduce acute symptoms of mental illness. Services are provided in a safe environment. Treatment is delivered by clinical staff supervised by a psychiatrist.
- **Crisis Transportation:** Transporting people receiving crisis or crisis follow-up and relapse prevention services from one location to another is a service. In accordance with state laws and regulations, transportation is provided by
law enforcement personnel or, when appropriate, by ambulance or qualified staff.

- **Extended Observation**: An up-to-48-hour emergency and crisis stabilization service. It provides emergency stabilization in a safe environment with clinicians (including medical and nursing professionals), supervised by a psychiatrist. There is immediate access to urgent or emergency medical evaluation and treatment, and people are transferred to a higher LOC when needed.

- **Mobile Crisis Outreach Team (MCOT)**: A team of medical and mental health professionals who respond immediately to where a psychiatric crisis is occurring. MCOT is available 24/7 and responds to calls from the home, school, street or clinic. To learn more, visit the Mobile Crisis Awareness Team webpage.

### Case Management

- **Routine Case Management**: Services that are primarily done on-site (at the LMHA/LBHA facility) that assist in gaining and coordinating access to necessary care and services that are appropriate to a person’s needs. Available in LOCs 1M, 1S, 2, 5 and Adult Early Onset. To learn more, visit the Case Management webpage.

- **Intensive Case Management**: Services that are primarily done in the community that assist a person in gaining and coordinating access to necessary care and services that are appropriate to their needs. Available in LOC-Transition Age Youth.

### Rehabilitative and Skills Training

- **Psychosocial Rehabilitation**: Social, educational, vocational, behavioral and cognitive interventions provided by members of a person’s treatment/recovery team that help improve their ability to develop and maintain relationships and independent living skills. They also increase people’s abilities to reach educational and occupational goals, as well as secure housing. This service includes treatment/recovery planning to facilitate recovery. It is available in LOCs 3, 4 and 5. To learn more, visit the Adult Services Array webpage.

- **Skills Training and Development**: Training that deals with serious mental illness and symptom-related problems that interfere with a person’s functioning. It provides opportunities for the person to acquire and improve skills needed to function appropriately and independently, and facilitate their community integration. This service is available in LOCs 1S, 2 and 5. To learn more, visit the Adult Services Array webpage.

- **Illness Management and Recovery (IMR)**: IMR is a curriculum used during Skills Training and Development and Psychosocial Rehabilitation and is designed to help people with SMI work with professionals to reduce their susceptibility to the illness and cope with their symptoms. IMR helps people
discover or rediscover their strengths and abilities for pursuing personal goals and developing a sense of identity, allowing them to grow beyond their mental illness. This service is available in LOCs 1S, 2, 3, 4 and 5. To learn more, visit the Evidence-Based Practices and Resources webpage.

- **Supported Employment:** This program offers services designed to help people with serious mental illness (SMI) gain employment stability and provide individualized assistance to clients in choosing and obtaining competitive employment in regular community jobs. Activities include:
  - Developing skills to reduce or manage symptoms with SMI that might interfere with job performance.
  - Matching client skills and preferences to the best possible job match.
  - Assisting with job applications and interview preparation.
  - Advocating with potential employers.
  - Providing unlimited job supports.
  - Approaching each job experience as a learning experience where there are no failures, only lessons learned by the person to add on to their skillset to help plan for their next job.

This service is available in LOCs 1S, 2, 3, 4, 5, AEO and TAY. To learn more, visit the Supported Employment webpage.

- **Permanent Supportive Housing:** This program offers activities to assist people in choosing, getting and keeping regular housing in the community. Services consist of assistance in finding and moving into habitable, integrated (for example, no more than 50 percent of units occupied by people with SMI) and affordable housing. This service is available in LOCs 1S, 2, 3, 4, 5, AEO and TAY. To learn more, visit the Adult Mental Health Housing webpage.

- **Peer Support:** An evidence-based mental health model of care which consists of a qualified peer support provider with lived experience who assists people with their recovery from mental illness and substance use disorders. As an adjunct to professional clinical services offered by other team members, peer support is the process of giving and receiving encouragement and assistance to achieve long-term recovery. Peers offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities and communities of support. This service is available in LOCs 1M, 1S, 2, 3, 4, 5, AEO and TAY. To learn more, visit the Adult Mental Health Peer Support webpage.

**Housing**

- **Healthy Community Collaborative (HCC):** The HCC program has services and supports for people experiencing homelessness with mental illness and/or substance use disorders including assistance with housing. Partners work together to help people get quality care and to help them understand the care they received. This service is available in all LOCs. To learn more, visit the Adult Mental Health Housing webpage.
- **Permanent Supportive Housing**: This program offers activities to assist people in choosing, getting and keeping regular housing in the community. Services consist of assistance in finding and moving into habitable, integrated (for example, no more than 50 percent of units can be occupied by people with SMI) and affordable housing. This service is available in LOCs 1S, 2, 3, 4, 5 and Adult Early Onset. To learn more, visit the Adult Mental Health Housing webpage.

- **Section 811**: This program provides rental assistance to people with disabilities who have low-income and are linked to long-term services. Availability of services is dependent on LOC and program availability (location). To learn more, visit the Adult Mental Health Housing webpage.

- **Supported Housing Rental Assistance**: This type of assistance consists of funds provided to LMHA/LBHAs to assist people with SMI who are experiencing homelessness or at risk for becoming homeless. Funds are used for one-time/time-limited payments to keep people housed or moved quickly into housing, depending on the person’s identified need. Other eligibility requirements apply and can be discussed through your LMHA/LBHA. Availability of services is dependent on LOC and program availability (location). To learn more, visit the Adult Mental Health Housing webpage.

- **Project Access**: This housing program is administered by the Texas Department of Housing and Community Affairs in partnership with HHSC. It provides 10 Housing Choice Vouchers (tenant-based rental assistance) and support services provided by the LMHA/LBHA to people residing in or recently discharged from a state-funded psychiatric hospital bed. This service is available in all LOCs. To learn more, visit the Adult Mental Health Housing webpage.

- **Projects for Assistance in Transition from Homelessness**: The PATH program provides eligible services to people experiencing homelessness, or at imminent risk of becoming homeless, and who have serious mental illnesses (eligible people might also have co-occurring substance use disorders). PATH offers the following services:
  - Outreach
  - Screening, diagnostic assessment and treatment
  - Habitation and rehabilitation
  - Community mental health services
  - Outpatient alcohol or drug treatment
  - Case management
  - Referral for primary health services, job training, educational services, human immunodeficiency virus (HIV) prevention activities, and relevant housing services
  - Assistance in obtaining income support services, including Supplemental Security Income and representative payee per appropriate regulations
  - Housing services, including planning for housing
  - Technical assistance in applying for housing assistance
  - Coordination of housing and services (improvement in coordinating these services). To learn more, visit the Adult Mental Health Housing webpage.
Employment and Education

- **Supported Employment:** This program offers services designed to help people with SMI gain employment stability and provide individualized assistance to clients in choosing and obtaining competitive employment in regular community jobs. Activities include:
  - Developing skills to reduce or manage symptoms with SMI that might interfere with job performance.
  - Matching client skills and preferences to the best possible job match.
  - Assisting with job applications and interview preparation.
  - Advocating with potential employers.
  - Providing unlimited job supports.
  - Approaching each job experience as a learning experience where there are no failures, only lessons learned by the person to add on to their skillset to help plan for their next job.

This service is available in LOCs 1S, 2, 3, 4, 5, AEO and TAY. To learn more, visit the [Supported Employment webpage](#).

- **Supported Education:** These services can be offered together with Supported Employment to help people pursue their educational goals. These services encourage people to think about and plan for their future, and promote career development to improve long-term work opportunities. This service is available in LOCs 1S, 2, 3, 4, 5, AEO and TAY.

- **Consumer Benefits:** People receiving services are routinely referred to the LMHA/LBHA’s consumer benefits office. The benefits officer helps the person apply for Supplemental Security Income or Supplemental Security Disability Income. A benefits officer will help people with the claims process, review the claims, take notes and offer feedback to help people get the benefits they need. This service is available in all LOCs.

Counseling

- **Cognitive Behavioral Therapy (CBT):** Person, family and group therapy used to lessen a person’s symptoms of mental illness. It is also used to increase the person’s ability to perform activities of daily living. CBT is the preferred treatment for adult counseling. This service includes treatment/recovery planning to improve recovery and resiliency. This service is available in LOCs 2, 4 and 5. To learn more, visit the [Adult Mental Health Counseling webpage](#).

- **Cognitive Processing Therapy (CPT):** Person therapy that aims to reduce or eliminate a person’s symptoms of post-traumatic stress disorder. CPT is the favored treatment for adults with PTSD, including military veterans. This service includes treatment/recovery planning to improve recovery and resiliency. This service is available in LOCs 1S, 2, 3, 4 and 5. To learn more, visit the [Adult Mental Health Counseling webpage](#).
Specialized Programs

- **Assertive Community Treatment (ACT):** An evidence-based practice that uses the person-centered recovery planning model. People who receive ACT services have a serious mental illness that gets in the way of living a quality life. Most have not improved after using traditional outpatient programs. ACT’s goal is to facilitate community living, psychosocial rehabilitation and recovery. This program is available in LOC-4. To learn more, visit the [Assertive Community Treatment webpage](#).

- **Coordinated Specialty Care for First Episode of Psychosis (CSC):** Coordinated Specialty Care is a team-based model designed to meet the needs of people between 15 and 30 years old who have experienced their first episode of psychosis within the past two years. CSC emphasizes shared decision-making and a recovery-focused approach. This program is available in LOC-Early Onset and at select locations across Texas. To learn more, visit the [Coordinated Specialty Care webpage](#).

- **Transition-Age Youth (TAY):** Transition-Age Youth is used to identify people between 18 and 20 years old. This age group undergoes tremendous changes in all domains of life and need to be identified and engaged early. TAY programs promote environments where youth can get skills necessary for success in adulthood by providing access to evidence-based assessments, treatment models and recovery services. These programs are available under LOC-TAY.

- **Home and Community-Based Services — Adult Mental Health (HBCS-AMH):** HCBS-AMH is a program that provides home and community-based services beyond traditional mental health services to adults with serious mental illness who meet additional needs-based criteria. The HCBS-AMH program provides an array of services, appropriate to each person’s needs, to enable them to live and experience successful tenure in their chosen community. Services are designed to support long-term recovery from mental illness and include the following:
  - Recovery Management
  - HCBS-AMH Psychosocial Rehabilitation
  - Community Psychiatric Supports and Treatment
  - Transition Assistance Service
  - Substance Use Disorder Services
  - Peer Support
  - Employment Services
  - Transportation Services
  - Adaptive Aids
  - Supported Home Living
  - Home-Delivered Meals
  - Host Home/Companion Care
  - Respite Care (short-term)
  - Assisted Living
  - Supervised Living Services
Minor Home Modifications
Flex Funds
Nursing

To learn more, visit the [Home and Community-based Services webpage](#).

- **Peer Supported Community Re-entry**: A practice where qualified peer support providers work directly with incarcerated people before release from county jail to develop a treatment/recovery plan for transitioning back into the community and recovery-based, clinically appropriate services. The peer provider continues to support the person in their path to recovery, as they connect with services, housing, job development and integrate into positive, recovery-focused community settings.

**Co-Occurring Psychiatric Substance Use Disorder**

- **Co-Occurring Psychiatric Substance Use Disorder**: A coordinated service practice that focuses on people who have conditions of mental health and substance use disorders. This coordinated care promotes concurrent treatment of best practices to assist these people with their recovery. To learn more, visit the [Co-Occurring Psychiatric Substance Use Disorder webpage](#).

**Forensic Services**

- **Outpatient Competency Restoration (OCR)**: Provides community-based services designed to restore competency for people who have been found by the court to be incompetent to stand trial. These people must also have been found by the court not to be a danger to others. Those found appropriate for OCR are eligible for the full range of services available to other people receiving mental health services. This service is available in LOCs 3 and 4.
- **Jail-based Competency Restoration**: Provides jail-based competency restoration services designed to restore competency for people who have been found by the court to be incompetent to stand trial.
- **Texas Correctional Office on Offenders with Medical or Mental Impairments**: The Texas Correctional Office on Offenders with Medical or Mental Impairments contracts with LMHA/LBHAs to provide mental health services to people on probation or parole. The LMHA/LBHAs work closely with parole and probation officers to help the person comply with the conditions of his or her release, specifically, as it pertains to engaging in mental health treatment. This service is available in LOCs 3 and 4.
5. Setting Goals and Choosing Strategies — Developing a Treatment/Recovery Plan

After the assessment process is done for your friend or family member and they are given a level of care, they will help put together their treatment/recovery plan that outlines their strengths, needs, goals and resources. This collaboration with the treatment/recovery team gives your friend or family member the opportunity to be a part of the process from the beginning, as well as discuss any concerns. This plan will also describe the services that will be provided to support building their resilience and recovery, and is reviewed and updated every 180 days to track progress.

Once a treatment/recovery plan is developed, a recovery team of professionals will be assigned to provide the services and supports. Sometimes one person might provide a few different types of services. To learn more, refer to the glossary toward the end of this guide.

Building Strengths and Resilience — Discharge

Progress includes a reduction in symptoms and the improvement of strengths, both of which are essential to building the resilience your friend or family member will need throughout life. If a person who is receiving services has shown improvement in their assessment, achieved their goals, and maintained their recovery, they will be eligible for discharge from services. A person receiving services should not be discharged abruptly, but rather be involved in their own discharge planning in collaboration with their treatment/recovery team.

We hope the care provided within the Texas mental health system provides resilience, hope and recovery for those people receiving services. Each person can develop a healthy sense of identity and well-being, and can succeed in the workplace, their personal lives, and in the community. Your local community mental health center is always there to offer support.

Frequently Asked Questions

- **What happens if I have a concern about the care my friend or family member was offered or receiving?**
  - The services providers at your LMHA/LBHA or local community mental health center are interested in helping you find solutions to the challenges faced by your friend or family member. First, try speaking to someone on the recovery/treatment team (case manager, therapist, doctor, etc.) about your concern. They will sit down and discuss any concerns you might have.
If you are not satisfied with the outcome of your conversation, ask the receptionist at your center to connect you to their Clients Rights Officer. Each LMHA/LBHA has a Clients Rights Officer to help people resolve concerns related to your friend or family member’s care.

- **What happens if my LMHA/LBHA is not addressing the concerns or complaints I have brought to their attention?**
  - If speaking with their Clients Rights Officer does not address your concern, you can contact the HHSC Office of the Ombudsman:

    Office of the Ombudsman
    Ombudsman for Behavioral Health
    Texas Health and Human Services Commission
    Mail Code H700
    P.O. Box 13247
    Austin, TX 78711
    1-800-252-8154

- **What happens if my friend or family member is placed on a waiting list for services?**
  - If your friend or family member has Medicaid coverage, they should not be placed on a waiting list to receive mental health care at the LMHA/LBHA. If Medicaid does not cover them, they might be placed on a waiting list depending on the LMHA/LBHAs capacity.
  - **At any time, your friend or family member experiences a psychiatric crisis, they are eligible for immediate services. See page 3 of this guide if you believe your friend or family member is experiencing a crisis.**
    - If your friend or family member is placed on a waiting list for services, a staff member from the LMHA/LBHA will contact you at least every 30 days to check in on your friend or family member’s condition while waiting for services. Contact the LMHA/LBHA if you think their condition has worsened.
    - If your friend or family member remains on a waiting list a full year before entering services, a staff member from the LMHA/LBHA will contact you to schedule another full assessment to determine if their needs have changed.

- **What if my friend or family member has specific kinds of needs that cannot be addressed at my LMHA/LBHA?**
  - If the assessment done by the LMHA/LBHA shows your friend or family member has special types of needs that cannot be addressed at the center, your case manager or therapist will likely advise you about providers in the community with the qualifications, expertise and
resources to address those needs. If center staff do not offer community provider referrals, just ask. They will help you identify resources.

- **How do I know if my friend or family member is eligible for financial help?**
  - All the LMHA/LBHAs accept Medicaid. Ask if your center helps in accessing other state/federal assistance programs or if they can provide information about local offices for these programs.

- **What community resources can my friend or family member find helpful?**
  - Dial 2-1-1 – This program is committed to helping Texans connect with the services they need. Whether by phone or internet, the goal is to present accurate, well-organized, and easy-to-find information from over 60,000 state and local health and human services programs.
6. Glossary — Technical Terms

**Assessment** — a systematic process for measuring a person’s service needs.

**Bipolar disorder** — a mental illness characterized by periods of elevated moods and periods of depression.

**Case Management** — the coordination of a variety of community services, monitoring the services and advocating for people suffering from ongoing mental health issues. Case management can also provide support for the families and friends of these people.

**Clinician** — a physician or other qualified person involved in the treatment and observation of living clients, as distinguished from one engaged in research.

**Confidential** — spoken, written and acted on, etc., in strict privacy or secrecy.

**Co-occurring psychiatric and substance abuse disorder (COPSD)** — a diagnosis that includes substance abuse and substance dependency problems, as well as psychiatric diagnoses.

**Deteriorate** — to become worse.

**Diagnosis** — the process of determining by examination the nature and circumstances of a diseased condition, or the decision reached from such an examination.

**Discharge plan** — a written plan that addresses the patient’s current needs and goals, specifies the services to be provided and by whom. Among the areas that should be addressed in the discharge plan are: mental health services, case management, living arrangements, economic assistance, employment supports, transportation and medication.

**Evidence-based practice (EBP)** — “integrating individual clinical expertise with the best available external clinical evidence from systematic research.” (Sackett D, 1996) EBP is the integration of clinical expertise, patient values and the best research evidence into the decision-making process for personal care.

**Intake** — a comprehensive assessment performed by a competent mental health professional or licensed practitioner of the healing arts to identify the person’s behavioral health needs, which might include community-based as well as facility-based services.

**Intervention** — action taken to improve a situation, especially a medical, behavioral or social disorder.
Level of care (LOC) — a designation given to the HHSC standardized sets of mental health services, based on the Utilization Management Guidelines and Manual, which specify the type, amount and duration of mental health rehabilitative services to be provided to a person.

Local Mental Health Authority (LMHA) — an entity to which HHSC delegates its authority and responsibility within a specific region for the planning, policy development, coordination, and resource development and allocation. LMHAs are also responsible for supervising and ensuring the provision of mental health services to people with mental illness in one or more local service areas. In several counties within the Dallas-Fort Worth Metropolitan Area, two agencies designated as a Local Behavioral Health Authority (LBHA) serve the same function as an LMHA.

Licensed Practitioner of the Healing Arts (LPHA) — is a licensed physician who can provide some or all of the mental health rehabilitative services and mental health targeted case management services.

Motivational Interviewing (MI) — a collaborative, person-centered form of guiding to elicit and strengthen motivation for change. It is an empathic, supportive counseling style that supports the conditions for change. Practitioners are careful to avoid arguments and confrontation, which tend to increase a person's defensiveness and resistance.

Peer Support Services — an evidence-based mental health model of care which consists of a qualified peer support provider with lived experience who assists people with their recovery from mental illness and substance use disorders.

Person-centered Recovery Planning (PCRP) — a collaborative process between the person, the treatment provider and the person’s natural supports. The goal of this collaboration is to develop and implement a plan of action to assist the person in achieving their unique, personal goals along the journey to recovery.

Post-traumatic Stress Disorder (PTSD) — a mental health condition that's triggered by a terrifying event — either experiencing it or witnessing it. Symptoms can include flashbacks, nightmares, severe anxiety, and uncontrollable thoughts about the event.

Psychosocial — relates to a person’s psychological development in, and interaction with, a social environment.

Psychosocial Rehabilitation — social, educational, vocational, behavioral and cognitive interventions provided by members of a person’s recovery/treatment team that help improve a person’s ability to develop and maintain relationships, occupational or educational achievement, independent living skills and housing. This service includes recovery/treatment planning to facilitate recovery.

Psychoactive Medication — a chemical substance that crosses the blood–brain barrier and acts primarily upon the central nervous system where it affects brain
function, resulting in alterations in perception, mood, consciousness, cognition and behavior.

**Psychoeducation** — education offered to people with a mental health condition and their families to help empower them and cope with their condition in an optimal way.

**Psychotherapy** — a therapeutic interaction or treatment contracted between a trained professional and a client, patient, family, couple or group.

**Psychosis** — an abnormal condition of the mind that involves a "loss of contact with reality." People experiencing psychosis might exhibit personality changes and thought disorder. Depending on its severity, this can be accompanied by unusual or bizarre behavior, as well as difficulty with social interaction and impairment in carrying out daily life activities.

**Qualified Mental Health Professional – Community Services** — This person received special training and credentialing enabling them to deliver some or all of the mental health rehabilitative services and mental health targeted case management services.

**Recovery** — a process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential.

**Rehabilitation** — a treatment (or multiple treatments) designed to facilitate the process of recovery from injury, illness or disease.

**Relapse** — the return of an illness or behavior after a period of improvement.

**Resilience** — having the ability to overcome challenges and adapt to stressful or life-changing situations.

**Respite Care Service** — a short-term period of care for a service recipient who has mental health, intellectual/developmental, behavioral or physical challenges. The purpose is to provide the service recipient’s family or regular caregiver with a time-limited break from the routine care that they provide.

**Schizophrenia** — a mental disorder often characterized by abnormal social behavior and failure to recognize what is real.

**Screening** — the initial contact between a clinician and potential client for gathering demographic data and other information, as necessary, to determine eligibility and need for services.

**Serious Mental Illness (SMI)** — an adult can be considered to have an SMI, and can receive mental health services, if they are experiencing significant functional impairment because of a mental health disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), including:
● Major depressive disorder, including single episode or recurrent major depressive disorder
● Post-traumatic stress disorder
● Schizoaffective disorder, including bipolar and depressive types
● Obsessive compulsive disorder
● Anxiety disorder
● Attention-deficit disorder
● Delusional disorder
● Bulimia nervosa, anorexia nervosa or other eating disorders not otherwise specified
● Any other diagnosed mental health disorder

A single diagnosis of substance abuse, an intellectual developmental disorder (IDD), a developmental disorder (e.g., autism), or any other organic conditions (e.g., head injury or dementia) does not meet the SMI standard.

**Social Security Disability Income (SSDI)** — this program is the largest of several federal programs that provide assistance to people with disabilities. It is administered by the Social Security Administration and only persons who have a disability and meet medical criteria may qualify for benefits.

**Supplemental Security Income (SSI)** — a federal income supplement program funded by general tax revenues (not Social Security taxes). It is designed to help aged, blind and disabled people who have little or no income. It also provides cash to meet basic needs for food, clothing and shelter.

**Symptomology (also, symptomatology)** — the set of symptoms characteristic of a medical condition or exhibited by a patient.

**Wraparound Approach** — a philosophy of care with a defined planning process used to build constructive relationships and support networks among children and youth with emotional or behavioral disorders and their families. It is community-based, culturally relevant, individualized, strengths-based and family-centered.
7. Glossary — Recovery Team of Professionals

**Psychiatrist** — A physician who specializes in psychiatry. The psychiatrist will provide a mental health diagnosis, prescribe medications and provide psychoeducation.

**Registered Nurse** — A person who is licensed by the nursing board to practice as an advanced practice nurse on the basis of completion of an advanced educational program.

**Licensed Vocational Nurse** — A person who holds a license as a vocational nurse.

**Case Manager** — The case manager coordinates services, keeps track of progress on the recovery plan, makes referrals to community resources, and advocates for your friend or family member.

**Qualified Mental Health Professional—Community Services** — This person received special training in a variety of evidence-based practices that help address behavioral health needs related to your friend or family member’s mental health diagnosis.

**Counselor** — Therapists are licensed mental health clinicians who received training in therapies that address emotional needs related to your friend or family member’s mental health diagnosis. They are usually Licensed Professional Counselors, Licensed Clinical Social Workers or Licensed Marriage and Family Therapists, among others.
Texas Statewide Behavioral Health Strategic Plan

featuring the
Texas Strategic Plan for Diversion, Community Integration and Forensic Services

STATEWIDE BEHAVIORAL HEALTH COORDINATING COUNCIL

As required by Chapter 531, Subchapter M-1, of the Texas Government Code

September 2022
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Message from the Coordinating Council

Message from the Statewide Behavioral Health Coordinating Council

This edition of the *Texas Statewide Behavioral Health Strategic Plan* was developed during the onset of the Coronavirus Disease 2019 (COVID-19). This historical event has had an unprecedented impact on the behavioral health of all Texans, not just on those formally diagnosed with severe and persistent mental illness or co-occurring mental health and substance use disorders. The residual impacts of these events on academic and work environments, economic infrastructure, civility, and more will be felt for decades.

According to the American Psychological Association, “nearly eight in 10 adults (78 percent) say the coronavirus pandemic is a significant source of stress in their life. Two in three adults (67 percent) say they have experienced stress over the course of the pandemic.”¹ The physiological response to these stressors has led to increased demand for behavioral health services, while the COVID-19 pandemic has diminished the behavioral health workforce, provider network, and provider infrastructure.² Congress enrolled the Coronavirus Response and Relief Act Supplemental Appropriation Act and American Rescue Plan Act of 2021, which have been significant sources of seed money that many agencies have used to expand existing mental health services and social supports. However, due to the parameters of the legislation and funder decisions there remains substantial need for resources and funding in the Texas behavioral health system.

At a high level, the following is suggested to ensure all Texans have access to quality care at the right time and place:

- Expanded and new behavioral health services and social supports that are financially supported by blended funding streams;
- Behavioral health services and social supports that are overseen and implemented through local collaborations and regional approaches to care;
- Behavioral health services and social supports that are contextualized by behavioral health equity to ensure that everyone has a fair and just opportunity to be as healthy as possible; and
- Three-branch approach to improving access to behavioral healthcare and health outcomes of Texans receiving services.

Furthermore, there is a sub-population of youth and adults receiving behavioral health services, those who are involved in the justice system, whose needs have
been exacerbated during the pandemic. The COVID-19 pandemic upended access to timely, quality, and appropriate behavioral health services and typical court procedures in processing civil and criminal court cases.\(^3\) As such, people involved in the justice system have experienced prolonged wait times in accessing care and processing of court cases.

There is a need to develop a statewide, strategic approach for preventing people from interacting with justice systems, reducing the period of involvement in justice systems, and decreasing rates of recidivism. The Statewide Behavioral Health Coordinating Council (SBHCC) developed the *Texas Strategic Plan for Diversion, Community Integration, and Forensic Services* to include strategies to prevent and reduce justice involvement for those with behavioral health needs.
Acknowledgments

These strategic plans represent voices from across Texas, including mental health, substance use, IDD, and peer service providers; criminal justice professionals; people with lived experience and their families; community leaders; and program and policy subject matter experts across other stakeholder systems. Every effort was made to ensure the strategic plans were reflective of the goals and priorities of diverse stakeholders. The SBHCC is grateful for the time and contributions provided to development of the strategic plans by members of the public, staff at member agencies, and the organizations listed below.

- Austin Area Mental Health Consumers and Prosumers International
- Association of Substance Abuse Programs
- Behavioral Health Advisory Council
- Bluebonnet Trails Community Services
- The Center for Health Care Services
- Federation of Families, Texas
- The Harris Center
- Hogg Foundation
- National Alliance and Mental Illness, San Antonio
- North Texas Behavioral Health Authority
- Peer Network Board
- Recovery Coalition of Texas
- Texas Council of Community Centers
- Texas Police Chiefs Association
- Texas Sheriff’s Association
- University Health System
- West Texas Centers
Executive Summary

In 2015, the 84th Texas Legislature established the SBHCC and required they develop a five-year strategic plan, report annual progress, and publish a statewide coordinated expenditure proposal. The SBHCC developed the first Texas Statewide Behavioral Health Strategic Plan for fiscal years 2017-2021. With the creation of the strategic plan, state agencies that receive general revenue funding for behavioral health services work together to fulfill their legislative charge to:

- Coordinate programs and services to eliminate redundancy;
- Utilize best practices in contracting standards;
- Perpetuate identified, successful models for mental health and substance use disorder treatment;
- Ensure optimal service delivery; and
- Identify and collect comparable data on results and effectiveness.

The SBHCC was codified by the 86th Legislature, Regular Session, 2019 in Subchapter M-1 of Chapter 531, Government Code. House Bill (H.B.) 3285, 86th Legislature, Regular Session, 2019 also required the SBHCC to create a sub-plan related to substance use services. SBHCC members met for strategic planning sessions to develop the next five-year iteration of the Texas Statewide Behavioral Health Strategic Plan including goals and strategies for mental health and substance use services.

The Joint Committee on Access and Forensic Services, established by Senate Bill (S.B.) 1507, 84th Legislature, Regular Session, 2015, recommended the SBHCC create a sub-plan related to diversion and forensic services. Published in this joint report, both strategic plans span fiscal years 2022 through 2026 to maximize opportunities for members to align use of funding and actions in collaborative support of achieving the goals of the plans.

While these plans are aligned, each plan features a unique vision and mission as well as distinct goals and strategies to advance mental health and substance use services and supports. SBHCC members developed the strategic plans concurrently, using stakeholder input to ensure a complementary and strategic approach. Closing the gaps identified in the strategic plans will require action from governments and external organizations at the local, state, and federal levels.
2016-17 General Appropriations Act (GAA), H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) established the SBHCC. The SBHCC is comprised of representatives of state agencies and institutions of higher education receiving General Revenue for behavioral health services. The initial purpose of the SBHCC was to develop a five-year *Texas Statewide Behavioral Health Strategic Plan* to include the following:

- an inventory of behavioral health programs and services provided by state agencies and institutions of higher education;
- a report on the number of people served with mental illness (MI) and/or substance use disorder by each agency; and
- a detailed plan to coordinate these programs and services to eliminate redundancy, utilize best practices in contracting standards, perpetuate identified, successful models for mental health and substance use disorder treatment, ensure optimal service delivery, and identify and collect comparable data on results and effectiveness.

In addition to developing the initial five-year behavioral health strategic plan, the SBHCC was directed to publish a coordinated statewide expenditure proposal that described how the identified appropriations at each agency or institution would be spent in accordance with, and to further the goals of the approved statewide behavioral health strategic plan.

The GAA of subsequent legislative sessions authorized the continuation of the SBHCC and expanded its scope of responsibilities. The 2018-19 GAA, Senate Bill (S.B.) 1, 85th Legislature, Regular Session, 2017, directed the SBHCC to annually publish a report on the progress of implementation of the behavioral health strategic plan and directed that certain community collaborative grant programs funded by the Legislature present twice annually to the SBHCC on the impact grant projects have on mental health outcomes for the populations served. The SBHCC was also expanded to include state agencies that received appropriations for mental health training, such as the Court of Criminal Appeals.

The 2020-21 GAA, H.B. 1, 86th Legislature, Regular Session, 2019, directed additional state agencies to appoint representation to the SBHCC. In the same session, H.B. 2813 codified the SBHCC by adding Subchapter M-1 to Chapter 531, Government Code, which details the purpose, membership, powers, and duties of...
Coordinating Council. Most recently, 2022-23 GAA, S.B. 1, 87th Legislature, Regular Session, 2021,\textsuperscript{10} appointed two additional agencies to the membership.

**Strategic Plans**

The SBHCC was charged with developing the first strategic plan following the 84th legislative session in 2015. The first edition of the *Texas Statewide Behavioral Health Strategic Plan* was published in 2016\textsuperscript{5} and an update was published in 2019.\textsuperscript{11} The actions of the first strategic plan spanned fiscal years 2017 through 2021. The codification of the SBHCC in 2019\textsuperscript{9} allows the group to facilitate opportunities to increase collaboration for the effective expenditure of available federal and state funds for the behavioral health services in Texas and implement the five-year strategic plan.

H.B. 3285, 86th Legislature, Regular Session, 2019\textsuperscript{12} also required the SBHCC to create a sub-plan related to substance use services. The new *Texas Statewide Behavioral Health Strategic Plan* must identify challenges of existing substance use prevention, intervention, and treatment programs; assess substance use prevalence, services, and gaps; and develop strategies for working with state agencies to expand treatment capacity.

**Membership**

The current list of agencies and organizations that comprise the membership of the SBHCC are shown in Table 1. Brief profiles for each member organization appointed through fiscal year 2021 are provided in Appendix C.

**Table 1. Statewide Behavioral Health Coordinating Council Membership**

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<thead>
<tr>
<th>Agency or Organization Name (listed alphabetically)</th>
<th>Abbreviation</th>
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<tr>
<td>Court of Criminal Appeals</td>
<td>CCA</td>
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<tr>
<td>Department of Family and Protective Services</td>
<td>DFPS</td>
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<tr>
<td>Department of State Health Services</td>
<td>DSHS</td>
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<tr>
<td>Health and Human Services Commission</td>
<td>HHSC</td>
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<tr>
<td>Agency or Organization Name (listed alphabetically)</td>
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<td>Health Professions Council, representing:</td>
<td>HPC</td>
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<td>• State Board of Dental Examiners</td>
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<tr>
<td>• State Board of Veterinary Medical Examiners</td>
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<td>• Texas Board of Nursing</td>
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<td>• Texas Medical Board</td>
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<td>• Texas Optometry Board</td>
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<td>• Texas State Board of Pharmacy</td>
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<tr>
<td>Judicial Commission on Mental Health (part of the Supreme Court of Texas)</td>
<td>JCMH/SCoT</td>
</tr>
<tr>
<td>Office of the Governor</td>
<td>OOG</td>
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<tr>
<td>Texas Child Mental Health Care Consortium</td>
<td>TCMHCC</td>
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<td>TCCO</td>
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<td>TCJS</td>
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<tr>
<td>Texas Commission on Law Enforcement</td>
<td>TCOLE</td>
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<td>Texas Correctional Office on Offenders with Medical or Mental Impairments (part of the Texas Department of Criminal Justice)</td>
<td>TCOOMMI/TDCJ</td>
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<td>Texas Education Agency</td>
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<tr>
<td>Texas Higher Education Coordinating Board</td>
<td>THECB</td>
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<td>Texas Indigent Defense Commission (part of the Office of Court Administration)</td>
<td>TIDC/OCA</td>
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<td>TSD</td>
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<td>Texas Tech University Health Sciences Center</td>
<td>TTUHSC</td>
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<td>TVC</td>
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<td>University of Texas Health Science Center at Houston</td>
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<tr>
<td>University of Texas Health Science Center at Tyler</td>
<td>UTHSC-T</td>
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</tbody>
</table>

Each member agency appoints a delegate to represent their agency or organization and liaise with the other members of the SBHCC.
Duties

The SBHCC has several responsibilities and duties, including:

• Meet at least quarterly, or more frequently at the call of the presiding officer;¹³
• Develop and oversee the implementation of the five-year statewide behavioral health strategic plan;¹¹
• Prepare an annual coordinated statewide behavioral health expenditure proposal incorporating past and proposed expenditures for the next fiscal year for all state agencies that receive behavioral health funds;¹⁴
• Publish an annual progress report on the strategic plan’s implementation and update the inventory of behavioral health programs and services funded by the state;¹⁵
• Prepare a biennial consolidated behavioral health schedule summarizing legislative appropriations requests by all state agencies that receive behavioral health funds;¹⁶ and
• Review and comment on proposed exceptional items related to behavioral health funding to avoid duplication and coordinate services across state agencies.¹⁶

The most recent publications and webpages associated with the duties above are cited in the related report endnotes.
Coordinated Impact of the Council

The first edition of the *Texas Statewide Behavioral Health Strategic Plan* was created by the original SBHCC member agencies through several months of planning and consultation with stakeholder groups and members of the public. The strategic plan was designed as a framework to address the most pressing gaps and challenges of the behavioral health system in Texas.

Many initiatives implemented by the SBHCC address multiple goals of the initial strategic plan. Annual progress reports highlight these initiatives by strategic plan goal. Some SBHCC successes are highlighted in this report to demonstrate ways they impact specific target areas. When state agencies coordinate to direct their focus and efforts at the same goals and issues, they can augment existing efforts, reduce duplication of services, and may enhance or expand existing resources.

Council Successes for Fiscal Years 2017-2021

The following successful initiatives demonstrate how the SBHCC made improvements to different areas of the behavioral health system over fiscal years 2017 through 2021. Additional successes are also listed by SBHCC member in Appendix D.

**Children and Adolescents**

The Child Psychiatry Access Network (CPAN) program,\(^{17}\) one of the four major programs developed by the TCMHCC, provides child and adolescent behavioral health consultation services and training opportunities for primary care providers. TTUHSC implements the CPAN program in 85 counties across West Texas with more than 430 primary care providers enrolled. These numbers are expected to increase as the program grows.

TCMHCC also coordinates the Texas Child Health Access Through Telemedicine (TCHATT) program.\(^{18}\) TCHATT provides telemedicine or telehealth programs to school districts to help identify and assess the behavioral health needs of children and adolescents and provide access to mental health services. Since September 2020, the TCHATT program at UT Health San Antonio has received over 700 student referrals from partnering school districts. Initially partnered with five school districts, the TCHATT program has continued to expand to other school districts within the region. TCHATT has begun partnerships with Education Service Centers.
Funding for the Mental Health Workforce Training program enables UTHSC-T to participate in all initiatives under the TCMHCC. Through CPAN, UTHSC-T psychiatrists provide free consultation to primary care providers throughout Northeast Texas. UTHSC-T also provides assessment and short-term treatment of high-risk children and adolescents referred by school districts from underserved areas through the TCHATT program.

The implementation of TCHATT made it possible for TTUHSC to expand the capacity of the school-based mental health services they provide to campuses in their region. TTUHSC provides school-based services through the Campus Alliance for Telehealth Resources (CATR), a program that delivers expanded mental health services for children and families including services to schools using an Extension for Community Health Outcomes (ECHO®) Model and direct psychiatric treatment when appropriate. CATR is made up of two components: CATR-Services for Professionals and CATR-Services for Students. CATR-Services for Professionals trains school personnel, such as counselors and other behavioral health specialists on school campuses. As of May 2021, 87 school districts signed agreements to engage in ECHO® sessions and 60 of the districts participated in at least one session. Collaborative discussions occur on topics such as vaping, coping strategies, resiliency through COVID-19, and more. School personnel are participating through videoconferencing at no cost which improves access to the training for rural and underserved areas.

**Adults**

The Texas Legislature invested funds during the 85th, 86th, and 87th legislative sessions to support expansion, renovation, and transformation of state hospitals. These projects and other changes are designed to:

- Enhance the safety, quality of care, and access to treatment for Texans with mental health issues;
- Expand capacity and reduce the waiting list for inpatient psychiatric treatment, particularly for maximum security units; and
- Increase collaboration with potential partners, including stakeholders, advocates, and higher education and health-related institutions.

Construction began at Kerrville, Rusk, Austin, and San Antonio state hospitals as well as the John S. Dunn Behavioral Sciences Center campus in Houston. State hospital system capacity expansion projects at the John S. Dunn Behavioral Sciences Center and Kerrville and San Antonio State Hospitals will increase access to inpatient services by 374 beds. In 2021, HHSC was provided funding from the legislature for the planning, design, land acquisition and construction of a new state
hospital to be built in the Dallas/Fort Worth metropolitan area in partnership with UT Southwestern Medical Center.

The HHSC State Hospital Transition Pilot Program is designed to step-down, or transition, people with complex psychiatric or medical needs from inpatient state hospital settings to the appropriate community-based settings. Intensive Transition Teams from the step-down providers assess people prior to enrollment in the pilot, create Individual Transition Plans, and deliver pre-transition services such as intensive behavioral health services and assistance with food, utility, and transportation costs. In the first year of the pilot, participation was limited to two sites: Bluebonnet Trails Local Mental Health Authority (LMHA) and Helen Farabee LMHA.

HHSC’s Supportive Housing Rental Assistance Program\(^{20}\) provides funding to LMHAs and Local Behavioral Health Authorities (LBHAs) to enhance their ability to provide rental and utility assistance to people with MI who are homeless or at imminent risk of becoming homeless and promote supportive housing services. Priority is given to people transitioning from hospitals (community or state psychiatric hospital), nursing facilities, and to high utilizers of crisis services. Thirty-six of the 39 LMHAs/LBHAs in Texas offer this program.

HHSC certifies eligible clinics as Certified Community Behavioral Health Clinics (CCBHCs).\(^{21}\) By using the CCBHC framework to create a more efficient and coordinated system, Texas is expanding the capacity for community-based behavioral health services and enhancing behavioral health care outcomes for vulnerable populations with serious mental illness (SMI), serious emotional disturbances (SED), and substance use disorders. Texas gained national recognition for the expansion from 12 to 24 CCBHC sites during years 2020 and 2021.

Self-directed care enables people to have authority over a portion of mental health expenditures and greater flexibility over what can be purchased than does traditional Medicaid. In 2018, HHSC partnered with Medicaid managed care organizations, state universities, and stakeholders, including people with lived experience, to implement My Voice, My Choice, a randomized trial of mental health self-directed care for adult Medicaid members with SMI.\(^{22}\) Independent evaluation concluded in 2020 and demonstrated self-directed care helped participants attain their self-defined goals and objectives; improved their mental well-being; and increased their confidence, self-esteem, hope, motivation, and sense of purpose. The pilot project increased people’s active participation in their mental health care, which can improve health outcomes over time. Self-directed care was cost neutral. Participants had no greater Medicaid utilization costs than people receiving
traditional care. HHSC is working with stakeholders to consider policy options for potential future inclusion of mental health self-direction in Medicaid managed care.

**Military Service Members, Veterans, and Their Families**

The TMD Personnel Services Division applied for funding through the National Guard Bureau’s Warrior Resilience & Fitness Innovation Incubator to provide military culturally competent Crisis Response Plan + Lethal Means Training to military chaplains, behavioral health officers, and related behavioral health staff. These personnel regularly interact with at-risk and risk-identified service members they support. The virtual training provides participants with additional assessment tools, crisis de-escalation techniques, and motivational interviewing skills.

To reduce suicide among Texas service members, veterans, and their families (SMVF), TVC’s Veterans Mental Health Department (VMHD) delivered suicide prevention training to thousands of people at no charge, funded through an interagency contract with HHSC. Each year, TVC provides hundreds of training opportunities for SMVF stakeholders, including other state agencies, mental health providers, criminal justice professionals, faith-based organizations, employers, and community partners. TVC’s suicide prevention efforts include facilitating evidence-based and research-informed curricula, such as Ask About Suicide to Save a Life (AS+K) and Counseling on Access to Lethal Means (CALM).

TVC’s VMHD is responsible for training and certifying Peer Service Coordinators and Peer Volunteers of the Military Veteran Peer Network across the state to provide access to suicide prevention training and Mental Health First Aid for the SMVF community at the local level. TVC works regularly with other SBHCC members to organize, host, and promote access to the suicide prevention trainings.

TVC’s VMHD also participates in the Governor’s and Mayor’s Challenges to Prevent Suicide among SMVF. The recommendations of the Governor’s Challenge and Mayor’s Challenge partners include engaging with faith-based communities. The activities promote the Faith and Allegiance Initiative, which equips faith communities in assisting SMVF as they transition out of the military by offering social connectedness, a sense of community, and renewed life purpose, thereby building upstream resiliency. Veterans are also encouraged to become Veterans Champions to serve as resource agents within their faith communities.

Terrell State Hospital opened a 20-bed renovated unit in July 2019 dedicated to serving veterans. The unit has been operating at full capacity since becoming fully
staffed. Many of the staff are veterans themselves and the unit gives its patients an opportunity to heal among people who share their background and experiences.

**People with Intellectual and Developmental Disabilities**

The first *Texas Statewide Behavioral Health Strategic Plan* identified unique challenges in the behavioral health system faced by people with IDD. People with IDD are underserved in the behavioral health system and often have trouble finding services and support that meet their needs. Stakeholders called on the SBHCC to develop a dedicated strategic plan for IDD services. The SBHCC published the *Foundation for the Statewide IDD Strategic Plan* in 2019,11 featuring an assessment of people with IDD in Texas, a summary of stakeholder input, and an inventory of services for people with IDD provided by SBHCC agencies. The foundational elements of the IDD strategic plan were published with the *Texas Statewide Behavioral Health Strategic Plan* with the intention that the IDD strategic plan would be a stand-alone plan. As such, in 2019 and 2020, a group of stakeholders with expertise in IDD services and supports joined to develop the strategic plan. The group developed the *Texas Statewide IDD Strategic Plan*23 for fiscal years 2020–2025, a roadmap for a statewide and strategic approach for addressing gaps in IDD services and policy.

TCJS coordinates an IDD Taskforce which prepared a report in 2020 titled, *Detention of Persons with IDD.*24 The report provides information for Texas county jails to help them develop best practices for procedures, treatment, and appropriate support for people arrested and detained who were determined to have IDD. The report also focuses on the role played by the Local Intellectual and Developmental Disability Authorities (LIDDA) and LMHAs/LBHAs relative to early identification/collection of information and service delivery; explores existing resources and programs; identifies state and national best practices; and formulated desired outcomes for Texas.

**People Involved in the Justice System**

TJJD enhanced and updated many of its core services and tools to support the behavioral health needs of youth in their facilities. Manuals for the Mental Health Treatment Program and Crisis Stabilization Unit were revised, and booster trainings were developed for coaches and other direct-care staff. These resources provide additional tools and strategies for the care of this high-need population. Evidence-based substance use disorder treatment services were expanded from dormitory-based programming to individual and group interventions focused specifically on addressing the person’s responsivity, needs, risks, and stage of change. Treatment
services are individualized, and enrollment has drastically increased. TJJD established a multidisciplinary workgroup to enhance the agency’s suicide prevention policies and procedures, to include best practices and modernized language. Peer-reviewed instruments were incorporated to assess risk for suicide and to assist with developing individualized treatment, transition, and aftercare planning.

TJJD created another multidisciplinary transformation team to implement gender-responsive and culturally competent services at its girls’ facility based on best practice. Gender responsive services are designed to meet the unique needs of females, value the female perspective, celebrate and honor the female experience, respect, and consider female development and empower young women to reach their full potential. TJJD is also investing in training and support for juvenile justice staff. Over 140 TJJD and county-level staff across Texas completed the newest version of the Trust Based Relational Intervention (TBRI) Practitioners Training by the Karyn Purvis Institute of Child Development. This training consisted of a 12-week online self-paced study course, Adult Attachment Inventory interview, and a two-week Zoom virtual session.

TCJS continued to provide specific training to county jails regarding mental health:
- TCOLE Course 4900, Mental Health Training for Jailers, was a mandated training required for all licensed jailers to be completed by August 31, 2021. This course assisted jailers in identifying the signs and symptoms of prominent categories of MI to gain an understanding of techniques utilized for communication during a time of crisis in a jail setting.
- TCOLE 4901, Suicide Prevention for Jailers, was developed in 2019. This course provides county jailers with required annual suicide prevention training and continues to be delivered on a regular basis to jailers across the state.
- TCOLE Course 2831, IDD Training for Jailers, provides techniques to assess and interact with people confined to county jail who were determined to have an IDD.

S.B. 562 and H.B. 601, 86th Legislature, Regular Session, 2019, allowed placement in the state’s maximum-security mental health hospitals to be determined by clinical and security needs rather than alleged offense. This allows patients to be treated in the most appropriate setting. In FY 2020 and 2021, 1,363 cases were reviewed, identifying 203 people who were determined appropriate to be served in non-maximum-security hospitals, reducing the maximum-security waitlist.
**Judges, Court Personnel, and Attorneys**

The intersection of mental health issues with the criminal justice system has emerged as an issue at the forefront of discussions among state leaders. Recognizing the need for judicial leadership on this issue, SCoT and CCA established the JCMH and have provided a great deal of collaborative efforts in mental health and pre-trial diversion.

In 2019, SCoT and CCA convened two JCMH task forces, composed of stakeholders in the courts and the mental health providers that intersect with the courts, including many SBHCC members, to study and make recommendations to improve or refine laws and rules relating to mental health and IDD. JCMH submitted the recommendations to the Texas Judicial Council in 2020, where the recommendations were unanimously approved and adopted as part of the *Texas Judicial Council’s Criminal Justice Committee’s 2020 Report and Recommendations to the Legislature.*

JCMH provides a suite of educational programs for judges and other stakeholders. Since 2017, these activities included:

- Three annual Judicial Summits on Mental Health for hundreds of participants focused on addressing challenges for people with behavioral health needs involved in the court system.

CCA’s Judicial Education Program funds and oversees training necessary to the continuing education of judges of all levels, court personnel, prosecuting attorneys, criminal defense attorneys representing indigents, public defenders, constables, law students, and staff. Eight organizations receive regular grant funds from the program, working with CCA to produce an across-the-board approach to educate all participants on issues like mental health and pre-trial diversion that are crucial to the improvement of the criminal-justice system. CCA directs specific educational topics to the grantees who then educate constituents through a series of lectures and presentations from state and national experts. Mental health topics range from
understanding need, screening and assessment tools, diversion and placement of special populations, and legislative directives.

CCA worked with grantee organizations to develop the Texas Mental Health Resource Guide. The Resource Guide provides an explanation of mental health services and lists resources indexed by type, region, and county. The Resource Guide is continually updated.

**Behavioral Health Workforce**

DSHS developed the Public Health Agency Action Plan for Addressing Substance Use in Texas for 2020-2022. Some of the DSHS action plan initiatives have been completed, including several that focus on supporting the behavioral health workforce. The Texas Emergency Medical Services (EMS) Peer Referral Program was developed in collaboration with the HHSC Texas Targeted Opioid Response program (TTOR) and is available for anyone in the EMS profession who is struggling with substance use issues. DSHS also developed a centralized webpage with updated links to substance use continuing education opportunities and links to help connect providers of behavioral health services to treatment and recovery services.

The UTHSC-T Mental Health Workforce Training Program addresses the workforce shortage in Northeast Texas by training competent psychiatrists and psychologists to provide effective treatments to those who need them, including people with chronic and SMI, at-risk youth, and people in rural underserved and disadvantaged populations. As both faculty and residents serve patients, this program has expanded much needed treatment access in Northeast Texas. The UTHSC-T Psychiatry Residency inaugural class of six began in 2017 and reached a full complement of 24 residents in 2020. Residents’ complete rotations in underserved areas including, but not limited to, Rusk State Hospital and Terrell State Hospital. Residents expand access to the Andrews Center by caring for patients through the TCMHCC Community Psychiatry Workforce Expansion initiative.

UTHSC-T is currently developing a Child and Adolescent Psychiatry Fellowship, which received accreditation in 2021. The Psychology Internship expanded to include additional interns, Post-Doctoral positions, and one Advanced Post-Doctoral position. Special focus is placed on training providers in the evidence-based treatment of youth who have suffered abuse and trauma.

In 2019, the SBHCC established a subcommittee to develop a plan to enhance the behavioral health workforce. The subcommittee analyzed existing report
recommendations, identified progress made to date, and focused on key next steps that Texas could take to address the issues moving forward and published the *Strong Families, Supportive Communities: Moving Our Behavioral Health Workforce Forward* report.\(^{34}\) This report is uniquely structured to quickly search topics of interest and includes over 60 next steps that the state could take to address the shortage, with 20 short-, mid-, and long-term steps that would make the biggest impact in areas including retention, recruitment, and incentives; high school job candidate pipeline; higher education; licensing and regulation; innovative system improvements; Medicaid administration; and others.

**Data Sharing and Collaboration**

H.B. 3980, 86th Legislature, Regular Session, 2019, required HHSC, in conjunction with DSHS, to prepare a summary report on the prevalence of suicide in Texas, as well as state policies and programs adopted across state systems and agencies to prevent suicides.\(^{35}\) The bill also required the SBHCC to use this summary to prepare a report on suicide in Texas identifying opportunities for state agencies and institutions to improve data collection for suicide-related events, use data to inform policy development for suicide prevention, and decrease suicide in Texas. HHSC collaborated with DSHS and the Texas Suicide Prevention Council to develop the summary report. The report found that a robust state-level surveillance system would enable suicide prevention policies to be designed and implemented more effectively. The SBHCC created a subcommittee to use the data from the summary report to recommend strategies to strengthen state and regional data collection around suicide deaths and attempts.\(^{36}\)

DSHS received funding from the Centers for Disease Control and Prevention to expand the state’s public health response to opioid use from 2018 to 2019. Grant projects strengthened DSHS opioid use surveillance and education efforts for the public and health professionals through:

- Adding more dashboards to the Texas Health Data interactive public data system to better visualize the scope of the opioid crisis in Texas.\(^{37}\)
- Collecting more data on opioid-related illnesses and other conditions in emergency rooms across the state to look for early warning signs and pinpoint opioid misuse throughout the state.
- Training more DSHS partners and stakeholders on how to access and use these data to understand opioid misuse at the local level.
- Educating public health personnel at regional and local levels on when and how to administer naloxone to prevent death from opioid overdose.
• Increasing the number of doctors, physician assistants, and nurse practitioners trained and permitted to prescribe buprenorphine to treat opioid use disorder.

HHSC initiated the Measure Up project in 2019 to utilize a cross-division committee of HHSC units and external stakeholders to:
• Develop performance measures that provide a standardized way to communicate outcomes and impact of HHSC behavioral health grants;
• Develop an efficient and effective way to collect, aggregate, and analyze reported data; and
• Identify consistent, contextualized messaging for external stakeholders, specifically legislators.

The Measure Up project collaboration resulted in a performance measure menu through which grantees select from a standard list of outputs and outcomes. This enables HHSC and its grantees to define program goals and assess what is working and what changes may be needed to further the goals of the matching behavioral health grant programs.
Texas Statewide Behavioral Health Strategic Plan
Assessment of Behavioral Health System in Texas

The Texas population is steadily increasing over time, presenting challenges for the state’s behavioral health system to keep up with the public’s needs for services and supports. The behavioral health system in Texas must manage some unique population characteristics that make it different from other states, such as:

- Large geographic service area with varying population density, local resources, and infrastructure;
- Large population of military service members, veterans, and their families;
- Growing population of young people; and
- Shortage of affordable housing.

Texas Population

Since the 2010 United States (U.S.) Census, the population of Texas grew by 15 percent to a total of 28,995,881 in 2019.\(^{38}\) Texas comprises nearly 9 percent of the country’s entire population.\(^{38}\) Approximately 8 percent of people living in Texas are military veterans.\(^{38}\) The overall population of Texas in 2019 was slightly younger than the national average: \(^{38}\)

- 26 percent are under 18 years of age;
- 61 percent are ages 18 to 64; and
- 13 percent are 65 years of age or older.

The racial identity of people living in Texas (Table 2) is similar to the national population. However, many more people in Texas identify their ethnicity as Latino or Hispanic (40 percent) than the country overall (19 percent).\(^{38}\)

Table 2. Racial Identity of People Living in Texas, 2019\(^{38}\)

<table>
<thead>
<tr>
<th>Race</th>
<th>Percentage</th>
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</thead>
<tbody>
<tr>
<td>White only</td>
<td>79</td>
</tr>
<tr>
<td>Black or African American only</td>
<td>13</td>
</tr>
<tr>
<td>American Indian or Alaska Native only</td>
<td>1</td>
</tr>
<tr>
<td>Asian only</td>
<td>5</td>
</tr>
<tr>
<td>Race</td>
<td>Percentage</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>------------</td>
</tr>
<tr>
<td>Native Hawaiian or other Pacific Islander only</td>
<td>less than 1</td>
</tr>
<tr>
<td>Two or more races</td>
<td>2</td>
</tr>
</tbody>
</table>

As the state becomes more diverse, more languages are spoken in the community. In Texas in 2019, about 35 percent of people ages five and older spoke a language other than English in their home. About two-thirds of the people in these households report they speak English very well while the remaining third do not.\(^{39}\) Spanish is overwhelmingly the language typically spoken other than English (29 percent of state population), though use of languages from other regions of the world is growing (6 percent).\(^{39}\)

Texas has 254 counties, each with different resources and needs. Texas uses official national designations to determine whether counties are rural or urban. About two-thirds of Texas counties (172) are designated as rural.\(^{40}\) Counties are also designated as border counties if they lie within 100 kilometers (or 62 miles) of the U.S.-Mexico Border. Thirty-two Texas counties are designated as border counties.\(^{40}\) See Figure 1 for a graph of these county designations.

**Figure 1. Designations for County Density and Proximity to the Border in Texas\(^{40}\)**

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

The average annual income in Texas per person was $31,277 and the median household income was $61,874 in 2019, which were about nine percent and two
percent less than the national averages, respectively. Additionally, more people live in poverty in Texas (14 percent) than across the country (11 percent).

**Prevalence of Behavioral Health Conditions**

Behavioral health conditions encompass both mental health and substance use-related conditions. These conditions may occur to varying degrees in people of all ages and demographic groups. Understanding the prevalence, or the number of people in Texas who have behavioral health needs, can help state agencies better plan, and deliver programs and services.

**Mental Health Conditions**

Mental health conditions affect a person’s mood, thinking, and behavior to the point where their activities and quality of life are severely impacted. These conditions can cause many problems for those who have them, including increased relationship strain, increased stress, impaired functioning, and physical pain. The conditions and their symptoms can interfere with personal relationships and work performance.

Some people experience symptoms of mental health conditions but may not have been assessed by a behavioral health professional to determine whether a mental health disorder exists. State agencies may use different definitions and eligibility criteria for behavioral health services (see Appendix E).

In a Substance Abuse and Mental Health Services Administration (SAMHSA) national survey, approximately 40 percent of adults in Texas reported receiving a mental health service for any MI through public and private treatment sources combined (2017-2019 annual average). In the same time period, about four percent of all adults age 18 and older had SMI, while seven percent of younger adults ages 18 to 25 had SMI. Four percent of all adults and nine percent of younger adults reported serious thoughts of suicide (see Table 3). SAMHSA defines SMI as occurring in people ages 18 and older who have diagnosable mental, behavioral, or emotional disorders that causes serious functional impairment that substantially interferes with or limits major life activities.

Table 3. Adults Who Reported Different Mental Health Conditions (2017-2019 annual average)

<table>
<thead>
<tr>
<th>Reported Condition and Age Group</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>SMI, reported by adults ages 18 and older</td>
<td>4</td>
</tr>
</tbody>
</table>
The same survey revealed 13 percent of adolescents ages 12 to 17 in Texas experienced a major depressive episode (2016-2019 annual average). During the same time period for the same age group, 34 percent of adolescents with a major depressive episode received mental health care.

**Substance Use Conditions**

Substance use disorders occur when the recurring use of alcohol or other drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home. When a person has both a mental health and substance use disorder, it is referred to as a co-occurring disorder.

In Texas, 35,995 adults and adolescents ages 12 and older were enrolled in substance use treatment provided by public and private treatment sources combined (single-day count in 2019), according to a survey of public and private treatment facilities. Table 4 shows the percentage of different age groups that reported experiences with substance use disorders during the same time period.

**Table 4. Adults and Adolescents Who Reported Substance Use Conditions (2017-2019 annual average)**

<table>
<thead>
<tr>
<th>Reported Condition and Age Group</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Substance use disorder, adults and adolescents combined</td>
<td>6</td>
</tr>
<tr>
<td>Substance use disorder, younger adults ages 18-25</td>
<td>13</td>
</tr>
<tr>
<td>Opioid use disorder, adults and adolescents combined</td>
<td>less than 1</td>
</tr>
</tbody>
</table>
Impact of Unrecognized and Untreated Conditions

Mental health and substance use conditions are likely to worsen if untreated. This can lead to development of more severe or additional disorders and negatively impacts people’s quality of life. School-aged children and adolescents may struggle to participate in school and are sometimes cited as having behavioral problems or being disruptive. Adults may have challenges keeping a job and safe, stable housing. Untreated conditions can contribute to a person’s vulnerability to victimization and trauma and may also lead to self-harm and suicide. Prevention and early intervention are key in supporting management and recovery of mental health and substance use conditions.

Services Provided by Council Agencies

The GAA, which is passed by the Texas Legislature every two years, appropriates funding to state agencies and directs how those funds should be spent. For SBHCC agencies receiving behavioral health funding, the GAA often includes directives for state agencies on the use of these funds for specific behavioral health services. In the 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Sec. 10.04) behavioral health services are defined as programs or services directly or indirectly related to the research, detection, or prevention of mental disorders and disabilities, and all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental disorder or disability, including persons whose mental disorders or disabilities result from alcoholism or drug addiction. Detailed inventories of SBHCC member services and eligibility are provided in Appendix E.

Populations Served

Texas state agencies providing behavioral health services have unique missions and populations they serve. These populations are diverse and include children and youth, military personnel and veterans, people with IDD, and people involved in the justice system. Age and other eligibility criteria shape the populations served by each agency.

Programs funded across various SBHCC member agencies have differing criteria for eligibility, including behavioral health need or diagnosis, age, and income level. Medical indigence is often the primary indicator of financial eligibility for state behavioral health programs; however, income level may or may not be a consideration for people receiving behavioral health services in other state agency
contexts. Therefore, the behavioral health services a person is eligible to receive varies by state agency.

Table 5 outlines the populations served or supported by SBHCC agencies across seven broad categories: youth, adults, veterans, people with IDD, people involved in criminal and juvenile justice settings (including staff, attorneys, and court justices), and the behavioral health workforce and first responders. At a high level, intersections among populations served provide opportunities for collaboration to improve outcomes for people.

**Table 5. Populations Served by SBHCC Members**

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<thead>
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</tbody>
</table>

SBHCC member agencies are researching ways to pool data to gain a better sense of the number of clients served across the Texas behavioral health system, particularly an unduplicated count of those who receive services from multiple Council members. The Texas Department of Information Resources hosts a portal that provides a secure option for sharing sensitive and confidential data across agencies. The SBHCC will explore the use of this portal and other resources.
**State Agency Services**

Behavioral health services supported by state agencies are delivered in many places, including local community clinics, schools, foster family homes, state hospitals, and counties. See detailed service inventories by SBHCC member agency in Appendix E.

**State Hospital System**

- While a full array of community-based services can reduce the need for inpatient care, the state hospitals are a critical component of the behavioral health system. HHSC has nine state psychiatric hospitals (one with three campuses), an adolescent psychiatric residential treatment center, and an outpatient primary care clinic, as shown in Figure 2 below. Each state hospital provides forensic and civil inpatient psychiatric services for adults who meet statutory admission requirements. Increasingly, civil patients admitted to state hospitals are people with complex needs who require extended treatment and cannot be appropriately served in community beds. Some state hospitals serve regional catchment areas while others serve people who live anywhere in Texas. Certain sites provide adult, child, or adolescent, and civil or forensic services.

**Table 6. State Hospital System**

<table>
<thead>
<tr>
<th>Facility</th>
<th>State-wide</th>
<th>Regional</th>
<th>Adult</th>
<th>Child/Adolescent</th>
<th>Civil Services</th>
<th>Forensic Services</th>
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<td>Facility</td>
<td>State-wide</td>
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<td>Adult</td>
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</table>

In addition to operating these facilities, HHSC partnered with UTHSC-H to construct and operate a new 264 bed psychiatric hospital that will also serve a regional catchment area, serving adult civil, forensic, and voluntary patients. HHSC also contracts with inpatient psychiatric hospitals in Montgomery County, Palestine, and at UTHSC-T for additional capacity. HHSC has also entered into a partnership with UT Southwestern Medical Center for the planning, design, and land acquisition for the construction of a 200-bed HHSC-owned state hospital in the Dallas/Fort Worth area that is expected to be operated by UT Southwestern.
State Hospital Improvement

State hospital infrastructure is aging. Infrastructure issues reduce capacity, increase emergency maintenance expenditures, and risk required accreditation by the Joint Commission and Medicare certification. Additionally, most of the older state hospital buildings are based on outdated models of inpatient care and lack the modern health care infrastructure necessary for the type of services people need.

S.B. 1, 85th Legislature, Regular Session, 2017 (Article II, HHSC, Rider 147) outlined the Texas Legislature’s intent for a three-phased approach to redesign the state hospitals. HHSC was appropriated approximately $745 million for state hospital infrastructure projects during the 2018-19 and 2020-21 biennia. H.B. 2, 87th Legislature, Regular Session, 2021 appropriated funds to complete the three-phased construction plan. H.B. 2 also appropriated funds to begin planning and land acquisition for a new state hospital in the Dallas/Fort Worth area.

The strategy for the State Hospital Improvement Initiative was outlined in the Comprehensive Plan for State-Funded Inpatient Mental Health Services, submitted to the Governor and Legislature in 2017 and updated in 2019 and 2021.
In the plan, HHSC established three guiding principles for the improvement projects that would provide:

- Unparalleled care – Texas state hospitals were built when mental health care and office space had different needs. The planned renovations and new buildings incorporate the latest evidence-based design elements for psychiatric hospitals, complementing cutting-edge services already provided. The design of behavioral health facilities can affect treatment and care.
- Easy access – HHSC developed the plan based on the idea that people and their families are better served when services are available close to home. The plan allows HHSC to provide services in locations that lack adequate inpatient treatment in their region and to incorporate technology that can help bridge geographic gaps, especially in areas where psychiatric staff are difficult to recruit.
- Systems-based continuum of care – This goal focuses on the array of mental health services and effective use of alternatives to inpatient psychiatric treatment. The plan recognizes that the inpatient care provided at the state hospitals should not be the first line of treatment for a person. People in Texas need access to the full array of mental health services, of which state hospitals are a critical component.

As of September 2021, HHSC is engaged in projects at six locations to repair, replace, and expand facilities.46

- Renovation is complete at San Antonio State Hospital’s Alamo Hall, which added 40 beds to the system capacity.
- The new state hospital in Houston, the John S. Dunn Behavioral Sciences Center, that HHSC is partnering with UTHSC-H to operate, is opening in March 2022, bringing an additional 264 beds online.
- Kerrville State Hospital’s renovated units are expected to open in Summer 2022, adding 70 maximum-security beds.
- Rusk State Hospital’s new 200 bed patient complex is scheduled to open in May 2023. While the overall capacity of Rusk will not increase, the new patient complex will provide an additional 60 maximum security beds to the state hospital system.
- Austin State Hospital’s 240-bed replacement hospital is scheduled to open in November 2023.
- San Antonio State Hospital’s 300-bed replacement hospital is scheduled to open January 2024.
- The planning, design and land acquisition are underway for the new state hospital in the Dallas/Fort Worth Metropolitan area. Ground-breaking is currently
anticipated for November 2022, with construction completion currently expected in May 2025.

**A Changing Population**

A defining trend for the state hospitals has been a shift toward an increasing percentage of people admitted on forensic commitments (e.g., incompetent to stand trial or not guilty by reason of insanity). This shift has resulted in significant changes in state hospital operations as shown in Figure 3.47

As the population has shifted, available capacity, programming, and the mission of the state hospitals has been impacted, which has resulted in delays to state hospital services. Increased mental health needs have required a fresh look at the continuum of care to address the needs of people with MI.

*Figure 3. Average Daily Census of State Hospitals, Civil versus Forensic Beds, by Fiscal Year, 2006-2021*47

**Community Beds**

To supplement state hospital capacity and meet the needs of people who require shorter-term hospitalization, HHSC contracts with LMHAs to purchase hospital beds
in community and private psychiatric hospitals to serve adults, adolescents, and youth. These beds are accessed through the LMHAs.

**Challenges of Existing Services and Strategies to Expand Capacity**

Existing behavioral health services are challenged by both longstanding issues and emerging circumstances. In 2020, two stakeholder surveys were conducted to assess the behavioral health system, service delivery, and options to make improvements. HHSC administered a survey regarding substance use services, which is described later in this report. The SBHCC administered a survey examining the full behavioral health system as described in Appendix F. Both surveys identified current challenges of existing services and strategies to expand treatment capacity as listed below.

Challenges to existing behavioral health services identified through the surveys include:
- Behavioral health workforce continuity and inconsistency due to staff shortages.
- Limited or disrupted communication between HHSC and state agency contract holders.
- Complex state agency contracting processes that create competition and gaps in service due to lack of integration of mental health and substance use services.
- Service reimbursement rates that are insufficient to support all costs and limit service capacity.
- Impact of social determinants of health and people’s holistic needs related to behavioral health.
- Lack of comprehensive substance use prevention, early intervention, treatment, and recovery strategies.
- Limited utilization and coordination of existing data to inform system improvements.

Strategies to expand behavioral health treatment capacity identified through the surveys include:
- Increasing awareness and visibility of behavioral health conditions, services, and resources, while reducing stigma associated with treatment.
- Continuing to create efficiencies in existing state agency administrative and contracting functions.
- Enhancing elements of existing shared data systems.
- Increasing technical assistance for contracted providers.
- Expanding the use of and infrastructure for recovery support services.
• Examining how other states support access to care and early intervention to make improvements in Texas systems.
• Coordinating across state agencies to better support people’s social and holistic needs.

Behavioral Health Workforce

Along with much of the nation, Texas has a shortage of behavioral health workers that is expected to grow over time. Many of the most experienced and skilled practitioners are approaching retirement (see Figure 4).\(^4^9\) Higher education institutions in Texas also have difficulty producing enough graduates to meet the demand.\(^4^9\)

**Figure 4. Behavioral Health Professional Median Ages, 2015\(^4^9\)**

Most of the state is federally designated as a geographic Health Professional Shortage Area (HPSA) by the Health Resources and Services Administration.\(^5^0\) This designation means the provider-to-population ratio is below the national target. Additionally, these shortage designations are categorized by three provider types: mental health, primary care, and dental health.\(^5^1\) As of January 2021, only Williamson County was not in a designated Mental Health Professional Shortage Area (MHPSA). Five counties are in partial shortage areas: Dallas, Galveston, Harris, Lubbock, and Wharton. The remaining 248 counties in Texas lie entirely in federally-designated shortage areas (see Figure 5).\(^5^2\)
Figure 5. Mental Health Professional Shortage Areas, 2021

Behavioral Health Services Funding

The Texas state budget for the 2020-21 biennium specifically identifies $4.4 billion related to behavioral health services in Article IX, Section 10.04. This funding is allocated to 18 of the 23 SBHCC member agencies and impacts health and human services, criminal justice, higher education, general government, and regulatory services.

In addition to funding specifically identified in Article IX, Section 10.04, Texas Medicaid is a major source of behavioral health funding, both through payments to health care providers for behavioral services and through the Delivery System Reform Incentive Payment (DSRIP) program included in the state's 1115 Transformation Waiver. Behavioral health-related Medicaid provider payments are estimated to be $3.3 billion in the 2020-21 biennium.

Figure 6 illustrates the amount of funding Texas allocated to behavioral health services in the 2020-21 biennium, reflecting the significant behavioral health investment made by the 86th Legislature, Regular Session, 2019.
Figure 6. Behavioral Health Services Funding for 2020-21 Biennium\textsuperscript{7}

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<tr>
<th></th>
<th>FY 2020</th>
<th>FY 2021</th>
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<tr>
<td></td>
<td>$1,674,103,834</td>
<td>$1,657,326,309</td>
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<tr>
<td>General Revenue for Non-Medicaid Programs</td>
<td>$542,091,738</td>
<td>$493,137,917</td>
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<td>Medicaid/CHIP (All Funds estimated)</td>
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Note: Excludes DSRIP and construction funds

**Additional Funding Mechanisms**

**Medicaid**

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

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

Texas Medicaid funds the following behavioral health services:

- Mental Health Targeted Case Management (TCM)
- Mental Health Rehabilitation
- Individual, Family, and Group Psychotherapy
- Psychological, Neuropsychological, and Neurobehavioral Testing
- Psychiatric Diagnostic Evaluation
- Inpatient Psychiatric Services
- Pharmacological Management, including Psychotropic Medications
- Substance Use Disorder Assessment/Evaluation
- Medication Assisted Treatment (MAT)
• Hospital-Based, Residential, and Outpatient Withdrawal Management
• Residential Substance Use Disorder Treatment
• Individual and Group Substance Use Disorder Counseling
• Electroconvulsive Therapy
• Screening, Brief Intervention, and Referral to Treatment (SBIRT)
• Peer Specialist Services for Substance Use Disorder or Mental Health Condition (adults ages 21 and older)
• Health and Behavioral Assessment and Intervention (HBAI) Services (children/adolescents)

As shown in Table 6, nearly 4 million people in Texas were estimated to be enrolled in Medicaid in early 2019.\textsuperscript{53} Approximately one in seven people in Texas use Medicaid, making it an important program to access behavioral health services.

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<td><strong>Fee-for-Service Sub-total</strong></td>
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</tr>
<tr>
<td><strong>Total Medicaid Enrollment</strong></td>
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</tr>
</tbody>
</table>

**Table 7. Texas Medicaid Enrollment, Estimated February 2019\textsuperscript{53}**

**Delivery System Reform Incentive Payments**

The Centers for Medicare & Medicaid Services (CMS) originally approved the Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver, known as the 1115 Transformation Waiver, as a five-year demonstration waiver through September 2016. The waiver allowed the state to expand Medicaid managed care while preserving federal supplemental hospital funding historically provided under the upper limit payment program. Part of the 1115 Transformation Waiver is the DSRIP funding pool, which provides incentive payments to providers for health care
innovation and quality improvements. The total amount of the original DSRIP pool was $11.4 billion (All Funds) over the initial five years of the waiver.\textsuperscript{11} The waiver was extended through 2022 with an additional $14.7 billion (All Funds) awarded.

It is important to note that while DSRIP is not an ongoing funding stream, DSRIP funding was a major catalyst for spearheading more than 400 innovative behavioral health projects across Texas that reinforced and improved the state behavioral health system. DSRIP behavioral health projects, which ended in September 2017, earned approximately $3.3 billion in incentive payments as of September 2019.\textsuperscript{11}

Beginning in demonstration year 7, DSRIP providers began reporting on behavioral health-related outcomes and have the potential to earn more than $1.9 billion in payments by January 2023 for demonstration years 7-10. As of July 2021, $1.5 billion DSRIP funds were paid for behavioral health-related outcomes for demonstration years 7-9.\textsuperscript{54}

**Maternal Opioid Misuse (MOM) Grant**

The Maternal Opioid Misuse (MOM) Model is a national service delivery model from the Center for Medicare and Medicaid Innovation (CMMI) that aims to improve the quality of care and reduce costs for pregnant and postpartum Medicaid beneficiaries with opioid use disorder through care transformation. Eight state Medicaid agencies are participating in the testing of this model and receive funding from CMMI. Texas’s model is centered on a multidisciplinary integrated clinic at Harris Health’s Ben Taub Hospital in Houston. The MOM Model began enrolling women at Ben Taub on July 1, 2021. Approximately 40-60 enrollees are expected in 2021. During the first year of the project in 2020, CMMI extended the pre-implementation period by six months due to the public health emergency. The project is currently in a transitional phase leading up to full implementation for January 1, 2022, when additional funding will be available based on performance and reporting.

Additional federal funding for the next 2-5 years will be based on the state’s performance. If all milestones and performance goals are met, Texas could receive up to $4.6 million in federal funds over the five-year period.

**Substance Abuse and Mental Health Services Administration Block Grants**

SAMHSA administers the Substance Abuse Prevention and Treatment Block Grant (SABG) and the Community Mental Health Services Block Grant (MHBG). HHSC receives both SABG and MHBG funds.
The SABG funds comprehensive substance misuse prevention, and substance use disorder intervention, treatment, and recovery support services through contracts with community organizations across the state. Funds are used to plan, implement, and evaluate related activities. Texas prioritizes admission to services for pregnant women who inject drugs, pregnant women, and people who inject drugs, in accordance with federal guidelines. HHSC was awarded $290,168,183 in SABG funds for federal fiscal years 2020-2021, constituting 54 percent of its non-Medicaid substance use services budget.55

The MHBG funds comprehensive community mental health services through contracts between HHSC and LMHAs/LBHAs across the state. Funds are used to plan, carry out, and evaluate related activities. Texas prioritizes adults with SMI and children with SED for state-funded treatment services that follow federal guidelines. HHSC was awarded $124,451,633 in MHBG funds for federal fiscal years 2020-2021, totaling 8 percent of its non-Medicaid mental health services budget.55

**Texas Targeted Opioid Response (TTOR)**

HHSC implemented the TTOR Program in 2017 to address the opioid crisis in Texas. The TTOR program aims to address the opioid crisis by reducing unmet treatment needs and opioid overdose-related deaths through prevention, treatment, and recovery activities. TTOR was awarded $100,766,337 in opioid-related grant funds for federal fiscal years 2020-2021, constituting almost 19 percent of HHSC’s non-Medicaid substance use services budget.56

**Collaborative Funding**

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

**Matching Grants Program**

HHSC operates four behavioral health matching grant programs.57 HHSC awards grants to eligible organizations and the grantees must contribute a monetary match, expanding the reach and impact of the original funding. The programs are described briefly below. More detail is available in Appendix D.

