Texas

UNIFORM APPLICATION
FY 2020/2021 Block Grant Application

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 04/19/2019 - Expires 04/30/2022
(generated on 07/24/2019 2.18.56 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year 2020

End Year 2021

State SAPT DUNS Number

Number 806781373

Expiration Date

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name Texas Health and Human Services Commission

Organizational Unit Behavioral Health Services/Medical and Social Services

Mailing Address P.O. Box 149347, Mail Code 2053

City Austin, Texas

Zip Code 78714-9347

II. Contact Person for the SAPT Grantee of the Block Grant

First Name Trina

Last Name Ita

Agency Name Health and Human Services Commission

Mailing Address P.O. Box 149347, Mail Code 2053

City Austin, Texas

Zip Code 78714-9347

Telephone (512) 380-4982

Fax

Email Address Trina.Ita01@hhsc.state.tx.us

State CMHS DUNS Number

Number 806781373

Expiration Date

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name Texas Health and Human Services Commission

Organizational Unit Behavioral Health Services/Medical and Social Services

Mailing Address P.O. Box 149347, Mail Code 2053

City Austin, Texas

Zip Code 78714-9347

II. Contact Person for the CMHS Grantee of the Block Grant

First Name Trina

Last Name Ita

Agency Name Health and Human Services Commission

Mailing Address	P.O. Box 149347, Mail Code 2053
City	Austin, Texas
Zip Code	78714-9347
Telephone	(512) 380-4982
Fax	
Email Address	Trina.Ita01@hhsc.state.tx.us

III. Third Party Administrator of Mental Health Services

Do you have a third party administrator? ○ Yes ◉ No

First Name	
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	
Revision Date	

VI. Contact Person Responsible for Application Submission

First Name	Corliss
Last Name	Powell
Telephone	(512) 380-4985
Fax	
Email Address	Corliss.Powell@hhsc.state.tx.us

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2020

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1921	Formula Grants to States	**42 USC § 300x-21**
Section 1922	Certain Allocations	**42 USC § 300x-22**
Section 1923	Intravenous Substance Abuse	**42 USC § 300x-23**
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	**42 USC § 300x-24**
Section 1925	Group Homes for Recovering Substance Abusers	**42 USC § 300x-25**
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	**42 USC § 300x-26**
Section 1927	Treatment Services for Pregnant Women	**42 USC § 300x-27**
Section 1928	Additional Agreements	**42 USC § 300x-28**
Section 1929	Submission to Secretary of Statewide Assessment of Needs	**42 USC § 300x-29**
Section 1930	Maintenance of Effort Regarding State Expenditures	**42 USC § 300x-30**
Section 1931	Restrictions on Expenditure of Grant	**42 USC § 300x-31**
Section 1932	Application for Grant; Approval of State Plan	**42 USC § 300x-32**
Section 1935	Core Data Set	**42 USC § 300x-35**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

to State (Clear Air) Implementation Plans under Section 176(c) of the Clean Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work place in accordance with 2 CFR Part 182 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-construction Programs and other Certifications summarized above.

State: _____

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

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Fiscal Year 2020

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Section 1911	Formula Grants to States	**42 USC § 300x**
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Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 2 CFR part 180, and its principals:

a. Agrees to comply with 2 CFR Part 180, Subpart C by administering each lower tier subaward or contract that exceeds $25,000 as a "covered transaction" and verify each lower tier participant of a "covered transaction" under the award is not presently debarred or otherwise disqualified from participation in this federally assisted project by:
   a. Checking the Exclusion Extract located on the System for Award Management (SAM) at http://sam.gov
   b. Collecting a certification statement similar to paragraph (a)
   c. Inserting a clause or condition in the covered transaction with the lower tier contract

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 2 CFR Part 182by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
   1. The dangers of drug abuse in the workplace;
   2. The grantee's policy of maintaining a drug-free workplace;
   3. Any available drug counseling, rehabilitation, and employee assistance programs; and
   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
   2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

3. Certifications Regarding Lobbying

Per 45 CFR §75.215, Recipients are subject to the restrictions on lobbying as set forth in 45 CFR part 93. Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions,"

generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs.

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

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

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA) (31 U.S.C § 3801- 3812)

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, AND SECTION 1557 OF THE AFFORDABLE CARE ACT

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973 (Pub. L. 93-112), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972 (Pub. L. 92-318), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.
4. The Age Discrimination Act of 1975 (Pub. L. 94-135), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Affordable Care Act (Pub. L. 111-148), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

The grantee, as the awardee organization, is legally and financially responsible for all aspects of this award including funds provided to sub-recipients in accordance with 45 CFR §§ 75.351-75.352, Subrecipient monitoring and management.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: _____

Signature of CEO or Designee[1]: _____

Title: _____ Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Title

Organization

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Steps

Step 1: Assess the strengths and organizational capacity of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's M/SUD prevention, early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual and gender minorities, as well as American Indian/Alaskan Native populations in the states.

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Mental Health Service System

Organization

HHSC's Mental Health Programs, Planning, and Policy (MHPPP) section is housed under Behavior Health Services (BHS), within the Intellectual and Developmental Disability and Behavioral Health (IDD-BH) division. The organization is designed to facilitate coordination and communications across mental health and substance use disorder program staff, business operations, contracts, and quality management staff. The BHS Associate Commissioner oversees MHPPP operations.

The Health and Human Services Commission (HHSC) provides a range of services for persons with mental illness across the state:

- HHSC contracts with 39 local mental or behavioral health authorities (Centers) for community-based outpatient mental health services. Centers serve as both authorities and local providers.
- HHSC operates 10 state hospitals for people with mental health issues. These hospitals are located across the state. Each serves a different population, which may include adults, children, and people involved with the justice system.
- HHSC contracts for 462 locally managed inpatient psychiatric hospital beds.
- For the 2018-2019 biennium, MHBG accounted for 6.2 percent of funding for mental health services for adults with a serious mental illness and children with a serious emotional disturbance.

Centers collaborate with community stakeholders to develop external provider networks. Many Centers subcontract with providers to provide pharmacological management, medication training and support, counseling, certain rehabilitative, and/or crisis services. HHSC contractually requires Centers to collaborate with community stakeholders to create Consolidated Local Area Service Plans. This ensures community members are working together and responsive to the needs of the local community.

Texas Resilience and Recovery

Until 2013, the state's community mental health system delivered evidence-based practices (EBPs) through the resiliency and disease management model per state legislative direction. In state fiscal year 2014, HHSC restructured this system to reflect a more recovery-oriented system of care. The Texas Resiliency and Recovery (TRR) model delivers EBPs and principles of recovery to obtain the best possible outcomes for individuals receiving services and maximize available dollars.

The TRR model establishes who is eligible to receive services through a uniform assessment; establishes ways to manage the use of services as outlined in the HHSC Utilization Management (UM) Guidelines; measures clinical outcomes or the impact of services; and considers the cost-effectiveness as well as evaluates the return on investment for the state.

The TRR model includes:

- Levels of Care (LOC): The LOC is designed to provide an appropriate array of evidence-based practices based on strengths and needs assessed from the uniform assessment. Each LOC is described in HHSC's Utilization Management Clinical Guidelines. This document outlines the core services for each level of care (i.e., case management, pharmacological management, rehabilitation) and describes the array of adjunct services available to meet an individual's needs. These guidelines establish eligibility and discharge criteria for each LOC.
- Communimetric tools: The Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS) communimetric tools were implemented to improve the accuracy of outcome data and promote self-directed care from the point of engagement under the Transformational Collaborative Outcomes Management (TCOM) model. Traditional assessment approaches focus on interpreting clinical interviews that lead to diagnostic testing and program-driven care. In a person-centered approach, the ANSA and CANS identify specific needs and strengths from the individual's perspective rather than as a diagnostic tool. This communimetric tool then informs appropriate LOC and continuity of care activities.
- Training: Coordinated trainings were developed by establishing the Centralized Training Infrastructure for EBPs (Centralized Training). Centralized Training promotes the use of evidence-based protocols for the provision of mental health services for adults and youth by using nationally recognized experts to provide coordinated regional trainings for HHSC-funded providers and other service providers in the areas of: Cognitive Behavioral Therapy (CBT) for depression and anxiety; Trauma Focused-CBT; Permanent Supportive Housing ; Parent Child Interaction Therapy; Preparing Adolescents for Young Adulthood; Seeking Safety; Nurturing Parenting; Aggression Replacement Training®; Skillstreaming; Barkley's Defiant Child and Teen; Wraparound Process Planning; Motivational Interviewing; Illness Management and Recovery; Supported Employment; Supportive Housing; Assertive Community Treatment (ACT); Cognitive Processing Therapy; TCOM-related trainings which include trainings on the CANS and ANSA; and Person-Centered Recovery Planning.

Centralized Training also coordinates technical assistance calls in collaboration with HHSC and nationally recognized subject matter experts to support the use of EBPs and provide consultation to contractors.

Adult Services

HHSC contracts with providers to ensure behavioral health services are available to adults with severe and persistent mental illness and individuals with co-occurring psychiatric and substance use disorders (COPSD). Persons meeting the definition for priority population include:

- adults with a severe and persistent mental illnesses (SPMI) diagnosis of schizophrenia, bipolar disorder, or major depressive disorder); and
- adults with a mental health diagnosis and significant functional impairment.

The TRR model promotes the use of EBPs in the provision of services. For the adult population, the following EBPs are required: Illness Management and Recovery; Substance Abuse and Mental Health Services Administration (SAMHSA) Supported Employment Kit; SAMHSA Supported Housing Kit; and SAMHSA ACT Kit.

The HHSC UM Guidelines assist the clinician in determining the best possible course of treatment for the individual. The TRR model for the adult population is comprised of the following LOC:

- LOC 0: Crisis Services
- LOC 1M: Basic Services (Medication Management)
- LOC 1S: Basic Services (Skills Training)
- LOC 2: Basic Services Including Counseling
- LOC 3: Intensive Services with Team Approach
- LOC 4: ACT
- LOC 5: Transitional Services
- LOC EO: Early Onset
- LOC TAY: Transition Age Youth

The LOC is determined by the ANSA recommendation; however, a clinician may override a recommended LOC based on clinical judgement. Adults are reassessed at least every 180 days to ensure their recovery plan is always up-to-date with their needs and life situation.

Reaching the Rural Communities

Texas has 254 counties of which 215 are considered rural with a population under 250,000. HHSC has identified mental health and substance use service availability at the right time and right place as a high priority. Senate Bill 633 (86th Texas Legislature, Regular Session, 2019) requires HHSC to create Regional Groups with Centers (RGCs) in counties with populations under 250,000. The RGCs will reduce:

- Cost to local governments of providing services to persons experiencing a mental health crisis;
- Transportation of persons to mental health facilities;
- Incarceration of persons with mental illness in county jails; and
- Number of hospital emergency room visits by persons with mental illness.

Reduced capacity has required some adaptations to evidence-based services. For example, the ACT Program has both urban and rural models. The rural model uses a lower staff-to-client ratio to compensate for the added travel time necessary to reach individuals. Similarly, mobile crisis response requirements have been adjusted in rural areas to accommodate the needs in those communities. Rural Mobile Crisis Outreach Teams (MCOTs) have two additional options in staffing combinations to include a team of two bachelor level or unlicensed master level mental health professionals; or a team of one bachelor level or unlicensed master level mental health professional and law enforcement professional. This model allows more flexibility in staffing in the event a licensed mental health professional is not available in the area. Additionally, service availability is reduced during peak hours in rural areas to reflect MCOT on duty for 56 hours per week for rural areas versus 84 hours

per week in urban areas. The MCOT is on call in all areas 24 hours a day, 7 days a week.

Telehealth

To better serve individuals living in rural areas, some providers have established the use of Interactive Communication Technology to address critical levels of mental health workforce shortages in Texas and increase access to psychiatric services, substance use screening, assessment, and group education. Home tele-monitoring services are available to Medicaid recipients who have one or more chronic illnesses, including SPMI or severe emotional disturbance and have risk factors associated with frequent emergency department admissions and documented history of poor adherence to medications. Additionally, non-medical providers are approved to provide Medicaid billable telehealth services. Finally, school-based services serve as a patient site for telemedicine services.

Peer Services

Peer services continue to steadily expand into the behavioral health service array. In 2017, House Bill 1486 (85th Texas Legislature, Regular Session, 2017) enabled the introduction of a new Medicaid "Peer Services" benefit. In accordance with state legislation, HHSC:

- Adopted rules describing the peer worker role;
- Set new training requirements requiring 250 hours of supervised work;
- Authorized the creation of a supervisory role for experienced peers, creating a career ladder; and
- Promotes fidelity to peer practices through a requirement of continuing education and peer supervision.

Creation of the new Medicaid benefit revealed a critical need for training and technical assistance as well as a stronger peer voice within HHSC. In response, HHSC established the Peer Services unit that reports to the Associate Commissioner for Behavioral Health Services. This unit of 3 is 100 percent staffed by peer workers.

A peer may be certified in one or more of the following specialty areas:

- Recovery Support Peer Specialist: person with lived experience in recovery from a substance use disorder and working with clients in a substance use disorder setting.
- Mental Health Peer Specialist: person with lived experience in recovery from a mental health disorder and working with clients in a mental health setting.
- Certified Family Partner: parent or guardian with lived experience raising a child with mental or emotional challenges who has learned to successfully navigate the systems of care.
- Peer Specialist Supervisor: peer specialist with additional training to be an effective supervisor to other recovery support peer specialists.

HHSC and the Texas Veterans Commission (TVC) coordinate to administer the Mental Health Program for Veterans (MHPV). This program provides peer counseling services to service members, veterans, and their families through contracts with Centers and Texas A&M University Health Science Center. In fiscal year 2018, Centers reported an overall increase in the number of services delivered and the number of individuals trained compared to fiscal year 2017:

- 168,947 peer services were delivered to service members, veterans, and their families, representing a 27 percent increase;
- 6,807 peers were trained, representing a 12 percent increase;
- 28,315 interactions with justice-involved service members, veterans, and their families occurred, representing a 56 percent increase.
- Increases in the amount of peer services delivered and interactions with trusted, trained peers, suggests the program successfully:
    - Engaged service members, veterans, and their families;
    - Increased awareness of mental health service options; and
    - Increased access to needed mental health care services.

In addition, recent legislation enabled the creation of a pilot effort to embed licensed mental health professionals in specific Centers serving rural parts of the state to increase access to mental health services for veterans and their families. As a part of the MHPV, these counselors are trained in military cultural competency to improve patient-provider interaction

Children's Services

Services are available for children ages 3 through 17 with a serious emotional disturbance (SED) (excluding a single diagnosis of substance use or misuse disorder, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impartment or who are:

1. At risk of disruption of a preferred living or child care environment due to psychiatric symptoms, or
2. Enrolled in special education because of a SED.

A child-centered and family-driven *System of Care* philosophy is employed. A system of care is a spectrum of effective community-based services and supports for children, adolescents, and young adults (and their families) with, or at risk for, mental illness and related challenges. The Texas System of Care[1] is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses cultural and linguistic needs to help the child or youth function better at home, in school, in the community, and throughout life. Services are delivered through the LOC based on the TRR service delivery model for children.

The TRR model for the children and youth is comprised of the following LOCs:

- LOC-0: Crisis Services
- LOC-1: Medication Management Services
- LOC-2: Targeted Services
- LOC-3: Complex Services

[1] http://www.txsystemofcare.org/what-is-system-of-care/

- LOC-4: Intensive Family Services
- LOC-5: Transitional Services
- LOC-EO: Early Onset
- LOC-YC: Young Child Services (under age 6)
- LOC-YES: Youth Empowerment Services
- LOC-RTC: Residential Treatment Center

The CANS is used to assess a child's needs and strengths and recommend a LOC; however, a clinician may override the recommended LOC based on clinical judgement. Youth are reassessed every 90 days due to the inherent daily changes in a child's learning and development. The LOC continuum for children and youth allows for movement to an intensive LOC based on progress made in treatment or increased emotional and behavioral needs. As treatment progresses, children and youth are expected to move down the continuum of care to less intensive LOCs until treatment is complete or the need for services is minimal (e.g., medication maintenance). Crisis services are available for any LOC should a psychiatric crisis occur.

Services for this population can include: 24-hour emergency screening and rapid crisis stabilization services; community-based crisis residential services or hospitalization; community-based assessments, including the development of inter-disciplinary, recovery-oriented treatment plans, diagnosis, and evaluation services; family support services, including respite care; case management services; pharmacological management; counseling; and skills training and development.

Children and their families have access to three levels of case management services, depending on the intensity of the assessed LOC and specific needs. These include routine case, intensive case, and family case management. The mental health case manager works with other service providers to address additional needs of the child such as education, rehabilitation, employment, housing (for older youth transitioning to adulthood), juvenile justice, substance use disorders, and physical health issues. The most intensive LOC utilizes Wraparound treatment planning based on the Systems of Care principals and philosophy. Wraparound is an ecologically based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports mobilizing resources and talents from a variety of sources resulting in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies (https://www.nwic.org/).

Family partners support services are offered to the primary caregiver of a child with SED who are receiving mental health community services. These services may include introducing the family to the mental health treatment process, modeling self-advocacy skills, providing information, making referrals, providing non-clinical skills training, and assisting in the identification of natural/ non-traditional and community supports for the child and family. Services are provided by a certified family partner or a family partner waiting to complete the approved training.

Zero Suicide
The Zero Suicide Texas grant closed in 2016 and efforts to continue the work have been underway with a new project entitled, Suicide Care Initiative (SCI). SCI focuses on implementation of a zero-suicide framework in the public mental health system. Key partners in Zero Suicide include HHSC, four Centers, the Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin, and the Texas Suicide Prevention Council (a group of statewide organizations and local coalitions). The purpose of Zero Suicide is to reduce deaths by suicide and suicide attempts among youth and young adults in Texas by developing and implementing select strategies from the National Strategy for Suicide Prevention and the Texas State Plan for Suicide Prevention.

Crisis Services
In Texas, Centers use a combination of federal block grant funds, local, and state funds to enhance behavioral health services provided to individuals experiencing mental health and substance use issues. This includes the following programs and services:

- Crisis Hotline – All Centers are required to operate a crisis hotline, accredited by the American Association of Suicidology. Crisis hotline services are available 24/7 and serve as the first point of contact for individuals experiencing a mental health and/or substance use crisis in the community. Qualified staff determines if mobile emergency services are required to further assess the caller's needs.
- Mobile Crisis Outreach Team (MCOT) – All Centers are required to operate an MCOT. These services are available 24/7 to provide face-to-face response to individuals in crisis. These are often the result of a referral that is obtained through the crisis hotline. MCOTs deploy to various sites in the community where a crisis has been reported. MCOTs may also accompany law enforcement in some cases.
- Psychiatric Emergency Service Center (PESC) Programs – PESC programs encompass facilities staffed with mental health, substance use disorder, and medical professionals offering assessment and psychiatric stabilization to individuals with behavioral health issues. These sites are alternatives to inpatient hospitalization and incarceration. Law enforcement is encouraged to utilize these services to for crisis stabilization. PESC programs include:
    - *Crisis Respite Services* – Crisis Respite Services provide short-term, community-based residential, crisis treatment to individuals who have low risk of harm to self or others and may have some functional impairment who require direct supervision and care, but, do not require hospitalization. There are 15 sites.
    - *Crisis Residential Services* – In contrast to crisis respite services, crisis residential services provide short-term, community-based residential crisis treatment to individuals who may pose some risk of harm to self or others, and who may have severe functional impairment. The recommended length of stay ranges from 1-14 days. There are 8 sites.
    - *Extended Observation Units (EOU)* – EOUs are designed to provide emergency stabilization to individuals in behavioral health crisis for up to 48 hours. There are 7 sites.
    - *Crisis Stabilization Units (CSU)* – CSUs provide 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 complies with crisis stabilization unit licensing requirements. There are 3 sites.

- *Rapid Crisis Stabilization Beds* – Rapid crisis stabilization beds provide brief stays in licensed hospitals to relieve acute symptomatology and restore an individual's ability to function in a less restrictive setting. There are 22 sites.
- *Inpatient Hospital 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 behavioral health crisis. Currently, HHSC has 33 contracts with the Centers to expand capacity for individuals on forensic and civil commitments for competency restoration and/or mental health treatment.

Crisis services include community-based services that assist in stabilizing crisis situations; minimize hospitalizations and re-hospitalizations; restore functioning; assist with adherence to medication regimens; promote integration into the larger community; and assist with linkage to other required community-based services. Individuals in crisis may be authorized to receive behavioral health services over the course of a 7- or 90-day period, including transitional supports for those not enrolled in longer-term treatment.

Centers provide or authorize the provision of assertive outreach to individuals who are more difficult to engage in ongoing care, including those who are chronically homeless and in need of substance use treatment. The TRR model includes access to intensive ongoing services such as ACT, for those who have been successfully engaged in crisis transitional services over the 90-day period. Intensive, ongoing services for children and youth include team-based, wraparound services and are available in the most intensive LOC. By expanding its capacity to provide intensive ongoing services to individuals entering the mental health system because of a crisis, the state is working to prevent future hospitalizations or incarcerations. State funds appropriated in legislative sessions following the initial crisis redesign have allowed the state to expand the array of crisis projects, particularly in underserved communities.

Transformation

Although Texas completed a Mental Health Transformation State Incentive Grant in 2010, there is continued momentum toward a fully transformed, recovery-oriented system of care. The grant enabled the state to build a foundation for delivering evidence-based mental health and related services, fostering recovery, improving quality of life, and meeting the needs of individuals in services across the life span. Initiatives involving peer workers, veterans, learning communities for supported employment and housing, children's system of care and others, have had a lasting impact beyond the funded grant period.

The most visible work of mental health transformation has continued primarily through new recovery-based initiatives, increasing recovery awareness and practices throughout the Centers, state psychiatric hospitals, and consumer-led organizations.

The former HHSC-funded contractor, Via Hope, provided family partner training and certification and peer training and continuing education with the Recovery Institute programming that includes promoting peer and consumer leadership and person-centered planning initiatives. Via Hope was guided by an advisory committee comprised of family members, consumers, members of local advocacy organizations, and Center representatives. House Bill 1486 (85th Texas Legislature, Regular Session, 2017), required the creation of a new Medicaid benefit "peer services" for both certified peer specialists and recovery coaches. One outcome of this legislation is the certification function for peer specialists is no longer with Via Hope and is housed in another entity that is not supported by this funding.

HHSC evaluates recovery-oriented transformational programs in partnership with the TIEMH. This work has enabled HHSC to make data-informed decisions about recovery-based programming, including the expansion of the Texas System of Care. TIEMH provides training, technical assistance, learning communities, evaluation, consultation and experts in Systems of Care development and implementation including cultural and linguistic competency, the development of family and youth voice, as well as, cross-systems collaboration, and systems transformation. TIEMH provides supportive an infrastructure to support the implementation of a comprehensive strategic plan to address state and local policy and practice barriers to System of Care statewide expansion. This includes aiding local communities implementing systems of care.

TIEMH will continue to report on important information on peer specialist billing practices in the Centers and is continuing the longitudinal survey of Certified Peer Specialists who completed the Via Hope Training to determine employment outcomes, satisfaction, and services offered by peer specialists. The Institute is collaborating with Centers to assess the ability to identify individuals in services who have worked with peer specialists to evaluate the service and health outcomes of individuals in services who receive peer support services in comparison to those who do not. Finally, TIEMH completed a detailed assessment of Clubhouses and consumer led organizations to identify areas for training and technical assistance in the future.

Homelessness and Supportive Housing

- **Texas Interagency Council for the Homelessness**
  HHSC is a member of the Texas Interagency Council on Ending Homelessness (TICH) which coordinates the state's resources and services to address homelessness. TICH serves as an advisory committee to the Texas Department of Housing and Community Affairs (TDHCA). Representatives from HHSC, DFPS, TDHCA, Texas Workforce Commission, Texas Veteran's Commission, Texas Education Agency, Department of Criminal Justice, and Texas Juvenile Justice Department sit on the council along with members appointed by the governor, lieutenant governor, and Texas House of Representatives speaker. In April 2017, the TICH released its annual report describing progress on its statutory requirements and its commitment to continue working within the framework established in *Pathways Home*, the study and resulting framework developed in 2014.

- **Homeless Outreach and Support Services**
  Outreach and services for adults who are homeless and have an SPMI, including those with a COPSD, are made available through the federally funded Project for Assistance in Transition from Homelessness (PATH) program. This program is additionally supported by state general revenue and local matching funds. PATH activities include outreach to locate homeless populations in need of services, screening and diagnostic treatment services, habilitation and rehabilitation services, community mental health and substance use services, case management services, primary health services, job training, supported employment, and relevant housing services. Outreach and services occur where the individual is currently residing, including homes, tent cities, bridges, streets, shelters, and other public areas. PATH provides services for individuals with SMI and/or COPSD and who are without a regular means of shelter. There are currently 16 PATH providers assisting homeless individuals connect with mainstream services and reaching their goals.

Supportive Housing and Services Targeting Homeless Individuals

HHSC recognizes housing for certain populations as a critical intervention to avoid or reduce homelessness in the state and avoid or reduce institutionalization and crisis costs to the state. There are several programs highlighted below targeting populations directly served by the Centers.