Behavioral health matching grant programs include:
• Community Mental Health Grant Program supports comprehensive, data-driven mental health systems that promote both wellness and recovery.
• Healthy Community Collaboratives program builds communities that support the ongoing recovery and housing stability of people who are homeless and have unmet behavioral health needs.
• Mental Health Grant Program for Justice-Involved Individuals addresses unmet physical and behavioral health needs of those in crisis to prevent initial or subsequent justice involvement and promote recovery.
• Texas Veterans + Family Alliance grant program supports community-based, sustainable, research-informed, and accessible behavioral health services to Texas veterans and their families to augment the work of the Veterans Administration.

Residential Treatment Center Project

The Residential Treatment Center (RTC) Relinquishment Avoidance Project is a partnership between DFPS and HHSC to provide intensive support for families who are at-risk of relinquishment to DFPS due to their child’s or adolescent’s mental health needs.58

The goal of the RTC Project is to prevent families from relinquishing their parental rights to DFPS by:
• Connecting families to mental health services available in their community through their LMHA or LBHA; and
• Providing state-funded residential placement to meet their child’s or adolescent’s mental health needs when families do not have the resources to access residential placement.

All 39 LMHAs and LBHAs in Texas provide services for the RTC Project in their communities.

Mental Health Program for Veterans

The 2020-21 General Appropriations Act, H.B. 1, 86th Legislature, Regular Session, 2019 (Article II, HHSC, Rider 59) appropriated $5 million each fiscal year of the biennium to provide services to veterans through the mental health program required by Health and Safety Code Sections 1001.221-224. HHSC funds the TVC’s VMHD to coordinate administration of the Mental Health Program for Veterans through its partnerships with 37 LMHAs in accordance with H.B. 2392, 83rd Legislature, Regular Session, 2013. The Mental Health Program for Veterans includes the provision of peer-to-peer counseling, access to licensed mental health
professionals, jail diversion services, community and faith-based engagement, and peer training.

In fiscal year 2020, LMHAs reported a reduction in the number of services delivered and the number of people trained compared to fiscal year 2019 due to decreased interaction resulting from the COVID-19 pandemic: 59

- 88,985 peer services were delivered
- 2,246 peers were trained
- 486 clinical mental health sessions to address military related trauma were performed
- 29,421 interactions occurred with people involved in the criminal justice system

Local Resources Support Initiatives

Local and private grants have been awarded to integrate primary and mental health care, increase access to autism services for children, provide Mental Health First Aid training, expand mental health services beyond the state target population, and enhance access to peer support services.

Proceeds from Texas Lottery Commission scratch-off games and donations received from the public through forms at the Texas Department of Public Safety, the Texas Department of Motor Vehicles, and the Texas Parks and Wildlife Department fund TVC's Fund for Veterans' Assistance grant program. TVC awards reimbursement grants to nonprofit organizations and units of local government to provide direct mental health services to veterans and their families.

Student Loan Repayment Programs

Several programs are available to assist behavioral health professionals with student loan repayment. Due to the shortage of behavioral health providers in this state, the student loan repayment programs would allow the state to recruit and retain students by incentivizing them with repayment of their student loans while serving in those communities with the greatest need.

Texas Higher Education Coordinating Board

The Texas Higher Education Coordinating Board (THECB) administers multiple programs. Information regarding these programs is available at the THECB Student Loans website. 60 Funding to support these programs varies by year and is not guaranteed to be available.

- The Physician Education Loan Repayment Program provides loan repayment funds for physicians, including psychiatrists, who agree to practice in a HPSA.
HPSAs are designated by the federal Health Resources and Services Administration as having shortages of primary care, dental care, or mental health providers. Participating physicians must provide health care services to recipients enrolled in Medicaid and the Children’s Health Insurance Program (CHIP). A limited number of physicians per year may qualify by serving patients in a TJJD or TDCJ facility.

- The Loan Repayment Program for Mental Health Professionals provides loan repayment funds to encourage certain mental health professionals to provide services in designated MHPSAs. This program is available to licensed chemical dependency counselors who have an associate degree related to chemical dependency counseling or behavioral science, advanced practice registered nurses who are board certified in psychiatric or mental health nursing, licensed professional counselors, licensed clinical social workers, licensed marriage and family therapists, psychiatrists, and psychologists.

Texas Department of Agriculture’s State Office of Rural Health

The Rural Communities Health Care Investment Program assists rural communities in recruiting non-physician health care professionals to practice in their community by providing partial student loan reimbursements or stipend payments to non-physicians for one year of service.61

Health Resources and Services Administration

The repayment programs below are all accessible from the Health Resources and Services Administration website about loan repayment programs.62

- The Nurse Corps Loan Repayment Program provides federal loan repayment program for registered nurses and advance nurse practitioners working at critical shortage facilities located in HPSAs. A critical shortage facility is a public or private nonprofit health care facility located in, designated as, or serving an HPSA.
- The Substance Use Disorder Treatment and Recovery Loan Repayment Program repays eligible educational loans for providers who work full-time for six years in a program-approved treatment facility.
- The Faculty Loan Repayment Program helps eligible health professions faculty from disadvantaged backgrounds to repay their student loans.

Other Federal Agencies

- National Institutes of Health Loan Repayment Programs are established by Congress and designed to recruit and retain highly qualified health professionals into biomedical or biobehavioral research careers.63
U.S. Department of Education Public Service Loan Forgiveness Program forgives the remaining balance on direct student loans after a person makes 120 qualifying monthly payments under a qualifying repayment plan while working full-time for a qualifying employer. Qualifying employers under this program include government agencies and non-profit organizations that provide qualifying public services.64
Past Behavioral Health Bill Implementation

The 86th Legislature provided several opportunities for SBHCC member agencies to improve behavioral health in Texas. Listed below are some of the most significant pieces of behavioral health legislation from that session and how each bill has been implemented thus far.

86th Legislature, Regular Session, 2019

<table>
<thead>
<tr>
<th>Bill Details</th>
<th>Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>H.B. 1, Article II, HHSC Appropriations, Rider 64, Substance Use Treatment Services</td>
<td>Implemented/Complete</td>
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</table>

**Description:** Allocates funding for substance use disorder services by addressing the treatment waitlist for pregnant women and women with dependent children and by increasing treatment rates for all providers.

**Implementation:** In Rider 64, the Legislature made two significant investments in substance use services:
- General Revenue funds of $23,634,844 for fiscal years 2020-2021 to reduce the treatment waitlist for pregnant women and women with dependent children. These funds were appropriated in fiscal year 2020 and used to provide services and expand provider capacity across the biennium to reduce the treatment waitlist for pregnant women and women with dependent children.
- Increase substance use disorder treatment rates with a funding allocation of $677,004 for fiscal year 2020 and $4,322,996 for fiscal year 2021.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Services for Special Populations

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<tr>
<th>Bill Details</th>
<th>Status</th>
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<tbody>
<tr>
<td>H.B. 1, Article II, HHSC Appropriations, Rider 66, Consolidated Reporting of Opioid-Related Expenditures</td>
<td>Implemented/Complete</td>
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</tbody>
</table>

**Description:** Requires HHSC to submit an annual legislative report about actual annual expenditures from the previous fiscal year for all opioid use and misuse-related programs at HHSC, DFPS, and DSHS.

**Implementation:** HHSC, DFPS, and DSHS collaborated to develop an annual consolidated report of expenditures. HHSC submitted the fiscal year 2018 and 2019 reports to the Governor and Legislature.\(^5\)\(^6\)
**H.B. 1, Article II, HHSC Appropriations, Rider 66, Consolidated Reporting of Opioid-Related Expenditures**

Status: Implemented/Complete

**Addresses Strategic Plan Gaps:**
- Shared and Usable Data

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**H.B. 1, Article II, HHSC Appropriations, Rider 67, Improve Efficiency of Substance Use Services**

Status: Implemented/Complete

**Description:** Requires HHSC to develop a proposal to improve the efficiency of administering substance use disorder treatment services and expand the capacity of substance use treatment services.

**Implementation:** HHSC surveyed key stakeholders to identify challenges with existing processes and the infrastructure of the substance use delivery system in Texas, as well as opportunities to address those challenges. Then HHSC developed recommendations for potential improvements and actions. The report was submitted to the Governor and Legislature in December 2020.67

**Addresses Strategic Plan Gaps:**
- Access to Timely Treatment Services
- Implementation of Evidence-based Practices
- Shared and Usable Data

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**H.B. 1, Article V, TCOOMMI Appropriations, Rider 65, TCOOMMI Rural Expansion**

Status: Implemented/Complete

**Description:** Expansion of TCOOMMI outpatient services in rural areas.

**Implementation:** The Legislature appropriated $2,412,500 in fiscal year 2020 and $2,362,500 in fiscal year 2021 in General Revenue to TCOOMMI, for the expansion of mental health caseloads for probationers and parolees that serve clients with a high criminogenic risk and clinical care need in rural areas. Through contract renewals, an additional 20 caseloads were added and co-location of mental health service providers with criminal justice supervision partners were facilitated beginning September 2019.
### H.B. 1, Article V, TCOOMMI Appropriations, Rider 65, TCOOMMI Rural Expansion

**Status:** Implemented/Complete

**Addresses Strategic Plan Gaps:**

- Access to Appropriate Behavioral Health Services
- Continuity of Care for Individuals Exiting County and Local Jails
- Access to Timely Treatment Services
- Services for Special Populations
H.B. 253
Postpartum Depression Strategic Plan
Author: Farrar
Status: Implemented/Complete

**Description:** Relating to a strategic plan to address postpartum depression. H.B. 253 requires HHSC to develop and implement a five-year strategic plan to improve access to postpartum depression screening, referral, treatment, and support services.

**Implementation:** HHS convened an internal cross-divisional maternal mental health workgroup across HHSC and DSHS to develop and implement the strategic plan. The plan provides background on postpartum depression in Texas and highlights research on current challenges and opportunities for improving access to maternal mental health screening, referral, treatment, and support services. In the September 2020 report, the workgroup developed 15 key strategies to increase awareness of postpartum depression and improve access to care.68 HHSC, DSHS, the SBHCC, and the Statewide Health Coordinating Council will annually review and update the strategic plan as necessary.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Coordination Across State Agencies
- Implementation of Evidence-based Practices
- Prevention and Early Intervention Services

S.B. 562/H.B. 601
Facility Designated by HHSC Instead of Crime
Author: Zaffirini/Price
Status: Implemented/Complete

**Description:** Relating to procedures and reporting requirements regarding criminal defendants who are or may be persons with a mental illness or an intellectual disability.

**Implementation:** Provided HHSC with the authority to determine the most appropriate security setting (maximum-security unit or non-maximum-security unit) for forensic admissions to the state hospitals. This has assisted with reducing the forensic waitlist for state hospitals that provide maximum-security services. Between September 2019 and August 2021, 1,363 commitment packets were reviewed, resulting in 203 people who were waived from the maximum-security unit.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Services for Special Populations
### H.B. 1070
**Mental Health First Aid Training Reporting Requirements**  
**Author:** Price  
**Status:** Implemented/Complete

**Description:** Relating to Mental Health First Aid (MHFA) training program reporting requirements. H.B. 1070 amends Chapter 1001, Health and Safety Code, Section 1001.25 to require annual reporting of the related expenditures and number of people trained in MHFA from the following groups: employees and contractors of LMHAs; university and school district employees and school resource officers; and other people trained by LMHAs.

**Implementation:** HHSC staff created a data collection page in the Clinical Management for Behavioral Health Services (CMBHS) system for LMHAs/LBHAs to submit the number of people trained in MHFA from the various groups and report expenditures via monthly invoices. HHSC compiles the data and annually submits a report on the MHFA program. The first MHFA annual report including these reporting requirements was submitted to the Governor and Legislature in November 2020.69

**Addresses Strategic Plan Gaps:**
- Coordination Across State Agencies
- Prevention and Early Intervention Services

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### H.B. 3980
**Suicide Prevalence and Prevention Strategies**  
**Author:** Hunter  
**Status:** Implemented/Complete

**Description:** Relating to a requirement that the SBHCC prepare a report regarding suicide rates in this state and state efforts to prevent suicides. H.B. 3980 requires a summary report of suicide prevalence and state agency policies as well as recommendations to monitor and prevent suicide.

**Implementation:** The SBHCC coordinated with HHSC and DSHS to compile suicide-related data and state agency suicide prevention efforts from the preceding 10 years. The report was submitted to the Governor and Legislature in May 2020.35 The SBHCC also created a Suicide Prevention Workgroup in collaboration with stakeholders to develop recommendations prevent suicide and routinely monitor data. The report was submitted to the Governor and Legislature in November 2020.36

**Addresses Strategic Plan Gaps:**
- Coordination Across State Agencies
- Implementation of Evidence-based Practices
- Prevention and Early Intervention Services
- Shared and Usable Data
S.B. 562
Pen Packet Enhancement
Author: Zaffirini
Status: Implemented/Complete

**Description:** S.B. 562 amends Section 8(a), Article 42.09 of the Code of Criminal Procedure relating to the delivery of certain mental health information provided to TDCJ from sending counties. Language is added to include a copy of any mental health records, mental health screening report, or similar information regarding the mental health of the defendant.

**Implementation:** The bill required the following records to be provided within the Pen Packet for people transferred to TDCJ custody: a copy of any mental health records, mental health screening reports, or similar information regarding the mental health of the defendant; updates made to the Pen Packet coversheet; memo coordinated with the TCJS sent to county jails; and coordination with HHSC on a statewide broadcast message.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Continuity of Care for IndividualsExiting County and Local Jails
- Services for Special Populations

S.B. 633
All Texas Access
Author: Kolkhorst
Status: Implemented/Complete

**Description:** Relating to an initiative to increase the capacity of LMHAs to provide access to mental health services in certain counties. S.B. 633 amends Chapter 531, Government Code, Section 531.0221 to require LMHAs/LBHAs that serve counties with populations of 250,000 or less to create regional development plans. Requires HHSC to conduct a statewide analysis of mental health services in counties of 250,000 people or less and prepare legislative recommendations to help implement the regional development plans. No regional group is required to implement their regional plans unless a funding source is identified.

**Implementation:** HHSC published the report on the HHSC website in December 2020. HHSC is working with the regional groups to identify and implement low-to-no-cost initiatives.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Use of Peer Services
- Consumer Transportation and Access to Treatment
- Prevention and Early Intervention Services
<table>
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<tr>
<th>S.B. 1177</th>
<th>Evidence-based Behavioral Health In-Lieu-of Services</th>
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<tbody>
<tr>
<td>Author: Birdwell</td>
<td>Status: In Progress</td>
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**Description:** Permits Medicaid managed care organizations (MCOs) to offer medically appropriate, cost-effective, evidence-based behavioral health services in lieu of specified Medicaid State Plan services. The list of services is to be approved by the State Medicaid Managed Care Advisory Committee (SMMCAC).

**Implementation:** HHSC divided the recommended services from SMMCAC into a phased implementation. Phase one services include services in lieu of inpatient hospitalization. Phase two services include services in lieu of outpatient services. A third group of services proposed by SMMCAC requires further consideration. HHSC determined that Phase one services were evidence-based and completed the cost-effectiveness review of these services. HHSC is awaiting approval from the Centers for Medicare & Medicaid Services (CMS) for Phase one services. HHSC will continue to work with SMMCAC on implementation of this bill, including for Phase two services.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Prevention and Early Intervention Services

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| TLETS Expansion |
|-----------------
| Funded by H.B. 1, Article II, HHSC Appropriations |
| Status: Implemented/Complete |

Description: Funding to improve the data sharing system between Mental and Behavioral Health Outpatient Data Warehouse (MBOW) and the Texas Law Enforcement Telecommunications System (TLETS) to allow clients with co-occurring conditions to be successfully tracked on entry and exit into each system. Funding for this project was an HHSC exceptional item request.

**Implementation:** HHSC expanded the TLETS interface with MBOW to allow jail staff to determine whether people being booked in jail were also clients with IDD being served by LIDDAs. HHSC conducted training for TDCJ staff and county jails. The TLETS expansion was fully deployed in August 2020.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Behavioral Health Services for Individuals with Intellectual Disabilities
- Shared and Usable Data
**IDD Crisis Continuum of Care**  
**Funded by H.B. 1, Article II,**  
**HHSC Appropriations**  
**Status: Implemented/Complete**

**Description:** This exceptional item provides $4 million in funding to maintain and expand services and supports to the IDD community crisis continuum of care for people with IDD and co-occurring behavioral health diagnoses. Additionally, this item provided $3 million in funding to establish IDD community outpatient mental health services.

**Implementation:** For IDD crisis intervention services, HHSC contracts with 39 LIDDAs serving all 254 counties statewide to ensure crisis services are available, including crisis respite. In 2019, HHSC established an IDD outpatient services learning collaborative with five LIDDAs to help assist in the development and piloting of outpatient services for people with IDD. In fiscal year 2021, the five pilot sites began implementing outpatient services and supports and will continue through fiscal year 2022.

**Addresses Strategic Plan Gaps:**  
- Behavioral Health Services for Individuals with Intellectual Disabilities

**Funding Expanded Capacity at Renovated State Hospitals**  
**Funded by H.B. 1, Article II,**  
**HHSC Appropriations**  
**Status: Delayed**

**Description:** Appropriations to allow the Health and Specialty Care System to operate beds at Kerrville and San Antonio State Hospitals once renovations are complete.

**Implementation:** While the Alamo Unit at San Antonio State Hospital (SASH) was completed and ready for occupancy on time, the opening of the unit coincided with the period of time when the state hospitals were experiencing significant staffing shortages, which has delayed SASH’s ability to staff the new unit.

Renovations at Kerrville State Hospital (KSH) have been delayed due to construction supply chain issues, delaying the availability of certain materials and equipment that are needed to complete the renovation project. KSH’s operations are now expected to begin in Summer 2022; however, like the staffing challenges experienced at SASH, KSH has been experiencing unprecedented staffing shortages.

**Addresses Strategic Plan Gaps:**  
- Access to Appropriate Behavioral Health Services  
- Behavioral Health Workforce Shortage
### Recruiting and Retaining a Capable and Competent Workforce

**Funded by H.B. 1, Article II, HHSC Appropriations**  
**Status: Implemented/Complete**

**Description:** These funds will be used to reduce turnover and vacancy rates at targeted HHSC facilities by increasing pay for the direct care staff at state supported living centers (SSLCs) and state hospitals. By targeting facilities at greatest risk for capacity reductions or severe overtime and contracting costs related to difficulty recruiting and retaining these positions, it ensures HHSC does not have to reduce service levels (e.g., take psychiatric beds offline).

**Implementation:** Eight facilities with the lowest fill rates received market rate increases for direct care staff: Abilene, Corpus Christi, Lubbock, San Angelo, and San Antonio SSLCs; and Big Spring, Rusk, and San Antonio State Hospitals. The increase has proven effective in increasing the fill rate by nine percent, which is associated with reduced cost associated with high turnover and vacancy rates.

**Addresses Strategic Plan Gaps:**  
- Behavioral Health Workforce Shortage

### 85th Legislature, Regular Session, 2017

At the time of publication of the *Texas Statewide Behavioral Health Strategic Plan Update* in 2019, the following key legislation had not been fully implemented. Below are updates on the implementation of those bills.

**S.B. 578**  
**Veteran Suicide Prevention**  
**Author: Lucio**  
**Status: In Progress**

**Description:** Relating to an HHSC veteran suicide prevention action plan. S.B. 578 amended Chapter 531, Government Code, Section 531.0925 to require HHSC to develop comprehensive short-term and long-term action plans to increase access to, and availability of professional health services to prevent veteran suicides in Texas.

**Implementation:** The short-term action plan was developed and submitted to the Governor and Legislature in September 2019. The long-term action plan, built on the results of the short-term action plan, was submitted to the Governor and Legislature in September 2021. This report aligns with state and national efforts in veteran suicide prevention. The initiatives and reforms in the long-term plan must be fully implemented by September 2027.
**S.B. 578**  
*Veteran Suicide Prevention*  
**Author:** Lucio  
**Status:** In Progress

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Coordination Across State Agencies
- Veteran and Military Service Member Supports
- Access to Timely Treatment Services
- Use of Peer Services
- Prevention and Early Intervention Services

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**S.B. 591**  
*Veteran Outreach Campaign*  
**Author:** Lucio  
**Status:** Implemented/Complete

**Description:** Relating to a community outreach campaign to increase awareness of veterans’ benefits and services. TVC must implement the outreach campaign.

**Implementation:** TVC’s Communication and Outreach Program utilizes several media channels and platforms to conduct community outreach, including a call center, radio, and television, print publications, social media, outreach and engagement events, and other events across the state.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Veteran and Military Service Member Supports
- Prevention and Early Intervention Services

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**S.B. 1326**  
*Jail-Based Competency Restoration*  
**Author:** Zaffirini  
**Status:** Implemented/Complete

**Description:** Relating to procedures regarding criminal defendants who are or may be persons with a mental illness or intellectual disability. S.B. 1326 allowed counties to establish jail-based competency restoration (JBCR) programs and enabled HHSC to inspect county-level JBCR programs. The JBCR pilot program was continued indefinitely.
S.B. 1326  
Jail-Based Competency Restoration  
Author: Zaffirini  
Status: Implemented/Complete

**Implementation:** Five LMHAs/LBHAs currently administer JBCR under contract monitoring and oversight by HHSC. HHSC developed an onsite tool and provider information for county-level JBCR inspections. HHSC monitors JBCR program performance targets and expenditures quarterly and may inspect any aspect of program. During fiscal year 2020, JBCR providers served a total of 422 people, exceeding the state’s target of 299. The JBCR programs are available at the following LMHAs/LBHAs:

- North Texas Behavioral Health Authority (Counties: Dallas, Ellis, Hunt, Kaufman, Navarro, Rockwall)
- StarCare Specialty Health System (Counties: Cochran, Crosby, Hockley, Lubbock, Lynn)
- MHMR of Tarrant County (Counties: Tarrant)
- PermiaCare (Counties: Brewster, Culberson, Ector, Hudspeth, Jeff Davis, Midland, Pecos, Presidio)
- Nueces Center for Mental Health and Intellectual Disabilities (Counties: Nueces)
- Harris Center for Mental Health and IDD (Counties: Harris)

**Addresses Strategic Plan Gaps:**
- Coordination Across State Agencies
- Continuity of Care for Individuals Exiting County and Local Jails

**Highlights from the 87th Legislature**

The 87th Legislature, Regular Session, 2021, created additional investments in behavioral health services and expanded the membership of the SBHCC. The legislation listed below highlights some of the opportunities for SBHCC member agencies to collaborate and further improve the behavioral health system. The gaps to be addressed by the legislation are updated to correspond with the new gaps identified through the update of the *Texas Statewide Behavioral Health Strategic Plan*. These gaps are described in Section 4. Additionally, the Texas School for the Deaf and the Texas Commission on Law Enforcement were added to the SBHCC membership.

**S.B. 1, Article II,  
HHSC Appropriations, Rider 54,  
Additional Mental Health Community Hospital Beds**

**Description:** Provides for additional mental health community hospital beds. Appropriates $15 million in general revenue for community hospital beds in rural areas and $15 million in urban areas.
**S.B. 1, Article II, HHSC Appropriations, Rider 54, Additional Mental Health Community Hospital Beds**

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services

**S.B. 1, Article II, HHSC Appropriations Operational Funding for the John S. Dunn Behavioral Sciences Center**

**Description:** Provides for operational funding for 168 beds designated for the state hospital patients at the new state hospital in Houston, the John S. Dunn Behavioral Sciences Center, operated by UTHSC-H.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services

**H.B. 2, HHSC Appropriations Planning, Design, and Land Acquisition for a New State Hospital in the Dallas/Fort Worth Metropolitan Area**

**Description:** Provides funding for the planning, design, and land acquisition for a new 200 bed state hospital in the Dallas/Fort Worth metropolitan area in partnership with UT Southwestern Medical Center.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
### S.B. 1, Article II, HHSC Appropriations, Rider 100, Step-down Housing Pilot for People with Serious Mental Illness

**Description:** Requires HHSC to develop an operational plan for a transitional living program for long-term patients of the state mental health hospitals that would be implemented on a SSLC campus. The operational plan must address admission criteria, interdisciplinary service provision, and explore potential site and funding for future expansion. Provides HHSC capital budget authority to transfer up to $12.7 million of available federal funds included in HHSC Rider 2, Capital Budget for the 2022-23 biennium to make necessary upgrades and to secure one or more appropriate buildings on a SSLC campus in preparation for the transitional living program.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Coordination Across State Agencies

### S.B. 1, Article IV, OCA Appropriations, Indigent Defense with Mental Health Needs

**Description:** Provides an additional $5 million in fiscal years 2022-2023 for TIDC to award grants to public defender offices and managed assigned counsel programs to expand the capacity of existing mental health defender programs, establish mental health defender programs in counties without these programs, or to sustain effective mental health defender programs.

**Addresses Strategic Plan Gaps:**
- Social Determinants of Health and Other Barriers to Care
- Prevention and Early Intervention Services

### S.B. 64 Peer Support Network for Law Enforcement

**Author:** Nelson

**Description:** Relating to a peer support network for certain law enforcement personnel. S.B. 64 requires creation of a peer support network for law enforcement officers, training for peers, technical assistance for program development, and retention of licensed mental health professionals.

**Addresses Strategic Plan Gaps:**
- Use of Peer Services
- Prevention and Early Intervention Services
### S.B. 454
**Continuation of All Texas Access**  
**Author:** Kolkhorst

**Description:** Relating to mental health services development plans as updated by HHSC and LMHA/LBHA regional groups. Requires each group to plan and implement regional strategies to reduce costs associated with use of crisis or emergency services and incarceration by meeting people’s needs before that point.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Social Determinants of Health and Other Barriers to Care
- Prevention and Early Intervention Services

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### S.B. 642
**Residential Treatment Center (RTC) Relinquishment Avoidance Program**  
**Author:** West

**Description:** Relating to the provision of mental health services for certain children at risk of relinquishment. Codifies the RTC relinquishment avoidance program and requires HHSC and DFPS to establish policies and procedures. Allows parents to access the RTC relinquishment avoidance program through LMHAs/LBHAs rather than through DFPS.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
- Social Determinants of Health and Other Barriers to Care
### S.B. 672
**Collaborative Care Model in Medicaid**
**Author:** Buckingham

**Description:** Relating to Medicaid coverage of certain collaborative care management services:
- S.B. 672 requires HHSC to make the billing codes associated with collaborative care management services payable in Medicaid for children and adults.
- The collaborative care model integrates behavioral health and general medical services. This evidence-based model involves a collaborative care team led by the primary care provider that includes behavioral health care managers, psychiatrists and other mental health professionals that provide care coordination, regular monitoring and treatment, and review and consultation with persons who do not show improvement. Each person served has an outcomes-based care plan.
- This model targets people with common mental health or substance use conditions (e.g., anxiety, depression, alcohol, or substance use), and typically lasts 6-9 months.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Prevention and Early Intervention Services

### S.B. 1808
**IDD Habilitative Support Services (IHSS)**
**Author:** Kolkhorst

**Description:** Relating to home and community support services licensing requirements. Exempts IHSS providers from Home and Community Support Services licensure under Health and Safety Code Chapter 142. Will allow implementation of IHSS services under approved Medicaid State Plan Amendment.

**Addresses Strategic Plan Gaps:**
- Behavioral Health Services for People with Intellectual and Developmental Disabilities

### S.B. 1827
**Opioid Abatement Account**
**Author:** Huffman

**Description:** Creates the Texas Opioid Abatement Fund Council under the auspices of the Texas Comptroller of Public Accounts for which the HHSC Executive Commissioner appoints six members. Directs spending for opioid abatement funds.
**S.B. 1827**
Opioid Abatement Account
Author: Huffman

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Implementation of Evidence-based Practices
- Prevention and Early Intervention Services

**S.B. 1921**
Medicaid Reimbursement for Certain Behavioral Health and Physical Health Services
Author: Lucio

**Description:** Relating to Medicaid reimbursement for the provision of certain behavioral health and physical health services, S.B. 1921:
- Requires Medicaid reimbursement for mental health targeted case management and mental health rehabilitation (MHTCM/MHR) private providers in traditional, fee-for-service Medicaid before a person is enrolled in Medicaid managed care.
- Further requires reimbursement to a public or private provider in Medicaid managed care for MHTCM/MHR once the person is enrolled in managed care.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services

**H.B. 4**
Telemedicine/Telehealth Services
Author: Price

**Description:** Relating to the provision and delivery of certain health care services in this state, including services under Medicaid and other public benefits programs, using telecommunications or information technology and to reimburse for some of those services.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Access to Timely Treatment Services
### H.B. 707
**Recovery Housing**  
**Author:** Moody

**Description:** Relating to a study on expanding recovery housing in this state. HHSC will conduct a statewide study on the current status, opportunities, challenges, and needs to expand recovery housing.

**Addresses Strategic Plan Gaps:**
- Access to Supported Housing and Employment

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### H.B. 2595
**Mental Health Condition and Substance Use Disorder Parity**  
**Author:** Price

**Description:** Relating to a parity complaint portal and educational materials and parity law training regarding benefits for mental health conditions and substance use disorders to be made available through the portal and otherwise. H.B. 2595 also designates October as mental health condition and substance use disorder parity awareness month.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Coordination Across State Agencies
- Access to Timely Treatment Services
### H.B. 2822
**Availability of Antipsychotic Drugs in Medicaid**  
**Author:** Hull

**Description:** Relating to the availability of antipsychotic prescription drugs under the vendor drug program and Medicaid managed care, H.B. 2822:

- Prohibits HHSC from requiring non-clinical prior authorization (PA) for a nonpreferred antipsychotic drug on the vendor drug formulary prescribed to an adult if the person unsuccessfully tries an antipsychotic drug for 14 days that is included on the preferred drug list; the patient was previously prescribed and had a prior authorization for the nonpreferred antipsychotic drug, and the prescription is for drug dosage titration; or the patient was previously prescribed and obtained PA for the a nonpreferred antipsychotic drug and the prescription modifies the dose, frequency of dose, or both of the drug as part of the same treatment for which the drug was previously prescribed.
- Requires HHSC to develop rules and standards to require the vendor drug program and Medicaid managed care to automate clinical PA for drugs in the antipsychotic drug class and ensures that a pharmacist is provided an immediate message if a prior authorization is required.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Shared and Usable Data

### H.B. 3088
**Mental Health Grant Programs**  
**Author:** Coleman

**Description:** Relating to the administration of certain mental health grant programs established by HHSC:

- Makes match requirements consistent across all four behavioral health matching grant programs administered by HHSC.
- Allows local government funds and private funds to be used as in-kind match for HCC grants and removes requirement for sustainability after seven years for HCC awardees.
- Allows use of up to five percent of appropriated funds by HHSC for administrative costs for each grant program.

**Addresses Strategic Plan Gaps:**
- Access to Appropriate Behavioral Health Services
- Supports for Service Members, Veterans, and their Families
- Continuity of Care for People of All Ages Involved in the Justice System
- Access to Supported Housing and Employment
### H.B. 4074
Use of Suicide Data by SBHCC
Author: Hunter

**Description:** Relating to the collection and use of suicide data by the SBHCC. H.B. 4074 amends Chapter 531, Government Code, Section 531.476 to require the SBHCC and its suicide prevention subcommittee to do the following:

- Include suicide prevention strategies in the Texas Statewide Behavioral Health Strategic Plan.
- Monitor and gather data about suicide and suicide prevention.
- Establish a method for identifying how suicide data reports are used to make policy.

**Addresses Strategic Plan Gaps:**

- Coordination Across State Agencies
- Prevention and Early Intervention Services
- Shared and Usable Data
Gaps in the Texas Behavioral Health System

The SBHCC administered an online survey in November 2020, as a follow up to previous public surveys conducted in 2016 and 2018. The 2020 Behavioral Health Strategic Plan Survey was used to gather public feedback on the behavioral health system in Texas and guide the direction of the new Texas Statewide Behavioral Health Strategic Plan.

The survey asked members of the public to respond to questions in four main topic areas:
- Survey respondent demographics;
- An assessment of changes in previously identified gaps in the behavioral health system;
- Identification of strengths, opportunities, weaknesses, and threats in the behavioral health system; and
- Whether the COVID-19 pandemic was having an impact on behavioral health services.

Over 2,200 survey responses were analyzed from people who have used behavioral health services in Texas, caregivers and family members of people who used services, service and support providers, and people who work in behavioral health organizations.

The survey asked respondents to assess whether behavioral health system gaps cited in the first Texas Statewide Behavioral Health Strategic Plan still exist. Most respondents indicated they agreed the behavioral health system has improved in use of evidence-based practices. Less than a quarter of respondents indicated the following areas improved: transportation for behavioral health services; secure housing for people with behavioral health needs; and an adequate behavioral health workforce. The survey findings indicate the gaps from the original strategic plan, listed below, should continue to be considered in development of the new strategic plans:
- Access to appropriate behavioral health services
- Behavioral health needs of public school students
- Coordination across state agencies
- Veteran and military service member supports
- Continuity of care for individuals exiting county and local jails
- Access to timely treatment services
- Use of peer services
• Behavioral health services for individuals with intellectual disabilities
• Consumer transportation and access to treatment
• Prevention and early intervention services
• Access to housing
• Behavioral health workforce shortage
• Services for special populations
• Shared and usable data

The survey featured four questions regarding strengths, weaknesses, opportunities, and threats (SWOT) related to the behavioral health system. While the questions were based on past surveys, the format changed from open-ended questions to multiple-choice questions to compare responses over time.

Respondents indicated several issues improved while some declined. Survey responses also helped identify potential support for making certain improvements to the behavioral health system in Texas. Figure 7 lists the results of the SWOT analysis and highlights issues to be considered in the development of the new strategic plans.
The survey responses regarding the COVID-19 pandemic demonstrated about two-thirds of survey respondents felt their own behavioral health was affected by the pandemic and three-quarters indicated access to behavioral health services was affected. Many respondents indicated they tried telehealth formats for behavioral health services after the pandemic began and the majority reported telehealth options improved their access to services.

A detailed report and data analysis summary is provided in Appendix F.

**Gaps Guiding the Council for Fiscal Years 2022-2026**

The SBHCC identified gaps in the behavioral health system. The gaps provide opportunities to strengthen the system as the strategic plan is implemented.
Gap 1: Access to Appropriate Behavioral Health Services

Underserved populations include people with substance use disorders; people with co-occurring psychiatric and substance use disorders; people with SMI; and those who are frequently booked in jails and admitted to emergency rooms and inpatient services. Depending on each person’s needs and preferences, they may face challenges accessing services that address these needs.

Gap 2: Behavioral Health Needs of Public School Students

School-aged children or adolescents with an undiagnosed or untreated behavioral health condition often experience adverse impacts on school attendance, classroom behavior, and overall academic performance. Public school-based mental health services may be delivered by a variety of professionals with different types of training, including nurses, school psychologists, social workers, and school counselors. Some schools have developed innovative mental health partnerships with community providers, while other schools have hired mental health professionals, such as psychologists and social workers, to supplement student learning supports. However, given the variability in behavioral health infrastructure in schools statewide, it is difficult to meet the growing behavioral health needs of students and disseminate best practices in early intervention and early detection across campuses and districts.

Gap 3: Coordination Across State Agencies

State agencies serve a significant number of people with behavioral health needs. Since 2014, considerable improvements have been made in communication between state agencies and coordination in the delivery of behavioral health services through the efforts of the SBHCC. Agencies work closer together to resolve challenges and partner on funding initiatives to maximize expertise and efficiencies. There are opportunities to strengthen coordination by exploring new relationships and advanced forms of collaboration. Cross-agency coordination is vital to ensuring state agencies maximize funding for services and address the multi-faceted needs of Texans.

Gap 4: Supports for Service Members, Veterans, and Their Families

Unidentified and untreated behavioral health needs of service members and veterans can degrade their health, decrease work productivity, damage social functioning, and have negative outcomes on family relationships. Some veterans
experience obstacles obtaining and maintaining employment or pursuing education after discharge. Veterans transitioning out of the military back into civilian communities can have difficulty finding social connectivity, a sense of community, and renewed life purpose. They risk experiencing homelessness and/or dying by suicide at rates significantly higher than their civilian counterparts. Additionally, the stigma associated with both admitting the need for, and seeking treatment for behavioral health conditions can prevent veterans and military personnel from accessing and utilizing services available to them.\textsuperscript{73}

**Gap 5: Continuity of Care for People of All Ages Involved in the Justice System**

State agencies have implemented and expanded continuity of care services for people exiting juvenile facilities, city and county jails, and the state prison systems. However, enhanced coordination between systems is needed to strengthen that support. Inadequate continuity of care can complicate reentry into the community and increase the risk of recidivism andrehospitalization. The first *Texas Strategic Plan for Diversion, Community Integration, and Forensic Services* is included in this joint publication and identifies strategies to enhance behavioral health continuity of care for people involved in the justice system.

**Gap 6: Access to Timely Treatment Services**

Considerable financial investments have been made to develop a robust psychiatric crisis service system that includes crisis hotlines, mobile models of care, and a continuum of psychiatric emergency services centers. In recent years, a major transformation of the state hospital system began. However, some people may still have difficulty accessing acute inpatient psychiatric services in a timely manner. Additionally, the Texas substance use treatment system has not evolved in parity to the mental health services system. If a person has behavioral health needs and requires substance use treatment, that person may experience lengthy wait times to access the appropriate level of care.

**Gap 7: Implementation of Evidence-Based Practices**

The availability of evidence-based practices for effective and efficient treatment of behavioral health conditions exists and continues to grow. Adoption of evidence-based and promising practices across Texas has increased and stakeholders recognize this, as expressed in the 2020 Behavioral Health Strategic Plan Survey. Cross-agency collaborations have resulted in implementation of evidenced-based practices such as Seeking Safety, Mental Health First Aid, Individual Placement and
Support, Permanent Supportive Housing, Illness Management and Recovery, Integrated Treatment for Co-Occurring Disorders, and more. The adoption and implementation of evidence-based practices is an ongoing effort as new evidence emerges and coordination of those practices across systems must be continuously monitored.

**Gap 8: Use of Peer Services**

Current research indicates that peer support services decrease substance use, reduce utilization of inpatient and emergency room care, and increase consumer engagement in care. In recent years, Texas made investments and improvements to bolster peer services. State legislation implemented since the first iteration of this strategic plan created a peer services benefit under Medicaid and aligned rules around the training and scope of peer support services across mental health and substance use services. HHSC also consolidated its peer and recovery programs and streamlined 54 contracts with community organizations. Further increasing access to peer support services offers a cost-effective strategy for expanding the behavioral health workforce and reducing reliance on crisis, inpatient, and other more restrictive types of care. Peers can also play an important role in crisis response and critical transitions, including community re-entry after hospitalization and incarceration.

**Gap 9: Behavioral Health Services for People with Intellectual and Developmental Disabilities**

Depression and anxiety are the most frequently identified mental health conditions among people with IDD, but the prevalence of schizophrenia is disproportionately high. Additionally, people with IDD frequently have behavioral health needs that are the result of post-traumatic stress. The behavioral health system in Texas has begun to focus more specifically on the mental health and wellness of those with IDD. People with IDD should have access to quality behavioral health services, trauma-informed care, and opportunities for recovery. Additionally, supports should be adequate in both approach and intensity to avoid unnecessary hospitalizations or incarcerations. The *Foundation for the IDD Strategic Plan* and first *Texas Statewide IDD Strategic Plan*, published in 2022, identify strategies to address gaps in IDD-related services, supports, and policies.
**Gap 10: Social Determinants of Health and Other Barriers to Care**

Conditions in the environments where people live, work, learn, and play may influence their health and are known as social determinants of health (SDOH). Other physical and system issues can also impede health outcomes. Examples of factors that can impact behavioral health include traumatic life experiences, access to services, transportation, stigma associated with behavioral health care, language accessibility, income, and food security. Making services available to people are not enough to disrupt population disparities in behavioral health. SDOH and other barriers to care must be addressed to support healthy lives.

**Gap 11: Prevention and Early Intervention Services**

Early identification of and intervention for behavioral health needs can improve and mitigate the impact of disabling and serious conditions. Implementation of large-scale prevention strategies can abate the factors that contribute to mental health crises or substance use. Services such as Coordinated Specialty Care support prevention and early intervention efforts, however continued expansion of more upstream efforts are needed.

**Gap 12: Access to Supported Housing and Employment**

Behavioral health challenges can lead to homelessness. People who are homeless typically have more chronic physical, mental health, and substance use needs than the general population. Behavioral health challenges can also impact a person’s ability to secure and maintain employment. During the last five years there has been significant investment of state and federal funds in the Supported Housing Rental Assistance, Health Community Collaboratives, and Section 811 programs that support housing needs for people with behavioral health conditions. Additionally, the state has made progress toward planning to increase efforts that focus on increasing tenancy support services for Medicaid populations. More ongoing supported housing and employment services are needed to help people find and maintain their homes and jobs. HHSC is coordinating an effort with other state agencies and stakeholders to develop a Housing Choice Plan, which will identify strategies to expand housing options for people with mental health conditions, substance use histories, and IDD.
**Gap 13: Behavioral Health Workforce Shortage**

Along with much of the nation, Texas has a shortage of behavioral health workers while its population grows. Most Texas counties are designated as MHPSAs. Many of the most experienced and skilled practitioners are approaching retirement. These factors have a direct impact on the availability of outpatient and inpatient providers, where capacity and access to services can be restricted by workforce shortages. The SBHCC published the report, *Strong Families, Supportive Communities: Moving Our Behavioral Health Workforce Forward*, in 2020 to compile workforce improvement recommendations from several sources and assess the factors impeding their implementation. State agencies as well as professional associations and universities can implement these strategies to bolster the behavioral health workforce.

**Gap 14: Shared and Usable Data**

Population health management combines person-centered care with a focus on the overall health of a population, recognizing that a person's health is determined by more than just the services they receive. Many health care experts believe that sharing usable population health data offers great promise for improving patient outcomes, satisfaction, and lowering costs. This approach requires systems to assess, track, and manage data on health conditions, treatments, and results for large populations across multiple care and social service settings. DSHS makes population health data available for decision making by utilizing a data-to-action approach with surveillance, data collection, analysis, and dissemination. Enhancements were made to Texas Health Data, developed by the DSHS Center for Health Statistics. Data on the prevalence and impact of opioids and other substances are available for user queries. Rich data sets exist throughout the Texas behavioral health and other systems, but more work must be done to create efficient technical and administrative processes to link this information and make it available in useful formats for timely decision making.
Development of the Behavioral Health Strategic Plan

SBHCC member agencies met for special strategic planning sessions in 2020 and 2021 to develop the next five-year iteration of the Texas Statewide Behavioral Health Strategic Plan, including a focus on substance use services. The strategic plan spans fiscal years 2022-2026.

The SBHCC assembled through a facilitated process to examine the behavioral health system in Texas and chart a path to make system improvements. The members had the opportunity to build on the work of the original strategic plan. They reviewed the vision and mission and reassessed the gaps originally identified. The members updated the vision and mission statements and found the gaps, while improved over the past five years, require continued collaborative efforts to reduce the impact on people in Texas. The members adjusted the scope of the gaps but retained most of them for the new strategic plans.

Next, the SBHCC member agencies broke into workgroups to develop parallel tracks focused on: 1) mental health issues and the behavioral health system, 2) substance use issues and integration with the behavioral health system, and 3) behavioral health issues impacting people involved in the justice system. The workgroups defined major themes to address and discussed the root causes of limitations or gaps in the behavioral health system. Each workgroup drafted goals and strategies to achieve change in their respective areas and presented them to the full SBHCC membership for discussion and revision. The workgroups focused on mental health, substance use, and forensic services and the full behavioral health system developed the updated Texas Statewide Behavioral Health Strategic Plan. The information generated related to people involved in the justice system was incorporated through separate processes to create the Texas Strategic Plan for Diversion, Community Integration, and Forensic Services.

The outcome of the strategic planning process includes vision and mission statements, guiding principles, and gaps that apply to the Texas Statewide Behavioral Health Strategic Plan as a whole. Distinct goals and strategies were created for the mental health and substance use services tracks. SBHCC members will begin implementing the new strategies in fiscal year 2022 and will collaboratively develop approaches to accomplish each goal.

The SBHCC used feedback from the public to shape the strategic plans. People offered individual input through the 2020 Behavioral Health Strategic Plan Survey.
Stakeholder organizations focused on behavioral health also provided feedback on a preliminary draft of the strategic plans.
Behavioral Health Strategic Plan

Making improvements to the behavioral health system and closing gaps in Texas requires a multi-layer approach. While SBHCC agencies can modify the services they deliver, that alone is not enough to make larger changes in the system. This strategic plan layers the efforts of all SBHCC members to impact access to services, service scope and delivery, the capacity of the behavioral health workforce, cross-system collaboration, and factors that complicate behavioral health needs.

Vision, Mission, and Guiding Principles

The following vision, mission, and guiding principles are applied to the Texas Statewide Behavioral Health Strategic Plan to promote integration of the behavioral health service system. The vision and mission statements describe the desired outcome and process for improving the behavioral health system. The guiding principles describe how the strategic plan strategies should impact people, services, and systems.

Vision

Ensure Texas has a strategic approach to the delivery of behavioral health services that allows all Texans to have access to quality care at the right time and place.

Mission

Implement a coordinated statewide plan for providing timely, accessible, and cost-effective behavioral health services to Texans.

Guiding Principles

The system must:
- Demonstrate coordination across Texas agencies and organizations to enhance continuity of care;
- Support recovery as an ever-evolving process where Texans with behavioral health challenges are empowered to take control of their lives;
- Value peers, family, friends, behavioral health professionals, and other stakeholders and their vital roles in a person’s journey;
- Be trauma-informed and acknowledge the widespread impact of trauma and seek to actively resist re-traumatization; and
• Utilize best practices in procurement and contracting standards to promote timely access to behavioral health services

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

Gaps

The identified gaps previously described are listed below by number. The gap numbers are cross-referenced with strategies in the strategic plan in the next sections to indicate which gaps will be impacted.

1. Access to Appropriate Behavioral Health Services
2. Behavioral Health Needs of Public School Students
3. Coordination Across State Agencies
4. Supports for Service Members, Veterans, and Their Families
5. Continuity of Care for People of All Ages Involved in the Justice System
6. Access to Timely Treatment Services
7. Implementation of Evidence-Based Practices
8. Use of Peer Services
9. Behavioral Health Services for People with Intellectual and Developmental Disabilities
10. Social Determinants of Health and Other Barriers to Care
11. Prevention and Early Intervention Services
12. Access to Supported Housing and Employment
13. Behavioral Health Workforce Shortage
14. Shared and Usable Data
Mental Health Services Track: Goals and Strategies

The SBHCC developed four goals for the mental health services track of the Texas Statewide Behavioral Health Strategic Plan. The goals are listed below in Figure 8.

Figure 8. Goals for the Mental Health Services Track

1. Intervene early to reduce the impact of trauma and improve social determinants of health outcomes

2. Collaborate across agencies and systems to improve behavioral health policies and services

3. Develop and support the behavioral health workforce

4. Manage and utilize data to measure performance and inform decisions

The strategic plan is detailed below with strategies defined for each goal for fiscal years 2022-2026.

Goal 1: Intervene early to reduce the impact of trauma and improve social determinants of health outcomes.

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>Expand trauma-informed care, linguistic, and cultural awareness training and build this knowledge into services</td>
<td>1, 10</td>
</tr>
<tr>
<td>1.2</td>
<td>Coordinate across local, state, and federal agencies to increase and maximize use of funding for client access to housing, employment, transportation, and other needs that impact health outcomes</td>
<td>2, 3, 4, 5, 10, 12</td>
</tr>
<tr>
<td>1.3</td>
<td>Explore financial, statutory, and administrative barriers to funding new or expanding behavioral health support services</td>
<td>1, 10</td>
</tr>
<tr>
<td>Number</td>
<td>Strategy</td>
<td>Gaps Addressed</td>
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<tr>
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</tr>
<tr>
<td>1.4</td>
<td>Implement services that are patient and family-centered across systems of care</td>
<td>10</td>
</tr>
<tr>
<td>1.5</td>
<td>Enhance prevention and early intervention services across the lifespan</td>
<td>2, 11</td>
</tr>
</tbody>
</table>

**Goal 2: Collaborate across agencies and systems to improve behavioral health policies and services.**

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Identify best practices in communication and information sharing to maximize collaboration across agencies</td>
<td>3</td>
</tr>
<tr>
<td>2.2</td>
<td>Collaborate to jointly develop behavioral health policies and implement behavioral health services to achieve a coordinated, strategic approach to enhancing systems</td>
<td>1, 3, 7</td>
</tr>
<tr>
<td>2.3</td>
<td>Identify and strategize opportunities to support and implement recommendations from SBHCC member advisory committees and SBHCC member strategic plans</td>
<td>3</td>
</tr>
<tr>
<td>2.4</td>
<td>Increase awareness of provider networks, services, and programs to better refer clients to the appropriate level of care</td>
<td>1, 11, 14</td>
</tr>
<tr>
<td>2.5</td>
<td>Identify gaps in continuity of care procedures to reduce delays in care and waitlists for services</td>
<td>1, 5, 6</td>
</tr>
<tr>
<td>2.6</td>
<td>Develop step-down and step-up levels of care to address the range of client needs</td>
<td>1, 5, 6</td>
</tr>
</tbody>
</table>
### Goal 3: Develop and support the behavioral health workforce.

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Ensure behavioral health workers are trained in evidence-based practices that support quality client care such as crisis de-escalation, cultural and linguistic sensitivity, trauma-informed care, and suicide prevention, intervention, and postvention</td>
<td>10, 13</td>
</tr>
<tr>
<td>3.2</td>
<td>Explore opportunities to provide emotional supports to workers who serve behavioral health clients</td>
<td>13</td>
</tr>
<tr>
<td>3.3</td>
<td>Use data to identify gaps, barriers, and opportunities for recruiting, retention, and succession planning of the behavioral health workforce</td>
<td>13, 14</td>
</tr>
<tr>
<td>3.4</td>
<td>Implement a call to service campaign to increase the behavioral health workforce</td>
<td>13</td>
</tr>
<tr>
<td>3.5</td>
<td>Develop and implement policies that support a diversified workforce</td>
<td>3, 13</td>
</tr>
<tr>
<td>3.6</td>
<td>Assess ways to ease state contracting processes to expand the behavioral health workforce and services</td>
<td>3, 13</td>
</tr>
</tbody>
</table>
Goal 4: Manage and utilize data to measure performance and inform decisions.

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Create a data subcommittee in the SBHCC to understand trends in service enrollment, waitlists, gaps in levels of care, and other data important to assessing the effectiveness of policies and provider performance</td>
<td>3, 14</td>
</tr>
<tr>
<td>4.2</td>
<td>Explore the use of a shared data portal as a mechanism for cross-agency data collection and analysis</td>
<td>3, 14</td>
</tr>
<tr>
<td>4.3</td>
<td>Explore opportunities to increase identification of service members, veterans, and their families who access state-funded services to understand their needs and connect them with appropriate resources</td>
<td>3, 4, 14</td>
</tr>
<tr>
<td>4.4</td>
<td>Collect data to understand the effectiveness of evidence-based practices and the quality of these services</td>
<td>7, 14</td>
</tr>
</tbody>
</table>
Substance Use Services Track: Goals and Strategies

The SBHCC developed six goals for the substance use services track of the Texas Statewide Behavioral Health Strategic Plan. The goals are listed below in Figure 9.

**Figure 9. Goals for Substance Use Services Track**

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>• Increase awareness and visibility of substance use conditions, services, and resources</td>
<td>1, 11</td>
</tr>
<tr>
<td>2</td>
<td>• Intervene early to reduce the impact of trauma and improve social determinants of health outcomes</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>• Expand substance use prevention resources</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>• Enhance access to care and improve early intervention and treatment services for substance use</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>• Strengthen substance use recovery services</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>• Implement system changes to improve the quality of substance use services</td>
<td></td>
</tr>
</tbody>
</table>

The strategic plan is detailed below with strategies defined for each goal for fiscal years 2022-2026.

**Goal 1: Increase awareness and visibility of substance use conditions, services, and resources**
### Goal 2: Intervene early to reduce the impact of trauma and improve social determinants of health outcomes

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>Expand awareness of SDOH and trauma-informed care in the behavioral health workforce and build this knowledge into services and supports</td>
<td>10</td>
</tr>
<tr>
<td>2.2</td>
<td>Increase coordination across services and supports for housing, employment, transportation, and other needs that impact health outcomes</td>
<td>2, 3, 4, 5, 10, 12</td>
</tr>
</tbody>
</table>

### Goal 3: Expand substance use prevention resources

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>Develop a comprehensive substance use prevention strategy that delivers evidence-based programming to high-risk populations</td>
<td>3, 7, 11</td>
</tr>
<tr>
<td>3.2</td>
<td>Reduce risk of non-medical substance use through promotion of safe drug disposal initiatives</td>
<td>11</td>
</tr>
</tbody>
</table>

### Goal 4: Enhance access to care and improve early intervention and treatment services for substance use

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Improve utilization and quality of Outreach, Screening, Assessment, and Referral (OSAR) services</td>
<td>1, 6, 11</td>
</tr>
<tr>
<td>4.2</td>
<td>Improve outcomes by promoting adherence to best practices of serving people in the least restrictive environment appropriate for the diagnosis</td>
<td>1, 7, 11</td>
</tr>
</tbody>
</table>
Goal 5: Strengthen substance use recovery services

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>Enhance integration of recovery strategy among state agencies</td>
<td>3, 7</td>
</tr>
<tr>
<td>5.2</td>
<td>Expand the use of certified peer recovery coaches and an evidence-based recovery support system</td>
<td>4, 7, 8</td>
</tr>
<tr>
<td>5.3</td>
<td>Identify strategies to sustain peer recovery system</td>
<td>3, 8</td>
</tr>
<tr>
<td>5.4</td>
<td>Assess the need for recovery housing for adolescents and young adults</td>
<td>12, 14</td>
</tr>
<tr>
<td>5.5</td>
<td>Increase community-based recovery resources across the state with focus on hard-to-reach populations, especially for people in rural areas</td>
<td>6, 10</td>
</tr>
</tbody>
</table>

Goal 6: Implement system changes to improve the quality of substance use services

<table>
<thead>
<tr>
<th>Number</th>
<th>Strategy</th>
<th>Gaps Addressed</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.1</td>
<td>Strengthen state agency partnerships to foster communication and promote collaborative program and policy initiatives</td>
<td>3</td>
</tr>
<tr>
<td>6.2</td>
<td>Utilize data to inform system improvements and make programmatic decisions</td>
<td>3, 14</td>
</tr>
<tr>
<td>6.3</td>
<td>Streamline systems for data collection and reporting</td>
<td>3, 14</td>
</tr>
<tr>
<td>6.4</td>
<td>Promote use of best practice models of care for substance use services</td>
<td>3, 7</td>
</tr>
</tbody>
</table>
Texas Strategic Plan for Diversion, Community Integration, and Forensic Services
Texas, like other states, faces a growing crisis in the number of people with MI, SUD, and/or IDD in the justice system. The best available data indicates that approximately 39 percent of people in Texas’ county jails have been in contact with or received public mental health services within the last three years. Combined with the number of people waiting for inpatient competency restoration in county jails, more than 2,300 at the publication of this plan, from the perspective of the SBHCC, a picture emerges of state and local behavioral health and justice systems that are over-burdened and resource-constrained. It is the opinion of the SBHCC that the human toll of this problem—and its cost to state and local agencies and taxpayers—is staggering.

Jails spend two to three times more money on incarcerated adults with diagnoses of MI, compared to those without this diagnosis. Yet, communities often do not see improvements to public safety as a result of these incarcerations. In addition, once incarcerated, people with MI, SUD, and/or IDD tend to stay longer in jail and upon release face higher physical and behavioral health risks, higher risk of suicide, higher recidivism rates, and other consequences such as loss of housing or employment.

Community stakeholders provided valuable insight for SBHCC to develop the Texas Statewide Behavioral Health Strategic Plan and identify gaps and challenges related to coordination, access, and service provision within the behavioral health system in Texas. These include:

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

Addressing these gaps and barriers will not only help to increase access to behavioral health services for Texans in general but will also help prevent and reduce justice involvement for people with MI, SUD, and/or IDD. Systems can be improved, best practices and data-driven strategies can be implemented, and lives can be changed. The SBHCC’s *Texas Strategic Plan for Diversion, Community Integration, and Forensic Services* can serve as the state’s roadmap to:  
1. Reduce and prevent justice-involvement for people with MI, SUD, and/or IDD;  
2. Enhance forensic services (see Appendix B for definition); and,  
3. Coordinate the collective efforts of State agencies and local behavioral health and justice systems to improve the health and well-being of Texas communities.  

This strategic plan aims to reduce justice-involvement for people with MI, SUD, and/or IDD and improve forensic services by focusing state and local efforts around five major goals:  
1. Support the expansion of robust crisis and diversion systems to reduce and prevent justice involvement for people with MI, SUD, and/or IDD.  
2. Increase coordination, collaboration, and accountability across systems, agencies, and organizations.  
3. Enhance the continuum of care and support services for people who are justice-involved with MI, SUD and/or IDD.  
4. Strengthen state hospital and community-based forensic services.  
5. Expand training, education, and technical assistance for community providers working at the intersection of behavioral health and criminal justice.  

The five goals reflect current research and best practices for improving state and local system-level responses that promote public safety, reduce justice involvement for people with MI, SUD, and/or IDD, and improve forensic services. First, broad consensus exists around the need for robust crisis response and pre-arrest diversion programs that connect youth and adults to services in lieu of arrest and incarceration, without compromising public safety. Communities across Texas have led the nation in implementing innovative crisis response and pre-arrest diversion programs with successful outcomes.  

Preventing and reducing justice involvement for people with MI, SUD, and/or IDD takes coordinated and collaborative responses between state and local behavioral health and justice systems and agencies. Ensuring people receive adequate services...
and supports to meet their behavioral health and other basic needs is shared by state and local partners, including agencies representing housing, human services, education, and physical health care. Coordination and collaboration are critical to ensuring people with MI, SUD, and/or IDD who are justice-involved do not have lapses in their care, particularly during periods of transition from the community to incarceration and upon reentry back into the community. Without a continuous, coordinated continuum of care throughout and following incarceration, people with MI, SUD, and/or IDD are at risk for re-incarceration, increased emergency department use, and increased hospitalization.

Strategies to strengthen inpatient and community-based forensic services serve as a necessary complement to the investments made by the Texas Legislature to improve state hospital infrastructure, expand state hospital patient capacity, and expand outpatient and jail-based competency restoration (CR) programs. The number of people waiting in county jails for inpatient CR is a crisis that requires right-sizing CR in Texas through education on the appropriate use of CR, as well as alternatives to inpatient CR.

Finally, disseminating best practices and programs at the intersection of behavioral health and justice systems across the state requires robust training, education, and technical assistance. Increases in implementation of best practices and programs by local communities and state agencies can reduce and prevent the justice-involvement of people with MI, SUD, and/or IDD, as appropriate, while keeping communities safe.

The Texas Strategic Plan for Diversion, Community Integration, and Forensic Services outlines ways state, local, and community partners, including faith-based organizations, universities, and philanthropic organizations, can contribute to the goals and objectives of this plan. It is through collective efforts that change can be realized.

**National Trends**

Each year, close to 11 million people move through the country’s local jails. An estimated 44 percent of people held in jails have been diagnosed with a MI by a professional, 63 percent have a substance use disorder, and 45 percent suffer from chronic health problems.\(^4\)\(^5\)\(^6\)

Nationally, the challenges driving these issues are complex.
- Inadequate funding for community behavioral health services resulting in people accessing treatment and care in restrictive and costly correctional settings.
• A lack of tailored behavioral services specifically addressing MI, SUD, and/or IDD and criminogenic risks and needs.
• An overuse of criminal justice responses to address behavioral health issues.
• Inadequate coordination and collaboration across behavioral health and justice systems and organizations.

Despite these challenges, there is a strong national focus on transforming behavioral health and justice systems. Federal lawmakers are making new investments to expand the crisis care continuum. Communities across the country are re-examining crisis systems and mental health, SUD, and IDD services. While challenges across behavioral health and justice systems have been incrementally addressed over the last few decades, an influx of new federal funding from the recent passage of the American Rescue Plan Act and the SAMHSA Mental Health Block Grant aim to transform systems in new ways. National initiatives centered on improving crisis response systems and diversion programs, such as the Stepping Up Initiative, Taking the Call, the National Judicial Task Force on Mental Illness, and the Data-Driven Justice Initiative are connecting communities across the country and supporting the implementation of best practices. Federal legislation, such as mandating the implementation of 988, a new three-digit phone number for Americans in crisis to connect with suicide prevention and mental health crisis counselors by July 2022, provides states with the opportunity to transform crisis response in their communities.

There is also increased attention to how states approach competence to stand trial processes. States across the country face a growing crisis in the number of people waiting in county jails for inpatient competency restoration services after being found incompetent to stand trial. As state hospitals reach capacity, people are left to wait in jail for months, and sometimes years, for a restoration bed to become available. These delays often result in litigation against states alleging violations of due process. The Council of State Governments Justice Center, American Psychiatric Association, the Judges and Psychiatrists Leadership Initiative, the National Association of State Mental Health Program Directors, National Center for State Councils, and the National Conference of State Legislatures have come together to develop a consensus view of an ideal competence to stand trial process with effective strategies for state officials to pursue.87

Racial equity is also front and center in communities across the country, with behavioral health and justice leaders examining how disparities in access to health care services and disproportionate incarceration adversely impact racial and ethnic groups. The incidence of disparities has been well-documented for years, but few
communities have systematically and comprehensively begun to address those issues until now.

Finally, COVID-19 has strained both behavioral health and justice systems in profound ways that will have lasting impacts on communities across the country. It has compromised the physical and mental health of people nationwide, exacerbated already existing behavioral health workforce shortages, and forced providers to adapt to new capacity limits and safety protocols. At the same time, it has fast-tracked the use of technology to expand healthcare access, changed community supervision strategies, modified court processes, and supported law enforcement responding to crises.

**State Trends**

Across Texas, there are significant efforts underway to enhance forensic services and reduce and prevent justice involvement for people with MI, SUD, and/or IDD. The following section describes trends in state forensic and justice involved populations, as well as state efforts to expand crisis and diversion services. Notable but not described are the significant efforts underway led by communities across the state. The SBHCC recognizes these efforts and stakeholders across local justice and behavioral health services working on the ground every day to ensure Texas is a well and safe community for all.

It is also important to note that despite the availability of crisis, diversion, and forensic services across the state, the need for these services far outweighs existing capacity. The *Texas Statewide Behavioral Health Strategic Plan* discusses several gaps within the behavioral health system, including limited access to appropriate behavioral health services, lack of access to timely treatment services, lack of continuity of care for people involved in the justice system, workforce shortage, as well as numerous other barriers to care. Gaps in the state’s behavioral health system have real consequences for people and communities. Most notably, these gaps have resulted in far too many people with MI, SUD, and/or IDD encountering the justice system, a quickly growing waitlist for inpatient competency restoration services, and increased rates of recidivism when people re-enter the community without treatment and supports. For additional information on the current behavioral health system in Texas, refer to the *Texas Statewide Behavioral Health Strategic Plan, Fiscal Years 2022-2026* in this document for an assessment of the behavioral health system in Texas, including an overview of the Texas population, prevalence of behavioral health conditions, services provided, and other information.
Justice-Involved and Forensic Populations in Texas

In fiscal year 2021, the Texas county jail population was approximately 700,000, which included people recently arrested or awaiting trial or sentencing. Of that population, nearly 39 percent had received services from the public mental health system within the last three years. However, this number is not inclusive of people served outside the public mental health system or who have not received a formal diagnosis and treatment, making the total percentage of the county jail population with diagnoseable MI, SUD, and/or IDD over 39 percent.

County jails also serve as holding facilities for people who were evaluated and found incompetent to stand trial and are awaiting admission into a state hospital for CR services. Jails are constitutionally required to provide medical care in the United States. And in Texas, jails must provide access to a mental health professional, which may be provided through telehealth services, 24 hours a day, 7 days a week (24/7). In fiscal year 2021, the average wait time for inpatient CR services was 359 days for people awaiting placement in a maximum-security unit (MSU) and 161 days for those waiting for a non-MSU placement. HHSC estimated the fiscal year 2021 incarceration cost for local governments for people with a mental health condition was $436 million.

Sequential Intercept Model and Texas

The Sequential Intercept Model (SIM) developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., is used by federal, state, and local agencies as a framework to understand how people with MI, SUD, and/or IDD encounter and move through the criminal justice system. The SIM has been used as a focal point for states and local communities to assess available resources, determine gaps in services, and plan for community change. Figure 13 below depicts the SIM Model.

Figure 10. Sequential Intercept Model (SIM)
In January 2020, HHSC hosted the state’s first Statewide SIM Mapping Summit. The goals for the summit were to:

- Develop a comprehensive picture of how people with MI, SUD, and/or IDD move through the criminal justice system along six distinct intercept points: (0) Community Services, (1) Law Enforcement, (2) Initial Detention and Initial Court Hearings, (3) Jails and Courts, (4) Reentry, and (5) Community Corrections.
- Identify gaps, resources, and opportunities at each intercept for people with MI, SUD, and/or IDD.
- Develop priorities for activities designed to improve system and service level responses for people with MI, SUD, and/or IDD.

As part of this effort, more than 140 stakeholders representing state agencies and urban, suburban, and rural communities from across Texas convened to identify key programs, opportunities, and stakeholders at each intercept. The following pages describe the SIM in Texas, highlighting key features, best practices, Texas programs and services, and SBHCC agencies at each intercept.

Table 8. Programs and Services across the SIM by SBHCC Members

<table>
<thead>
<tr>
<th>SBHCC Member</th>
<th>Intercept 0: Community Services</th>
<th>Intercept 1: Law Enforcement</th>
<th>Intercept 2: Initial Detention/ Court Hearing</th>
<th>Intercept 3: Jails/Courts</th>
<th>Intercept 4: Reentry</th>
<th>Intercept 5: Community Corrections</th>
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<td>Intercept 1: Law Enforcement</td>
<td>Intercept 2: Initial Detention/ Court Hearing</td>
<td>Intercept 3: Jails/Courts</td>
<td>Intercept 4: Reentry</td>
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</tr>
</tbody>
</table>
### Intercept 0: Early Intervention and Community Services

**Figure 11. Intercept 0**

**Overview**

Intercept 0 encompasses the early intervention points for people with MI, SUD, and/or IDD prior to possible arrest by law enforcement. It captures systems and services designed to connect people with treatment before a crisis begins or at the earliest possible stage of system interaction.

**Key Features**

- Connects people who have MI and SUD with services before they encounter the criminal justice system.

---

<table>
<thead>
<tr>
<th>SBHCC Member</th>
<th>Intercept 0: Early Intervention and Community Services</th>
<th>Intercept 1: Law Enforcement</th>
<th>Intercept 2: Initial Detention/Initial Court Hearing</th>
<th>Intercept 3: Jails/Courts</th>
<th>Intercept 4: Reentry</th>
<th>Intercept 5: Community Corrections</th>
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<td>No</td>
</tr>
</tbody>
</table>

- Supports law enforcement in responding to both public safety emergencies and mental health crises.
- Enables diversion to treatment before an arrest takes place.
- Reduces pressure on resources at local emergency departments and inpatient psychiatric beds for urgent but less acute mental health needs.

**Best Practices**

**Table 9. Intercept 0 Best Practices**

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Warm lines and hotlines</td>
<td>Warm lines and hotlines can serve as alternatives to 911. They link people to treatment and services without the involvement of law enforcement. This allows emergency response agencies to direct their resources to other community needs.</td>
</tr>
<tr>
<td>Co-Responder Teams</td>
<td>Co-responder teams allow behavioral health clinicians and law enforcement to respond together to people in crisis in the community. Co-responder teams can stabilize a person in crisis, identify underlying reasons for the person’s symptoms, and initiate or link the person to case management services. Co-responder teams can also reconnect a person with a MI, SUD, and/or IDD to case managers or treatment providers who have already worked with them.</td>
</tr>
<tr>
<td>Law enforcement-friendly crisis services.</td>
<td>Instead of arresting people in crisis or bringing them to a hospital emergency department, law enforcement officers can bring them to locations such as stabilization units, or crisis respite centers. Processes that allow quick and simple drop-offs make this diversion option more effective.</td>
</tr>
<tr>
<td>Peer-operated crisis response support and/or respite</td>
<td>Peer-operated crisis response support and/or respite is provided by people with lived experience with a mental or substance use disorder who may also have been involved in the justice system. Peers can provide helpful information and support shaped by their own experience to help people with MI, SUD, and/or IDD. Programs run by peers and services employing peers have shown promising results in helping people recover.</td>
</tr>
<tr>
<td>Program or Service</td>
<td>Description</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Substance use-focused early diversion strategies</td>
<td>Self-referral programs, active outreach, and opioid response teams are showing promising outcomes in reducing substance use, overdoses, and fatalities due to overdose. These strategies rely on partners from different fields, such as behavioral health providers, emergency medical services and fire departments, law enforcement, prosecutors, and public defenders (where applicable), working together to provide life-saving treatments and support.</td>
</tr>
</tbody>
</table>

**Texas Programs and Services**

Crisis services make up a critical component of Intercept 0. In Texas, crisis services are available 24/7 and include prompt face-to-face crisis assessment, crisis intervention services, and crisis follow-up and relapse prevention services. LMHAs/LBHAs operate an array of crisis programs consisting of crisis hotlines, mobile crisis outreach teams (MCOTs), several types of crisis facilities, and inpatient psychiatric beds. Having a continuum of crisis services available in any community can help prevent and reduce justice-involvement for people with MI, SUD, and/or IDD.

- Crisis Hotline: The Crisis Hotline is a 24/7 telephone service operated by trained crisis staff providing crisis screening and assessment, crisis intervention services, mental health and substance use referrals, and general mental health and substance use information to the community. The crisis hotline is an integrated component of the overall crisis service delivery system and is accessible toll-free throughout each LMHA/LBHA service area. In accordance with Texas Health and Safety Code (THSC) §534.053(a)(1) and 26 TAC, Chapter 301, Subchapter G (relating to Mental Health Community Services Standards), any entity providing crisis hotline services must be accredited by the American Association of Suicidology (AAS).
- MCOTs: MCOTs are qualified professionals deployed into the community to provide a combination of crisis services including emergency care services (response within one hour) and provision of urgent care services (response within eight hours), crisis follow-up, and relapse prevention to children, adolescents, or adults 24 hours a day, every day of the year. An MCOT program consists of a roster of dedicated or rotating staff working in a team deployed into the community to provide crisis intervention services. MCOT staff coordinate with the crisis hotline and community partners to determine when and where crisis outreach services are needed in the community. In fiscal year 2021,
85,935 people received mobile crisis outpatient services funded by general revenue and administered by HHSC.\textsuperscript{92}  

- **Crisis Facilities:** Several LMHAs operate crisis facilities funded and administered by HHSC. Crisis facilities may be staffed with mental health professionals, medical professionals, or others (such as peer providers) offering assessment, support, and services to achieve psychiatric stabilization to people with behavioral health needs. In fiscal year 2021, 16,704 people received general revenue-funded and HHSC administered crisis residential services.\textsuperscript{93} Facilities include:
  
  o **Extended Observation Units (EOU):** EOUs provide adult individuals, presenting on voluntary or involuntary status, with access to emergency psychiatric care 24/7. EOU services are provided in a safe and secure environment and staffed by medical personnel, mental health professionals, and trained crisis support staff. Some EOUs may also provide services to children and adolescents.  
  
  o **Psychiatric Emergency Services Centers (PESC):** PESCs include extended observation beds and services in a secure treatment environment that is co-located in a licensed hospital or in a crisis stabilization unit. A PESC provides walk-in access to immediate behavioral health emergency screening and assessment, extended observation services, and a continuum of crisis and behavioral emergency stabilizing treatment for individuals whose behavioral symptoms cannot be stabilized within 48 hours.  
  
  o **Crisis Stabilization Units (CSU):** Crisis stabilization units provide short-term residential treatment 24/7 in a secure and protected environment.  

**SBHCC Member Spotlights**

- HHSC seeks to ensure that Texans have access to MH, SUD, and IDD services at the right time and place and in the most appropriate setting. Through coordination of the public mental health system and collaboration with external partners, HHSC seeks to achieve meaningful clinical and cost-effective outcomes for all Texans. Key departments within HHSC, which provide services to people with MI, SUD, and/or IDD include Intellectual and Developmental Disability and Behavioral Health Services, Health and Specialty Care System, and Medicaid and CHIP Services.  

- TDHCA is the state agency responsible for affordable housing, community and energy assistance programs, colonial activities, and regulation of the state's manufactured housing industry. TDHCA partners with cities and counties, nonprofit and community-based organizations, private developers, and public housing authorities to support residents in need. For example, through Project Access TDHCA assists low-income persons with disabilities transitioning from
institutions into the community by providing Housing Choice Vouchers. TDHCA also oversees the Section 811 Project Rental Assistance program, which provides project-based rental assistance for extremely low-income persons with disabilities linked with voluntary long-term services through one of the participating HHSC agencies.

- DFPS works with communities to promote safe and healthy families and protect children and vulnerable adults from abuse, neglect, and exploitation. DFPS partners with HHSC to provide targeted case management and psychiatric rehabilitative services for high-needs children in the foster care system.
- TEA is the state agency that oversees primary and secondary public education. It is headed by the commissioner of education. The TEA improves outcomes for all public-school students in the state by providing leadership, guidance, and support to school systems. TEA coordinates a Mental Health Resource Inventory, is developing a Student Mental Health Statewide Plan, and facilitates the Collaborative Task Force on Public School Mental Health Services.
- TCMHCC was created by the 86th Legislature to leverage the expertise and capacity of the health-related institutions of higher education to address urgent mental health challenges and improve the mental health care system in this state in relation to children and adolescents. Texas Child Health Access Through Telemedicine (TCHATT) creates or expands telemedicine and telehealth programs to identify and assess the mental health needs of at-risk children and youth, providing short-term, school-based access to services. It aims to maximize the number of school districts served in diverse regions of Texas.

**Intercept 1: Law Enforcement**

**Figure 12. Intercept 1**

![Diagram of Intercept 1: Law Enforcement](image)

**Overview**

Intercept 1 encompasses initial contact with law enforcement and other emergency service responses. Law enforcement officers have considerable discretion in responding to a situation in the community involving a person with a MI, SUD,
and/or IDD who may be engaging in criminal conduct, experiencing a mental health crisis, or both. Intercept 1 captures systems and programs that are designed divert people away from the justice system and toward treatment when safe and feasible.

**Key Features**

- Begins when law enforcement responds to a person with a MI, SUD, and/or IDD or a person who is in crisis.
- Ends when the person is arrested or diverted into treatment.
- Is supported by trainings, programs, and policies that help behavioral health providers and law enforcement to work together.

**Best Practices**

**Table 10. Intercept 1 Best Practices**

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dispatcher training</td>
<td>Dispatcher training about mental health and mental crises can improve dispatcher ability to detect when responders with mental health expertise are needed.</td>
</tr>
<tr>
<td>Specialized law enforcement training</td>
<td>Specialized law enforcement training can teach law enforcement officers how to identify the signs and symptoms of mental disorders and de-escalate crises. These trainings prepare responders to effectively support people with a MI, SUD, and/or IDD when they see them.</td>
</tr>
<tr>
<td>Specialized law enforcement responses</td>
<td>Specialized law enforcement responses include partnerships between law enforcement and behavioral health clinicians or case managers. Specialized law enforcement responses can help people with mental and substance use disorders access the services they need.</td>
</tr>
<tr>
<td>Data sharing</td>
<td>Law enforcement agencies can collect and share information with other systems to enhance diversion services and connections to care. For example, law enforcement agencies, crisis services, and hospitals can use data to identify people who are coming into frequent contact with these crisis systems of care. Once these people are identified, they can be connected with the preventive care needed.</td>
</tr>
</tbody>
</table>
Texas Programs and Services

In Texas, pre-arrest diversion is the practice of law enforcement or multidisciplinary teams connecting people to behavioral health treatment as an alternative to arrest. LMHA/LBHAs, police departments, and sheriff’s offices may offer pre-arrest diversion program that include mental health deputies, Crisis Intervention Teams (CIT), law enforcement and behavioral health co-response teams and multidisciplinary teams that include law enforcement, behavioral health, developmental disability, and emergency medical services.

- Mental Health Deputies (MHD): Several LMHAs subcontract with local sheriffs’ departments to deploy a certified MHD to address people in crisis. An MHD is an officer specially trained in crisis intervention who works collaboratively with the community and the LMHA’s crisis response teams. MHDs help improve the crisis response system by diverting people in need of behavioral health crisis services from hospitals and jails to community-based alternatives providing effective behavioral health treatment. In fiscal year 2021, 5,771 mental health deputy contacts were made.\(^9^4\)

- CIT: CIT programs are local initiatives designed to improve the way law enforcement and the community respond to people experiencing mental health crises. They are built on strong partnerships between law enforcement, mental health provider agencies, and people and families affected by MI and developmental disabilities.