- **Supportive Housing Rental Assistance Program**
  HHSC funds direct rental and utility assistance to 37 Centers across the state along with the supportive housing and mental health services already provided to individuals with SMI and/or COPSD. There are four priority populations for these funds within the Centers:
    - Individuals who are homeless;
    - Individuals at-risk of homelessness;
    - Individuals exiting a state hospital; and
    - Individuals at-risk of being hospitalized

  Since its inception in 2014, over 32,000 individuals have been assisted financially. Every year has resulted in a reduction in both crisis episodes and hospitalizations for those assisted with these funds.

  Centers are encouraged to become federal HOME Tenant-Based Rental Assistance (TBRA) administrators through TDHCA which allows them to access federal subsidies for housing and bridge to a permanent housing subsidy if needed. To date, seven of the Centers have become TBRA administrators. HHSC staff are currently have an implementation plan to provide more technical assistance to the Centers to increase capacity for rental administration and the likelihood a Center would be approved for TBRA funds.

- **Healthy Community Collaborative Program**
  HHSC funds collaborative projects in the four most populous urban municipalities: Austin, San Antonio, Fort Worth, and Dallas to serve individuals

experiencing homelessness and mental illness and/or COPSD. These projects promote community collaboration based on locally identified priorities, leveraging dollar-for-dollar matching funds in an amount equal to the grant awarded, and creatively addressing homelessness, criminal recidivism, emergency room utilization, SUDs, employment rates, and tracking the economic benefit. Services provided include mental health treatment, substance abuse treatment, detox, case management services, primary medical care, supported employment, supportive housing, and other individualized services as appropriate. The goal of the Healthy Community Collaborative is to assist the people experiencing homelessness in becoming independent and integrated into the community through a network of providers from all disciplines in the community. Senate Bill 58 (85th Texas Legislature, Regular Session, 2017) instructs HHSC to expand to rural communities in Texas. A Learning Community has been implemented to increase the capacity of rural organizations to create a community collaborative. House Bill 4468 (86th Texas Legislature, Regular Session, 2019) will go into effect on September 1, 2019. This will change the match to allowing in-kind match or only up to a twenty-five percent private cash match requirement for rural communities.

Supportive Housing Services

- **Project Access Pilot Program**
  The Project Access pilot program is a collaborative program co-managed by HHSC and TDHCA as part of a larger state Project Access program using United States Department of Housing and Urban Development (HUD) Housing Choice vouchers to help low-income people with disabilities transition from institutional settings. The pilot specifically targets low-income individuals with mental illness and COPSD in state-funded psychiatric hospitals who want to transition into the community by providing access to affordable housing and support services.

- **HUD 811 Project Rental Assistance (811 PRA)**
  TDHCA partners with HHSC to implement the 811 PRA program. This program provides project-based rental assistance and support services provided through the Centers in the below metropolitan services areas:
  - Austin
  - Corpus Christi
  - Dallas/Ft. Worth/Arlington
  - El Paso
  - Houston/Woodlands/Sugar Land
  - McAllen/Edinburg/Mission
  - San Antonio

  HHSC trains Centers to become qualified referral agents and service coordinators who will identify eligible individuals and assist with ongoing housing service needs.

TDCHA is responsible for selecting multi-family properties applying to be in this program. As of July 2019, 2,293 individuals have been referred to the waiting list and 252 people have been housed. Over 95 percent of those on the wait list and housed are from the Centers and individuals living with serious mental illness.

Services Targeting Individuals with Behavioral Health Disabilities

- **Underserved Racial/Ethnic, Disabled, LGBTQ[2]**
  HHSC contracts and TAC rules require both mental health and SUD providers to ensure culturally, linguistically, and developmentally appropriate services are provided in a non-discriminatory (including physical disabilities) manner for individuals, families and/or significant others. For those who are deaf or hard of hearing, HHSC-funded contractors are able to access interpreter services from HHSC. Additionally, the contracts and rules require training for staff in cultural competency. HHSC has a standing internal HHSC *Cultural Competency Workgroup* tasked with developing more culturally competent interactions and services with Texas' three federally-recognized Native American Tribes, as well as how to incorporate the latest revision of the Culturally and Linguistically Appropriate Services Standards into provider contracts.

- **Transition-Age Youth**
  Texas has created a unique level of care to address the needs of individuals ages 18-20 in their transition towards independent living. This level of care allows a flexible array of services including supports to match the individuals educational or vocational goals. Texas is continuing to develop this level of care including an expansion to include individuals younger than 18.

- **Early-Onset Psychosis**
  The 10% set-aside requirement of the Mental Health Block Grant has allowed Texas to implement a Coordinated Specialty Care (CSC) program for individuals experiencing an early onset of psychosis. These programs focus on early identification and intervention to reduce the time between a first episode of psychosis and treatment for psychosis. The programs rely on strong team-based services along with maintaining a small caseload per team. Texas now has CSC programs in 23 of its 39 LMHA/LBHAs.

- **Older Adults**
  HHSC offers Applied Suicide Intervention and Skills Training across the state. The evidence-based program provides caseworkers with suicide prevention tools to assist them with handling suicide, including suicide among the aging population. The state's Area Agencies on Aging and Aging and Disability Resource Centers are encouraged to contact the Centers directly for this training to help assist the prevention of suicides in older adults.

[2] Lesbian, gay, bisexual, transgendered, and questioning

Texas was one of 30 states selected to receive federal funding to assist people who are elderly or who have disabilities transition from institutional settings to the community. HHSC will identify a new representative to the National Association of State Mental Health Program Directors-Older Persons Division which provides opportunities for HHSC to be a part of developing programming and booklets to serve the aging and mental health population.

HHSC is a member of the Texas Council on Alzheimer's disease and related disorders to assist in addressing the aging and behavioral health needs.

- **Military and Families**
  In addition to being served in the ongoing mental health and SUD service system, veterans and their family members are served through several specific initiatives originating between 2005 and 2011, from the work of the Mental Health Transformation Workgroup (TWG) composed of state agencies, consumers and stakeholders serving that population. TWG produced two reports for the Texas Legislature regarding returning veterans' behavioral health needs and gaps in services. This ultimately lead to allocation of state funding to expand training for veteran peer support; enhance mental health and SUD services; and improve access to information about services by veterans, service members, and their families. This funding has allowed mental health professionals to complete training to provide evidence-based trauma-focused treatments such as CPT to treat Post-Traumatic Stress Disorder. This resulted in a growing number of Centers offering this service.

  Currently a contract is in place with TexVet to enhance resources through a database for members of the Military Veteran Peer Network which provides direct peer services to service members, veterans, and family members in Centers across the state. This database also provides information about community-based services, resources with contact information, and eligibility criteria for military service members, veterans, and their families.

  HHSC has also implemented the veterans' Jail Diversion and Trauma Recovery initiative providing trauma-informed jail diversion services for veterans suffering from military trauma. The initiative was piloted in San Antonio, a city with a number of military installations. Using the Sequential Intercept Model developed by the GAINS Center for Behavioral Health and Justice Transformation of SAMHSA, eight expansion sites across Texas have implemented trauma-informed services. Veteran peer support specialists and mental health providers who work at the expansion sites were trained in Seeking Safety, an EBP to address the needs of veterans impacted by trauma that use substances. These veteran peer support providers provide Seeking Safety services to justice-involved veterans. HHSC and the TVC jointly organize and host an annual statewide training conference involving health and human service providers and criminal justice professionals to enhance services to service members, veterans, and family members.
  In state fiscal year 2013, HHSC received a SAMHSA grant to address trauma and children. The Texas Children Recovering from Trauma Initiative (Trauma

Initiative) increased access to trauma-focused treatments to children ages 3-17 in military families by waiving the state's eligibility criteria if the child/youth has been exposed or experienced trauma. Children of military/veteran families receive trauma screenings, assessment and trauma-focused evidence-based treatments (Trauma-Focused Cognitive Behavior Therapy or Parent Child Interaction Therapy) depending on the child's age and developmental needs. This Trauma Initiative also provides training to organizations serving children of military or veteran families in the following topics: trauma screenings; addressing the needs of children of military families; trauma focused EBPs for military families; and trauma-informed care. The Trauma Initiative has also participated in multiple collaborations with several Veteran Administration facilities in Texas to enhance the capacity of their workforce through training to address the needs of children and veteran families. The Trauma Initiative also served to create a trauma-informed care learning collaborative providing training to the workforce on military culture, military-informed services, and how to address the needs of military and veterans and their families in services. The SAMHSA grant funding concluded at the end of federal fiscal year 2016 but Texas has dedicated state resources to continue work toward trauma-informed care including serving military families.

The Trauma Initiative also participated in SAMHSA's Military/Veterans Families Implementation Policy Academy and created a Military Families Forum to address the needs of children of military and veterans and increase their access to services. Multiple stakeholders representing military organizations, non-profit, private sector, state government (including DFPS) and the TVC attended this meeting and identified needs and priorities for the children and families in Texas. The forum's recommendations were incorporated into the TVC legislative report, resulting in House Bill 19 (84th Texas Legislature, Regular Session, 2015) concerning the provision of prevention and early intervention services to military families to prevent child abuse, neglect, and trauma. The bill requires DFPS to develop and implement a preventive services program for veterans and their families with a history, or at risk, of family violence or abuse or neglect; requires TVC and HHSC to coordinate to administer a mental health intervention program; and directs HHSC to foster community collaborations to support veterans and military families. In addition, HHSC established written policies in mental health and SUD provider contracts addressing the management and monitoring of waiting lists for children of military and veteran families to ensure that their names remain on the list with the same date, for at least one year, if the family has to move out of the service area because of military life transitions or death of the military or veteran family member.

In 2016, HHSC implemented the Texas Veterans + Family Alliance grant program. This program seeks to improve the quality of life of Texas Veterans and their families by supporting local communities across the state to expand the availability of, increase access to, and enhance the delivery of mental health treatment and services. Grant awards are made to existing or developing community collaboratives to support veterans and their families by

connecting them with effective, responsive mental health and supportive service systems.

Criminal Justice

- **Behavioral Health Services for Adult and Juveniles in the Criminal Justice System**
  Adults or youth involved with the criminal justice system and referred to Centers are provided mental health services using the TRR model. Most Centers in the more populated regions have contracts with the Texas Correctional Office on Offenders with Mental and Medical Impairment (TCOOMMI), which connects juvenile and adult offenders with special needs to a full array of psychiatric, medical, and behavioral health services upon their release on probation or parole. These individuals are generally identified by the courts to need mental health treatment. As a condition of their probation or parole, they must engage in mental health treatment provided through the Center. It also provides TCOOMMI staff to work with individuals on parole and probation and supports other re-entry initiatives. If the individual complies with treatment, charges may be dropped, or the severity of the offense or the sentence may be reduced. Additionally, in partnership with Texas Juvenile Justice Department (TJJD), TCOOMMI collaborates on the Special Needs Diversionary Program. This program provides mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further into the criminal justice system.

  Larger urban areas also have OCR programs for individuals who have been found incompetent to stand trial (IST). The state's most populous county, Harris County, has launched a Jail Diversion Pilot Program in which the framework for treatment is guided by principles of Critical Time Intervention. In addition to OCR programs, state legislation has been passed allowing the establishment of a Jail-Based Competency Restoration pilot program and county programs to provide mental health and COPSD, as well as legal education for these individuals.

  SUD services for adults and juveniles involved with the criminal justice system are also provided statewide. Local providers work with city, county, state, and federal corrections systems to address the SUD issues of individuals in the criminal justice system. A contract with TDCJ provides outpatient treatment for adult probationers through the Treatment Alternative to Incarceration Program, and a contract with TJJD provides intensive and moderate residential treatment services for youth within the institutional settings. Other initiatives related to the criminal justice system include coordination with specialized courts throughout the state. HHSC provides technical assistance related to policy and assist with the development of specialized drug, mental health and veteran courts. In addition to the ongoing efforts of numerous Centers, four counties receive specific funding to provide mental health deputy training and staff to divert individuals with mental illness from the criminal justice system.

- **Mentally Ill Offender Screening and Coordination**
  The Texas law enforcement telecommunications system (TLETS) was established by the 80th Texas Legislature. When an individual is booked into any county jail, this tracking system matches their information (last name, first name, date of birth, social security number, sex, ethnicity, and race) against the CMBHS System. If a partial or exact match is yielded, the jail receives a report with the individual's name and location of the last Center in which a service was provided. The jail staff then contacts the Center to conduct a screening and provide linkage to mental health services provided in the community via the Center. HHSC is working to build similar functionality in TLETS to have the same capacity to match youth in the Juvenile Justice System as it currently does for adults.

  HHSC contracts with Centers throughout the state to engage in jail diversion activities, as well as activities to enhance continuity of care for incarcerated adults and youth with a mental illness. The Sequential Intercept Model is used as a conceptual framework for points to intervene and facilitate TRR services for individuals involved in the criminal justice system. HHSC also collaborates with the TDCJ and the Texas Department of Public Safety Bureau of Identification and Records to exchange real time data for individuals with a current or history of state mental health care who are arrested and booked in to county jails.