- Mental Health and Law Enforcement Co-Responder Teams: Several LMHA/LBHAs operate teams that pair specially trained officers and mental health clinicians to respond to mental health calls for service. The most common approach is for the officer and crisis worker to ride together in the same vehicle for an entire shift.

- Mental Health Drop-Off Centers: LMHA/LBHA-operated drop off centers, such as the Judge Ed Emmett Mental Health Diversion Centers in Harris County, provide law enforcement with a centralized location to “drop off” people with MI who are in crisis and at-risk of arrest.

- Substance Use Drop-Off Centers: HHSC, through funding provided by the SAMHSA State Opioid Response (SOR) grants, implements certain services for people with justice involvement and a history of opioid and/or stimulant use. These include drop-off centers for pre-arrest diversion that provide referral to treatment, recovery support services, access to Naloxone, basic medical care, and medical monitoring. In 2021, these centers served 288 people and distributed 771 Narcan kits.\(^9^5\) Expanding the capacity of Texas drop-off centers helps reduce the risk of re-occurrence and overdose to substance use while increasing stable community tenure and medication-assisted recovery.
SBHCC Member Spotlight

- TCOLE’s mission is to establish and enforce standards to ensure that the people of Texas are served by highly trained and ethical law enforcement, corrections, and telecommunications personnel. TCOLE oversees licensing and certification of officers, including Mental Health Officer Certification.

*Intercept 2: Initial Detention / Initial Court Hearings*

**Figure 13. Intercept 2**

**Overview**

A person moves to Intercept 2 of the model once arrested. At Intercept 2, a person is detained and faces an initial hearing presided over by a judge or magistrate. This is the first opportunity for judicial involvement, including interventions such as intake screening, early assessment, appointment of counsel and pretrial release of those with a MI, SUD, and/or IDD.

**Key Features**

- Involves arrested people experiencing MI, SUD, and/or IDD who are going through intake, booking, and an initial hearing with a judge or magistrate.
- Supports early identification and screening to inform decision making around a person’s care, treatment continuation, and pretrial orders.
- Supports policies that allow bonds to be set to enable diversion to community-based treatment and services.
- Includes post-booking release programs that route people into community-based programs.
- Represents the moment when the question of competence is first raised.
## Best Practices

### Table 11. Intercept 2 Best Practices

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening for MI, SUD, and/or IDD</td>
<td>Using validated screening instruments for MI, SUD, and/or IDD allows jails to identify people with these conditions. Once identified, people are linked with jail-based or community-based services. Brief screenings are performed for all people entering the system and conducted by non-clinical staff at jail booking, in police holding cells, in court lock ups, and prior to the first court appearance. Screening every defendant at intake or booking assists jails in measuring the number of people with MI, SUD, and/or IDD entering and cycling through the jails.</td>
</tr>
<tr>
<td>Data matching</td>
<td>Data matching involves linking information that different systems have on an individual person. Data matching between the jail and community-based behavioral health and developmental disability providers help develop diversion options that meet all of a person’s needs. It can also help determine if newly arrested people received behavioral health or developmental disability services. If they have, they can then be linked back to existing case managers and resources, improving service delivery.</td>
</tr>
<tr>
<td>Counsel at Magistration</td>
<td>Counties can provide defense counsel at magistration, typically through a public defender’s office. Such programs help identify defendants with MH, IDD, and SUD; increase pretrial release through mental health personal bonds; facilitate early entry into MI and SUD services; and improve case outcomes.</td>
</tr>
<tr>
<td>Pretrial supervision and diversion services</td>
<td>Some defendants pose a risk of criminal behavior or failing to appear in court but not to the extent that a jail stay is needed. Pretrial services with specialized mental health services can reduce the need to detain this population. These teams can make sure people with a MI, SUD, and/or IDD receive services in a timely manner and avoid getting worse while waiting for their case to be resolved.</td>
</tr>
<tr>
<td>Post-booking release</td>
<td>Some programs allow defendants to be released into treatment while a charge is deferred. These programs can improve the person’s health and social outcomes by reducing the long-term impacts of a jail stay and criminal conviction.</td>
</tr>
<tr>
<td>Program or Service</td>
<td>Description</td>
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<tr>
<td>Indigent Defense Coordinators</td>
<td>Indigent defense coordinators can ensure timely appointment of counsel for defendants with MI, IDD, and SUD. Early appointment of counsel can result in more timely access to services and medication for defendants and can help resolve cases more quickly with better outcomes.</td>
</tr>
</tbody>
</table>

**Texas Programs and Services**

Post-booking diversion is the practice of criminal justice agencies connecting people to behavioral health treatment after arrest and booking into jail. Post-booking diversion can include screening for MI, SUD, and/or IDD at jail intake; data matching to identify people who had contact with or received public behavioral health and developmental disability services system; and pre-trial diversion programs.

In Texas, data matching and identification of people who received services from an LMHA/LBHA is completed at jail booking through a Continuity of Care Query (CCQ). The Texas Law Enforcement Telecommunications System (TLETS) uses an electronic data exchange process with HHSC’s Clinical Management for Behavioral Health Services (CMBHS) database to search for matches based on the following demographic data: last name, first name, date of birth, social security number, gender, and race. The search identifies people in CMBHS who have within the last three years, been hospitalized in a state psychiatric hospital; admitted to an HHSC-funded contracted psychiatric hospital bed; or assessed, authorized, or received a mental health or developmental disability community service by an LMHA, LBHA, or LIDDA. The three-year look-back window does not apply to people under the age 18. Between September 1, 2020 and June 17, 2021, 664,795 mental health related queries were submitted using the TLETS system. TCJS now requires all county jails to submit a TLETS query for each person booked into jail and can use this information to inform post-booking diversion decisions.

**SBHCC Member Spotlights**

- TCJS was created by the Texas Legislature to promulgate reasonable written rules and procedures establishing minimum standards, inspection procedures, enforcement policies and technical assistance for: the construction, equipment, maintenance, and operation of jail facilities under its jurisdiction; the custody, care, and treatment of inmates; and programs of rehabilitation, education, and
recreation for inmates confined in county and municipal jail facilities under its jurisdiction. TCJS provides training for county jailers, among other programs on mental health issues ranging from initial screening to observation while in custody to release from the jail facility.

- TDCJ manages people in state prisons, state jails, and private correctional facilities under contract with the TDCJ. The agency also provides funding and certain oversight of community supervision and is responsible for the supervision of people released from prison on parole or mandatory supervision. Through the Texas Correctional Office on Offenders with Medical/Mental Impairments, TDCJ oversees several specialized diversion programs for people with a MI or IDD.
- The TIDC was created by the Texas Legislature in 2001 to fund, oversee and improve public defense throughout the State of Texas. TIDC oversees a grant program to assist counties in setting up and operating specialized mental health and indigent defense programs to improve outcomes, cut unnecessary jail days, and reduce recidivism.

** Intercept 3: Jails / Courts **

**Figure 14. Intercept 3**

**Overview**

During Intercept 3 of the model, people with a MI, SUD, and/or IDD not yet diverted at earlier intercepts may be held in pretrial detention at a local jail while awaiting the disposition of their criminal cases.

**Key Features**

- Involves people with MI, SUD, and/or IDD held in jail before and during their trials.
- Includes court-based diversion programs that allow the criminal charge to be resolved while addressing the defendant’s behavioral health needs in the community.
- Includes constitutional protections including the right to due process and to representation by a defense attorney at no cost if indigent. Includes services that prevent the worsening of a person’s mental or substance use symptoms during their incarceration.

**Best Practices**

**Table 12. Intercept 3 Best Practices**

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>Treatment courts for high-risk/high-need people</td>
<td>Treatment courts for high-risk/high-need people work within the legal process to help treat the root causes of justice involvement. These programs provide services through a pre-plea or post-plea process. They may include drug courts, mental health courts, Driving While Impaired (DWI) courts, veterans’ courts, and others.</td>
</tr>
<tr>
<td>Mental Health Defender Programs</td>
<td>Mental health defender programs, including public defender offices and managed assigned counsel programs, can help ensure that defendants with MI, IDD, and SUD are represented by a defense team that is well-versed in behavioral health issues, available services, and treatments. Such programs have been shown to reduce incarceration and improve case outcomes.</td>
</tr>
<tr>
<td>Alternatives to prosecution programming</td>
<td>Some people may not need an intensive treatment court but still would benefit from services in the community. For these people, alternatives to prosecution programs, where a charge may be placed “on hold” and then dismissed when a person completes the program, may meet their needs. Programs that require clients to pay a fee or restitution prior to participation should ensure that this does not result in negative consequences or unfair impacts among people with fewer resources.</td>
</tr>
<tr>
<td>Jail-based programming and health care services</td>
<td>Jail health care providers are required to provide medical and behavioral health services to people detained and who need treatment. Trauma-informed and evidence-based spaces and programs for people with MI, SUD, and/or IDD help ensure a jail stay does not worsen a person’s illness. Jails can also use suicide prevention plans and procedures to prevent suicide among people with and without known mental health concerns.</td>
</tr>
<tr>
<td>Program or Service</td>
<td>Description</td>
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<tr>
<td>Partnerships with community-based providers of mental health and substance use treatment</td>
<td>When jails partner with community-based providers, they increase the number of treatments and services that people can access during their detention. This can also help build relationships between patients and providers, making it more likely the person will feel comfortable with continuing services after release from jail. These “in-reach” services can also help identify people with MI, SUD, and/or IDD who may be better placed in community-based or inpatient treatment.</td>
</tr>
<tr>
<td>Mental health jail liaisons or diversion clinicians</td>
<td>It takes a lot of work to figure out what community-based resources are available for people with MI, SUD, and/or IDD. Because of this, many of these people are not connected with important services. Mental health jail liaisons and diversion clinicians can help make these connections. They can also provide another layer of treatment or programs in addition to the services delivered by the jail treatment provider.</td>
</tr>
<tr>
<td>Collaboration with Veterans Justice Outreach</td>
<td>Collaborations between Veterans Justice Outreach specialists, behavioral health specialists, and local justice system partners strengthen timely access to diversion resources and services for justice-involved veterans.</td>
</tr>
<tr>
<td>Prosecutorial Diversion Programs</td>
<td>Diversion programs offer the prospect of “off-ramping” suitable cases early in the court process, potentially alleviating the strain on overburdened criminal justice agencies and resulting in increased case processing efficiency, reduced court backlogs, and better decision-making by court players. Prosecutor-led pretrial diversion programs can encompass pre-filing (before the prosecutor’s office formally files charges) and post-filing/pre-adjudication models (after the prosecutor’s office has formally filed charges, but before the case is adjudicated); accept felonies and misdemeanors; target specific crimes (e.g., drug, property, or prostitution) or an array of charges; and range in approach from ordering defendants to lengthy periods of drug or mental health treatment to offering short educational classes or job training.</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>Training for Competency to Stand Trial (CST) evaluators, defense attorneys, and prosecutors</td>
<td>Additional training for CST evaluators, defense attorneys, and prosecutors can foster simultaneous pursuit of competence evaluation and restoration, when needed, and diversion strategies when appropriate. This could include maximizing access to treatment records, improving communication pathways with community mental health services, expanding community-based restoration options, and supporting efforts for community mental health providers working with defense counsel to present plans in court.</td>
</tr>
</tbody>
</table>

**Texas Programs and Services**

**Forensic Services**

Forensic mental health services are provided to people who may be or who are found incompetent to stand trial (IST) and committed by a criminal court to receive competency restoration services as well as people acquitted not guilty by reason of insanity (NGRI).

People determined IST may receive CR services in a state hospital, or if available, in an outpatient competency restoration (OCR) or jail-based competency restoration program (JBCR). In fiscal year 2021, 1067 people were admitted to the state hospital for inpatient CR services and 991 people were discharged for adjudication of their criminal case. The average length of stay (LOS) at discharge for a person receiving CR services in a state hospital non-MSU was 265 days and for those in an MSU, the LOS was 231 days. The percentage of people discharged who were restored to competency was 77 percent in fiscal year 2021.

The forensic population in Texas’ state hospitals have remained steady at 65 percent from fiscal year 2020 to fiscal year 2021. In fiscal year 2021, the state hospitals served:

- 32 percent adults admitted under civil commitments;
- 49 percent adults who were IST; and
- 18 percent adults who were NGRI.

HHSC provides funding to 18 of the 39 LMHAs/LBHAs for OCR programs and to five local authorities for JBCR. In fiscal year 2021, 279 people received OCR and 537 people received JBCR services. The average LOS for OCR programs in fiscal year 2021 was 211 days. Restoration rates for OCR were nearly 35 percent.
Figures 10 and 11 below provide maps of OCR and JBCR programs in Texas.

**Figure 15. Outpatient Competency Restoration Services**

![](image)
Specialty Courts

Specialty Courts combine rigorous monitoring and supervision with intensive community-based treatment services to reduce recidivism, prevent incarceration, and promote recovery. In Texas, specialized courts cover distinct populations and offenses, including drug courts (adult and juvenile), family drug courts, veterans’ treatment courts, and mental health courts. The goal of these courts is essentially to divert the defendant from the criminal justice system and to assure the defendant receives access to the treatment and social programs necessary for the person’s success within the community. If defendants successfully complete the specialty court program, they can petition the court to enter an order of nondisclosure of criminal history record information for the offense for which they entered the specialty court program.

In fiscal year 2021, TVC VMHD’s Justice Involved Veteran Program provided technical assistance to 45 local court systems, provided training to 1,693 criminal justice professionals, and responded to over 1,700 requests for assistance from justice-involved veterans resulting in 4,672 referrals to mental health and
supportive services. In fiscal year 2021, VMHD’s Military Veteran Peer Network (MVPN) had 12,127 statewide interactions with justice-involved veterans at the local level, trained over 600 hundred people in military cultural competency, and trained over 1,000 people in suicide prevention.

**Detention**

Criminal and juvenile justice systems include detention and rehabilitation for incarcerated people in jails, prisons, and youth detention centers. In Texas, TDCJ oversees custody of adults in prisons and state jails. TJJD has five secure facilities and five halfway houses to meet the individual needs of youth.

Currently, TCJS inspects 238 county jails across the state of Texas. Each of these jails is owned by the county and operated by the Sheriff as one of their primary duties. As of December 1, 2021, these 238 jails were housing 66,146 inmates. Managing inmates with mental health issues is consistently listed as the biggest challenge that jails face when surveyed. To assist jails and the staff that operate them, TCJS provided mental health training to 6,054 officers in fiscal years 2020 and 2021. This training not only educates staff about the standards in place that pertain to mental health and what is required, it also provides them a better understanding of MI and IDD.

**SBHCC Member Spotlights**

- JCMH was created by a joint order of the SCoT and the CCA. The mission of the JCMH is to engage and empower court systems through collaboration, education, and leadership, thereby improving the lives of people with mental health needs and IDD. JCMH develops educational materials for judges and attorneys to gather useful information related to cases involving people with MI and IDD, including *The Texas Mental Health and Intellectual and Developmental Disabilities Law Bench Book and Bench Cards* focused on improving the courts’ response to mental health and IDD.

- The OOG Public Safety Office promotes strategies to improve public safety, support victims of crime, prevent terrorism, and prepare communities for the threats and hazards posing the greatest risk to Texans. Through the Specialty Courts Program, the OOG provides grant funds to counties, judicial districts, or juvenile boards to support Specialty Courts (Drug/DWI, Mental Health, Veteran, Family, and Commercially Sexually Exploited Persons). Services provided by the drug court programs include intense supervision, drug testing, counseling and therapy, and case management.
The OCA is a unique state agency in the Judicial Branch that operates under the direction and supervision of the Supreme Court of Texas and Chief Justice. The mission of the OCA is to provide resources and information for the efficient administration of the Judicial Branch of Texas. The OCA provides information technology solutions and fiscal consultation for appellate and specialty courts.

UT Health Science Centers are one of Texas' resources for health care education, innovation, scientific discovery, and excellence in patient care. As comprehensive health science universities, the mission of UTHSC system is to educate health science professionals, discover and translate advances in the biomedical and social sciences, and model the best practices in clinical care and public health. UTHSC-Houston provides outpatient care for people with MI; implements clinical training and interventions to enhance the ability and capacity to treat MI; and conducts evidence-based research. UTHSC-Tyler oversees the Mental Health Training Program, which aims to expand the mental health workforce in northeast Texas by training competent psychiatrists and psychologists to provide effective treatments to those who need them, including the chronically and seriously mentally ill, at-risk youth, and rural underserved and disadvantaged populations.

**Intercept 4: Reentry**

**Figure 17. Intercept 4**

Overview

At Intercept 4 of the model, people plan for and transition from jail or prison into the community. Supportive re-entry establishes strong protective factors for justice-involved people with MI, SUD, and/or IDD re-entering a community.

**Key Features**

- Provides transition planning and support to people with MI, SUD, and/or IDD who are returning to the community after incarceration in jail or prison.
• Ensures people have workable plans in place to provide seamless access to medication, treatment, housing, health care coverage, and services from the moment of release and throughout their reentry.

• Should be well planned, resourced, and individual-centric to help set people up for success and avoid lapses in recidivism.

**Best Practices**

**Table 13. Intercept 4 Best Practices**

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>Transition planning by the jail or in-reach providers</td>
<td>Transition planning by the jail or in-reach providers improves reentry outcomes by shaping services around a person’s needs before release. Planning for reentry should begin at intake and continue during the person’s incarceration; it should involve providers and resources across criminal justice, behavioral health, and physical health care systems.</td>
</tr>
<tr>
<td>Alternatives to prosecution programming</td>
<td>Some people may not need an intensive treatment court but still benefit from services in the community. For this population, alternatives to prosecution programs, where a charge may be placed “on hold” and then dismissed when a person completes the program, may meet their needs. Programs that require clients to pay a fee or restitution prior to participation should ensure this does not result in negative consequences or unfair impacts among people with fewer resources.</td>
</tr>
<tr>
<td>Jail-based programming and health care services</td>
<td>Jail health care providers are required to provide medical and behavioral health services to people detained and who need treatment. Trauma-informed and evidence-based spaces and programs for people with mental and substance use disorders help ensure that a jail stay does not worsen a person’s illness. Jails can also use suicide prevention plans and procedures to prevent suicide among people with and without known mental health concerns.</td>
</tr>
<tr>
<td>Medication and prescription access upon release from jail or prison</td>
<td>When released, people should have enough medications and prescriptions to allow them to follow their treatment plans and avoid relapse while waiting to see their community-based medical provider.</td>
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<tr>
<td>Program or Service</td>
<td>Description</td>
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<tr>
<td>Warm hand-offs from corrections to providers increases engagement in services</td>
<td>People picked up upon release and provided transportation directly to services often see more ideal outcomes compared to people simply released to the streets. Ideally, the community-based worker doing the pick-up would already have provided in-reach services throughout Intercept 3, built relationships, and become a trusted partner for the reentry process.</td>
</tr>
<tr>
<td>Benefits and health care coverage immediately following or upon release</td>
<td>States are encouraged to suspend rather than end Medicaid coverage while a person is incarcerated. This allows people returning to the community to quickly access important treatment services and medications. Where possible, paperwork to start or restart benefits and/or health care coverage should be done before release. Doing so ensures these essential resources are available to people with MI, SUD, and/or IDD during their transition to the community.</td>
</tr>
<tr>
<td>Peer support services</td>
<td>People who transitioned from jail or prison to the community can provide valuable peer support. They can help people plan for reentry, identify safe housing, and learn about triggers or issues that could lead back to the justice system. Peer staff may be employed by the jail or by in-reach providers to deliver transition planning services.</td>
</tr>
<tr>
<td>Reentry coalition participation</td>
<td>Many communities have a group that meets and plans for supporting people reentering the community from prison or jail. Partners from criminal justice, behavioral health, and all types of supportive services should be involved. These partners can help coordinate the processes and resources available to people with MI, SUD, and/or IDD as they plan their transition.</td>
</tr>
</tbody>
</table>

**Texas Programs and Services**

**Reentry**

In Texas, reentry programs are designed to help returning citizens successfully "reenter" society following their incarceration, thereby reducing recidivism, improving public safety, and saving money.

The Mental Health Peer Reentry program enables mental health peer support providers with prior justice involvement to provide “reach-in” services to people with a MI incarcerated in county jails. The program uses certified peer specialists
employed by LMHAs/LBHAs to support the successful transition of inmates with a MI from the county jail into clinically appropriate community-based care.

In fiscal year 2021, 440 people were served by the program. Program participants saw a significant decrease in jail admissions at 71 percent, and increased connection to care through HHSC crisis services and HHSC-funded hospitalizations. Since the program’s inception in fiscal year 2016, 2,516 people have participated.105

HHSC, through funding provided by SAMHSA SOR grants, expanded to 11 the number of recovery support sites (RSS) that provide “in-reach” support to county jail, prisons, and other rehabilitative settings to ensure incarcerated people successfully transition into clinically appropriate community-based care. Expanding the capacity of recovery service sites reduces the risk of re-occurrence and overdose to substance use post-release, and increases stable community tenure, decreases recidivism, and promotes medication-assisted recovery.

During May – September of fiscal year 2021, these RSS sites served:
• 208 people through “in-reach” recovery services in a rehabilitative setting, and
• 95 people through “in-reach” services who continue to receive post-release recovery services from a rehabilitative setting.106
Figure 18. Texas Targeted Opioid Response (TTOR) Pre-Arrest Diversion and Recovery Reentry Sites

TTOR Programs and Services for Justice-Involved and Forensic Populations

TCOOMMI, under the authority of Texas Health and Safety Code §614, provides pre-release screening and referrals to aftercare treatment services for people with special needs releasing from correctional settings, local jails, or other referral sources. TCOOMMI contracts with all 39 LMHAs/LBHAs across the state to provide mental health treatment services for juveniles and adults on probation or parole by linking them with community-based interventions and support services. People receive services based on their level of care needs, to include case management services, continuity of care coordination, court resource diversion programs, and placement into dual diagnosis residential programs. Through these mental health initiatives, 41,023 people were served in FY 2020 and 46,633 in FY 2021. The impact of TCOOMMI case management initiatives is evaluated annually using the Legislative Budget Board performance measures for the three-year recidivism rate.
The most current recidivism rate for participants enrolled in the TCOOMMI case management initiative for 12 or more consecutive months is almost 16 percent, which is below the 20 percent rate for prison-released inmates. TCOOMMI provides ongoing technical support and assessment of LMHA/LBHA compliance with contractual requirements and program guidelines through a team of compliance monitors. In addition to mental health, TCOOMMI also coordinates and collaborates on medical continuity of care, veteran services, and programs, medically recommended intensive supervision, and the wrongfully imprisoned program. Grant initiatives are pursued and utilized to enhance and expand TCOOMMI services. TCOOMMI and the TCOOMMI Advisory Committee, a twenty-eight-member committee composed of gubernatorial appointees, state agencies, experts, and advocacy organizations; work as a collective body to ensure continuity of care for the special needs’ population is achieved through evidence-based and research-informed practices.

**SBHCC Member Spotlight**

- TCOOMMI provides a formal structure for criminal justice entities, health and human service providers, and other affected organizations to communicate and coordinate on policy, legislative, and programmatic issues affecting people with special needs who are involved in the justice system. TCOOMMI contracts with 39 LMHAs/LBHAs across Texas to provide screening and assessments; referral to aftercare treatment for those released from custodial institutions or other referral sources; psychiatric services; medication management; benefit assistance; referrals to community resources; among other resources. TCOOMMI also contracts with LMHAs/LBHAs across the state to provide continuity of care services for persons on probation or parole by linking them with community-based interventions and support services (Intercept 5).

- TVC’s VMHD is focused on ensuring access to competent mental health services for service members, veterans, and their families. VMHD accomplishes this task by providing training, certification, and technical assistance across Texas. In addition to connecting veterans in need directly to local services, VMHD also works with partners at the national, state, and local level. VMHD consists of the Military Veteran Peer Network, Veteran Provider Program, Community & Faith-Based Partners Program, Homeless Veteran Initiative, and the Justice Involved Veteran Program. The Justice Involved Veteran Program works to improve veteran services across the entire criminal justice continuum. The Justice Involved Veteran Program Coordinators serve as resource to provide technical assistance and training to all Veteran Treatment Courts across Texas, to partner with the local and state law enforcement to deliver relevant trainings such as...
trauma affected veterans and crisis intervention strategies to officers, and to collaborate with the local jail and state prison systems to better ensure that incarcerated veterans have access to veteran-specific programming and reentry services.

- TWC is the state agency charged with overseeing and providing workforce development services to employers and job seekers of Texas. TWC strengthens the Texas economy by providing the workforce development component of the Governor's economic development strategy. TWC, through Workforce Solutions Vocational Rehabilitation Services, provides services for people with disabilities, including people with MI or IDD, to help them prepare for, obtain, retain, or advance in employment. TWC also oversees a grant program to offer career pathway options for former offenders in high demand sectors of Texas.

**Intercept 5: Community Corrections**

*Figure 19. Intercept 5*

**Overview**

People under correctional supervision are usually on probation or parole as part of their sentence, as part of the step-down process from prison, or as part of other requirements by state statutes. The last intercept of the model aims to combine justice system monitoring with person-focused service coordination to establish a safe and healthy post-criminal justice system lifestyle.

**Key Features**

- Involves people with MI, SUD, and/or IDD under community corrections’ supervision.
- Strengthens knowledge and ability of community corrections officers to serve people with MI, SUD, and/or IDD.
- Addresses the persons’ risks and needs.
- Supports partnerships between criminal justice agencies and community-based behavioral health, mental health, or social service programs.

**Best Practices**

**Table 14. Intercept 5 Best Practices**

<table>
<thead>
<tr>
<th>Program or Service</th>
<th>Description</th>
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<tbody>
<tr>
<td>MH training for all community corrections officers</td>
<td>Mental health training for all community corrections officers should be provided. Officers with specialized caseloads should receive additional, more in-depth training to learn about the specific needs of the people under their supervision.</td>
</tr>
<tr>
<td>Specialized caseloads of people with MI and SUD</td>
<td>The use of smaller and specialized mental health or substance use caseloads shows promising results. Specialized caseloads allow community corrections officers to provide support for maintaining their clients on the path to recovery, increases connections to services and appointments, and reduces the chance of violations and jail stays.</td>
</tr>
<tr>
<td>Community partnerships</td>
<td>As people under community supervision get jobs and become more self-sufficient, they may no longer qualify for critical supports. Community corrections officers work with partners to make sure their clients have the support they need to remain independent, continue recovering, and avoid returning to the criminal justice system.</td>
</tr>
<tr>
<td>Medication-assisted treatment</td>
<td>Medication-assisted treatment (MAT) is a substance use disorder treatment program that combines behavioral therapy with the use of medications approved by the Food and Drug Administration. These medications include methadone, naltrexone, and buprenorphine for targeting opioid use disorder. MAT can help reduce the risk of overdose and relapse among people with substance use disorders once they are back in the community.</td>
</tr>
<tr>
<td>Access to recovery supports</td>
<td>Housing and work with a livable wage are just as important as access to behavioral health services. However, there are many barriers to employment and housing for people who have been in jail or prison. Community corrections officers can help reduce these barriers by helping their clients get government-issued photo identification, start, or reinstate health care coverage, and access criminal record expungement.</td>
</tr>
</tbody>
</table>
SBHCC Member Spotlights

- TJJD is dedicated to caring for the youth in the Texas juvenile justice system and promoting the public safety of all Texans. TJJD's Probation Services Division works with probation departments across the state to enhance the many services offered to local youth referred to them. TJJD facilitates quality interaction between juvenile boards and juvenile probation departments and the various divisions within TJJD. For example, TJJD provide grants to probation departments for mental health treatment and specialized supervision to rehabilitate juveniles and prevent them from penetrating further into the criminal justice system.
Development of the Diversion, Community Integration, and Forensic Services Plan

The Texas Strategic Plan for Diversion, Community Integration, and Forensic Services represents voices from across Texas, including mental health, substance use, and IDD service providers and peer specialists; criminal and juvenile justice professionals; people with lived experience and their families; community leaders; and program and policy subject matter experts. To ensure the strategic plan reflects the goals and priorities of diverse stakeholders, the SBHCC engaged in a yearlong planning process, which included a State SIM Summit, five strategic planning sessions with the SBHCC, and seven stakeholder listening sessions.

Recommendation by the Joint Committee on Access and Forensic Services

The Joint Committee on Access and Forensic Services (JCAFS), an advisory committee to HHSC, recommended in its Report on State Hospital Bed Day Allocation Methodology and Utilization Review Protocol for Fiscal Year 2020, develop a comprehensive, state-level strategic plan for the coordination and oversight of forensic services in Texas.

As the Texas Statewide Behavioral Health Strategic Plan serves as the guidepost for behavioral health system transformation in Texas and given the number of juvenile and criminal justice and judicial partners serving as members of the SBHCC, in fiscal year 2021, the forensic strategic plan was developed as a sub-plan of the overarching Texas Statewide Behavioral Health Strategic Plan. The foundation for the forensic strategic plan already exists in the Texas Statewide Behavioral Health Strategic Plan with criminal justice identified as a gap, need, and priority.

SBHCC Strategic Planning Sessions

SBHCC member agencies met for special strategic planning sessions in 2020 and 2021 to develop the next five-year iteration of the Texas Statewide Behavioral Health Strategic Plan, which initiated strategic planning for the Texas Strategic Plan for Diversion, Community Integration, and Forensic Services.

The SBHCC convened through a facilitated process to examine the behavioral health system in Texas and chart a path to make system improvements. Through the process, members had the opportunity to build on the work of the original
Behavioral Health Strategic Plan by reviewing the vision and mission and reassessing the gaps originally identified. The members updated the vision and mission statements and found the gaps, while improved over the past five years, require continued collaborative efforts to reduce the impact on people in Texas. The members adjusted the scope of the gaps but retained most of them for the new strategic plans.

Next, the SBHCC member agencies broke into workgroups to develop parallel strategic plans focused on: 1) mental health issues and the behavioral health system as a whole; 2) substance use issues and integration with the behavioral health system; and 3) forensic services. The workgroups defined major themes to address and discussed the root causes of limitations or gaps in the behavioral health system. Each workgroup drafted goals and strategies to achieve change in their respective areas and presented them to the full SBHCC membership for discussion and revision.

The outcome of the strategic planning process included development of vision and mission statements, guiding principles, goals, objectives, and strategies. The SBHCC used feedback from the State SIM Summit, stakeholder listening sessions and a public survey to shape and finalize the strategic plan.

Stakeholder Listening Sessions

HHSC facilitated seven stakeholder listening sessions from January – July 2021 to receive input from key stakeholders in the development of this strategic plan. Below is a list of organizations and agencies who participated in strategic planning and listening sessions, as well as a description of each session’s attendees. See Appendix G for more details on listening sessions and key themes.

- West Texas Centers: This organization serves as the designated LMHA and LIDDA for Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum counties. They hosted a listening session which included a behavioral health provider, an IDD provider, a substance use treatment provider, a mental health deputy, a judge, and a jail caseworker, among other stakeholders.

- North Texas Behavioral Health Authority: North Texas Behavioral Health Authority serves as the designated LBHA for Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. This listening session included behavioral health providers, a district attorney, a municipal judge, law enforcement, a public defender, a jail coordinator, among other stakeholders.
• National Alliance for Mental Illness, Texas: This organization is a 501(c)3 nonprofit organization with nearly 2,000 members made up of people living with MI, family members, friends, and professionals. Its purpose is to help improve the lives of people affected by MI through education, support, and advocacy. This listening session included peer service providers, behavioral health service providers, IDD service providers, advocates, and people with lived experience.

• HHSC, Behavioral Health Services’ Peer and Recovery Services Programs, Planning and Policy: This listening session included peer service providers from across the state.

• HHSC, Health and Specialty Care System: This listening session included state hospital superintendents and other state hospital staff.

• TIDC: The Texas Legislature created the Texas Task Force on Indigent Defense in 2001 to remedy persistent deficiencies in Texas indigent defense: access to counsel, quality of counsel, and data collection. The TIDC listening session included public defenders and assigned counsel.

• JCMH: The JCMH was created in 2018 by a joint order of the Supreme Court of Texas and the Court of Criminal Appeals of Texas to strengthen courts for people with MI, SUD, and/or IDD. The JCMH listening session included a justice of the peace, a law clerk, judges, a district attorney, among other stakeholders.

State Sequential Intercept Mapping Summit

HHSC facilitated the state’s first SIM Mapping Summit in January 21-22, 2021, to develop a comprehensive picture of how people with MI and co-occurring disorders flow through the criminal justice system; identify gaps, resources, and opportunities at each intercept for people with MI; and develop priorities for activities designed to improve system and service level responses.

The SIM Summit was divided into four sessions based on which agencies and regions the participants represented: 1) state agencies and key stakeholder organizations; 2) rural west Texas; 3) rural east Texas; and 4) urban/suburban areas. Participants for each session including stakeholders representing mental health and substance use providers, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, and family members. The summit culminated in the development of a report with recommendations to reduce justice-involvement for Texans with MI and help ensure all Texans gain access to care at the right time and the right place.

See Appendix G for summit strategic priorities and recommendations.
**Forensic Strategic Plan Public Survey**

Finally, on behalf of the SBHCC, HHSC facilitated the release of a public survey from August 31 - September 14, 2021, titled “Survey for the Texas Plan for Diversion, Community Integration, and Forensic Services.” The survey was promoted through GovDelivery and shared with external stakeholders who were asked to disseminate the survey with their network.

For a detailed summary of responses and a blank version of the survey, see Appendix G.
The following vision, mission, and guiding principles are applied to the Texas Strategic Plan for Diversion, Community Integration, and Forensic Services to enhance forensic services and reduce and prevent justice involvement for people with MI, SUD, and/or IDD. The vision and mission statements describe the desired outcome and process for advancing toward our collective vision. The guiding principles describe how the strategic plan strategies should impact people, services, and systems.

**Vision, Mission, and Principles**

**Vision**

Texans receive the right care in the right place at the right time, preventing and reducing justice involvement for adults and youth with MI, SUD, and/or IDD.

**Mission**

Develop and implement a high-quality, data-informed, and well-coordinated system of services and supports across the continuum of care to improve the delivery and quality of forensic services and prevent and reduce justice-involvement for people with MI, SUD, and/or IDD.

**Principles**

The following principles will guide the implementation and evaluation of the strategic plan.

1. A full continuum of care, from early intervention and diversion to competency restoration, reentry, and community supervision, is needed to reduce and prevent justice-involvement for people with MI, SUD, and/or IDD.
2. The social determinants of health (e.g., access to housing, healthcare, transportation, and jobs) are also drivers of justice-involvement and should inform prevention, intervention, and diversion strategies.
3. People with lived experience are valuable contributors to the behavioral health workforce and should be part of policy development and planning for behavioral health services.
4. Racial, economic, and geographic disparities should be evaluated in efforts across the continuum of care to ensure state resources facilitate equitable access to behavioral health care and aim to reduce justice-involvement for all Texans.

5. The stigma associated with MI, SUD, and/or IDD, as well as justice-involvement, should be actively addressed through cultural change in the behavioral health, IDD and justice systems.

6. Behavioral health and justice systems should be evidence-based, trauma-informed, person-centered, and integrate best practices for rehabilitation and restoration.

7. Policy, programs, and services should be data-informed and well-coordinated.

8. Resources should be utilized efficiently and effectively, leveraging public-private partnerships and blended funding streams whenever possible.

Goals, Objectives, and Strategies

Building on the vision, mission, and guiding principles, this strategic plan is supported by a series of goals, objectives, and strategies to guide innovation, encourage collaboration, and foster opportunities to leverage resources across state agencies:

1. Support the expansion of robust crisis and diversion systems to reduce and prevent justice involvement for people with MI, SUD, and/or IDD.

2. Increase coordination, collaboration, and accountability across systems, agencies, and organizations.

3. Enhance the continuum of care and support services for justice-involved people with MI, SUD, and/or IDD.

4. Strengthen state hospital and community-based forensic services.

5. Expand training, education, and technical assistance for stakeholders working at the intersection of behavioral health and justice.

Each goal area outlined in this section has objectives, and each objective is followed by a group of supporting strategies. These strategies may evolve as a result of research, emerging best practices, or other external factors. The flexibility of strategies allows the SBHCC the opportunity to ensure resources are maximized and agencies can respond actively to new trends, the needs of populations, and legislation. Each strategy also identifies stakeholders who play a role in implementation, as well as intercepts along the SIM where strategies should be implemented.
Table 15. Stakeholder Descriptions and Symbols Key

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Description</th>
<th>Icon</th>
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<tbody>
<tr>
<td>State</td>
<td>State partners include state agencies, state level commissions, and statewide professional associations. State partners are represented by a star icon.</td>
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<tr>
<td>Local</td>
<td>Local partners include county and city agencies, local mental and behavioral health authorities, school districts and other local leadership. Local partners are represented by an icon with a house enclosed by a bubble.</td>
<td></td>
</tr>
<tr>
<td>Community</td>
<td>Community partners include universities, faith-based organizations, non-profit providers, local advocates, and other community organizations. Community partners are represented by an icon with a group of people.</td>
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<tr>
<td>Intercept</td>
<td>The SIM provides a conceptual model to inform community-based responses to the involvement of people with MI, SUD, and/or IDD in the justice system. Each strategy includes a mini SIM chart that highlights specific intercepts where strategies can be implemented. The intercepts are indicated with their numbers illustrated in the SIM model.</td>
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**Goal 1: Crisis Response and Diversion**

Develop robust crisis and diversion systems to reduce and prevent justice involvement for people with MI, SUD, and/or IDD.
**Objective 1.1: Expand and scale the use of crisis and pre-arrest diversion strategies and programs.**

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<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>1.1.1</td>
<td>Ensure coordination between law enforcement, behavioral health providers, housing service providers, schools, and other stakeholders to develop crisis and pre-arrest diversion programs.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-2</td>
</tr>
<tr>
<td>1.1.2</td>
<td>Support the development of strategies and programs focused on people with complex care needs that frequently cycle between justice, behavioral health, housing, and other systems.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-2</td>
</tr>
<tr>
<td>1.1.3</td>
<td>Support expansion of crisis receiving centers, such as law enforcement drop-off, crisis stabilization, crisis respite, and sobering centers.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-1</td>
</tr>
<tr>
<td>1.1.4</td>
<td>Promote the expansion of round-the-clock mobile crisis outreach teams, co-responder programs, mental health deputies, and other specialized law enforcement responses.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-1</td>
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<tr>
<td>Strategy</td>
<td>Strategy Description</td>
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<tr>
<td>1.1.5</td>
<td>Explore pilot programs that promote partnerships with public safety answering points (911), 9-8-8 (the new three-digit suicide prevention hotline), crisis call centers, school-based law enforcement officers and warm lines to improve emergency call taking, dispatch, and crisis response for people with MI, SUD, and/or IDD.</td>
<td>State, Local, Community</td>
<td>Intercepts 0-1</td>
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</table>

**Objective 1.2: Increase use of jail, detention, and court-based diversion off-ramps.**

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<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>1.2.1</td>
<td>Support increased use of jail and pre-trial diversion programs.</td>
<td>State and Local</td>
<td>Intercepts 2-3</td>
</tr>
<tr>
<td>1.2.2</td>
<td>Support increased use of specialized probation for people with MI, SUD, and/or IDD.</td>
<td>State, Local, Community</td>
<td>Intercepts 3-5</td>
</tr>
<tr>
<td>1.2.3</td>
<td>Promote expanded use of treatment and problem-solving courts, such as specialty courts, for people with MI, SUD, and/or IDD.</td>
<td>State and Local</td>
<td>Intercept 3</td>
</tr>
<tr>
<td>1.2.</td>
<td>Support universal screening for MI, SUD, IDD, veteran status and suicidality at jail booking.</td>
<td>State and Local</td>
<td>Intercept 2</td>
</tr>
<tr>
<td>Strategy</td>
<td>Strategy Description</td>
<td>Key Partners</td>
<td>Intercept</td>
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<tr>
<td>1.2.5</td>
<td>Support the expansion of Mental Health Public Defender programs to cover every county in the state.</td>
<td>State and Local</td>
<td>0 1 2 3 4 5 Intercepts 2-3</td>
</tr>
<tr>
<td>1.2.6</td>
<td>Support increased use of counsel at magistration to identify defendants with MI, SUD, and/or IDD.</td>
<td>State and Local</td>
<td>0 1 2 3 4 5 Intercepts 2-3</td>
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</table>

**Objective 1.3: Increase diversion using data and technology.**

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<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>1.3.1</td>
<td>Enhance and refine the TLETS Continuity of Care Query (CCQ), the Behavioral Health Services Online Query, and the Veterans Reentry Search Services (VRSS) to support the identification and continuity of care of adults, youth, and veterans with MI, SUD, and/or IDD who are justice-involved.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5 Intercepts 0-2</td>
</tr>
<tr>
<td>1.3.2</td>
<td>Explore opportunities to incorporate telehealth and teleresponse into crisis response and pre-arrest diversion programs to expand reach and availability of behavioral health treatment and supports across communities, including rural and frontier communities.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5 Intercepts 0-1</td>
</tr>
</tbody>
</table>
**Goal 2: Coordination, Collaboration and Accountability**

Increase coordination, collaboration, and accountability across systems, agencies, and organizations.

**Objective 2.1: Enhance community collaboration through strategic planning and coordination.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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</thead>
</table>
| 2.1.1     | Utilize a whole-community approach for addressing issues at the intersection of behavioral health and justice that includes partnerships with:  

  - housing authorities,  
  - city and state housing departments,  
  - hospitals,  
  - universities and medical schools,  
  - faith-based organizations,  
  - schools,  
  - federally qualified health centers (FQHCs),  
  - child welfare agencies,  
  - other regional and local agencies, and  
  - community organizations.  | State, Local, Community                                 | 0-1-2-3-4-5                                           | Intercepts 0-5 |
<p>| 2.1.2     | Identify opportunities to maximize resources at a regional level to fund and operate programs that reduce justice-involvement for people with MI, SUD, and/or IDD.                                                                 | State, Local, Community                                 | 0-1-2-3-4-5                                           | Intercepts 0-5 |</p>
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<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>2.1.3</td>
<td>Engage local coordinating bodies and positions to provide statewide training and technical assistance on expanding and enhancing behavioral health and justice collaborations.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 (Intercepts 0-5)</td>
</tr>
<tr>
<td>2.1.4</td>
<td>Support the provision of SIM Mapping workshops to support strategic planning and collaboration in local communities.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 (Intercepts 0-5)</td>
</tr>
<tr>
<td>2.1.5</td>
<td>Promote best practices for care coordination between Certified Community Behavioral Health Clinics and justice partners.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 (Intercepts 0-5)</td>
</tr>
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</table>

Table 20. Objective 2.2: Increase information sharing across state and local agencies.

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<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>2.2.1</td>
<td>Promote technological solutions to safely and securely share relevant information with key stakeholders to better understand a person’s case, prior justice involvement, previous service referrals, and current connections to care.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5 (Intercepts 2-3)</td>
</tr>
<tr>
<td>2.2.2</td>
<td>Promote local data sharing pilots in select communities to better identify those in need of services and to support continuity of care.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 (Intercepts 0-5)</td>
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<td>Strategy</td>
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<tr>
<td>2.2.3</td>
<td>Communicate data sharing needs between state agencies to develop a long-term data strategy for the state that supports policy development, oversight, and ongoing improvement efforts.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>

**Goal 3: Continuum of Care and Support Services**

Enhance the continuum of care and support services for people who are justice-involved with MI, SUD, and/or IDD.

**Objective 3.1: Enhance care and support services across the continuum of care.**

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<th>Strategy</th>
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<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>3.1.1</td>
<td>Promote coordination and collaboration among all possible points of contact/levels of care (e.g., correctional facilities, outpatient treatment, inpatient treatment, transitional housing, schools, etc.) for seamless transitions and appropriate continuity of care.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.1.2</td>
<td>Support the expansion and enhancement of programs that focus on providing intensive, culturally relevant, home- and community-based wraparound services for people with complex needs cycling among multiple systems.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
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<tr>
<td>Strategy</td>
<td>Strategy Description</td>
<td>Key Partners</td>
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<tr>
<td>3.1.3</td>
<td>Increase collaboration between hospitals, correctional facilities, schools, detention centers, defense counsel and community providers to ensure warm handoffs and connection to care when people return to the community.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 2-5</td>
</tr>
<tr>
<td>3.1.4</td>
<td>Support the expansion of Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) to serve more people and reduce the risk of recidivism for people with MI, SUD, and/or IDD.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5 Intercepts 0-5</td>
</tr>
<tr>
<td>3.1.5</td>
<td>Support expanded access to substance use treatment and prevention programs across the continuum of care.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-5</td>
</tr>
<tr>
<td>3.1.6</td>
<td>Explore opportunities to expand and integrate behavioral health and physical health care for persons who are justice-involved through FQHCs and other partnerships.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0, 2, 4-5</td>
</tr>
<tr>
<td>3.1.7</td>
<td>Engage employers at the state and local level to address challenges with recruitment and retention of behavioral health, developmental disability, and justice workforces.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0-5</td>
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</table>
**Objective 3.2:** Increase connection to mental health and substance use treatment and tailored supports for special populations, including people with IDD, youth, and veterans.

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<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
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<tbody>
<tr>
<td>3.2.1</td>
<td>Ensure training, technical assistance, and other supports to law enforcement, local mental and behavioral health authorities (LMHAs/LBHAs), specialty courts, and other stakeholders to promote best practices and increase use of diversionary paths across the SIM for special populations.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.2.2</td>
<td>Support expansion of early intervention and prevention programs and school- and home-based- services for MI and SUD for children and youth.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.2.3</td>
<td>Explore increasing the capacity of crisis and residential treatment services for children and youth.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.2.4</td>
<td>Build community awareness of Local Intellectual and Developmental Disability Authorities (LIDDAs) as part of the continuum of care.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.2.5</td>
<td>Promote improvement of screening for people with indicators of IDD and veteran status when entering county jails.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
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<tr>
<td>Strategy</td>
<td>Strategy Description</td>
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<tr>
<td>3.2.6</td>
<td>Support increased access to housing and tailored support services for people with a diagnosis of IDD or veteran status to reduce justice-involvement.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5</td>
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<td></td>
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<td>Intercepts 0 and 4</td>
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<tr>
<td>3.2.7</td>
<td>Enhance collaboration among federal, state, and local agencies and local veterans support organizations, including veteran serving programs, the Military Veteran Peer Network, Veteran Justice Outreach, Justice Involved Veteran Coordinators, Veteran Treatment Courts, and other community, volunteer, and faith-based organizations.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5</td>
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<td>Intercepts 0-5</td>
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**Objective 3.3:** Address the social determinants of health that increase the risk of justice-involvement, including housing, employment, and transportation.

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<th>Strategy</th>
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<th>Key Partners</th>
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<tbody>
<tr>
<td>3.3.1</td>
<td>Work collaboratively with local public and private stakeholders to explore expansion of the full continuum of housing options with appropriate services, paying attention to landlord selection criteria, landlord incentives, and transitions between institutions and community.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5</td>
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<td>Intercepts 0, 4-5</td>
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<td>Strategy</td>
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</tr>
<tr>
<td>3.3.2</td>
<td>Support programs that increase access to healthcare, employment, education, safe neighborhoods, and transportation to reduce the risk of recidivism for people with behavioral health needs that are justice-involved.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.3.3</td>
<td>Explore cross-system collaborations between justice, housing, and hospital partners to increase access to housing.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.3.4</td>
<td>Support the expedient resumption of Supplemental Security Income (SSI) for people reentering the community and expand SOAR case management support to aid in Social Security Disability Insurance applications.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.3.5</td>
<td>Expand awareness of SUD and peer benefits in Medicaid.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>
Objective 3.4: Expand access to peer-based recovery services across the continuum of care, including recovery support services, peer-led mental health supports, youth recovery communities, and family support services.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.4.1</td>
<td>Support the strengthening and expansion of peer programs and family support services in justice and behavioral health settings to support people with MI, SUD, and/or IDD who are justice-involved and their families.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.4.2</td>
<td>Provide statewide technical assistance to increase the utilization of peer service providers.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.4.3</td>
<td>Promote peer specialists with lived experience of the justice system as critical component of the behavioral health workforce, creating career paths, formal certifications, educational opportunities, and training.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>3.4.4</td>
<td>Support the expansion of peer models for special populations.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>

Table 25. Objective 3.5: Leverage data and technology to expand access to care

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.5.1</td>
<td>Maximize the use of telehealth support (including telemedicine, peer services, remote evaluation, telepsychiatry services for jails, competency evaluation, and teletherapy).</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>
### Strategy	Strategy Description	Key Partners	Intercept
---
3.5.2 | Support the collection and sharing of accurate and relevant data at the state and local level to help identify and address racial, ethnic, and economic disparities and guide system improvements. | State and Local | 0-1-2-3-4-5 \ Intercept 2

3.5.3 | Study improvements to data sharing between state agencies to support continuity of care. | State and Local | 0-1-2-3-4-5 \ Intercept 0, 2, 4-5

3.5.4 | Support system improvements at the local level through educational initiatives, policy initiatives, and technical assistance to convert local behavioral health and justice data into actionable insights and information. | State, Local, Community | 0-1-2-3-4-5 \ Intercepts 0-5

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### Goal 4: State Hospital and Community-Based Forensic Services

Strengthen state hospital and community-based forensic services.

**Objective 4.1: Right-size competency restoration services.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1.1</td>
<td>Promote the expanded use of court-ordered outpatient mental health treatment in lieu of criminal prosecution when public safety is not a threat.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5 \ Intercepts 2-3</td>
</tr>
<tr>
<td>Strategy</td>
<td>Strategy Description</td>
<td>Key Partners</td>
<td>Intercept</td>
</tr>
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</tr>
<tr>
<td>4.1.2</td>
<td>Explore ways to amend current state requirements to prevent people with misdemeanors from being committed to inpatient competency restoration services.</td>
<td>State</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>4.1.3</td>
<td>Enhance relationships through engagement and learning among state hospitals, judges, courts, LMHA/LBHAs and other partners.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>4.1.4</td>
<td>Provide statewide technical assistance on competency restoration and best practices to reduce the number of people waiting for inpatient competency restoration services.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>

**Objective 4.2: Expand evidence-based and research informed programs across the state to reduce the waitlist for inpatient competency restoration services.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.2.1</td>
<td>Explore funding opportunities for jail in-reach coordinators to support diversion, stakeholder coordination and monitoring for people on the waitlist for inpatient competency restoration services and coordinate with LMHAs/LBHAs, state hospitals, jails, and courts.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>Strategy</td>
<td>Strategy Description</td>
<td>Key Partners</td>
<td>Intercept</td>
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</tr>
<tr>
<td>4.2.2</td>
<td>Develop learning and technical assistance opportunities to support jail in-reach for people awaiting inpatient competency restoration services.</td>
<td>State, Local, Community</td>
<td>0, 1, 2, 3, 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intercepts 0, 2-3</td>
</tr>
<tr>
<td>4.2.3</td>
<td>Promote expanded use of Outpatient Competency Restoration (OCR) Program and Jail-Based Competency Restoration (JBCR) Programs.</td>
<td>State, Local, Community</td>
<td>0, 1, 2, 3, 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intercepts 0, 2-3</td>
</tr>
</tbody>
</table>

**Objective 4.3:** Maximize the use of telemedicine for forensic services in communities where access and staffing are limited.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3.1</td>
<td>Explore statewide infrastructure needs to expand the use of telemedicine in forensic services delivery.</td>
<td>State</td>
<td>0, 1, 2, 3, 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intercepts 0, 2-3</td>
</tr>
<tr>
<td>4.3.2</td>
<td>Support expanded use of telehealth infrastructure for virtual competency evaluations.</td>
<td>State, Local, Community</td>
<td>0, 1, 2, 3, 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intercepts 0, 2-3</td>
</tr>
<tr>
<td>4.3.3</td>
<td>Support the expansion and utilization of virtual court hearings for defendants committed to state hospitals for competency restoration services and people in outpatient and jail-based competency restoration programs.</td>
<td>State and Local</td>
<td>0, 1, 2, 3, 4, 5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Intercepts 0, 2-3</td>
</tr>
</tbody>
</table>
### Objective 4.4: Identify efficiencies and improvements in state hospital and community-based forensic services.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.4.1</td>
<td>Expand and enhance capacity of behavioral health providers to provide competency restoration services to people who have a diagnosis of IDD.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercepts 0, 2-3</td>
</tr>
<tr>
<td>4.4.2</td>
<td>Encourage collaboration between LMHAs/LBHAs and state hospitals in the completion of standardized outpatient management plans for people found Not Guilty by Reason of Insanity and those committed for competency restoration services who are discharging from a state hospital to jail for adjudication.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5 Intercepts 0, 2-4</td>
</tr>
<tr>
<td>4.4.3</td>
<td>Identify forensic data collection needs and drive data-informed interventions throughout the continuum of care.</td>
<td>State and Local</td>
<td>0-1-2-3-4-5 Intercepts 0, 2-4</td>
</tr>
</tbody>
</table>

### Objective 4.5: Strengthen oversight and quality of competency evaluations.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.5.1</td>
<td>Support the provision of statewide technical assistance to courts on quality competency evaluations.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5 Intercept 2-3</td>
</tr>
<tr>
<td>Strategy</td>
<td>Strategy Description</td>
<td>Key Partners</td>
<td>Intercept</td>
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</tr>
<tr>
<td>4.5.2</td>
<td>Explore the creation of a voluntary statewide registry for community competency evaluators and a statewide peer review process to ensure high quality evaluations.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5 Intercept 2-3</td>
</tr>
</tbody>
</table>

**Goal 5: Training, Education and Technical Assistance**

Expand training, education, and technical assistance for stakeholders working at the intersection of behavioral health and justice.

**Objective 5.1: Provide statewide training and technical assistance on trauma-informed, culturally competent, evidence-based practices for behavioral health providers, law enforcement, jails, courts, and community corrections.**

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1.1</td>
<td>Increase focus in behavioral health professions on the intersections of justice and behavioral health and promote evidence-based and promising practices and programs for justice-involved populations with MI, SUD, and/or IDD.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5 Intercepts 0-5</td>
</tr>
<tr>
<td>5.1.2</td>
<td>Coordinate, expand, and promote training and technical assistance operated by state agencies, universities, and professional associations to increase education and training to behavioral health, justice, and other relevant professionals.</td>
<td>State, Local, Community</td>
<td>0 1 2 3 4 5 Intercepts 0-5</td>
</tr>
</tbody>
</table>
Objective 5.2: Promote workforce wellness and resiliency for behavioral health and justice professionals.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Strategy Description</th>
<th>Key Partners</th>
<th>Intercept</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.2.1</td>
<td>Provide training and technical assistance on trauma informed practices and compassion fatigue to community members, justice professionals, and behavioral health providers.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>5.2.2</td>
<td>Identify and reduce barriers to accessing behavioral health care for law enforcement and other justice professionals.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
<tr>
<td>5.2.3</td>
<td>Promote the expansion of peer support and workforce wellness programs for justice professions.</td>
<td>State, Local, Community</td>
<td>0-1-2-3-4-5</td>
</tr>
</tbody>
</table>
Next Steps, Accountability, and Continuous Improvement

The SBHCC is legislatively charged with ensuring a statewide strategic approach to addressing gaps in behavioral health services. The SBHCC’s publication of the Texas Statewide Behavioral Health Strategic Plan, Coordinated Statewide Behavioral Health Expenditure Proposal, and annual Behavioral Health Strategic Plan Progress Reports represent transparency and accountability to the Texas Legislature and the public regarding the good stewardship of state and federal funds to address gaps in behavioral health care for Texans. Most importantly, the plan is a guidepost for addressing gaps in the behavioral health services system in order to increase access to timely and appropriate services that yield long-term recovery in clients served.

Over half of the 254 Texas counties are designated as rural. It can be problematic to develop behavioral health policy that can be implemented in both the state’s largest and the smallest counties. It is challenging to ensure timely, quality behavioral health services are equitably accessible in urban and rural Texas, yet these are the strategic plan goals important to achieve.

Since inception, the SBHCC has tried to achieve these goals by:
- Maximizing financial resources;
- Increasing SBHCC membership and the public’s awareness of the array of behavioral health services and supports;
- Collaborating to reduce and eliminate unnecessary barriers to people accessing behavioral health services and supports; and
- Assessing opportunities to collect better data on client outcomes which drive decisions regarding policy changes and services.

The updated Texas Statewide Behavioral Health Strategic Plan for fiscal years 2022-2026 and the Texas Strategic Plan for Diversion, Community Integration, and Forensic Services are expected to lead to improvements in cross-agency coordination by addressing identified gaps through a coordinated and strategic approach and maximizing the use of existing resources and services. A more efficient and effective state government approach to behavioral health service delivery will result in Texans having a greater awareness of, and access to behavioral health services.
A commitment to implementation by state, local, and community partners will help achieve a unified and coordinated approach to enhancing the Texas behavioral health system which will enhance forensic services and reduce and prevent people with MI, SUD, and/or IDD from becoming involved in the justice system. State, local, and community partners can participate in implementing these strategic plans in the following ways, as examples:

- Determining benchmarks (i.e., outputs and outcomes) for each goal, objective and strategy and evaluating the success of implementation;
- Leveraging state-level training and technical assistance to achieve objectives and strategies;
- Convening cross-disciplinary advisory committees or workgroups to monitor planning, and implementation of the strategic plans; and
- Developing cross-disciplinary coalitions and partnerships to implement local or statewide behavioral health initiatives.
# Appendix A. List of Acronyms and Abbreviations

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Full Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>CATR</td>
<td>Campus Alliance for Telehealth Resources</td>
</tr>
<tr>
<td>CCA</td>
<td>Court of Criminal Appeals</td>
</tr>
<tr>
<td>CCBHC</td>
<td>Certified Community Behavioral Health Clinics</td>
</tr>
<tr>
<td>CCQ</td>
<td>Continuity of Care Query</td>
</tr>
<tr>
<td>CHIP</td>
<td>Children’s Health Insurance Program</td>
</tr>
<tr>
<td>CIT</td>
<td>Crisis Intervention Training</td>
</tr>
<tr>
<td>CMHG</td>
<td>Community Mental Health Grant program</td>
</tr>
<tr>
<td>CMS</td>
<td>Centers for Medicare &amp; Medicaid Services</td>
</tr>
<tr>
<td>COVID-19</td>
<td>Coronavirus Disease 2019</td>
</tr>
<tr>
<td>CPAN</td>
<td>Child Psychiatry Access Network</td>
</tr>
<tr>
<td>CR</td>
<td>Competency Restoration</td>
</tr>
<tr>
<td>CSC</td>
<td>Coordinated Specialty Care</td>
</tr>
<tr>
<td>DFPS</td>
<td>Department of Family and Protective Services</td>
</tr>
<tr>
<td>DSHS</td>
<td>Department of State Health Services</td>
</tr>
<tr>
<td>DSM</td>
<td>Diagnostic Statistical Manual</td>
</tr>
<tr>
<td>DSRIP</td>
<td>Delivery System Reform Incentive Payment</td>
</tr>
<tr>
<td>ECHO</td>
<td>Extension for Community Health Outcomes</td>
</tr>
<tr>
<td>EMS</td>
<td>Emergency Medical Services</td>
</tr>
<tr>
<td>FQHC</td>
<td>Federally Qualified Health Centers</td>
</tr>
<tr>
<td>GAA</td>
<td>General Appropriations Act</td>
</tr>
<tr>
<td>H.B.</td>
<td>House Bill</td>
</tr>
<tr>
<td>HCC</td>
<td>Health Community Collaborative program</td>
</tr>
<tr>
<td>HHSC</td>
<td>Health and Human Services Commission</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
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</tr>
<tr>
<td>HPC</td>
<td>Health Professions Council</td>
</tr>
<tr>
<td>HPSA</td>
<td>Health Professional Shortage Area</td>
</tr>
<tr>
<td>IDD</td>
<td>Intellectual and developmental disabilities</td>
</tr>
<tr>
<td>IST</td>
<td>Incompetent to Stand Trial</td>
</tr>
<tr>
<td>JBCR</td>
<td>Jail-based competency restoration</td>
</tr>
<tr>
<td>JCAFS</td>
<td>Joint Committee on Access and Forensic Services</td>
</tr>
<tr>
<td>JCMH</td>
<td>Judicial Commission on Mental Health</td>
</tr>
<tr>
<td>JTIP</td>
<td>Juvenile Training Immersion Program</td>
</tr>
<tr>
<td>LBHA</td>
<td>Local Behavioral Health Authority</td>
</tr>
<tr>
<td>LIDDA</td>
<td>Local Intellectual and Developmental Disability Authority</td>
</tr>
<tr>
<td>LMHA</td>
<td>Local Mental Health Authority</td>
</tr>
<tr>
<td>LOS</td>
<td>Length of Stay</td>
</tr>
<tr>
<td>MAT</td>
<td>Medication assisted treatment</td>
</tr>
<tr>
<td>MCO</td>
<td>Managed care organization</td>
</tr>
<tr>
<td>MCOT</td>
<td>Mobile Crisis Outreach Team</td>
</tr>
<tr>
<td>MH</td>
<td>Mental Health</td>
</tr>
<tr>
<td>MHBG</td>
<td>Community Mental Health Services Block Grant</td>
</tr>
<tr>
<td>MHFA</td>
<td>Mental Health First Aid</td>
</tr>
<tr>
<td>MHGJII</td>
<td>Mental Health Grant Program for Justice-Involved Individuals</td>
</tr>
<tr>
<td>MHPSA</td>
<td>Mental Health Professional Shortage Area</td>
</tr>
<tr>
<td>MI</td>
<td>Mental Illness</td>
</tr>
<tr>
<td>MSU</td>
<td>Maximum Security Unit</td>
</tr>
<tr>
<td>MVPN</td>
<td>Military Veteran Peer Network</td>
</tr>
<tr>
<td>NGRI</td>
<td>Not Guilty by Reason of Insanity</td>
</tr>
<tr>
<td>OCA</td>
<td>Office of Court Administration</td>
</tr>
<tr>
<td>OCR</td>
<td>Outpatient Competency Restoration</td>
</tr>
<tr>
<td>Abbreviation</td>
<td>Full Form</td>
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<td>--------------</td>
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</tr>
<tr>
<td>OOG</td>
<td>Office of the Governor</td>
</tr>
<tr>
<td>OSAR</td>
<td>Outreach, Screening, Assessment, and Referral</td>
</tr>
<tr>
<td>RTC</td>
<td>Residential treatment center</td>
</tr>
<tr>
<td>S.B.</td>
<td>Senate Bill</td>
</tr>
<tr>
<td>SABG</td>
<td>Substance Abuse Prevention and Treatment Block Grant</td>
</tr>
<tr>
<td>SAMHSA</td>
<td>Substance Abuse and Mental Health Services Administration</td>
</tr>
<tr>
<td>SBHCC</td>
<td>Statewide Behavioral Health Coordinating Council</td>
</tr>
<tr>
<td>SBIRT</td>
<td>Screening, Brief Intervention, and Referral to Treatment</td>
</tr>
<tr>
<td>SCoT</td>
<td>Supreme Court of Texas</td>
</tr>
<tr>
<td>SDOH</td>
<td>Social determinants of health</td>
</tr>
<tr>
<td>SED</td>
<td>Serious emotional disturbances</td>
</tr>
<tr>
<td>SIM</td>
<td>Sequential Intercept Model</td>
</tr>
<tr>
<td>SMI</td>
<td>Serious mental illness</td>
</tr>
<tr>
<td>SMVF</td>
<td>Service members, veterans, and families</td>
</tr>
<tr>
<td>SOR</td>
<td>State Opioid Response grants</td>
</tr>
<tr>
<td>SSLC</td>
<td>State supported living center</td>
</tr>
<tr>
<td>SUD</td>
<td>Substance Use Disorder</td>
</tr>
<tr>
<td>SWOT</td>
<td>Strengths, weaknesses, opportunities, and threats</td>
</tr>
<tr>
<td>TCCO</td>
<td>Texas Civil Commitment Office</td>
</tr>
<tr>
<td>TCHATT</td>
<td>Texas Child Health Access Through Telemedicine</td>
</tr>
<tr>
<td>TCJS</td>
<td>Texas Commission on Jail Standards</td>
</tr>
<tr>
<td>TCM</td>
<td>Targeted case management</td>
</tr>
<tr>
<td>TCMHCC</td>
<td>Texas Child Mental Health Care Consortium</td>
</tr>
<tr>
<td>TCOLE</td>
<td>Texas Commission on Law Enforcement</td>
</tr>
<tr>
<td>TCOOMMI</td>
<td>Texas Correctional Office on Offenders with Medical or Mental Impairments</td>
</tr>
<tr>
<td>Acronym</td>
<td>Full Name</td>
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<tr>
<td>----------</td>
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</tr>
<tr>
<td>TDCJ</td>
<td>Texas Department of Criminal Justice</td>
</tr>
<tr>
<td>TDHCA</td>
<td>Texas Department of Housing and Community Affairs</td>
</tr>
<tr>
<td>TEA</td>
<td>Texas Education Agency</td>
</tr>
<tr>
<td>THECB</td>
<td>Texas Higher Education Coordinating Board</td>
</tr>
<tr>
<td>TIDC</td>
<td>Texas Indigent Defense Commission</td>
</tr>
<tr>
<td>TJJD</td>
<td>Texas Juvenile Justice Department</td>
</tr>
<tr>
<td>TLETS</td>
<td>Texas Law Enforcement Telecommunications System</td>
</tr>
<tr>
<td>TMD</td>
<td>Texas Military Department</td>
</tr>
<tr>
<td>TTOR</td>
<td>Texas Targeted Opioid Response</td>
</tr>
<tr>
<td>TTUHSC</td>
<td>Texas Tech University Health Sciences Center</td>
</tr>
<tr>
<td>TV+FA</td>
<td>Texas Veterans + Family Alliance</td>
</tr>
<tr>
<td>TVC/VMHD</td>
<td>Texas Veterans Commission/Veterans Mental Health Department</td>
</tr>
<tr>
<td>TWC</td>
<td>Texas Workforce Commission</td>
</tr>
<tr>
<td>U.S.</td>
<td>United States of America</td>
</tr>
<tr>
<td>UTHSC-H</td>
<td>University of Texas Health Science Center at Houston</td>
</tr>
<tr>
<td>UTHSC-T</td>
<td>University of Texas Health Science Center at Tyler</td>
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<tr>
<td>VR</td>
<td>Vocational Rehabilitation</td>
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<tr>
<td>VRSS</td>
<td>Veterans Affairs Veterans Reentry Service System</td>
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<td>VRD</td>
<td>Vocational Rehabilitation Division</td>
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<tr>
<td>WRAP</td>
<td>Wellness Recovery Action Plan</td>
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</table>
Appendix B. Glossary of Terms

**Behavioral health:** The 2022-23 General Appropriations Act, S.B. 1, 87th Legislature, Regular Session, 2021 (Article IX, Sec. 10.04) defines behavioral health services as “programs or services directly or indirectly related to the research, prevention, or detection of mental disorders and disabilities, and all services necessary to treat, care for, control, supervise, and rehabilitate persons who have a mental disorder or disability, including persons whose mental disorders or disabilities result from alcoholism or drug addiction.”

**Biopsychosocial assessments:** An evidence-based biopsychosocial approach to care including a person-centered and trauma-informed treatment plan.

**Collaborative Care Case Management:** A holistic case management approach focused on increasing access to needed services and creating a team of medical, psychiatric, mental health, and paraprofessionals to address the person’s unique needs.

**Competency restoration:** means the treatment or education process for restoring a person's ability to consult with the person's attorney with a reasonable degree of rational understanding, including a rational and factual understanding of the court proceedings and charges against the person.110

**Community integration:** Community integration is designed to help persons to optimize their personal, social, and vocational competency to live successfully in the community.

**Continuity of care:** The degree to which the care of a patient is not interrupted over time.

**Co-occurring:** Term used when a person has a mental health and substance use disorder or other condition.

**Delivery System Reform Incentive Payment (DSRIP):** An incentive payment related to the development or implementation of a program of activity that supports a Regional Healthcare Partnership's efforts to enhance access to health care, the quality of care, and the health of patients and families the Regional Healthcare Partnership serves. A DSRIP payment is not considered patient-care revenue and is not offset against Disproportionate Share Hospital expenditures or other expenditures related to the cost of patient care.
**Evidence-based practices:** Integrate clinical expertise, expert opinion, external scientific evidence, and client, patient, and caregiver perspectives to help providers offer high-quality services that reflect the interests, values, needs, and choices of the people served. A **best practice** is a method or technique that is accepted as being correct or most effective. A **promising practice** is one that leads to an effective and productive result and must have measurable results that demonstrate success over time.

**Forensic population:** “Forensic population” refers to individuals committed under 46C and 46B of the Texas Code of Criminal Procedure. The term “46C” refers to Chapter 46C of the Texas Code of Criminal Procedure and applies to cases in which an individual has been found not guilty by reason of insanity. The term “46B” refers to Chapter 46B of the Texas Code of Criminal Procedure and applies to an individual charged with a felony or with a misdemeanor punishable by confinement who may be incompetent to stand trial.

**Forensic services:** "Forensic services" refers to services for the “forensic population,” including competency examinations, competency restoration services, or mental health or intellectual disability services provided to a current or former forensic patient in the community or at a department facility. According to the Texas Health and Safety Code, "forensic services" are defined as competency examination, competency restoration services, or mental health or intellectual disability services provided to a current or former forensic patient in the community or at a HHSC facility. A "Forensic patient" is a person with mental illness or a person with an intellectual disability who is: (A) examined on the issue of competency to stand trial by an expert appointed under Subchapter B, Chapter 46B, Code of Criminal Procedure; (B) found incompetent to stand trial under Subchapter C, Chapter 46B, Code of Criminal Procedure; (C) committed to court-ordered mental health services under Subchapter E, Chapter 46B, Code of Criminal Procedure; (D) found not guilty by reason of insanity under Chapter 46C, Code of Criminal Procedure; (E) examined on the issue of fitness to proceed with juvenile court proceedings by an expert appointed under Chapter 51, Family Code; or (F) found unfit to proceed under Subchapter C, Chapter 55, Family Code.

**Home- and Community-Based Services:** Home and community-based services (HCBS) provide opportunities for Medicaid beneficiaries to receive services in their own home or community rather than institutions or other non-community-based settings. These programs serve a variety of targeted populations groups, such as people with intellectual or developmental disabilities, physical disabilities, and/or mental illnesses.
Incompetent to Stand Trial (IST): A person is incompetent to stand trial if the person does not have: (1) sufficient present ability to consult with the person's lawyer with a reasonable degree of rational understanding; or (2) a rational as well as factual understanding of the proceedings against the person.\textsuperscript{111}

Integrated care: The systematic coordination of general and behavioral health care. Integrating mental health, substance abuse, and primary care services produces the best outcomes and proves the most effective approach to caring for people with multiple health care needs.

Integrated housing: Ordinary living arrangements typical of the general population. Integrated housing is achieved when people with disabilities have the choice of ordinary, typical housing units located among people who do not have disabilities or other special needs.

Intellectual and developmental disability (IDD): Includes many severe, chronic conditions that are due to mental and/or physical impairments. IDD can begin at any time up to 18 or 22 years of age, depending on the condition, and usually lasts throughout a person's lifetime. People who have IDD require support with major life activities such as language, mobility, learning, self-help, and independent living.

Jail-based Competency Restoration (JBCR): Jail-based competency restoration provides services to people with mental health or co-occurring psychiatric and substance use disorders in jail. Services include behavioral health treatment services and competency education for people found incompetent to stand trial, consistent with other competency restoration services.

Managed care: A system in which the overall care of a patient is coordinated by a single provider or organization. Many state Medicaid and CHIP programs include managed care components to improve quality and control costs.

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

Outpatient Competency Restoration (OCR): Outpatient Competency Restoration are programs that provide community-based competency restoration services, which include mental health and substance use treatment services, as well as legal education for people found Incompetent to Stand Trial. In general,
outpatient competency restoration programs are designed to: (1) Reduce the number of IST people with mental illness or co-occurring psychiatric and substance use disorders on the state mental health hospital clearinghouse waiting list for inpatient competency restoration services. (2) Increase prompt access to clinically appropriate outpatient competency restoration services for people determined to be IST who don't require the restrictiveness of a hospital setting. (3) Reduce the number of bed days in state mental health hospitals used by forensic patients from a contractor's local service area.

**Peer services:** Services designed and delivered by people who have experienced a mental or substance use disorder and are in recovery. They also include services designed and delivered by family members of those in recovery. Peer specialists foster hope and promote a belief in the possibility of recovery.

**Person-centered care:** People have control over their services, including the amount, duration, and scope of services, as well as choice of providers. Person-centered care also is respectful and responsive to the cultural, linguistic, and other social and environmental needs of the person.

**Post-Booking Diversion:** Post-booking diversion is the practice of criminal justice agencies connecting people to behavioral health treatment after an arrest has been made and the person has been booked into jail. Post-booking diversion can include screening for mental and substance use disorders at jail intake; data matching to identify people who have used public behavioral health services; and pre-trial diversion programs.

**Pre-Arrest Diversion:** Pre-arrest diversion is the practice of law enforcement or multidisciplinary teams connecting people to behavioral health treatment as an alternative to arrest.

**Reentry:** The transition from life in jail or prison to life in the community.\(^{113}\)

**Sequential Intercept Model (SIM):** The SIM, developed by Mark R. Munetz, M.D. and Patricia A. Griffin, Ph.D., is used by federal, state, and local agencies as a framework to understand how people with MI and SUD encounter and move through the criminal justice system. The SIM has been used as a focal point for states and local communities to assess available resources, determine gaps in services, and plan for community change.\(^{91}\)

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

**Serious mental illness (SMI):** A diagnosable mental, behavior, or emotional disorder that causes serious functional impairment for a person age 18 and older that substantially interferes with or limits one or more of major life activities.

**Social determinants of health (SDOH):** The conditions in the environments where people are born, live, learn, work, play, worship, and that affect a wide range of health and quality-of-life outcomes and risks.

**State of Texas Access Reform (STAR):** A statewide Medicaid managed care program primarily for pregnant women, low-income children, and their caretakers. Most people in Texas Medicaid get their coverage through STAR.

**STAR Health:** A statewide Medicaid managed care program that provides coordinated health services to children and youth in foster care and kinship care. STAR Health benefits include medical, dental, and behavioral health services, as well as service coordination and a web-based electronic medical record, known as the Health Passport.

**STAR Kids:** A statewide Medicaid managed care program for children and youth age 20 and younger with disabilities, including children and youth receiving benefits under the Medically Dependent Children Program (MDCP) waiver.

**STAR+PLUS:** A statewide Medicaid managed care program for adults with disabilities and those age 65 and older.

**Substance use disorder:** Occur when the recurrent use of alcohol or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home.

**Telemedicine:** The definition for telemedicine varies by the context applied.

Per the Texas Occupations Code, “telemedicine medical service" means a health care service delivered by a physician licensed in this state, or a health professional acting under the delegation and supervision of a physician licensed in this state and acting within the scope of the physician's or health professional's license to a patient at a different physical location than the physician or health professional using telecommunications or information technology."
Per the Texas Administrative Code, telemedicine services are defined under Medicaid as a health care service, initiated by a physician who is licensed to practice medicine in Texas under Title 3, Subtitle B of the Occupations Code or provided by a health professional acting under physician delegation and supervision, that is provided for purposes of patient assessment by a health professional, diagnosis, or consultation by a physician, or treatment, or for the transfer of medical data, and that requires the use of advanced telecommunications technology, other than telephone or facsimile technology, including:

- Compressed digital interactive video, audio, or data transmission;
- Clinical data transmission using computer imaging by way of still-image capture and store and forward; and
- Other technology that facilitates access to health care services or medical specialty expertise.\footnote{115}

**Texas Healthcare Transformation and Quality Improvement Program 1115 Waiver:** The Texas Healthcare Transformation and Quality Improvement Program Section 1115 Waiver enables the State to expand its use of Medicaid managed care to achieve program savings, while also preserving locally funded supplemental payments to hospitals. The goals of the demonstration are to:

- Expand risk-based managed care statewide;
- Support the development and maintenance of a coordinated care delivery system;
- Improve outcomes while containing cost growth; and
- Transition to quality-based payment systems across managed care and providers.

**Trauma-informed care:** Treatment interventions that specifically address the consequences of trauma on a person and are designed to facilitate healing. A trauma-informed approach has the following principles: safety, trustworthiness, peer support, collaboration and mutuality, empowerment, voice, and choice. Trauma-informed care should also consider cultural, historical, and gender issues.
Appendix C. SBHCC Agency Profiles

The following information provided by each SBHCC member agency appointed through fiscal year 2021 outlines their populations of focus and eligibility requirements for services.