  Youth referred to the juvenile justice system are screened for mental health and SUD prior to adjudication by a licensed individual using an assessment tool approved by the TJJD. The youth is then referred to a Center for further assessment and offered specialized services. HHSC uses the CANS to assess all individuals referred to mental health services. HHSC uses the substance use screening and assessment tool which is based on the Assessment Screening Index for all individuals referred to SUD treatment. Both assessments are housed within the CMBHS electronic medical record.

- **Outpatient Competency Restoration**
  HHSC funds an Outpatient Competency Restoration (OCR) Program that provides community-based restoration treatment to justice-involved individuals with serious mental illness and COPSD. Aside from competency restoration treatment, OCR clients receive the core psychiatric care and services afforded through the Centers. Twelve of the 39 Centers operate OCR programs, most of which are in urban areas.

- **Other Forensic Services**
  Through state psychiatric hospitals and contracts with local community hospitals, inpatient services are provided to individuals on forensic commitments (i.e., Not Guilty by Reason of Insanity or IST). These are funded by state general revenue dollars. When it is determined an individual on a forensic commitment is no longer in need of inpatient care, the court dismisses the commitment and the individual transitions to the community where mental health services are provided by a Center. These individuals are authorized to

receive an LOC which may include, but is not limited to, the following services: case management, psychosocial rehabilitation, skills training, supported housing, supported employment, and cognitive-behavioral therapy. Additionally, if these individuals are granted community supervision in the form of probation, mental health staff work closely with criminal justice agencies to provide support in the form of transportation to probation offices or court. All these services work to reduce the likelihood of recidivism. Additionally, the 84th Texas Legislature directed HHSC to hire a forensic director responsible for statewide coordination and oversight of forensic mental health services and programs. This position oversees a forensic workgroup to make recommendations relating to the effective coordination of forensic services.

Substance Use Disorder Service System

Organization

HHSC's Substance Use Disorder Programs, Planning, and Policy (SUDPPP) section is housed under Behavior Health Services (BHS), within the Intellectual and Developmental Disability and Behavioral Health (IDD-BH) division. The organization is designed to facilitate coordination and communications across substance use disorder and mental health program staff, business operations, contracts, and quality management staff. The BHS Associate Commissioner oversees SUDPPP operations.

SUDPPP includes the Substance Use and Misuse Prevention and Substance Use Disorder (SUD) units which fund community-based and state-licensed treatment providers delivering substance misuse and prevention, intervention, treatment and recovery support services. For the 2018-2019 biennium, SABG accounted for 76 percent of state-funded substance use funding. SABG funds are distributed through contracts with community-based and/or state licensed treatment providers and other state agencies (e.g., Texas Department of Criminal Justice, Texas Department of Family Protective Services).

Contracts are governed by State Government Code, Texas Health and Safety Code, and Texas Administrative Code (TAC). All contracted providers are required by state administrative rules and contracts to protect individual/individual-identifying information and records from unauthorized disclosure. Confidentiality is also monitored during the annual peer reviews with remedies including technical assistance, increased monitoring, or requirements to implement improvement or corrective action plans. Funded contractors use the state's electronic data system, Client Management Behavioral Health System (CMBHS) to further secure confidentiality and measurement of services, performance and outcome measures, as well as billing.

Funding methodologies determine the amount of funding allocated across the state and contracts are procured in accordance with HHSC policy. Texas has a Medicaid benefit for outpatient, residential, and peer recovery services. Each of the state's 11 Health and Human Service (HHS) Regions have a continuum of care provided in accordance with the block grant guidelines, legislative direction, and Texas Statewide Behavioral Health Strategic Plan (TBHSP), 2017-2021. The state's fiscal year 2020 will begin a new 5-year procurement term for prevention contracts and fiscal year 2021 will begin the new procurement terms for intervention, treatment and recovery support services.

HHSC currently uses SABG funds to directly contract with one SUD entity meeting the requirements of Charitable Choice. Charitable Choice requirements are included in the SUD provider performance contract and a complaint process is in place for all individuals receiving services. The requirements follow the regulations outlined in 42 U.S.C. 300x-65 and 42, C.F.R. part 54 (42 C.F.R. 54.8(c) (4) and 54.8(b), Charitable Choice Provisions and Regulations. The contract provisions require providers to inform individuals of their choice options for treatment and offer

alternatives prior to admission. These requirements are described further as follows:

- A faith-based provider must ensure recipients are advised of provider's religious character, recipient's freedom not to engage in religious activities, and recipient's right to receive services from an alternate provider. If the individual objects to the religious nature of the program, the provider must be prepared to offer an accessible, high-quality alternative service with another provider in the same location. The faith-based provider must have made advance arrangements with the alternate provider which includes access and transportation to the nearby provider.

HHSC has agreements with the regional, county, local and tribal authorities. In addition, HHSC has a standing internal *Cultural Competency Workgroup* tasked with developing more culturally competent interactions and services with Texas' three federally-recognized Native American Tribes. HHSC requires adherence to the National Culturally and Linguistically Appropriate Services (CLAS) Standards by our SUD contractors in Health and Health Care for all served populations in accordance with the most current version of the Texas Cultural Competence Guidelines for Behavioral Health Organizations which is comprised of a set of requirements, implementation strategies, and additional resources to help providers/programs establish and expand culturally and linguistically appropriate services.

Substance Use and Misuse Prevention Services

HHSC funds a comprehensive array of prevention services, ranging from direct services in schools and communities to data collection and population-based strategies. There were 5 service types procured for funding in state fiscal year 2014 and continuing with the fiscal year 2020 procurement: Youth Prevention Universal (YPU), Youth Prevention Selective (YPS), Youth Prevention Indicated (YPI), Community Coalition Partnerships (CCP), and Prevention Resource Centers (PRCs). The state currently funds a total of 217 contracts among the 5 service types. These include 163 youth prevention programs, 43 coalitions, and 11 PRCs were funded for a 5-year fund cycle across the state. This procurement was based on the TBHSP developed in June 2012 and recently updated for the state fiscal years 2017-2021. The data collected and reviewed for the TBHSP supports the determination of Texas' prevention priorities which have been expanded to include alcohol (underage drinking), marijuana and cannabinoids, tobacco and nicotine products and prescription drug misuse. All programs are structured according to the Strategic Prevention Framework and incorporate the Center for Substance Abuse Prevention's six strategies to ensure a comprehensive continuum of prevention services.

Youth Prevention

The core strategy for these programs is the prevention education/skills training component driven by an evidence-based curriculum approved through the discontinued National Registry of Evidence-based Programs and Practices and proven effective with specific target groups in school and community sites. Program types YPU, YPS, YPI target the primary youth population, and YPI also targets young adults. These program types serve a secondary adult target population, including parents, guardians, and grandparents of the youth who participate in

family-focused curricula. YPU direct services are designed to reach the general population, ages 6-18, without regard to individual risk factors, and are generally intended to reach a very large audience. YPS direct services target subgroups of the general population, ages 6-18, determined to be at an elevated risk for substance use or misuse, due to environmental risk factors. YPI direct services target youth (ages 11-17) and young adults (ages18-21) exhibiting early signs of substance use or misuse and/or other related problem behaviors associated with substance use. The curricula are delivered in a structured setting and the fidelity of the curriculum design must be maintained. Pre- and post-tests are given to the participants enrolled in the curriculum, and outcome measures are reported to HHSC. Family-focused programs provide an opportunity for the youth and their family to meet to improve the family unit's relationships and participation in the lives of their children. Additionally, YP programs provide Alcohol, Tobacco and Other Drugs (ATOD) presentations, Positive Alternatives and Community-Based Processes. These activities are substance-free and age-appropriate events to teach and reinforce skills that promote a healthy and substance-free lifestyle. YPs also provide identification of problems and referral to other support services for those parents and youth in the program who may need assistance beyond the scope of primary prevention.

Community Coalition Partnerships (CCPs)
The CCPs work to engage and mobilize various sectors of the community to implement evidence-based environmental strategies with a primary focus onchanging policies and influencing social norms related to substance use and misuse.
Coalitions use the Strategic Prevention Framework (SPF), a 5-step process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention activities throughout the 11 HHS Regions. The coalition's focus must be to prevent alcohol/underage drinking in addition to one or more of the state's other prevention priorities which include marijuana and other cannabinoids, tobacco and nicotine products, or prescription drug misuse based on the identified needs of the community. The primary population is adolescents, young adults ages 18-25 in colleges and universities, and the general community. The coalitions begin their work by conducting a needs assessment to identify the targeted county, zip code, neighborhood area, or community. The coalitions then assess capacity and mobilize coalition members and key stakeholder to begin discussing the needs assessment data and establish the goals and priorities for their communities. The data collected determines the direction in which the members will focus their time and effort in establishing written policy, attitude, and behavioral change. This community work impacts the total population as policies, ordinances, city priorities, and school policies are implemented.

Prevention Resource Centers, Synar Program, and Tobacco Prevention
There is one PRC in each of the 11 HHS Regions functioning as the central data collection repository and substance abuse prevention training liaison for the region. Each PRC also coordinates prevention trainings in its respective region.

The PRC also facilitates and maximizes regional resources in data collection to develop a Regional Needs Assessment. Data is gathered by the PRC's Data Coordinator and compiled into a structured document, which is updated annually. The data collection must focus on the state's four prevention priorities, which include alcohol/underage drinking, marijuana and cannabinoids, tobacco and nicotine products, and prescription drug misuse.

Each PRC has a tobacco prevention coordinator (TPC) to support the state's efforts to comply with the Federal Synar Amendment and restrict youth access to tobacco and other nicotine products. States may have a retail violation rate of no more than 20 percent. The TPCs are required to conduct on-site voluntary retail compliance checks with tobacco retailers in their respective regions. Additional duties include ensuring retailers use the most up-to-date signage from the State Comptroller's Office. TPCs also conduct on-site follow-up visits to retailers not in compliance with and/or cited for non-compliance with the Texas tobacco laws during a voluntary compliance check. In addition, they conduct retail merchant education and provide informational presentations for parents on the dangers of tobacco use by minors. Adults also may receive brochures or videos about the dangers of tobacco and second-hand smoking.

Additional tobacco prevention, including Synar activities, is a key area of focus. The tobacco program promotes coordinated efforts to establish smoke-free policies, assist tobacco users to quit, reduce youth access to tobacco products, and prevent initiation of tobacco use. The use of media campaigns, cessation programs, and the implementation of smoke free ordinances are examples of the tobacco prevention efforts in the state.

In addition, specific tobacco-related activities are incorporated into ongoing prevention services, such as information presentation and dissemination. The state contracts with Texas State University for the Tobacco program. Texas State University is responsible for completing the annual Synar survey which consistently achieves a retail violation rate of 20 percent or less.

Training and Resources

HHSC funds the Texas Prevention Training (TPT) statewide training entity which works collaboratively with the PRCs to coordinate regional training on alcohol, marijuana and cannabinoids, tobacco and nicotine products, and other drugs. The TPT coordinates trainings for HHSC-funded providers on the HHSC-approved evidenced-based prevention curricula and required prevention trainings based on the training needs identified by providers and HHSC.

HHSC also funds the Drug-Free Texas statewide media campaign and a digital text-messaging campaign. These campaigns work with HHSC-funded substance use and misuse providers to disseminate prevention messaging across the state that targets youth, their families, and those who work with youth. Additionally, HHSC hosts an annual Red Ribbon Rally Kickoff Event held in Austin, Texas. Hundreds of fifth and sixth grade youth, parents, and educators from Texas cities (such as Corpus Christi, Dallas, Houston, and San Antonio) participate in the annual event.

Substance Use Intervention

Outreach, Screening, Assessment, and Referral (OSAR): OSAR programs help individuals seeking substance use services. OSAR programs are in all 11 HHS regions to provide screenings and/or assessments, education, information dissemination, risk reduction education, case management coordination, referral to treatment and other appropriate support services. OSAR programs assist individuals with transportation before and after treatment, if needed, and help individuals move through the continuum of care and link them to community-based support services. Since 2017, each OSAR program receives funding fora Priority Admission Counselor to assist with better coordination of individuals in the state's priority population.

Human Immunodeficiency Virus/Early Intervention (HIV/HEI): HIV/HEI contracting will end state fiscal year 2020. In state fiscal year 2021, HHSC will integrate substance use services into the public health system. Services will increase linkage and retention for Texas residents in medical services who are using substances. Texas continues to prohibit the distribution of clean needles and syringes along with needle exchange programs. Along with the federal laws and regulations prohibiting the use of federal dollars to purchase these items in HIV prevention programming, this prohibition is clearly stated in all substance use disorder contracts.

Pregnant, Postpartum Intervention (PPI): In state fiscal year 2020, PPI programs providing community-based, gender-specific services for pregnant, postpartum, and parenting women at risk of developing substance use disorders or who have substance use disorders will transition in state fiscal year 2021 to use state-funding to address high risk pregnant and postpartum women who are using substances.