<table>
<thead>
<tr>
<th>Court of Criminal Appeals (CCA)</th>
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<tr>
<td><strong>Populations Served:</strong></td>
</tr>
<tr>
<td>- Judges and court personnel from all courts in the state of Texas (appellate, district, county, justice of the peace, and municipal), prosecuting attorneys, and criminal defense attorneys.</td>
</tr>
<tr>
<td><strong>Groups Served by Programs:</strong></td>
</tr>
<tr>
<td>- The programs follow a master strategic plan to assist criminal justice stakeholders in identifying, assessing, and providing proper treatment of alleged offenders with mental deficiencies. The programs encompass an appreciation for mental health disorders, treatment options, and legislative enactments designed to facilitate proper treatment, deferment, or placement of mentally impaired people. An across-the-board approach to statewide mental health behavioral problems will allow all stakeholders to understand the roles of all involved as to best address the needs of our citizens.</td>
</tr>
</tbody>
</table>
### Department of Family and Protective Services (DFPS)

**Populations Served:**
- All Texans

**Eligibility Requirements for Services and Programs:**
- Families in communities identified as having a high level of maltreatment risk factors including poverty, instability, poor health outcomes, substance abuse, and mental illness, targeted for voluntary prevention and family-strengthening programs.
- Families who either have a child in foster care or are receiving in-home family-based safety services due to the high-risk of having a child removed due to abuse or neglect and being placed in foster care absent preventive measures. Services are provided to children who are in substitute care, children who remain in their homes, and their caregivers and families.
- Families who need assistance to facilitate the achievement of the child's or family's service plan to resolve risk factors related to child abuse and neglect. Services are provided to children who are in substitute care, children who remain in their homes, and to their caregivers and families including those in family-based safety services.
- Children in DFPS conservatorship with serious mental or behavioral health needs.
- Adults 65 and older and adults 18 to 64 with a disability in Adult Protective Services cases who are in need of protective services.

### Department of State Health Services (DSHS)

**Populations Served:**
- All Texans

**Eligibility Requirements for Services and Programs:**
DSHS delivers population services to improve the health, safety, and well-being of Texans through good stewardship of public resources, and a focus on core public health functions including:
- Improving health through prevention and population health strategies;
- Enhancing public health response to disasters and disease outbreaks;
- Reducing health problems through public health consumer protection; and
- Expanding the effective use of health information.

### Health and Human Services Commission (HHSC)

**Populations Served:**
- Varies by program or services
Behavioral Health Services – Populations Served:
- Mental Health: adults with SMI and children with SED
- Substance Use Prevention: youth and adults in the general population, with some services focused on people deemed at risk for substance use or misuse
- Substance Use Intervention and Treatment: youth and adults at risk for substance use disorder or with a substance use disorder

Behavioral Health Services - Eligibility Requirements:
- Mental Health Children Services: Children ages 3 to 17 years with SED (excluding a single diagnosis of substance use disorder, IDD, or autism spectrum disorder) and who: (1) have a serious functional impairment; or (2) are at risk of disruption of a preferred living or childcare environment due to psychiatric symptoms; or (3) are enrolled in special education because of SED. Also, the federal block grant requires prioritization of services for Early SMI (known in Texas as Coordinated Specialty Care) to address the needs of persons coming into care for the first time.
- Youth Empowerment Services (YES) 1915c Waiver Program: Serves youth ages 3 through 18 (up to the last day before their 19th birthday) with serious mental, emotional, and behavioral difficulties at risk of being removed from their home due to their mental health needs. Must meet the criteria to be in a psychiatric hospital and be eligible for Medicaid (parents’ income does not apply).
- Mental Health - Adults: people age 18 or older who have a diagnosis of an SMI with significant functional impairment and the highest need for intervention, including schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, bulimia nervosa, anorexia nervosa or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment in accordance with Texas Health and Safety Code, Sec. 533.0354. Also, the federal block grant requires prioritization of Crisis Services to strengthen the crisis continuum.
- Home and Community Based Services - Adult Mental Health: Designed to increase support services for adults with SMI who have a history of long-term psychiatric hospitalization, frequent arrests, or frequent hospital emergency room use. Must be 18 years or older, with active Medicaid or determined to be Medicaid eligible if residing in a state hospital, not be dually-enrolled or receiving HCBS services by any other means, and must meet one of the following needs-based criteria:
  - Long Term Psychiatric Hospitalization: Three or more cumulative or consecutive years in an inpatient psychiatric hospital during the five years prior to referral; or
  - Jail Diversion: Two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations or an outpatient psychiatric crisis that meets inpatient psychiatric criteria) and four or more discharges from correctional facilities during the three years prior to the referral; or
  - Emergency Department Diversion: Two or more psychiatric crises (i.e., inpatient psychiatric hospitalizations or outpatient psychiatric crisis that meets inpatient psychiatric criteria) and 15 or more total emergency department visits during the three years prior to the referral.
• **Substance Use:**
  ‣ Prevention: Substance use prevention services are available to youth and adult populations. Prevention programs are designed to: (1) outreach to the general population; (2) serve priority groups determined to be at risk for substance use or misuse; and (3) support people experiencing early signs of substance use but not diagnosed with a substance use disorder; (4) establish and maintain collaborative partnerships with individuals and/or organizations that collectively strive to address prevention and behavioral health promotion; (5) collect and analyze data relevant to prevention and health promotion; (6) distribute messaging statewide that promotes behavioral health.
  ‣ Intervention and Treatment: Low-income adults and youth determined to have one of the following:
    ◊ Misuse: This refers to using substances that can impact a person’s health and safety but does not meet the criteria for substance use disorder. People in this category can benefit from Intervention services.
    ◊ Disorder is a diagnosis based on the evidence of impaired control, social impairment, and pharmacological criteria as defined by the current version of the Diagnostic Statistical Manual (DSM).
  ‣ Also, the federal block grant requires prioritization of certain activities such as prevention services and priority access groups, including pregnant women who inject drugs, pregnant women, and people who inject drugs.

**Health and Specialty Care System – Populations Served:**
- Children and youth less than 17 years old
- Adults 18 years and older

**Health and Specialty Care System – Eligibility Requirements:**

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

**State Supported Living Centers**
The Health and Safety Code (Title 7, Section 593.052) establishes four mandatory admission criteria:
- The individual is a person with an intellectual disability;
### Health and Human Services Commission (HHSC)

- Evidence (per Texas Administrative Code Title 40, Part 1, Chapter 2, Subchapter F, Division 2, Section 2.255) is presented showing that because of the intellectual disability the individual:
  - Represents a substantial risk of physical impairment or injury to self or others; or
  - Is unable to provide for and is not providing for his/her most basic personal physical needs.
- The individual cannot be adequately and appropriately habilitated in an available, less restrictive setting; and
- The facility provides habilitation services, care, training, and treatment appropriate to the individual's needs.

### Medicaid – Populations Served:
- All ages

### Medicaid – Eligibility Requirements:
- A child or youth who meets income, citizenship, residency, and program requirements. Children in foster care, and children receiving SSI automatically qualify for Medicaid.
- An adult who meets income, citizenship, residency, and program requirements. In order to qualify, an adult must care for a child receiving Medicaid (must be a related caretaker), be pregnant, have a disability, or is 65 and older and qualifies for Medicaid for the Elderly and People with Disabilities. Adults with SSI automatically qualify for Medicaid.

### CHIP Services – Populations Served:
- Children age 0 through 18.

### CHIP – Eligibility Requirements:
- Be a child aged 0 through 18 whose family earns too much to qualify for Medicaid. Texans who apply and do not qualify for Medicaid are automatically tested for CHIP eligibility.
Health and Human Services Commission (HHSC)

Health Professions Council (HPC)

**Populations Served:**
- Licensees of organizations listed below

**Eligibility Requirements for Services and Programs:**
There are several agencies within the HPC which operate some form of peer assistance program. The agencies themselves do not provide mental health services. Licensees of the following organizations are eligible to participate in activities:
  - Texas Board of Dental Examiners
  - Texas Board of Pharmacy
  - Texas Board of Veterinary Medical Examiners
  - Texas Optometry Board
  - Texas Peer Assistance Program for Nurses
  - The Texas Medical Board

Judicial Commission on Mental Health (JCMH), Supreme Court of Texas

**Populations Served:**
- Courts, judges, and attorneys

**Groups Served by Programs:**
The mission of JCMH is to engage and empower court systems through collaboration, education, and leadership, thereby improving the lives of people with mental health needs and people with IDD.

The Office of the Governor (OOG): Criminal Justice Division

**Populations Served:**
- Juveniles (10 years up to age of maturity or 17)
- Adults (17 years and older) with substance abuse problems and/or mental illness
The Office of the Governor (OOG): Criminal Justice Division

**Eligibility Requirements for Services and Programs:**

- **Specialty Courts Program:** Individuals are eligible to participate in specialty courts if they are determined to be high-risk/high-need and referred to a court program usually by the district attorney or Judge.
- **Residential Substance Abuse Treatment Program:** Individuals in correctional and detention facilities diagnosed with a substance use disorder.
- **Juvenile Justice and Delinquency Program:** Youth who are at-risk of or currently involved in the juvenile justice system.
- **Edward Byrne Justice Assistance Grant Program:** Individuals at-risk of or currently in the adult or juvenile justice system.
- **Crime Victim Assistance Program:** Victims of crime.
- **Violence Against Women Program:** Women who have experienced a violent crime.

Texas Child Mental Health Care Consortium (TCMHCC)

**Populations Served:**

- Children and Adolescents
Texas Child Mental Health Care Consortium (TCMHCC)

**Groups Served by Programs:**
The TCMHCC was created by the 86th Texas Legislature in S.B. 11 to address gaps in mental health care for children and adolescents in Texas. Through the TCMHCC, Texas has a unique opportunity to implement evidence-based programs across the state and to enhance the collaboration of the state’s many health-related institutions, state agencies and nonprofits. Building on the ability and success of existing programs at these institutions, new programs are being developed and improved in conjunction with local school districts and local community mental health providers. The work of the TCMHCC also addresses the shortage of psychiatrists in Texas by providing additional training opportunities and fellowship programs. The TCMHCC was funded by the Legislature through the THECB, which was appropriated $99 million for the work of the Consortium in Rider 58 under H.B. 1.

The TCMHCC is responsible for implementing the following initiatives:

- **Child Psychiatry Access Network (CPAN):** A network of child psychiatry access centers based at the health-related institutions that will provide child and adolescent behavioral health consultation services and training opportunities for pediatricians and primary care providers (PCP).
- **Texas Child Health Access Through Telemedicine (TCHATT):** Telemedicine or telehealth programs using HRIs to support local school districts (ISDs) to assist schools in identifying and assessing the behavioral health needs of children and adolescents and providing access to mental health services.
- **Community Psychiatry Workforce Expansion (CPWE):** Full-time academic psychiatrists are funded to serve as academic medical directors at facilities operated by community mental health providers, and new psychiatric resident rotation positions are established at these facilities.
- **Child and Adolescent Psychiatry Fellowships (CAP Fellowships):** This program expands both the number of child and adolescent psychiatry fellowship positions in Texas, and the number of these training programs at Texas HRIs.
- **Research:** Development of a plan to promote and coordinate mental health research across state university systems in accordance with the statewide behavioral health strategic plan developed by HHSC.
<table>
<thead>
<tr>
<th>Texas Civil Commitment Office (TCCO)</th>
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<tr>
<td><strong>Populations Served:</strong></td>
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<tr>
<td>• Adults that have been civilly committed as repeat sexually violent offenders who suffer from a behavioral abnormality.</td>
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<tr>
<td><strong>Eligibility Requirements for Services and Programs:</strong></td>
</tr>
<tr>
<td>• Clients are sexually violent predators who have been civilly committed as defined by Chapter 841 of the Health and Safety Code. The populations served by TCCO are repeat sexually violent offenders that suffer from a behavioral abnormality which is not amenable to traditional mental health treatment modalities whereby the clients receive sex offender specific treatment. The clients have been adjudicated to be sexually violent predators. Sexually violent predators targeted for services under this strategy may also suffer from concurrent behavioral health diagnoses and require mental health or substance abuse treatment.</td>
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<th>Texas Commission on Jail Standards (TCJS)</th>
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<td><strong>Populations Served:</strong></td>
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<tr>
<td>• County jails, including inmates</td>
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<tr>
<td><strong>Groups Served by Programs:</strong></td>
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<tr>
<td>• TCJS employs one trainer who does the following:</td>
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<tr>
<td>▶ Educate county jailers in an understanding of mental impairments and their impact within the jail system and teach constructive techniques to use when communicating in a time of crisis in a jail setting.</td>
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<tr>
<td>▶ Identify local resources and partnerships to assist with individuals in crisis and in need of supportive services.</td>
</tr>
<tr>
<td>▶ Train jailers to utilize the screening tool for identification of suicide risk and the questions and actions necessary when an individual is identified as a suicide risk.</td>
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Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI), Texas Department of Criminal Justice (TDCJ)

**Populations Served:**
- Youth ages 10 to 17 years
- Adults ages 18 years and older

**Eligibility Requirements for Services and Programs:**

**Mental Illness:**
- Youth on Probation must be concurrently enrolled with the Special Needs Diversionary Program at TJJD. This program pairs a TDCJ-TCOOMMI funded mental health caseworker and a local juvenile probation officer for coordinated treatment goals, to provide family/community wrap-around support and a team approach between supervision and treatment.
- Youth on Parole from TJJD are served through continuity of care and must have a mental health diagnosis as noted in the latest version of the Diagnostic Statistical Manual.
- Adults on Pre-trial, Probation, and/or on Parole supervision having a mental health diagnosis that is severe or persistent in nature. Diagnoses include but not limited to bipolar disorder, schizophrenia, schizoaffective disorder, major depressive disorder, post-traumatic stress disorder, delusional disorder, and anxiety.
- Adults incarcerated are served regardless of severity of the mental health disorder or intellectual disability.

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

**Developmental Disabilities Program:**
- All individuals entering the TDCJ are screened for potential intellectual and adaptive behavioral deficiencies. Inmates identified with a diagnosis of Intellectual Disability or Borderline Intellectual Functioning are eligible for placement in the Developmental Disabilities Program.
- Services available through the Developmental Disabilities Program for inmates include but are not limited to sheltered housing within the institution, educational instruction, appropriate job/vocational training, individual and group counseling, case management services, chaplaincy, psychiatric services, and pre-release counseling/preparation.
- The goal is to improve people’s level of function so they can successfully reenter the community.
### Texas Department of Housing and Community Affairs (TDHCA)

#### Populations Served:
- All ages

#### Eligibility Requirements for Services and Programs:
- **Section 811 Project Rental Assistance** is limited to individuals who are part of the Target Population and receiving services through DFPS or one of the HHSC Agencies participating in the program. Eligible households must have a qualified member of the Target Population that will be at least 18 years of age and under the age of 62 at the time of admission and is at or below 30 percent AMFI at the time of admission. All three Target populations are eligible for community-based, long-term care services as provided through Medicaid waivers, Medicaid state plan options, or state funded services and have been referred to TDHCA through their service provider or coordinator. The Target population includes people with disabilities living in institutions, people with SMI and youth with disabilities exiting foster care.
- The **Project Access** program utilizes Section 8 Housing Choice Vouchers administered by TDHCA to assist low-income persons with disabilities in transitioning from institutions into the community by providing access to affordable housing. Eligible households must have incomes at or below 50 percent AMFI at the time of admission.

### Texas Education Agency (TEA)

#### Populations Served:
- Children and youth ages 5 to 21 years
- Adults ages 21 to 26 years

#### Eligibility Requirements for Services and Programs:
- A person who, on the first day of September of any school year, is at least 5 years of age and under 21 years of age or is at least 21 years of age and under 26 years of age and is admitted by a school district to complete the requirements for a high school diploma is entitled to the benefits of the available school fund for that year in accordance with Chapter 25 of the Texas Education Code. Any other person enrolled in a prekindergarten class or Special Education Program under Chapter 29 is entitled to the benefits of the available school fund. All persons who meet the admission criteria are eligible to be served in Texas public school programs.
Texas Indigent Defense Commission (TIDC), Office of Court Administration

**Populations Served:**
- Indigent adults and juveniles charged with criminal offenses
- Judges, magistrates, court personnel, and attorneys

**Groups Served by Programs:**
- Specialized Indigent Defense Program Grants: Texas counties are eligible to apply for grants to create or expand programs representing adults or juveniles with mental illness facing criminal charges. Eligible programs use multi-disciplinary teams to provide representation and advocacy focused on improving defendant outcomes and reducing recidivism through treatment-based alternatives to incarceration.
- Judges, court personnel, and attorneys: TIDC helps counties, judges, attorneys, public defender offices, and managed assigned counsel programs improve their public defense systems and programs through system building, training, mentoring, model forms, and publications.

Texas Juvenile Justice Department (TJJD)

**Populations Served:**
- Youth ages 10 to 18 years

**Eligibility Requirements for Services and Programs:**
- TJJD serves youth who have been adjudicated delinquent of felony offenses and committed to the agency by a juvenile court. In order for a youth to be committed to TJJD, the delinquent act must occur when the youth is between 10 and 17 years of age. TJJD may retain jurisdiction over a youth until his or her 19th birthday. The youth sent to TJJD are the state's most serious or chronically delinquent offenders.
- In addition to providing services to state-committed youth, TJJD provides support to 165 county probation departments across the state of Texas. County Probation Departments provide a wide variety of community-based programs to promote positive outcomes for youth, increase resilience, decrease risk factors, and ultimately divert youth form penetrating deeper into the juvenile or criminal justice systems.

Texas Military Department (TMD)

**Populations Served:**
- Adults 18 years and older

**Eligibility Requirements for Services and Programs:**
- Texas Military Department members (Army and Air National Guard, State Guard)
### Texas Tech University Health Sciences Center (TTUHSC)

**Populations Served:**
- Children and youth grades 4-12 in Texas public schools

**Eligibility Requirements for Services and Programs:**
- Youth are eligible for telehealth outpatient services if they exhibit serious emotional, behavioral, or substance use disorders.

### Texas Veterans Commission (TVC): Veterans Mental Health Department (VMHD)

**Populations Served:**
- All ages

**Eligibility Requirements for Services and Programs:**
- Fund for Veterans Assistance: Individual grantees define their target populations within the larger population of veterans, their families, and surviving spouses.
- VMHD provides training and technical assistance to state, local, community, and faith-based stakeholders related to the mental health needs of Texas service members, veterans, and their families. VMHD also provides certification, training, and technical assistance to Peer Service Coordinators of the Military Veteran Peer Network and licensed mental health professionals servings as Veteran Counselors.

### Texas Workforce Commission (TWC)

**Populations Served:**
- All Texans with disabilities

**Eligibility Requirements for Services and Programs:**
A person is eligible for vocational rehabilitation services if they:
- Have a disability which results in substantial barriers to employment.
- Require services to prepare for, obtain, retain, or advance in employment.
- Are able to obtain, retain or advance in employment as a result of services.

**Disabilities Served:**
- Behavioral and mental health conditions
- Hearing impairments, including deafness
- Alcoholism or drug addiction
- Intellectual, learning, and developmental disabilities
- Physical disabilities, including traumatic brain and spinal cord injury, back injury, paralysis, and impaired movement
- Vision-related disabilities: blindness, significant visual impairments, and deaf blindness
### University of Texas Health Science Center at Houston (UTHSC-Houston)

<table>
<thead>
<tr>
<th>Populations Served:</th>
<th>Eligibility Requirements for Services and Programs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Children and youth ages 4 to 17 years</td>
<td>• Individuals are eligible for services if they meet clinical criteria for admission to an acute care inpatient psychiatric hospital.</td>
</tr>
<tr>
<td>• Adults ages 18 years and older</td>
<td>• Individuals are eligible for outpatient services if they exhibit serious emotional, behavioral, mental health or substance use disorders.</td>
</tr>
</tbody>
</table>

### University of Texas Health Science Center at Tyler (UTHSC-Tyler)

<table>
<thead>
<tr>
<th>Populations Served:</th>
<th>Eligibility Requirements for Services and Programs:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Programming addresses the shortage of mental health providers in rural and underserved areas.</td>
<td>• The UTHSC-Tyler Mental Health Workforce Training Program supports a Psychiatry Residency, Psychology Internship, and Psychology Post-Doctoral program.</td>
</tr>
<tr>
<td></td>
<td>• There are currently 14 Psychiatry Faculty members and 24 Psychiatry Residents.</td>
</tr>
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<td></td>
<td>• The first residency class will graduate in June 2021.</td>
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<tr>
<td></td>
<td>• There are currently 8 Psychology Faculty members, 10 Psychology Interns, and 6 Post-Doctoral Interns. UTHSC-Tyler will have 2 Advanced Post-Doctoral positions starting this year.</td>
</tr>
<tr>
<td></td>
<td>• Psychiatry residents and psychology interns complete training rotations at Rusk State Hospital and Terrell State Hospital.</td>
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</table>
Appendix D. Successes by SBHCC Agency

SBHCC members have implemented programs and systems that significantly improved behavioral health outcomes. Highlights of these initiatives are listed in this appendix; however, this is not an exhaustive list. The SBHCC publishes annual progress reports that are available online.15

Department of Family and Protective Services

Revision of DFPS Substance Use Policy

DFPS Substance Use Policy was revised after ten years to modify organizational changes, law or regulatory changes, and external partner changes. Through an internal collaboration between legal, policy, field, state, and substance use specialists over a six-month period, DFPS Substance Use Policy was revised to address gaps identified in the original Texas Statewide Behavioral Health Strategic Plan related to service access and coordination. Further, the immediate and long-term impact of the revision to the policy will promote and support behavioral health program and service coordination to ensure continuity of services and access points across state agencies and reduce duplication of effort and maximize resources through program and service coordination. SBHCC members were part of the internal collaboration at DFPS.

DFPS-HHSC Communication Process

DFPS and HHSC identified a barrier in communication between agencies. A DFPS-HHSC Communication Process was developed to better communicate concerns, questions, and issues between agency staff. When requesting information related to the status for a DFPS case, a secure email is sent between agencies to ensure confidentiality. The DFPS-HHSC Communication Process improved gaps related to agency coordination and access to services.

Strengthening and Expanding Family Drug Treatment Courts

DFPS performed targeted work in Nueces County collaborating with the stakeholders of that Family Drug Court system to ensure the court system had both the framework and training to function effectively. Multiple trainings were provided, and the team was connected with other Family Drug Courts to share successes and challenges. The Nueces County court was also referred to federal grant programs to further stabilize the funding and positions necessary for the successful continuation of the court.
Additionally, Williamson County and DFPS worked to establish a Family Recovery Court. The Family Recovery Court applies a non-adversarial, collaborative approach and utilizes a multidisciplinary team including the presiding judge, DFPS, prosecutors, attorneys and guardian’s ad litem, case-managers, treatment providers, and community support services. The Family Recovery Court focuses on cases of abuse or neglect involving parents with substance abuse disorders and other co-occurring disorders. The Family Recovery Court Team supports better outcomes for families involved in these cases by providing problem-solving court services to the child and parents.

**Family-Strengthening Programs that Support Healthy Parenting**

DFPS’s Prevention and Early Intervention division funds family-strengthening programs and initiatives that support healthy parenting relationships and positive conflict resolution while promoting positive outcomes for children, youth, and families. While these programs are aimed at mitigating the need for more intensive interventions, including behavioral health services, they also involve more targeted interventions and referrals when necessary. The Service Members, Veterans, and Families Program provides parenting, education, counseling, and other support services to military families experiencing the stress and uncertainty of a service member’s deployment, return, and coping with symptoms of post-traumatic stress disorder. The Texas Home Visiting program allows communities to implement the Family Connects program model - an evidence-based, universal, home visiting program for families with newborns that links the family to community resources, including behavioral health services, if needed.

**Family First Prevention Services Act Planning**

DFPS is engaged in planning for implementation of the Family First Prevention Services Act (FFPSA), which seeks to reduce entry to foster care, limit the use of congregate care, and to increase access to substance abuse and mental health service. DFPS is working with legislative partners, providers, researchers, and other organizations to develop and implement FFPSA eligible services. As DFPS considers FFPSA implementation, collaboration with HHSC regarding mental health and substance abuse programs is critical.
Public Health Agency Action Plan for Addressing Substance Use in Texas

DSHS used achievements from their Centers for Disease Control and Prevention grant for the state’s public health response to opioid use and stakeholder feedback to develop the Public Health Agency Action Plan for Addressing Substance Use in Texas for 2020-2022.31 The plan details a total of 19 initiatives in three public health areas of focus, including surveillance, education, and resource development. Thus far, 10 of the 19 DSHS action plan initiatives have been completed.

Behavioral Health Matching Grants Programs

Community Mental Health Grant Program

The Community Mental Health Grant (CMHG) Program was originally authorized by H.B. 13, 85th Legislature, Regular Session, 2017, to support community mental health programs providing services and treatment for people experiencing mental illness. The program is designed to foster community collaboration, maximize existing community mental health resources, and strengthen continuity of care for people receiving services through a diverse local provider network. The program is financed with both state general revenue and local funding secured by selected applicants. Matching grants are typically required to either multiply the effects of state funds or help awardees achieve self-sustaining status.

The purpose of the grant program is to:

- Support community programs providing mental health care services and treatment to people with a mental illness; and
- Coordinate mental health care services for people with a mental illness with other transition support services.

During fiscal year 2021, CMHG sites served over 36,000 people, covering 155 counties. Of these sites, 137 were counties with populations under 250,000.116 Figure D-1 shows the distributions of grants for the CMHG Program through fiscal year 2021.
Healthy Community Collaboratives

S.B. 58, 83rd Legislature, Regular Session, 2013 required HHSC to create a grant program according to Texas Government Code, Chapter 539, to establish or expand community collaboratives, which are partnerships that bring the public and private sectors together to provide services to people experiencing homelessness and with mental health and substance use conditions. The sites funded through the Healthy Community Collaborative (HCC) program help participants obtain and maintain housing and employment and achieve substance recovery from mental and substance use disorders.

Initially, collaboratives are expected to leverage matching funds in an amount at least equal to the state grant award. The required match was reduced to 25-50 percent for rural community award recipients, dependent on population size, through modification of Section 539.002(c) of the Government Code by H.B. 3088, 87th Legislature, Regular Session, 2021. Matching funds encourage community
buy-in and commitment, create opportunities for creativity, and can increase the long-term sustainability of services after the grant funding ends.

The Texas Legislature continued funding the HCC program with appropriations for fiscal years 2014 through 2021. S.B. 1849, 85th Legislature, Regular Session, 2017, amended Texas Government Code, Chapter 539, to expand the HCC program into rural or less densely populated areas of the state. Among clients supported across the collaboratives in fiscal year 2021, there was a 23 percent decrease in use of crisis services and a 25 percent decrease in psychiatric hospitalizations.117

The LMHA for Harris County, called the Harris Center, is using part of its HCC grant funding to operationalize the Hospital to Home program. This program supports people who are experiencing homelessness and have behavioral health needs, with emphasis on those discharging from emergency or inpatient psychiatric facilities (principally UT Health Harris County Psychiatric Center and state hospitals). The Hospital to Home program consists of 24 beds that are available to provide rehabilitation services to people experiencing homelessness and have a serious mental illness. The people served receive comprehensive rehabilitation services to help them successfully transition to more permanent housing options. The estimated length of stay in the program is 90-180 days. For fiscal year 2021, 60 people transitioned from the Hospital to Home Program into permanent supportive housing.117

In fiscal year 2021, HHSC completed the second HCC procurement and the HCC Rural Expansion procurement, funding 6 grantees in 11 counties. The original cohort of HCC grantees engaged a total of 33,379 unduplicated people, of which 5,737 were served in a full Texas Resilience and Recovery (TRR) Level of Care at a LMHAs/LBHAs in fiscal year 2021. Outcomes for HCC in fiscal year 2021 included a 23 percent decrease in the number of crisis services, 25 percent decrease in number of HHSC-funded hospitalizations, and 50 percent decrease in the number of crisis services required when people were served in a full TRR Level of Care and HCC services.117

Mental Health Grant Program for Justice-Involved Individuals

S.B. 292, 85th Legislature, Regular Session, 2017, added the Mental Health Grant Program for Justice-Involved Individuals (MHGJII) to Chapter 531, Government Code, Sections 531.0993 and 531.09935. MHGJII reduces recidivism rates, arrests, and incarceration among people with mental illness, as well as the wait time for forensic commitments. These grants fund local collaborative efforts between
counties, mental health authorities, hospital districts, and other designated entities. This program supports community grants by:

- Providing behavioral health care services to people with a mental illness encountering the criminal justice system; and
- Facilitating the local cross-agency coordination of behavioral health, physical health, and jail diversion services for people with mental illness involved in the criminal justice system.

In fiscal year 2021, over 47,000 people were served by the program. Over 6,800 clients with significant needs were diverted to community-based programs.\textsuperscript{118} Figure D-2 shows the distributions of grants for the MHGJII program through fiscal year 2021.

Figure D-2. Distribution of Mental Health Grant Program for Justice-Involved Individuals Sites through Fiscal Year 2021\textsuperscript{118}

\textit{Texas Veterans + Family Alliance Grant Program}
S.B. 55, 84th Legislature, Regular Session, 2015, created the Texas Veterans + Family Alliance (TV+FA) grant program to support communities and to identify and address the mental health needs of veterans and family members through grant-supported projects. Through S.B. 822, 86th Regular Legislative Session, the match requirement was amended for TV+FA grantees. Both bills led to inclusion of TV+FA in Chapter 531, Government Code, Section 531.0992.

There have been five phases of TV+FA grant periods with total awards of over $46 million in state funds to support 74 projects across the state. Through these five phases, 51,575 veterans and family members have been served through grant-funded activities.¹¹⁹

TV+FA-supported treatment and services include:
- Evidence-based therapies and treatment;
- Individual, group, family, and couples peer support services;
- Suicide prevention initiatives to help community members, veterans, and their family members develop awareness and skills in recognizing, assisting, and referring to mental health services;
- Treatment of substance use disorders; and
- Individual and family counseling

TV+FA funding supports activities essential to the provision of mental health services including:
- Family-related services, including childcare;
- Emergency financial support;
- Transportation;
- Housing;
- Infrastructure costs, such as telemedicine equipment; and,
- Training for staff and health care providers, including training in military-cultural competence or evidence-based practices that directly impact the number of veterans and family members served during the grant period.

**Coordinated Specialty Care**

The Coordinated Specialty Care (CSC) program provides outpatient behavioral health services to people ages 15-30 years experiencing an early onset of psychosis. Services are provided via a team-based approach with the goal to empower the person’s ability to lead a self-directed life. The CSC team includes a psychiatrist, a Licensed Professional of the Healing Arts, a Supported Education/Employment Specialist, a Certified Family Partner, and a Certified Peer Specialist. CSC is a time-limited program with a maximum length of stay of three years. At that time, it is anticipated people in the program are discharged out of services or transitioned to the most appropriate level of care. There are currently 24 CSC sites in Texas.

In fiscal year 2021, the Texas CSC programs served 1,059 people. The number of crisis services utilized by CSC clients decreased by 63 percent. Before CSC program
participation, these clients utilized 2,726 crisis services in a year and after participating in the CSC program this decreased to 992 crisis services utilized.\textsuperscript{122}

**Mental Health Texas Website**

MentalHealthTX.org is an SBHCC-sponsored website that serves as a one-stop resource for behavioral health services across the state.\textsuperscript{123} The website interfaces with 2-1-1 Texas to link visitors to behavioral health providers and resources in their communities. SBHCC agency members post information on behavioral health topics and their activities.

**Outreach, Screening, Assessment, and Referral**

Outreach, Screening, Assessment and Referral (OSAR) is a no-cost service available to all Texas residents seeking access to substance use services.\textsuperscript{124} OSAR reduces barriers for people by conducting outreach and offering screenings and assessments, in various community settings and through electronic communication platforms. Through coordinated efforts with other state agencies and contracts with LMHAs/LBHAs, people can receive OSAR services and connect with behavioral health services to meet their individual needs ensuring continuum of care.

OSAR services provide referrals to community resources (e.g., physical health, housing, and peer support services, etc.) to help address any unmet needs. OSAR programs also incorporate peer support services to provide support and increase engagement throughout the continuum of care. There are 14 OSAR service providers across Texas.

OSAR programs have consistently conducted over 34,000 substance use screenings for the past four fiscal years. In fiscal year 2021, OSAR programs achieved and, in some cases, exceeded their outcome targets for referrals to substance use treatment, recovery support services, and mental health services.\textsuperscript{125}

Despite the challenges brought about by COVID-19, OSAR programs were able to maintain collaboration with community partners. In fiscal year 2021, OSAR screened over 12,000 individuals referred by DFPS, conducted outreach activities virtually and at various community locations, cultivated relationships with external stakeholders, and held quarterly calls with regional stakeholders and community partners. In addition, the directors from each of the 14 OSAR programs participated in four quarterly technical assistance calls held by HHSC.\textsuperscript{125}
For fiscal year 2022, the OSAR program has some exciting opportunities they were selected to participate in. The OSAR program will be undergoing an environmental scan to evaluate specific programmatic functions and will be featured on a panel at the Texas Substance Use Symposium in March 2022.125

**Texas Resilience and Recovery**

The Texas Resilience and Recovery (TRR) model for general revenue-funded outpatient mental health services establishes eligibility for services through a uniform assessment; establishes ways to manage the use of services as outlined in the HHSC Utilization Management Guidelines; and measures clinical outcomes or the impact of services. When an LMHA/LBHA is unable to assist a person, they may place the person on a waitlist. The LMHA/LBHA must manage the waitlist according to HHSC’s waitlist guidelines. HHSC staff also seek individualized details from LMHAs/LBHAs with a waitlist to determine the reasons for the waitlist and what actions are being taken to address the need.

As a result of the COVID-19 pandemic, LMHAs/LBHAs increased the use of teleservices. In fiscal year 2021, LMHAs/LBHAs served a total of 227,027 adults (average 96,158 per month) and 65,718 children (average 26,297 per month). For both adults and children, LMHAs/LBHAs exceeded the Texas legislature’s fiscal year 2021 goals for people served despite the public health emergency.126

**Texas Targeted Opioid Response**

Since May 2017, Texas has received more than $280 million in federal funding to fight the opioid crisis through the TTOR program.127 As of August 2021, more than 900,000 people have received prevention, treatment, and recovery support services, including overdose prevention education and naloxone, prescription drug disposal services, workforce training, medication assisted treatment, peer recovery coaching, and overdose-related emergency response services. TTOR services benefit not only people with opioid use disorder, but their family members, partners, and supportive allies as well. Within the justice-involved population, individuals seeking to reenter community life may have access to recovery services but often lack the complete set of resources needed to start a life free of substance use. In fiscal year 2021, TTOR-funded recovery providers continued to offer both direct and indirect recovery supports, including safe storage boxes for medication-assisted treatment prescriptions; bus passes for travel to and from MAT service providers, some of which are over an hour away; alcohol- and substance-free social activities; referrals to clothing closets, food banks, and mental health services; financial assistance for housing, utilities, transportation, and health and wellness
supports, including hygiene products; and access to the Humane Society for pet food. Meeting the immediate needs of these clients by providing a comprehensive set of resources helps save lives and supports a successful return to community life.

**Office of the Governor**

**Adult Drug Court Best Practice Standards**

Texas Government Code Sections 772.0061 and 121 required the Governor’s Criminal Justice Division work with the Specialty Advisory Council to make recommendations for programmatic best practices for specialty courts in Texas. The National Association of Drug Court Professionals conducted a longitudinal study targeting drug courts to identify Adult Drug Court Best Practice Standards. The standards are also widely accepted in the field as generally applicable to all specialty and problem-solving courts. In June 2016, the Texas Judicial Council approved the adoption of the National Association of Drug Court Professionals’ *Adult Drug Court Best Practice Standards*[^128] for all adult drug courts in Texas. The Criminal Justice Division worked with courts to implement the new standards by 2019.

**Texas Commission on Jail Standards**

S.B. 1849, 85th Legislature, Regular Session, 2017 amended Occupations Code 1701.310(a) to require TCJS to provide eight hours of mental health training to all currently licensed jailers by August 31, 2021. TCJS employs one Mental Health Trainer to develop and instruct the course, “Mental Health Training for Jailers.” This program concludes on August 31, 2021, but the agency continues to identify additional areas for which to develop mental health training for jailers.

In 2019, TCJS developed and implemented training course certified by the Texas Commission on Law Enforcement titled, “Suicide Prevention for Jailers”. The course was created to provide jailers with techniques to help prevent suicide attempts. The course also helped county jails satisfy annual training requirements and has been well received. TCJS continues to receive requests from jails across the state to provide the training.
Texas Correctional Office on Offenders with Medical or Mental Impairments, Texas Department of Criminal Justice

Rural Expansion

With additional funding allocated through the 86th Legislature, TCOOMMI was able to increase accessibility of services in rural communities and expand staff in LMHA-TCOOMMI programs. Additionally, intake and telehealth opportunities were expanded allowing the program to bring access to care closer to people involved in the justice system residing in rural communities, resulting in an additional 18 caseloads with allocations for increases to psychiatrist time, medication monitoring, and counseling services. Through rural expansion, additional opportunities were solidified for co-location between criminal justice supervision partners and the LMHAs, resulting in increased communication and partnerships between supervision and treatment as an interdisciplinary treatment team.

TCOOMMI Advisory Committee

TCOOMMI Advisory Committee members and TCOOMMI program staff worked on updates to the Texas Uniform Health Status Form. This form is critical in exchanging both medical and mental health information when a person is transferring between custody in the county jails and the TDCJ. The TCJS was an important partner with the TCOOMMI Advisory Committee’s subcommittee, sending joint messages to jail administrators on the critical nature of this form. This form and the exchange of continuity of care data is important for quality and prompt care between systems.

TCOOMMI Advisory Committee members and TCOOMMI program staff worked to enhance the sharing of information by completing the modifications to the Collection of Information Form, associated with Article 16.22, Texas Code of Criminal Procedure. The form updates resulted from H.B. 601, 86th Legislature, Regular Session, 2019. The form provides critical information on mental health and intellectual disability diagnosis. Upon completion, the form is given to the appropriate magistrate to assist their critical and timely decisions during the criminal justice process.

Texas Department of Housing and Community Affairs

TDHCA operates the Project Access Program and the Section 811 Project Rental Assistance Program by collaborating with HHS and DFPS.
**Project Access**

TDHCA’s Project Access Program assists people with low incomes and disabilities transitioning out of institutions into the community by providing access to affordable housing using federally-funded Housing Choice (Section 8) Vouchers. TDHCA dedicates 140 Housing Choice Vouchers to Project Access. Since the program began in 2003, over 1,702 households have used the voucher program.

Through a pilot project coordinated by TDHCA and HHSC, people relocating from state psychiatric hospitals use 18 of the Project Access Housing Choice Vouchers to transition from state-funded psychiatric hospital beds into the community by providing access to affordable housing. Eligible applicants must meet disability criteria, and either be a current resident of a state-funded psychiatric hospital or have been discharged from a state-funded psychiatric hospital within 60 days of the application date. To date, 140 people were supported with a Project Access Voucher through this pilot program.

**Section 811 Project Rental Assistance**

The Section 811 Project Rental Assistance (PRA) Program is a federally-funded, project-based program that allows TDHCA, HHS, and DFPS to create rental assistance opportunities for people with extremely low incomes with a disability and are eligible to receive services and supports. The program operates through an Interagency Partnership Agreement that commits TDHCA, HHSC, and DFPS to operate the program, meet no less than quarterly to discuss program barriers for the target populations, troubleshoot problems with the long-term services and supports delivery, and discuss any necessary program changes needed to accomplish the program’s objectives. TDHCA has partnerships with 148 properties across the state and has successfully housed 551 households to date. Most people served through the program (92 percent) have been people with serious mental illness referred by LMHAs/LBHAs.

**Texas Indigent Defense Commission, Office of Court Administration**

TIDC improves public defense for people with mental illness by providing grants to counties to establish mental health defender programs; providing technical assistance in the form of planning studies for counties seeking to establish mental health defender programs; providing trainings for attorneys, social workers, and case managers; and issuing publications.
Mental Health Defender Grants

To date in the 2020-2021 biennium, TIDC has awarded $4.7 million in grant funds to 10 Texas counties for programs specifically focused on representation of people with mental illness in criminal cases. Several additional grants for comprehensive indigent defense programs include elements focused on improving representation for clients with mental illness.

Some program highlights from fiscal year 2021 include:

- **Galveston County Misdemeanor Mental Health Public Defender Office:** In 2020, TIDC’s board approved a $780,334 grant for Galveston County to establish a Misdemeanor Mental Health Public Defender Office. The seven-member office will include a Chief Public Defender, two assistant public defenders, two caseworkers and a licensed clinical social worker to represent misdemeanor defendants with mental illness. This multi-disciplinary defense team will fulfill the goal of reducing incarceration, reducing recidivism, and improving treatment outcomes.

- **McLennan County Mental Health Managed Assigned Counsel Program:** In 2020, TIDC’s board approved a $169,280 grant to McLennan County to establish a managed assigned counsel program to improve the representation of defendants with mental illness. The two-person MAC includes an attorney director and case manager. The office will approve, train, and oversee private attorneys representing indigent defendants with mental illness; provide case management services for clients; and ensure that quality representation and services will be provided to clients.

- **The 86th Legislature directed TIDC to make $5 million in grants in fiscal years 2020-2021 to expand programs in existing public defender offices for representing people with mental illness.**

Planning Studies

In 2020, TIDC developed a planning study for the Galveston County Misdemeanor Mental Health Public Defender Office. The County submitted a grant application to establish the office, which was approved, based on this planning study.

Trainings/Workshops

In 2021, TIDC hosted the Juvenile Training Immersion Program (JTIP), in partnership with the Texas Criminal Defense Lawyers Association and the National Juvenile Defender Center. As part of its curriculum, JTIP focuses on youth mental
health through specific trainings on adolescent development and competence to stand trial.

In 2020, TIDC hosted the Indigent Defense Workshop for county stakeholders who work with indigent defense. A session entitled “What’s New? What Works? Effectively Addressing Defendants with Mental Illness,” featured panelists including the Deputy Director from a Managed Assigned Counsel system representing people with mental illness, the TIDC Director of Grant Funding, and Mental Health Statewide Coordinator.

In December 2019, the TIDC Improvement Team attended a Train the Trainer session on the Sequential Intercept Model (SIM), hosted by the Texas Judicial Commission. The SIM Mapping tool helps counties outline their criminal justice processes as it relates to mental health. TIDC staff can now help counties go through this important process.

In November 2019, TIDC hosted the 3rd Texas Roundtable on Representation of Defendants with Mental Illness. This one-day workshop, aligned with the 2019 JCMH Summit, included panels on working effectively with social workers, effective communication with defendants with mental illness, ethics, and using data to document successes and outcomes related to mental health representation.

**Publications**

In October 2018, TIDC published *Texas Mental Health Defender Programs.*\(^{129}\) The publication describes the intersection between the criminal justice and mental health systems, the benefits of mental health defender programs, and the operations of mental health defender programs in Texas, all of which have been established or expanded with TIDC grant funds. The publication is designed to educate judges, county commissioners, and other policymakers on the benefits of coordinated mental health defender operations, including reducing jail populations, reducing competency evaluations, reducing recidivism, improving quality of representation, and improving government efficiency. The publication also describes the components of successful mental health defender programs and their outcomes.

**Texas Juvenile Justice Department**

TJJD increased cross-collaboration with other state agencies, including HHSC and DFPS, to strengthen case coordination and communication. TJJD assists probation departments in case staffing, complex mental health needs, trauma responsive practices, and risk, needs, and responsivity-based interventions. In addition, TJJD
provides funding and assistance to promote the establishment of research-based programming for youth in community-based and residential treatment.

**Texas Military Department**

*Diversity and Resilience Program*

The TMD historically held a quarterly Commanders Ready & Resilient Council (CR2C) made up of departments that support health, wellness, resilience, behavioral health, family assistance and suicide prevention. The intent was to integrate the departments and provide an overall picture of the health of TMD service members to leadership, along with any initiatives and to gain feedback from leadership. TMD is now moving the CR2C towards a larger effort, revamping that council and renaming it the Diversity and Resilience program. The effort will remain the same, but with the intent to reinforce TMD’s “People First” vision and boost trust and respect throughout the ranks, while being more inclusive of the commanders who are intended to execute related programs.

*Army National Guard Substance Abuse Prevention Program*

TMD is using the Army Unit Risk Inventory Survey and the Reintegration Unit Risk Inventory as tools to identify existing high-risk behaviors in units. Survey results aid in targeting education and early intervention strategies that directly contribute to increased readiness and retention. The Texas Army National Guard is incorporating the Army Unit Risk Inventory Survey and Reintegration Unit Risk Inventory report data and the subsequent Risk Mitigation Plans into leadership culture to reduce overall risk and efficiently coordinate risk mitigation resources. TMD counselors are integrated into the Risk Mitigation Plans, providing targeted prevention education, where needed.

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

Campus Alliance for Telehealth Resources

TTUHSC operates Campus Alliance for Telehealth Resources (CATR), a program that delivers expanded mental health services for children and families including services to schools using an Extension for Community Health Outcomes (ECHO®) Model and direct psychiatric treatment when appropriate. CATR is made up of two components: CATR-Services for Professionals and CATR-Services for Students.\(^{19}\)

In addition to the activity described in Section 2, the CATR ECHO® program expanded to provide a collaborative, educational program for community mental and behavioral health professionals who work with youth in the community. In the spring of 2021, CATR-Services for Professionals developed partnerships with Education Service Centers providing 163 participants training in behavioral health concerns of school age children. CATR-Services for Students provides free assessments and short-term treatment of high-risk children and adolescents for 87 school districts in the Panhandle and West Texas areas of the state. From August 2020 through April 2021, the CATR program at TTUHSC received over 387 student referrals from partnering school districts.\(^{19}\)

Texas Veterans Commission

VMHD Reporting Tool

TVC’s VMHD collaborated with TexVet and HHSC to develop and implement a new online SMVF Engagement Activity Reporting Tool for use by the Military Veteran Peer Network (MVPN). The impact of this new reporting tool has reduced hours spent on data entry and increased reporting efficiency by giving VPN Peer Service Coordinators and Peer Volunteers the ability to report real-time interactions with veterans in need of assistance directly from their mobile devices as they occur.

Texas Workforce Commission

TWC’s Vocational Rehabilitation Division (VRD) created five major initiatives that began on fiscal year 2021 and will continue through fiscal year 2022 to enhance and update services for Vocational Rehabilitation (VR) customers experiencing a behavioral health disability. The initiatives will better align VR services with the Mental Health Individual Placement and Support (IPS) model. IPS is an evidence-based practice model of supported employment services for people with serious
mental illness that uses work as part of active treatment. The initiatives include the following:

- **Update framework for VR services:** TWC’s VRD received technical assistance to review policies and make recommendations for change to develop a new framework for delivery of VR services for people with behavioral health conditions.

- **Remove sobriety clause from VR Services Manual:** The sobriety clause was removed from the VR Services Manual to reduce exclusion and remove obstacles to services.

- **Explore Mental Health Peer Support model:** VR Services staff are receiving training on the peer support model related to obtaining, maintaining, and advancing employment. VRD will identify funding to support certification of eligible customers as Peer Support Specialists.

- **Pilot Clubhouse Model at employment service providers:** TWC VRD is partnering with Clubhouse Texas to develop a model for establishing Employment Service Provider sites at existing recovery clubhouses, integrating vocational rehabilitation and behavioral health supports.

- **Expand access to Wellness Recovery Action Plan:** The Wellness Recovery Action Plan (WRAP) is a prevention and wellness process designed to help people with serious mental illness who are in recovery reach their goals, including employment. While WRAP services have been available for several years, VR Services has very few certified WRAP providers. A webinar will be developed to introduce VR Services staff to WRAP to promote use of the service.
Appendix E. Inventory of Behavioral Health Programs and Services by Agency

The inventory describes how the identified programs, services, initiatives, and expenditures will further the goals of the strategic plan and outlines behavioral health programs and services to be provided by SBHCC agencies for fiscal year 2022.

Court of Criminal Appeals (GAA, Article IV)

The Court of Criminal Appeals does not deliver these services directly. These services are funded by CCA but delivered by other organizations.

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<tr>
<th>Services &amp; Appropriation Strategies</th>
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</thead>
<tbody>
<tr>
<td>Judicial and Court Personnel Mental Health Education and Training; Judicial Education; Strategy B.1.1.</td>
<td>Judges and court personnel from all courts in the state of Texas (appellate, district, county, justice of the peace, and municipal), prosecuting attorneys, and criminal defense attorneys.</td>
<td>The programs follow a master strategic plan to assist criminal justice stakeholders in identifying, assessing, and providing proper treatment of alleged offenders with mental deficiencies. The programs encompass an appreciation for mental health disorders, treatment options, and relative enactments designed to facilitate proper treatment, deferment, or placement of mentally impaired people. An across-the-board approach to statewide mental health behavioral problems will allow all stakeholders to understand the roles of all involved as to best address the needs of our citizens.</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Post-Adoption/Post-Permanency Purchased Services; Strategy B.1.5</td>
<td>Children and youth at risk of re-entering conservatorship following an adoption.</td>
<td>Provide payments to contractors for short-term residential behavioral health services to provide families with critical supports to promote permanency and reduce re-entry into the foster care system and dissolution of consummated adoptions.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
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</table>
| Substance Abuse Prevention and Treatment Services; Strategy B.1.7 | Families who either have a child in foster care or are receiving in-home family-based safety services due to the high-risk of having a child removed and placed in foster care absent preventive measures. | Provide payments to contractors for substance abuse prevention and treatment services (education, counseling, and treatment) delivered to families where needs were not met by HHSC services. Services may include:  
- Substance abuse assessment and diagnostic consultation.  
- Individual, group and/or family substance abuse counseling and therapy, including home-based therapy. | no                     | yes                    | no                   | yes                 | no                  | no      | no          | no                  | no    |
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<tr>
<td>Counseling and Therapeutic Services; Strategy B.1.8</td>
<td>Families who need assistance to facilitate the achievement of the child's or family's service plan. Services are provided to children who are in substitute care, children who remain in their homes, and to their caregivers and families including those in family-based safety services. Provide payments to contractors for counseling and therapeutic services delivered to meet service plan needs, where not met by STAR Health or other services. Services may include: - Psychological testing, psychiatric evaluation, and psychosocial assessments. - Individual, group, and/or family counseling and therapy, including home-based therapy.</td>
<td>no</td>
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<tr>
<td>Adult Protective Services (APS) Emergency Client Services; Strategy D.1.3</td>
<td>Persons 65 and older and adults 18 to 64 with a disability in APS cases that are receiving services, and their family members. Provide payments to contractors for mental health services to assess capacity and meet service plan needs where services are not already provided through HHSC or other funding sources.</td>
<td>no</td>
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<td>yes</td>
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</table>
| Prevention and Early Intervention Services; Strategy C | Families in communities identified as having a high level of maltreatment risk factors including poverty, instability, poor health outcomes, substance abuse, and mental illness, targeted for voluntary prevention and family-strengthening programs. | Fund family-strengthening programs and initiatives that support healthy parenting relationships and positive conflict resolution while promoting positive outcomes for children, youth, and families to:  
- Mitigate the need for more intensive interventions.  
- Make referrals and offer complementary auxiliary support to families. | yes | yes | yes | no | no | no | no | yes | no |
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<tr>
<th>Department of State Health Services (GAA, Article II)</th>
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<td><strong>Services &amp; Appropriation Strategies</strong></td>
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<tr>
<td>Texas Center for Infectious Disease (TCID) Behavioral Health Services; A.2.5; Mental Health Services; Inpatient</td>
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<tr>
<td>HIV Care Services, Ryan White Part B HIV Grant Program; A.2.2; Substance Use Disorder Services; Outpatient</td>
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<td><strong>Services &amp; Appropriation Strategies</strong></td>
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<td>Services &amp; Appropriation Strategies</td>
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<tr>
<td>Maternal and Child Health Programs; B.1.1; Research</td>
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<td>Services &amp; Appropriation Strategies</td>
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<tr>
<td>Article II, Department of State Health Services; Specialized Health and Social Services; B.1.1 primary; A.3.3; and A.4.1; Mental Health Services; Other</td>
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## Health and Human Services Commission (GAA, Article II)

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<tr>
<td>Community Mental Health Services for Adults; Strategy D.2.1</td>
<td>Adults with mental illness</td>
<td>Support adults in their movement toward independence and recovery through the provision of an array of community-based services. Examples include medication-related services, rehabilitation services, counseling, case management, peer support services, crisis intervention services, and special programs such as Clubhouses and services provided throughout the Texas Targeted Opioid Response.</td>
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<td>1915(i) Home and Community Based Services (HCBS); Strategy D.2.5</td>
<td>Adults with extended tenure in state mental health facilities, high utilization of emergency room, and/or frequent incarcerations.</td>
<td>Support the recovery of adults with extended tenure in state mental health facilities, high utilization of emergency rooms, and/or frequent incarcerations by providing intensive wrap-around home and community-based services. People enrolled in HCBS-Adult Mental Health (AMH) are eligible for all Medicaid behavioral health services as well as those specific to the HCBS-AMH program, such as supervised living services, home modifications, home delivered meals, and transportation services.</td>
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<td>Community Mental Health Services for Children; Strategy D.2.2</td>
<td>Children and adolescents (ages 3 through 17) with serious emotional disturbance</td>
<td>Improve the mental health and well-being of children and youth experiencing serious emotional disturbances through the provision of community mental health services that are child-centered, family-driven that can increase children's strengths and supports, and foster resilience, recovery and functioning in the family, school, and community. Examples of the services provided include assessment, case management, psychosocial rehabilitation, skills training, counseling, family support services, and crisis intervention services.</td>
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<tr>
<td>Relinquishment Slots (DFPS); Exceptional Item 6c, Strategy D.2.2</td>
<td>Children and youth ages 5 to 17 referred to DFPS who are at risk for parental relinquishment of rights</td>
<td>Provide intensive residential treatment for children and youth referred to DFPS who are at risk for parental relinquishment of rights solely due to a lack of mental health resources to meet the needs of children with severe emotional disturbance whose symptoms make it unsafe for the family to care for the child in the home.</td>
<td>yes</td>
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<tr>
<td>YES Waiver; Strategy D.2.5</td>
<td>Children at risk of hospitalization or parental relinquishment due to a need for services to treat serious emotional disturbance (SED).</td>
<td>Provide intensive wrap-around services, including community living supports, family supports, flexible funding for transition services, minor home modifications, adaptive aids and supports, respite, specialized therapies, and paraprofessional services. Children enrolled in YES are eligible for all Medicaid behavioral health services as well as those that are specific to the YES service array.</td>
<td>no</td>
<td>yes</td>
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<tr>
<td>Community Mental Health Crisis Services; Strategy D.2.3</td>
<td>Adults and children with mental illness or in crisis and at risk of unnecessary hospitalization, incarceration, or use of emergency rooms.</td>
<td>Provide an array of community crisis services in the least restrictive environment and ensure statewide access to crisis hotlines, mobile crisis response, and facility-based crisis services, including community-based competency restoration services and other specialized projects to support persons in periods of crisis. Goals also include preventing the utilization of more intensive services.</td>
<td>yes</td>
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<td>Jail-Based Competency; Community Mental Health Crisis Services; Strategy D.2.3</td>
<td>Defendants in county jails participating in the program and people first not able to be served in outpatient competency restoration in designated pilot site.</td>
<td>Implement a pilot project to provide competency restoration services for people in a county jail setting.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Substance Abuse Prevention; Strategy D.2.4</td>
<td>Primarily youth and young adult populations. Some services target risk factors and some are aimed at the general population.</td>
<td>Reduce the use of alcohol, tobacco, and other drugs among youth and adults and prevent substance abuse problems from developing. Prevention services include community and school-based services including but not limited to: Youth Prevention Programs, Adult Prevention, Community Coalitions Programs, Strategic Prevention Framework Partnership for Success, and prevention services targeting opioid use and prescription misuse.</td>
<td>yes</td>
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| Substance Abuse Intervention; Strategy D.2.4 | Targeted people who are at risk or high risk of substance use. | - Reduce substance use and/or substance use effects to target populations. Outreach, Screening, Assessment and Referral (OSAR) Centers provide coordinated access to a continuum of substance use disorder services.  
- Parenting Awareness and Drug Risk Education (PADRE) programs provide community-based, gender-specific services to parenting males and expecting fathers who at risk for involvement or currently involved with child welfare who use substances.  
- Pregnant and Postpartum Intervention (PPI) programs provide community-based, gender-specific intervention and outreach services for pregnant, postpartum, and parenting females who use substances.  
- Rural Border Intervention (RBI) programs provide integrated prevention and intervention services through coordinated care to members of the rural border communities who are using substances.  
- Community Health Worker (CHW) programs increase access to existing behavioral and physical health services for marginalized communities. | yes | yes | yes | no | no | no | no | no | no | no | no |
<p>| Substance Abuse Treatment; Strategy D.2.4 | Adults (18 and above) who are diagnosed with a substance use disorder. Youth (aged 13-17) diagnosed with a substance use disorder. | State-funded substance use disorder treatment services serve youth and adults. For youth, residential and outpatient services are available. For adults, detoxification, residential, and outpatient services are available. | no | yes | yes | yes | no | yes | no | no | no | no |</p>
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<td>Recovery; Strategy D.2.4</td>
<td>Recovery support service organizations provide services to increase long-term recovery and recovery quality. Services are provided by peers.</td>
<td>In 2014, HHSC issued a competitive bid to provide recovery support services to people with substance use disorders. The goals of the initiative include: 1. embedding long-term recovery support services into peer-based organizations, community-based organizations, and substance use disorder treatment programs in local communities across Texas; and 2. expanding the recovery supports that are available to people in their natural community environments. Services include a wide array of non-clinical services and supports to help people initiate, support, and maintain recovery from alcohol and other drug use problems. One of the key elements of in the project was the recruitment and utilization of recovery support peer specialists. Services also included peer-run Recovery Support Services increase the prevalence and quality of long-term recovery from substance use disorders by enhancing quality of life and increased social connections through sustained long-term engagement.</td>
<td>yes</td>
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<td>Substance Abuse: Neonatal Abstinence Syndrome (NAS); Strategy D.2.4</td>
<td>Pregnant women who use opioids, including certain prescription medications, during pregnancy, possibly causing NAS.</td>
<td>Reduce the incidence, severity, and costs associated with NAS. This project supports a range of health care services, products, and community-based activities.</td>
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<tr>
<td>Community Mental Health Crisis Services; Strategy D.2.3.</td>
<td>People involved in the criminal justice system with a serious and persistent mental illness</td>
<td>Statewide Diversion Grant Program. Reduce recidivism rates, arrests, and incarceration among people with mental illness and reduce wait times for forensic commitments. This is a matching grant program to support community projects that provide services and programs for people with mental illness encountering the criminal justice system.</td>
<td>yes</td>
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<tr>
<td>Community Mental Health Crisis Services; Strategy D.2.3.</td>
<td>Children in the foster care system</td>
<td>Targeted Case Management and Services for Foster Care Children Grant. Increase access to targeted case management (TCM) and psychiatric rehabilitative services for high-needs children in the foster care system. This is a grant program to fund LMHAs and other nonprofit entities making investments to become providers of these services or to increase their capacity to provide these services to children in foster care in the Intense Service Level.</td>
<td>no</td>
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<td>Mental Health Community Hospital Beds; Strategy G.2.2</td>
<td>People experiencing mental illness</td>
<td>Community Mental Health Grant (CMHG) Program. Funding to improve and increase the availability of and access to mental health services and treatment for people with mental illness and coordinate mental health care services with other transition support services. This is a matching grant program to support community collaboratives.</td>
<td>yes</td>
<td>yes</td>
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<td>Intellectual and Developmental Disability (IDD) Crisis Respite and Behavioral Intervention Programs; Strategy A.1.1</td>
<td>People with intellectual and developmental disabilities (IDD) who have significant behavioral and psychiatric challenges.</td>
<td>Outpatient Biopsychosocial approach for IDD services (OBI) offers security of services that will meet individual’s long-term needs. These services provide: • Evidence-based biopsychosocial approach to care including a person-centered and trauma-informed treatment plan; • Education and training on co-occurring IDD and mental health conditions to practitioners in mental health, substance use, or other related fields to establish, expand, or enhance Community-based Crisis Services; • Holistic case management approach focused on increasing access and creating a team of medical, psychiatric, mental health and paraprofessionals to address the person’s unique needs; and • Both the person and their support system mental wellness support and skills training.</td>
<td>yes</td>
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<td>Crisis Intervention Services:</td>
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<td>• Intervention for individuals experiencing a crisis and linking to other LIDDA supports like the Transition Support Team;</td>
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<td>• Follow-up care to monitor and provide support to people with IDD who received crisis services; and</td>
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<td>• Support to existing crisis mobile units (such as a Mobile Crisis Outreach Team [MCOT]) to include the availability of a behavioral specialist who is specifically trained on addressing crisis situations with people with IDD/Developmental Disability (DD).</td>
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<td>Crisis Respite Services:</td>
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<td>• Provides people with IDD in crisis with access to temporary stabilization through in-home or out-of-home crisis respite services</td>
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<td>• Crisis respite services for people with IDD/DD and IDD/Mental Illness which excludes mental illness only.</td>
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| Community providers and LIDDA's who serve people with IDD at risk of being admitted into an institution, and those who have moved from institutional settings, including state supported living centers (SSLCS) and nursing facilities (NFs). | Provide the following:  
- Quarterly educational activities, webinars, videos, and other correspondence, to increase the expertise of LIDDA and provider staff in supporting the targeted population.  
- Technical assistance, upon request from LIDDA's and providers, on specific disorders and diseases, with examples of best practices and evidence-based services for people with significant medical, behavioral, and psychiatric challenges.  
- De-identified (as necessary) case-specific peer review support to service planning teams that need assistance planning and providing effective care for an individual. | yes | no | no | no | no | no | no | yes | no |
| People with IDD residing in an institution, such as an SSLC or NF, who are transitioning to a community Medicaid waiver program or community Intermediate Care Facilities for People with an Intellectual Disability or Related Conditions (ICF/IID). | Provide information to:  
- The individual and the individual's legally authorized representative (LAR) about available community living options, services, and supports, in addition to the information provided during the community living options process;  
- The individual and LAR are provided opportunities to visit community resources;  
- The individual is provided intensive and flexible support to achieve success in a community setting; and  
- The individual is provided enhanced pre- and post-transition services. | no | no | yes | no | no | no | no | no | no |
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<td>Mental Health Wellness for Individuals with IDD (MHW-IDD); CMS Grant Funded Initiative</td>
<td>Direct service workers who support people with IDD with behavioral health needs. People with IDD who have behavioral health needs and co-occurring mental illness (MI).</td>
<td>Provide eLearning courses designed to support the enhancement and development of a highly skilled workforce staff (i.e., direct support workers, clinicians, and physicians) to support the behavioral health needs of people with an IDD and a co-occurring mental health condition; and promote their successful placements in community settings of their choice.</td>
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<td>Community Resource Coordination Group (CRCG) Program Support (Information Technology); Strategy A.1.1</td>
<td>People (children, youth, and adults) with complex needs (physical, health, social, behavioral, emotional, and/or developmental ) which can best be addressed through a coordinated multiagency approach.</td>
<td>• Provide complex, individualized service planning utilizing local resources and interagency coordination and collaboration. Local CRCG members identify service gaps and barriers and assist CRCG consumers in avoiding duplication in service provision through local CRCGs. • Provide program oversight, technical assistance, training support, and policy guidance, subject matter expertise to local CRCGs through State CRCG Office and Workgroup. The State CRCG Workgroup is made up of the 11 state agencies mandated to participate in CRCG service planning and coordination at the state and local level.</td>
<td>yes</td>
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<td>Rio Grande State Center Outpatient Clinic; Strategy G.1.3</td>
<td>Adults living in the lower Rio Grande Valley in four counties: Cameron, Hidalgo, Willacy, and Starr.</td>
<td>Provide the following: • A physical health care clinic that also makes referrals to local mental health authorities for mental health services. • Funding includes all Rio Grande State Center (RGSC) activity and not just activity related directly to behavioral health.</td>
<td>no</td>
<td>yes</td>
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<td>Repair and Renovation of Mental Health Facilities; Strategy G.4.2</td>
<td>State Hospital Infrastructure</td>
<td>Repair, renovate, and construct projects required to maintain the state's 10 psychiatric hospitals at acceptable levels of effectiveness and safety.</td>
<td>no</td>
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| System of Care Expansion; Strategy A.1.1 | Children or youth who have mental health difficulties or other behavioral challenges and are at risk of out-of-home placement due to their mental health condition. Families of these children or youth. | Implement the System of Care (SOC) cross-systems framework through a five-year strategic plan to local communities throughout the state with support of state child/youth agency leadership and advice from additional stakeholders.  
- Expand from pilot/demonstration to statewide implementation for developing local systems of care.  
- Maintain and implement a comprehensive strategic plan and supportive infrastructure for statewide delivery of mental health services and supports to children and families using a collaborative SOC framework or approach, increasing:  
  - Access to services and supports  
  - Community implementation capacity  
  - Use of cross-system data  
  - Diverse funding opportunities | yes                    | no                     | yes                   | no                | yes                | no                 | yes          | yes        | yes                  | yes   |
| Mental Health Program for Veterans; Strategy D.2.1.1, Community Mental Health Services for Adults | Texas service members, veterans, their families | Mental Health Program for Veterans is collaboratively implemented by HHSC and TVC and supports providing:  
- Peer-to-peer counseling  
- Access to licensed mental health professionals  
- Peer training and technical assistance  
- Jail diversion services  
- Identification, retention, and screening of community-based licensed mental health professionals  
- Suicide prevention training for coordinator and peers  
- Promotion of engagement of faith-based organizations | yes                    | yes                   | yes                   | yes                | no                 | yes                | yes          | yes        | yes                  | no    |
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<td>Children’s Health Insurance Program (CHIP); Strategy C.1.1</td>
<td>CHIP provides health coverage to low-income, uninsured children in families with incomes too high to qualify for Medicaid. CHIP is administered by CMS and is jointly funded by the federal government and the states. CHIP covers children in families who have too much income to qualify for Medicaid but cannot afford to buy private insurance.</td>
<td>Inpatient mental health services, including for serious mental illness, furnished in a free-standing psychiatric hospital, psychiatric units of general acute care hospitals, and state-operated facilities. Outpatient mental health services, including for serious mental illness, provided on an outpatient basis, including, but not limited to: • Neuropsychological and psychological testing • Medication management • Rehabilitative day treatments • Residential treatment services • Sub-acute outpatient services (partial hospitalization or rehabilitative day treatment) • Skills training (psycho-educational skill development) Inpatient substance abuse treatment services including but not limited to residential substance abuse treatment services including detoxification and crisis stabilization, and 24-hour residential rehabilitation programs. Outpatient substance abuse treatment services including: • Prevention and intervention services that are provided by physician and non-physician providers, such as screening, assessment, and referral for chemical dependency disorders • Intensive outpatient services • Partial hospitalization</td>
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| STAR                              | Pregnant women, families, newborns, and children with limited income | Benefits include:  
• Mental health targeted case management  
• Mental health rehabilitation  
• Individual, family & group psychotherapy  
• Psychological, neuropsychological, and neurobehavioral testing  
• Psychiatric diagnostic evaluation  
• Pharmacological management  
• Electroconvulsive therapy  
• Substance use disorder (SUD) assessment/evaluation  
• SUD - outpatient, residential and inpatient withdrawal management  
• SUD - individual and group counseling  
• SUD - residential treatment  
• Medication assisted treatment (e.g., methadone for opioid addiction)  
• Screening, Brief Intervention, and Referral to Treatment (SBIRT) (10 years of age and older)  
• Inpatient psychiatric services  
• Health and Behavior Assessment and Intervention (HBAI) services (children/adolescents)  
• Peer specialist services for substance use disorder or mental health condition (adults ages 21 and older) | yes | yes | yes | yes | yes | no | yes | yes | no |


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<td>STAR+PLUS</td>
<td>People who are age 65 or older and adults with disabilities receive services through a managed care organizations (MCOs) under contract with the HHSC.</td>
<td>The Medicaid STAR+PLUS program provides acute care services plus long-term services and supports (LTSS) by integrating primary care, pharmacy services, and LTSS. Benefits include: • Mental health targeted case management • Mental health rehabilitation • Individual, family &amp; group psychotherapy • Psychological, neuropsychological, and neurobehavioral testing • Psychiatric diagnostic evaluation • Pharmacological management • Electroconvulsive therapy • Substance use disorder (SUD) assessment/evaluation • SUD - outpatient, residential and inpatient withdrawal management • SUD - individual and group counseling • SUD - residential treatment • Medication assisted treatment (e.g., methadone for opioid addiction) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) (10 years of age and older) • Inpatient psychiatric services • Health and Behavior Assessment and Intervention (HBAI) services (children/adolescents) • Peer specialist services for substance use disorder or mental health condition (adults ages 21 and older)</td>
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<td>STAR Kids</td>
<td>Children and young adults age 20 or younger who have disabilities receive most of their services through managed care organizations (MCOs) under contract with the HHSC.</td>
<td>STAR Kids is a managed care program that provides Medicaid-covered acute care and community-based long-term services &amp; supports to children and young adults age 20 or younger with disabilities. Benefits include: • Mental health targeted case management • Mental health rehabilitation • Individual, family &amp; group psychotherapy • Psychological, neuropsychological, and neurobehavioral testing • Psychiatric diagnostic evaluation • Pharmacological management • Electroconvulsive therapy • Substance use disorder (SUD) assessment/evaluation • SUD - outpatient, residential and inpatient withdrawal management • SUD - individual and group counseling • SUD - residential treatment • Medication assisted treatment (e.g., methadone for opioid addiction) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) (10 years of age and older) • Inpatient psychiatric services • Health and Behavior Assessment and Intervention (HBAI) services (children/adolescents)</td>
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<td>STAR Health</td>
<td>Children and youth in conservator-ship of DFPS, including those in foster care and kinship care. Services are delivered through a single Managed Care Organizations (MCO) under contract with HHSC.</td>
<td>Other qualifications include:  • Young adults aged 18 through the month of their 22nd birthday who voluntarily agree to continue in a foster care placement also qualify for STAR Health;  • Young adults aged 18 through the month of their 21st birthday who are participating in the Former Foster Care Children (FFCC) program or are participating in the Medicaid for Transitioning Foster Care Youth (MTFCY) Program due to ineligibility for the FFCC program;  • Children and youth with disabilities who are participating in the DFPS Adoption Assistance or Permanency Care Assistance programs; and  • An infant born to a Medicaid-eligible mother enrolled in STAR Health MCO. STAR Health is a statewide program designed to provide medical, dental, vision, and behavioral health benefits, including unlimited prescriptions. • Mental health targeted case management • Mental health rehabilitation • Individual, family &amp; group psychotherapy • Psychological, neuropsychological, and neurobehavioral testing • Psychiatric diagnostic evaluation • Pharmacological management • Electroconvulsive therapy • Substance use disorder (SUD) assessment/evaluation • SUD - outpatient, residential and inpatient withdrawal management • SUD - individual and group counseling • SUD - residential treatment • Medication assisted treatment (e.g., methadone for opioid addiction) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) (10 years of age and older) • Inpatient psychiatric services • Health and Behavior Assessment and Intervention (HBAD) services (children/adolescents) • Peer specialist services for substance use disorder or mental health condition (adults ages 21 and older)</td>
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<td>Medicaid Fee for Service</td>
<td>Some Medicaid clients are served through a traditional fee-for-service (FFS) delivery system. Health care providers are paid for each service they provide, such as an office visit, test, or procedure. The FFS model allows access to any Medicaid provider. The provider submits claims directly to the Texas Medicaid claims administrator for reimbursement of Medicaid covered services.</td>
<td>Services include: • Mental health targeted case management • Mental health rehabilitation • Individual, family &amp; group psychotherapy • Psychological, neuropsychological, and neurobehavioral testing • Psychiatric diagnostic evaluation • Pharmacological management • Electroconvulsive therapy • Substance use disorder (SUD) assessment/evaluation • SUD - outpatient, residential and inpatient withdrawal management • SUD - individual and group counseling • SUD - residential treatment • Medication assisted treatment (e.g., methadone for opioid addiction) • Screening, Brief Intervention, and Referral to Treatment (SBIRT) (10 years of age and older) • Inpatient psychiatric services • Health and Behavior Assessment and Intervention (HBAI) services (children/adolescents) • Peer specialist services for substance use disorder or mental health condition (adults ages 21 and older)</td>
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<td>yes*</td>
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| Healthy Texas Women (HTW) Plus     | HTW Plus is an enhanced postpartum services package. HTW clients who have been pregnant in the 12 months prior to HTW enrollment are eligible to receive additional HTW Plus services to treat certain health conditions including behavioral health conditions, like postpartum depression or substance use disorders. Services include:  
• Individual, family & group psychotherapy  
• Pharmacological management*  
• Substance use disorder SUD assessment/evaluation  
• SUD - individual and group counseling  
• Medication assisted treatment (e.g., methadone for opioid addiction)  
• Screening, Brief Intervention, and Referral to Treatment (SBIRT)  
• Peer specialist services for substance use disorder or mental health condition (adults aged 21 and over)  
• Postpartum depression screening and treatment*  
*Office visits including mental health screenings and antidepressant medications are covered in the core HTW benefit package rather than HTW Plus. | yes | yes | no | yes | no | no | no | no | no | no | no |

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### Board of Dental Examiners

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| Peer Assistance Program; Strategy A.1.2 | Dentists impaired by chemical dependency or mental illness. | Provide services to impaired dentists to support recovery and monitor people to allow for continued employment and prevent unsafe professional practice:  
- Monitor impaired dentists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery.  
- Identify dentists with a potential impairment and coordinate evaluation to assess impairment for dentists.  
- Provide referrals to qualified mental health professionals to evaluate and provide mental health services to dentists, including treatment and counseling.  
- Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services.  
- Allow for self-referral of dentists to access mental health services in a confidential manner through a support agreement without professional disciplinary action.  
- Provide crisis intervention through peer assistance program. | no | no | no | no | no | no | no | no | no | yes |
### Board of Nursing

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| Peer Assistance Program; Strategy B.1.2 | Registered and licensed vocational nurses, whose practice is impaired or suspected of being impaired by chemical dependency, mental illness, or diminished mental capacity. | Provide services to registered and licensed vocational nurses, whose practice is impaired or suspected of being impaired by chemical dependency, mental illness, or diminished mental capacity. Texas Peer Assistance Program for Nurses (TPAPN) identifies, monitors, and assists with locating appropriate treatment so that they may return to practice safe nursing.  
- Statewide peer advocacy  
- Statewide monitoring  
- A network of trained peer volunteer advocates  
- Physical and psychological evaluations  
- Substance abuse treatment  
- Drug screening  
- Individual and group psychotherapy | yes | no | yes | no | no | no | yes | no | no |

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| Peer Assistance Program; Strategy B.1.2 | Pharmacists or eligible pharmacy students impaired by chemical abuse or mental or physical illness. | Provide services to impaired pharmacists to support recovery and monitor people to allow for continued employment, prevent unsafe professional practice:  
- Monitor impaired pharmacists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery.  
- Identify pharmacists with a potential impairment and coordinate evaluation to assess impairment for pharmacists.  
- Provide referrals to qualified mental health professionals to evaluate and provide mental health services to pharmacists, including treatment and counseling.  
- Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services.  
- Allow for self-referral of pharmacists to access mental health services in a confidential manner through a support agreement without professional disciplinary action.  
- Provide crisis intervention through peer assistance program. | no | no | no | no | no | no | no | yes | yes |
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</table>
| Peer Assistance Program; Strategy A.2.2 | Veterinarians impaired by chemical dependency or mental illness. | Provide services to impaired veterinarians to support recovery and monitor people to allow for continued employment and prevent unsafe professional practice:  
- Monitor impaired veterinarians to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery.  
- Identify veterinarians with a potential impairment and coordinate evaluation to assess impairment for veterinarians.  
- Provide referrals to qualified mental health professionals to evaluate and provide mental health services to veterinarians, including treatment and counseling.  
- Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services.  
- Allow for self-referral of veterinarians to access mental health services in a confidential manner through a support agreement without professional disciplinary action.  
- Provide crisis intervention through peer assistance program. | no | no | no | no | no | no | no | no | yes | yes |
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<tr>
<td>Physician Health Program; Strategy B.1.2</td>
<td>Licensees of the Medical Board and associated boards (physicians, physician assistants, acupuncturists, and surgical assistants).</td>
<td>Provide for the oversight and monitoring of licensees who may have a substance abuse disorder, mental health issue, or physical illness or impairment that has the potential to compromise a licensee's ability to practice.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
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</table>
| Peer Assistance Program; Strategy A.1.4 | Optometrists impaired by chemical abuse or mental or physical illness. | Provide services to impaired optometrists to support recovery and monitor people to allow for continued employment and prevent unsafe professional practice:  
  • Monitor impaired optometrists to ensure safe practice and allow for rehabilitation for the professional to enter safe, healthy recovery.  
  • Identify optometrists with a potential impairment and coordinate evaluation to assess impairment for optometrists.  
  • Provide referrals to qualified mental health professionals to evaluate and provide mental health services to optometrists, including treatment and counseling.  
  • Coordinate treatment among mental health professionals to ensure proper and efficient treatment and services.  
  • Allow for self-referral of optometrists to access mental health services in a confidential manner through a support agreement without professional disciplinary action.  
  • Provide crisis intervention through peer assistance program. | no | no | no | no | no | no | no | no | no | yes |
### Officer of the Governor, Trusteed Programs (GAA, Article I)

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<tr>
<td>Violence Against Women; Mental Health Services; Strategy B.1.1</td>
<td>Women charged who have been identified through testing as suffering from a substance abuse or mental health problem.</td>
<td>Provide grant funding to local governments and non-profit corporations to provide mental health services to victims of crime.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
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<td>yes</td>
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<tr>
<td>Crime Victim Assistance; Mental Health Services; Strategy B.1.1</td>
<td>Adults and juveniles who have been identified through testing as suffering from a substance abuse or mental health problem.</td>
<td>Provide grant funding to local governments and non-profit corporations to provide mental health services to victims of crime.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Criminal Justice / Residential Substance Abuse Treatment; Strategy B.1.1</td>
<td>Adults and juveniles charged with an offense who have been identified through testing as suffering from a substance abuse problem.</td>
<td>Provide direct treatment services to the eligible offender populations of state agencies, counties, and community supervision and corrections departments operating secure correctional facilities.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Criminal Justice / Specialty Courts; Strategy B.1.1</td>
<td>Adults (charges include Drug/Driving While Intoxicated (DWI), Mental Health related, Veteran, Family, and Commercially Sexually Exploited Persons) and juveniles charged with a nonviolent offense and who are suffering from substance abuse or mental health problem.</td>
<td>Provide grant funds to counties, judicial districts, or juvenile boards to support Specialty Courts (Drug/DWI, Mental Health, Veteran, Family, and Commercially Sexually Exploited Persons). Services provided by the drug court programs include intense supervision, drug testing, counseling and therapy, and case management.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Criminal Justice / Juvenile Justice and Delinquency Program; Strategy B.1.1</td>
<td>At-risk youth and juveniles who have had contact with the juvenile justice system. Local communities with a high population of mentally ill or population suffering from substance abuse problems.</td>
<td>Provide grant funding to local communities and non-profit organizations to improve the juvenile and adult criminal justice system in a variety of ways, including increased access to mental health and substance abuse programs. Services include: • Early Intervention and Prevention activities and services such as academic tutoring, truancy, suspension, and expulsion prevention services. • Substance abuse, alcohol, and mental health prevention services. • Work awareness and training projects. • Diversion activities to prevent youth from further involvement in the juvenile justice system.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Edward Byrne Memorial Justice Assistance; Mental Health Services; Strategy B.1.1</td>
<td>Adults and juveniles charged with an offense who have been identified through testing as suffering from a substance abuse or mental health problem.</td>
<td>Provide grant funding to states and local governments to improve the administration of the criminal justice system to include substance abuse treatment and mental health services.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Child Psychiatry Access Network (CPAN)</td>
<td>Children and adolescents.</td>
<td>Network of child psychiatry access centers that provides consultation services and training opportunities to pediatricians and primary care providers operating in each center’s geographical region to support them in providing better care for children and youth with behavioral health needs.</td>
<td>no</td>
<td>yes</td>
<td>no</td>
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<td>no</td>
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<tr>
<td>Texas Child Health Access Through Telemedicine (TCHATT)</td>
<td>Children and adolescents.</td>
<td>Creates or expands telemedicine or telehealth programs to identify and assess the behavioral health needs of at-risk children and youth, providing short-term, school-based access to mental health services. It aims to maximize the number of school districts served in diverse regions of Texas.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Community Psychiatry Workforce Expansion</td>
<td>Children and adolescents.</td>
<td>Funds community psychiatric workforce expansion projects through partnerships between health-related institutions of higher education and community mental health providers. It develops training opportunities for residents and supervising residents.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Child and Adolescent Psychiatry (CAP) Fellowships</td>
<td>Children and adolescents.</td>
<td>Funds additional child and adolescent psychiatry fellowship positions at health-related institutions of higher education.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Centralized Operations Support Hub</td>
<td>Children and adolescents.</td>
<td>Provides centralized communications and data management systems to health-related institutions providing services through Child Psychiatry Access Network (CPAN), Texas Child Health Access Through Telemedicine (TCHATT) and Community Psychiatry Workforce Expansion. Provides high level coordination and facilitates collaboration between physicians providing CPAN and TCHATT consultations through a Medical Director position.</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Sexually Violent Predator Mental Health Services; Strategy M.1.1</td>
<td>Sexually violent predators who suffer from a behavioral abnormality which is not amenable to traditional mental health treatment modalities. A portion of the sexually violent predators have concurrent mental health diagnoses that require traditional mental health or substance abuse treatment.</td>
<td>Provide and/or contract for behavioral health services, for clients in the community, which include but are not limited to: • Substance abuse treatment • Assessments • Psychiatric case management • Medication • Rehabilitation • Counseling • Crisis services • Psychiatric hospitalization • Other related services</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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Provide and/or contract for behavioral health services, for clients in the community, which include but are not limited to:

- Substance abuse treatment
- Assessments
- Psychiatric case management
- Medication
- Rehabilitation
- Counseling
- Crisis services
- Psychiatric hospitalization
- Other related services

Execute contracts to provide behavioral health services for the identified areas of need in order to provide services for civilly committed sex offenders who reside in the community.
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</table>
| Sexually Violent Predator Mental Health Services; Strategy M.1.1 | Sexually violent predators who suffer from a behavioral abnormality which is not amenable to traditional mental health treatment modalities. A portion of the sexually violent predators have concurrent mental health diagnoses that require substance abuse treatment. | Provide and/or contract for behavioral health services, for clients in the Texas Civil Commitment Center, which include but are not limited to:  
- Substance abuse treatment  
- Assessments  
- Substance abuse testing  
- Rehabilitation  
- Other related services  
Execute contracts to provide behavioral health services for the identified areas of need in order to provide services for civilly committed sex offenders who reside in the Texas Civil Commitment Center. | yes | yes | yes | yes | no | no | yes | no | no |
## Services & Appropriation Strategies

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<td>Training for County Jailers; Strategy A.2.2</td>
<td>All current county jailers.</td>
<td>One full-time employee for the agency allocated for the Mental Health Trainer position, assigned to the Management Consultation strategy. The trainer will provide training to county jailers statewide regarding mental health issues, ranging from initial screening to observation while in custody to release from the jail facility.</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Peer Support Network, Technical Assistance; Strategy B.1.2</td>
<td>Appointed peace officers of Municipal police departments, county law enforcement agencies, and Texas Dept. of Public Safety</td>
<td>TCOLE will subcontract with the Caruth Police Institute at The University of North Texas Dallas to do the following:  • Recruit peers throughout the regional catchment area to serve as volunteer peers.  • Provide TCOLE-approved peer training to volunteer peers in person and virtually.  • Provide app registration codes to approved volunteer peers.  • Coordinate peer network events throughout the region and provide calendar events to the Network Coordinator to be placed on the App at TCOLE.  • Market the network throughout the region to departments and officers.  • Identify and recruit culturally appropriate clinical providers to become members of the network providing low-cost services to first responders.  • Keep deidentified statistics.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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<td>Diversion Programs / Specialized Mental Health Caseloads; Strategy A.1.2</td>
<td>Defendants on probation.</td>
<td>Support specialized community supervision caseloads for offenders with mental health disorders.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Diversion Programs / Discretionary Grants – Substance Abuse Programs; Strategy A.1.2</td>
<td>Defendants on probation.</td>
<td>Provide grants to local adult probation departments for outpatient programs to divert offenders with substance abuse disorders from further court action and/or prison.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>yes</td>
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<tr>
<td>Diversion Programs / Discretionary Grants – Substance Abuse Programs; Strategy A.1.2</td>
<td>Defendants on probation.</td>
<td>Provide grants to local adult probation departments to divert offenders with substance abuse disorders from prison through residential beds for substance abuse treatment.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Diversion Programs / Substance Abuse Felony Punishment Facilities (SAFPF) Aftercare; Strategy A.1.2</td>
<td>Defendants on probation.</td>
<td>Provide funding to local adult probation departments for continuum of care management services and aftercare outpatient counseling for felony substance abuse probationers after their release from a TDCJ SAFPF.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>Community Corrections; Strategy A.1.3</td>
<td>Defendants on probation.</td>
<td>Provide formula funding to Community Supervision and Corrections Departments for substance abuse services to serve primarily as diversions from prison.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Treatment Alternatives to Incarceration Program; Strategy A.1.4</td>
<td>Defendants on probation.</td>
<td>Provide grants to local adult probation departments for treatment to divert offenders from incarceration, including screening, evaluation, and referrals to appropriate services.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Special Needs Programs and Services / TCOOMMI – Adult; Strategy B.1.1</td>
<td>Adult incarcerated inmates, paroled clients, defendants on probation, pre-trial defendants.</td>
<td>Provide grants for community-based treatment programs, funding a continuity of care program and responsive system for local referrals from various entities for adult offenders with special needs (serious mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities).</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>yes</td>
<td>yes</td>
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<tr>
<td>Special Needs Programs and Services / TCOOMMI – Juvenile; Strategy B.1.1</td>
<td>Juvenile detainees, incarcerated juveniles, paroled juveniles, juveniles on probation, discharged youth.</td>
<td>Provide grants for community-based treatment programs, funding a continuity of care program and responsive system for local referrals from various entities for juvenile offenders with special needs (serious mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities).</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Unit and Psychiatric Care; Strategy C.1.8</td>
<td>Incarcerated inmates.</td>
<td>Provide mental health care for incarcerated inmates.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Managed Health Care – Pharmacy; Strategy C.1.10</td>
<td>Incarcerated inmates.</td>
<td>Provide pharmacy services, both preventive and medically-necessary care, consistent with standards of good medical practice for mental health cases.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Treatment Services / Parole Special Needs; Strategy C.2.3</td>
<td>Paroled clients.</td>
<td>Provide specialized parole supervision and services for clients with mental illness, intellectual disabilities, developmental disabilities, terminal illness, and physical disabilities. Provide subsidized psychological counseling to sex offenders.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Treatment Services / Sex Offender Treatment Program; Strategy C.2.3</td>
<td>Incarcerated inmates.</td>
<td>Provide sex offender education for lower risk inmates, though a four-month program addressing healthy sexuality, anger management, and other areas. Provide sex offender treatment for higher risk inmates, through a 9-month or 18-month intensive program using a cognitive-behavioral model.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Reentry Initiatives / Transitional Coordinators; Strategy C.2.3.</td>
<td>Incarcerated inmates.</td>
<td>Provide for 10 designated reentry transitional coordinators for special needs inmates.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Substance Abuse Felony Punishment Facilities (SAFPF); Strategy C.2.4</td>
<td>Incarcerated inmates.</td>
<td>Provide a six-month substance abuse program for inmates (nine-months for inmates with special needs) who are sentenced by a judge as a condition of community supervision or as a modification to parole or community supervision. Upon completion of the incarcerated phase, clients must complete a Transitional Treatment Center for residential and outpatient care/counseling.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>In-Prison Substance Abuse Treatment &amp; Coordination; Strategy C.2.5</td>
<td>Incarcerated inmates.</td>
<td>Provide a six-month substance abuse program for inmates within six months of parole release. Upon completion of the incarcerated phase, clients must complete a Transitional Treatment Center for residential and outpatient care/counseling.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Driving While Intoxicated (DWI) Treatment; Strategy C.2.5</td>
<td>Incarcerated inmates.</td>
<td>Provide a six-month program that offers a variety of educational modules that accommodate the diversity of needs presented in the DWI inmate population, including treatment activities, and group and individual therapy.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<td>no</td>
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<tr>
<td>State Jail Substance Abuse Treatment; Strategy C.2.5</td>
<td>Incarcerated inmates.</td>
<td>Provide a substance abuse program for inmates who have been convicted of a broad range of offenses and are within four months of release. The program is designed to meet the needs of the diverse characteristics of TDCJ’s state jail population.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Substance Abuse Treatment and Coordination; Strategy C.2.5</td>
<td>Incarcerated inmates.</td>
<td>Provide support services for pre-release substance abuse facilities, to include alcoholism and drug counseling, treatment programs, and continuity of care services.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Parole Supervision; Strategy E.2.1.</td>
<td>Paroled clients.</td>
<td>Provide outpatient substance abuse counseling to parolees.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Intermediate Sanction Facility Treatment; Strategy E.2.3</td>
<td>Paroled clients.</td>
<td>Provide substance abuse and or cognitive treatment slots for Intermediate Sanction Facility beds.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<tr>
<td>Project Access; Strategy A.15</td>
<td>Low income persons with disabilities transitioning out of institutions.</td>
<td>Assist low-income persons with disabilities in transitioning from institutions into the community by providing Section 8 Housing Choice vouchers. Program administratively supported in part by Money Follows the Person funds and program coordinated with HHSC.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Section 811; Strategy A.1.6</td>
<td>People with disabilities living in institutions, people with serious mental illness, and youth and young adults with disabilities exiting foster care receiving services through DFPS.</td>
<td>Provide project-based rental assistance for extremely low-income people with disabilities linked with voluntary long-term services through HHSC or DFPS. Program coordinated via an Interagency Agreement with HHSC.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
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</tbody>
</table>
The Texas Indigent Defense Commission does not deliver these services directly. These services are funded by TIDC but delivered by other organizations.

| Services & Appropriation Strategies | Target Population | Goal/ Services Description                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     | Prevention / Promotion | Screening / Assessment | Service Coordination | Treatment / Rehab. | Psychosocial Rehab. | Housing | Employment | Crisis Intervention | Other |
|-------------------------------------|-------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------|------------------------|------------------------|-------------------|-------------------|-----------------|------------|------------|-------------------|-------|
| Improve Indigent Defense Practices and Procedures; Strategy D.1.1 | Adults and juveniles with mental illness or IDD charged with crimes who cannot afford to hire defense counsel. | Grant program to assist counties in setting up & operating specialized mental health indigent defense programs to improve outcomes, cut unnecessary jail days, and reduce recidivism. Provide specialized attorneys and social workers to address criminal charges in the context of mental health needs, connect defendants with supports that stabilize them, and address the causes of the conduct that led to criminal charges. Social workers or case workers may provide case coordination, jail release planning, service referrals, mitigation investigations and other support and advocacy to help stabilize defendants in the community, improve case outcomes. | no                     | yes                    | yes                     | no                | no                | no               | no         | no         | no                | yes   |
## Texas Juvenile Justice Department (GAA, Article V)

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>Probation Grants: Special Needs Diversionary Program; Strategy A.1.3</td>
<td>Juvenile offenders under the jurisdiction of a juvenile probation department</td>
<td>Provide grants to probation departments for mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
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<tr>
<td>Probation Grants: Community Programs; Strategy A.1.3</td>
<td>Juvenile offenders under the jurisdiction of a juvenile probation department</td>
<td>Provide assistance to local juvenile probation departments for community-based services for misdemeanors, enhanced community-based services for felonies, and other behavioral health programs.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
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<tr>
<td>Probation Grants: Commitment Diversion Initiatives; Strategy A.1.5</td>
<td>Juvenile offenders under the jurisdiction of a juvenile probation department</td>
<td>Funding to local juvenile probation departments for community-based and/or residential alternatives to commitment to state residential facilities.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>Probation Grants: Mental Health Services; Strategy A.1.7</td>
<td>Juvenile offenders under the jurisdiction of a juvenile probation department</td>
<td>Provide grants and technical assistance to local juvenile probation departments for mental health services.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
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<tr>
<td>Probation Grants; Regional Diversion Alternatives; Strategy A.1.8.</td>
<td>Juvenile offenders under the jurisdiction of a juvenile probation department</td>
<td>Provide discretionary grants to local juvenile probation departments to build additional mental health resources.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
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<tr>
<td>State Programs: Psychiatric (Mental Health) Services; Strategy B.1.1</td>
<td>Youth at the intake and orientation unit with mental health problems who require psychiatric treatment and psychotropic medication and/or require a comprehensive psychiatric evaluation based on the assignment of a 12 Minimum Length of Stay or longer.</td>
<td>Psychiatric services provided by contract psychiatric providers for services to youth who are assigned to intake and assessment unit.</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>State Programs: Psychiatric (Mental Health) Services; Strategy B.1.7</td>
<td>Juveniles in residential care who are receiving ongoing psychiatric services as part of their rehabilitation program. Youth are assigned to any of the state-operated programs.</td>
<td>Psychiatric services provided by contract psychiatric providers for services to youth who are assigned to TJJD residential facilities.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
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<tr>
<td>State Programs: General Rehabilitation Treatment; Strategy B.1.8</td>
<td>Juveniles in state-operated residential care except orientation and assessment and the designated mental health residential treatment center.</td>
<td>Support all rehabilitation treatment services to target population including case management, correctional counseling, ongoing assessment of risk and protective factors, case planning, review by Youth Service Team (YST), crisis intervention and management, reintegration planning and family involvement.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
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<td>State Programs: Specialized Rehabilitation Treatment; Strategy B.1.8</td>
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<tr>
<td>Juveniles in state-operated residential care except orientation and assessment who require specialized treatment services in addition to general rehabilitation treatment.</td>
<td>TJJD administers four specialized treatment programs: sexual behavior, capital and serious violent offender, alcohol/other drug, and mental health programs. 99% of youth entering TJJD have a need for one or more of these programs. Services include assessment, group and/or individual counseling, YST collaboration, and re-integration planning, which are provided by licensed or those under the supervision of a licensed clinician.</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
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<th>State Programs: Parole Programs and Services; Strategy C.1.2</th>
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<tr>
<td>Juveniles who have been released from residential programs to parole and who require aftercare services in addition to general parole services. A youth may reside in an approved home or home substitute while receiving aftercare services.</td>
<td>Youth who have completed specialized treatment in residential placements required aftercare services in those areas as a condition of their parole in order to improve outcomes.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
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</table>
| Mental Health Services; Strategy C.1.3 | Texas Military Department members (Texas Army National Guard, Texas Air National Guard, and Texas State Guard) | • Provide mental health and counseling services on the topics of stress, anxiety, depression, anger, grief, family/relationship problems, and more.  
• Develop support plans for TMD service members.  
• Respond to critical incidents and provide post-vention care.  
• Coordinate with TMD unit leadership to support behavioral health awareness and wellness promotion plans.  
• Conduct behavioral health training for TMD.  
• Provide support through the 24/7 Counseling Line.  
• Coordinate with Texas Military Forces (TXMF) Family Support Services (FSS) programs to offer holistic care to TMD Service members.  
• Assist and execute plans for behavioral health assistance to TMD Service members during disaster response missions.  
• Provide appropriate referrals to care for non TMD service members (dependents, veterans, non-TMD service members). | yes | yes | yes | yes | yes | yes | no | no | yes |


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</table>
| Mental Health Services; Sexual Assault Response Counselor; Strategy C.1.3 | Texas Military Department members (Texas Army National Guard, Texas Air National Guard, and Texas State Guard) and service members’ surviving family | • Provide mental health and counseling services on the topics of stress, anxiety, depression, anger, grief, family/relationship problems, and more.  
• Develop support plans for TMD service members.  
• Facilitates individual and group counseling sessions for survivors of domestic and/or sexual violence as a priority, supporting general behavioral health counseling as needed.  
• Facilitate individual and group violence intervention sessions for military sexual offenders.  
• Coordinate with TMD unit leadership to support behavioral health awareness and wellness promotion plans.  
• Conduct behavioral health training for TMD.  
• Coordinate with TXMF Family Support Services (FSS) programs to offer holistic care to TMD Service members.  
• Assist and execute plans for behavioral health assistance to TMD Service members during disaster response missions.  
• Provide appropriate referrals to care for non TMD service members (dependents, veterans, non-TMD service members). | yes | yes | yes | yes | yes | yes | no | no | yes |
## Texas School for the Deaf (GAA, Article III)

<table>
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<th>Psychosocial Rehab.</th>
<th>Housing</th>
<th>Employment</th>
<th>Crisis Intervention</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Related &amp; Support Services, A.1.3</td>
<td>Deaf and Hard of Hearing students and Residential Services staff</td>
<td>Provide Mental Health Counselor (State Classification: Health Specialist VI) to support the mental health needs of our deaf and hard of hearing students during evening hours through risk assessments, increased services and interventions and mental health training.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
</tr>
</tbody>
</table>


<table>
<thead>
<tr>
<th>Services &amp; Appropriation Strategies</th>
<th>Target Population</th>
<th>Goal/ Services Description</th>
<th>Prevention / Promotion</th>
<th>Screening / Assessment</th>
<th>Service Coordination</th>
<th>Treatment / Rehab.</th>
<th>Psychosocial Rehab.</th>
<th>Housing</th>
<th>Employment</th>
<th>Crisis Intervention</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rural Health Care; Strategy D.4.1.</td>
<td>Children and adolescents in rural school districts</td>
<td>The Campus Alliance for Telehealth Resources (CATR) program seeks to improve the mental health of communities across West Texas through partnership with independent school districts. CATR improves access to mental health care expertise through free, time-limited mental health services to youth in need of urgent behavioral or emotional assessment and care. The CATR ECHO® Program will create community learning collaboratives among participating schools, increase learning experience in virtual communities, expand force multiplication through interprofessional practice, and improve outcomes.</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
<tr>
<td>Services &amp; Appropriation Strategies</td>
<td>Target Population</td>
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<td>Treatment / Rehab.</td>
<td>Psychosocial Rehab.</td>
<td>Housing</td>
<td>Employment</td>
<td>Crisis Intervention</td>
<td>Other</td>
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</tr>
<tr>
<td>Veteran Mental Health Grants; Texas Veterans Commission (TVC) Strategy B.1.1.1 General Assistance Grants</td>
<td>Texas veterans, their families, and survivors.</td>
<td>Fund for Veterans Assistance Grants provides assistance to veterans, their families, and survivors by making grants to local nonprofit organizations and units of local governments providing direct services.</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Veterans Mental Health Department (VMHD), Texas Veterans Commission (TVC) Strategy A.1.4. Veterans Outreach</td>
<td>Texas service members, veterans, their families.</td>
<td>The Veterans Mental Health Department (VMHD) of TVC provides multiple trainings on veteran mental health needs including military trauma, suicide prevention, military cultural competency/military-informed care; provides certification and technical assistance to the Military Veteran Peer Network (MVPN) made up of peer service coordinators and peer volunteers who connect veterans and their families to local resources to address mental health needs including military trauma. VMHD also provides training and technical assistance to community-based licensed mental health professionals, community-based organizations, and faith-based organizations; and coordinates services for justice-involved veterans involved in veteran treatment courts and criminal justice settings.</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
<td>yes</td>
</tr>
<tr>
<td>Services &amp; Appropriation Strategies</td>
<td>Target Population</td>
<td>Goal/ Services Description</td>
<td>Prevention / Promotion</td>
<td>Screening / Assessment</td>
<td>Service Coordination</td>
<td>Treatment / Rehab.</td>
<td>Psychosocial Rehab.</td>
<td>Housing</td>
<td>Employment</td>
<td>Crisis Intervention</td>
<td>Other</td>
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</tr>
<tr>
<td>Vocational Rehabilitation; Strategy A.2.1</td>
<td>All Texans with disabilities including people with behavioral health disorders or IDD.</td>
<td>Workforce Solutions Vocational Rehabilitation Services provides services for people with disabilities to help them prepare for, obtain, retain, or advance in employment.</td>
<td>no</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>yes</td>
<td>no</td>
<td>no</td>
</tr>
<tr>
<td>Services &amp; Appropriation Strategies</td>
<td>Target Population</td>
<td>Goal/ Services Description</td>
<td>Prevention / Promotion</td>
<td>Screening / Assessment</td>
<td>Service Coordination</td>
<td>Treatment / Rehab.</td>
<td>Psychosocial Rehab.</td>
<td>Housing</td>
<td>Employment</td>
<td>Crisis Intervention</td>
<td>Other</td>
</tr>
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<td>------------</td>
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</tr>
</tbody>
</table>
| Psychiatric Services [UTHealth Department of Psychiatry & Behavioral Sciences] | Adults and children with mental health issues treatable in outpatient settings, including UT Physicians Clinics, Harris Health, and integrated-care community-health centers | This strategy is an Article III appropriation for research. The other services listed below are not funded through a state appropriation:  
  - Provide outpatient care for people with mental illness.  
  - Implement clinical training and interventions to enhance the ability and capacity to treat mental illness.  
  - Conduct evidence-based research to allow for long-term follow-up with validation of treatment and its effect. | yes | yes | yes | yes | yes | no | no | yes | no |
| UTHealth Harris County Psychiatric Center | Adults and children assessed with mental health disorders (includes non-resource funding, i.e., state or county funds) |  
  - Funding for the services listed comes through a state appropriation to DSHS in Article II.  
  - Provide acute inpatient care with screening, stabilization, and planning for aftercare services.  
  - Educate professionals in the fields of nursing, medicine, pharmacy, psychology, and social work.  
  - Conduct research into the treatment of mental illness. | no | yes | yes | yes | yes | no | no | yes | no |
<table>
<thead>
<tr>
<th>Services &amp; Appropriation Strategies</th>
<th>Target Population</th>
<th>Goal/ Services Description</th>
<th>Prevention / Promotion</th>
<th>Screening / Assessment</th>
<th>Service Coordination</th>
<th>Treatment / Rehab.</th>
<th>Psychosocial Rehab.</th>
<th>Housing</th>
<th>Employment</th>
<th>Crisis Intervention</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Training Programs; Strategy D.1.2</td>
<td>Psychiatry residents, Psychology interns, and other mental health professionals and providers</td>
<td>This strategy does not fund direct patient services; it funds new educational programs designed to increase the mental health workforce in rural underserved areas. Strategy D.1.2 provides funding for workforce training programs. Residents complete rotations in underserved areas including, but not limited to, Rusk State Hospital and Terrell State Hospital.</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>no</td>
<td>yes</td>
</tr>
</tbody>
</table>
Appendix F. Behavioral Health 2020 Survey Data Summary

The SBHCC administered an online survey in 2016 to inform the first Texas Statewide Behavioral Health Strategic Plan. The survey asked members of the public to indicate the strengths, weaknesses, opportunities, and threats of the state-delivered behavioral health system in Texas. A minor variation on the survey was administered in 2018 to update the state assessment. In 2020, the SBHCC administered a new survey to gather input from the public to use in the development of the second edition of the Texas Statewide Behavioral Health Strategic Plan. The 2020 Behavioral Health Strategic Plan Survey had a similar scope and framework to make limited comparisons to the results of the 2018 Survey.

Survey Promotion and Administration

The SBHCC hosted the 2020 Survey. The survey was designed to be completed by any person involved in the behavioral health system in Texas, including:
- People who have used state-delivered behavioral health services;
- Caregivers, family members, and friends of people who have used services;
- Direct behavioral health service providers; and
- People who work for behavioral health advocacy, support, or service organizations and agencies.

The survey was promoted by SBHCC member agencies throughout the state using a variety of channels, including:
- Announcements for behavioral health services recipients;
- Website and social media announcements;
- Notices directed to LMHAs, LIDDAAs, and MCOs; and
- Agency advisory committees.

The survey was hosted using an online platform and a general web link was provided for use by anyone who wanted to take the survey. The survey was open for responses from November 8 - 21, 2020.

Response Rate and Methods

A total of 3,059 people initiated the survey. Any respondents who did not complete at least one opinion question were not included in the analysis. After removing blank surveys and those without opinion responses, the final pool of surveys for analysis included 2,211 respondents.
Gap Questions

Development

The first Texas Statewide Behavioral Health Strategic Plan, published in 2016, identified 15 gaps within the Texas behavioral health system. These gaps were identified based on expert knowledge of the system and feedback from external stakeholders.

To assess progress related to these gaps, the 2020 Survey developed questions aimed at assessing stakeholder perceptions about which gaps were still present in the Texas behavioral health system. Each of the fifteen gaps included in the 2016 Strategic Plan were worded as positive statements in the survey (see Table F-1 for each 2016 Strategic Plan gap and the corresponding 2020 Survey statement). Participants were then asked how strongly they agreed or disagreed with the statement using a four-point Likert type scale.

Table F-1. Gaps Assessed in 2020 Survey

<table>
<thead>
<tr>
<th>Full Item</th>
<th>Abbreviation/Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>There are enough behavioral health workers to support the needs of people in Texas</td>
<td>Enough Behavioral Health Workers</td>
</tr>
<tr>
<td>People with behavioral health conditions have secure housing options</td>
<td>Secure Housing Options Available</td>
</tr>
<tr>
<td>There are enough transportation resources for people to get to their behavioral health services</td>
<td>Enough Transportation to Get to Services</td>
</tr>
<tr>
<td>Public school students get the behavioral health services they need at school</td>
<td>Public School Students Needs Met</td>
</tr>
<tr>
<td>People released from prison or jail continue to get behavioral health services if needed</td>
<td>Behavioral Health (BH) Services Continued After Incarceration</td>
</tr>
<tr>
<td>Adequate peer support services are available in the community</td>
<td>Peer Support Available in Community</td>
</tr>
<tr>
<td>People are able to get substance use treatment services when they need them</td>
<td>Timely Substance Use (SU) Treatment</td>
</tr>
<tr>
<td>Full Item</td>
<td>Abbreviation/Domain</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>People are able to get the behavioral health services that best meet their needs</td>
<td>Behavioral Health (BH) Services Meet Needs</td>
</tr>
<tr>
<td>Veterans and military service members get the long-term, community behavioral health services they need</td>
<td>Veterans/Military Members Get Community Services</td>
</tr>
<tr>
<td>People with intellectual and developmental disabilities can get mental health or substance use services when they need are needed</td>
<td>People with IDD Get Needed Mental Health (MH) and Substance Use (SU) Services</td>
</tr>
<tr>
<td>State agencies and local service providers coordinate well on behavioral health services</td>
<td>State and Local Coordination on Services</td>
</tr>
<tr>
<td>People’s behavioral health needs are identified quickly</td>
<td>Quick Needs Identification</td>
</tr>
<tr>
<td>Community-based behavioral health services are available for people with distinct needs (examples: people with disabilities, mothers with postpartum depression, people who were incarcerated)</td>
<td>Community Services Available for People with Distinct Needs</td>
</tr>
<tr>
<td>State agencies and local service providers share useful data</td>
<td>Agencies and Providers Share Data</td>
</tr>
<tr>
<td>Behavioral health service providers implement evidence-based practices whenever possible</td>
<td>Evidence-Based Practices Implemented</td>
</tr>
</tbody>
</table>

**Analysis**

To analyze the strategic plan gap questions, which were rated on a four-point Likert type scale from “Strongly Agree” to “Strongly Disagree,” horizontal bar graphs were constructed to reflect the percentage of respondents who selected a given option for the question. Dark green was used to show the percentage who selected “Strongly Agree,” light green was used to show the percentage who selected “Agree,” light red was used to show the percentage who selected “Disagree,” and dark red was used to show the percentage who selected “Strongly Disagree.” This coloring made it easy to see the percentage of people who selected one of the four options, as well as quickly compare the percentage who agreed overall (selected “Agree” or “Strongly Agree”) with the percentage who disagreed overall (selected...
“Disagree” or “Strongly Disagree”). The gaps were then ranked from most overall agreement to least overall agreement for display in the graph.
**SWOT Questions**

**Development**

In 2018, a survey was administered to update the first *Texas Statewide Behavioral Health Strategic Plan*. The survey asked four open-ended questions about the strengths and weaknesses within the behavioral health system and opportunities and threats facing the system. This permitted what is otherwise known as a “SWOT” analysis, because it captures internal strengths and weaknesses and external opportunities and threats. There were 409 total responses for the 2018 survey.

For the 2020 Survey, a survey designer reviewed the 2018 responses to create response categories. Categorical responses are quantifiable and were used to improve the content validity of questions used for the 2020 Survey. The response categories were identified using the open-ended responses from the 2018 Survey, which provided a template for developing a survey instrument with measurable responses. It also provided an opportunity to compare responses by survey year moving forward. Responses could be placed into multiple categories, as appropriate.

After the 2018 responses were categorized, the survey design team calculated the percentage of responses that could be represented by each category. The team then discussed appropriate cutoffs for category exclusion. Strengths, opportunities, and threats categories used a cut-off of 10 percent, meaning if a category had less than 10 percent of the responses classified under it, it was removed from the list of categories. Weaknesses used the same method but had a cut-off of 15 percent. This left 9 categories each for strengths, weaknesses, opportunities, and threats. Further discussion among the survey design team resulted in additional categories being included in the weakness, opportunities, and threats areas. Two categories were added to the weakness areas, six categories were added to the opportunities area, and two were added to the threats area. These categories formed the pre-defined options for participants to select from for the 2020 Strengths, Weaknesses, Opportunities, and Threats survey questions. There were no open-ended response options on the 2020 Survey. Table F-2 through F-5 below show the categories derived from the 2018 Survey and the categories included in the 2020 Survey.

Participants were then asked in four separate questions to select all the options they felt were strengths given all of the strengths options, weaknesses given all of the weaknesses options, opportunities given all of the opportunity’s options, and threats given all of the threat’s options (see Tables F-2 through F-5). Selecting the
item indicated the participant agreed that the item was a strength, weakness, opportunity, or threat in the given context.

**Table F-2. Strengths Topics Assessed**

<table>
<thead>
<tr>
<th>Strengths - Full Item</th>
<th>Abbreviation/Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>People can access behavioral health services when they need them</td>
<td>Access</td>
</tr>
<tr>
<td>Collaboration between state agencies and local behavioral health providers</td>
<td>Collaboration</td>
</tr>
<tr>
<td>Consistency or standardization of care</td>
<td>Standardization of Care</td>
</tr>
<tr>
<td>Funding to support behavioral health services</td>
<td>Funding</td>
</tr>
<tr>
<td>State government’s awareness of need for behavioral health services</td>
<td>Government Awareness</td>
</tr>
<tr>
<td>Local control of behavioral health resources</td>
<td>Local Control</td>
</tr>
<tr>
<td>Availability of peer services</td>
<td>Peer Services</td>
</tr>
<tr>
<td>Care is focused on the person</td>
<td>Person-centered</td>
</tr>
<tr>
<td>Service providers are dedicated to people’s care</td>
<td>Workforce</td>
</tr>
</tbody>
</table>

**Table F-3. Weaknesses Topics Assessed**

<table>
<thead>
<tr>
<th>Weaknesses - Full Item</th>
<th>Abbreviation/Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty accessing services</td>
<td>Access</td>
</tr>
<tr>
<td>Affordability of services</td>
<td>Affordable</td>
</tr>
<tr>
<td>Lack of collaboration between service providers and state agencies</td>
<td>Collaboration</td>
</tr>
</tbody>
</table>
### Weaknesses - Full Item

<table>
<thead>
<tr>
<th>Weaknesses - Full Item</th>
<th>Abbreviation/Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not enough funding for behavioral health services</td>
<td>Funding</td>
</tr>
<tr>
<td>Lack of government awareness of the need for behavioral health services</td>
<td>Government Awareness</td>
</tr>
<tr>
<td>Lack of coverage for some services</td>
<td>Insurance Coverage</td>
</tr>
<tr>
<td>Services are not focused on the person</td>
<td>Person-centered</td>
</tr>
<tr>
<td>Behavioral health workforce or provider shortage</td>
<td>Workforce</td>
</tr>
<tr>
<td>Lack of resources for providers to offer range of services to the community</td>
<td>Resources</td>
</tr>
<tr>
<td>Poor behavioral health service quality</td>
<td>Quality</td>
</tr>
<tr>
<td>Lack of data sharing</td>
<td>Data Sharing</td>
</tr>
</tbody>
</table>

### Table F-4. Opportunities Topics Assessed

<table>
<thead>
<tr>
<th>Opportunities - Full Item</th>
<th>Abbreviation/Domain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enhance behavioral health service accessibility</td>
<td>Accessible</td>
</tr>
<tr>
<td>Attract more behavioral health service providers</td>
<td>Attract Providers</td>
</tr>
<tr>
<td>Improve communication with the public</td>
<td>Communication</td>
</tr>
<tr>
<td>Create a comprehensive range of behavioral health services (or continuum of care)</td>
<td>Continuum of Care</td>
</tr>
<tr>
<td>Prevent disruptions in care (or continuity of care)</td>
<td>Continuity of Care</td>
</tr>
<tr>
<td>Opportunities - Full Item</td>
<td>Abbreviation/Domain</td>
</tr>
<tr>
<td>------------------------------------------------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Improve data sharing</td>
<td>Data Sharing</td>
</tr>
<tr>
<td>Make services easier to find</td>
<td>Service Navigation</td>
</tr>
<tr>
<td>Increase funding to support more behavioral health services</td>
<td>Funding</td>
</tr>
<tr>
<td>Expand service provider roles and responsibilities to permit care for more people</td>
<td>Provider Roles</td>
</tr>
<tr>
<td>Provide additional support for vulnerable populations</td>
<td>Vulnerable</td>
</tr>
<tr>
<td>Increase inpatient behavioral health services</td>
<td>Inpatient Services</td>
</tr>
<tr>
<td>Expand use of telehealth technology</td>
<td>Telehealth</td>
</tr>
<tr>
<td>Increase availability of crisis intervention services</td>
<td>Crisis</td>
</tr>
<tr>
<td>Increase access to housing for people with behavioral health issues</td>
<td>Housing</td>
</tr>
<tr>
<td>Improve use of justice diversion options</td>
<td>Justice Diversion</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Table F-5. Threats Topics Assessed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Threats - Full Item</td>
</tr>
<tr>
<td>Inability to get transportation to service locations</td>
</tr>
<tr>
<td>Services are too expensive</td>
</tr>
<tr>
<td>Reduction of funding to support behavioral health services</td>
</tr>
<tr>
<td>Threats - Full Item</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>Lack of insurance for services needed</td>
</tr>
<tr>
<td>Increased demand for behavioral health services</td>
</tr>
<tr>
<td>Lack of political support for funding and services</td>
</tr>
<tr>
<td>Poor quality of care</td>
</tr>
<tr>
<td>Disruptions in care (or continuity of care)</td>
</tr>
<tr>
<td>Lack of communication across behavioral health services</td>
</tr>
<tr>
<td>Stigma experienced by people seeking behavioral health care</td>
</tr>
<tr>
<td>Lack of person-focused care</td>
</tr>
</tbody>
</table>

**Analysis**

To compare results from the 2018 Survey to the 2020 Survey, slope graphs were created. Slope graphs allow for a visual representation of the change in a value from one point to another. In this instance, the change in the percentage is displayed in the slope of the line, allowing for a visual comparison of the change in percentage for the categories in a given area.

For this analysis, the percentage of respondents whose response was classified into one of the categories for the 2018 Survey was compared to the percentage of respondents who selected the same category on the 2020 Survey. A true comparison is not possible at this time, given the different manner of survey administration between the 2018 and 2020 surveys. However, the slope graph seemed the most appropriate way to show potential differences between the surveys. Changes displayed in the slope graphs should be critically considered in light of the difference in survey modalities.
**COVID-19 Questions**

**Development**

The COVID-19 questions were developed to examine concerns the COVID-19 pandemic was impacting access to behavioral health services. These questions used survey skip logic so only survey respondents who had services disrupted by COVID-19 were eligible to answer the follow-up questions. This resulted in certain questions only being answered by a subset of the survey respondents.

**Analysis**

Percentages were illustrated using a bar graph to analyze responses for the COVID-19 questions.

**Pilot Test**

The 2020 Survey was pilot tested by 15 people with knowledge of the Texas behavioral health system who were not involved with the survey creation. The goal of this pilot was to solicit feedback about the readability and substance of the survey questions to ensure the demographic questions covered all appropriate categories and opinion questions were clear and concise.

The pilot data were used to inform the development of the analysis strategy, and aid in turnaround time for the larger dataset collected when the survey was officially distributed to stakeholders.

**Results**

**Respondent Demographics**

Over half of the 2020 Survey responses were submitted by people who identified as service providers working in the behavioral health system (see Figure F-1). About 25 percent of respondents had received behavioral health services at some point, 34 percent were connected to service recipients as caregivers, family members, or friends, and 36 percent worked with the behavioral health system in other ways (see Figure F-1). Respondents were able to choose more than one answer to allow them to best describe their experience with the behavioral health services.
Respondents were also asked to report whether they live in large urban, small urban, or rural areas. Two-thirds of respondents lived in large urban areas, while 23 percent lived in small urban areas and 9 percent lived in rural areas (see Figure F-2).
Gaps

Below is a graphical presentation of the responses to the gap’s statements (see Figure F-3). Table F-1 lists the full statements to which participants responded. The percentage of respondents selecting the given response (strongly agree, agree, disagree, or strongly disagree) are shown within the bars. Bars without percentages displayed had less than 3 percent of the total responses.
<table>
<thead>
<tr>
<th>Gap</th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>Evidence-Based Practices Implemented</td>
<td>20%</td>
<td>59%</td>
<td>14%</td>
<td>7%</td>
</tr>
<tr>
<td>Agencies and Providers Share Data</td>
<td>5%</td>
<td>36%</td>
<td>35%</td>
<td>24%</td>
</tr>
<tr>
<td>Community Services Available for People with Distinct Needs</td>
<td>5%</td>
<td>33%</td>
<td>39%</td>
<td>23%</td>
</tr>
<tr>
<td>Quick Needs Identification</td>
<td>7%</td>
<td>27%</td>
<td>46%</td>
<td>19%</td>
</tr>
<tr>
<td>State and Local Coordination on Services</td>
<td>5%</td>
<td>29%</td>
<td>41%</td>
<td>24%</td>
</tr>
<tr>
<td>People with IDD Get Needed Mental Health (MH) and Substance Use (SU) Services</td>
<td>4%</td>
<td>29%</td>
<td>39%</td>
<td>29%</td>
</tr>
<tr>
<td>Veterans/Military Members Get Community Services</td>
<td>5%</td>
<td>27%</td>
<td>44%</td>
<td>24%</td>
</tr>
<tr>
<td>Behavioral Health (BH) Services Meet Needs</td>
<td>5%</td>
<td>25%</td>
<td>44%</td>
<td>26%</td>
</tr>
<tr>
<td>Timely Substance Use (SU) Treatment</td>
<td>5%</td>
<td>24%</td>
<td>42%</td>
<td>29%</td>
</tr>
<tr>
<td>Peer Support Available in Community</td>
<td>5%</td>
<td>25%</td>
<td>45%</td>
<td>26%</td>
</tr>
<tr>
<td>Behavioral Health (BH) Services Continued After Incarceration</td>
<td>4%</td>
<td>21%</td>
<td>41%</td>
<td>34%</td>
</tr>
<tr>
<td>Public School Students Needs Met</td>
<td>3%</td>
<td>22%</td>
<td>46%</td>
<td>29%</td>
</tr>
<tr>
<td>Enough Transportation to Get to Services</td>
<td>3%</td>
<td>17%</td>
<td>42%</td>
<td>38%</td>
</tr>
</tbody>
</table>
The data used to create the graph above are shown in table format below (see Table F-6).

**Table F-6. Gaps Responses from Most Agreement to Least Agreement**

Most respondents indicated they agreed the behavioral health system has improved in use of evidence-based practices. Between one-third and half of respondents agreed the following areas improved:

- Agencies and providers share data;
- Community services available for people with distinct needs;
- Quick behavioral health needs identification;
- State and local coordination of behavioral health services;
• People with IDD get needed mental health and substance use services; and
• Veterans/military members get community services needed.

Less than a quarter of respondents indicated improvement in transportation for behavioral health services, secure housing for people with behavioral health needs, and an adequate behavioral health workforce.

**SWOT**

Slope graphs are presented below to show the change in percentage of respondents who indicated a given item was a strength, weakness, opportunity, or threat. It is important these results are considered with limitations in mind, given the difference in the survey methods from 2018 to 2020.

The percentages and overall ranking of the options from the 2020 Survey are displayed to the left edge of the graphs. Color coding is used to point out the greatest changes in the percentages from 2018 to 2020. Green indicates a positive change (items that increased percentage in the strengths and opportunities, and items that decreased percentage in the weakness and threats categories). Red indicates a negative change (items that decreased percentage in the strengths and opportunities, and items that increased in the weakness and threats categories).

**Strengths**

- Figure F-4 demonstrates the change in percentage from 2018 to 2020 for the strengths categories. The right edge of the graph shows the rank order sorted by the percentage of respondents who selected the item as a strength on the 2020 Survey.
The data used to create the graph above are shown in table format below (see Table F-7). The percentage of responses for each option in the 2018 and 2020 surveys are listed along with the amount of change between surveys.

**Table F-7. Strengths Comparison by Amount of Change, 2018 to 2020**

<table>
<thead>
<tr>
<th>Strengths Response</th>
<th>2018 Survey Percentage</th>
<th>2020 Survey Percentage</th>
<th>Percentage Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workforce</td>
<td>12%</td>
<td>49%</td>
<td>37%</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>4%</td>
<td>35%</td>
<td>31%</td>
</tr>
<tr>
<td>Government Awareness</td>
<td>10%</td>
<td>24%</td>
<td>14%</td>
</tr>
<tr>
<td>Collaboration</td>
<td>10%</td>
<td>22%</td>
<td>13%</td>
</tr>
<tr>
<td>Peer Services</td>
<td>3%</td>
<td>17%</td>
<td>14%</td>
</tr>
<tr>
<td>Strengths Response</td>
<td>2018 Survey Percentage</td>
<td>2020 Survey Percentage</td>
<td>Percentage Point Change</td>
</tr>
<tr>
<td>---------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Local Control</td>
<td>5%</td>
<td>15%</td>
<td>11%</td>
</tr>
<tr>
<td>Standardization of Care</td>
<td>6%</td>
<td>15%</td>
<td>9%</td>
</tr>
<tr>
<td>Funding</td>
<td>4%</td>
<td>9%</td>
<td>5%</td>
</tr>
<tr>
<td>None</td>
<td>13%</td>
<td>18%</td>
<td>4%</td>
</tr>
<tr>
<td>Access</td>
<td>17%</td>
<td>18%</td>
<td>1%</td>
</tr>
<tr>
<td>Unknown</td>
<td>21%</td>
<td>9%</td>
<td>-12%</td>
</tr>
</tbody>
</table>

The greatest positive changes were seen in the number of respondents who indicated the workforce and person-centered care were strengths of the behavioral health system. Additionally, fewer respondents indicated they did not know what the strengths of the behavioral health system were.

**Weaknesses**

Figure F-5 demonstrates the change in percentage from 2018 to 2020 for the weaknesses categories. The right edge of the graph shows the rank order sorted by the percentage of respondents who selected the item as a weakness on the 2020 Survey.
Figure F-5. Weaknesses Comparison, 2018 to 2020

The data used to create the graph above are shown in table format below (see Table F-8). The percentage of responses for each option in the 2018 and 2020 surveys are listed along with the amount of change between surveys.

Table F-8. Weaknesses Comparison by Amount of Change, 2018 to 2020

<table>
<thead>
<tr>
<th>Weaknesses Response</th>
<th>2018 Survey Percentage</th>
<th>2020 Survey Percentage</th>
<th>Percentage Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Funding</td>
<td>15%</td>
<td>83%</td>
<td>68%</td>
</tr>
<tr>
<td>Insurance Coverage</td>
<td>15%</td>
<td>80%</td>
<td>65%</td>
</tr>
<tr>
<td>Affordable</td>
<td>5%</td>
<td>57%</td>
<td>52%</td>
</tr>
<tr>
<td>Workforce</td>
<td>22%</td>
<td>74%</td>
<td>52%</td>
</tr>
<tr>
<td>Weaknesses Response</td>
<td>2018 Survey Percentage</td>
<td>2020 Survey Percentage</td>
<td>Percentage Point Change</td>
</tr>
<tr>
<td>---------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Government Awareness</td>
<td>6%</td>
<td>57%</td>
<td>51%</td>
</tr>
<tr>
<td>Access</td>
<td>30%</td>
<td>75%</td>
<td>45%</td>
</tr>
<tr>
<td>Collaboration</td>
<td>12%</td>
<td>56%</td>
<td>44%</td>
</tr>
<tr>
<td>Resources</td>
<td>28%</td>
<td>68%</td>
<td>40%</td>
</tr>
<tr>
<td>Data Sharing</td>
<td>1%</td>
<td>41%</td>
<td>40%</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>NA</td>
<td>30%</td>
<td>30%</td>
</tr>
<tr>
<td>Quality</td>
<td>11%</td>
<td>38%</td>
<td>26%</td>
</tr>
<tr>
<td>Unknown</td>
<td>NA</td>
<td>2%</td>
<td>2%</td>
</tr>
<tr>
<td>None</td>
<td>0%</td>
<td>1%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Funding for services, insurance coverage for behavioral health services, the workforce, affordability of services, and government awareness of the need for behavioral health services had the steepest increases in the percentage of respondents who indicated these areas are weaknesses. The behavioral health workforce appears as a weakness in the survey responses as well as a strength. This suggests improvements have been made building the workforce since 2018 but it remains an area that should be further addressed.

**Opportunities**

Figure F-6 demonstrates the change in percentage from 2018 to 2020 for the opportunities categories. The right edge of the graph shows the rank order sorted by the percentage of respondents who selected the item as an opportunity on the 2020 Survey.
The data used to create the graph above are shown in table format below (see Table F-9). The percentage of responses for each option in the 2018 and 2020 surveys are listed along with the amount of change between surveys.

### Table F-9. Opportunities Comparison by Amount of Change, 2018 to 2020

<table>
<thead>
<tr>
<th>Opportunities Response</th>
<th>2018 Survey Percentage</th>
<th>2020 Survey Percentage</th>
<th>Percentage Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accessible</td>
<td>NA</td>
<td>76%</td>
<td>76%</td>
</tr>
<tr>
<td>Vulnerable</td>
<td>0%</td>
<td>76%</td>
<td>76%</td>
</tr>
<tr>
<td>Attract Providers</td>
<td>3%</td>
<td>74%</td>
<td>71%</td>
</tr>
<tr>
<td>Housing</td>
<td>2%</td>
<td>72%</td>
<td>70%</td>
</tr>
<tr>
<td>Opportunities Response</td>
<td>2018 Survey Percentage</td>
<td>2020 Survey Percentage</td>
<td>Percentage Point Change</td>
</tr>
<tr>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>Funding</td>
<td>14%</td>
<td>82%</td>
<td>68%</td>
</tr>
<tr>
<td>Communication</td>
<td>0%</td>
<td>67%</td>
<td>67%</td>
</tr>
<tr>
<td>Service Navigation</td>
<td>2%</td>
<td>67%</td>
<td>65%</td>
</tr>
<tr>
<td>Crisis</td>
<td>1%</td>
<td>66%</td>
<td>65%</td>
</tr>
<tr>
<td>Telehealth</td>
<td>NA</td>
<td>63%</td>
<td>63%</td>
</tr>
<tr>
<td>Inpatient Services</td>
<td>2%</td>
<td>63%</td>
<td>61%</td>
</tr>
<tr>
<td>Continuum of Care</td>
<td>16%</td>
<td>70%</td>
<td>54%</td>
</tr>
<tr>
<td>Justice Diversion</td>
<td>NA</td>
<td>55%</td>
<td>55%</td>
</tr>
<tr>
<td>Provider Roles</td>
<td>NA</td>
<td>55%</td>
<td>55%</td>
</tr>
<tr>
<td>Data Sharing</td>
<td>NA</td>
<td>50%</td>
<td>50%</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>19%</td>
<td>67%</td>
<td>48%</td>
</tr>
<tr>
<td>Unknown</td>
<td>NA</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>None</td>
<td>NA</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Several categories were selected by a large portion of respondents as opportunities for the behavioral health system to be more successful. The categories with the largest increase in selections since 2018 included providing additional support for vulnerable populations, improving accessibility of services, attracting behavioral health providers to the workforce, and increasing access to housing for people with behavioral health needs. The categories with the next largest increase in selection were communication with the public, making services easier to find, increasing funding for public services, expanding telehealth options, and increasing crisis
intervention services. The results of the opportunities question may be an indicator of community support for different improvements to the behavioral health system.

**Threats**

Figure F-7 demonstrates the change in percentage from 2018 to 2020 for the threats categories. The right edge of the graph shows the rank order sorted by the percentage of respondents who selected the item as a threat on the 2020 Survey.
Figure F-7. Threats Comparison, 2018 to 2020

The data used to create the graph above are shown in table format below (see Table F-10). The percentage of responses for each option in the 2018 and 2020 surveys are listed along with the amount of change between surveys.

Table F-10. Threats Comparison by Amount of Change, 2018 to 2020

<table>
<thead>
<tr>
<th>Threats Response</th>
<th>2018 Survey Percentage</th>
<th>2020 Survey Percentage</th>
<th>Percentage Point Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insurance Coverage</td>
<td>6%</td>
<td>72%</td>
<td>66%</td>
</tr>
<tr>
<td>Stigma</td>
<td>3%</td>
<td>68%</td>
<td>65%</td>
</tr>
<tr>
<td>Demand</td>
<td>5%</td>
<td>67%</td>
<td>62%</td>
</tr>
<tr>
<td>Transportation</td>
<td>3%</td>
<td>65%</td>
<td>62%</td>
</tr>
<tr>
<td>Threats Response</td>
<td>2018 Survey Percentage</td>
<td>2020 Survey Percentage</td>
<td>Percentage Point Change</td>
</tr>
<tr>
<td>-------------------------</td>
<td>------------------------</td>
<td>------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td>Political Support</td>
<td>7%</td>
<td>66%</td>
<td>59%</td>
</tr>
<tr>
<td>Affordable</td>
<td>1%</td>
<td>53%</td>
<td>52%</td>
</tr>
<tr>
<td>Communication</td>
<td>5%</td>
<td>55%</td>
<td>50%</td>
</tr>
<tr>
<td>Continuity of Care</td>
<td>15%</td>
<td>64%</td>
<td>49%</td>
</tr>
<tr>
<td>Funding</td>
<td>28%</td>
<td>72%</td>
<td>44%</td>
</tr>
<tr>
<td>Quality</td>
<td>1%</td>
<td>35%</td>
<td>34%</td>
</tr>
<tr>
<td>Person-Centered</td>
<td>2%</td>
<td>31%</td>
<td>29%</td>
</tr>
<tr>
<td>Unknown</td>
<td>NA</td>
<td>2%</td>
<td>3%</td>
</tr>
<tr>
<td>None</td>
<td>NA</td>
<td>1%</td>
<td>1%</td>
</tr>
</tbody>
</table>

Many of the categories for threats showed marked increase from 2018 to 2020. The greatest increases occurred with lack of insurance coverage for behavioral health services, increasing demand for services, lack of transportation to services, and stigma experienced by people seeking behavioral health care.

**COVID-19**

**Access and Impact on Behavioral Health Services**

The graphs below summarize the responses to questions regarding the effect of COVID-19 on behavioral health access and service delivery. Many participants indicated that COVID-19 has already affected their behavioral health (Figure F-8) and their access to behavioral health services (Figure F-9). Also, 85% of respondents indicated they are concerned about the long-term impact of COVID-19 on availability of behavioral health services (Figure F-10).
Figure F-8. COVID-19 Affected Individual Behavioral Health

Figure F-9. COVID-19 Affected Access to Behavioral Health Care
Figure F-10. Concerns Regarding Long-Term Impact of COVID-19 on Availability of Services

![Bar chart showing concerns regarding long-term impact of COVID-19 on availability of services.]

**Telehealth Services**

The percentage of respondents who had used telehealth behavioral health services greatly increased after the COVID-19 pandemic began, increasing from only 21 percent prior to COVID-19 to 67 percent after onset of the pandemic (see Figure F-11). This is a 46 percentage-point swing.

Figure F-11. Use of Telehealth for Behavioral Health Services

![Bar chart showing use of telehealth for behavioral health services.]

Among respondents that have used telehealth services since the start of COVID-19, 88 percent indicated telehealth improved access to behavioral health services (see Figure F-12). Among the same group, 55 percent indicated that telehealth was just as good as in-person behavioral health visits (see Figure F-12).
Figure F-12. Evaluation of Telehealth Behavioral Health Services

Limitations

The current iteration of the survey does have several limitations. The current iteration collects many more responses than the 2018 Survey because it did not rely on open-ended text responses. However, that means the respondents for the 2020 Survey were not able to enter new responses to the SWOT questions. Participants were only able to select from the options given. This can also result in respondents selecting options they may not have considered without the prompt. Future iterations of the survey could be easily paired with more qualitative assessments like focus groups or open-ended text surveys, like the 2018 Survey, to make sure the response options presented in this type of survey are relevant and cover most or all potential options.

While this survey was promoted through state agency websites, social media, and announcements to provider networks, online surveys can have limited reach to consumers. More targeted marketing may be necessary in the future to increase participation by consumers and people who speak Spanish. Working with service providers could enhance the voices of frontline providers as well as consumers who may not have access to social media or internet otherwise.
Conclusions

Gaps

Among the gaps assessed, the greatest improvement reported in the behavioral health system was in implementation of evidence-based practices. All of the remaining gaps continue to require an investment by state agencies and partners to make change. It is important to note the behavioral health workforce is considered a gap related to the quantity of available professionals. However, the workforce is considered a strength in the SWOT assessment. The responses to the 2018 Survey acknowledged the shortage of qualified behavioral health professionals but reported the workforce is dedicated and works hard to support clients.

SWOT

The SWOT analysis highlighted some strengths of the behavioral health system, but more importantly identified areas for improvement and opportunities where there may be a strong level of support for change. The issues cited most often in the SWOT questions are listed in the SWOT analysis diagram below (see Figure F-13).
Figure F-13. SWOT Analysis

**STRENGTHS**
- Dedicated workforce
- Person-centered care

**WEAKNESSES**
- Funding for services
- Insurance coverage for behavioral health needs
- Workforce capacity
- Service affordability
- Government awareness of need for services

**OPPORTUNITIES**
- Support vulnerable people
- Improve accessibility
- Attract providers
- Increase access to housing
- Improve communication
- Make services easier to find
- Increase funding
- Expand telehealth
- Increase crisis services

**THREATS**
- Lack of insurance coverage for behavioral health services
- Increased demand for services
- Lack of transportation to services
- Stigma related to seeking care
Survey

2020 BEHAVIORAL HEALTH STRATEGIC PLAN SURVEY

Survey Instructions

Welcome to the Statewide Behavioral Health Coordinating Council’s (SBHCC) survey. We want your feedback about behavioral health services in Texas. Your responses will help the SBHCC update the Statewide Behavioral Health Strategic Plan. This plan guides state agencies in providing services that meet people’s needs. (Haga clic en el lado derecho de la pantalla para cambiar el idioma.)

The term “behavioral health services” refers to services that treat and promote the health and recovery of people with mental health and substance use conditions. These services include the prevention and treatment of mental and substance use disorders like mental health conditions in adults, severe emotional disturbance in children, post-traumatic stress, and alcohol/drug addiction. Behavioral health services supported by state agencies can be delivered in many places, including local community clinics, schools, foster family homes, state hospitals, and jails.

Important information to know about this survey:

- Your responses are anonymous. We will not know who you are.
- Anyone who has been involved with behavioral health services over the past 24 months is invited to take the survey. Maybe you use services yourself or you take care of someone who does. You might be a service provider or work for the government. We want your feedback.
- The survey takes approximately 10 minutes to complete. You must complete the survey all at once, so please give yourself enough time to answer all the questions.
- You may take this survey on a computer or mobile device, but it is easier on a computer. If you use a mobile device, be sure to answer all questions.
- You may take this survey only once.
- The survey is available in English or Spanish. Go to the right side of the screen to change the language.
- This survey will end on November 21, 2020.

For questions about this survey, please email MentalHealth_SBHCC@hhsc.state.tx.us.

If you or someone you know is experiencing anxiety, stress, or emotional challenges due to the COVID-19 pandemic, call the Statewide COVID-19 Mental
Health Support Line 24 hours a day, 7 days a week toll-free at 833-986-1919 or visit https://mentalhealthtx.org/
**Survey Questions**

**Respondent Demographics**

1. Which options describe your experience with behavioral health services in Texas? (check all that apply)
   - a) I receive or have received behavioral health services
   - b) I am a friend, family member, or caregiver of someone who has received behavioral health services
   - c) I am a behavioral health service provider (all types of services and provider levels)
   - d) I work with the behavioral health system in other ways
   - e) I have no experience with the behavioral health system [skips to end]

[Branched question based on responses to Question 1]

<table>
<thead>
<tr>
<th>Service Recipients</th>
<th>Family</th>
<th>Providers</th>
<th>Other Workers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1A: Which options describe your personal experience receiving services? (check all that apply)</td>
<td>Q1B: What is your experience as a friend, family member, or caregiver of a person receiving services? (check all that apply)</td>
<td>Q1C: Which options best describe you as a service provider? (check all that apply)</td>
<td>Q1D: How do you work with behavioral health services?</td>
</tr>
<tr>
<td><strong>Service Recipients</strong></td>
<td><strong>Family</strong></td>
<td><strong>Providers</strong></td>
<td><strong>Other Workers</strong></td>
</tr>
<tr>
<td>------------------------</td>
<td>------------</td>
<td>---------------</td>
<td>------------------</td>
</tr>
<tr>
<td>a) I receive mental health services now or in the past.</td>
<td>a) I have friends or family who are receiving or have received mental health services.</td>
<td>a) I am a mental health service provider.</td>
<td>a) I work for a local mental health or local behavioral health authority (LMHA/LBHA), also called an MHMR.</td>
</tr>
<tr>
<td>b) I receive substance use services now or in the past.</td>
<td>b) I have friends or family who are receiving or have received mental health services.</td>
<td>b) I am a substance use service provider.</td>
<td>b) I work for a substance use prevention organization.</td>
</tr>
<tr>
<td>c) I received mental health services in the past while in jail, prison, juvenile detention, or on parole or probation.</td>
<td>c) I have friends or family who are receiving or have received mental health services in jail, prison, juvenile detention, or on parole or probation.</td>
<td>c) I provide mental health services to people in jail, prison, juvenile detention, or on parole or probation.</td>
<td>c) I work for an organization that provides advocacy, peer services, transportation, housing, employment assistance, service referral or other support services.</td>
</tr>
<tr>
<td>d) I received substance use services in the past while in jail, prison, juvenile detention, or on parole or probation.</td>
<td>d) I have friends or family who are receiving or have received mental health services in jail, prison, juvenile detention, or on parole or probation.</td>
<td>d) I provide substance use services to people in jail, prison, juvenile detention, or on parole or probation.</td>
<td>d) I work for a managed care organization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>e) I work in education.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>f) I work in law enforcement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>g) I work in local government, other than law enforcement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>h) I work in state government, other than law enforcement.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>i) I provide services not named here.</td>
</tr>
</tbody>
</table>
2. What is your current employment status?
   a) Private sector employee (non-government organization or company)
   b) Government employee
   c) Self-employed
   d) Other employment (work in a for-profit family business or farm for 15 hours or more per week, with or without pay)
   e) Unemployed [no branching following this response]

[Branch question based on responses to Question 2]

<table>
<thead>
<tr>
<th>Private Sector</th>
<th>Government</th>
<th>Self-Employed</th>
<th>Other Employment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2A: What type of private sector employer do you work for?</td>
<td>Q2B: What type of government agency do you work for?</td>
<td>Q2C: How are you self-employed?</td>
<td>Q2D: Describe your other employment</td>
</tr>
<tr>
<td>a) A for-profit organization (examples: retail store, food service, bank)</td>
<td>a) Local government (examples: city or county agency or school district)</td>
<td>a) Owner of non-incorporated business, professional practice, or farm</td>
<td>[open text box for response]</td>
</tr>
<tr>
<td>b) A non-profit organization (including tax-exempt and charitable organizations)</td>
<td>b) State government (including state colleges/universities)</td>
<td>b) Owner of incorporated business, professional practice, or farm</td>
<td></td>
</tr>
<tr>
<td>c) Active duty U.S. Armed Forces or Commissioned Corps</td>
<td>c) Federal government civilian agency</td>
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<tr>
<td>d)</td>
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</tbody>
</table>

3. What was your total individual income for the PAST 12 MONTHS (no matter what income source)?
   a) Under $30,000 annually
   b) $30,001-$50,000 annually
   c) $50,001-$80,000 annually
   d) $80,001-$120,000 annually
   e) Above $120,000 annually
4. Which description best identifies where you live?
   a) A large urban area (population of over 50,000)
   b) A small urban area (population between 2,500 and 50,000)
   c) A rural area (population less than 2,500)

5. How old are you? [drop-down menu of individual ages]

6. What is the highest level of school you have COMPLETED?
   a) Grade 12 or below (no diploma) [no branching following this response]
   b) High school graduate or equivalent
   c) Technical/career program or professional certification
   d) Undergraduate school
   e) Graduate school

[Branched question based on responses to Question 6]

<table>
<thead>
<tr>
<th>High School</th>
<th>Tech/Career</th>
<th>Undergraduate</th>
<th>Graduate School</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q6A: Describe your level of high school completion:</td>
<td>Q6B: Describe your level of technical/career program completion:</td>
<td>Q6C: Describe your level of undergraduate school completion:</td>
<td>Q6D: Describe your level of graduate school completion:</td>
</tr>
<tr>
<td>a) Regular high school diploma</td>
<td>a) Some technical/career program</td>
<td>a) Some college</td>
<td>a) Master’s degree (for example: MA, MS, MEng, MEd, MSW, MBA)</td>
</tr>
<tr>
<td>b) GED or alternative</td>
<td>b) Professional certification or diploma</td>
<td>b) College graduate</td>
<td>b) Advanced professional degree (for example: MD, DDS, DVM, LLB, JD)</td>
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<tr>
<td></td>
<td>c) Apprentice</td>
<td></td>
<td>c) Doctorate degree (for example: PhD, EdD)</td>
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<td></td>
<td>d) Journeyman</td>
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<td></td>
</tr>
</tbody>
</table>

7. Are you of Hispanic, Latino, or Spanish origin?
   a) No
   b) Yes
   c) I don’t know
   d) Prefer not to answer
8. What is your race?
   a) American Indian or Alaska Native
   b) Asian or Pacific Islander (for example: Chinese, Korean, Filipino, Pakistani, Asian Indian, Native Hawaiian, Samoan)
   c) Black (for example: African American, Jamaican, Haitian, Nigerian, Ethiopian)
   d) White (for example: German, Irish, English, Italian, Lebanese, Egyptian)
   e) Multiple races
   f) Other race
   g) Prefer not to answer

9. Do you have a disability (deaf, hard of hearing, blind, low vision, mobility impairment, or others)?
   a) Yes
   b) No

   9a. [If yes] Do you think your disability has been a barrier to obtaining behavioral health services?
      a) Yes
      b) No
      c) I don’t know

Gaps

10. Rate how much you agree with the statements below based on your experience with the behavioral health system in Texas.

<table>
<thead>
<tr>
<th>Statement</th>
<th>Strongly Disagree</th>
<th>Disagree</th>
<th>Agree</th>
<th>Strongly Agree</th>
<th>Does Not Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>People’s behavioral health needs are identified quickly.</td>
<td></td>
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<tr>
<td>People are able to get the behavioral health services that best meet their needs.</td>
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<tr>
<td>People are able to get substance use treatment services when they need them.</td>
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<tr>
<td>Veterans and military service members get the long-term, community behavioral health services they need.</td>
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<tr>
<td>State agencies and local service providers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
<td>Does Not Apply</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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<tr>
<td>coordinate well on behavioral health services.</td>
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<tr>
<td>Behavioral health service providers implement evidence-based practices whenever possible.</td>
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<tr>
<td>Public school students get the behavioral health services they need at school.</td>
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<tr>
<td>People released from prison or jail continue to get behavioral health services if needed.</td>
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<tr>
<td>Adequate peer support services are available in the community.</td>
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<tr>
<td>People with behavioral health conditions have secure housing options.</td>
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<tr>
<td>There are enough transportation resources for people to get to their behavioral health services.</td>
<td></td>
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</tr>
<tr>
<td>People with intellectual and developmental disabilities can get mental health or substance use services when they need are needed.</td>
<td></td>
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</tr>
<tr>
<td>Community-based behavioral health services are available for people with distinct needs (examples: people with disabilities, mothers with postpartum depression, people who were incarcerated).</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>There are enough behavioral health workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Statement</td>
<td>Strongly Disagree</td>
<td>Disagree</td>
<td>Agree</td>
<td>Strongly Agree</td>
<td>Does Not Apply</td>
</tr>
<tr>
<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>to support the needs of people in Texas.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>State agencies and local service providers share useful data.</td>
<td></td>
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</tr>
</tbody>
</table>

**SWOT Comparison**

11. Which items below are things the Texas behavioral health system does well (STRENGTHS)? (check all that apply)
   a) People can access behavioral health services when they need them
   b) Collaboration between state agencies and local behavioral health providers
   c) Consistency or standardization of care
   d) Funding to support behavioral health services
   e) State government’s awareness of need for behavioral health services
   f) Local control of behavioral health resources
   g) Availability of peer services
   h) Care is focused on the person
   i) Service providers are dedicated to people’s care
   j) Unknown
   k) None

12. Which of the items below are WEAKNESSES of the behavioral health system in Texas? (check all that apply)
   a) Difficulty accessing services
   b) Affordability of services
   c) Lack of collaboration between service providers and state agencies
   d) Not enough funding for behavioral health services
   e) Lack of government awareness of the need for behavioral health services
   f) Lack of coverage for some services
   g) Services are not focused on the person
   h) Behavioral health workforce or provider shortage
   i) Lack of resources for providers to offer range of services to the community
   j) Poor behavioral health service quality
   k) Lack of data sharing
   l) Unknown
   m) None
13. Which of the items below are OPPORTUNITIES for the behavioral health system in Texas to be more successful? (check all that apply)
   a) Enhance behavioral health service accessibility
   b) Attract more behavioral health service providers
   c) Improve communication with the public
   d) Create a comprehensive range of behavioral health services (or continuum of care)
   e) Prevent disruptions in care (or continuity of care)
   f) Improve data sharing
   g) Make services easier to find
   h) Increase funding to support more behavioral health services
   i) Expand service provider roles and responsibilities to permit care for more people
   j) Provide additional support for vulnerable populations
   k) Increase inpatient behavioral health services
   l) Expand use of telehealth technology
   m) Increase availability of crisis intervention services
   n) Increase access to housing for people with behavioral health issues
   o) Improve use of justice diversion options
   p) Unknown
   q) None

14. Which of the items below are THREATS that can hurt the behavioral health system in Texas? (check all that apply)
   a) Inability to get transportation to service locations
   b) Services are too expensive
   c) Reduction of funding to support behavioral health services
   d) Lack of insurance for services needed
   e) Increased demand for behavioral health services
   f) Lack of political backing for funding and services
   g) Poor quality of care
   h) Disruptions in care (or continuity of care)
   i) Lack of communication across behavioral health services
   j) Stigma experienced by people seeking behavioral health care
   k) Lack of person-focused care
   l) Unknown
   m) None

**COVID-19 Impact on Behavioral Health**

COVID-19 may affect people’s mental health and substance use recovery and their access to behavioral health services. The questions below are about COVID-19 and impact on behavioral health care. Everyone taking this survey can respond to these questions.
15. Has COVID-19 affected your behavioral health?
   a) Yes [if yes, jump to 15a]
   b) No

15a. What has COVID-19 affected?
   a) Mental health
   b) Substance use
   c) Both

16. Has COVID-19 affected access to behavioral health services?
   a) Yes [if yes, jump to 16a]
   b) No

16a. What services has COVID-19 affected access to?
   a) Mental health
   b) Substance use
   c) Both

17. Prior to COVID-19, did you ever use telehealth for behavioral health services or appointments?
   a) Yes
   b) No

18. Since COVID-19, have you used telehealth for behavioral health services or appointments?
   a) Yes
   b) No

[Branch question based on responses to Questions 18]

<table>
<thead>
<tr>
<th>If yes...</th>
<th>If no...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q18A: Has telehealth improved access to behavioral health services?</td>
<td>Q18B: Do you think telehealth improves access to behavioral health services?</td>
</tr>
<tr>
<td>a) Yes</td>
<td>a) Yes</td>
</tr>
<tr>
<td>b) No</td>
<td>b) No</td>
</tr>
<tr>
<td>c) I don’t know</td>
<td>c) I don’t know</td>
</tr>
</tbody>
</table>

Q18C: Do you think telehealth visits are just as good as in-person behavioral health visits?
   a) Yes
   b) No
   c) I don’t know

(End of question)
19. Are you concerned about the long-term impact of COVID-19 on the availability of behavioral health services?
   a) Yes [if yes, jump to 19a]
   b) No
19a. I am concerned about COVID-19’s long-term impact on:
   a) Mental health services
   b) Substance use services
   c) Both mental health and substance use services

**Thank You**

If you or someone you know is experiencing anxiety, stress, or emotional challenges due to the COVID-19 pandemic, call the Statewide COVID-19 Mental Health Support Line 24 hours a day, 7 days a week toll-free at 833-986-1919 or visit [https://mentalhealthtx.org/](https://mentalhealthtx.org/).
Appendix G. Summary of Findings from Justice-Related Stakeholder Engagement

People across Texas were consulted to develop the *Texas Strategic Plan for Diversion, Community Integration, and Forensic Services*. State agencies, organizations, and local partners gathered mental health, substance use, IDD service providers and peer specialists; justice professionals; people with lived experience and their families; community leaders; and program and policy subject matter experts. To ensure that the strategic plan is reflective of the goals and priorities of diverse stakeholders, on behalf and as a member of the SBHCC, HHSC hosted a State Sequential Intercept Mapping Summit, five strategic planning sessions, seven listening sessions, four targeted informational interviews, and a public survey. Each effort is described in detail below.

**Strategic Planning and Listening Sessions**

On behalf of the SBHCC, HHSC hosted five strategic planning sessions, seven listening sessions, and four targeted informational interviews January-July 2021 to engage key stakeholders in the development of the strategic plan. Below is a list of organizations and agencies who helped host strategic planning and listening sessions, as well as a description of each session’s attendees. Also, included is a summary of key themes from listening sessions, and ranked strategic priorities.

- HHSC, Office of Mental Health Coordination: The State Forensic Director and Office of Mental Health Coordination facilitated three strategic planning sessions with HHSC staff representing all levels of leadership and teams across IDD and Behavioral Health Services, Health and Specialty Care Services, and Medicaid and CHIP Services departments.
- HHSC, Office of Mental Health Coordination: The State Forensic Director and OMHC facilitated two strategic planning sessions with SBHCC members.
- West Texas Centers: This organization serves as the designated LMHA and LIDDA for Andrews, Borden, Crane, Dawson, Fisher, Gaines, Garza, Glasscock, Howard, Kent, Loving, Martin, Mitchell, Nolan, Reeves, Runnels, Scurry, Terrell, Terry, Upton, Ward, Winkler, and Yoakum counties. West Texas Centers hosted listening session included a behavioral health provider, an IDD provider, a substance use treatment provider, a mental health deputy, a judge, and a jail caseworker, among other stakeholders.
- North Texas Behavioral Health Authority: This organization serves as the designated LBHA and LIDDA for Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. The North Texas Behavioral Health Authority listening session
included behavioral health providers, a district attorney, a municipal judge, law enforcement, a public defender, a jail coordinator, among other stakeholders.

- National Alliance for Mental Illness, Texas: This 501(c)3 nonprofit organization has nearly 2,000 members made up of people living with MI, family members, friends, and professionals. Its purpose is to help improve the lives of people affected by mental illness through education, support, and advocacy. This listening session included peer service providers, behavioral health service providers, IDD service providers, advocates, and people with lived experience.
- HHSC, Behavioral Health Services Peer and Recovery Services Programs, Planning and Policy team: This listening session included peer service providers from across the state.
- HHSC, State Hospital System team: This listening session included state hospital superintendents and other state hospital staff.
- The Judicial Commission on Mental Health (JCMH): The JCMH was created in 2018 by a joint order of the Supreme Court of Texas (SCoT) and the Court of Criminal Appeals (CCA) of Texas to strengthen courts for people with diagnosable MI, SUD, and/or IDD. The JCMH listening session included a justice of the peace, a law clerk, judges, a district attorney, among other stakeholders.