Parenting Awareness and Drug Risk Education Services (PADRES): In state fiscal year 2020, PADRES will provide community-based, gender-specific intervention services to parenting males and expecting fathers at risk for involvement or currently involved with Department of Family and Protective Services (DFPS) with substance use disorders or at risk of developing substance use disorders. In state fiscal year 2021, PADRES will expand to serve males and females who are at risk of developing substance use disorders through education and information dissemination.

Rural Border Intervention (RBI): The RBI programs provide community and home-based substance use prevention and intervention services in remote rural border areas. Individuals engaged in RBI services receive case management to community resources and enhanced support services. These programs operate in the Colonias (within 62 miles of Texas-Mexico border). The RBI programs develop and implement a comprehensive behavioral health model promoting and embracing culturally and linguistically competent prevention, intervention, and treatment for youth and adults in rural border communities, including approximately 25 colonias. These unique programs have a three-fold approach which includes primary prevention for youth using evidence-based curricula; substance use and mental health screening and short-term intervention services using motivational interviewing; and a community-wide approach promoting local community action

and establishing linkages with existing services and resources. All three of the current RBI programs provide some of their services using community health workers or *Promotoras*. These community health workers usually come from the communities they serve and often act as indigenous outreach workers and provide information and education. They are also able to identify some mental health and substance use concerns and make appropriate referrals for children and their families. The RBI programs also works to create strong alliances among agencies and organizations to leverage existing resources, strengthen the local workforce and infrastructure, and increase access to health and social services in the rural border areas.

Training and Resources: HHSC has historically contracted for training services for intervention statewide; however, in state fiscal year 2020, a Coordinated Training Services (CTS) contract will be used to provide regionally-specific educational training to contracted providers for intervention, treatment, and recovery support services.

Substance Use Disorder Treatment Services
HHSC SUD Treatment services for adults and adolescent (defined as ages 13-17) engage the individual and the family in recovery efforts through the continuum of care. Treatment approaches are evidence-based, holistic in design, and emphasize coordination of care across the continuum. HHSC requires evidence-based Motivational Enhancement Therapy in all SUD treatment settings.

Priority Populations: HHSC has established priority populations for treatment in accordance with SABG regulations and state designation. Treatment contractors shall give preference for treatment services in the following order of priority:

a) pregnant injecting drug users;
b) pregnant substance abusers; and
c) injecting drug users.

Contractors shall adhere to the state established screening procedures to identify members of the priority population. When space is not available in a contractor's program service area, the contractor shall guarantee successful and timely referral to another suitable state-funded contractor (immediately for pregnant women or within 120 calendar days for injecting substance users), or Waiting List and Capacity Management Coordinator, if a placement is not possible. Contractors shall accept applicants from every region in the state when space is available. If two applicants are of equal priority status, preference may be given to an applicant living in the contractor's program service area. Each OSAR and treatment contractor shall include a statement in all its brochures, and shall post a notice in its lobby, concerning the priority population admission requirements.

Infectious Disease: HHSC requires all treatment programs to conduct and document screening for HIV, tuberculosis (TB), communicable diseases, and hepatitis B and C; and provide or make referrals for testing and treatment for these diseases. When individuals are placed on a waiting list, a contractor shall document referral of the client to an entity that provides testing, counseling, and treatment for HIV,

TB, and sexually transmitted diseases. Texas has one residential SUD treatment providing specialized services for individuals living with HIV.

Capacity and Waiting List: Contractors document their treatment services daily capacity management report through CMBHS.

Collaboration/Continuity of Care: HHSC requires all treatment programs to establish formal agreements with available providers in SUD, mental health, health care, and social services to address the multi-dimensional needs of individuals and facilitate referrals for family members needing services. Treatment programs provide case management and refer individuals to ancillary services to help individuals meet their treatment goals. Treatment programs also conduct follow-up with individuals leaving treatment, as well as individuals on their waiting list, to ensure successful linkage with referral destinations.

Assessment and Levels of Care designation: HHSC established Individual Placement Guidelines based on the American Society of Addiction Medicine (ASAM) levels of care designation.

- **Outpatient – ASAM Level 1 – Outpatient Services:** To provide treatment services that facilitate recovery from substance use disorders to clients who do not require a more structured environment such as residential services to meet treatment goals.
- **Supportive Residential – ASAM Level 3.1 – Clinically Managed Low-Intensity Residential Services:** To provide low intensity residential treatment services that facilitate recovery from substance use disorders for clients based on System Agency's Client Placement Guidelines
- **Intensive Residential – ASAM Level 3.5 Clinically Managed High-Intensity Residential Services:** To provide intensive treatment services in a residential setting that facilitate recovery from substance use disorders for clients based on System Agency's Client Placement Guidelines.
- **Ambulatory Detoxification – ASAM Level 2-WM Withdrawal Management:** To provide safe withdrawal for clients physically dependent upon alcohol and other drugs and who are able to also engage and participate in concurrent treatment services
- **Residential Detoxification – ASAM Level 3.7 Withdrawal Management:** To provide a structured environment for clients who are physically dependent upon alcohol and other drugs to safely withdraw from those substances and for clients who are intoxicated to be medically monitored until achieving a non-intoxicated state; and to prepare and engage clients for ongoing treatment services.

In addition, all individuals completing the CMBHS assessment, will also complete the Adverse Childhood Experience Questionnaire to ensure trauma-informed care to individuals.

Specialized Female - *Set Aside*
Specialized female services promote recovery from SUD for pregnant and parenting women meeting clinical criteria. Treatment is designed to promote stable recovery

from substance use disorders. Specialized female services provide gender-specific, evidenced-based, and trauma-informed services. In state fiscal year 2020, SABG funds nine Women and Children's Residential treatment facilities.

Pharmacotherapy Services
Pharmacotherapy services provide opioid treatment services (OTS) to adults to alleviate the adverse physiological effects of withdrawal from the use of opioids as required to meet the individualized needs of the client. OTS providers administer and dispense opioid drugs for the treatment of opioid addiction along with providing counseling and behavioral therapy. Additionally, OTS providers perform communicable disease testing, immunizations and chronic disease prevention, and treatment for comorbid conditions such as abscesses due to injection drug use, Hepatitis C, and/or co-occurring psychiatric disorders within the context of OTS to provide clients with an opportunity to improve their health and the quality of their overall lives while also obtaining help for their substance use disorder. In state fiscal year 2021, SABG will coordinate with State Opioid Response (SOR) program unit to ensure non-duplication of services and better facilitate streamlined contracting processes.

Recovery Support Services
HHSC continues to refine and expand recovery services, principles, and best practices across the state. In state fiscal year 2020, HHSC funds 32 Recovery Support Service providers (treatment, community and standalone peer-run organizations) responsible for integrating recovery support services throughout their local system of care strengthening the alignment of treatment services with a recovery-oriented approach while expanding community supports available to assist individuals in successfully integrating into their communities.

In January 2019, Texas Medicaid established a procedure code to bill "Peer Specialist Services" for individual and group services. In fiscal year 2021, Texas will allocate $4.4 million of SABG funds for Recovery Support Services.

Recovery-Oriented System of Care (ROSC)
HHSC implemented a non-funded statewide ROSC initiative to help ensure individuals affected by substance use and mental health disorders are provided a continuum of care that continuously promotes a path to recovery. HHSC assists communities across the state with initiating and understanding the ROSC concept in their local area by conducting onsite informational trainings; providing ongoing technical assistance to the local communities; and participating in individual and local ROSC community meetings.

YRCs (Youth Recovery Communities)
Youth Recovery Communities support and increase the prevalence of long-term recovery from substance use disorders of youth between the ages of 13-21 years by mobilizing community organizations who will utilize a Peer Recovery Leader workforce. The community-based youth recovery community center will establish effective linkages in the community to support youths' efforts to initiate and sustain their recovery.

Oxford Houses
HHSC created statewide Oxford Houses through a revolving state loan program to establish and maintain housing opportunities for individuals in recovery. The Oxford House concept allows for the administration of start-up funds to eligible applicants from HHSC-funded SUD programs to move into or be part of the opening of a new Oxford House. Residents live in democratically run, self-supporting, and drug-free homes. Currently, HHSC has assisted in the establishment of **273** Oxford Houses throughout Texas. In addition, HHSC provides Oxford House Outreach Workers support for the delivery of services to the individuals in the **2,119** beds in Texas.

Tribes
HHSC has agreements with each of three federally-recognized Native American Tribes.

Military and Families
SUD contracts include a requirement related to persons identified with military status (a member of the United States military serving in the army, navy, air force, marine corps, or coast guard on active duty) to ensure the individual military member and/or their spouse and dependents maintain their positions on the states' treatment waiting lists.

COPSD
COPSD programs provide adjunct services to adults and youth with active psychiatric and SUD receiving services in existing mental health and SUD residential and outpatient treatment programs. These services target individuals who require crisis resolution and/or specialized support in treatment because of their co-occurring diagnoses. COPSD services address both disorders and employ engagement, stabilization, and coordination strategies to help individuals benefit from treatment.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current M/SUD system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's M/SUD system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

A data-driven process must support the state's priorities and goals. This could include data and information that are available through the state's unique data system (including community-level data), as well as SAMHSA's data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorder prevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

In addition to in-state data, SAMHSA has identified several **other data sets** that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[16] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[16] **http://www.healthypeople.gov/2020/default.aspx**

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Footnotes:

Step 2: Unmet Needs and Services Gaps

Texas is a geographically expansive state with a population of 28.7 million in 254 counties. Texas has 82 metropolitan or urban counties with the remaining 172 counties classified as rural. Two Metropolitan areas account for 54% of the population in Texas. The diversity of the urban and rural settings contributes to the contrasting needs, capability, and capacity of substance use services. It is known that the population in need of Mental Health and Substance Abuse Prevention/Treatment services outnumber the services provided. Stated below are the unmet needs and gaps in services along with plans to mitigate the issues.

Estimates for Adult Mental Health Treatment Needs in Texas

Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for the adult population (source: U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999). Approximately 22-23% of the adult population has some diagnosable mental disorder. The Center for Mental Health Services within the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA) requires the use of a specific methodology for estimating the number of adults with SPMI.

The methodology is defined in the Federal Register, Volume 64, Number 121, Thursday, June 24, 1999, Notices, pages 33890 – 33897. It is estimated that 5.4% of the total adult population has a serious mental illness during a given year. Those with an SPMI represent approximately 2.6% of the total adult population. There are many more adults in need of services than are currently served. In state fiscal year 2018, 202,722 (or 69.5% of the 291,881 adults with SPMI living below 200% of the Federal Poverty Level (FPL)) were served by state-funded community mental health centers (for estimate methodology, see *Federal Register,* Volume 64, Number 121, June 24, 1999, pp. 33890-33897; National Advisory Mental Health Council 1993[1]; Kessler et al., 1996[2]).

Estimates for Child Mental Health Treatment Needs in Texas

Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for children and adolescents (source: U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999). Approximately 20% of children and adolescents have some type of mental health disorder. Those children and adolescents diagnosed with a SED represent approximately 7% of the child and adolescent population. The prevalence estimates of SED in these studies are based on children and adolescents ages 9 to 17 (estimates for children under the age of 9 were not provided).

There are many more children in need of services than are currently served. In FY 2018, 66,216 (or 58.6%) of the 113,011 children with SED living below 200% of FPL were served by state-funded community mental health centers (for estimate methodology, see

Federal Register, Volume 64, Number 121, June 24, 1999, pp. 33890-33897; National Advisory Mental Health Council 1993; Kessler et al., 1996).

Intervention Needs

The state of Texas is no longer a designated HIV state and the HIV related programs will end after fiscal year 2020. The outreach aspect of the current HIV contracts has been identified as a service need to allow a path for individuals not reached through OSAR outreach. Therefore, the state has concentrated on retaining the outreach service to continue to locate the population in need of SUD services, but otherwise unaware.

The Rural Border Intervention (RBI) programs continue to struggle with the large service areas, and lack of community resources available in the regions. The 3 RBI contracts will have increased funding in fiscal year 2021 to allow for additional FTEs to provide services.

Treatment Needs

In Texas, at minimum, there is a full treatment continuum of care (detoxification, residential and outpatient) within each service region; however, each service region spans a significant distance whereby daily transportation to and from a facility on a consistent basis is unreasonable to the indigent population we serve.

Telehealth has continued to be explored as a possibility in serving the population; however, there continues to be challenges with administrative rules adherence. Better utilizing the OSAR contracts to provide logistics for transporting those being served will be discussed a implemented in fiscal year 2021.

SABG funds are the payor of last resort. The low Medicaid reimbursement rates for treatment services does not attract new providers. HHSC is working to identify and reset the rate structure for female services to expand capacity.

In Texas, opioid overdose is the leading cause of maternal mortality with the highest rate occurring after Medicaid coverage has expired[3]. This is a significant gap in treatment services for women with dependent children. SABG along with the Texas Targeted Opioid Response (TTOR) grant are coordinating to provide these services.