Targeted informational interviews were also held with HHSC Medicaid and CHIP Services department, HHSC Behavioral Health Services department, Texas State Affordable Housing Corporation, and the Texas Department of Housing and Community Affairs (TDHCA).

**Strategic Planning and Listening Session Themes**

Through the strategic planning and listening sessions, several themes emerged. Below is a description of each theme with proposed strategies shared by listening session attendees.

1. **The Importance of Expanding Crisis Systems of Care and Pre-Arrest Diversion Strategies:** Behavioral health and justice systems face challenges from the growing number of people experiencing behavioral health crises. In many communities across Texas, there are few options available for a person in crisis. Law enforcement agencies, emergency departments, jails, and prisons have become the safety nets, yet are often underequipped to provide the care
people need. Throughout the strategic planning and listening sessions, multiple stakeholders emphasized the importance of State and local partners working together to better address the behavioral health needs of people and the community and to enhance diversion opportunities. Specifically, participants suggested the plan include strategies that focus on:

- Developing a resource hub on diversion programs;
- Communicating information about diversion programs to stakeholders (public, communities, schools, faith-based communities, etc.);
- Increasing the use of diversionary paths, specialty courts, and relevant reentry efforts for special populations including justice-involved veterans;
- Establishing mental health defender programs that cover every county in the state;
- Ensuring that every community has a place where people can voluntarily receive de-escalation, respite, and connection to services, particularly places that offer peer support;
- Utilizing trained mental health law enforcement to respond to crisis calls;
- Diverting mental health calls, when safe and feasible, away from law enforcement;
- Training 911 operators to dispatch mental health calls to mental health providers;
- Developing diversion programs in rural counties;
- Ensuring all crisis services are safe, accessible, accountable, and well-funded; and
- Leveraging technology to support crisis response and diversion.

2. **The Cyclical Relationship Between Housing Instability and Justice Involvement:** There is a cyclical relationship between housing and justice involvement. Law enforcement procedures can contribute to arrest for behaviors associated with experiencing homelessness, such as criminal trespass. A lack of stable housing is viewed as a risk factor for justice-involvement and reduces courts’ willingness to divert people from jail or prison. Criminal history serves as a barrier to housing, contributing to housing instability and homelessness. Lack of stable housing upon reentry contributes to supervision failure and increases a persons’ risk of recidivism. All issues are amplified for people with diagnosable MI, SUD, and/or IDD. Throughout the strategic planning and listening sessions, participants shared ideas for helping state and local leaders understand the scope of the problem, promoting collaborative strategies to expand housing options for this population, and developing targeted investments in effective interventions from both the housing and justice systems. Specifically, participants suggested the plan include strategies that focus on:
• Expanding supportive living options, particularly for people who have a diagnosis of an IDD;
• Addressing overly restrictive landlord requirements;
• Providing safe housing in safe neighborhoods for people reentering the community; and
• Adding housing as a component of OCR.

3. The Opportunity to Strengthen Local Collaborations: Cross-system collaboration is key to ensuring better outcomes for people with diagnosable MI, SUD, and/or IDD. Collaboration can be difficult and funding “silos” make cross-systems efforts more challenging. Limited resources create a competitive and/or protective environment. Systems represent different cultures with their own histories, languages, values, concerns, and operations. Positively, collaboration fosters comprehensive thinking, brings diverse people, organizations, and sectors together, and can change the way communities solve problems. Throughout the strategic planning and listening sessions, participants emphasized the importance of bringing behavioral health, justice, housing, and other key stakeholders together to address issues facing their community. Specifically, participants suggested the plan include strategies that focus on:

• Refining and enhancing a full continuum of care for people who are justice involved through local collaboration and coordination;
• Establishing forensic services coordinators that cover every county in the state;
• Strengthening relationships between housing, justice, and behavioral health services to improve reentry, reintegration;
• Strengthening local behavioral health and law enforcement collaborations;
• Offering opportunities for team building between state hospitals and community partners; and
• Supporting increased collaboration between state hospitals, jails and LMHAs/LBHAs to improve the initial handoff when people are released from jail and returning to the community.

4. The Need for Cross-System Training and Education: Robust community-based care and supports can help minimize justice contact for people with diagnosable MI, SUD, and/or IDD. Such programs also provide opportunities for diversion once a person is involved in the justice system. Collaboration, education, and cross-training (involving both justice and behavioral health stakeholders) is critical in driving practice and policy changes. Throughout the strategic planning and listening sessions, participants identified multiple strategies to build on and enhance cross-system training and education for law enforcement, behavioral
health providers, courts and the judiciary, sheriffs, state hospitals, and other key stakeholders. Specifically, participants suggested this plan include strategies that focus on:

- Developing a coordinated resource and technical support strategy;
- Educating judges and defense and prosecuting attorneys on the components of quality competency evaluations;
- Promoting general education for the public on how to access treatment and avoid justice-involvement;
- Improving mental health training for attorneys;
- Providing trauma-informed training for law enforcement;
- Promoting Mental Health First Aid for all professionals working with people who have diagnosable MI, SUD, and/or IDD;
- Promoting awareness across the SIM of MH, SUD, and IDD resources that exist in local communities;
- Promoting general training and awareness on the importance of diversion to all stakeholders across the SIM;
- Developing community education and awareness campaigns regarding local community resources and SUD treatment; and
- Expanding academic partnerships with local partners, including city and county governments.

5. **The Challenges in the Competency to Stand Trial Process:** The competency to stand trial process is designed to protect the rights of people who do not understand the charges against them and are unable to assist in their own defense. Like other states, Texas faces a growing crisis in the number of people who are waiting in county jails for inpatient competency restoration services. Throughout the strategic planning and listening sessions, participants identified strategies to reduce the number of people waiting for inpatient competency restoration services and improve competency restoration services for those that need them. Specifically, participants suggested this plan include strategies that focus on:

- Promoting diversion to reduce the number of people who are arrested and booked into jail with diagnosable MI, SUD, and/or IDD;
- Developing a statewide registry of qualified competency evaluators;
- Improving the quality of trial competency evaluation reports;
- Expanding OCR and JBCR Programs;
- Reconciling the costs associated with defense attorney’s fees for OCR and JBCR;
• Identifying the appropriate competency restoration pathways for people found IST based on clinical need or acuity and public safety risk using a research-based framework; and
• Developing new discharge opportunities for long-term 46B commitments who have been determined not be restorable in the foreseeable future.

6. **The Value of Information Sharing and Using Data to Inform Policy Development and Service Delivery:** Tracking and understanding data are critical to the development of a robust continuum of care and the reduction of justice system involvement for people with diagnosable MI, SUD, and/or IDD. Throughout the strategic planning and listening sessions, participants expressed the need for state and local partners to work collaboratively to identify opportunities to gather, analyze, and use data to inform policy development and improve service delivery across the continuum of care. Specifically, participants suggested the plan include strategies that focus on:
  - Increasing information sharing across systems, agencies, and organizations;
  - Developing a Global Client’s record system for people who are justice-involved;
  - Improving information sharing between court officials, including magistrates, prosecutors, and defense attorneys;
  - Improving information sharing with law enforcement to support pre-arrest diversion; and
  - Evaluating crisis and diversion programs to assess impact and support the scaling of successful programs.

In addition to the themes listed above, strategic planning and listening session participants raised the importance of prevention and early intervention for youth, particularly when it comes to substance use; the need for improved education and services for people who have diagnoses of IDD across the SIM; the importance of expanding round-the-clock SUD services to rural communities; the need to remove unnecessary barriers to treatment for people with diagnosable MI, SUD, and/or IDD; the need to address the social determinants of health (access to housing, employment, and transportation); and the role of telehealth support in maximizing access to care across all intercepts.

**Listening Session Strategic Priorities**

At sessions hosted by West Texas Centers (West Texas), North Texas Behavioral Health Authority (North Texas), National Alliance for Mental Illness Texas (NAMI), HHSC’s Peer and Recovery Services (Peers) and State Hospital Superintendents
(State Hospital), TIDC, and JCMH, participants were asked to prioritize strategies through anonymous polling discussed during their respective listening session. Figures G-1 through G-19 below illustrate the prioritized strategies for each strategic goal and objective. Tables G-1 through G-19 list text versions of the information in the figures.

**Goal 1: Develop robust crisis and diversion systems to reduce and prevent justice involvement for people with diagnosable MI, SUD, and/or IDD.**

**Figure G-1. Spread and Scale Use of Crisis and Pre-Arrest Diversion Programs and Strategies (number of votes)**

![Bar chart showing prioritized strategies for Goal 1.](chart.png)
<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
<th>West Texas</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Support local planning for crisis and pre-arrest diversion programs.</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>B. Expand crisis receiving, crisis stabilization, crisis respite, and sobering centers.</td>
<td>5</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>C. Identify and reduce barriers to crisis response and pre-arrest diversion.</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>D. Promote the expansion of round-the-clock mobile crisis outreach teams and co-responder programs, and identify best practices that can scale across rural, suburban, and urban communities.</td>
<td>5</td>
<td>0</td>
<td>6</td>
</tr>
<tr>
<td>E. Identify opportunities to pilot emergency department diversion programs and promote connections to care for people with complex behavioral health needs.</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>F. Promote specialized law enforcement training programs to improve outcomes in interactions between law enforcement and people with diagnosable MI, SUD, and/or IDD.</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>G. Coordinate with law enforcement, behavioral health providers, housing service providers, and other stakeholders to develop programs focused on people with complex care needs that frequently cycle between systems.</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>H. Increase Mental Health Deputies.</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure G-2. Increase Use of Diversion Off-Ramps across Intercepts 2 and 3 (number of votes)

Table G-2. Increase Use of Diversion Off-Ramps across Intercepts 2 and 3 (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
<th>West Texas</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Ensure universal screening for MI, SUD and IDD at jail booking.</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>B. Establish mental health public defender programs that cover every county in the state.</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>C. Support the uptake of diversion strategies at arraignment and to inform pre-trial services.</td>
<td>6</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>D. Expand pretrial supervision and diversion services to reduce episodes of incarceration.</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strategy</td>
<td>North Texas</td>
<td>West Texas</td>
<td>Peers</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------------</td>
<td>-------</td>
</tr>
<tr>
<td>E. Increase the use of pre-trial diversion programs, specialty courts, and specialized probation and parole for justice-involved people with behavioral health needs.</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F. Expand tailored services for people with SUD and co-occurring issues.</td>
<td>0</td>
<td>6</td>
<td>0</td>
</tr>
<tr>
<td>G. Expand use of jail coordinators to support diversion and reentry.</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>H. Engage peer counselors to support judges and provide education and training.</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
</tbody>
</table>

**Figure G-3. Increase Diversion through Use of Data and Technology (number of votes)**

Prioritized Strategies: Increase Diversion through Use of Data and Technology (see table for strategy details)
Table G-3. Increase Diversion through Use of Data and Technology (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
<th>West Texas</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Enhance current technology to support the identification and case management of people with diagnosable MI, SUD, and/or IDD who are justice involved.</td>
<td>0</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>B. Promote the use of virtual supports to enhance crisis response and diversion through statewide technical assistance.</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>C. Explore opportunities to incorporate technology into crisis response and pre-arrest diversion programs to expand reach and availability across communities, including rural and frontier communities.</td>
<td>6</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>D. Utilize technology to inventory local supports and services in the community for first responders.</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Goal Two: Increase coordination, collaboration, and accountability across systems, agencies, and organizations.
Figure G-4. Enhance Community Collaboration through Strategic Planning and Coordination (number of votes)

Table G-4. Enhance Community Collaboration through Strategic Planning and Coordination (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Provide SIM Mapping workshops to support strategic planning and collaboration in local communities.</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>B. Provide statewide training and technical assistance on expanding and enhancing behavioral health-criminal justice collaborations through local coordinating bodies.</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>C. Adopt the Sequential Intercept Model framework for local planning and collaboration.</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>D. Identify opportunities to fund local forensic and diversion coordinators responsible for coordination between behavioral health providers, jails, courts, community corrections, and state hospitals.</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>E. Explore best practice models for local coordination, including criminal justice coordinating councils and regional planning and oversight bodies.</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>F. Increase local partnerships to expand the social safety net and connect justice-involved persons with supportive services.</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>G. Fund local and regional collaborative projects focused on coordination and information sharing to reduce and prevent justice-involvement of people with behavioral health needs.</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>H. Expand State's support to local communities to increase communication, collaboration, and education across the SIM.</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure G-5. Increase Information Sharing at State and Local Levels (number of votes)

Table G-5. Increase Information Sharing at State and Local Levels (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Explore data sharing needs between state agencies to develop a long-term data strategy for the state to support policy development, oversight, and ongoing improvement efforts.</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>B. Explore the development of a Global Client Record to ensure data sharing for continuity of care.</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>C. Support data sharing pilots in select communities to better identify those in need of services and to support continuity of care.</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>D. Promote the use of data use agreements, business associate agreements, and universal consent forms for information sharing between local government agencies (e.g., HHSC Medicaid and TDCJ, TJJD, and jails).</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Strategy</td>
<td>TIDC</td>
<td>JCMH</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
</tr>
<tr>
<td>E. Develop and standardize training for prosecutors and defense</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>attorneys who handle cases related to MI, SUD and IDD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Partner with the Texas State Bar to create legal education on MI,</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>SUD, and IDD.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Safely and securely share information with prosecutors, defense</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>attorneys and judges to better understand a person’s case, prior justice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>involvement, previous referrals, and current connections to care.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Figure G-6. Increase Strategic Partnerships between State, Local, Regional, and Community Agencies and Organizations (number of votes)**

Prioritized Strategies: Increase Strategic Partnerships between State, Local, Regional, and Community Agencies and Organizations (see table for strategy details)

- TIDC
- JCMH
Table G-6. Increase Strategic Partnerships between State, Local, Regional, and Community Agencies and Organizations (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Explore opportunities to streamline and maximize state benefits and supportive services through state agency partnerships.</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>B. Promote best practices of care coordination between CCBHCs and criminal justice partners.</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>C. Utilize a whole-community approach for addressing issues at the intersection of behavioral health and criminal justice that includes partnerships with housing authorities, hospitals, universities and medical schools, faith-based organizations, schools, and other agencies and organizations.</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>D. Maximize resources at a regional level to fund and operate programs that reduce justice involvement for people with diagnosable MI, SUD, and/or IDD.</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>E. Enhance MOUs, interlocal agreements and other contracts to support the expansion of the mental health workforce.</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>F. Ensure every county has Mental Health Deputies who work with LMHA/LBHAs to reduce and prevent justice involvement for people with diagnosable MI, SUD, and/or IDD.</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>G. Create liaison/coordinator positions within LMHA/LBHAs to coordinate care for people with diagnosable MI, SUD, and/or IDD through someone’s entire experience in the justice system and support re-entry.</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>H. Promote trust building and collaboration among prosecution and defense, supporting more collaboration between attorneys involved.</td>
<td>0</td>
<td>3</td>
</tr>
</tbody>
</table>

**Goal Three:** Enhance the continuum of care and support services for people who are justice-involved with diagnosable MI, SUD, and/or IDD.
Figure G-7. Enhance Effectiveness of Care and Support Service Coordination across the Continuum of Care (number of votes)

![Bar chart showing prioritized strategies]

<table>
<thead>
<tr>
<th>Strategy</th>
<th>West Texas</th>
<th>NAMI</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Utilize CCBHCs to increase care coordination and integrated physical and behavioral health services for people who are justice-involved.</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>B. Explore the use of a system-wide drug formulary to ensure medication continuity.</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>C. Expand TCOOMMI to serve more moderate and high-risk people and reduce the risk of recidivism for people with diagnosable MI, SUD, and/or IDD.</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>D. Enhance substance use services in rural communities to decrease the risk of recidivism for justice-involved people with diagnosable MI, SUD, and/or IDD.</td>
<td>5</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Strategy</td>
<td>West Texas</td>
<td>NAMI</td>
<td>Peers</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>E. Expand and enhance programs that focus on providing intensive,</td>
<td>5</td>
<td>3</td>
<td>6</td>
</tr>
<tr>
<td>wraparound services for people with complex needs cycling among multiple</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>systems.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Promote coordination and collaboration among all possible points of</td>
<td>3</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>contact/levels of care for a seamless transition and appropriate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>continuity of care.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. Explore opportunities to increase access to medication-assisted</td>
<td>0</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>treatment in county jails and at reentry to the community.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Expand access to substance use treatment across the SIM.</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I. Promote the development of crisis response models that reduce the</td>
<td>0</td>
<td>5</td>
<td>0</td>
</tr>
<tr>
<td>need for law enforcement to respond to mental health calls.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Expand the crisis continuum to ensure people have places to go in</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>the community to de-escalate.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Promote prevention and early intervention, identify people who have</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>fallen through the cracks and reengage.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure G-8. Increase Connection to Treatment and Tailored Supports for Special Populations, including People with IDD, Youth, and Veterans (number of votes)

Table G-8. Increase Connection to Treatment and Tailored Supports for Special Populations, including People with IDD, Youth, and Veterans (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>West Texas</th>
<th>NAMI</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Remove barriers to diversion for special populations by developing actionable and tailored solutions through state partnerships and state-local collaborations.</td>
<td>4</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>B. Provide training, technical assistance, and other supports to law enforcement, LMHA/LBHAs, and other stakeholders to promote best practices for special populations.</td>
<td>6</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Compile strategies and resources for addressing the needs of people with IDD into a format that is easy to understand and that is easily accessible to all county jails.</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>Strategy</td>
<td>West Texas</td>
<td>NAMI</td>
<td>Peers</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>D. Early prevention and intervention for substance use and youth</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E. Increase access to housing, supports and services for people with an IDD diagnosis to reduce justice involvement.</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>F. Improve screening for people with an IDD diagnosis when entering county jails.</td>
<td>0</td>
<td>3</td>
<td>0</td>
</tr>
<tr>
<td>G. Expand the use of youth peer specialists to support youth: focus on prevention and early intervention.</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>H. Provide more focused, wrap around services, peer engagement to people who have justice involvement - meet people where they are.</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>I. Ensure continued access to medication assisted treatment for pregnant women.</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>
Figure G-9. Address the Social Determinants of Health that Increase the Risk of Justice Involvement, including Housing, Employment, and Transportation (number of votes)

Table G-9. Address the Social Determinants of Health that Increase the Risk of Justice Involvement, including Housing, Employment, and Transportation (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>West Texas</th>
<th>NAMI</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Promote supported housing and employment through dedicated funding streams.</td>
<td>5</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>B. Explore opportunities to maximize access and enrollment in benefits and supports to address housing, employment, and transportation.</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>C. Support the development of a full continuum of housing options with appropriate services and attention to transitions between institutions and community.</td>
<td>0</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Strategy</td>
<td>West Texas</td>
<td>NAMI</td>
<td>Peers</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>D. Promote awareness of opportunities to reduce the barriers to housing for justice-involved persons, including tenancy selection criteria.</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>E. Support the development of dedicated position(s) at each LMHA, LBHA, and LIDDA to provide housing navigation, employment, transportation, and education services for people with diagnosable MI, SUD, and/or IDD who have a history of justice involvement.</td>
<td>3</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>F. Promote fair chance housing practices through rule changes that encourage the development of “low barrier” housing for units built with state-administered funds.</td>
<td>3</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>G. Explore opportunities to utilize the expungement of misdemeanor criminal records to facilitate connection with employment and housing, when appropriate.</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>H. Work collaboratively with local stakeholders to expand housing options with attention to landlord criteria and transitions between institutions and community.</td>
<td>5</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>I. Promote safe housing options.</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
</tbody>
</table>
Figure G-10. Increase Use of Peers across the SIM (number of votes)

Table G-10. Increase Use of Peers across the SIM (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>West Texas</th>
<th>NAMI</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Expand peer programs in criminal justice and behavioral health settings to support people with behavioral health needs who are justice-involved.</td>
<td>5</td>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>B. Provide statewide technical assistance to increase the utilization of peers to support justice-involved persons with behavioral health needs.</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>C. Create a Texas certification for justice-involved peer specialists.</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>D. Explore opportunities to incorporate peers into crisis response, diversion, specialty courts, and reentry.</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>E. Promote communication between peer-supports in lock-up settings and other peer-based services to provide continuity of support upon reentry.</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure G-11. Leverage Data and Technology to Expand Access to Care Across the SIM (number of votes)

Table G-11. Leverage Data and Technology to Expand Access to Care Across the SIM (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>West Texas</th>
<th>NAMI</th>
<th>Peers</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Maximize use of telehealth support across the SIM (including telemedicine, peer services, telepsychiatry services for jails, competency evaluation, teletherapy).</td>
<td>4</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>B. Explore the development of a Global Client’s record system for Justice-Involved people to promote sharing of client-level data across agencies to support continuity.</td>
<td>5</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>C. Connect the Department of Public Safety (DPS) Texas Law Enforcement Telecommunication System (TLETS), and the Veterans Affairs Veterans Reentry Service System (VRSS) or other approved Veterans Affairs identification program to provide veterans information to county jails for the purposes of continuity of care and veterans benefits.</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Strategy</td>
<td>West Texas</td>
<td>NAMI</td>
<td>Peers</td>
</tr>
<tr>
<td>------------------------------------------------------------------------</td>
<td>------------</td>
<td>------</td>
<td>-------</td>
</tr>
<tr>
<td>D. Collect accurate data, using systems already in place and mandated in county jails, of the number of individuals incarcerated who may have an IDD diagnosis.</td>
<td>5</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>E. Promote navigation system for officers to support crisis response and pre-arrest diversion.</td>
<td>0</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

**Goal Four: Strengthen state hospital and community-based services.**
Figure G-12. Develop Evidence-Based Guidance for the Appropriate Use of the Competency Restoration Continuum to “Right-Size” Competency Restoration in Texas (number of votes)

Table G-12. Develop Evidence-Based Guidance for the Appropriate Use of the Competency Restoration Continuum to “Right-Size” Competency Restoration in Texas (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Provide statewide technical assistance on competency restoration and best practices to reduce the waitlist for inpatient competency restoration services.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>B. Promote and expand use of court-ordered outpatient mental health treatment in lieu of criminal arraignment and prosecution.</td>
<td>5</td>
<td>3</td>
<td>10</td>
<td>5</td>
</tr>
<tr>
<td>C. Explore statutory changes to prevent people with lower, non-violent offenses (misdemeanors) from being placed on the competency restoration waitlist.</td>
<td>3</td>
<td>3</td>
<td>10</td>
<td>6</td>
</tr>
<tr>
<td>Strategy</td>
<td>TIDC</td>
<td>JCMH</td>
<td>State Hospitals</td>
<td>NAMI</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>------</td>
<td>------</td>
<td>----------------</td>
<td>------</td>
</tr>
<tr>
<td>D. Explore use of technology to compile list of available local service providers and pertinent information related to their services.</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E. Expand housing options and awareness of housing options for people transitioning out of institutions and into the community.</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F. Expand and enhance behavioral health services for people inside jails for anyone in need of services, not just those of have been found IST.</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G. Enhance relationships among state hospitals, judges, courts, LMHAs, and other partners by creating opportunities for authentic engagement and learning (conferences, site visits, role playing exercises, etc.).</td>
<td>0</td>
<td>0</td>
<td>8</td>
<td>0</td>
</tr>
</tbody>
</table>
Figure G-13. Expand Outpatient and Jail-Based Competency Restoration Programs and Jail In-Reach Coordinators across the State to Reduce the Waitlist for Inpatient Competency Restoration Services (number of votes)

Table G-13. Expand Outpatient and Jail-Based Competency Restoration Programs and Jail In-Reach Coordinators across the State to Reduce the Waitlist for Inpatient Competency Restoration Services (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Explore incorporating outpatient (OCR) and jail-based competency restoration (JBCR) as part of the service array provided by LMHAs and LBHAs.</td>
<td>2</td>
<td>3</td>
<td>10</td>
<td>4</td>
</tr>
<tr>
<td>B. Explore funding opportunities for jail in-reach coordinators that monitor people on the waitlist for inpatient competency restoration services and coordinate with LMHAs/LBHAs, state hospitals, jails, and courts.</td>
<td>3</td>
<td>4</td>
<td>6</td>
<td>0</td>
</tr>
</tbody>
</table>
### Strategy

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>C. Develop innovative learning and technical assistance opportunities to</td>
<td>2</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>support jail in-reach for people on 46B.073 commitments awaiting</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>inpatient competency restoration services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. Explore the development of OCR, JBCR, and jail in-reach coordinator</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>programs through braided and blended funding and federal funding.</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>E. Expand access to housing, or add residential component to OCR, to</td>
<td>4</td>
<td>4</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>expand OCR programs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Develop standardized trainings and support to promote the</td>
<td>2</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>expansion of OCR programs.</td>
<td></td>
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</tbody>
</table>

**Figure G-14. Maximize Use of Telemedicine for Forensic Services (number of votes)**

<table>
<thead>
<tr>
<th>Number of People Who Selected Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>25</td>
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<tr>
<td>20</td>
</tr>
<tr>
<td>15</td>
</tr>
<tr>
<td>10</td>
</tr>
<tr>
<td>5</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

Prioritized Strategies: Maximize Use of Telemedicine for Forensic Services (see table for strategy details)

- TIDC
- JCMH
- State Hospitals
- NAMI
Table G-14. Maximize Use of Telemedicine for Forensic Services (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Explore statewide infrastructure needs for the widespread use of telemedicine in forensic services delivery, with attention to rural communities.</td>
<td>4</td>
<td>4</td>
<td>8</td>
<td>6</td>
</tr>
<tr>
<td>B. Utilize telehealth infrastructure for virtual competency evaluations.</td>
<td>0</td>
<td>6</td>
<td>11</td>
<td>6</td>
</tr>
<tr>
<td>C. Utilize telehealth infrastructure for virtual court hearings for defendants committed to state hospitals for competency restoration services.</td>
<td>3</td>
<td>4</td>
<td>9</td>
<td>6</td>
</tr>
<tr>
<td>D. Provide education on the ways in which telemedicine can be used and how it can enhance client outcomes.</td>
<td>5</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
Table G-15. Identify Effectiveness and Improvements in State Hospital and Community-Based Forensic Processes and Services (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Standardize competency restoration curriculum (CRC) for use throughout the State Hospital System and explore the expansion of such CRC to other levels of services.</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>B. Encourage collaboration between LMHAs/LBHAs and state hospitals in the completion of standardized outpatient management plans.</td>
<td>3</td>
<td>3</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>Strategy</td>
<td>TIDC</td>
<td>JCMH</td>
<td>State Hospitals</td>
<td>NAMI</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>C. Identify forensic data collection needs across the continuum of care and formulate a data dashboard to understand trends, benchmark processes, and drive data-informed interventions throughout the continuum of care.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>D. Explore the creation of a statewide dashboard to report forensic statistics and trends across state hospitals, counties, and courts with the goal of targeting technical assistance efforts across the continuum of care.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>E. Strengthen focus on youth found unfit to proceed through increased partnership between HHSC and TJJD.</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>F. Examine the effectiveness and cost-benefit of competency restoration for individuals charged with misdemeanor crimes.</td>
<td>3</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>G. Explore opportunities to support forensics and diversion coordinators through each LMHA to ensure coordination with the state hospitals, courts, jails, law enforcement, community corrections, and community health and mental health providers.</td>
<td>4</td>
<td>0</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>H. Consider the development of new model for reviewing and making decisions on who to release, similar to a parole board.</td>
<td>0</td>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Strategy</td>
<td>TIDC</td>
<td>JCMH</td>
<td>State Hospitals</td>
<td>NAMI</td>
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<tr>
<td>------------------------------------------------------------------------</td>
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<td>------</td>
</tr>
<tr>
<td>I. Develop state guidance on reporting, fees, and other requirements</td>
<td>0</td>
<td>3</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>for doctors who complete competency evaluations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Improve the medication reimbursement program to ensure jails can</td>
<td>0</td>
<td>0</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>easily apply and get reimbursed for medications.</td>
<td></td>
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</tr>
</tbody>
</table>

**Figure G-16. Strengthen Oversight and Quality of Competency Evaluations (number of votes)**
### Table G-16. Strengthen Oversight and Quality of Competency Evaluations (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>TIDC</th>
<th>JCMH</th>
<th>State Hospitals</th>
<th>NAMI</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Develop a State Hospital System (SHS) registry of credentialed competency evaluators in the SHS to ensure high quality competency evaluations.</td>
<td>3</td>
<td>6</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>B. Provide statewide technical assistance to courts on quality competency evaluations.</td>
<td>4</td>
<td>0</td>
<td>9</td>
<td>5</td>
</tr>
<tr>
<td>C. Explore development of state credentialing for competency evaluators with professional licensing boards.</td>
<td>0</td>
<td>3</td>
<td>7</td>
<td>0</td>
</tr>
<tr>
<td>D. Explore the creation of a voluntary statewide registry for community competency evaluators and a statewide peer review process to ensure high quality evaluations.</td>
<td>3</td>
<td>4</td>
<td>8</td>
<td>5</td>
</tr>
<tr>
<td>E. Institute a SHS trial competency evaluation (TCE) peer review process to enhance the quality of competency evaluations and TCE reports filed with court.</td>
<td>3</td>
<td>3</td>
<td>0</td>
<td>4</td>
</tr>
</tbody>
</table>

**Goal Five: Expand training, education, and technical assistance for stakeholders working at the intersection of behavioral health and justice.**
Figure G-17. Provide Statewide Technical Assistance to Promote Best Practices for Diversion for Behavioral Health Providers, Law Enforcement, Jails, Courts, and Community Corrections (number of votes)

Table G-17. Provide Statewide Technical Assistance to Promote Best Practices for Diversion for Behavioral Health Providers, Law Enforcement, Jails, Courts, and Community Corrections (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Develop centers for training and technical assistance focused on the intersection of behavioral health and criminal justice.</td>
<td>2</td>
</tr>
<tr>
<td>B. Promote criminal justice competency in the behavioral health workforce to improve outcomes for people who are justice-involved with diagnosable MI, SUD and/or IDD.</td>
<td>2</td>
</tr>
<tr>
<td>C. Foster learning communities among LMHAs/LBHAs, courts, jails, and law enforcement.</td>
<td>4</td>
</tr>
<tr>
<td>D. Increase the use of validated and reliable criminogenic risk assessment instruments to support structured decision-making across the SIM.</td>
<td>2</td>
</tr>
</tbody>
</table>
E. Enhance training for jailers on veteran's trauma, needs, benefits and services.

3

**Figure G-18. Leverage Existing Training Infrastructures through Partnerships to Provide Education and Training to Criminal Justice and Behavioral Health Professionals (number of votes)**

<table>
<thead>
<tr>
<th>Number of People Who Selected Strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
</tr>
<tr>
<td>3</td>
</tr>
<tr>
<td>0</td>
</tr>
</tbody>
</table>

A. Utilizing existing training platforms operated by HHSC, TCOLE, TCJS, TDCJ, LEMIT, and CMIT, increase education and training to behavioral health, criminal justice, and other relevant professionals.

4

B. In a partnership with HHSC, Texas Judicial Commission on Mental Health, the Supreme Court Commission on Children, Youth, and Families, the Texas Children’s Mental Health Care Consortium, the Juvenile Law Section of the Texas State Bar, and the TxSOC identify potential opportunities to develop and launch a training module with information related to children’s behavioral health and the system of care approach.

5

**Table G-18. Leverage Existing Training Infrastructures through Partnerships to Provide Education and Training to Criminal Justice and Behavioral Health Professionals (number of votes)**

<table>
<thead>
<tr>
<th>Strategy</th>
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<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>4</td>
</tr>
<tr>
<td>B.</td>
<td>5</td>
</tr>
</tbody>
</table>

Prioritized Strategies: Leverage Existing Training Infrastructures through Partnerships to Provide Education and Training to Criminal Justice and Behavioral Health Professionals (see table for strategy details)

North Texas
Figure G-19. Promote Workforce Wellness and Resiliency (number of votes)

Table G-19. Promote Workforce Wellness and Resiliency (number of votes)

<table>
<thead>
<tr>
<th>Strategy</th>
<th>North Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Provide training and technical assistance on trauma as an experience shared by community members, law enforcement and behavioral health providers.</td>
<td>4</td>
</tr>
<tr>
<td>B. Identify and reduce barriers to accessing behavioral health care for law enforcement.</td>
<td>4</td>
</tr>
<tr>
<td>C. Promote the expansion of peer support and workforce wellness programs for criminal justice professions across the SIM.</td>
<td>3</td>
</tr>
</tbody>
</table>
HHSC hosted the state’s first SIM Mapping Summit on January 21-22, 2021, to develop a comprehensive picture of how people with diagnosable MI and co-occurring disorders flow through the criminal justice system; identify gaps, resources, and opportunities at each intercept for people with diagnosable MI; and develop priorities for activities designed to improve system and service level responses.

The SIM Summit was divided into four sessions based on which agencies and regions the participants represented: 1) State Agencies; 2) Rural West Texas; 3) Rural East Texas; and 4) Urban/Suburban Areas. Participants for each session including stakeholders representing mental health and substance use providers, law enforcement, pretrial services, courts, jails, community corrections, housing, health, social services, peers, and family members. The summit culminated in the development of a report with recommendations to reduce justice-involvement for Texans with MI and help ensure all Texans gain access to care at the right time and the right place.

**State SIM Summit Strategic Priorities**

Strategic priorities to improve outcomes for people with MI and co-occurring disorders involved with the criminal justice system were identified through a discussion of gaps in each session and ranked through a voting process where each participant had three votes. The ranked priorities are grouped in topical categories in the Table G-20 through G-22 below.
<table>
<thead>
<tr>
<th>Focus</th>
<th>State Agencies</th>
<th>Rural Areas</th>
<th>Urban/Suburban Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Resource Lists and 911 Dispatch</td>
<td>N/A</td>
<td>Develop a list of mental health, substance use, and IDD resources that are available, and educate the community about those resources.</td>
<td>Additional training for 911 call takers/dispatchers (e.g., Crisis Intervention Team training, Mental Health First Aid). Partnerships with LMHAs/LBHAs where professionals are trained and included in 911 Dispatch operations responding to MH calls. Communication and coordination between 911 dispatch community-based treatment providers and community education around mental health/substance use/IDD resources and the role of crisis services vs. law enforcement.</td>
</tr>
<tr>
<td>Focus</td>
<td>State Agencies</td>
<td>Rural Areas</td>
<td>Urban/Suburban Areas</td>
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</tr>
<tr>
<td>Law Enforcement and Crisis Response</td>
<td>Development of relationships and collaborations between Sheriffs and LMHAs to improve access to mental health and substance use services, particularly in rural areas (i.e., Mental Health Deputy approach). Ongoing cross-system training and provision of information to law enforcement/first responders about mental and substance use disorders, as well as about local services. Self-care/wellness resources for law enforcement and other first responders. Access to mobile crisis services.</td>
<td>Expansion of multi-disciplinary mobile crisis response teams. Include people with lived experience and family members in multi-disciplinary teams. Immediate access to services, particularly during nights and weekends. Law enforcement officers who respond to calls involving individuals experiencing a mental health or substance use crisis in the region are often unable to connect individuals with treatment and other support services. Expand capacity and scope of Mobile Crisis Outreach Team (MCOT) which currently only responds to acute crisis situations (i.e., potential suicide risk). MCOT not currently responding to individuals’ homes due to safety concerns unless law enforcement is present. Explore development of a co-responder program. Involve people with lived experience in MCOT. Expand harm reduction initiatives including Naloxone distribution to law enforcement, other first responders, and the public.</td>
<td>Expansion of efforts focusing on Intercept 0 and expansion/development of pre-arrest diversion processes, triage, and non-refusal drop-off facilities, avoiding detours to hospitals. Expansion and utilization of mobile crisis services (i.e., increasing referrals, building capacity, reducing response time).</td>
</tr>
<tr>
<td>Focus</td>
<td>State Agencies</td>
<td>Rural Areas</td>
<td>Urban/Suburban Areas</td>
</tr>
<tr>
<td>-------------------------------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>Community-Based Service Providers and Hospitals</td>
<td>Collaboration between LMHAs and other community-based service providers. People picking up criminal charges while in hospitals or while attempting to receive/receiving services elsewhere. Substance use disorder treatment needs to be a focus of the conversation.</td>
<td>Alternatives to providing in-person services (both now and post-COVID-19), including utilization of teleservices and access to mobile devices and adequate internet service, particularly in rural areas. Law enforcement officers, particularly in rural areas, often transport people long distances to the nearest state hospital for screening to determine eligibility for admission (consider pre-screening options prior to transport to state hospitals). Increase the amount of crisis stabilization beds. Regional Crisis Stabilization Unit to help address shortage of hospital beds. Increase access to civil and forensic beds at hospitals. Transitioning people out of the hospital in a timely manner, when appropriate. Specific strategies for people who are/have been in the hospital for long periods of time. People placed on waiting lists for accessing community-based services may be required to contact the providers periodically to maintain their positions on the waiting lists. Deal with the psychiatrist workforce shortage. Access to substance use detox facilities/programs, including insurance requirements.</td>
<td>Transition people out of the hospital in a timely manner, when appropriate, ensuring information sharing to maintain continuity of care. Specific strategies for people who are/have been in the hospital for long periods of time or continuously cycle in and out of the hospital (i.e., finding alternatives and dismissing charges). State hospital redesign (i.e., increasing efficiency, create more recovery-oriented environment/space). Expansion of Certified Community Behavioral Health Clinic (CCBHC) and wraparound services model. Strategies for reducing the arrest of people who are attempting to/receiving treatment at hospitals and other treatment provider facilities. Access to substance use treatment, particularly opioid use disorder treatment and medication assisted treatment.</td>
</tr>
<tr>
<td>Focus</td>
<td>State Agencies</td>
<td>Rural Areas</td>
<td>Urban/Suburban Areas</td>
</tr>
<tr>
<td>-------------------------------</td>
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</tr>
<tr>
<td>Peer Supports and Advocates</td>
<td>Involvement of people with lived experience and family members in operation of crisis lines and mobile crisis services. Utilization of peer-run organizations and peer-delivered programs and services, as well as funding to support them. Community engagement and the development of mechanisms for gathering feedback from community members about their experiences in the behavioral health and criminal justice systems. Support for families of people with diagnosable MI, SUD, and/or IDD who are involved in the criminal justice system.</td>
<td>N/A</td>
<td>Embed peer support specialists across the intercepts (i.e., in crisis services and hospital emergency departments, conducting jail-in reach and assisting with reentry). Also, additional funding for peer support services and appropriate compensation. Distribution of resources for family members of people with diagnosable MI who are involved in the criminal justice system and appreciation for their role in recovery.</td>
</tr>
<tr>
<td>Focus</td>
<td>State Agencies</td>
<td>Rural Areas</td>
<td>Urban/Suburban Areas</td>
</tr>
<tr>
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</tr>
<tr>
<td>Competency to Stand Trial and Assisted Outpatient Treatment</td>
<td>People who may be IST face long wait times for competency evaluation and restoration.</td>
<td>Establishment of mental health/substance use training requirements for attorneys. Utilization of Assisted Outpatient Treatment (AOT) and outpatient competency restoration.</td>
<td>Jail-based initiation of medications for people requiring competency evaluation/restoration who are being held waiting for hospital bed. Expand outpatient competency restoration residences/programs through capacity building to offer more intensive levels of care and security. Development of processes for reviewing the lists of people awaiting competency restoration to monitor/follow up and determine if it is still needed. Explore what data exists that can be analyzed to determine how frequently people are arriving at hospitals and found to be competent.</td>
</tr>
</tbody>
</table>
Focus | State Agencies | Rural Areas | Urban/Suburban Areas
--- | --- | --- | ---
Jail Medication and Mental Health Services | Medication continuity (immediate access) and formulary consistency for people booked into jails. | Quick access to medication and continuity at jail booking. Establish a mental health advocate position in jails. Improve communication between jails and LMHAs (some jails and LMHAs communicate and collaborate more than others). Ensuring jails regularly submit information about people booked into the jail booking information to the Veterans Reentry Search Service. Jails to provide medications for opioid use disorder and offer a continuum of medication-assisted treatment (MAT). Strategies for providing jail-based and reentry services, particularly during COVID-19 pandemic (i.e., teleservices). | Advance opportunities for shared professional resources (MDs, PAs, RNs, MAs, Pharmacy, Psychiatrists, Counselors and QMHPs) at a time of professional shortages.

Table G-22. Ranked Priorities for Intercepts 4 and 5 (Reentry and Community Corrections)

<table>
<thead>
<tr>
<th>Focus</th>
<th>State Agencies</th>
<th>Rural Areas</th>
<th>Urban/Suburban Areas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jail and Hospital Reentry</td>
<td>Direct linkage (warm handoffs) during times of transition such as when individuals are released from jails or hospitals.</td>
<td>Jails providing a sufficient temporary supply of medications to people being released Jail clearance for people with lived experience in peer support/recovery coaching roles who have prior criminal histories Jail releases can be unpredictable and happen quickly, such as from court</td>
<td>Jails providing temporary supply of medications at time of release. Also, the development of strategies to address unpredictability and coordinate transportation and direct linkage “warm hand-off” to LMHA or other community-based treatment and service providers</td>
</tr>
<tr>
<td>Focus</td>
<td>State Agencies</td>
<td>Rural Areas</td>
<td>Urban/Suburban Areas</td>
</tr>
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<td>-----------------------</td>
<td>-------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Probation and Parole</td>
<td>Access to/continuation of services for people being released from jail who are being supervised by probation or parole.</td>
<td>Share information with community corrections about a person’s relevant mental health/substance use treatment history and results of recent assessments from LMHAs and other treatment and service providers. Better communication between LMHAs and probation departments regarding bond hearings.</td>
<td>Addition/expansion of Dual Diagnosis Residential Programs (DDRPs) within community corrections agencies.</td>
</tr>
<tr>
<td>Employment</td>
<td>N/A</td>
<td>Increasing employment opportunities and incentives for hiring people with prior criminal history. Minimizing collateral consequences of criminal justice involvement including eliminating barriers to accessing job training.</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**State SIM Summit Recommendations by Policy Research Associates**

PRA developed a set of recommendations based on priorities identified in breakout groups, national initiatives, and PRA’s experience consulting with other states and localities. The following publications also informed recommendations in this report: *All Texas Access Report; Report on the Mental Health Peer Reentry Program; Texas Court of Criminal Appeals Mental Health Resource Guide; Hogg Foundation A Guide to Understanding the Mental Health System and Services in Texas; Texas Statewide Behavioral Health Strategic Plan; The Joint Committee on Access and Forensic Services (JCAFS): 2019 Annual Report.*

1. **Establish a Statewide Technical Assistance and Training Coordination Effort:** Programs across Texas have demonstrated good outcomes, but a gap exists in identifying best practices and scaling those across the state. PRA recommends Texas develop a statewide or regional training and technical assistance effort to:
   a. Provide coordination across criminal justice and behavioral health system stakeholders;
b. Promote data utilization across programs and serve, in partnership with state universities, as an evaluation and technical assistance hub; and c. Share information regarding criminal justice/mental health resources, events, and initiatives.

2. **Launch a Local Housing Pilot and Maximize Key Learnings:** Though not identified as a priority in regional voting, lack of a continuum of housing options for people who have behavioral health needs and/or are justice-involved was identified as a major gap across all of the four SIM Summit sessions, particularly in the Intercept 0-1 and Intercept 4-5 discussions. Housing is also listed as a priority in 5 of the 6 regions cited in the *All Texas Access Report* and listed as a gap in the *Texas Statewide Behavioral Health Strategic Plan*. PRA recommends Texas develop strategies to address housing challenges, including the launch of local housing pilots to support people exiting institutions with complex behavioral health needs. PRA also recommends Texas address shelter and landlord housing criteria that limit or exclude people with criminal justice or mental health or substance use issues.

3. **Expand and Collaborate with CCBHCs, FQHCs, and LMHAs/LBHAs across the State:** Texas has an array of CCBHCs which are an integrated and sustainably financed model for care delivery that has dramatically increased access to mental health and SUD treatment, expanded states’ capacity to address the overdose crisis, and established innovative partnerships with law enforcement, schools, and hospitals to improve care, reduce recidivism, and prevent hospital readmissions. PRA recommends Texas continue to expand and enhance collaborations between CCBHCs, FQHCs, and LMHAs/LBHAs.

4. **Expand Utilization of People with Lived Experience (Peers) across the Intercepts:** It is important to develop diversion programming inclusive of people with mental illness and/or those who have been affected by the criminal justice system. Expanding peer services was identified as a priority across regions. In addition, both the *All-Texas Access Report* and the *Texas Statewide Behavioral Health Strategic Plan* identify utilization of peers as a gap. PRA recommends Texas expand utilization of people with lived experience across all Intercepts.

5. **Develop/Enhance Officer Wellness Strategies:** Officer wellness was listed as a priority in the State Agency Workshop, and there was substantial discussion about the importance of addressing this topic in the Rural East Workshop with one department identifying the topic as an urgent issue. Given resource challenges in rural communities in particular, police officer wellness may be a more critical
concern in these areas. PRA recommends Texas support the development and provision of officer safety and wellness programs.

6. **Increase Access to Transportation:** A common and under-addressed gap nationally is access to transportation, especially for justice-involved people. This not only impacts access to health care but also impacts criminal justice outcomes. Not surprisingly, transportation was identified as a gap in the Rural East and Rural West sessions. Transportation was also identified in both the *All Texas Access Report* and in the *Texas Statewide Behavioral Health Strategic Plan* as significant gaps in rural regions of Texas. PRA recommends Texas support the implementation of programs that increase access to transportation for justice-involved populations.

7. **Expand Use of Technology across the Intercepts:** The pandemic has altered how people access behavioral health services and even how courts and community supervision programs operate. Use of videoconferencing and teleconferencing has allowed people to initiate or maintain access to services, courts, and community supervision agencies.

   As noted in the *All Texas Access Report*:

   “From January to June 2020, face-to-face encounters decreased by 67 percent while video encounters increased by 137 percent, and telephone encounters increased 365 percent. Compared to the same period in 2019, there was a net increase in services to people who receive ongoing services at the LMHA/LBHAs. This continuation of services is significant because HHSC’s analysis has shown that 98 to 99 percent of persons receiving ongoing services at the LMHA/LBHAs avoid psychiatric hospitalizations. HHSC will conduct further analysis over time about the impact of this telephonic/telehealth demonstration; however, the early analysis is promising.”

   PRA recommends Texas continue to expand the use of technology across the Intercepts to increase access to care and improve continuity of care. PRA also supports the All Texas Access legislative recommendations to encourage closer coordination with the newly formed Broadband Development Council to expedite and expand broadband access to local communities.

8. **Continue to Expand and Refine Competency to Stand Trial Evaluation/Restoration Backlogs:** Participants echoed the work of the *JCAFS 2019 Annual Report*, the *All Texas Access Report*, and the *Texas Statewide Behavioral Health Strategic Plan* in addressing challenges around people who may be IST in Texas. In general, restoration settings from most restrictive to least include inpatient (usually at a state mental health hospital), jail-based, and
community-based outpatient. PRA recommends Texas continue to support and expand current state and local initiatives to reduce the number of competence evaluations ordered, provide both outpatient and jail-based competence restoration, improve custodial treatment, and expedite transition from state hospital beds to local communities. In addition, the Texas JCMH Law Bench Book advises against using the competency process for people charged with misdemeanors. PRA recommends Texas explore legislation other states are pursuing regarding this issue.

9. **Facilitate County and Regional Criminal Justice and Behavioral Health Planning in Rural Areas:** Participants described great disparity in criminal justice and behavioral health collaboration between the urban/suburban areas and rural areas. These disparities included: level of LMHA collaboration with law enforcement and the jails; information sharing between jails and LMHAs and the need for additional HIPAA training among LMHAs; ensuring utilization and effectiveness of the jail matching capability; jail treatment services and awareness and utilization of local resources; and lack of opportunities to develop regional approaches and sharing of resources. PRA recommends Texas continue to facilitate county and regional criminal justice and behavioral health planning in rural areas, like that promoted through All Texas Access regions.

10. **Develop more Formal and Coordinated Diversion Strategies for Arraignment Diversion (Intercept 2) and Pretrial Diversion (Intercept 3) especially in Rural Communities and including Validated Risk Assessments:** Early diversion opportunities in rural communities are hampered by a lack of resources, collaboration, and training for assigned counsel, the judiciary, and prosecutors. Training for judges, attorneys, and court staff is critical to the success of these programs. Increasing MI understanding and how various tools measure pretrial risk (as opposed to risk of violence) facilitates informed decision-making by court-based professionals. Specialty courts are not required for diversion especially in rural areas. Cross-system collaboration is crucial though to ensure time screening and access to services. PRA recommends Texas develop more formal and coordinated diversion strategies for arraignment diversion and pretrial diversion, especially in rural communities. PRA also suggested state leaders look to other states who are expanding the use of pretrial services, relying on validated risk assessment instruments to guide release decisions.

11. **Further Explore Substance Use Service and Program Needs Particularly in Rural Communities:** Across regions (particularly rural regions), there were gaps reported for access to detoxification and substance use residential treatment
and jail-based MAT. One of the services CCBHCs implemented in Texas provide is MAT. PRA recommends Texas review current MAT processes in the community and jail for a continuum of options. PRA also suggests Texas ensure support, especially peer support, to help people maintain MAT and their recovery.

12. **Further Explore Training and Service Access for Justice-Involved People with IDD:** IDD encompasses a spectrum of disorders that limit intellectual functioning such as reasoning, learning, and integration (e.g., problem-solving), and adaptive behavior (conceptual, social, and practical skills). While not listed as a priority by participants, services specific to people with diagnosable IDD did arise as a gap in the Rural East and Suburban/Urban regions where both noted there was a high number of people with diagnosable IDD in the jails. PRA recommends Texas further explore training and service access for people who are justice involved with diagnosable IDD.

PRA also identified two overarching issues that should be addressed:

- **Racial equity and disparity:** While the focus of the State SIM Summit was on people with MI and co-occurring disorders, disparities in health care access and criminal justice involvement should also be addressed to ensure comprehensive system change.
- **Trauma:** It is estimated 90 percent of justice-involved people have experienced traumatic events at some point in their life. It is critical that both the healthcare and criminal justice systems be trauma-informed and there be trauma screening and trauma-specific treatment available for this population. A trauma-informed approach incorporates three key elements:
  - Realizing the prevalence of trauma;
  - Recognizing how trauma affects all people involved with the program, organization, or system, including its own workforce; and
  - Responding by putting this knowledge into practice with trauma-informed care in behavioral health services.

**Public Survey**

**Logistics**

On behalf of the SBHCC, HHSC hosted a public survey August 31-September 14, 2021, titled “Survey for the Texas Plan for Diversion, Community Integration, and Forensic Services.” The survey was promoted through GovDelivery and shared with external stakeholders who were asked to disseminate the survey with their network. The survey instrument is provided at the end of this appendix.
Responses

A total of 588 people started the survey. All the survey questions were optional to encourage participation. Respondents were not included in the survey analysis if they:

- Did not identify as living in Texas;
  - Survey respondents who did not answer this question and/or did not explicitly identify as not living in Texas were included in the survey analysis;
- Did not answer any of the questions relating to strategies and/or leave an open-ended comment; or
- Did not have experience with the behavioral health or criminal justice system were not included in the analysis.

The number of surveys included in this analysis is 546. If survey respondents met the criteria for survey inclusion, yet did not respond to certain questions, their non-responses were not included in the survey analysis.

Objectives

Prior to the survey, five objectives were identified for The Texas Strategic Plan for Diversion, Community Integration, and Forensic Services. For each of these objectives, strategies were identified that could be help Texas advance the objectives. Some of the objectives had as many as 15 strategies identified while other objectives had as few as two strategies identified. Survey participants were asked to select the top strategies they felt were most important to furthering the objectives.

Survey participants were generally asked to select the top three strategies for each objective yet could choose to select all strategies per question due to survey limitations. Survey participants who did the following were excluded from the survey analysis (amounting to less than 5 percent of the responses):

- Selected more than half of the strategies per Objective 1.1, Objective 3.1, Objective 3.2, Objective 3.3;
- Selected all of the strategies for an objective; and/or
- Selected more than 5 strategies per objective were excluded from the survey analysis.

Strategies for Each Objective

The most-commonly selected strategies for each objective are listed below.
Objective 1.1: Expand and scale use of crisis and pre-arrest diversion programs and strategies at Intercepts 0 and 1.

- (17 percent) Coordinate with law enforcement, behavioral health providers, housing service providers, and other stakeholders to develop programs focused on people with complex care needs that frequently cycle between systems.
- (15 percent) Promote Crisis Intervention Team training and other specialized law enforcement training programs to improve outcomes in interactions between law enforcement and people with diagnosable MI, SUD, and/or IDD.
- (16 percent) Expand crisis receiving centers such as, crisis stabilization, crisis respite, and sobering centers.
- (13 percent) Promote the expansion of round-the-clock MCOT and co-responder programs and identify best practices that can scale across rural, suburban, and urban communities.
- (8 percent) Identify opportunities to pilot emergency department diversion programs and promote connections to care for people with complex behavioral health needs.

Objective 1.2: Increase use of diversion pathways across intercept 2 and 3.

- (19 percent) Increase the use of pre-trial diversion programs, specialty courts, and specialized probation and parole for justice-involved people with behavioral health needs.
- (19 percent) Increase the use of pre-trial diversion programs, specialty courts, and specialized probation and parole for justice-involved people with behavioral health needs.
- (15 percent) Ensure universal screening for MI, SUD, and IDD at jail booking.
- (12 percent) Promote best practices and supports in treatment courts for high-risk/high-need people.
- (11 percent) Expand tailored services for people with SUD and co-occurring issues.

Objective 1.3: Increase diversion through the use of data and technology across the SIM.

- (25 percent) Enhance and refine current technology to support the identification and case management of people with diagnosable MI, SUD, and/or IDD who are justice involved (e.g., Texas Law Enforcement Telecommunication System [TLETS] Continuity of Care Query).
- (24 percent) Explore opportunities to incorporate technology into crisis response and pre-arrest diversion programs to expand reach and availability across communities, including rural and frontier communities.
- (20 percent) Use appropriately shared data to support decision-making and linkages to care.
• (15 percent) Utilize technology to inventory local supports and services in the community for first responders.
• (15 percent) Promote the use of virtual supports to enhance crisis response and diversion through statewide technical assistance.

Objective 2.1: Enhance community collaboration through strategic planning and coordination across the SIM.
• (21 percent) Identify opportunities to fund local forensic and diversion coordinators responsible for coordination between behavioral health providers, jails, courts, community corrections, and state hospitals.
• (20 percent) Fund local and regional collaborative projects focused on coordination and information sharing to reduce and prevent justice-involvement of people with behavioral health needs.
• (20 percent) Increase local partnerships to expand the social safety net and connect justice-involved people with supportive services.
• (14 percent) Provide statewide training and technical assistance on expanding and enhancing behavioral health-criminal justice collaborations through local coordinating bodies.
• (10 percent) Explore best practice models for local coordination, including criminal justice coordinating councils and regional planning and oversight bodies.
• (10 percent) Extend support to local communities to increase communication, collaboration, and education across the SIM.

Objective 2.2: Increase information sharing at state and local levels.
• (19 percent) Work with county judges to require attorneys to receive specialized training to take on cases related to MI, SUD, and IDD.
• (19 percent) Safely and securely share information with prosecutors, defense attorneys, and judges to better understand a person’s case, prior justice involvement, previous service referrals, and current connections to care.
• (12 percent) Explore the development of a Global Client Record to ensure data sharing for continuity of care.
• (12 percent) Support data sharing pilots in select communities to better identify those in need of services and to support continuity of care.
• (11 percent) Explore data sharing needs between State agencies to develop a long-term data strategy for the state to support policy development, oversight, and ongoing improvement efforts.

Objective 2.3: Increase strategic partnerships between state, local, regional, and community agencies and organizations.
• (26 percent) Utilize a whole-community approach for addressing issues at the intersection of behavioral health and criminal justice that includes partnerships
with housing authorities, hospitals, universities and medical schools, faith-based organizations, schools, FQHCs, and other regional and local agencies and organizations.

- (24 percent) Maximize resources at a regional level to fund and operate programs that reduce justice involvement for people with diagnosable MI, SUD, and/or IDD, including regional crisis receiving facilities.
- (22 percent) Expand liaison/coordinator positions within LMHA/LBHAs to coordinate care for people with diagnosable MI, SUD, and/or IDD throughout their entire experience in the justice system and during reentry.
- (17 percent) Promote best practices for care coordination between CCBHCs and criminal justice partners.
- (12 percent) Explore opportunities to streamline and maximize state benefits and supportive services through State agency partnerships.

**Objective 3.1: Enhance care and support services across the SIM.**

- (14 percent) Promote coordination and collaboration among all possible points of contact/levels of care (e.g., jails, outpatient treatment, inpatient treatment, transitional housing, etc.) for seamless transitions and appropriate continuity of care.
- (13 percent) Expand and enhance programs that focus on providing intensive, wraparound services for people with complex needs cycling among multiple systems.
- (13 percent) Increase collaboration between hospitals, jails, and community providers to ensure warm handoffs and connection to care when people return to the community.
- (10 percent) Focus on prevention and early intervention in substance use for youth to reduce the likelihood of entering the juvenile justice system.
- (8 percent) Enhance substance use services in rural communities to decrease the risk of recidivism for justice-involved people with diagnosable MI, SUD, and/or IDD.

**Objective 3.2: Increase connection to treatment and tailored supports for special populations, including people with IDD, youth, and veterans.**

- (13 percent) Increase access to housing and support services for people with diagnosable IDD to reduce justice involvement.
- (11 percent) Provide training, technical assistance, and other supports to law enforcement, LMHA/LBHAs, and other stakeholders to promote best practices and increase use of diversionary paths across the SIM for special populations.
- (10 percent) Increase the capacity of residential treatment centers for children and youth.
• (9 percent) Reduce barriers to diversion across the SIM for special populations by developing actionable and tailored solutions through state partnerships and state-local collaborations.
• (9 percent) Improve screening for people with diagnosable IDD when entering county jails.

**Objective 3.3: Address the social determinants of health that increase the risk of justice involvement, including housing, employment, and transportation.**

• (10 percent) Work collaboratively with local public and private stakeholders to expand housing options with attention to landlord criteria and transitions between institutions and community, including step-down and transitional housing, adult residential settings, and sober living/recovery home options.
• (9 percent) Support the development of a full continuum of housing options with appropriate services and attention to transitions between institutions and community, including step-down and transitional housing, adult residential settings, and sober living/recovery home options.
• (9 percent) Support programs that address the social determinants of health and reduce the risk of recidivism for people with behavioral health needs who are involved with the criminal justice systems.
• (9 percent) Support the development of dedicated position(s) at each LMHA, LBHA, and LIDDA to provide housing navigation, employment, transportation, and education services for people with diagnosable MI, SUD, and/or IDD and justice-involvement.
• (9 percent) Explore hospital and housing partnerships to reduce the utilization of emergency rooms and increase housing for people with complex care needs cycling between systems.

**Objective 3.4: Increase the use of peers across the SIM.**

• (23 percent) Expand peer programs in criminal justice and behavioral health settings to support people with behavioral health needs who are justice-involved.
• (19 percent) Explore opportunities to incorporate peers into crisis response, diversion, specialty courts, and reentry.
• (15 percent) Explore comprehensive approaches to incorporate youth peer support training and services into juvenile justice alternative education programs and disciplinary alternative education programs.
• (13 percent) Provide statewide technical assistance to increase the utilization of peers to support justice-involved persons with behavioral health needs.
• (12 percent) Create a Texas certification for justice-involved peer specialists.
• (11 percent) Work with philanthropy and faith-based organizations to support peer-run crisis respite and recovery homes.

Objective 3.5: Leverage data and technology to expand access to care across the SIM.
• (28 percent) Maximize use of telehealth support across the SIM (including telemedicine, peer services, telepsychiatry services for jails, competency evaluation, and teletherapy).
• (25 percent) Connect the Texas Department of Public Safety’s TLETS, and the VRSS or other approved Veterans Affairs identification program to provide veterans information to county jails for the purposes of continuity of care and veterans benefits.
• (25 percent) Collect accurate data, using systems already in place and mandated in county jails, of the number of people incarcerated who may have an IDD diagnosis.
• (25 percent) Explore the development of a Global Client’s record system for justice-involved clients to promote sharing of client-level data across agencies to support continuity.

Objective 4.1: Develop evidence-based guidance for the appropriate use of the competency restoration continuum to “right-size” competency restoration in Texas.
• (22 percent) Promote and expand use of court-ordered outpatient mental health treatment in lieu of criminal arraignment and prosecution.
• (18 percent) Expand housing options for people transitioning out of institutions into the community.
• (15 percent) Explore statutory changes to prevent people with lower, non-violent offenses (misdemeanors) from being placed on the competency restoration waitlist.
• (13 percent) Enhance relationships among state hospitals, judges, courts, LMHA/LBHAs, and other partners by creating opportunities for engagement and learning.
• (13 percent) Identify the appropriate competency restoration pathways for people found incompetent to stand trial based on clinical need/acuity and public safety risk using a research-based framework.

Objective 4.2: Expand outpatient and jail-based competency restoration programs and jail in-reach coordinators across the state to reduce the waitlist for inpatient competency restoration services.
• (65 percent) Explore funding opportunities for jail in-reach coordinators who monitor people on the waitlist for inpatient competency restoration services and coordinate with LMHAs/LBHAs, state hospitals, jails, and courts.
• (35 percent) Develop innovative learning and technical assistance opportunities to support jail in-reach for people on 46B.073 commitments awaiting inpatient competency restoration services.

Objective 4.4: Identify efficiencies and improvements in state hospital and community-based forensic processes and services.
• (16 percent) Explore opportunities to support forensics and diversion coordinators through LMHA/LBHAs to ensure coordination with the state hospitals, courts, jails, law enforcement, community corrections, and community health and mental health providers.
• (14 percent) Expand and enhance capacity of behavioral health providers to provide restoration services to people with diagnosable IDD.
• (14 percent) Encourage collaboration between LMHAs/LBHAs and state hospitals in the completion of standardized outpatient management plans (for people found not guilty by reason of insanity and those committed for competency restoration services who are discharging from a state hospital and into the community).
• (13 percent) Expand access to Home and Community Based Services-Adult Mental Health waivers.
• (10 percent) Examine the effectiveness and cost-benefit of competency restoration for people charged with misdemeanor crimes.

Objective 4.5: Strengthen oversight and quality of competency evaluations.
• (28 percent) Develop a SHS registry of credentialed competency evaluators in the SHS to ensure high quality competency evaluations.
• (25 percent) Explore development of state credentialing for competency evaluators with professional licensing boards.
• (24 percent) Provide statewide technical assistance to courts on quality competency evaluations.
• (23 percent) Explore the creation of a voluntary statewide registry for community competency evaluators and a statewide peer review process to ensure high quality evaluations.

Objective 5.1: Provide statewide technical assistance on the SIM to promote best practices for diversion for behavioral health providers, law enforcement, jails, courts, and community corrections.
• (18 percent) Increase focus in behavioral health professions on the intersections of behavioral health and evidence-based and promising interventions and programs for justice-involved populations with behavioral health needs.
• (17 percent) Promote criminal justice competency in the behavioral health workforce to improve outcomes for justice-involved people with diagnosable MI, SUD, and/or IDD.
• (15 percent) Develop centers for training and technical assistance focused on the intersection of behavioral health and criminal justice.
• (14 percent) Partner with universities and medical schools to increase focus in behavioral health professions on the intersections of behavioral health and evidence-based promising interventions and programs for justice-involved populations with behavioral health needs.
• (14 percent) Enhance training for jailers on veterans' trauma, needs, benefits, and services.

**Open-Ended Input**

Survey participants were also invited to provide SBHCC open-ended input concerning forensics and behavioral health services at the end of the survey. A sampling of responses is listed below with minor editing for clarity or grammatical errors:

• This population needs housing before they can work on their other issues. Encourage developers to build in low-income options into their development plans. Low-income housing is getting more scarce.
• Creating financial opportunities and rewards for communities to develop, adopt, and coordinate local applications of SIM principles will change Texas for the better the fastest.
• The largest gap we have in our criminal and behavioral health system is in early identification and gaps in continuity of care.
• These issues cannot be solved if there is nowhere to take people with IDD. Group homes don't want them back, and Adult Protective Services believes jails are the safest place for them. Until this issue is solved, training and sharing information is a moot point.
• My daughter was incarcerated and not treated for five months at Del Valle before receiving mental health competency restoration at the Conroe mental health facility. I saw her in stripes and chains through a thick window like a common criminal. No physical contact, hardly able to hear... Her crime was officially driving under the influence. Her real "crime" was schizophrenia.
• My own experience in Tarrant County Jail was a terrible one. I had one 5-minute conversation with a psychiatrist, and he misdiagnosed me and that was it. I was in for 140 days and on the wrong meds. Having a diversion program, advocate, or peer would have made it a much less traumatic experience.
• One of the things I see lacking is the ability of someone to maintain medications once released from prison. Assisting those that were on disability before incarceration to reestablish that income in coordination with the release.
• There is too much focus ... on correcting problems after MH/IDD clients enter the criminal justice system rather than on providing benefits, services, treatment, and medication before clients ever enter the criminal justice system. It is far more cost effective and efficient to prevent a problem than to fix it afterwards.

• The forensic outpatient services offered by each LMHA vary significantly, and many LMHAs have no forensic (46B or 46C) specific program(s) that exist or can be offered to people who qualify and could be managed on outpatient. This keeps many people in a hospital setting when they could be appropriately placed and managed in a lesser restrictive environment, and therefore keeps hospital beds unavailable for other people in jails and in the community in need of inpatient care.

• The criminal justice system and the providers need to come together and share relevant information in order to better serve the person.

**Demographics**

The “Survey for the Texas Plan for Diversion, Community Integration, and Forensic Services” asked several demographic questions. A general analysis of the responses to each demographic question is provided below as Figures G-20 though G-30.

**Figure G-20. Which options describe your experience with behavioral health services in Texas?**

<table>
<thead>
<tr>
<th>Option</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>I receive or have received behavioral health services</td>
<td>32</td>
</tr>
<tr>
<td>I am a friend, family member, or caregiver of someone who has</td>
<td>63</td>
</tr>
<tr>
<td>received behavioral health services</td>
<td></td>
</tr>
<tr>
<td>I am a behavioral health provider</td>
<td>204</td>
</tr>
<tr>
<td>I work with the behavioral system in other ways</td>
<td>123</td>
</tr>
<tr>
<td>I work with the criminal justice system</td>
<td>124</td>
</tr>
</tbody>
</table>
Figure G-21. What is your current employment status?

- Government employee: 256
- Private sector employee: 182
- Self-employed: 41
- Unemployed: 19
- Other employment: 9
- Prefer not to say: 39

Figure G-22. What was your total individual income for the past 12 months?

- Under $30,000: 51
- $30,001 - $50,000: 121
- $50,001 - $80,000: 142
- $80,001 - $120,000: 96
- Above $120,000: 59
- Prefer not to say: 75
Figure G-23. How old are you?

Figure G-24. What is the highest level of school you have completed?
Figure G-25. Are you of Hispanic, Latino, or Spanish origin?

- Not Hispanic: 75%
- Hispanic: 19%
- Prefer not to say: 6%
- I don't know: 0%

Figure G-26. What is your race?

- White: 385
- Black: 65
- Asian or Pacific Islander: 10
- American Indian or Alaska Native: 6
- Other race: 20
- Two or more races: 20
- Prefer not to say: 40
Figure G-27. Do you have a disability?

![Pie chart showing distribution of responses to the question about having a disability.

Figure G-28. Do you think your disability has been a barrier to obtaining behavioral health services?

![Pie chart showing distribution of responses to the question about the impact of disability on obtaining behavioral health services.]}
Figure G-29. Population Size for County of Residence

- Urban (pop. over 250,000): 344
- Suburban (pop. between 100,000 and 250,000): 97
- Rural (pop. under 100,000): 102
Surveys

Survey for the Texas Plan for Diversion, Community Integration, and Forensic Services

Survey Instructions

The survey will be open from Tuesday, August 17 to Tuesday, August 31. Your answers will be anonymous and will help HHSC develop Well and Safe: The Texas Strategic Plan for Diversion, Community Integration, and Forensic Services.

Survey Questions

1. Which options describe your experience with behavioral health services in Texas? (check all that apply)
a. I receive or have received behavioral health services
b. I am a friend, family member, or caregiver of someone who has received behavioral health services
c. I am a behavioral health service provider
d. I work within the criminal justice system
e. I work with the behavioral health system in other ways
f. I have no experience with the behavioral health or criminal justice system

[If a.] Which options describe your personal experience receiving services? (check all that apply)
a. I receive mental health services now or in the past
b. I receive substance use services now or in the past
c. I received mental health services in the past while in jail, prison, juvenile detention, or on parole or probation
d. I received substance use services in the past while in jail, prison, juvenile detention, or on parole or probation
e. Other:
[If b.] What is your experience as a friend, family member, or caregiver of a person receiving services? (check all that apply)
   a. I have friends or family who are receiving or have received mental health services
   b. I have friends or family who are receiving or have received substance use services
   c. I have friends or family who are receiving or have received mental health services in jail, prison, juvenile detention, or on parole or probation
   d. I have friends or family who are receiving or have received substance use services in jail, prison, juvenile detention, or on parole or probation
   e. Other:

[If c.] Which options best describe you as a service provider? (check all that apply)
   a. I am primarily a mental health service provider for community services
   b. I am primarily a substance use service provider for community services
   c. I primarily provide mental health services to people in jail, prison, juvenile detention, or on parole or probation
   d. I primarily provide substance use services to people in jail, prison, juvenile detention, or on parole or probation
   e. I primarily provide inpatient care
   f. Other:

[If d.] Which options best describe you as working within the criminal justice system?
   a. I work for a law enforcement agency
   b. I work with the courts
   c. I work within the jails or with jail administration
   d. I work with probation or parole
   e. I am a defense attorney or public defender
   f. I am a district or county attorney
   g. Other:
[If e.] How do you work with behavioral health services?
   a. I work for a substance use prevention organization
   b. I work for an organization that provides advocacy, peer services, transportation, housing, employment assistance, service referral or other support services
   c. I work for a managed care organization
   d. I work in education
   e. I work in local government
   f. I work in state government
   g. Other:

2. What is your current employment status?
   a. Private sector employee (non-government organization or company, including non-profits)
   b. Government employee
   c. Self-employed
   d. Other employment (work in a for-profit family business or farm for 15 hours or more per week, with or without pay)
   e. Unemployed
   f. Prefer not to say

3. What was your total individual income for the PAST 12 MONTHS (no matter what income source)?
   a. Under $30,000 annually
   b. $30,001-$50,000 annually
   c. $50,001-$80,000 annually
   d. $80,001-$120,000 annually
   e. Above $120,000 annually
   f. Prefer not to say

4. How old are you?
   a. Under 18
   b. 18-24
   c. 25-34
   d. 35-44
   e. 45-54
   f. 55-64
   g. Over 65
   h. Prefer not to say
5. What is the highest level of school you have COMPLETED?
   a. Grade 12 or below (no diploma) [no branching following this response]
   b. High school graduate or equivalent
   c. Technical/career program or professional certification
   d. Undergraduate school
   e. Graduate school
   f. Prefer not to say

6. Are you of Hispanic, Latino, or Spanish origin?
   a. No
   b. Yes
   c. I don’t know
   d. Prefer not to say

7. What is your race?
   a. American Indian or Alaska Native
   b. Asian or Pacific Islander (for example: Chinese, Korean, Filipino, Pakistani, Asian Indian, Native Hawaiian, Samoan)
   c. Black (for example: African American, Jamaican, Haitian, Nigerian, Ethiopian)
   d. White (for example: German, Irish, English, Italian, Lebanese, Egyptian)
   e. Other race
   f. Prefer not to say

8. Do you have a disability (deaf, hard of hearing, blind, low vision, mobility impairment, or others)?
   a. Yes
   b. No
   c. Prefer not to say

   [If a.] Do you think your disability has been a barrier to obtaining behavioral health services?
   d. Yes
   e. No
   f. I don’t know
   g. Prefer not to say

9. What county do you reside in?
The purpose of *Well and Safe: The Texas Plan for Diversion, Community Integration, and Forensic Services* is to lay out a vision and a clear, actionable, and achievable plan for reducing justice involvement and increasing community integration for Texans with mental health (MH) and substance use disorders (SUD) and intellectual and developmental disabilities (IDD) by ensuring all Texans receive care in the right place at the right time.

Two final notes: (1) There are several references to the Sequential Intercept Model (SIM) in the goals and strategies listed below. The SIM helps communities identify resources and gaps in services at each intercept and develop local strategies. The infographic below visually illustrates the SIM. You can also visit [https://www.samhsa.gov/criminal-juvenile-justice/sim-overview](https://www.samhsa.gov/criminal-juvenile-justice/sim-overview) for more information. (2) You will also see references to behavioral health services and behavioral health providers. These terms are catch all for MH, SUD, and IDD services and providers in Texas.

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**Goal 1 of 5**

Develop robust crisis and diversion systems to reduce and prevent justice involvement for people with MH, SUD, and IDD.

10. Objective 1.1: Expand and scale use of crisis and pre-arrest diversion programs and strategies at Intercepts 0 and 1. Please select the top three strategies you think are most important to pursue.

   a. Support local planning for crisis and pre-arrest diversion programs.
   b. Expand crisis receiving centers such as, crisis stabilization, crisis respite, and sobering centers.
   c. Leverage 988 to reduce justice involvement through improved emergency call taking, dispatch, and crisis response.
   d. Identify and reduce barriers to crisis response and pre-arrest diversion at the local level.
e. Conduct statewide education and technical assistance on the value of pre-arrest diversion programs and ways different stakeholders can support implementation.

f. Explore the use of state opioid funding and other federal and state programs to establish and expand diversion programs for substance use.

g. Promote the expansion of round-the-clock mobile crisis outreach teams and co-responder programs, and identify best practices that can scale across rural, suburban, and urban communities.

h. Identify opportunities to pilot emergency department diversion programs and promote connections to care for people with complex behavioral health needs.

i. Promote Crisis Intervention Team training and other specialized law enforcement training programs to improve outcomes in interactions between law enforcement and people with MH, SUD, and IDD.

j. Study the feasibility of providing local law enforcement access to relevant information for the purpose of diverting individuals with MH, SUD, and IDD into proper treatment instead of jail.

k. Explore federal and philanthropic funding for crisis and pre-arrest diversion programs.

l. Coordinate with law enforcement, behavioral health providers, housing service providers, and other stakeholders to develop programs focused on people with complex care needs that frequently cycle between systems.

m. Partner with universities and medical schools to increase local behavioral health service capacity and expand the behavioral health workforce.

n. Promote education and outreach to the community and justice partners to increase awareness of crisis and behavioral health services.

o. Expand mental health deputy programs across the state.

11. Objective 1.2: Increase use of diversion pathways across intercept 2 and 3. Please select the top three strategies you think are most important to pursue.

a. Ensure universal screening for MH, SUD, and IDD at jail booking.

b. Establish mental health public defender programs that cover every county in the state.

c. Support the uptake of diversion strategies at arraignment.

d. Expand pretrial supervision and diversion services to reduce episodes of incarceration.

e. Promote best practices and supports in treatment courts for high-risk/high-need people.
f. Increase the use of pre-trial diversion programs, specialty courts, and specialized probation and parole for justice-involved individuals with behavioral health needs.
g. Expand tailored services for people with substance use disorders and co-occurring issues.
h. Expand the use of jail coordinators to support diversion and reentry.

12. Objective 1.3: Increase diversion through the use of data and technology across the SIM. Please select the top three strategies you think are most important to pursue.
   a. Enhance and refine current technology to support the identification and case management of people with MH, SUD, and IDD who are justice involved (e.g., TLETS Continuity of Care Query).
   b. Promote the use of virtual supports to enhance crisis response and diversion through statewide technical assistance.
   c. Explore opportunities to incorporate technology into crisis response and pre-arrest diversion programs to expand reach and availability across communities, including rural and frontier communities.
   d. Use appropriately shared data to support decision-making and linkages to care.
   e. Utilize technology to inventory local supports and services in the community for first responders.

Goal 2 of 5

Increase coordination, collaboration, and accountability across systems, agencies, and organizations.

13. Objective 2.1: Enhance community collaboration through strategic planning and coordination across the SIM. Please select the top three strategies you think are most important to pursue.
   a. Provide SIM Mapping workshops to support strategic planning and collaboration in local communities.
   b. Provide statewide training and technical assistance on expanding and enhancing behavioral health-criminal justice collaborations through local coordinating bodies.
   c. Adopt the SIM framework for local planning and collaboration.
   d. Identify opportunities to fund local forensic and diversion coordinators responsible for coordination between behavioral health providers, jails, courts, community corrections, and state hospitals.
e. Explore best practice models for local coordination, including criminal justice coordinating councils and regional planning and oversight bodies.

f. Increase local partnerships to expand the social safety net and connect justice-involved people with supportive services.

g. Fund local and regional collaborative projects focused on coordination and information sharing to reduce and prevent justice-involvement of people with behavioral health needs.

h. Extend support to local communities to increase communication, collaboration, and education across the SIM.