Veterans, with SUD, need coordinated care services with The Veterans' Administration clinics. HHSC will explore the agreements required to ensure continuum of care is available to veterans in Texas.

Youth treatment services is an underutilized service. HHSC is currently exploring initiating a new curriculum to replace the Cannabis Youth Treatment (CYT) curriculum. Currently, the State Youth Treatment grant awarded by SMAHSA is providing data to support an option to or replacement of CYT with Seven Challenges curriculum, which is believed by HHSC to provide better outcomes. HHSC will determine the effectiveness and roll out statewide in the 2025 procurement.

Wait List

To understand where gaps in services may exist, monitoring statewide wait list data on a weekly basis is key. Technical assistance is provided to contractors struggling with various topics, ranging from management of the waitlist, delivering interim services, and coordinating out-of-region communication. HHSC analyzes aggregate and client level wait list data in several ways including: at the state, region, provider, level of care levels with attention to priority populations.

Recovery Services:

Recovery Support Services has helped fill the progression of recovery after SUD treatment gaps in communities across the state. Implementing recovery support services in all areas of need will require significantly more funding than what can be made available. Research indicates that sustained recovery is best facilitated when treatment services focus on developing strong therapeutic alliances, incorporate peer and community-based supports, address global health, promote life skills, include families and/or other significant allies, and adopt a chronic care approach to treatment.[4] In FY21, HHSC plans to fund quantitative and qualitative research to further support use of Recovery Support Services statewide.

Expansion of local community supported Peer-run Community Recovery Centers (RC) in rural communities across the state is a direction HHSC is promoting. RC's bridge the gap between clinical treatment and long-term recovery. RC's provide a place for an individual in recovery and their family members to build relationships with other recovering people and families. The centers provide community education, resources for connecting with job and housing leads, and other resources to sustain recovery.

As with the Adult Recovery Services, expansion of Youth Recovery Communities (YRC) is needed in all the HHSC service regions to allow youth to remain in their families' home while abstaining from substance use and learning new skills. The YRC contracts will be provided an increase in funds beginning fiscal year 2020 to provide additional FTEs and increase the number of youths to be served.

Prevention and Promotion Needs in Texas

The Regional Needs Assessments (RNAs), developed by the eleven Prevention Resource Centers (PRCs), provide the regional healthcare-related data necessary to inform data-drive decision-making for their region. The RNAs provide summarized data and information about region-specific substance use consumption, trends, programs, and consequences for applicable adults and youth. Regional prevention needs are considered by PRC leadership, who are expected to use data-driven decision-making to identify and serve these populations appropriately. Survey data, such as that collected using the TSS, the NSDUH, and the Texas Behavioral Risk Factor Surveillance System (BRFSS) demonstrate the scope of substance use behaviors among the varied age groups, ethnic groups, and geographic areas. Consequence data, such as the outcomes of alcohol and/or illicit drug abuse or dependence (i.e., substance-related deaths, hospital/psychiatric admissions, etc.) and justice-related outcomes (i.e., substance-related arrests, drug &

property crimes, etc.) are used to depict the negative impact of substance use across all demographic groups.

Revitalization of the State Epidemiological Outcomes Workgroup (SEOW) in 2019 will produce a State Epidemiological Profile to underpin data-driven decision making for statewide fiscal prevention expenditures. In addition to the RNAs, data is collected from other State programs and agencies (i.e., HHSC Decision Support Service, DSHS, TJJD, etc.) and is utilized for the "Epi Profile" development. Accuracy in data collection, analyses, and reporting is paramount to addressing the needs of Texas residents and achieving HHSC outcomes.

With a new procurement cycle approaching, SAP's heightened awareness of community need encouraged a re-examination of the current funding model. The data-driven assessment resulted in a formula revision, which placed greater weight on community need, and slightly reduced emphasis on poverty-weighted population areas; areas that likely receive funding from other private sources. Making this change permits HHSC to focus funding on more needy areas: those that previously received little or no services. As such, SAP looks forward to funding a broad range of programming across a larger geographic area, with more children served in hard-to reach areas. With new outcome measures in place, these changes will allow a closer scrutiny of programming success and assessment of return on investment.

As of the third fiscal quarter of FY19, an average of 154,659 youth is served by HHSC-funded substance abuse prevention programs each quarter. It is anticipated that approximately 151,000 youth will continue to be served by these programs for the 4th quarter of FY19, including Youth Prevention Indicated, Selective, and Universal populations, as well as Community Coalition Partnerships and Prevention Resource Centers.

HHSC-funded Youth Prevention program (YPs) providers incorporate the Strategic Prevention Framework (SPF) model within their funding application to demonstrate the priorities that are needed in their local communities. In addition, HHSC-funded providers are mandated through their Scopes of Work (SOWs) to incorporate the SPF model in its entirety throughout the life of their prevention efforts. To determine the needs within the local communities and schools, the entities use the TSS and other local data sources to demonstrate the current trends regarding alcohol, tobacco, and other drugs. Providers then select an approved, evidence-based curriculum that had been determined effective with a similar target population within their catchment area. The community coalitions also utilize the SPF process throughout the life of their respective prevention efforts. These coalitions implement evidence-based and promising environmental strategies that are appropriate within their service catchment area. The Prevention Resource Centers (PRCs) are required to collaborate with the CCPs and the YPs to review the data that was already established for their area, as well as review any other relevant data sources to address their local needs and assist in future prevention planning efforts.

HHSC determined through internal communication a need to develop an agency-wide implementation strategy for tobacco prevention and cessation operations. Through this initiative, HHSC seeks to:

1) understand the overall department investment and efforts toward tobacco prevention and cessation;
2) maximize the use of the departments' resources to reduce tobacco use and in Texas;
3) reduce youth access to tobacco and other nicotine products,
4) chart a course for a department-wide approach toward all tobacco-related efforts; and
5) define HHSC's role(s) in tobacco prevention among its stakeholders and partners. The goal is to reduce tobacco use in Texas and develop the best overall strategies that use current resources to provide the best health outcomes for Texans.

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

Mental Health Workforce Shortages in Texas

In the document *Mental Health Workforce Shortages in Texas*, September 2014, mental health workforce shortages and related concerns are clearly delineated. The 83rd Texas Legislature passed a series of bills to help address the state's mental health infrastructure and workforce shortages. The state conducted a review of the causes and potential solutions for mental health workforce issues across Texas and the nation. The five themes identified for state consideration in policymaking were: increasing the size of the mental health workforce, improving the distribution of the mental health workforce, improving the diversity of the mental health workforce, supporting innovation educational models, and improving data collection and analysis. Moving forward, all state agencies are expected to work from these themes when creating new policies and expanding or implementing programs across the state. The document may be viewed here: [https://www.dshs.state.tx.us/legislative/2014/Attachment1-HB1023-MH-Workforce-Report-HHSC.pdf].

Texas Behavioral Health Strategic Plan (TBHSP)

In an effort to improve coordination between state agencies and to create a strategic approach to providing behavioral health services, through the 2016-17 General Appropriations Act, H.B. 1, 84th Legislature, Regular Session, 2015 (Article IX, Section 10.04) Texas lawmakers directed 18 state agencies that receive General Revenue behavioral health funding to work collectively to develop this collaborative five-year behavioral health strategic plan and coordinated expenditures proposal. This strategic plan is the result of several months of collaboration involving these agencies that represent the diverse landscape of behavioral health services in Texas. The plan focuses on five strategic goals: Program and Service Coordination, Program and Service Delivery, Prevention and Early Intervention, Financial Alignment, and Statewide Data Collaboration. https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf

HHSC Strategic Plan 2019-2023

In the summer of even numbered years, HHSC and the other agencies within the health and human services (HHS) enterprise, creates a strategic plan to be submitted and approved by the state's legislature. This plan consists of detailed descriptions of the state's federal and state legislative mandates in addition to the goals and objectives set by the executives of each agency. HHS state agencies use this information to plan for the coming years and ensure the state remains on a consistent course of action aimed at a

better served Texas constituency. The HHSC Strategic plan may be found at: https://hhs.texas.gov/about-hhs/budget-planning/health-human-services-system-strategic-plans-2019-2023

Texas's State Funded Grant Programs

Texas' 85th legislative session in 2017 and 86th legislative session in 2019 created and continued mental health focused grant programs to address the unique needs of local areas. Applicants must demonstrate their local needs and the plan for how grant funding will address gaps within their community. These grant programs help to supplement the Statewide Strategic Plan's goals by extending to all providers an opportunity to identify and address the gaps within their individual service areas.

LMHA and LBHA (Center) Equity Funding

The equity measure is used to compare how much baseline funding for mental health services each Local Mental Health Authority (LMHA) or Local Behavioral Health Authority (LBHA) receives from the state, in relation to the size of the population it serves. It is expressed as a per capita rate (dollars per person) and includes funding for adult services, children's services, and crisis services. It excludes funding for special programs that are not uniform across all LMHAs and LBHAs. The baseline funding each LMHA/LBHA receives is based on historical allocations and subsequent changes in state and federal funding. When new funding has been appropriated, equity is one of the factors used to allocate funds among local authorities. The equity formula gives extra weight to the portion of the population with incomes less than 200% of FPL:

> LMHA/LBHA total baseline funding / (LSA total population) + (LSA population < 200% of FPL)

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

1. National Advisory Mental Health Council. (1993). Health care reform for Americans with severe mental illnesses: Report of the National Advisory Mental Health Council. *American Journal of Psychiatry, 150*, 1447–1465
2. Kessler, R. C., Berglund, P. A., Zhao, S., Leaf, P. J., Kouzis, A. C., Bruce, M. L., Friedman, R. M., Grossier, R. C., Kennedy, C., Narrow, W. E., Kuehnel, T. G., Laska, E. M., Manderscheid, R. W., Rosenheck, R. A., Santoni, T. W., & Schneier, M. (1996). The 12-month prevalence and correlates of serious mental illness, in Manderscheid, R. W., & Sonnenschein, M. A. (Eds.), *Mental health, United States, 1996* (DHHS Publication No. (SMA) 96- 3098, pp. 59–70). Washington, DC: U.S. Government Printing Office.
3. Texas Department of State Health Services. (2018). *Maternal Mortality and Morbidity Task Force and Department of State Health Services Joint Biennial Report.* Texas: Department of State Health Services.
4. White, W. (2008). Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, and Philadelphia Department of Behavioral Health and Mental Retardation Services.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention of Substance Abuse and Mental Illness

Priority Type: SAP, MHS

Population(s): SMI, SED, PP, Other (Adolescents w/SA and/or MH, Students in College, Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Focus on the prevention of substance abuse, SMI and SED by maximizing opportunities where individuals, families, communities, and systems are motivated and empowered to manage their overall emotional, behavioral, and physical health.

Objective:

1) SA Prevention programs (SAP): Maintain the number of youth and adults receiving prevention services.
2) Mental Health First Aid (MHFA) (MHS & SAP/SMI, SED, Other): Increase the number of school based and higher education personnel, the number of community members, and the number of veterans and veterans' immediate family members trained in MHFA. Increase the number of Local Mental Health Authority/Local Behavioral Health Authority personnel trained as trainers in MHFA.

Strategies to attain the objective:

1) SA Prevention programs: Provide targeted technical assistance to providers so that strategies are centered on funded priorities; identify barriers to consumer access of prevention services and the challenges of service delivery; and provide technical assistance that allows contractors to concentrate their efforts on enrolling more youth and adults in prevention education while stabilizing their efforts of other prevention strategies, such as alternative activities and ATOD presentations.
2) MHFA: Contract with LMHA/LBHAs to provide evidence-based MHFA training to public school personnel, higher education personnel, community members, and veterans and veterans' immediate family members and provide ongoing technical assistance support to providers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Prevention of Substance Use Disorder and Mental Illness

Baseline Measurement: FY2019 Adults: 520,167 Youth: 1,636,415

First-year target/outcome measurement: maintain baseline

Second-year target/outcome measurement: maintain baseline

Data Source:

CMBHS

Description of Data:

Number of youths, and adults receiving substance abuse prevention services.

Data issues/caveats that affect outcome measures::

Services include mental health prevention/promotion efforts. There is no current way to separate out these integrated programs. Program measures are aggregate reports and not based on individual level services for each strategy. For individuals who receive more than one service, there will be duplication in the total count.

Indicator #: 2

Indicator: Number of individuals trained in evidence-based Mental Health First Aid (MHFA) Training

Baseline Measurement: 18,763 individuals trained in SFY2018

First-year target/outcome measurement: An additional 20% in SFY 2020 for a total of 22,516

Second-year target/outcome measurement: An additional 10% in SFY 2021 for a total of 24,768

Data Source:

Office of Mental Health Coordination LMHA/LBHA MHFA training sign-in sheets, certificates, pass/fail records, invoices, and annual reports.

Description of Data:

Number and type of participants who attend MHFA training and become certified.