14. Objective 2.2: Increase information sharing at state and local levels. Please select the top three strategies you think are most important to pursue.

  a. Explore data sharing needs between state agencies to develop a long-term data strategy for the state to support policy development, oversight, and ongoing improvement efforts.
  
  b. Explore the development of a Global Client Record to ensure data sharing for continuity of care.
  
  c. Support data sharing pilots in select communities to better identify those in need of services and to support continuity of care.
  
  d. Improve TLETS matching and other data sharing platforms to identify those in need of services in both the adult and juvenile population.
  
  e. Examine system data and information to pinpoint areas for improvement across justice and behavioral health services.
  
  f. Explore the use of data use agreements, business associate agreements, and universal consent forms for information sharing between local government agencies.
  
  g. Work with county judges to require attorneys to receive specialized training to take on cases related to MH, SUD, and IDD.
  
  h. Safely and securely share information with prosecutors, defense attorneys, and judges to better understand a person's case, prior justice involvement, previous service referrals, and current connections to care.

15. Objective 2.3: Increase strategic partnerships between state, local, regional, and community agencies and organizations. Please select the top three strategies you think are most important to pursue.

  a. Explore opportunities to streamline and maximize state benefits and supportive services through state agency partnerships.
  
c. Utilize a whole-community approach for addressing issues at the intersection of behavioral health and criminal justice that includes partnerships with housing authorities, hospitals, universities and medical schools, faith-based organizations, schools, Federally Qualified Health Centers, and other regional and local agencies and organizations.
d. Maximize resources at a regional level to fund and operate programs that reduce justice involvement for people with MH, SUD and IDD, including regional crisis receiving facilities.
e. Expand liaison/coordinator positions within LMHA/LBHAs to coordinate care for people with MH, SUD and IDD throughout their entire experience in the justice system and during reentry.

Goal 3 of 5

Enhance the continuum of care and support services for people who are justice-involved with MH, SUD, and IDD.

16. Objective 3.1: Enhance care and support services across the SIM. Please select the top three strategies you think are most important to pursue.
   a. Utilize Certified Community Behavioral Health Clinics to increase care coordination and integrated physical and behavioral health services for people who are justice-involved.
b. Provide statewide technical assistance on evidence-based and best practices for behavioral health care, integrated physical and behavioral health care, and supportive services for people who are justice-involved.
c. Explore the use of a system-wide drug formulary to ensure medication continuity.
d. Increase the Medicaid provider base to create additional capacity for crisis and outpatient services.
e. Expand Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) to serve more moderate and high-risk people and reduce the risk of recidivism for people with MH, SUD, and IDD.
f. Prioritize coordination between local communities, law enforcement, and public safety answering points in state planning and implementation of 988.
g. Enhance substance use services in rural communities to decrease the risk of recidivism for justice-involved people with MH, SUD, and IDD.
h. Explore opportunities to expand physical health care for persons who are justice-involved through Federally Qualified Health Centers.
i. Expand and enhance programs that focus on providing intensive, wraparound services for people with complex needs cycling among multiple systems.
j. Promote coordination and collaboration among all possible points of contact/levels of care (e.g., jails, outpatient treatment, inpatient treatment, transitional housing, etc.) for seamless transitions and appropriate continuity of care.

k. Expand access to substance use treatment across the SIM.

l. Focus on prevention and early intervention in substance use for youth to reduce the likelihood of entering the juvenile justice system.

m. Increase collaboration between hospitals, jails, and community providers to ensure warm handoffs and connection to care when people return to the community.

17. Objective 3.2: Increase connection to treatment and tailored supports for special populations, including people with IDD, youth, and veterans. Please select the top three strategies you think are most important to pursue.

a. Reduce barriers to diversion across the SIM for special populations by developing actionable and tailored solutions through state partnerships and state-local collaborations.

b. Provide training, technical assistance, and other supports to law enforcement, LMHA/LBHAs, and other stakeholders to promote best practices and increase use of diversionary paths across the SIM for special populations.

c. Compile strategies and resources for addressing the needs of people with IDD into a format that is easy to understand and that is easily accessible to all county jails.

d. Increase the capacity of residential treatment centers for children and youth.

e. Enhance collaboration amongst state agencies and local veterans support organizations, including volunteer and faith-based organizations, to provide support and funding for veterans PODS/Dorms and county jails.


g. Create opportunities for shared learning and interaction between the IDD community and law enforcement.

h. Expand prevention and early intervention for substance use and youth.

i. Expand the use of youth peer specialists to support youth.

j. Expand access to medication assisted treatment for pregnant women with SUDs.

k. Expand the use of peer services for people with IDD.

l. Build awareness of LIDDAs as part of the continuum of care.
m. Increase access to housing and support services for people with IDD to reduce justice involvement.
n. Improve screening for people with IDD when entering county jails.

18. Objective 3.3: Address the social determinants of health that increase the risk of justice involvement, including housing, employment, and transportation. Please select the top three strategies you think are most important to pursue.
   a. Promote supported housing and employment through dedicated funding streams.
   b. Explore opportunities to maximize access and enrollment in benefits and supports to address housing, employment, and transportation.
   c. Support the development of a full continuum of housing options with appropriate services and attention to transitions between institutions and community, including step-down and transitional housing, adult residential settings, and sober living/recovery home options.
   d. Provide statewide technical assistance to local housing authorities and developers receiving state-administered funds on behavioral health, stigma, tenancy selection criteria, and opportunities to provide housing to people with current or prior justice involvement.
   e. Leverage Project Access and Home and Community Based Services-Adult Mental Health to provide housing to people transitioning from inpatient and correctional settings into communities.
   f. Promote awareness of opportunities to reduce the barriers to housing for justice-involved persons, including tenancy selection criteria.
   g. Support the development of dedicated position(s) at each LMHA, LBHA and LIDDA to provide housing navigation, employment, transportation, and education services for people with MH, SUD, and IDD and justice-involvement.
   h. Promote fair chance housing practices through rule changes that encourage the development of “low barrier” housing for units built with state-administered funds.
   i. Expand the use of the SOAR (SSI/SSDI Outreach, Access, and Recovery) model to increase access to benefits and supports.
   j. Explore opportunities to utilize the expungement of misdemeanor criminal records to facilitate connection with employment and housing, when appropriate.
   k. Work collaboratively with local public and private stakeholders to expand housing options with attention to landlord criteria and transitions between institutions and community, including step-down and transitional housing, adult residential settings, and sober living/recovery home options.
l. Support programs that address the social determinants of health and reduce the risk of recidivism for people with behavioral health needs that are involved with the criminal justice systems.
m. Explore hospital and housing partnerships to reduce the utilization of emergency rooms and increase housing for people with complex care needs cycling between systems.
n. Fund innovative housing initiatives at the local level.

19. Objective 3.4: Increase the use of peers across the SIM. Please select the top three strategies you think are most important to pursue.
   a. Expand peer programs in criminal justice and behavioral health settings to support people with behavioral health needs who are justice-involved.
   b. Provide statewide technical assistance to increase the utilization of peers to support justice-involved persons with behavioral health needs.
   c. Create a Texas certification for justice-involved peer specialists.
   d. Explore comprehensive approaches to incorporate youth peer support training and services into juvenile justice alternative education programs and disciplinary alternative education programs.
   e. Expand peer clubhouses, including virtual clubhouses.
   f. Explore opportunities to incorporate peers into crisis response, diversion, specialty courts, and reentry.
   g. Work with philanthropy and faith-based organizations to support peer-run crisis respite and recovery homes.

20. Objective 3.5: Leverage data and technology to expand access to care across the SIM. Please select the top three strategies you think are most important to pursue.
   a. Maximize use of telehealth support across the SIM (including telemedicine, peer services, telepsychiatry services for jails, competency evaluation, and teletherapy).
   b. Explore the development of a Global Client’s record system for Justice-Involved clients to promote sharing of client-level data across agencies to support continuity.
   c. Connect the Department of Public Safety (DPS) Texas Law Enforcement Telecommunication System (TLETS), and the Veterans Affairs Veterans Reentry Service System (VRSS) or other approved Veterans Affairs identification program to provide veterans information to county jails for the purposes of continuity of care and veterans benefits.
d. Collect accurate data, using systems already in place and mandated in county jails, of the number of people incarcerated who may have an IDD diagnosis.

**Goal 4 of 5**

Revolutionize state hospital and community-based forensic services.

21. **Objective 4.1:** Develop evidence-based guidance for the appropriate use of the competency restoration continuum to “right-size” competency restoration in Texas. Please select the top three strategies you think are most important to pursue.
   a. Identify the appropriate competency restoration pathways for people found incompetent to stand trial based on clinical need/acuity and public safety risk using a research-based framework.
   b. Provide statewide technical assistance on competency restoration and best practices to reduce the number of individuals waiting for inpatient competency restoration.
   c. Promote and expand use of court-ordered outpatient mental health treatment in lieu of criminal arraignment and prosecution.
   d. Explore statutory changes to prevent people with lower, non-violent offenses (misdemeanors) from being placed on the competency restoration waitlist.
   e. Provide technical assistance to local courts on competency restoration services.
   f. Pilot demonstration projects of best practices across the SIM and measure results.
   g. Enhance relationships among state hospitals, judges, courts, LMHA/LBHAs and other partners by creating opportunities for engagement and learning.
   h. Expand housing options for people transitioning out of institutions into the community.

22. **Objective 4.2:** Expand outpatient and jail-based competency restoration programs and jail in-reach coordinators across the state to reduce the waitlist for inpatient competency restoration services. Please select the top strategy you think is most important to pursue.
   a. Explore funding opportunities for jail in-reach coordinators that monitor individuals on the waitlist for inpatient competency restoration services and coordinate with LMHAs/LBHAs, state hospitals, jails, and courts.
   b. Develop innovative learning and technical assistance opportunities to support jail in-reach for individuals on 46B.073 commitments awaiting inpatient competency restoration services.
23. Objective 4.4: Identify efficiencies and improvements in state hospital and community-based forensic processes and services. Please select the top three strategies you think are most important to pursue.
   a. Standardize competency restoration curriculum (CRC) for use throughout the State Hospital System and explore the expansion of such CRC to other levels of services (i.e., OCR, JBCR and community contractors).
   b. Encourage collaboration between LMHAs/LBHAs and state hospitals in the completion of standardized outpatient management plans (for individuals found not guilty by reason of insanity and those committed for competency restoration services who are discharging from a state hospital and into the community).
   c. Identify forensic data collection needs across the continuum of care and formulate a data dashboard to understand trends, benchmark processes, and drive data-informed interventions throughout the continuum of care.
   d. Explore the creation of a statewide dashboard to report forensic statistics and trends across state hospitals, counties, and courts with the goal of targeting technical assistance efforts across the continuum of care.
   e. Strengthen focus on youth found unfit to proceed through increased partnership between HHSC and Texas Juvenile Justice Department.
   f. Examine the effectiveness and cost-benefit of competency restoration for individuals charged with misdemeanor crimes.
   g. Explore opportunities to support forensics and diversion coordinators through LMHA/LBHAs to ensure coordination with the state hospitals, courts, jails, law enforcement, community corrections, and community health and mental health providers.
   h. Expand access to Home and Community Based Services Adult Mental Health waivers.
   i. Expand and enhance capacity of behavioral health providers to provide restoration services to individuals with IDD.

24. Objective 4.5: Strengthen oversight and quality of competency evaluations. Please select the top three strategies you think are most important to pursue.
   a. Develop a State Hospital System (SHS) registry of credentialed competency evaluators in the SHS to ensure high quality competency evaluations.
   b. Provide statewide technical assistance to courts on quality competency evaluations.
   c. Explore development of state credentialing for competency evaluators with professional licensing boards.
d. Explore the creation of a voluntary statewide registry for community competency evaluators and a statewide peer review process to ensure high quality evaluations.

**Goal 5 of 5**

Expand training, education, and technical assistance for stakeholders working at the intersection of behavioral health and criminal justice.

25. **Objective 5.1:** Provide statewide technical assistance on the SIM to promote best practices for diversion for behavioral health providers, law enforcement, jails, courts, and community corrections. Please select the top three strategies you think are most important to pursue.

   a. Develop centers for training and technical assistance focused on the intersection of behavioral health and criminal justice.

   b. Promote criminal justice competency in the behavioral health workforce to improve outcomes for justice-involved people with MH, SUD, and IDD.

   c. Foster learning communities among LMHAs/LBHAs, courts, jails, and law enforcement to help facilitate the implementation of best practices for each region of the state.

   d. Increase the use of validated and reliable criminogenic risk assessment instruments to support structured decision-making across the SIM.

   e. Enhance training for jailers on veterans' trauma, needs, benefits, and services.

   f. Increase focus in behavioral health professions on the intersections of behavioral health and evidence-based and promising interventions and programs for justice-involved populations with behavioral health needs.

   g. Partner with universities and medical schools to increase focus on behavioral health professions on the intersections of behavioral health and evidence-based promising interventions and programs for justice-involved populations with behavioral health needs.

**Final Question!**

Is there anything else you like to share with HHSC concerning forensic and behavioral health services?

**Thank you!**

Thank you for participating in the survey!
If you or someone you know is experiencing anxiety, stress, or emotional challenges due to the COVID-19 pandemic, call the Statewide COVID-19 Mental Health Support Line 24 hours a day, 7 days a week toll-free at 833-986-1919 or visit https://mentalhealthtx.org/.
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INTRODUCTION:
Mental health concerns and cases can absorb a vast number of police resources in San Marcos due to the nature of cases the Mental Health (MH) Unit at SMPD is assigned. The unit tends to have anywhere from 10 to 30 cases worked by the three officers and a full-time qualified mental professional who acts as a Crisis Response Care Coordinator. These four individuals currently make up the unit in addition to a therapy K-9. They work under the mission of providing resources to those who would otherwise not have help or support, making it a point to touch base with individuals they feel may need follow-up or continued care. Resultantly, their caseload and dispersion of services are highly dependent upon the specific needs of each citizen contacted.

SCOPE OF DATA:
All mental health call response and outcomes occurring in San Marcos from August 2, 2022 to July 20, 2023 were recorded and analyzed for the current memorandum. These calls were pulled from the San Marcos Police Department’s computer-aided dispatch system on July 21, 2023. During this span of time, the San Marcos dispatch center received 1,932 calls for service that involved a mental health or suspected mental health consumer. These calls included both officer-initiated work and citizen-initiated calls for service. Because officer-initiated calls, in this case, tended to be case follow-ups (wherein officers visited with patients and consumers), officer-initiated calls were removed from analysis. Therefore, only calls that originated from the 911 or non-emergency lines were included, resulting in an analysis of 1,179 calls. These calls were divided by outcome, namely those that ended in emergency detention and those that did not.

SUPPORTING CHARTS AND TABLES:
Included in the current document is:
Chart One: Mental Health calls ending in Emergency Detention by Priority Assigned..................................Page 2
Chart Two: Unit Dispatched by Priority in Mental Health calls ending in Emergency Detention..............Page 3
Chart Three: Mental Health Calls not ending in Emergency Detention by Priority Assigned..................Page 4
Chart Four: Unit Dispatched by Priority in Mental Health calls not ending in Emergency Detention..Page 5
Table One: Officer Narrative of Calls ending in Arrest.................................................................Page 6
I. ANALYSIS OF MENTAL HEALTH CALLS ENDING WITH EMERGENCY DETENTION

Of the 1,179 mental health-related calls originating from the 911 or non-emergency call line, 217 (18%) ended in emergency detention. Emergency detainments for mental health consumers are taken very seriously by the San Marcos Police Department and only used in incidents where the in-crisis individual meets the threshold of being an imminent danger to themselves or others. Otherwise, officers will simply aid in de-escalating the situation as emergency detainments or efforts to forcibly remove individuals from public property involves removing individual rights.

*It should be noted that 14 additional emergency detentions occurred as a result of officer-initiated calls (making up 2% of the 753 officer-initiated calls). Ten (71%) of these calls originated from the Mental Health Unit, two (14%) of these calls originated from Patrol, and two (14%) of these calls originated from School Resource Officers.*

For calls that ended in emergency detention:
- 51% (118 calls) were made in response to a known mentally ill individual (or mental health investigation)
- 38% (90 calls) regarded a suicidal subject
- 4% (9 calls) involved an overdose or poisoning
- 3% (8 calls) involved a law enforcement assist in the field
- The remaining 3% (6 calls) involved injuries/pain, service calls, or welfare checks

IA. ANALYSIS OF MENTAL HEALTH CALLS ENDING WITH AN EMERGENCY DETENTION BY PRIMARY UNIT RESPONSE

Please note that primary responding unit simply refers to the first unit dispatched. This does not mean that the Mental Health Unit was not dispatched, just not dispatched first, depending on the priority assigned, circumstances of the call when received in dispatch, or availability of the unit (see Chart One for a breakdown of priority assigned in the analyzed calls).

For calls that ended in Emergency Detention:
- Patrol was the primary responding unit in 156 calls (72%)
- Mental Health was the primary responding unit in 37 calls (17%)
- EMS or Fire were the primary responding unit in 22 calls (10%)

*Chart One: Mental Health calls ending in Emergency Detention by Priority Assigned*

**Notes:** Chart One provides a break-down of the priority level of Mental Health calls ending in Emergency Detention. Priority 1 represents the highest priority.
To better illustrate how primary unit response occurs, Chart Two provides an illustration of primary unit dispatched by priority in the calls that ended in emergency detention.

Chart Two: Unit Dispatched by Priority in Mental Health calls ending in Emergency Detention

When broken down in this way, it is apparent that:

- EMS or Fire tended to be primarily dispatched in priority 1 or 2 calls. This represents physical injury or loss of life.
- Mental Health tended to be primarily dispatched in priority 3 calls.
- Patrol was primarily dispatched evenly across priority 1, 2, and 3 calls. This should be indicative of call center policy which highlights that patrol is the default dispatch when circumstances are unknown, a criminal offense is suspected to have occurred, or a mental health officer is not available.

IB. ANALYSIS OF CASE CLOSURE FOR MENTAL HEALTH CALLS ENDING WITH AN EMERGENCY DETENTION

Mental Health calls that ended in emergency detention largely resulted in a mental health investigation (203, 94%). However:

- 3% (6 calls) of emergency detentions led to no case created due to lack of follow-up (determined by lack of compliance or no need for follow-up)
- 3% (6 calls) of emergency detentions ended in a suicide attempt case
- 1% (1 call) of emergency detentions ended in a lost property case
- 1% (1 call) of emergency detentions ended in a Criminal Mischief case

0 of these calls led to an arrest.
II. ANALYSIS OF MENTAL HEALTH CALL NOT ENDING IN EMERGENCY DETENTION BY PRIMARY UNIT RESPONSE

In 82% of calls originating from the 911 or non-emergency lines, the individual or situation responded to did not meet emergency detainment requirements. For these calls:

- Patrol was the primary responding unit in 58% of calls (678 calls)
- Mental health was the primary responding unit in 20% of calls (232 calls)
- EMS and Fire were the primary responding units in 3% of calls (40 calls)

Remaining calls were primarily responded to by:

- The Crime Reduction Unit (3 calls) or
- School Resource Officers (2 calls)

Based on primary response, it may be assumed that a majority of the mental health-related calls coming into the San Marcos dispatch center—that did not end in emergency detention—have been a lower priority. In this case, Patrol is dispatched first if the Mental Health Unit is not available (in the case that Mental Health Officers are not available, two patrol officers are dispatched). A priority analysis finds that 55% of calls that did not end in emergency detainment were listed priority 3 and 2% were priority 4 (see Chart Three):

*Chart Three: Mental Health Calls not ending in emergency detention by Priority Assigned*

Note. Chart three provides a break-down of the priority level of Mental Health calls that did not end in Emergency Detention. Priority 1 represents the highest priority.

Again, to better illustrate how primary unit response occurs, Chart Four provides an illustration of primary unit dispatched by priority in the calls that did not end in emergency detention.

From this chart, it is evidenced that:

- EMS and Fire were less likely to be dispatched primarily than in calls that ended in emergency detention, but remained to be most likely dispatched in higher priority calls that did not end in emergency detention.
- The Mental Health Unit was more likely to be primarily dispatched to priority 3 calls
- Patrol appeared to be the primary response for a majority of the higher priority calls. Again, this should highlight dispatch policy that patrol is the default dispatch when circumstances are unknown, a criminal offense is suspected to have occurred, or a mental health officer is not available.
IIA. ANALYSIS OF CASE CLOSURE FOR MENTAL HEALTH CALLS NOT ENDING WITH AN EMERGENCY DETENTION

Of the 962 calls that did not end in Emergency Detention:

- 96% (927 calls) ended in no case created
  - No arrests derived from these calls and circumstances did not warrant an offense report or mental health follow-up
- 1% (13 calls) ended in a mental health investigation
  - 11 of these cases prompted Mental Health Unit follow-up
  - 2 of these cases led to arrests involving drug offenses and defying a protective order (see Table One for details)
- .5% (4 calls) involved alcohol offense cases
- .3% (3 calls) involved death investigations
- .2% (2 calls) involved assault cases
- .2% (2 calls) involved criminal mischief cases
- .2% (2 calls) involved narcotics/drug laws
- .2% (2 calls) involved drunkenness cases

The remaining seven cases involved (1 call) driving while intoxicated, (1 call) missing persons, (1 call) runaway, (1 call) sex offense, (1 call) trespass, (1 call) violation of court order, and (1 call) warrant service.

Stemming from these 35 cases, 18 arrests were made in response to criminal offenses (see Table One for the officer’s narrative and reasoning for arrest).
<table>
<thead>
<tr>
<th>Case Type Created</th>
<th>Condensed Officer Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol Offense</td>
<td>Mental Health Officers responded to CSR for a Mental Health Investigation. It was determined that O1 did not meet criteria for an Emergency Detention, but that he was extremely intoxicated. O1 admitted to having consumed Mushrooms and Vodka. O1 was being extremely belligerent with hospital staff, and he could barely stand up on his own without assistance. O1 was arrested for Public Intoxication and transported to HCLEC without issue.</td>
</tr>
<tr>
<td>Alcohol Offense</td>
<td>Officers were dispatched in reference to a suicidal person. Officers arrived and spoke to O1 who said his girlfriend tried to kill herself. O1 was obviously drunk, slurring his speech, unsteady on his feet, and smelling strongly of alcohol. O1 stated he would show officers how he would hurt himself and was then placed in handcuffs and placed under arrest at approximately 2045hrs based on the danger to himself or others.</td>
</tr>
<tr>
<td>Alcohol Offense</td>
<td>O1 charged with public intoxication.</td>
</tr>
<tr>
<td>Alcohol Offense</td>
<td>An intoxicated, suicidal male entered the SMPD lobby where he became verbally and physically resistant with officers. The male was placed into a WRAP restrain for his safety; transported for medical clearance and jailing for his charges.</td>
</tr>
<tr>
<td>Assault</td>
<td>Officers were dispatched in reference to a mental health investigation. Upon arrival, it was learned that O1 assaulted V1 during a verbal argument. O1 was later placed under arrest for Assault Causing Bodily Injury Family Member and transported to HCLEC.</td>
</tr>
<tr>
<td>Assault</td>
<td>V1 called to report his girlfriend O1 was trying to kill herself inside his apartment. When officers arrived, it was discovered that V1 had been punched in the face and suffered a bloody nose. O1 also did not want V1 to leave her so she stood in the doorway preventing him from leaving the apartment. She was arrested for Assault FV and Unlawful Restraint.</td>
</tr>
<tr>
<td>Drunkenness</td>
<td>A call-for-service was generated for an intoxicated male who was un-clothed. Officers made contact with subject at the location and he was determined to be publicly intoxicated. He was placed under arrest for PI.</td>
</tr>
<tr>
<td>Drunkenness</td>
<td>Officers were dispatched in reference to a verbal disturbance. Upon arrival, officers made contact with O1 outside who was intoxicated. O1 was placed under arrest and transported to the Hays County jail for booking.</td>
</tr>
<tr>
<td>DWI</td>
<td>Officers responded to a mental health investigation. Officers located a vehicle which was driving on two flat tires on the IH 35 Frontage Road. The vehicle was driven by O1. Officers conducted field-sobriety tests on O1 after signs of intoxication were observed. O1 was placed under arrest for DWI.</td>
</tr>
<tr>
<td>Mental Health Investigation</td>
<td>O1 was arrested for Violation of Conditions of Bond stemming from a recent Protective Order for a family violence related incident.</td>
</tr>
<tr>
<td>Mental Health Investigation</td>
<td>SMPD responded regarding a mental health call for service. Once on scene, officers met with O1 and O2. O1 and O2 had active warrants out of Eagle Pass. O1 also had narcotics on her person when she was searched.</td>
</tr>
<tr>
<td>Narcotics/Drug Laws</td>
<td>Officers responded to a mental health investigation. Upon talking to O1, he was found to have possession of a controlled substance (Methamphetamine). O1 was arrested and taken to HCLEC.</td>
</tr>
<tr>
<td>Narcotics/Drug Laws</td>
<td>Officers were dispatched regarding a mental health investigation. O1 was subsequently arrested for possession of a controlled substance (THC).</td>
</tr>
</tbody>
</table>
Table One Cont.

<table>
<thead>
<tr>
<th>Case Type Created</th>
<th>Condensed Officer Narrative</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trespass</td>
<td>SMPD arrested O1 for criminal trespass.</td>
</tr>
<tr>
<td>Criminal Mischief</td>
<td>SMPD Officers were dispatched regarding a Physical Disturbance. Upon arrival officers made contact with O1. After conducting an investigation, O1 was placed under arrest for Criminal Mischief after she caused significant damage to one of the hospital rooms. O1 was transported to HCLE.</td>
</tr>
<tr>
<td>Criminal Mischief</td>
<td>Officers responded to hospital for a vandalism call. Suspect had destroyed a phone belonging to the hospital and was arrested.</td>
</tr>
<tr>
<td>Violation of Court Order</td>
<td>Officers were dispatched in reference to a verbal disturbance. O1 had consumed alcoholic beverages when he had been court ordered he to not possess or use any alcohol. O1 was placed under arrest and transported to jail without further incident.</td>
</tr>
<tr>
<td>Warrant Service</td>
<td>Officer was dispatched regarding a suicidal subject formally diagnosed with bipolar disorder. While enroute to the location, I requested SMPD dispatch to check the subject for active warrants. O1 was shown to have a warrant in TCIC out of Austin for Criminal Mischief at the felony level. Once the warrant was confirmed, I transported O1 to HCLE for booking. I notified booking of his mental health status. O1 was compliant without issue.</td>
</tr>
</tbody>
</table>
Opportunities for Crisis and Pre-Arrest Diversion in Rural and Urban Texas Counties: Law Enforcement Perspectives
Stacey Stevens Manser, Ph.D.
Peter Arellano, MSW

This work is funded through a contract with the Texas Health and Human Services Commission, the Office of Forensic Coordination, and supported by a Transformation Transfer Initiative (TTI) grant from the National Association of State Mental Health Program Directors (NASMHPD). The contents are solely the responsibility of the authors and do not necessarily represent the official views of Texas Health and Human Services Commission.

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Executive Summary

The Texas Health and Human Services Commission (HHSC) Office of Forensic Coordination contracted with The Texas Institute for Excellence in Mental Health to conduct a survey of Texas police chiefs and other leaders in police departments or law enforcement. The survey sought to gain their perspectives on what would assist in diverting Texans experiencing mental health or substance use disorders or development disabilities from justice involvement into more appropriate behavioral health crisis and treatment services. Results from the survey items and open-ended responses revealed a desire and priority for diversion, opportunities to increase crisis response or diversion, as well as reports of lack of access to treatment, staff, and resources to implement diversion that impede the priority – with these issues more frequently reported in rural counties. Responses also revealed a need for more collaborative partnerships and increased understanding between law enforcement and other providers on current system resources and capacity and opportunities for improvement. A review of the results along with opportunities is presented in this summary.

Counties Represented

There were 557 survey responses from 153 counties across Texas (60.2% of 254 counties). Almost all urban counties (90.5%; 19 of 21) and a majority of rural counties (57.5%; 134 of 233) were represented. The most represented regions were East Texas, North Texas, Upper Gulf Coast, and Central Texas, followed by South Texas, The Rio Grande Valley, the Panhandle, and West Texas. Results are not generalizable to the county or the state, but provide important law enforcement perspectives on crisis and pre-arrest diversion in rural and urban counties.

Survey Responder Characteristics

There was no difference in years of service (over 26 years) comparing urban and rural county responders, with a majority of the job titles reflecting a leadership role such as Police Chief (49.6% of urban and 52.6% of rural). Most who responded to the survey were male (88.6%) and white, with more racial and ethnic diversity in urban counties. A majority of rural and urban responders worked in smaller departments (department size 1-10 or 11-50), which may result in fewer staff or funding resources for diversion efforts. This is reflected in the open-ended survey responses where a combined 37.3% took the time to report that resources including staff, funds, and time were barriers to diversion.

Crisis Response and Pre-Arrest Diversion

A majority of responders indicated that diversion is a priority in their department (59.8% urban and 49.8% rural), however, the remaining percentages reporting somewhat, no, and unsure were significant. Follow up items revealed lower percentages reporting that a crisis response and pre-arrest diversion program had been identified for their department or community (37.4% urban; 25.1% rural) with about the same percentages reporting a departmental representative managing or overseeing these programs (37.6% urban; 26.2% rural). The open-ended responses provide context to these data, with the highest barriers to diversion reported as lack of access to treatment, time, resources (i.e., staffing and dollars), and support from treatment providers hindering diversion efforts.

Opportunity: Given those indicating diversion was a priority but that resources were barriers to implementation, county or community-wide diversion efforts become more important as effective
solutions (both financially and in terms of best practice). Engaging counties in Sequential Intercept Mapping to identify and prioritize a county-wide plan for diversion and offering technical assistance and support for implementation could advance county crisis response and diversion efforts.

For those reporting a crisis response or pre-arrest diversion program as yes, underway, or planned, the majority reported that these programs were focused on mental health, followed by intellectual and developmental disabilities. Substance use disorder diversion was reported less frequently, perhaps because these programs occur more often post-arrest or because substance use treatment is more challenging to access in areas of the state.

**Opportunity:** Responses reveal opportunities to support local partnerships and collaboration around crisis response and diversion efforts as well as to better understand the barriers departments experience, particularly related to pre-arrest substance use diversion. Sequential Intercept Mapping is an effective method for counties to work collaboratively to identify strengths, gaps, and develop plans for diversion.

**Crisis and Diversion Partnerships**

A high percentage were aware of crisis services available from local treatment providers (85.7% urban; 79.1% rural) but less than half reported interagency MOUs guided referrals to these providers (45.7% urban; 41.9% rural). A slightly higher percentage reported that they had community partners to discuss issues related to criminal justice (52.4% urban; 42.1% rural), and in both rural and urban counties, these discussions were reported more frequently with mental health providers. Around 25% of urban responders reported partnering with substance use or IDD providers and 12-15% of rural responders reported partnering with substance use or IDD providers.

**Opportunity:** The high awareness of services available yet lower reported interagency collaboration represents opportunities to bring community stakeholders together to co-create community response to crisis and examine opportunities for pre-arrest diversion. In addition, mapping actual availability of crisis response and treatment services (including limits to accessibility due to treatment service resource limits) may provide additional insight into law enforcement experiences in less resourced counties and more rural counties throughout the state. The low percentage of rural and urban responders who reported partnering with substance use or IDD providers points to an important need to identify where these services are not easily accessible or available.

**Crisis Response and Diversion Programs Provided or Planned**

Of the 16 crisis response and diversion program types listed in the survey, only two programs – specialized mental health training for peace officers (78.2% urban; 53.1%) and mental health officers (67.8% urban; 54.6% rural) – were reported as provided by over 50% of both rural and urban responders. Urban county responders reported crisis intervention teams/officers (57.0%) and dispatcher training (46.3%) as the next two most provided programs and rural county responders reported crisis intervention teams/officers (33.6%) and overdose reversal programs (32.7%) as the next two most provided programs.

The lack of crisis response and diversion programs provided or planned is significant and complex. Open-ended responses to diversion barriers and improvements reveal that many police departments in urban
and rural counties reported a lack of accessible alternatives to arrest or incarceration for a person in crisis. Although most reported diversion was a priority, they also reported that their priority is safety for the community, and that a well-resourced collaborative response is necessary for diversion.

Some also reported a lack of time and resources necessary to interact with the person in crisis, to wait on scene for crisis support, to wait in facilities for disposition and transfer to treatment systems, or to even have these options available and accessible in their counties. A smaller number reported that other systems were more appropriate to respond in these instances (e.g., behavioral health and emergency medical services), and that the expansion of their scope of work (and whether this is an appropriate expansion) kept them from their primary mission of enforcing laws, preventing crime, maintaining the peace, and ensuring the public and community safety.¹

**Opportunity:** The Office of Forensic Coordination and their organizational partners will be providing ways for agencies within counties to collaborate on their diversion efforts. The soon to be launched Texas Behavioral Health and Justice Technical Assistance Resource Center can provide a variety of resources to police departments. Resources to increase awareness of the different types of crisis response and diversion programs that departments could explore will be included as downloads or links on the website. A portal to submit requests for individual technical assistance will be offered. Opportunities to apply for Sequential Intercept Mapping will be provided through the website. A learning collaborative for law enforcement to advance diversion in their communities will be upcoming. There will also be an opportunity to participate in a community of practice to advance county level progress on completed sequential intercept model plans.

**Data Systems for Tracking Mental Health or Substance Use Calls**

Although the percentages were significantly lower in rural compared to urban counties (44.5% urban; 28.8% urban), both urban and rural county responders reported that data systems were in place to track mental health or substance use service calls less than 50% of the time. Follow up items also revealed less ability to amend call identifiers after arrival if the service call was mental health or substance use related and even less ability to add a secondary call identifier if the primary code must remain in place.

**Opportunity:** The reported lack of data systems to track mental health or substance use calls reveal opportunities for improving these systems. As the 988 crisis line is implemented in the state, those providing technical assistance to systems might look to existing guidance documents, such as the *Public Safety Answering Points* playbook,² to support communities in identifying strategies for data tracking and roles for different community organizations to serve in 988 implementation. Additionally, there are methods for tracking service calls that are mental health or substance use involved and these can be shared with police departments to raise awareness and increase adoption.

**Use of Screening Tools to Support Identification**

About two-thirds of all responders (65.7% rural; 61.7% urban) reported not using formal screening tools to support identification of people with mental health or substance use crisis or needs, and even more reported not using screening tools for IDD related calls (71.1% rural; 70.0% urban).

¹ Understanding that each Police Department has its own unique mission statement.
² National Association of State Mental Health Program Directors. 2022. 988 Implementation Guidance Playbooks. https://www.nasmhpd.org/content/988-implementation-guidance-playbooks
Opportunity: Providing support for the exploration and adoption of screening tools appropriate for the justice system\(^3\) may be helpful for identification, with an understanding that accessible diversion points are also necessary for this to be a successful practice. Importantly, identifying IDD is different than identifying someone experiencing a mental health or substance use challenge and requires a different approach. Increasing the awareness and knowledge of IDD among law enforcement officers may be a first step in identification and diversion.\(^4\)

Training for Identification and Crisis Response

Two survey items asked about existing training for identification and crisis response. 33.1% of urban and 20.8% of rural county responders reported that 911 and dispatch received training on the identification and management of calls related to mental health, substance use, and IDD crisis or related issues.

Opportunity: The low reports of 911 and dispatch receiving training on the identification and management of calls related to mental health, substance use, and IDD crisis or related issues presents a significant opportunity to offer standardized, best practice statewide training to increase the number of individuals working in 911 and dispatch trained to identify and manage these calls.

A high percentage (77.9% urban; 59.7% rural) reported that officers in their departments received mental health/substance use crisis response training which aligned with, but was higher than the percentages reporting that diversion for mental health and substance use was a priority (59.8% urban and 49.8% rural) in their department.

Opportunity: The percentages of rural and urban police departments reporting that their officers received mental health/substance use crisis response training was higher than the percentage reporting crisis diversion as a priority in their department. This lack of consistent alignment between priority and practice represents opportunities to support diversion as a priority in collaboration with other community partners as well as to examine the similarities and differences of crisis response trainings provided across the state. There are also significant percentages who reported not receiving crisis response training, again presenting opportunities for additional trainings, perhaps statewide, to offer economies of scale.

Most Useful Crisis Response and Pre-Arrest Diversion Resources

A list of seven resource types were ranked by responders to understand which would be most helpful in their diversion efforts. In-person or on-line training or webinars on recognizing and responding to crisis was the highest ranked resource by both urban and rural county responders (urban 49.1%; rural 46.7%), followed by in-person or on-line training or webinars on effective interventions and diversion to treatment for both rural and urban counties. Completing the top three ranked resources, rural county responders ranked seeing where and what types of diversion programs exist across the state as the third most useful resource while urban responders reported written guides or toolkits on effective crisis interventions and diversion to treatment.

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\(^3\) U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. 2019. Screening and Assessment of Co-Occurring Disorders in the Justice System.

**Opportunity:** The Office of Forensic Coordination and partner agencies can use the type of resources preferred by police departments to target their online and in-person training and technical assistance efforts. In addition, to provide information about diversion programs across the state, the soon to be launched Texas Behavioral Health and Justice Technical Assistance Resource Center will host a state map that includes promising diversion practices submitted by communities, the Sequential Intercept Maps and plans of participating counties, as well as links and downloadable diversion toolkits and resources.

**Barriers to Diversion**

Of all responders (n=557), 132 (23.7%) provided open-ended feedback that identified 161 barriers to diversion. Thematic analysis identified the following categories of barriers to diversion, presented in descending order of frequency, with a separate report providing additional details on these responses.

- Access to Treatment
- Resources
- Time
- Lack of Support from Treatment Providers
- Issues with Support from Prosecutors or Other Law Enforcement
- Issues Specific to Independent School District Officers
- Training Needs
- The Individual’s Willingness to Participate in Treatment

**Improving Crisis Response and Increasing Pre-Arrest Diversion**

Of all responders (n=557), 132 (23.7%) provided open-ended feedback that included 152 suggestions or strategies for improving diversion. Thematic analysis identified the following categories of improvement for diversion, presented in descending order of frequency, with a separate report providing additional details on these responses.

- Access to Services
- Support from Treatment Providers
- Training
- Resources
- Other Improvements

**Opportunities:** The improving crisis response suggestions address many of the described barriers. Providing opportunities for collaboration among agencies within counties and communities to assess their resources, identify gaps, and then develop targeted strategic plans can increase understanding, advocacy for each other’s systems, and effective strategies that divert more community members from involvement with the justice system.
Introduction

As Texans experiencing mental health and substance use disorders and intellectual and developmental disabilities are involved with law enforcement and the criminal justice system, there is a need to understand this issue from the perspective of law enforcement to develop and implement effective diversion strategies. To gain this viewpoint, the Texas Health and Human Services Commission (HHSC) Office of Forensic Coordination contracted with the Texas Institute for Excellence in Mental Health (TIEMH) to conduct a survey of Texas police chiefs or their designated responders. The survey sought to gain insights and perspectives on resources or practices that would assist in diverting these individuals from justice involvement into more appropriate behavioral health crisis and treatment services. The survey also intended to identify the status of diversion programs across the state and the challenges experienced by law enforcement in utilizing and implementing diversion programs. Ultimately, the survey results are intended to inform development of the Texas Behavioral Health and Justice Technical Assistance Resource Center, an online source of information, technical assistance, consultation, and peer-to-peer networking to support effective crisis intervention and diversion in communities across Texas.

Survey Development and Distribution

The survey was developed using a collaborative, iterative process. Survey items were based on original items developed by the Texas Police Chiefs Association (TPCA) and finalized in collaboration with the Texas HHSC Office of Forensic Coordination or and UT-TIEMH researchers (see Appendix D). This survey was determined not research by the University of Texas at Austin Institutional Review Board.

Survey items addressed the following topical areas and report results are presented in this order:

- Rural and Urban Counties Represented
- Survey Responder Demographics, Job Title, Tenure in Position
- Priority of Pre-Arrest Diversion
- Crisis Response and Pre-Arrest Diversion Program Planning
- Crisis Diversion Partnerships
- Crisis Response and Pre-arrest Diversion Programs Provided or Planned
- Data Systems for Tracking Mental Health or Substance Use Service Calls
- Use of Screening Tools
- Crisis and Diversion Training
- Crisis Response and Pre-Arrest Diversion Resources
- Barriers to Diversion
- Improving Diversion

TPCA and the Law Enforcement Management Institute of Texas (LEMIT) distributed the survey invitation and link to their e-mail listservs in support of the HHSC Office of Forensic Coordination. The survey was open from August 24 to November 4, 2021. After the survey closed, survey data were cleaned and descriptive and content analysis was completed.
Results

Counties Represented

For purposes of this report, rural is defined as a Texas county with a population of 250,000 or less, in alignment with the definition used in the All Texas Access Report. Using this definition, 233 of 254 Texas counties are rural and 21 are urban. There were 134 of 233 (57.5%) rural counties represented by survey responders and 19 of 21 (90.5%) urban counties represented by survey responders. Throughout the report, results are presented by comparing urban and rural counties to illuminate any differences in the perspectives of law enforcement who serve those areas.

The Texas county map in Figure 1 presents the counties who were represented (blue for rural and yellow for urban) and not represented (gray for rural and dark gray for urban) by responders to the survey. A table of the number of responders for each county is included in Appendix A, along with a list of the counties with no survey responders.

*Figure 1. Texas counties represented by responders to the survey*

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Survey Responder Characteristics

There were 557 survey responders from 153 counties (60.2% of 254 Texas counties). Not all responders answered each survey question, so the number of responses is provided for each survey item presented in this report. Results are not generalizable to county or to the state but provide important perspectives from law enforcement on the status of diversion activities and what resources would assist in diverting individuals with mental health, substance use, or intellectual and development disabilities from justice involvement into more appropriate behavioral health crisis and treatment services.

Given the focus of the survey and membership of the TPCA and LEMIT listservs, about half of all responders in urban counties (n=116; 49.6%) and rural counties (n=170; 52.6%) were police chiefs. Most of the remaining titles provided (n=144) indicated leadership roles in their law enforcement communities (e.g., Assistant Chief, Deputy Chief, Lieutenant, Captain, Sergeant, Sheriff, Chief Deputy). Over 20% (n=127) of rural and urban responders did not provide their title. For a full table of the titles provided by survey responders, see Appendix A.

**Figure 2. Number of Responders by Rural and Urban County**

<table>
<thead>
<tr>
<th></th>
<th>Rural (n=323)</th>
<th>Urban (n=234)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Police Chief</td>
<td>52.6%</td>
<td>49.6%</td>
</tr>
<tr>
<td>All other titles</td>
<td>22.9%</td>
<td>29.9%</td>
</tr>
<tr>
<td>No title provided</td>
<td>24.5%</td>
<td>20.5%</td>
</tr>
</tbody>
</table>

There were no significant differences in tenure between rural and urban responders, with an average tenure of over 26 years of service for both (Table 1). This longer tenure is likely due to survey responders serving in leadership positions and the time and experience required to serve in these positions (e.g., police chiefs), with a majority reporting being in the age range of 51 to 65 years. Based on age range and years of service, most responder careers have been protecting and serving the public in law enforcement.

**Table 1. Rural and urban tenure in the field**

<table>
<thead>
<tr>
<th>Tenure in the Field</th>
<th>n</th>
<th>Mean</th>
<th>SD</th>
<th>Min</th>
<th>Max</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>142</td>
<td>26.87</td>
<td>9.67</td>
<td>1.25</td>
<td>51.75</td>
</tr>
<tr>
<td>Rural</td>
<td>167</td>
<td>26.55</td>
<td>10.16</td>
<td>2.75</td>
<td>50.67</td>
</tr>
</tbody>
</table>
Responders were asked to report the size of the department where they worked (Table 2), meaning the number of employees working in their departments. Overall, those who responded to the survey worked in smaller departments (50 or less) in both urban (42.8%) and rural (63.8%) counties, with more variability in department size reported from those working in urban counties. This data aligns with previously published data from the Texas Commission on Law Enforcement on the majority of small police departments in Texas.6

Table 2. Department size of urban and rural responders

<table>
<thead>
<tr>
<th>Department Size</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 – 10</td>
<td>24</td>
<td>10.3</td>
<td>111</td>
<td>34.4</td>
</tr>
<tr>
<td>11 – 50</td>
<td>76</td>
<td>32.5</td>
<td>95</td>
<td>29.4</td>
</tr>
<tr>
<td>51 – 100</td>
<td>40</td>
<td>17.1</td>
<td>26</td>
<td>8.0</td>
</tr>
<tr>
<td>101 - 250</td>
<td>14</td>
<td>6.0</td>
<td>6</td>
<td>1.9</td>
</tr>
<tr>
<td>251 - 500</td>
<td>23</td>
<td>9.8</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>501 - 1,000</td>
<td>4</td>
<td>1.7</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>1,001 or more</td>
<td>6</td>
<td>2.6</td>
<td>…</td>
<td>…</td>
</tr>
<tr>
<td>No response</td>
<td>47</td>
<td>20.1</td>
<td>78</td>
<td>24.1</td>
</tr>
<tr>
<td>Total</td>
<td>234</td>
<td>100</td>
<td>323</td>
<td>100</td>
</tr>
</tbody>
</table>

Note: … indicates no responders reporting this department size

As shown in Figure 3, among all responders, 88.6% were male and 11.4% were female, in alignment with national and state data that indicate women constitute less than 13% of total officers and a much smaller proportion of leadership roles.7

When comparing urban and rural counties (see Table 3), there was slightly higher female representation in survey responses from urban counties (13.2%) compared to rural counties (9.9%).

Figure 4 shows that regardless of working in urban or rural counties, most responders were White, followed by Hispanic, and then Black/African-American. Responders were also a majority white in both urban (74.8%) and rural (83.3%) counties, with higher representation of Hispanic, Black/African American, and Asian American/Pacific Islanders in urban counties compared to rural. This follows past reporting in Texas on the demographic gaps that exist between law enforcement and communities that they serve and protect.8

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6 Texas Commission on Law Enforcement (TCOLE). https://www.tcole.texas.gov/content/current-statistics


The majority of responders were in the age range of 51 to 65 years for both urban (n= 102) and rural (n= 139) areas (see Table 3). The trend lines in Figure 5 display the similarity and slight differences between urban and rural counties in age range, with urban counties age ranges slightly lower than rural counties and rural counties age ranges slightly higher than urban counties. This may be explained by survey focus on leadership and the average tenure in the field of 26.7 years (SD=9.9).

**Figure 4. Race/Ethnicity of Urban and Rural Responders**

![Race/Ethnicity of Urban and Rural Responders](image)

**Figure 5. Responder age range (%) by urban or rural county**

![Responder age range (%) by urban or rural county](image)
Table 3 serves as an overview of the descriptive data presented above and includes the demographic characteristics of survey responders by the rural or urban county that they serve.

**Table 3. Characteristics of survey responders by urban or rural county**

<table>
<thead>
<tr>
<th>Gender</th>
<th>Urban n=231</th>
<th>Urban %</th>
<th>Rural n=321</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female</td>
<td>31</td>
<td>13.2</td>
<td>32</td>
<td>9.9</td>
</tr>
<tr>
<td>Male</td>
<td>200</td>
<td>85.5</td>
<td>289</td>
<td>89.5</td>
</tr>
<tr>
<td>No response</td>
<td>3</td>
<td>1.3</td>
<td>2</td>
<td>0.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity/Race</th>
<th>Urban n=</th>
<th>Urban %</th>
<th>Rural n=</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>45</td>
<td>19.2</td>
<td>36</td>
<td>11.1</td>
</tr>
<tr>
<td>White</td>
<td>175</td>
<td>74.8</td>
<td>269</td>
<td>83.3</td>
</tr>
<tr>
<td>Black/African American</td>
<td>20</td>
<td>8.5</td>
<td>10</td>
<td>3.1</td>
</tr>
<tr>
<td>American Indian/Alaskan Native</td>
<td>5</td>
<td>2.1</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>Asian American/Pacific Islander</td>
<td>7</td>
<td>3.0</td>
<td>5</td>
<td>1.5</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Age Range</th>
<th>Urban n=228</th>
<th>Urban %</th>
<th>Rural n=316</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>under 25</td>
<td>1</td>
<td>0.4</td>
<td>...</td>
<td>...</td>
</tr>
<tr>
<td>26-30</td>
<td>3</td>
<td>1.3</td>
<td>2</td>
<td>0.6</td>
</tr>
<tr>
<td>31-35</td>
<td>5</td>
<td>2.1</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>36-40</td>
<td>18</td>
<td>7.7</td>
<td>12</td>
<td>3.7</td>
</tr>
<tr>
<td>51-55</td>
<td>59</td>
<td>25.2</td>
<td>68</td>
<td>21.1</td>
</tr>
<tr>
<td>56-60</td>
<td>43</td>
<td>18.4</td>
<td>71</td>
<td>22.0</td>
</tr>
<tr>
<td>61-65</td>
<td>32</td>
<td>13.7</td>
<td>38</td>
<td>11.8</td>
</tr>
<tr>
<td>66-70</td>
<td>10</td>
<td>4.3</td>
<td>22</td>
<td>6.8</td>
</tr>
<tr>
<td>71-75</td>
<td>5</td>
<td>2.1</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>228</td>
<td>97.4</td>
<td>316</td>
<td>97.8</td>
</tr>
<tr>
<td>No response</td>
<td>6</td>
<td>2.6</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>Total</td>
<td>234</td>
<td>100.0</td>
<td>323</td>
<td>100.0</td>
</tr>
</tbody>
</table>
Priority of Pre-Arrest Diversion

Law enforcement responders were asked if pre-arrest diversion for people with mental health and substance use was a priority in their department (Table 4). A majority indicated that diversion is a priority, with a greater percentage of urban responders reporting “yes” (59.8%) than rural responders (49.8%). The combined percentages of “somewhat” and “no” responses reveal opportunities to support prioritization of diversion in departments throughout counties in the state.

Table 4. Priority of pre-arrest diversion for mental health or substance use

<table>
<thead>
<tr>
<th>Priority of pre-arrest diversion</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>113</td>
<td>59.8</td>
<td>121</td>
<td>49.8</td>
</tr>
<tr>
<td>Somewhat</td>
<td>58</td>
<td>30.7</td>
<td>80</td>
<td>32.9</td>
</tr>
<tr>
<td>No</td>
<td>16</td>
<td>8.5</td>
<td>32</td>
<td>13.2</td>
</tr>
<tr>
<td>Unsure</td>
<td>2</td>
<td>1.1</td>
<td>10</td>
<td>4.1</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100</td>
<td>243</td>
<td>100</td>
</tr>
</tbody>
</table>

Crisis Response and Pre-Arrest Diversion Program Planning

Two items asked about pre-arrest diversion and crisis response in departments, with a follow up item that asked if planning was occurring in specific areas of mental health, substance use, or intellectual and development disabilities. Despite the majority indicating the priority of pre-arrest diversion, a majority of responders reported that their departments do not have a designated representative for diversion or crisis programs (Table 5), close to 50% in urban counties and 60% in rural counties.

Table 5. Department representative oversees/manages diversion or crisis programs

<table>
<thead>
<tr>
<th>Department representative for diversion or crisis programs</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>71</td>
<td>37.6</td>
<td>64</td>
<td>26.2</td>
</tr>
<tr>
<td>Underway</td>
<td>9</td>
<td>4.8</td>
<td>9</td>
<td>3.7</td>
</tr>
<tr>
<td>Planned</td>
<td>18</td>
<td>9.5</td>
<td>22</td>
<td>9.0</td>
</tr>
<tr>
<td>No</td>
<td>89</td>
<td>47.1</td>
<td>143</td>
<td>58.6</td>
</tr>
<tr>
<td>I don't know</td>
<td>2</td>
<td>1.1</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100</td>
<td>244</td>
<td>100</td>
</tr>
</tbody>
</table>

When asked if a crisis response or diversion program had been identified for their department and community, responses differed when comparing rural to urban counties and were more variable across the response options for urban counties. In urban counties, 61.5% reported yes, underway, or planned in response to the item that a crisis response/pre-arrest diversion program was identified. This compared to 44.4% of rural communities who reported this (Table 6). In rural counties, 53.1% reported a program was not identified compared to 36.4% in urban counties, with a little over 2% in both urban and rural counties reporting they did not know.
If the response was yes, underway, or planned (in Table 6), a follow up item asked about the population of focus the crisis response/pre-arrest diversion program was occurring (Table 7). In both urban and rural areas, the most common response was mental health, followed by intellectual and developmental disabilities. Substance use represented the lowest percentages, almost 20% of urban and almost 8% of rural county responses, perhaps indicating that substance use crisis or diversion programs typically do not occur at pre-arrest and instead occur post-arrest. Open-ended feedback also revealed the lack of substance use services available, so these responses may reflect that issue.

### Table 6. Crisis response/pre-arrest diversion program identified for department/community

<table>
<thead>
<tr>
<th>Crisis response/pre-arrest diversion program identified</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>70</td>
<td>37.4</td>
<td>61</td>
<td>25.1</td>
</tr>
<tr>
<td>Underway</td>
<td>28</td>
<td>15.0</td>
<td>19</td>
<td>7.8</td>
</tr>
<tr>
<td>Planned</td>
<td>17</td>
<td>9.1</td>
<td>28</td>
<td>11.5</td>
</tr>
<tr>
<td>No</td>
<td>68</td>
<td>36.4</td>
<td>129</td>
<td>53.1</td>
</tr>
<tr>
<td>I don't know</td>
<td>4</td>
<td>2.1</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Total</td>
<td>187</td>
<td>100</td>
<td>243</td>
<td>100</td>
</tr>
</tbody>
</table>

*If responder reported yes, underway, or planned in Table 6, a follow-up item asked with which population this was occurring.*

### Table 7. Crisis response/pre-arrest diversion program identified for which population

<table>
<thead>
<tr>
<th>Area</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>112</td>
<td>47.9</td>
<td>103</td>
<td>31.9</td>
</tr>
<tr>
<td>Intellectual &amp; Developmental Disabilities</td>
<td>56</td>
<td>23.9</td>
<td>35</td>
<td>10.8</td>
</tr>
<tr>
<td>Substance Use Disorders</td>
<td>45</td>
<td>19.2</td>
<td>25</td>
<td>7.7</td>
</tr>
</tbody>
</table>

### Crisis and Diversion Partnerships

A majority of rural and urban responders were aware of crisis services available from local providers (Table 8). The percentage of urban (11.7%) and rural (16.8%) who responded “no” or “I don’t know” about available crisis services reveal opportunities for increased communication and collaboration with local treatment providers. Additionally, open-ended responses to barriers to crisis and diversion highlight that despite being aware of crisis services, access to these services more difficult (Figure 31).

### Table 8. Awareness of crisis services available from local treatment providers

<table>
<thead>
<tr>
<th>Crisis services available from local treatment providers</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>162</td>
<td>85.7</td>
<td>193</td>
<td>79.1</td>
</tr>
<tr>
<td>Underway</td>
<td>2</td>
<td>1.1</td>
<td>6</td>
<td>2.5</td>
</tr>
<tr>
<td>Planned</td>
<td>3</td>
<td>1.6</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td>No</td>
<td>19</td>
<td>10.1</td>
<td>37</td>
<td>15.2</td>
</tr>
<tr>
<td>I don't know</td>
<td>3</td>
<td>1.6</td>
<td>4</td>
<td>1.6</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100</td>
<td>244</td>
<td>100</td>
</tr>
</tbody>
</table>
Less than 50% of responders reported that they had interagency MOUs with LMHAs/LBHAs or other providers for treatment referrals (Table 9) with slightly more reporting that they were involved with community partners in discussion on criminal justice and mental health, substance use, and intellectual developmental disorders (see Table 10). This high awareness of services available (Table 8) yet lower interagency collaboration (Tables 9 & 10) represents opportunities to bring community stakeholders together to co-create community response to crisis and examine opportunities for pre-arrest diversion.

**Table 9. Interagency MOUs guide referrals to LMHA/LBHA or other treatment providers**

<table>
<thead>
<tr>
<th>Interagency referral MOUs</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>86</td>
<td>45.7</td>
<td>101</td>
<td>41.9</td>
</tr>
<tr>
<td>Underway</td>
<td>14</td>
<td>7.4</td>
<td>12</td>
<td>5.0</td>
</tr>
<tr>
<td>Planned</td>
<td>10</td>
<td>5.3</td>
<td>15</td>
<td>6.2</td>
</tr>
<tr>
<td>No</td>
<td>69</td>
<td>36.7</td>
<td>101</td>
<td>41.9</td>
</tr>
<tr>
<td>I don't know</td>
<td>9</td>
<td>4.8</td>
<td>12</td>
<td>5.0</td>
</tr>
<tr>
<td>Total</td>
<td>188</td>
<td>100</td>
<td>241</td>
<td>100</td>
</tr>
</tbody>
</table>

For those reporting yes, underway or planned to “involved in discussions with community partners” (Table 10), a majority of both urban and rural responders reported that these discussions were with mental health providers (Table 11). In urban areas, after mental health, responders then reported discussion with IDD providers followed by substance use providers. This was reversed for rural responders, who reported discussions with substance use providers next, followed by IDD providers.

**Table 10. Involved in discussion on criminal justice and MH/SU and IDD with community partners**

<table>
<thead>
<tr>
<th>Community partner discussions</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>99</td>
<td>52.4</td>
<td>101</td>
<td>42.1</td>
</tr>
<tr>
<td>Underway</td>
<td>11</td>
<td>5.8</td>
<td>16</td>
<td>6.7</td>
</tr>
<tr>
<td>Planned</td>
<td>13</td>
<td>6.9</td>
<td>25</td>
<td>10.4</td>
</tr>
<tr>
<td>No</td>
<td>57</td>
<td>30.2</td>
<td>93</td>
<td>38.8</td>
</tr>
<tr>
<td>I don't know</td>
<td>9</td>
<td>4.8</td>
<td>5</td>
<td>2.1</td>
</tr>
<tr>
<td>Total</td>
<td>189</td>
<td>100</td>
<td>240</td>
<td>100</td>
</tr>
</tbody>
</table>

**Table 11. Who are community partners on criminal justice, MH/SU, and IDD**

<table>
<thead>
<tr>
<th>Who have you partnered with? (if yes, underway, or planned)</th>
<th>Urban n</th>
<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Providers</td>
<td>122</td>
<td>52.1</td>
<td>138</td>
<td>42.7</td>
</tr>
<tr>
<td>Substance Use Providers</td>
<td>57</td>
<td>24.4</td>
<td>49</td>
<td>15.2</td>
</tr>
<tr>
<td>IDD Providers</td>
<td>61</td>
<td>26.1</td>
<td>38</td>
<td>11.8</td>
</tr>
</tbody>
</table>

*If responder reported yes, underway, or planned in Table 10, a follow-up item asked who they had partnered with.
Crisis Response and Pre-Arrest Diversion Programs Provided or Planned

Survey responders were asked about 16 program or service areas of crisis response and pre-arrest diversion provided or planned in their counties. Figure 6 presents the percentage of responders from rural and urban counties who reported no, they did not provide or plan to provide these specific program types, with higher percentages representing less likelihood for that program. Overall, rural counties reported programs being provided or planned as “no” more frequently than urban counties. Both urban and rural counties reported “Specialized Mental Health Training for Peace Officers” as the top program provided or planned and “Sobering Centers” or “Homeless Outreach” as the programs least provided or planned.

Figure 6. Urban and Rural County Responding "No" to Provided or Planned Crisis Response and Pre-arrest Diversion

On the page immediately following, individual figures for each of the program areas are presented, including the full range of responses for rural and urban county law enforcement responders.
Of the 16 program areas, the four most common crisis response and pre-arrest diversion programs reported as “yes” by both rural and urban areas are presented in Figures 7, 8, 9, and 10 below. “Specialized Training for Peace Officers,” “Mental Health Officers,” “Crisis Intervention Team(s)/Officers,” and “Overdose Reversal” programs were reported more commonly than other program types. Despite these programs being the top four reported as “yes,” overdose reversal programs were still reported less frequently as provided or planned programs by both rural (32.7%) and urban (42.6%) counties. Rural counties also reported “Crisis Intervention Team(s)/Officer(s)” as “yes” only one-third of the time with about 24% planned or underway.

**Figure 7. Specialized MH Training for Peace Officers**

**Figure 8. Mental Health Officers**

**Figure 9. Crisis Intervention Team(s)/Officer(s)**

**Figure 10. Overdose Reversal Programs**
For 13 out of 16 program areas, 50% or less of responders from rural and urban counties reporting the program areas were provided or planned. The differences between rural and urban counties in reporting “yes” reveal potential for new program development or further discussion about what would work best in each of these communities and if program development would be supported.

**Figure 12. Dispatcher Training**

**Figure 11. Psychiatric Emergency/Crisis Stabilization Programs**

**Figure 14. Crisis Drop-off/Diversion Centers**

**Figure 13. Law Enforcement Assisted Diversion**
The diversion program types presented in Figures 16, 17, 18, and 18 are common crisis response and diversion programs but were less likely reported as existing, underway, or planned by law enforcement from both rural and urban counties. Besides emergency department diversion, these programs may be the responsibility of local mental health or behavioral health authorities and law enforcement may have responded with that in mind.

**Figure 15. Other Police Department and MH/SU Collaboration**

**Figure 16. Intervention with Frequent Utilizers**

**Figure 17. Mobile Crisis Outreach Team(s)**

**Figure 18. Emergency Department Diversion Programs**
The following four program types in Figures 19 to 22 were the least reported as provided or planned. With growing evidence for “Crisis Outreach Response & Engagement (CORE)” and its applicability to populations such as people who are unhoused or experiencing mental health or substance use crisis, there may be opportunities to explore its feasibility in Texas counties.9

**Figure 19. Data Matching with MH/SU Agencies**

**Figure 20. Homeless Outreach Teams**

**Figure 21. Sobering Centers**

**Figure 22. Virtual Co-Response (CORE)**

---

Data Systems for Tracking Mental Health or Substance Use Service Calls

Three items asked law enforcement responders about their data systems and ability to track and follow the outcomes of mental health and substance use related service calls. There were significant differences in responses between urban and rural county responders (Figure 23), with those in rural counties reporting that data systems were in place significantly less frequently (44.5% urban; 28.8% urban). As the new 988 crisis line is implemented in the state, there are guidance documents that might support communities in identifying strategies for data tracking and roles for different community organizations to play, such as the Public Safety Answering Points playbook. Additionally, there are opportunities for tracking service calls that are mental health or substance use involved and these can be shared with police departments to raise awareness and increase adoption.

Figure 23. Systems in Place to Track MH/SU Service Calls and Outcomes (Urban n=182; Rural n=233)

A follow up item asked if data systems allowed a call identifier to be updated or amended by the officer if the call was identified as mental health or substance use related after the officer had arrived. Responses (Figure 24) closely mirrored the data systems item, with a little more than half of urban responders reporting yes, underway, or planned (53.9%) and less rural responders reporting yes, underway or planned (34.4%).

Figure 24. Ability to Update Call Identifier if Mental Health or Substance Use Related (Urban n=180; Rural n=232)

10 National Association of State Mental Health Program Directors. 2022. 988 Implementation Guidance Playbooks. https://www.nasmhpd.org/content/988-implementation-guidance-playbooks
The final data system item asked if responders had the ability to add a secondary call identifier or code to identify the call as mental health or substance use related if the original identified was required to stay in place (Figure 25). Even fewer responders reported this ability in their systems, with urban responders reporting this ability 44.2% and rural responders reporting this ability 27.6% of the time.

Figure 25. Ability to Add Secondary Call Identifier if Original Identifier Must Remain (n=412)

Use of Screening Tools

Law enforcement responders were asked if their departments used any formal screening tools to support identification of people with mental health, substance use, or intellectual or development disability needs (Figure 26). There were similarities across rural and urban counties, where a majority reported no formal screening tools being used to identify these needs (over 60% in both). Support in identifying screening tools that are appropriate for law enforcement and that can be easily implemented in existing systems and processes may support future use.¹¹

Figure 26. Urban and Rural Counties Reporting Use of Mental Health & Substance Use Screening Tools

When asked about use of screening tools for Intellectual and Development Disabilities (IDD), a majority of urban (70%) and rural (71.1%) counties reported that they did not use screening tools (Figure 27). Identifying IDD is different and requires a different approach than identifying someone experiencing a mental health or substance use crisis or challenge. The Office of Community Oriented Policing Services (COPS Office) and The Arc National Center on Criminal Justice & Disability have partnered to provide resources to increase awareness and tools to increase knowledge and skills among law enforcement officers.12

**Figure 27. Reported Use of Tools to Identify Intellectual and Developmental Disabilities**

![Bar chart showing reported use of tools to identify IDD](chart)

Training for Identification of and for Crisis Response

Law enforcement responders were asked if training was provided to their 911 and dispatch staff on the identification and management of calls related to mental health, substance use, and IDD crisis or other related issues (Figure 28). There was variability in responses, but no represented the largest percentage in both urban (34.8%) and rural (49.4%) counties. This was followed by yes for urban (33.1%) and rural (20.8%) counties providing this type of training, next by I don’t know, and then that the training was either planned or underway. The large percentage of departments reporting no training for 911 or dispatch to identify and manage mental health, substance use, and IDD crisis represents an opportunity to provide a universal identification training that can support departments across Texas.

**Figure 28. 911 and Dispatch Staff Trained to Identify and Manage Calls**

![Bar chart showing training for crisis response](chart)

---

The final training item asked if departments required mental health/substance use crisis response training for officers (Figure 29). A majority of urban (77.9%) and rural (59.7%) county responders reported yes. There are opportunities to increase the number of departments who require this training, with 14.9% of urban and 23.4% of rural county responders reporting this training was not required for officers.

Figure 29. Department Requires MH/SU Crisis Response Training for Officers

Most Useful Crisis Response and Pre-Arrest Diversion Resources

To determine what resources would be helpful for law enforcement in rural and urban counties, responders were asked to select the top three most useful resources from a list of seven resource types. Both urban (n=115; 49.1%) and rural (n=151; 46.7%) county responders selected in-person or on-line training or webinars on recognizing and responding to crisis as the most useful resource. The top three resources selected as the most useful by rural and urban counties are presented in Table 12 below.

Table 12. Top Three Resources Selected as Most Useful by Rural and Urban Counties

<table>
<thead>
<tr>
<th>Resource</th>
<th>Urban (n=234)</th>
<th>Rural (n=323)</th>
</tr>
</thead>
<tbody>
<tr>
<td>In-person or on-line training or webinars on recognizing &amp; responding to crisis in people with MH, SU, or intellectual &amp; development disabilities</td>
<td>115 (49.1%)</td>
<td>151 (46.7%)</td>
</tr>
<tr>
<td>In-person or on-line training or webinars on effective interventions and diversion to treatment</td>
<td>80 (34.2%)</td>
<td>92 (28.5%)</td>
</tr>
<tr>
<td>Written guides or toolkits on effective crisis interventions and diversion to treatment</td>
<td>80 (34.2%)</td>
<td>92 (28.5%)</td>
</tr>
<tr>
<td>Seeing where and what types of diversion programs exist across the state</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Figure 30 presents all of the resource type choices and the number of responders who selected each one in order of resource selected as most useful to the resource least selected as useful. The two resources selected with the least frequency by both rural and urban counties were “consultation or technical assistance on effective interventions and diversion to treatment” (urban n=42; rural n=53) and “peer-to-peer networking or consultation from other effective diversion programs in the state” (urban n=36; rural n=48). These resource types may have been selected with less frequency but since responders were often representing a department or a county, these also represent the need for targeted technical assistance to meet the needs of unique departments.

**Figure 30. Resource Types in Order of Selection by Usefulness**

Barriers to Diversion

An open-ended survey item asked responders to describe the barriers they experience if they wanted to divert individuals with mental health, substance use, or IDD from criminal justice involvement and connect them to treatment and services. This report includes the overall themes and example responses, with a separate report providing additional information on the detailed responses. Of all survey responders, 132 of 557 (23.7%) provided open-ended feedback that included 161 identified barriers. These barriers clustered into eight thematic areas:

- Access to treatment resources (n=64; 39.8%);
- General issues with resources (n=31; 19.3%);
- Issues with time (n=29; 18%);
- Issues with or lack of support from treatment providers (n=20; 12.4%);
- Issues with support from prosecutors or other law enforcement (n=5; 3.1%);
- Issues specific to Independent School District officers (n=5; 3.1%);
- Training needs (n=4, 2.5%); and,
- Issues regarding the individual’s willingness to participate in treatment programs (n=3; 1.9%).
Examples of comments representing barrier in the thematic areas are presented in Table 13 below. This is a brief overview of responses. A separate report describes the reported barriers in more detail.

Table 13. Law Enforcement Reported Barriers to Diversion

<table>
<thead>
<tr>
<th>Theme Area</th>
<th>Thematic Comment Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Treatment (n=64)</td>
<td>“No realistic availability of MH/SU/IDD services in our rural county.”</td>
</tr>
<tr>
<td></td>
<td>“Hospital will not take to medically clear or evaluate”</td>
</tr>
<tr>
<td></td>
<td>“Lack of local treatment facilities” or “Lack of places that will accept patients”</td>
</tr>
<tr>
<td></td>
<td>“A serious lack of mental health or crisis stabilization units”</td>
</tr>
<tr>
<td></td>
<td>“We have no programs for substance use”</td>
</tr>
<tr>
<td></td>
<td>“Treatment centers are full and do not have beds available”</td>
</tr>
<tr>
<td></td>
<td>“There are no beds at the state facilities. Private hospitals tend to cut them loose as soon as the insurance runs out regardless of where there are in their care and follow up care is solely left up to the mentally ill”</td>
</tr>
<tr>
<td>Time (n=29)</td>
<td>“Long waits in ER for evaluation. Drain on resources for small department”</td>
</tr>
<tr>
<td></td>
<td>“Closest MH service is over an hour away, if anyone will respond. My single on duty officer cannot sit and wait for them”</td>
</tr>
<tr>
<td></td>
<td>“Difficult to get proper screenings and evaluations in a timely manner. Often waiting several hours to get someone screened”</td>
</tr>
<tr>
<td>Lack of Resources (n=31)</td>
<td>“Lack of local and regional resources due to the rural nature of the operating environment”</td>
</tr>
<tr>
<td></td>
<td>“The lack of resources in our community is a barrier”</td>
</tr>
<tr>
<td></td>
<td>“Small county with lack of resources because of the unavailability of funding/grants”</td>
</tr>
<tr>
<td></td>
<td>“Not enough manpower”</td>
</tr>
<tr>
<td>Theme Area</td>
<td>Thematic Comment Example</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Support from Treatment Providers</td>
<td>“Someone has to get to point of being suicidal or threatening to harm someone before local health authority can/will do something”</td>
</tr>
<tr>
<td>(n=20)</td>
<td>“Currently they only respond from 8-5 off weekends. This is not effective. When the issues occur the mental health professionals are not available”</td>
</tr>
<tr>
<td></td>
<td>“No help from other agencies, hospitals, the state”</td>
</tr>
<tr>
<td></td>
<td>“The main barrier that we face in RURAL TEXAS is the time spent waiting for the MHMR service workers to come and evaluate. For example, I have been waiting for 1 week to hear back on placement for an individual and have yet to hear back from anyone”</td>
</tr>
<tr>
<td></td>
<td>“Lack of consistency with Mental Health treatment centers intake, rules, etc”</td>
</tr>
<tr>
<td>Prosecutors/Law Enforcement</td>
<td>“Push back from DA and community. Perception is reality”</td>
</tr>
<tr>
<td>(n=5)</td>
<td>“Usually the crime they have committed [is a barrier to diversion]”</td>
</tr>
<tr>
<td></td>
<td>“Prosecutorial agreement”</td>
</tr>
<tr>
<td>Individuals Refuse Treatment</td>
<td>“The big barrier is the mentally ill themselves. They are adults and LE cannot place them anywhere unwillingly, unless they are dangerous”</td>
</tr>
<tr>
<td>(n=3)</td>
<td></td>
</tr>
<tr>
<td>Training Needs</td>
<td>“Lack of knowledge for the officers on the outside of mental health agencies”</td>
</tr>
<tr>
<td>(n=4)</td>
<td>“Information concerning contacts of who to call and what type of services they are willing to provide”</td>
</tr>
<tr>
<td>ISD Specific</td>
<td>“We are an ISD Police Department and have several team members in place to assist us in these matters almost eliminating any barriers.”</td>
</tr>
<tr>
<td>(n=5)</td>
<td>“I work for an ISD and one of our barriers is that parents do not always include us in MH evaluations of their child until we have them on our radar for something else”</td>
</tr>
</tbody>
</table>

**Improve Crisis Response and Increase Pre-Arrest Diversion**

An open-ended survey item asked responders to describe what would be helpful to improve crisis response and increase pre-arrest diversion of individuals with mental health, substance use, or IDD from criminal justice involvement. This report includes the overall themes and example responses, with a separate report providing more detail on the suggested strategies for improvement in diversion. Of all survey responders, 132 of 557 (23.7%) provided open-ended feedback that included 152 suggestions or strategies for improvement. These strategies clustered into five thematic areas:

- Access to Services (n=84; 58.3%);
- Support from Treatment Providers (n=17; 11.8%);
- Training (n=17; 11.8%);
- Resources (n=10; 6.9%); and,
- Other (n=16; 11.1%).
Examples of comments in each of the diversion strategy thematic areas are presented in Table 14 below. A separate report describes the suggestion and strategies provided by law enforcement in more detail.

**Table 14. Law Enforcement Reported Strategies to Increase Crisis Response and Pre-Arrest Diversion**

<table>
<thead>
<tr>
<th>Theme Area</th>
<th>Thematic Comment Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Access to Services (n=84)</td>
<td>“Have a diversion center to transport those with low level misdemeanor crimes to instead of involving the criminal justice system.”</td>
</tr>
<tr>
<td></td>
<td>“We need sobering locations as well as mental health diversion locations that allow us to transport persons suffering from a mental crisis (but not presenting a danger to themselves or others) to a location where they can be seen and helped by mental health professionals.”</td>
</tr>
<tr>
<td></td>
<td>“A countywide response plan that utilizes the hospital as the central hub to receive the necessary support from all service providers. There is no way to get a response to rural areas in a timely manner, and often not at all, in rural counties, especially after normal business hours.”</td>
</tr>
<tr>
<td></td>
<td>“More facilities with adequate staff and facility capability to handle intake and appropriate services so officers can drop individuals off and return to the street versus sitting with them for hours.”</td>
</tr>
<tr>
<td></td>
<td>“The availability of diversion centers that provide MH assistance and ready access to services to those who are mentally ill or may be experiencing a MH episode. Instances of LE involvement with people with MH/SU and IDD are on the rise. A solution might be for each county to partner with the state to develop diversion centers to help lower the demand on jails and more importantly provide a service for those individuals who are in need. Jail obviously is not the answer to every issue.”</td>
</tr>
<tr>
<td></td>
<td>“Any services that are available for patients in crisis are much more easily accessible during business hours. Options are scarce overnight, or on weekends. The local emergency room is the most likely venue for getting a person that needs to see a doctor immediately in front of a”</td>
</tr>
<tr>
<td>Theme Area</td>
<td>Thematic Comment Example</td>
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<td>--------------------------------</td>
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</tr>
</tbody>
</table>
| Treatment Provider Support/Collaboration (n=17) | “Protocols in place that minimize patient’s ability to get the proper treatment and counseling. Currently there is a minimum of 4 to 7 hours from initial contact before treatment is provided due to our rural location and policies in place between our local hospital and MH providers.”  

“The Mobile Crisis Team is short-handed. You try to call and have to leave a message. Sometimes you cannot wait on a return phone call from the crisis team. I haven’t even been able to get them to come to our town because they are short-staffed and nobody is available to come in person.”  

“Having a way to get someone help before they reach the point of being in crisis. Officers are tasked with spending hours with a person, to get them calmed down, to take their medicine, or to wait for health authority. Mental Health and IDD is not a criminal act but is the responsibility of law enforcement to address the calls.”  

“Hospitals/MCOT or local mental health providers and law enforcement need to come together to learn each other’s jobs and struggles before we can all work together. I would like to know the struggles of hospitals and social workers so I can help them with what I’m doing on the streets.”  

“Law enforcement has been forced into the position of being a MH officer due to the failure of medical providers caring enough to handle situations other than providing narcotics and releasing that person out into the public. There are insufficient numbers of facilities available throughout rural areas of the state to assist in these matters.”  