Data issues/caveats that affect outcome measures::

This information is dependent on accurate data collection and reporting activities from the LMHAs/LBHAs. Information is provided to the state on a monthly and yearly (cumulative) basis. Numbers are affected by the willingness of the groups to whom the LMHA/LBHA makes outreach to actually participate in the training. Some groups have chosen less lengthy options or elect to take online training versus an instructor-led course.

Priority #: 2

Priority Area: Health Care and Health Systems Integration

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, PWID, EIS/HIV, TB, Other ()

Goal of the priority area:

Focus on health care and services coordination and integration across systems. Integration efforts will seek to increase access to appropriate high-quality prevention, treatment, recovery and wellness services and supports.

Objective:

1) Tobacco Cessation (MHS, SAP, SAT/All priority populations): Coordinate support for local health departments, community based interventions, and wraparound services with targeted resources.
2) Outreach Screening Assessment and Referral (OSAR): (All priority populations): Support OSAR functions into LMHA/LBHA services. Combine substance use disorder hotline functions with mental health hotline functions to provide one unified crisis number in each of the 11 regions across the state.
3) NAS (SAT/PWWDC,PP,PWID): Increase the number of Pregnant Women and Women with Dependent Children (PWWDC) screened through existing Pregnant and Postpartum Intervention (PPI) programs.
4) NAS (SAT/PADRE,PP,PWID): Maintain the number of parenting males and expecting fathers at risk for involvement or currently involved with child welfare with a substance use disorder or who are at risk of developing a substance use disorder screened through existing Parenting Awareness and Drug Risk Education (PADRE) programs.
5) Medication Assisted Therapy (MAT) (SAP and SAT/All Priority Populations): Medical testing and immunization of individuals with Opioid Use Disorder (OUD).
6) Crisis Services (MHS/SMI & SED): Maintain current levels of access to crisis services for individuals with mental health and/or substance use disorders.
7) Expand and maintain the number of individuals in the First Episode of Psychosis Pilot Program who access integrated services.

Strategies to attain the objective:

1) Tobacco Cessation: Continue the cross-agency collaboration within the Health and Human Services (HHS) system; through this collaboration, maintain the Tobacco Specialists within the PRCs in each of the 11 HHS regions.
2) OSAR: Contract with LMHAs/LBHAs to administer OSAR functions relating to the provision of substance use disorder services and integrate hotline functions with existing mental health hotlines. Provide technical assistance to support the
integration of services.
3) NAS/PWWDC: Amend existing Pregnant and Post-Partum Intervention (PPI) provider contracts to expand services.
4) NAS/PADRE: Continue to provide PADRE services across the state and provide ongoing technical assistance and on-site monitoring to support the PADRE programs.
5) MAT: Increase medical testing(infectious disease screening and prevention panel and immunizations) of individuals with OUD.
6) Crisis Services: Continue providing crisis residential facilities across the state focusing on special populations and rural areas. Provide ongoing technical assistance and on-site monitoring to support the crisis programs.
7) First Episode of Psychosis Program: Monitor and support current and future First Episode of Psychosis pilot programs to establish and maintain access to integrated care for participants.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Program and Service Coordination

Baseline Measurement: Memorandum of Understandings (MOUs) with other state agencies and Tribal Authorities

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

System of Contract Operation and Reporting (SCOR)

Description of Data:

HHSC will have active MOUs with other state agencies Department of Criminal Justice, Juvenile Justice Department, Department of Family and Protective Services, Department of State Health Services and the three federal recognized Tribal Authorities to address program and service coordination to promote and support behavioral health program and service coordination to effectively meet the diverse needs of people and communities.

Data issues/caveats that affect outcome measures::

None

Indicator #: 2

Indicator: Priority Population Admission

Baseline Measurement: Pregnant, injecting women and pregnant women who were immediately admitted into treatment services.

First-year target/outcome measurement: FY2020 – Increase by 10% up to 95%

Second-year target/outcome measurement: FY2021 – Increase by 10% up to 95%

Data Source:

CMBHS

Description of Data:

Numerator: The Number of pregnant, injecting women and pregnant women who were immediately admitted into treatment services.
Denominator: The Number of pregnant, injecting women and pregnant women who were screened and/or assessed for treatment.

Data issues/caveats that affect outcome measures::

None

Indicator #: 3

Indicator: Percent of adult clients released to stable housing

Baseline Measurement: 80%

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBHS

Description of Data:

Numerator: The Number of adult clients admitted into services
Denominator: The Number of adults completing services and released to stable housing

Data issues/caveats that affect outcome measures::

None

Indicator #: 4

Indicator: Intervention Services

Baseline Measurement: FY2018 Numbers served in PADRE (824) and RBI (8393) - 9,217

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBHS

Description of Data:

PADRE
Number of adult/youth clients screened for substance abuse risk factors for involvement or currently involved with child welfare with a substance use disorder or who are at risk of developing a substance use disorder.
RBI -
Number of Adults served
Number of youth served.

Data issues/caveats that affect outcome measures::

Number served may be impacted by procurement, which new contracts will begin in fiscal year 2021

Indicator #: 5

Indicator: Prevention Resource Center Tobacco Education

Baseline Measurement: 40 trainings to begin fiscal year 2021

First-year target/outcome measurement: FY2020 - Train 11 Tobacco Specialists to provide education on tobacco and tobacco cessation to providers within Behavioral Health Services.

Second-year target/outcome measurement: FY2021 - provide, at minimum, 40 specialized tobacco education and cessation trainings to regional providers to include Local Mental Health Authorities and Local Behavioral Health Authorities in each region.

Data Source:

CMBHS

Description of Data:

Performance Measure

Data issues/caveats that affect outcome measures::

None

Indicator #: 6

Indicator: Number of individuals with mental health and/or substance use disorders receiving crisis residential services.

Baseline Measurement: 25,000 individuals received crisis residential services in SFY 2018

First-year target/outcome measurement: Maintain Baseline Number

Second-year target/outcome measurement: Maintain Baseline Number

Data Source:

Consumer Analysis Date Warehouse - Texas LBB Measures

Description of Data:

Number of persons served as described.

Data issues/caveats that affect outcome measures::

Number served may be impacted once exact details of budget allocation become available.

Indicator #: 7

Indicator: Number of individuals in the First Episode of Psychosis pilot program who access integrated care.

Baseline Measurement: 520 individuals enrolled

First-year target/outcome measurement: 780 individuals enrolled

Second-year target/outcome measurement: 780 individuals enrolled

Data Source:

CMBHS/MBOW

Description of Data:

Number of persons served in the early onset levels of care for the associated state fiscal year.

Data issues/caveats that affect outcome measures::

New programs have started in spring of 2019 that will need time for ramp-up. These sites are also in more rural locations so targets may need to be adjusted after initial assessment of implementation of new program sites.

Priority #: 3

Priority Area: Trauma and Justice

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, EIS/HIV, TB, Other (Criminal/Juvenile Justice)

Goal of the priority area:

As Texas population grows, maintain prompt access to ongoing care by adult and youth with mental illness and substance use disorder. Ensure this care is focused on trauma and justice by integrating a trauma-informed approach throughout the system and support the use of innovative strategies to reduce the involvement of individuals with trauma and behavioral health issues in the criminal and juvenile justice systems.

Objective:

1) Substance Use Disorder Treatment (SAT/All priority populations, Other): Maintain prompt access to Substance Use Disorder treatment.
2) Crisis Services (MHS/SMI & SED, Other): Provide the appropriate crisis services to individuals in the community.
3) Trauma Informed Care (SAT & MHS/All priority populations): Create pathways for sharing information on TIC and develop mutual framework from which to work on TIC objectives within the system

Strategies to attain the objective:

1) Maintain average monthly number of adults served by Substance Use Disorder treatment providers.
2) Increase access to crisis response services for persons waiting for access to ongoing mental health care.
3) Trauma Informed Care: Develop workgroups to identify mutual collaborations and workspace within TIC, particularly around training

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Substance Use Disorder adult treatment services.

Baseline Measurement: FY18 number adult treatment program services - 34,450

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBHS

Description of Data:

Number of adult Treatment (TRA) program services is a total served in TRA and LBHA-TRA services. This number will reflect the same individual served in multiple services.

Data issues/caveats that affect outcome measures::

Number served may be impacted by procurement, where new contracts will begin in fiscal year 2021 and will be affected by a rate increase if determined to be required.

Indicator #: 2

Indicator: Number of persons receiving crisis outpatient services

Baseline Measurement: 72,200 persons received crisis outpatient services in SFY 2018

First-year target/outcome measurement: Maintain baseline numbers

Second-year target/outcome measurement: Maintain baseline numbers

Data Source:

Consumer Analysis Data Warehouse - Texas LBB Measures

Description of Data:

Number of persons served as described.

Data issues/caveats that affect outcome measures::

Number served may be impacted once exact details of the budget allocation become available.

Indicator #: 3

Indicator: Texas Cross-System and HHSC Trauma Transformation Team workgroups are developed and share a charter to inform and develop collaborations around Trauma-Informed Care work.

Baseline Measurement: Two workgroups have formed with the intent of developing a shared TIC framework to increase collaborations

First-year target/outcome measurement: TIC charter is developed and activities towards implementation begin.

Second-year target/outcome measurement: Ongoing collaboration through regularly scheduled meetings and shared objectives are identified. Implementation of identified activities within the charter continues.

Data Source:

OMHC Trauma Transformation Lead and Programs TIC Subject Matter Expert

Description of Data:

Charter, Shared Objectives and Goals, meeting minutes and collective work output (training or learning forums/conferences)

Data issues/caveats that affect outcome measures::

Priority #: 4

Priority Area: Recovery Support

Priority Type: SAT, MHS

Population(s): SMI, SED, PWWDC, PP, EIS/HIV, TB, Other (Criminal/Juvenile Justice, Homeless)

Goal of the priority area:

Focus on partnering with people in recovery from mental and substance use disorders and their family members, with an emphasis on person-centered planning, to guide the behavioral health system and promote individual, program, and system level approaches that foster health and resilience; increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports.

Objective:

1) Supported Housing (MHS & SAT/SMI, SED, Homeless): SMI and all priority populations): Reduce the need for emergency care access by providing supportive housing rental assistance.
2) Enhance Texas' current behavioral health service delivery system through the use of client-driven practices.
3) Certified Mental Health Peer Specialists and Recovery Support Peer Specialists (SAT/All Priority Populations): Maintain the number of certified Peer Specialists and Recovery Coaches.

Strategies to attain the objective:

1) Supported Housing: Continue to provide level funding to SHR that provides rental assistance to individuals. Provide monthly supported housing technical assistance calls and conduct site visits as needed to support providers.
2) Utilize current state expertise in addition to expert training and consultation to create a PCRP implementation workgroup and plan that addresses the needs of Texans.
3) Certified Mental Health Peer Specialists and Recovery Support Peer Specialists : Continue to contract with providers to offer training and certification for MHPS and RSPS in SFY 2020 and SFY 2021. Provide ongoing technical assistance to support Recovery Support Services provider (for persons with SUD) and LMHA/LBHA development and retention of certified MHPSs and RSPSs..

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number enrolled in long-term coaching

Baseline Measurement: FY18 number enrolled in long-term coaching -

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBHS

Description of Data:

Number of individuals enrolled to receive long-term (12 months) coaching

Data issues/caveats that affect outcome measures::

Number served may be impacted by procurement, which new contracts will begin in fiscal year 2021

Indicator #: 2

Indicator: Youth Recovery

Baseline Measurement: FY2018 numbers served 3096

First-year target/outcome measurement: FY20 - 10% increase in numbers served for baseline

Second-year target/outcome measurement: FY21 10% increase in numbers served in FY20

Data Source:

CMBHS

Description of Data:

Increase of the performance measure: Total number of particpants with open cases for the reporting month. FY20 will reflect an increase of funds for the contractors and FY21 will begin the new procurement term with additional contractors.

Data issues/caveats that affect outcome measures::

Funding levels affecting contract funding

Indicator #: 3

Indicator: Reduce crisis episodes and psychiatric hospitalizations for individuals receiving supportive housing rental assistance (SHR)

Baseline Measurement: Number of crisis episodes and psychiatric hospitalizations one year prior to entry into the SHR program

First-year target/outcome measurement: Reduce psychiatric hospitalizations by 20 percent and crisis episodes by 30 percent

Second-year target/outcome measurement: Reduce psychiatric hospitalizations by 30 percent and crisis episodes by 40 percent

Data Source:

CMBHS/MBOW - Reports run for SHR business reports

Description of Data:

Data will look at hospitalization and crisis episode data prior to SHR program entry and annual number of hospitalizations and crisis episodes.

Data issues/caveats that affect outcome measures::

Indicator #: 4

Indicator: Develop and implement person centered recovery planning principles and activities to support a client-centered service delivery system.

Baseline Measurement: Formulation and creation of PCRP workgroup and identified members.