“I never understood why EMS, who are trained medical personnel to begin with, are not tasked with providing the initial response, assessment and transport of these patients.”  

“Treating MH and IDD calls as medical calls instead of police calls would be hugely beneficial. I know we cannot get completely out of these types of calls due to the dangers of it, but a regional authority that does more follow up could prevent things from getting to crisis point.” |
| Training (n=17) | “Law enforcement, Mental Health, and Counseling personnel training together.”  

“Training of civilian response units as well as perspective training for officers to address crisis needs and social needs rather than punitive needs.”  

“Education of family members re: response expectations, follow-up, how they can help minimize contacts with the police and/or the criminal justice system.” |
<table>
<thead>
<tr>
<th>Theme Area</th>
<th>Thematic Comment Example</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>“… increased training for officers, so they feel comfortable with their decision to divert from jail - SIM mapping to increase understanding and likelihood of diversion at multiple intercepts of the legal justice system.”</td>
</tr>
<tr>
<td></td>
<td>“I would like to see the larger agency in the county, i.e., Sheriff, respond when we have an EDO situation to prevent the small agency from having no coverage when we get tied to a MH/SU or IDD call. They have resources that we simply do not have.”</td>
</tr>
<tr>
<td></td>
<td>“County government understanding their role and responsibility for this important issue.”</td>
</tr>
<tr>
<td>Resources (n=10)</td>
<td>“...increased funding in this area to provide transportation to services.”</td>
</tr>
<tr>
<td></td>
<td>“I believe having more local resources to help us get the crisis under control would be a good starting point.”</td>
</tr>
<tr>
<td></td>
<td>“Time, staff, funds and planning.”</td>
</tr>
<tr>
<td>Other Comments (n=16)</td>
<td>“Legislation providing officers with follow up diagnosis of individuals taken for evaluation. This information is currently not available to officers and departments due to HIPPA restrictions. This information would better assist law enforcement with addressing the needs of clients and determining appropriate resources to assist them.”</td>
</tr>
</tbody>
</table>
Appendix A – Number of Responders by County and Counties with No Responders

There were 19 of 21 urban counties (90.5%) with at least one survey response and a total of 234 urban county responders.

**Number of Responders from Urban Counties in Texas**

<table>
<thead>
<tr>
<th>Urban Counties</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Harris County</td>
<td>32</td>
<td>13.7</td>
</tr>
<tr>
<td>Dallas County</td>
<td>28</td>
<td>12.0</td>
</tr>
<tr>
<td>Tarrant County</td>
<td>20</td>
<td>8.5</td>
</tr>
<tr>
<td>McLennan County</td>
<td>18</td>
<td>7.7</td>
</tr>
<tr>
<td>Collin County</td>
<td>16</td>
<td>6.8</td>
</tr>
<tr>
<td>Bexar County</td>
<td>14</td>
<td>6.0</td>
</tr>
<tr>
<td>Denton County</td>
<td>14</td>
<td>6.0</td>
</tr>
<tr>
<td>Travis County</td>
<td>12</td>
<td>5.1</td>
</tr>
<tr>
<td>Hidalgo County</td>
<td>11</td>
<td>4.7</td>
</tr>
<tr>
<td>Brazoria County</td>
<td>10</td>
<td>4.3</td>
</tr>
<tr>
<td>Bell County</td>
<td>9</td>
<td>3.8</td>
</tr>
<tr>
<td>Montgomery County</td>
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<td>3.8</td>
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<tr>
<td>Cameron County</td>
<td>8</td>
<td>3.4</td>
</tr>
<tr>
<td>Galveston County</td>
<td>8</td>
<td>3.4</td>
</tr>
<tr>
<td>Lubbock County</td>
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<tr>
<td>Fort Bend County</td>
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<td>1.3</td>
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<tr>
<td>Webb County</td>
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<td>1.3</td>
</tr>
<tr>
<td>Jefferson County</td>
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<tr>
<td>Nueces County</td>
<td>2</td>
<td>0.9</td>
</tr>
<tr>
<td>Total Urban County</td>
<td>234</td>
<td>100.0</td>
</tr>
</tbody>
</table>

There were 134 of 233 rural counties (57.5%) with at least one survey response and a total of 323 rural county responders.

**Number of Responders from each Rural County in Texas**

<table>
<thead>
<tr>
<th>Rural Counties</th>
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<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kaufman County</td>
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<td>3.1</td>
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<tr>
<td>Cass County</td>
<td>9</td>
<td>2.8</td>
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<tr>
<td>Johnson County</td>
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<td>2.8</td>
</tr>
<tr>
<td>Smith County</td>
<td>9</td>
<td>2.8</td>
</tr>
<tr>
<td>Henderson County</td>
<td>7</td>
<td>2.2</td>
</tr>
<tr>
<td>Bowie County</td>
<td>6</td>
<td>1.9</td>
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<tr>
<td>Cherokee County</td>
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<td>1.9</td>
</tr>
<tr>
<td>Orange County</td>
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<td>1.9</td>
</tr>
<tr>
<td>Polk County</td>
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<td>1.9</td>
</tr>
<tr>
<td>Rural Counties</td>
<td>n</td>
<td>%</td>
</tr>
<tr>
<td>-----------------------------</td>
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</tr>
<tr>
<td>Rusk County</td>
<td>6</td>
<td>1.9</td>
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<tr>
<td>Van Zandt County</td>
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</tr>
<tr>
<td>Cooke County</td>
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<tr>
<td>Grayson County</td>
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<tr>
<td>Kerr County</td>
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<tr>
<td>Red River County</td>
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<tr>
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<tr>
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<tr>
<td>Eastland County</td>
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<tr>
<td>Hays County</td>
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<tr>
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<td>Nacogdoches County</td>
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<tr>
<td>Rural Counties</td>
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<tr>
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<tr>
<td>Rural Counties</td>
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<td>%</td>
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<tr>
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</tr>
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<td>Total Rural County Responders</td>
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Counties with no or incomplete responses:

There were 99 of 233 rural counties (42.5%) without at least one survey response.

These counties included:

In addition, the 9 rural county responders in Crockett, Hunt, Kendall, La Salle, Leon, Taylor, Tom Green, Ward, and Wharton counties provided initial information (county and some demographics) but did not complete the rest of the survey.

There were 2 of 21 urban counties (9.5%) without at least one survey response.

These counties included:
El Paso and Williamson Counties.
### Job Titles Reported by Survey Responders

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### Rural Job Titles

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## Appendix C - Crisis Response and Pre-Arrest Diversion Programs Provided

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<th>Rural n</th>
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<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
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<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
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<th>Urban %</th>
<th>Rural n</th>
<th>Rural %</th>
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<td>166</td>
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</table>
Every day, Texas peace officers encounter people with mental health (MH) and substance use (SU) disorders and intellectual and developmental disabilities (IDD) in their communities. Crisis response and pre-arrest diversion programs (e.g., co-responder teams, crisis intervention teams, mobile crisis teams, mental health deputies) redirect people with MH/SU disorders and/or IDD away from criminal justice pathways into treatment systems. In an effort to engage and support law enforcement across the state in diverting this population from incarceration to treatment and services, the Texas Institute for Excellence in Mental Health at the University of Texas at Austin is conducting this survey on behalf of Texas Health and Human Services (HHS) to gain your insights and perspectives.

The information that you provide will inform HHS programs and services and contribute to the development of a centralized resource of information, peer-to-peer networking, consultation, and technical assistance to support effective crisis interventions and diversions to treatment for Texans with mental health or substance use disorders or intellectual and developmental disabilities.

This survey is confidential and results will be reported in aggregate by county or region of the state. It will take about 15-20 minutes to complete. Your participation is voluntary and you may choose to answer all of the questions or skip any you do not want to answer. We know your time is important and greatly value the information you will provide - thank you!
Q2 County that you work in: (select county from pull-down menu)

Q3 What is your gender?
- Female
- Male

Q4 Race/Ethnicity: (select all that apply)
- Hispanic
- White
- Black/African American
- American Indian/Alaskan Native
- Asian American/Pacific Islander

Q5 Age range:
- under 25
- 26-30
- 31-35
- 36-40
- 41-45
- 46-50
- 51-55
- 56-60
- 61-65
- 66-70
- 71-75

Q6 What is your job title? _______________________________________________________________

Q7 How many years have you served the public as a peace officer? (please indicate years and months)
- Years: ________________________________________________
- Months: ________________________________________________

Q8 What is the size of your agency?
- 1-10
- 11-50
- 51-100
- 101-250
- 251-500
- 501-1,000
- 1,001 or more

Q9 Is pre-arrest diversion of people with mental health and substance use a priority for your department?
- Yes
- No
- Somewhat
• Unsure

### Q10 Planning for a Crisis Response and Pre-Arrest Diversion Program

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<tr>
<th>Question</th>
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<th>Planned</th>
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<tr>
<td>Do you have a single representative (ideally senior level) that is responsible for overseeing/managing crisis response and/or pre-arrest diversion programs?</td>
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<td>Have you identified a crisis response and/or pre-arrest diversion program that will work for your department and community?</td>
<td></td>
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</table>

If you responded yes or underway to the previous question “Have you identified a crisis response and/or pre-arrest diversion program that will work for your department and community, please respond to the following question:

### Q11 For which has a crisis response and/or pre-arrest diversion program been identified? (select all that apply)

- Mental health
- Substance use disorders
- Intellectual and Development Disorders

### Q12 Partnerships

<table>
<thead>
<tr>
<th>Question</th>
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<th>Planned</th>
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<tr>
<td>Are you aware of the crisis services available from local treatment providers, including your local mental health authority/local behavioral health authority (LMHA/LBHA)</td>
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<tr>
<td>Do you have interagency MOUs to help guide referrals from your department to your LMHA/LBHA or other treatment providers?</td>
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<tr>
<td>Have you partnered with local community stakeholders to discuss issues related to criminal justice and MH/SU and IDD?</td>
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</table>

If you responded Yes, Underway, or Planned to the previous question “Have you partnered with local community stakeholders to discuss issues related to criminal justice and MH/SU and IDD?” please respond to the next item:

### Q13 For which have you partnered with local community stakeholders to discuss issues related to criminal justice? (select all that apply)

- Mental health
- Substance use disorders
- Intellectual and Development Disorders
Q14 Which crisis response and pre-arrest diversion programs do you provide or are you planning to provide?

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<tr>
<th>Program</th>
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<th>Planned</th>
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<td>Dispatcher Training</td>
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<td>Specialized Mental Health Training for Peace Officers such as Crisis Intervention Team Training</td>
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<td>Virtual Co-Response (e.g., Clinician and Officer Remote Evaluation Program (CORE))</td>
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<td>Intervention(s) with Frequent Utilizers of 911, Emergency Department, Crisis Services</td>
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Q15 Tool Development, Data Tracking, and Workforce Utilization

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<tr>
<td>Do you have a system in place to track MH/SU related calls for service and the outcome of those calls?</td>
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<tr>
<td>Do you have a system that allows a call identifier (code, call code, etc.) to be updated or amended by the officer if it is discovered the call was MH/SU related after officer arrival?</td>
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<td>•</td>
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<td>Do you have a system that allows a secondary call identifier (code, call code, etc.) to be added if it is discovered a call was MH/SU related, even if the original call identifier (code, call code, etc.) must stay in place?</td>
<td>•</td>
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</table>
Does your department use formal tools to screen for MH/SU?

• • • • •

Does your department use formal tools to screen for Intellectual or Developmental Disabilities?

• • • • •

Q16 Training

<table>
<thead>
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<th>Yes</th>
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</table>

Do you provide any type of MH/SU and IDD call identification and management training to your 911 call taking and dispatch staff?

• • • • •

Does your department require MH/SU crisis response training for officers?

• • • • •

Q17 Which of the following types of crisis response and pre-arrest diversion resources would be most useful for your community? *(please select the top three most useful resources)*

• In-person or on-line training or webinars on recognizing and responding to crisis in people with mental health, substance use, or intellectual and development disabilities (1)
• In-person or on-line training or webinars on effective interventions and diversion to treatment (2)
• Consultation or technical assistance on effective interventions and diversion to treatment (3)
• Written guides or toolkits on effective crisis interventions and diversion to treatment (4)
• Peer-to-peer networking or consultation from other effective diversion programs in the state (5)
• Workshops to support your community in identifying gaps, resources, and opportunities for diversion (6)
• Seeing where and what types of diversion programs exist across the state (7)

Q18 What barriers do you experience if you want to divert people with MH/SU and IDD from criminal justice involvement and connect to treatment and services?

Q19 What would be helpful to improve crisis response and increase pre-arrest diversion of people with MH/SU and IDD from criminal justice involvement and allow you to spend more time in the field serving and protecting your community?

Thank you again for participating in the survey. We appreciate you sharing your important insights.

If you would be willing to participate in a 20-30 minute follow up interview to provide more information about diversion activities in your community or the supports you would find helpful to effectively implement diversion programs, please click here to provide your contact information.

This link is not connected to the responses you provided on this survey.
**Introduction**

Texas Resiliency and Recovery, or TRR, is a term to describe the service delivery system in Texas for community mental health services. While there have been some slight changes in the system, the mission remains the same: To foster resilience and recovery with respect to mental illness and severe emotional disturbances. A primary aim of the Health and Human Services Commission’s (HHSC’s) service delivery system is to ensure the provision of interventions and evidence-based practices with empirical support to promote recovery from psychiatric disorders and resilience from severe emotional disturbances.

The Substance Abuse and Mental Health Services Administration, or SAMSHA, defines Recovery from Mental Disorders and Substance Use Disorders as follows:

*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*

Through the **Recovery Support Strategic Initiative**, SAMHSA has delineated four major dimensions that support a life in recovery:

- **Health**: overcoming or managing one’s disease(s) as well as living in a physically and emotionally healthy way;
- **Home**: a stable and safe place to live;
- **Purpose**: meaningful daily activities, such as a job, school, volunteerism, family caretaking, or creative endeavors and the independence, income, and resources to participate in society; and
- **Community**: relationships and social networks that provide support, friendship, love, and hope.

The Texas Resilience and Recovery Model, or public mental health service design in Texas, includes the following components:

a) establishes who is eligible to receive services through a uniform assessment - Adult Needs and Strengths Assessment (ANSA), which determines a Level of Care Recommended (LOC-R)  
b) establishes ways to manage the use of services as outlined in the “Utilization Management (UM) Guidelines,” which determines a Level of Care Authorized (LOC-A).  
c) measures clinical outcomes or the impact of services; and  
d) determines how much these services should cost.

The “UM Guidelines” are an integral part of the program to ensure the delivery of mental health services are properly tailored to the individual’s needs and strengths in order to achieve the best possible results, while utilizing limited available resources in the most efficient and cost-effective manner possible.

These guidelines assist the clinician in determining the best possible course of treatment for the individual. The Diagnostic Statistical Manual of Mental Disorders (DSM) and Global Assessment of Functioning for LOC determination continues to be utilized within the existing Clinical Management for Behavioral Health Services (CMBHS) use case specifications guide for recommended authorizations. There will be circumstances when an individual may require a greater or lesser level of care. The services offered within each level of care are designed to provide the optimum care for the individual.
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I. LEVEL OF CARE 0: Crisis Services

**Purpose for Level of Care**
The services in this level of care are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse.

These services do not require prior authorization. However, Utilization Management (UM) staff must authorize the crisis service within 2 business days of presentation. If further crisis follow-up and relapse prevention services are needed, then the individual may be authorized for Level of Care 5 (LOC-5).

*Note: A provider is not required to develop a recovery/treatment plan for the provision of crisis services within this LOC; however, an individual crisis treatment plan is required.*

**Level of Care Assignment**
The admission criteria to be met are:
- No diagnosis is needed for admission to LOC-0;
- The Adult Needs Strengths Assessment (ANSA) indicates a Recommended Level of Care (LOC-R) of 0; or ANSA indicates LOC-R of 1,2,3,4,5 or 9 and it is clinically determined that the individual is in crisis.

**Criteria for Level of Care Review**
- Level of Care Authorized LOC-A - 0 is only available at intake, with new individuals or individuals who have received services and no longer have a current assessment. Any individual already in a LOC receives crisis services within that current LOC-A.
- This LOC-A will terminate in 7 days, unless reauthorized. Additional authorizations may be given as medically necessary.
- Following a crisis, providers should reassess the individual to determine further eligibility and the most appropriate LOC-1S – 5 for continuation of services.
- LOC-0 is the highest outpatient LOC-A available. If acuity level increases, inpatient level of care may be indicated.

**Expected Outcomes**
- Individual self-reports reduction or stabilization in symptoms as verified by scores in ANSA.
- Individual is able to use natural and community support systems as resources.

**Discharge Criteria**
*ANY of these indicators would support discharge from this LOC:*
- Identified crisis is resolved and the individual has been transitioned to LOC-1S-5.
- Identified crisis is resolved and the individual is placed on a waiting list for LOC-1S-4.
- Referred and linked to community resources outside the HHSC system.
- Individual terminates services.
- Individual is referred to a higher LOC for crisis management (e.g. inpatient level of care).
## LOC-0 Table Overview

<table>
<thead>
<tr>
<th>Authorization Period 7 Days</th>
<th>Unit Type</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Crisis Services</strong></td>
<td></td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>15 min</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>Event</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>Event (avg. event = 25 min per mo.)</td>
</tr>
<tr>
<td>Crisis Transportation (Event)</td>
<td>Event</td>
</tr>
<tr>
<td>Crisis Transportation (Dollar)</td>
<td>$1</td>
</tr>
<tr>
<td>Safety Monitoring</td>
<td>15 min</td>
</tr>
<tr>
<td>Day Programs for Acute Needs (when indicated)</td>
<td>45-60 min</td>
</tr>
<tr>
<td>Extended Observation</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Crisis Residential Treatment</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Crisis Flexible Benefits (Event) LOC-0 &amp; LOC-5</td>
<td>Event</td>
</tr>
<tr>
<td>Crisis Flexible Benefits (Dollar) LOC-0 &amp; LOC-5</td>
<td>$1</td>
</tr>
<tr>
<td>Respite Services: Community-based</td>
<td>15 min</td>
</tr>
<tr>
<td>Respite Services: Program-based (not in home)</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Event</td>
</tr>
<tr>
<td>Inpatient Services (Psychiatric)</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Emergency Room Services (Psychiatric)</td>
<td>Event</td>
</tr>
<tr>
<td>Crisis Follow-up &amp; Relapse Prevention</td>
<td>15 min</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

*Available services vary from location to location.*
II. LEVEL OF CARE 1M (Medication Management): Basic Services

Purpose for Level of Care
Individuals appropriate for this level of care are individuals who meet the HHSC definition for priority population. Services in Level of Care (LOC) 1M (Medication Management) are generally intended for adults who have attained and maintained a level of recovery in treatment such that, except for the ongoing need for medications, would be eligible for discharge from services. This level of service is intended only to complement natural and/or alternative supports available in the community that promote the individual’s recovery and his or her continued pursuit of goals related to social inclusion and participation, independence, and/or productivity. Individuals appropriate for this level of care are ready to transition out of the public mental health system and would make that transition except for the limited community resources available to allow these individuals to make that transition (i.e., no available physicians in the community, no pharmacological resources available to this individual).

The general focus of this service is to prevent deterioration of the individual’s condition, specifically through medication therapy, until such time that he or she is able to access psychiatric and pharmacological resources in the community. Treatment is provided in outpatient, office-based settings and is limited to medication therapy and routine case management.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The recovery/treatment plan review is required at least every 365 days for LOC-1M.

Level of Care Assignment Criteria
The admission criteria to be met are:

- The individual must be determined to have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder) and experiencing significant functional impairment; (GAF ≤ 50 at intake).
- The individual has maintained an LOC-R of 1 during all on-going assessments administered during the previous 12 month period. Please note initial assessments are not counted.
- ANSA scores reveal extreme stability and remain for at least 12 months.
- There is no crisis event/episode for an individual in the level of care or period of decompensation during the previous 12 months; and
- There was no inpatient level of care hospitalization relating to mental condition during the previous 12 months.

Expected Outcomes

- Continued recovery and stability resulting in improved quality of life.
- Individuals participating in LOC-1M services will eventually move into a provider system outside of their local authority provider system when resources are available for them to do so.

Discharge Criteria

- Community resources outside the authority provider system have been identified that can provide the necessary services (e.g., there is a primary care physician available to provide medication-related services) and the individual has been successfully referred to those services.
- The individual declines or opts out of services despite not having an identified provider in the community. Please note there should be sufficient education regarding risk factors related to relapse if there is no identified provider upon discharge.
**LOC-1M Table Overview**

**Authorization Period: 365 Days**

The hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.

<table>
<thead>
<tr>
<th>Level of Care 1M Estimated Utilization Per Month</th>
</tr>
</thead>
</table>

| **Core Services**: Identified by the uniform assessment and indicated in the recovery/treatment plan. | **Standard Therapeutic**: .5 hours per 6 months | **High Need Therapeutic hours per 6 months** |
| Pharmacological Management | .5 hour/2 units | .75 hour/ 3 units |

| **Adjunct Services**: Identified by the uniform assessment and indicated in the recovery/treatment plan. | **Standard Therapeutic** | **High Need Therapeutic** |
| Psychiatric Diagnostic Interview Examination | N/A (1 Event per year) | N/A (1 Event per year) |

| Routine Case Management | .5 hour/2 units | 2.15 hours/ 9 units |

| Screening Brief Intervention and Referral to Treatment (SBIRT) | 25 hours/2 units per year |
| **Screening/No Brief Intervention Provided** | 25 hours/2 units per year |

| Screening Brief Intervention and Referral to Treatment (SBIRT) | 25 hours/4 units per year |
| **Screening and Brief Intervention Provided** | 25 hours/4 units per year |

**Crisis Services Array**: Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
III. LEVEL OF CARE 1S (Skills Training): Basic Services

**Purpose for Level of Care**
Services in this level of care (LOC) are generally intended for individuals who meet the HHSC definition for priority population. Individuals in this level of care present with very little risk of harm and have supports and a level of functioning that does not require higher levels of care.

The general focus of this array of services is to facilitate recovery by reducing or stabilizing symptoms, improve the level of functioning, and/or prevent deterioration of the individual's condition. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings, and are primarily limited to medication, rehabilitative services, and education.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The recovery/treatment plan review is required at least every 180 days for LOC-1S.

**Level of Care Assignment Criteria**
The admission criteria to be met are:
- The individual must be determined to have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder) and experiencing significant functional impairment (GAF ≤ 50 at intake).
- This level of care may also be provided to individuals eligible for a higher LOC, but due to lack of capacity must be served in LOC-1S until capacity is available.

**Special Considerations Regarding Peers and Recovery**
SAMHSA recognizes peer services as a critical component to the recovery process. HHSC endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:
- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e., share experience related to use of medication as a tool in one’s own recovery).
- Provide education about LOC-1S.
- Provide engagement interventions to individuals to foster full participation in treatment.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the very peer specific functions such as shared individual experience.

**Expected Outcomes**
The following outcome(s) can be expected as a result of delivering services at this level of care. The individual receiving services:
- reports stabilization of symptoms or maintenance of stability;
- will need a lesser level of care; or
- achieves a level of recovery that allows them to move out of authority provider system and receive services in their community of choice with a provider of their choice.
Discharge Criteria

ANY of these indicators would support discharge from this LOC:

- Clinical documentation exists to support that the individual has obtained the maximum benefit from this LOC and further treatment will not promote continued relief and/or change (e.g., individual has progressed sufficiently and thus no longer needs the service).
- Individual is not receptive to all treatment even after reasonable efforts and accommodations have been made to engage the individual, and the individual is not at risk of harm to self or others if treatment is suspended. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual’s eligibility to receive other services]
- Individual withdraws or requests discharge from treatment or moves outside service area.
- Community resources outside the authority provider system have been identified that can provide the necessary services (e.g., there is a primary care physician available to provide medication-related services) and the individual has been successfully referred to those services.

This indicator supports discontinuation of Cognitive Processing Therapy (CPT):
If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.
LOC-1S Table Overview

Authorization Period: 180 Days
Recovery/Treatment Plan: 180 Days

Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.

<table>
<thead>
<tr>
<th>Level of Care 1S</th>
<th>Estimated Utilization Per Month</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Services:</strong> Identified by the uniform assessment and indicated in the recovery/treatment plan</td>
<td><strong>Standard Therapeutic- 1.3 hours per month</strong></td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>.25 hours/1 unit</td>
</tr>
<tr>
<td>Routine Case Management</td>
<td>.75 hours/3 units</td>
</tr>
<tr>
<td><strong>Adjunct Services:</strong> Identified by the uniform assessment and indicated in the recovery/treatment plan</td>
<td><strong>Standard Therapeutic</strong></td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>N/A (1 Event per year)</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
<td>1 hour/4 units</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
<td>.75 hours/3 units</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>1.5 hours/6 units</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Individual)</td>
<td>2 hours/8 units</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Group)</td>
<td>.75 hours/3 units</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>3 hours/12 units</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3 hours/12 units</td>
</tr>
<tr>
<td>Cognitive Processing Therapy (Standard duration- 12 sessions)</td>
<td>3 hours/3 units</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Non-billable</td>
</tr>
<tr>
<td>Flexible Funds</td>
<td>Unit type: $1</td>
</tr>
<tr>
<td>Flexible Community Supports</td>
<td>Unit type: 15 min = 1 unit</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

**Crisis Services Array:** Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
IV. LEVEL OF CARE 2: Basic Services including Counseling

Purpose for Level of Care
Services in this level of care (LOC) are intended for individuals with symptoms of Major Depressive Disorder (MDD) with or without psychosis MDD (GAF ≤ 50 at intake) who present very little risk of harm, have supports, have a level of functioning that does not require more intensive levels of care, and can benefit from psychotherapy.

The overall focus of services in this level care is to improve level of functioning and/or prevent deterioration of the individual’s condition so that the individual is able to continue to work towards identified recovery goals. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings and include psychotherapy services in addition to those offered in LOC-1.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The recovery/treatment plan review is required at least every 180 days for LOC-2.

Level of Care Assignment Criteria
The admission criteria to be met are:
- The individual must be determined to have a MDD regardless of the diagnostic qualifier of with or without psychosis;
- The individual has MDD (GAF ≤ 50 at intake) and still has a significant level of residual symptoms;
- The ANSA indicates a LOC-R of 2.

Special Considerations Regarding Peers and Recovery
SAMHSA recognizes peer services as a critical component to the recovery process. HHSC endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of care:
- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e., share experience related to use of medication as a tool in one’s own recovery).
- Provide education about LOC-2.
- Provide engagement interventions to individuals to foster full participation in therapy.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment-providing staff with the exception of the very peer specific functions such as shared individual experience.

Expected Outcomes
The following outcome(s) can be expected as a result of delivering services at this level of care:
- The individual completes the CBT counseling protocol.
- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual develops the necessary skills needed to continue working towards, maintaining or achieving recovery.
**Discharge Criteria**

ANY of these indicators would support discharge from this LOC:

- Individual has met the psychotherapy objectives as defined upon admission to this LOC.
- Individual refuses to participate in psychotherapy. [Note – an individual discharged from this LOC under this provision should generally be served in LOC-1S unless clinically contraindicated.]

**This indicator supports discontinuation of Cognitive Processing Therapy (CPT):**

If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.
**LOC-2 Table Overview**

**Authorization Period: 180 Days**  
**Recovery/Treatment Plan: 180 Days**

Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.

<table>
<thead>
<tr>
<th>Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.</th>
<th>Level of Care 2 Estimated Utilization Per Month</th>
<th>High Need Therapeutic- 5.5 hours per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacological Management</td>
<td>.25 hours/1 unit</td>
<td>.5 hours/2 units</td>
</tr>
<tr>
<td>Routine Case Management</td>
<td>.25 hours/1 unit</td>
<td>1 hour/4 units</td>
</tr>
<tr>
<td>Counseling (CBT - Individual) Standard duration – 16 sessions</td>
<td>3 hours/3 Events</td>
<td>4 hours/4 units</td>
</tr>
<tr>
<td><strong>Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Counseling (CBT - Group) Standard duration – 16 sessions</td>
<td>2 hours/2 Events</td>
<td>3 hours/3 Events</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>N/A (1 Event/year)</td>
<td>N/A (1 Event/year)</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
<td>1 hour/4 units</td>
<td>1.5 hours/6 units</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
<td>.75 hours/3 units</td>
<td>2.15 hours/9 units</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>1.5 hours/6 units</td>
<td>2.25 hours/5 units</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Individual)</td>
<td>1 hour/4 units</td>
<td>2 hours/8 units</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Group)</td>
<td>1 hour/4 units</td>
<td>4.25 hours/17 units</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>3 hours/12 units</td>
<td>4.5 hours/18 units</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3 hours/12 units</td>
<td>4.5 hours/18 units</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Non-billable</td>
<td>Non-billable</td>
</tr>
<tr>
<td>Cognitive Processing Therapy (Standard duration - 12 sessions)</td>
<td>3 hours/3 Events</td>
<td>4 hours/4 Events</td>
</tr>
<tr>
<td>Flexible Funds</td>
<td>Unit type: $1</td>
<td>Unit type: $1</td>
</tr>
<tr>
<td>Flexible Community Supports</td>
<td>Unit type: 15 min=1 unit</td>
<td>Unit type: 15 min=1 unit</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
<td>.25 hours/2 units per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

**Crisis Services Array:** Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
V. LEVEL OF CARE 3: Intensive TRR Services with Team Approach

**Purpose for Level of Care**
The general focus of services in this level of care is to support the individual served in his or her recovery, through a team approach that engages the individual served as a key partner, to stabilize symptoms that interfere with the person’s functioning, improve functioning, develop skills in self-advocacy, and increase natural supports in the community and sustain improvements made in more intensive level of care (LOC). Service focus is on leveraging identified strengths and amelioration of functional deficits through skill training activities focusing on symptom management; independent living; self-reliance; non-job-task specific employment interventions; impulse control; and effective interaction with peers, family, and community. Services are provided in outpatient office-based settings and community settings.

Services in this level of care are generally intended for individuals who enter the system of care with moderate to severe levels of need (or for those whose LOC-R has increased) who require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school). This may include maintaining the current level of functioning. A rehabilitative case manager who is a member of the therapeutic team must provide supported housing and Co-Occurring Psychiatric and Substance Abuse Disorders (COPSD) services, if indicated. Supported employment services must be provided by a rehabilitative case manager or a supported employment specialist. It is highly recommended a dedicated employment specialist provide the supported employment services.

*The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.*

*The Recovery/Treatment Plan review is required at least every 180 days for LOC-3.*

**Level of Care Assignment Criteria**
The admission criteria to be met are:
- The individual must be determined to have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder with or without psychosis), be experiencing significant functional impairment, and have a Quick Inventory of Depressive Symptomatology QIDS score \( \geq 16 \), (GAF\( \leq 50 \) at intake).
- Individuals who meet the definition of the priority population, GAF\( \leq 50 \) may be overridden into services if the override criteria are met.
- ANSA indicates a LOC-R of 3.

**Special Considerations Regarding Peers and Recovery**
SAMHSA recognizes peer services as a critical component to the recovery process. HHSC endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:
- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (*i.e.* share experience related to use of medication as a tool in one’s own recovery).
- Provide education about LOC 3.
- Provide engagement interventions to individuals to foster full participation in treatment.
If a peer has been credentialed as a Certified Peer Specialist, he or she may serve as a member of the treatment team offering feedback to other providers regarding his or her observations of an individual’s stage of recovery and/or efforts made towards fulfilling the individual’s recovery goals.

NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the peer specific only functions such as shared individual experience.

**Expected Outcomes**
The following outcome(s) can be expected as a result of delivering services at this level of care:
- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual begins to develop natural supports in the community and sustains improvement acquired in a higher level of care.
- The individual will develop additional skills needed to continue working towards, maintaining, or achieving recovery.

**Discharge Criteria**
This indicator supports discharge from this LOC:
Individual refuses all services. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual's eligibility to receive other services.]

This indicator supports discontinuation of Cognitive Processing Therapy (CPT): If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.
## LOC-3 Table Overview

**Authorization Period: 180 Days**  
**Recovery/Treatment Plan: 180 Days**

Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.

### Level of Care 3  
**Estimated Utilization Per Month**

<table>
<thead>
<tr>
<th>Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.</th>
<th>Standard Therapeutic- 5.87 hours per month</th>
<th>High Need Therapeutic- 20.35 hours per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacological Management</td>
<td>.25 hours/ 1 unit</td>
<td>0.5 hr/ 2 units</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services (Individual)</td>
<td>3.5 hours/ 14 units</td>
<td>7 hours/ 29 units</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services (Group)</td>
<td>2.25 hours/ 9 units</td>
<td>8.6 hours/ 35 units</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3 hours/ 12 units</td>
<td>4.25 hours/ 17 units</td>
</tr>
</tbody>
</table>

**Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.**

<table>
<thead>
<tr>
<th>Psychiatric Diagnostic Interview Examination</th>
<th>N/A (1 Event/year)</th>
<th>N/A (1 Event/year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
<td>1 hour/4 units</td>
<td>1.5 hours/ 6 units</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
<td>.75 hour/ 3 units</td>
<td>5 hours/ 21 units</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>1.5 hours/ 6 units</td>
<td>2.25 hours/ 9 units</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>3 hours/ 12 units</td>
<td>4.5 hours/ 18 units</td>
</tr>
</tbody>
</table>

**Cognitive Processing Therapy (Standard duration- 12 sessions)**

<table>
<thead>
<tr>
<th>Day Programs for Acute Needs</th>
<th>Unit type: 45-60 continuous min</th>
<th>Unit type: 45-60 continuous min</th>
</tr>
</thead>
<tbody>
<tr>
<td>Residential Treatment</td>
<td>Unit type: bed day</td>
<td>Unit type: bed day</td>
</tr>
<tr>
<td>Flexible Funds</td>
<td>Unit type: $1</td>
<td>Unit type: $1</td>
</tr>
</tbody>
</table>

**Flexible Community Supports**

<table>
<thead>
<tr>
<th>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</th>
<th>.25 hours/2 units per year</th>
<th>.25 hours/2 units per year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

**Crisis Services Array:** Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
VI. LEVEL OF CARE 4: Assertive Community Treatment (ACT)

Purpose for Level of Care
The purpose of ACT is to provide a comprehensive program that serves as the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses. Persons receiving ACT services may have a diagnosis of schizophrenia or another serious mental illness such as bipolar disorder and have experienced multiple psychiatric hospital admissions either at the state or community level.

Using an integrated services approach, the ACT team merges clinical and rehabilitation staff expertise (e.g., psychiatric, substance abuse, employment, and housing) within a mobile service delivery team that works in partnership with the person in recovery from his or her home. Accordingly, there will be minimal referral of individuals to other programs for treatment, rehabilitation, and support services. Limited use of group activities designed to reduce social isolation or address substance use/abuse issues is also acceptable as part of ACT.

ACT includes an Urban ACT program and a Rural ACT program. The local authority provider system’s ACT designation status shall be based on the total number of individuals with a LOC-R-4. If an authority provider system has 60 or greater individuals with an LOC-R of 4 or the population density for the local authority provider system’s service area is greater than or equal to 300 individuals per square mile, then the local authority provider system shall be considered an Urban ACT team. All other teams shall be considered to be a Rural ACT team. (Performance Contract contains details for each local authority provider system.)

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for additional service amounts or a change in level of care authorized.

The Recovery/Treatment Plan review is required at least every 180 days for LOC-4.

Level of Care Assignment Criteria
The admission criteria to be met are:
- The individual must be determined to have severe and persistent mental illnesses (diagnoses of schizophrenia, bipolar disorder, or major depressive disorder with psychosis) and experiencing significant functional impairment (GAF ≤ 50 at intake).
- Individuals who meet the definition of the priority population, GAF≤ 50, may be overridden into services if the override criteria are met;
- ANSA indicates a LOC-R of 4.

Special Considerations Regarding Peers and Recovery
SAMHSA recognizes peer services as a critical component to the recovery process. The HHSC endeavors to facilitate processes that acknowledge this role. As such, the following recommendation(s) highlight how peers might be best utilized within this level of service:
- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate to the peer specialist role (i.e. share experience related to use of medication as a tool in one’s own recovery).
- Provide education about LOC-4.
- Provide engagement interventions to individuals to foster full participation in treatment.
- If a peer has been credentialed as a Certified Peer specialist, he or she may serve as a member of the treatment team offering feedback to other providers regarding his or her observations of an individual’s stage of recovery and/or efforts made towards fulfilling the individual’s recovery goals.
NOTE: All the tasks identified in this section are services/assistance that can be provided by any treatment providing staff with the exception of the very peer specific functions such as shared individual experience.

**Expected Outcomes**
The following outcome(s) can be expected as a result of delivering services at this level of care:
- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual begins to develop natural supports in the community and sustains improvement.
- The individual will develop additional skills needed to continue working towards, maintaining or achieving recovery.
- The individual will move to a lower level of care and continue to work towards self-directed recovery goals.

**Discharge Criteria**
ANY of these indicators would support discharge from this LOC:
- The individual moves outside of the geographic service area of the ACT team. To the extent possible, the ACT team must facilitate referral of the individual to a provider of services sufficiently capable of satisfactorily addressing the individual’s needs.
- Individual refuses all services. [Note: In accordance with 25 TAC, Chapter 412, Subchapter G, the refusal of, or non-compliance with one type of service does not affect the individual’s eligibility to receive other services]

**This indicator supports discontinuation of Cognitive Processing Therapy (CPT):**
If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.
### LOC- 4 Table Overview

#### Authorization Period: 180 Days
#### Recovery/Treatment Plan: 180 Days

Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate.

<table>
<thead>
<tr>
<th>Core Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.</th>
<th>Standard Therapeutic- 10 hours per month</th>
<th>High Need Therapeutic- 26.65 hours per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacological Management</td>
<td>.25 hours/ 1 unit</td>
<td>.3 hours/ 2 units</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services (Individual)</td>
<td>5.75 hours/ 23 units</td>
<td>14, 25 hours/ 57 units</td>
</tr>
<tr>
<td>Psychosocial Rehabilitative Services (Group)</td>
<td>2.5 hours/ 10 units</td>
<td>8.6 hours/ 35 units</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3 hours/ 12 units</td>
<td>3.5 hours/ 14 units</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.</th>
<th>Standard Therapeutic</th>
<th>High Need Therapeutic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>N/A (1 Event per year)</td>
<td>N/A (1 Event per year)</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
<td>1 hour/ 4 units</td>
<td>2.5 hours/ 10 units</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
<td>.75 hour / 3 units</td>
<td>2.75 hours/ 11 units</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td>1.5 hours / 6 units</td>
<td>1.75 hours/ 7 units</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>3 hours/ 12 units</td>
<td>3.5 hours/ 14 units</td>
</tr>
<tr>
<td>Cognitive Processing Therapy (standard duration-12 sessions)</td>
<td>3 hours/ 3 Events</td>
<td>3.5 hours/ 14 Events</td>
</tr>
<tr>
<td>Counseling (CBT - Individual) Standard duration – 16 sessions</td>
<td>3 hours/3 Events</td>
<td>4 hours/ 4 Events</td>
</tr>
<tr>
<td>Counseling (CBT - Group) Standard duration – 16 sessions</td>
<td>2 hours/2 Events</td>
<td>3 hours/3 Events</td>
</tr>
<tr>
<td>Day Programs for Acute Needs</td>
<td>Unit type: 45-60 continuous min</td>
<td>Unit type: 45-60 continuous min</td>
</tr>
<tr>
<td>Residential Treatment</td>
<td>Unit type: bed day</td>
<td>Unit type: bed day</td>
</tr>
<tr>
<td>Flexible Funds</td>
<td>Unit type: $1</td>
<td>Unit type: $1</td>
</tr>
<tr>
<td>Flexible Community Supports</td>
<td>Unit type: 15 min = 1 unit</td>
<td>Unit type: 15 min = 1 unit</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
<td>.25 hours/2 units per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

**Crisis Services Array:** Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this Level of Care is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
VII. LEVEL OF CARE 5: Transitional Services

**Purpose for Level of Care**

The major focus for this LOC is to provide flexible services that assist individuals in maintaining stability, preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary dependent on individual need. This LOC is available for up to 90 days.

The authorization at the LOC level and medical necessity determination at the LOC level is required prior to service delivery. Medical necessity must be established with any new/initial authorization. Medical Necessity must be reestablished with any request for a change in the level of care authorized.

A Recovery/Treatment Plan is required. In the event that an additional LOC-5 post-initial 90 days is required, a new plan would be required for every 90 day LOC-5 authorization.

**Special Considerations during Crisis**

As in other LOCs, if a crisis occurs during the time an individual is in LOC-5, crisis services are considered a part of the authorization for LOC-5 and crisis services should be delivered without a change in the LOC. LOC-0 may only be used for an individual who is newly admitted to services, or who has been transitioned/discharged out of LOC-5 and experiencing a crisis.

**Level of Care Assignment Criteria**

The admission criteria to be met are:

- The individual has been discharged from LOC-0 services or released from the hospital and is not eligible for ongoing services, and is in need of more than crisis services to stabilize; or
- The individual has been discharged from LOC-0 services or released from the hospital and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual and the individual is in need of transitional services; or
- The individual is identified as part of a high need population; e.g., homelessness, substance abuse issues, primary healthcare needs, or has a history of criminal justice involvement and is not eligible for ongoing services but is in need of more than crisis services to stabilize; or
- The individual is identified as part of a high need population; e.g., homelessness, substance abuse issues, primary healthcare needs, or has a history of criminal justice involvement and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual and the individual is in need of transitional services; or
- The individual has been discharged from LOC-0 services, released from the hospital or is part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs, or has a history of criminal justice involvement and has chosen an external provider for ongoing services but is in need of transitional services.

**Special Considerations**

In addition to the above level of care assignment criteria, the following may indicate this as the most appropriate LOC:

- Individual is high need and is underserved or on the Waiting List for all services LOC A 8. This individual may be authorized into LOC-5 to stabilize or avoid repeated crises until the appropriate level of care is provided for up to 90 days.
- Special care needs to be provided for individuals who receive Medicaid benefit to ensure access to medically necessary services.

**Adjunct Service Criteria:**
Counseling (Cognitive Processing Therapy (CPT)):
- CPT is clinically indicated when there is a diagnosis of PTSD.

Any of the following may indicate the need to continue Cognitive Processing Therapy (CPT):
- Even if an individual has obtained maximum benefit or has located other community resources, if he or she has not completed all 12 sessions in the CPT protocol, the individual is not discontinued from CPT unless he or she requests discontinuation.
- If an individual's condition worsens and a more intensive Level of Care is appropriate and available, CPT or any other add-on service is continued in the new Level of Care as clinically appropriate as long as the individual is willing to continue services.
- A follow-up session to assess progress and target problem areas is recommended approximately one month after completion of CPT and may be conducted individually or in a group. This 13th session is at the individual's and therapist's discretion.

**Criteria for Level of Care Review**
Continued Stay: This LOC will terminate in 90 days. If eligibility criteria are met, continued services may be provided in LOCs 1S-4 or LOC-0.

**Indication for potential increase in LOC:** Individual's condition worsens as indicated by a LOC- R 0-4 on the ANSA.

**Discharge Criteria**
ANY of these indicators would support discharge from this LOC:
- Referred to a higher LOC for crisis management, e.g. in patient level of care psychiatric hospitalization.
- The identified crisis is resolved and the individual has been engaged and transitioned to LOC-1S-4.
- The identified crisis is resolved, but resources do not support placement of the individual in LOC-1S-4. Therefore, the individual is placed on a waiting list for LOC 1S-4.
- Individual has been referred and linked to community resources outside the HHSC system.
- The individual terminates services.

**This indicator supports discontinuation of Cognitive Processing Therapy (CPT):**
- If an individual has not made progress in symptoms or cognition after several sessions, he or she should be re-evaluated for his or her appropriateness for CPT versus other treatment options.

**Expected Outcomes**
- Individual self-reports reduction or stabilization in presenting problem severity and improved quality of life as evidenced by scores on the ANSA.
- Individual becomes engaged into the appropriate level of care.
- Individual is better able to use natural and community support systems as resources.
**LOC-5 Overview**

LOC-5 is designed to flexibly meet the needs of the individual prior to admission into ongoing services. All services are available in this Level of Care. Services should reflect the individual’s needs.

<table>
<thead>
<tr>
<th>UM Guidelines</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Level of Care 5 Transitional Services</strong></td>
</tr>
<tr>
<td>Routine Case Management</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
</tr>
<tr>
<td>Pharmacological Management</td>
</tr>
<tr>
<td>Medication Training and Support Services (Individual, Curriculum-based)</td>
</tr>
<tr>
<td>Medication Training and Support Services (Group, Curriculum-based)</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Individual)</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Group)</td>
</tr>
<tr>
<td>Supported Employment</td>
</tr>
<tr>
<td>Supported Housing</td>
</tr>
<tr>
<td>Flexible Funds</td>
</tr>
<tr>
<td>Flexible Community Supports</td>
</tr>
<tr>
<td>Engagement Activity</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
</tr>
</tbody>
</table>

**The following Crisis Services are also considered Core Services for LOC 5 and are Available to All individuals During Crisis**

<table>
<thead>
<tr>
<th>Services</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counseling (Cognitive Processing Therapy)</td>
<td>45-60 min</td>
</tr>
<tr>
<td>Counseling (CBT - Individual) Standard duration – 16 sessions</td>
<td>16 hrs/16 Events</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td>15 min</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>Event</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>Event 25 min</td>
</tr>
<tr>
<td>Crisis Transportation (Event)</td>
<td>Event</td>
</tr>
<tr>
<td>Crisis Transportation (Dollar)</td>
<td>$1</td>
</tr>
<tr>
<td>Safety Monitoring</td>
<td>15 min</td>
</tr>
<tr>
<td>Day Programs for Acute Needs (when indicated)</td>
<td>45-60 min</td>
</tr>
<tr>
<td>Extended Observation</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Crisis Residential Treatment</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Flexible Funds (Dollars)</td>
<td>$1</td>
</tr>
<tr>
<td>Flexible Community Supports (Time)</td>
<td>15 min</td>
</tr>
<tr>
<td>Respite Services: Community-based</td>
<td>15 min</td>
</tr>
<tr>
<td>Respite Services: Program-based (Not In Home)</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Inpatient Hospital Services</td>
<td>Event</td>
</tr>
<tr>
<td>Inpatient Services (Psychiatric)</td>
<td>1 bed day</td>
</tr>
<tr>
<td>Emergency Room Services (Psychiatric)</td>
<td>Event</td>
</tr>
<tr>
<td>Crisis Follow-up &amp; Relapse Prevention</td>
<td>15 min</td>
</tr>
</tbody>
</table>
VIII LEVEL OF CARE EO: Early Onset (LOC-EO)

Purpose for Level of Care

The purpose of LOC-EO is to provide a specialized treatment approach for those experiencing their first episode of psychosis. Individuals in this level of care will have a diagnosis that includes psychotic features and will vary in terms of need and severity. The Early Onset LOC’s goal is to identify and help individuals before their symptoms and/or diagnosis are the primary feature of his/her life. Due to the early intervention model, many individuals may be entering behavioral health services for the first time and require a comprehensive array of services be available.

The team-based approach is a vital aspect of the assistance an individual will receive when they participate in LOC-EO. Coordinated Specialty Care (CSC) Teams are trained in the CSC model and provide an individual with all of the clinical and support services so care is provided efficiently and with a focus on recovery.

Level of Care Assignment/Deviation Criteria

The admission criteria to be met are:

The individual must be between the ages of 15 and 30.
- The individual must have a diagnosis which contains psychosis that was first given within the last two years.
- Individual must live in the service area of a pilot site.

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. DSHS endeavors to facilitate processes that acknowledge this role. As such, the following recommendations highlight how peers and/or family partners might be best utilized within this level of service:

- Share individual experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process.
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate.
- Provide education about the Early Onset Program.
- Provide Engagement interventions to individuals to foster full participation in treatment.
- Certified Peer Specialists and/or Certified Family Partners may serve as a member of the treatment team offering feedback to other providers regarding his or her observations of an individual’s stage of recovery and/or efforts made towards fulfilling the individual’s recovery goals.

Note: All the tasks identified in this section are services/assistance that can be provided by any treatment-providing staff with the exception of peer-specific functions, such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this LOC:

- The individual receiving services reports stabilization of symptoms or maintenance of stability.
- The individual will develop additional skills needed to continue working toward, maintaining, or achieving
recovery.
- The individual will obtain skills to prepare for gainful employment and/or educational obtainment.

**Discharge Criteria**

ANY of these indicators would support discharge or transition from this LOC:
- The individual moves outside of the geographic service area of the CSC team. To the extent possible, the CSC team must facilitate referral of the individual to a provider of services sufficiently capable of satisfactorily addressing the individual’s needs.
- Individual is determined to not have a qualifying diagnosis. Due to diagnostic uncertainty when first entering this LOC, it is possible an individual may be assigned this LOC initially before a true diagnosis is given. Should the individual be given a diagnosis that is not on the allowable list, the individual must be transitioned to the next most appropriate LOC.
- The individual has been enrolled in LOC-EO for a total of 36 months.
- The individual is determined to not meet the age requirement.
## LOC-AEO Table Overview

### Authorization Period: 90 Days

### Recovery Plan: 90 Days

**Average Monthly Utilization Standard for this Level of Care Is Based on Determined Need**

Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.

### Level of Care AEO

**Estimated Utilization Per Month (These Are Guidelines Only)**

<table>
<thead>
<tr>
<th>Core Services: Identified by the uniform assessment and indicated in the recovery plan.</th>
<th>Standard Therapeutic 5.87 hours per month</th>
<th>High Need Therapeutic 20.35 hours per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td>1 Event/year</td>
<td>1 Event/year</td>
</tr>
<tr>
<td>Routine Case Management</td>
<td>1 hr/4 units</td>
<td>6 hours/24 units</td>
</tr>
<tr>
<td>Psychosocial Rehab (Individual)</td>
<td>3.5 Hours/14 units</td>
<td>7 hours/29 units</td>
</tr>
<tr>
<td>Psychosocial Rehab (Group)</td>
<td>2.25 Hours/9 units</td>
<td>8.6 hours/35 units</td>
</tr>
<tr>
<td>Peer Support</td>
<td>Non-billable</td>
<td>Non-billable</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td>0.25 hours/1 unit</td>
<td>0.5 hour/2 units</td>
</tr>
<tr>
<td>Administration of an injection</td>
<td>1 unit</td>
<td>1 unit</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
<td>1 hour/4 units</td>
<td>1.5 hours/6 units</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
<td>0.75 hour/3 units</td>
<td>5 hours/21 units</td>
</tr>
<tr>
<td>Family Counseling</td>
<td>3 hours/3 events</td>
<td>4 hours/16 events</td>
</tr>
<tr>
<td>Individual Psychotherapy</td>
<td>3 hours/3 events</td>
<td>4 hours/16 units</td>
</tr>
<tr>
<td>Group Counseling (other than multiple family)</td>
<td>3 hours/3 events</td>
<td>4 hours/16 events</td>
</tr>
<tr>
<td>Supported Housing</td>
<td>3 hours/12 units</td>
<td>4.25 hours/17 units</td>
</tr>
<tr>
<td>Supported Employment</td>
<td>3 hours/12 units</td>
<td>4.5 hours/18 units</td>
</tr>
<tr>
<td>Engagement Activity</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Flexible Funds</td>
<td>Unit type: $1</td>
<td>Unit type: $1</td>
</tr>
</tbody>
</table>

**Adjunct Services: Identified by the uniform assessment and indicated in the recovery/treatment plan.**

<table>
<thead>
<tr>
<th>Flexible Community Supports</th>
<th>Standard Therapeutic Unit type: 15 min=1 unit</th>
<th>High Need Therapeutic Unit type: 15 min=1 unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
<td>.25 hours/2 units per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
<td>.25 hours/4 units per year</td>
</tr>
</tbody>
</table>

**Crisis Service Array:** Authorized as medically necessary and available during psychiatric crisis. Utilization of crisis services within this LOC is the same as LOC-0. Please refer to LOC-0 for utilization guidelines.
LEVEL OF CARE TAY: Transition Age Youth (LOC-TAY)

Purpose for Level of Care

The purpose of LOC-TAY is to identify and help persons 16 through 20 years of age who may undergo tremendous change in all domains of life including physical, cognitive, relationships, educational, vocational, and housing. Early identification and engagement around transitions with youth and their caregivers, while promoting environments where youth and their caregivers may obtain skills necessary for success in transition to adulthood is central to LOC-TAY. Persons in this level of care will have a diagnosis varying in terms of need and severity. Co-Occurring Psychiatric and Substance Use Disorders (COPSD) services shall be provided, if indicated. The goal of LOC-TAY is to provide access to evidenced-based assessments, treatment models, and recovery services supported by the strengthening of the existing service delivery structure in a wraparound approach with “transition age” youth/young adults.

Level of Care Assignment/Deviation Criteria

The admission criteria to be met are:

- The person must be between the ages of 18 and 20
- The person must have had involvement in one or more systems of care:
  - Juvenile / Criminal Justice
  - Foster Care
  - Family Protective Services
  - School District 504 consideration
  - Alternative Education Program
  - Substance Use Disorder Services
  - Chronic Medical Condition services
  - Community Mental Health
- Person must have one or more of the following Strengths Domain = not yet identified (3)
  - Family
  - Social Connectedness
  - Optimism
  - Educational
  - Job history
  - Community connection
  - Natural supports

Special Considerations Regarding Peers and Recovery

SAMHSA recognizes peer services as a critical component to the recovery process. HHSC endeavors to facilitate processes that acknowledge this role. As such, the following recommendations highlight how peers and/or family partners might be best utilized within this level of service:

- Share personal experience related to recovery and act as a model of hope and resilience.
- Provide education about the recovery process
- Promote social integration by educating about resources in the community that may support continued recovery, such as individual-operated service providers, mutual aid groups, social organizations related to the individual’s interests, health clubs, etc.
- Provide medication training and support as appropriate

1 Transition Age Youth Level of Care is provided through deviation as assessed medically necessary by a Licensed Professional of the Healing Arts (LPHA)
• Provide Engagement interventions to individuals to foster full participation in treatment
• Certified Peer Specialists and/or Certified Family Partners may serve in collaboration as a member of the treatment team offering feedback to other providers regarding his or her observations of an individual’s stage of recovery and/or efforts made towards fulfilling the individual’s recovery goals.

Note: All the tasks identified in this section are services/assistance that can be provided by any treatment-providing staff with the exception of peer-specific functions, such as shared individual experience.

Expected Outcomes

The following outcome(s) can be expected as a result of delivering services at this LOC:
• The person receiving services reports stabilization of symptoms or maintenance of stability
• The person will develop additional skills needed to continue working toward, maintaining, or achieving recovery
• The person will develop strengths in recovery related to the utilization of natural and community supports
• The individual will obtain skills to prepare for gainful employment and/or educational obtainment

Discharge Criteria

ANY of these indicators would support discharge or transition from this LOC:
• The person moves outside of the geographic service area of the wraparound service plan. To the extent possible, the provider must facilitate referral of the individual to a provider of services sufficiently capable of satisfactorily addressing the person’s needs
• The person is recommended or determined to meet medical necessity for a higher LOC
• The person is determined to not meet the age requirement
### LOC-TAY Table Overview

**Authorization Period:** 180 Days  
**Recovery Plan:** 180 Days

**Average Monthly Utilization Standard for this Level of Care:** 7.5 hours

Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services when clinically appropriate and indicated in the recovery plan.

#### Level of Care TAY

<table>
<thead>
<tr>
<th>Estimated Utilization Per Month (These Are Guidelines Only)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Core Services:</strong> Identified by the uniform assessment and indicated in the recovery plan.</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
</tr>
<tr>
<td>Intensive Case Management (Wraparound)</td>
</tr>
<tr>
<td>Skills Training &amp; Development includes any/all of the following:</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Individual)</td>
</tr>
<tr>
<td>Skills Training &amp; Development (Group)</td>
</tr>
<tr>
<td>Peer Support</td>
</tr>
<tr>
<td>Pharmacological Management</td>
</tr>
<tr>
<td>Administration of an injection</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Individual)</td>
</tr>
<tr>
<td>Medication Training &amp; Support Services (Group)</td>
</tr>
<tr>
<td>Family Counseling</td>
</tr>
<tr>
<td>Individual Psychotherapy</td>
</tr>
<tr>
<td>Group Counseling (other than multiple family)</td>
</tr>
<tr>
<td>Supportive Housing</td>
</tr>
<tr>
<td>Supported Employment</td>
</tr>
<tr>
<td>Supported Education</td>
</tr>
<tr>
<td>Engagement Activity</td>
</tr>
<tr>
<td>Flexible Funds</td>
</tr>
</tbody>
</table>

**Adjunct Services:** Identified by the uniform assessment and indicated in the recovery/treatment plan.

<table>
<thead>
<tr>
<th></th>
<th><strong>Standard Therapeutic</strong></th>
<th><strong>High Need Therapeutic</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Flexible Community Supports</td>
<td>Unit type: 15 min=1 unit</td>
<td>Unit type: 15 min=1 unit</td>
</tr>
<tr>
<td>Family Partner Supports</td>
<td>2 hours</td>
<td>6.25 hours/25 units</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided</td>
<td>.25 hours/2 units per year</td>
<td>Twice per year</td>
</tr>
<tr>
<td>Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided</td>
<td>.25 hours/4 units per year</td>
<td>4 encounters per year</td>
</tr>
</tbody>
</table>
X LOC – 6, 8, 9 Overview

LOC – 6 Overview:

Individual Refuses Services (LOC-A only)

The Adult Needs Strengths Assessment (ANSA) indicates a Recommended Level of Care (LOC-R) of 1M-4; however, the individual refuses services. These individuals will be authorized into Level of Care (LOC-A) 6.

LOC – 8 Overview:

Waiting for all Authorized Services (LOC-A only)

All providers who maintain a waitlist must adhere to the standards outlined in the performance contract. For information related to managing a waitlist, please refer to the performance contract.

LOC – 9 Overview:

Not Eligible for Services (LOC-R or A)

The Adult Needs Strengths Assessment indicates a Recommended Level of Care (LOC-R) 9.

A provider may request a review from the each provider’s Utilization Management Department if, based on the individual’s clinical presentation and the provider’s clinical judgment, it is determined that a different level of care may be clinically appropriate. The necessary clinical information will be reviewed in accordance with the provider’s Utilization Management Policy and Procedures for those individuals with a LOC-R of 9. If it is determined the individual is clinically appropriate to receive services the individual may be authorized into a level of care.

XI. Deviations

Definitions and Usage

The following Reasons for Deviation are allowed with indicated requirements when authorizing a level of care (LOC-A) other than the level of care recommended (LOC-R):

Resource Limitations: To be used when the Utilization Management staff member identifies that there are not enough resources to offer services at the recommended level of care (Note: Resources are defined as individual, a slot within a specific level of care, or monetary resources necessary to provide services within the level of care).
Recommendation:
- This reason for deviation is not to be used to increase a level of care.

**Individual Refused:** To be used when the individual is provided with information necessary to make an informed decision and refuses the recommended level of care. The information discussed with the individual must be documented in the medical record.

Recommendation:
- A contractual threshold will be established for this deviation reason

**Clinical Need:** To be used when the LPHA’s judgment identifies the clinical need for a more or less intensive level of care than the level of care recommended. Justification for the deviation must be documented in the medical record.

The following is an example of appropriate utilization of this deviation reason:
- The Uniform Assessment recommends a lower level of care than the individual is currently receiving but based on individual’s history and needs, the clinician recommends and the local authority provider system authorizes the current level of care to ensure that improvements are maintained (identified needs must be documented in the Uniform Assessment).

- Mandatory description of the reason for deviation in the notes section when deviating to a LOC-A that is lower than the LOC-R

**Continuity of Care:** To be used when there is an identified need to authorize a level of care that is different from the level of care recommended by HHSC in order to maintain continuity of care for the individual. Justification for the deviation must be documented in the medical record.

The following are examples of appropriate utilization of this deviation reason:
- The individual is incarcerated or placed in juvenile detention center but continues to need services from the provider that the facility is not obligated to provide or are provided under a contract with the facility;

Or

- The individual is hospitalized and provider communicates with the individual and hospital staff regarding care and transition to the community.

**Other:** To be used when none of the reasons listed above accurately describe the Reason for Deviation. Justification for the deviation must be documented in the “Notes” field of the uniform assessment and retained in the medical record.
### Deviation Reasons and Deviation Grid Table

<table>
<thead>
<tr>
<th>LOC-R</th>
<th>LOC-A Deviation Reason(s)</th>
</tr>
</thead>
</table>
| 1M    | No deviations allowed into LOC-1M from other LOC's.  
|       | May deviate into LOC-1S through LOC-4 due to clinical need. |
| 1S    | No deviations allowed into LOC-1M.  
|       | May deviate LOC-2 through LOC-4 due to clinical need. |
| 2     | No deviations allowed into LOC 1M.  
|       | May deviate into LOC 1S due to resource limitations, clinical need or individual refused services.  
|       | May deviate into LOC-3 or LOC-4 due to clinical need. |
| 3     | No deviations allowed into LOC-1M.  
|       | May deviate into LOC-1S due to resource limitations, clinical need or individual refused services.  
|       | May deviate into LOC-2 or LOC-4 due to clinical need. |
| 4     | No deviations allowed into LOC-1M.  
|       | May deviate into LOC-1S due to resource limitations, clinical need or individual refused services.  
|       | May deviate into LOC-2 due to clinical need, or resource limitations.  
|       | May deviate into LOC-3 due to clinical need, resource limitations or individual refused. |
| 9     | Deviations into LOC-9 are limited to 2 consecutive authorization periods.  
|       | May deviate into LOC 1S-4 due to clinical need, or resource limitation.  
|       | May deviate to LOC-5 if the individual has been recently discharged from crisis services or released from a hospital, after being treated for a psychiatric condition, and is not eligible for ongoing services, and there is a need for more than crisis services to stabilize, due to clinical need  
|       | May deviate to LOC-5 if the individual is identified as part of a high need population (e.g. homelessness, substance abuse issues, primary healthcare needs, or has a history of criminal justice involvement and is not eligible for ongoing services, but is in the need of transitional services due to clinical need. |
| 1S-4  | May deviate to LOC-5 if the individual has been recently discharged from crisis or inpatient level of care psychiatric hospital, after being treated for a psychiatric condition, and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual and the individual is in need of transitional services, due to clinical need  
|       | May deviate to LOC-5 if the individual is identified as part of a high need population e.g. homelessness, substance abuse issues, primary healthcare needs or has a history of criminal justice involvement and is eligible for ongoing services, but ongoing services are not available or the provider has had difficulty engaging the individual but is in the need of transitional services, due to clinical need  
|       | May deviate to LOC-5, if the individual has been recently discharged from crisis services, released from inpatient level of care psychiatric hospital, after being treated for a psychiatric condition, or is part of a high need population e.g. homelessness, substance abuse issues, primary healthcare |
| 1S-9  | May deviate into LOC-0, if the individual does not have a current Authorization due to clinical need/medical necessity warrants crisis services.
**Purpose of the Level of Care Deviation**

The purpose of the Request for Deviation Option, or LOC-D, is to allow the provider the option to request a deviation from the recommended LOC (LOC-R) as calculated by the ANSA/Uniform Assessment.

**Options for the Use of LOC-D**

- The individual does not have an authorization of LOC 1-5; (no current UA); if the clinical circumstances warrant the individual may be deviated into LOCA-0 (intake UA only).
- The LOC-R is 1-4 or 9; then the LOC-D, shall only be completed when requesting a deviation from the LOC-R. (Intake or Update UA).
- The clinician provides the reason for deviation. See the above table - Deviation Reasons and Deviation Grid Table for each LOC-R and LOC-A.

**Expected Outcomes**

The individual receives the appropriate care, based on clinical need through the deviation request.

The individual will eventually be authorized in the LOC based on the LOC-R.

**XII. Service Definitions**

**Key Terms**

*Core Service definition:* The services in a level of care that are essential and are expected to be delivered to all individuals to support their recovery.

Exceptions for not providing core services include:

- The UA does not indicate the need for a specific core service; or
- Delivery of a core service is clinically contraindicated (documentation required); or
- The individual refuses a core service (documentation required; engagement services must be delivered and efforts documented.)

*Adjunct Service definition:* Clinically indicated services that are customized and may be delivered to support the recovery of the individual.

Note: When a level of care is authorized, all core and adjunct services are also authorized; however, some local authority provider system’s may require additional authorizations for certain Core and Adjunct Services. Please follow your local authorization policy.

**Service Definitions:**

- **Counseling (Cognitive Behavioral Therapy (CBT)):** Individual, family and group therapy focused on the reduction or elimination of an individual’s symptoms of mental illness and increasing the individual’s ability to perform activities of daily living. Cognitive-behavioral therapy is the selected treatment model for adult counseling services. Counseling must be
provided by a Licensed Practitioner of the Healing Arts (LPHA), practicing within the scope of
their license or by an individual with a master’s degree in a human services field pursuing
licensure under the direct supervision of an LPHA, if not billed to Medicaid. Providers of CBT
must pass a competency review. This service includes recovery/treatment planning to
enhance recovery and resiliency. Note: Group CBT falls under the category of adjunct
service.

- **Counseling [Cognitive Processing Therapy (CPT)]:** Individual therapy focused on the
  reduction or elimination of an individual’s symptoms of post-traumatic stress disorder (PTSD).
  CPT is the selected treatment model for adults with PTSD, including but not limited to military
  veterans. CPT is clinically indicated when there is an Axis I diagnosis of PTSD. Counseling
  must be provided by a Licensed Practitioner of the Healing Arts (LPHA), also trained in CPT
  by HHSC, practicing within the scope of their license. Alternative CPT Certification may be
  sought for those individuals who have received adequate CPT training outside of HHSC. CPT
  may also be provided by an individual with a master’s degree in a human services field
  pursuing licensure under the direct supervision of an LPHA who has been trained in CPT, if
  not billed to Medicaid. This service includes recovery/treatment planning to enhance
  recovery and resiliency.

- **Crisis Flexible Benefits:** Non-clinical supports that reduce crisis situations, symptomatology,
  and enhance an individual’s ability to remain in the home or community. Benefits in adult
  mental health services include spot rental, partial rental subsidies, utilities, emergency food,
  housewares, clothing, transportation assistance, and residential services. (LOC 0 & LOC 5)

- **Crisis Follow-up and Relapse Prevention:** Supported services provided to individuals who
  are not in imminent danger of harm to self or others but require additional assistance to avoid
  reoccurrence of the crisis event. The service is provided to ameliorate the situation that gave
  rise to the crisis event, ensure stability, and prevent future crisis events. (This service
  includes ongoing assessment to determine crisis status and needs, provides time-limited (up
  to 30 days) brief, solution-focused interventions to individuals and families and focuses on
  providing guidance and developing problem-solving techniques to enable the individual to
  adapt and cope with the situation and stressors that prompted the crisis event).

- **Crisis Intervention Services:** Interventions in response to a crisis in order to reduce
  symptoms of severe and persistent mental illness or emotional disturbance and to prevent
  admission of an individual or individual to a more restrictive environment. Must be provided
  in accordance with Title 25 of the Texas Administrative Code (TAC), Chapter 419,
  Subchapter L, *MH Rehabilitative Services.* This service does not require prior authorization.
  The average time necessary to stabilize the crisis is 4.5 hours per crisis episode.

- **Crisis Residential Treatment:** Short-term, community-based residential treatment to
  individuals with some risk of harm who may have fairly severe functional impairment and who
  require direct supervision and care but do not require inpatient level of care psychiatric
  hospitalization.

- **Crisis Stabilization Unit:** Short-term residential treatment designed to reduce acute
  symptoms of mental illness provided in a secure and protected clinically staffed,
  psychiatrically supervised, treatment environment that is licensed under and complies with a
  crisis stabilization unit licensed under Chapter 577 of the Texas Health and Safety Code and
  25 TAC, Chapter 411, Subchapter M, *Standards of Care and Treatment in Crisis Stabilization
  Units.* The maximum length of stay is 14 days.

- **Crisis Transportation:** Transporting individuals receiving crisis services or crisis follow-up
  and relapse prevention services from one location to another. Transportation is provided in
  accordance with state laws and regulations by law enforcement personnel or, when
  appropriate, by ambulance or qualified staff.
• **Day Programs for Acute Needs:** Programs that provide short-term, intensive treatment to an individual who requires multidisciplinary treatment in order to stabilize acute psychiatric symptoms or prevent admission to a more restrictive setting. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, and MH Rehabilitative Services.

• **Engagement Activity:** Face-to-face activities with the individual or collaterals (in accordance with confidentiality requirements) in order to develop treatment alliance and rapport with the individual and includes activities such as motivational interviewing, providing an explanation of services recommended, education on service value, education on adherence to the recommended LOC and its importance in recovery, and short term planned activities designed to develop a therapeutic alliance and strengthen rapport. This service shall not be provided in a group.

• **Extended Observation:** Up to 48 hour emergency and crisis stabilization service that provides emergency stabilization in a secure and protected, clinically staffed (including medical and nursing professionals), psychiatrically supervised treatment environment with immediate access to urgent or emergent medical evaluation and treatment. Individuals are provided appropriate and coordinated transfer to a higher LOC when needed.

• **Flexible Community Supports:** Non-clinical supports that assist individuals with community integration, reducing symptomatology, and maintaining quality of life. Non-clinical supports must be:
  o Included as strategies in the individual’s Case Management Plan;
  o Based on the preference of the individual and focus on the outcomes that the individual chooses;
  o Monitored for effectiveness by the Case Manager and adjusted based on effectiveness;
  o Available through GR funding; and
  o Not readily available through other sources (e.g., other agencies, volunteers).

  Flexible community supports include but are not limited to: transportation services, educational training, (e.g. computer skills, budgeting, etc.) temporary child care, job development and placement activities, and independent living support.

• **Flexible Funds:** These should be considered funds of last resort as applicable.
  o The Local Authority has the responsibility to evaluate the need and prioritize the use of available dollars.
  o NOTE: A general formula guideline may be applied to calculate the amount of the stipend:
    - (Amount of Income) X (0.30) = Individual Contribution
    - (Cost of Housing) – (Individual Contribution) = Center Contribution
  o This support is not intended as a source of funds for individuals wishing to change residences for reasons not related to either one’s mental illness or one’s recovery/treatment plan (it is not simply a moving fund).

  Flexible funds include:
  o **Non-Clinical Supports** - Services for assisting individuals to access and maintain safe and affordable housing in the community. Services consist of assistance with rent and utility deposits, initial rent/utilities or temporary rental/utilities assistance or other necessities, to facilitate independent living.
  o **Transportation** - Temporary transportation to meet needs of the recovery/treatment plan or to address basic life needs that may have a clinical impact if not met. It is anticipated that most individuals will receive one-time situational/temporary transportation assistance. However, for some individuals, the plan may indicate that an extended period of assistance is necessary before other resources are available to the individual.

• **Inpatient Hospitalization Services:** Hospital services staffed with medical and nursing professionals who provide 24-hour professional monitoring, supervision, and assistance in an environment designed to provide safety and security during acute psychiatric crisis. Staff will provide intensive interventions designed to relieve acute psychiatric symptomatology and
restore patient's ability to function in a less restrictive setting. The hospital must be contracting with or operated by Contractor.

- **Inpatient Services (Psychiatric):** Inpatient psychiatric hospital bed days - Room and Board.

- **Medication Training & Support Services:** Education and guidance about medications and their possible side effects as described in 25 TAC, Part 1, Chapter 419, Subchapter L, *MH Rehabilitative Services*, provided to individuals and family members. The department has reviewed and approves the use of the material that are available on the department's internet site at [http://www.HHSC.state.tx.us/mhsa/patient-family-ed/](http://www.HHSC.state.tx.us/mhsa/patient-family-ed/)

- **Pharmacological Management:** A service provided by a physician or other prescribing professional which focuses on the use of medication and the in-depth management of psychopharmacological agents to treat a individual's signs and symptoms of mental illness.

- **Psychiatric Diagnostic Interview Examination:** An assessment that includes relevant past and current medical and psychiatric information and a documented diagnosis by a licensed professional practicing within the scope of his/her license. Must be provided in accordance with 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards*.

- **Psychosocial Rehabilitative Services:** Social, educational, vocational, behavioral, and cognitive interventions provided by members of a individual's therapeutic team that address deficits in the individual's ability to develop and maintain social relationships, occupational or educational achievement, independent living skills, and housing, that are a result of a severe and persistent mental illness. This service includes recovery/treatment planning to facilitate recovery. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services*.

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

- **Residential Treatment:** Twenty-four hour specialized living environments. Residential treatment includes administration of medications, room and board, and all daily living needs. Adult Foster Care, Individual Care Homes, and Assisted Living facilities are included in this category.

- **Routine Case Management:** Primarily site-based services that assist an adult, child or adolescent, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs. Routine case management activities must be provided in accordance with 25 TAC, Chapter 412, Subchapter I, *MH Case Management Services. Contractor shall not subcontract for the delivery of these services*.

- **Safety Monitoring:** Ongoing observation of an individual to ensure the individual's safety. An appropriate staff individual must be continuously present in the individual’s immediate vicinity, provide ongoing monitoring of the individual’s mental and physical status, and ensure rapid response to indications of a need for assistance or intervention. Safety monitoring includes maintaining continuous visual contact with frequent face-to-face contacts as needed.

- **Screening Brief Intervention and Referral to Treatment (SBIRT):** A comprehensive, public health approach to the delivery of early intervention and treatment services for clients with alcohol and/or substance use disorders, as well as those who are at risk of developing these disorders, when provided by physicians, registered nurses (RNs), advanced practice nurses (APRNs), physician assistants (PAs), psychologists, licensed clinical social workers (LCSWs), licensed professional counselors (LPCs), certified nurse midwives (CNMs),
outpatient hospitals, federally qualified health centers (FQHCs), and rural health clinics (RHCs), when provided in the office, home, outpatient hospital, and other location settings. SBIRT is intended to be used for individualized intervention and not for group intervention. Providers who deliver SBIRT must be trained in the correct practice of this method and must complete at least 4 hours of training in SBIRT. Proof of training completion must be maintained in an accessible manner at the provider’s place of service.

- **Skills Training & Development:** Training provided to an individual that addresses the severe and persistent mental illness and symptom-related problems that interfere with the individual’s functioning, provides opportunities for the individual to acquire and improve skills needed to function as appropriately and independently as possible in the community, and facilitates the individual’s community integration and increases his or her community tenure. This service may address skill deficits in vocational and housing areas and includes recovery/treatment planning to facilitate recovery. Must be provided in accordance with 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services.*

- **Supported Employment:** Intensive services designed to result in employment stability and to provide individualized assistance to individuals in choosing and obtaining employment in integrated work sites in regular community jobs. Includes activities such as assisting the individual in finding a job, helping the individual complete job applications, advocating with potential employers, assisting with learning job-specific skills, and employer negotiations. Concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

- **Supported Housing:** Activities to assist individuals in choosing, obtaining, and maintaining regular, integrated housing. Services consist of individualized assistance in finding and moving into habitable, regular, integrated (i.e., no more than 50% of the units may be occupied by individuals with serious mental illness), and affordable housing. Supported housing includes:
  - **Housing Assistance** - Funds for rental assistance (unless the Contractor has and documents evidence that housing is affordable for people on SSI or that rental assistance funds are guaranteed from another source). To receive rental assistance, individuals must be willing to make application for Section 8/public housing or have a plan to increase individual income so housing will become affordable without assistance. Housing assistance without services and supports cannot be counted as supported housing.
  - **Services and Supports** - Assistance in locating, moving into and maintaining regular integrated housing that is habitable. This service includes recovery/treatment planning to facilitate recovery. While activities that fall under services and supports cannot be billed as rehabilitative services, concurrent rehabilitative training should be identified as a separate encounter with the appropriate rehabilitative service code.

**XII. Provider Qualifications**

In accordance with 25 TAC, Chapter 412, Subchapter G, *MH Community Services Standards:* 

“All staff must demonstrate required competencies before contact with individuals and periodically throughout the staff’s tenure of employment or association with the local authority provider system, MCO, or provider.” Pharmacological Management: MD, RN, PA, Pharmacy D, APN, LVN Psychiatric Diagnostic Interview Examination: LPHA Counseling: LPHA or LPHA Intern (See Add-On Definitions for CPT Provider Requirements)

Routine Case Management: QMHP-CS, or CSSP
Rehabilitative Services: QMHP-CS, Licensed medical personnel, CSSP, or Peer Provider
(consult 25 TAC, Chapter 419, Subchapter L, *MH Rehabilitative Services* for specific credential requirements for sub-component services)
Supported Employment: QMHP-CS or CSSP or Peer Provider
Supported Housing: QMHP-CS or CSSP or Peer Provider
Crisis Intervention Services: QMHP-CS