First-year target/outcome measurement: Develop a plan for coordinated PCRP efforts across state agencies including opportunities and barriers to implementation.

Second-year target/outcome measurement: Implement PCRP planned activities as identified by the PCRP workgroup.

Data Source:

Texas PCRP workgroup lead. BHS Peer Support Unit, quantitative and qualitative updates.

Description of Data:

Additional specific data points may be created as activities are identified.

Data issues/caveats that affect outcome measures::

Indicator #: 5

Indicator: Number of certified Mental Health Peer Specialists (MHPS) and Recovery Support Peer Specialist (RSPS).

Baseline Measurement: 387 MHPS and 185 RSPS

First-year target/outcome measurement: Maintain baseline numbers

Second-year target/outcome measurement: Maintain baseline numbers

Data Source:

The records from the two organizations that certify peers. The Texas Certification Board and Wales Counseling DBA Texas Peers.

Description of Data:

Number of individuals that have received MHPS training, RSPS Training and applied for and have been granted certification.

Data issues/caveats that affect outcome measures::

The 85th Texas Legislature, Regular Session passed a bill that required the certification process to be separated from organizations that provided training. The full implications of this new legislation on the number of MHPS and RSPS are currently unknown.

Priority #: 5

Priority Area: Workforce Development

Priority Type: SAP, SAT, MHS

Population(s): SMI, SED, PWWDC, PP, EIS/HIV, TB

Goal of the priority area:

Focus on strategies to strengthen the behavioral health workforce. Through technical assistance, training, and focused programs that promote an integrated, aligned, competent workforce that enhances the availability of prevention and treatment for substance abuse and mental illness; strengthens the capabilities of behavioral health professionals; and promotes the infrastructure of health systems to deliver competent, organized behavioral health services.

Objective:

1) Provide training opportunities in the area of trauma-informed care for service delivery providers and within the HHSC system

Strategies to attain the objective:

1) Partner with regional MHTTC with an expertise in trauma, which will be developing trauma-informed care training tracks - from TIC 101, to training of trainer, as well as training on supervision which sustains TIC in targeted efforts to address secondary traumatic stress through support and supervision of the workforce.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: TIC training aimed at building capacity and supporting the workforce is developed in partnership with regional MHTTC.

Baseline Measurement: Previous work done through Texas Children Recovering From Trauma (TCRFT) grant and trauma-focused EBPs made available through Texas' service delivery system.

First-year target/outcome measurement: Development of additional trauma training options through the MHTTC

Second-year target/outcome measurement: Report on number of provider staff and Texas HHSC staff trained in trauma-informed care

Data Source:

MHTTC and OMHC developed tracking tool to share sourced data.

Description of Data:

TIC training plans and number of persons trained who work within service delivery system to include LMHAs/LBHAs and HHSC staff.

Data issues/caveats that affect outcome measures::

Reliability of data for webinars may be difficult to obtain – may consider doing a pre and post-test to assess

OMB No. 0930-0168 Approved: 04/19/2019 Expires: 04/30/2022

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2020/2021. ONLY include funds expended by the executive branch agency administering the SABG

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$0		$0	$0	$0	$0	$0
a. Pregnant Women and Women with Dependent Children**	$0		$0	$0	$0	$0	$0
b. All Other	$0		$0	$0	$0	$0	$0
2. Primary Prevention	$0		$0	$0	$0	$0	$0
a. Substance Abuse Primary Prevention	$0		$0	$0	$0	$0	$0
b. Mental Health Primary Prevention							
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)							
4. Tuberculosis Services	$0		$0	$0	$0	$0	$0
5. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
6. State Hospital							
7. Other 24 Hour Care							
8. Ambulatory/Community Non-24 Hour Care							
9. Administration (Excluding Program and Provider Level)	$0		$0	$0	$0	$0	$0
10. Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA will use available funds to provide authorized services for the planning period for state fiscal years 2020/2021.

Planning Period Start Date: 7/1/2019 Planning Period End Date: 6/30/2021

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
a. Substance Abuse Primary Prevention							
b. Mental Health Primary Prevention*		$0	$0	$0	$0	$0	$0
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)**		$0	$0	$0	$0	$0	$0
4. Tuberculosis Services							
5. Early Intervention Services for HIV							
6. State Hospital			$0	$0	$0	$0	$0
7. Other 24 Hour Care		$0	$0	$0	$0	$0	$0
8. Ambulatory/Community Non-24 Hour Care		$0	$0	$0	$0	$0	$0
9. Administration (Excluding Program and Provider Level)***		$0	$0	$0	$0	$0	$0
10. Total	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 3B should include Early Serious Mental Illness programs funded through MHBG set aside

*** Per statute, Administrative expenditures cannot exceed 5% of the fiscal year award.

Footnotes:

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	0	0
2. Women with Dependent Children	0	0
3. Individuals with a co-occurring M/SUD	0	0
4. Persons who inject drugs	0	0
5. Persons experiencing homelessness	0	0

Please provide an explanation for any data cells for which the state does not have a data source.

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Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Expenditure Category	FFY 2020 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment*	
2 . Primary Substance Abuse Prevention	
3 . Early Intervention Services for HIV**	
4 . Tuberculosis Services	
5 . Administration (SSA Level Only)	
6. Total	**$0**

* Prevention other than Primary Prevention

** For the purpose of determining the states and jurisdictions that are considered ?designated states? as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a ?designated state? in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state?s AIDS case

rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

A		B
Strategy	**IOM Target**	**FFY 2020 SA Block Grant Award**
1. Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
2. Education	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
3. Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
4. Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
	Universal	

5. Community-Based Process	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
6. Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
7. Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
8. Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	**$0**
Total Prevention Expenditures		**$0**
Total SABG Award*		**$0**
Planned Primary Prevention Percentage		

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FFY 2020 SA Block Grant Award
Universal Direct	
Universal Indirect	
Selective	
Indicated	
Column Total	**$0**
Total SABG Award*	**$0**
Planned Primary Prevention Percentage	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2020 and FFY 2021 SABG awards.

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Targeted Substances	
Alcohol	☑
Tobacco	☑
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☑
Military Families	☑
LGBTQ	☑
American Indians/Alaska Natives	☑
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☑
Underserved Racial and Ethnic Minorities	☐

Footnotes:

Planning Tables

Table 6 Non-Direct Services/System Development [SA]

Planning Period Start Date: 10/1/2019 Planning Period End Date: 9/30/2021

Activity	FY 2020 A. SABG Treatment	B. SABG Prevention	C. SABG Combined*
1. Information Systems			
2. Infrastructure Support			
3. Partnerships, community outreach, and needs assessment			
4. Planning Council Activities (MHBG required, SABG optional)			
5. Quality Assurance and Improvement			
6. Research and Evaluation			
7. Training and Education			
8. Total	**$0**	**$0**	**$0**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Planning Tables

Table 6 Non-Direct-Services/System Development [MH]

MHBG Planning Period Start Date: 09/01/2019 MHBG Planning Period End Date: 08/31/2021

Activity	FFY 2020 Block Grant
1. Information Systems	
2. Infrastructure Support	
3. Partnerships, community outreach, and needs assessment	
4. Planning Council Activities (MHBG required, SABG optional)	
5. Quality Assurance and Improvement	
6. Research and Evaluation	
7. Training and Education	
8. Total	**$0**

0930-0378 Approved: 09/11/2017 Expires: 09/30/2020

Footnotes:

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[22] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[23] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[24]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[25] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[26] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[27]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and M/SUD with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[28]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[29] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and M/SUD include: developing models for inclusion of M/SUD treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[30] Use of EHRs - in full compliance with applicable legal requirements - may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow M/SUD prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[31] and ACOs[32] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting M/SUD providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[33] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[34]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[35] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[36] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who experience health insurance coverage eligibility changes due to shifts in income and employment.[37] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with M/SUD conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[38] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of M/SUD conditions and work with

partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.
SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[39] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to M/SUD services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds.
The SSAs and SMHAs should collaborate with their states' Medicaid authority in ensuring parity within Medicaid programs.
SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues.
Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[40]
SAMHSA recognizes that certain jurisdictions receiving block grant funds - including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[41] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

[22] BG Druss et al. Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Med Care. 2011 Jun; 49(6):599-604; Bradley Mathers, Mortality among people who inject drugs: a systematic review and meta-analysis, Bulletin of the World Health Organization, 2013; 91:102-123 **http://www.who.int/bulletin/volumes/91/2/12-108282.pdf**; MD Hert et al., Physical illness in patients with severe mental disorders. I. Prevalence, impact of medications and disparities in health care, World Psychiatry. Feb 2011; 10(1): 52-77

[23] Research Review of Health Promotion Programs for People with SMI, 2012, **http://www.integration.samhsa.gov/health-wellness/wellnesswhitepaper**; About SAMHSA's Wellness Efforts, **https://www.samhsa.gov/wellness-initiative**; JW Newcomer and CH Hennekens, Severe Mental Illness and Risk of Cardiovascular Disease, JAMA; 2007; 298: 1794-1796; Million Hearts, **https://www.samhsa.gov/health-care-health-systems-integration**; Schizophrenia as a health disparity, **http://www.nimh.nih.gov/about/director/2013/schizophrenia-as-a-health-disparity.shtml**

[24] Comorbidity: Addiction and other mental illnesses, **http://www.drugabuse.gov/publications/comorbidity-addiction-other-mental-illnesses/why-do-drug-use-disorders-often-co-occur-other-mental-illnesses** Hartz et al., Comorbidity of Severe Psychotic Disorders With Measures of Substance Use, JAMA Psychiatry. 2014; 71 (3):248-254. doi:10.1001/jamapsychiatry.2013.3726; **http://www.samhsa.gov/co-occurring/**

[25] Social Determinants of Health, Healthy People 2020, **http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39**; **https://www.cdc.gov/nchhstp/socialdeterminants/index.html**

[26] **http://www.samhsa.gov/health-disparities/strategic-initiatives**

[27] **http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/**

[28] Integrating Mental Health and Pediatric Primary Care, A Family Guide, 2011. **https://www.integration.samhsa.gov/integrated-care-models/FG-Integrating_12.22.pdf**; Integration of Mental Health, Addictions and Primary Care, Policy Brief, 2011, **https://www.ahrq.gov/downloads/pub/evidence/pdf/mhsapc/mhsapc.pdf**; Abrams, Michael T. (2012, August 30). Coordination of care for persons with substance use disorders under the Affordable Care Act: Opportunities and Challenges. Baltimore, MD: The Hilltop Institute, UMBC. **http://www.hilltopinstitute.org/publications/CoordinationOfCareForPersonsWithSUDSUnderTheACA-August2012.pdf**; Bringing Behavioral Health into the Care Continuum: Opportunities to Improve Quality, Costs and Outcomes, American Hospital Association, Jan. 2012, **http://www.aha.org/research/reports/tw/12jan-tw-behavhealth.pdf**; American Psychiatric Association, **http://www.psych.org/practice/professional-interests/integrated-care**; Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series (2006), Institute of Medicine, National Affordable Care Academy of Sciences, **http://books.nap.edu/openbook.php?record_id=11470&page=210**; State Substance Abuse Agency and Substance Abuse Program Efforts Towards Healthcare Integration: An Environmental Scan, National Association of State Alcohol/Drug Abuse Directors, 2011, **http://nasadad.org/nasadad-reports**

[29] Health Care Integration, **http://samhsa.gov/health-reform/health-care-integration**; SAMHSA-HRSA Center for Integrated Health Solutions, (**http://www.integration.samhsa.gov/**)

[30] Health Information Technology (HIT), http://www.integration.samhsa.gov/operations-administration/hit; Characteristics of State Mental Health Agency Data Systems, Telebehavioral Health and Technical Assistance Series, **https://www.integration.samhsa.gov/operations-administration/telebehavioral-health**; State Medicaid Best Practice, Telemental and Behavioral Health, August 2013, American Telemedicine Association, **http://www.americantelemed.org/home**; National Telehealth Policy Resource Center, **http://telehealthpolicy.us/medicaid**;

[31] Health Homes, **http://www.integration.samhsa.gov/integrated-care-models/health-homes**

[32] New financing models, **https://www.integration.samhsa.gov/financing**

[33] Waivers, **http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html**; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, **http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf**

[34] What are my preventive care benefits? **https://www.healthcare.gov/what-are-my-preventive-care-benefits/**; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); **http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html**

[35] Medicare-Medicaid Enrollee State Profiles, **http://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/StateProfiles.html**; About the Compact of Free Association, **http://uscompact.org/about/cofa.php**

[36] Dual-Eligible Beneficiaries of Medicare and Medicaid: Characteristics, Health Care Spending, and Evolving Policies, CBO, June 2013, **http://www.cbo.gov/publication/44308**

[37] BD Sommers et al. Medicaid and Marketplace Eligibility Changes Will Occur Often in All States; Policy Options can Ease Impact. Health Affairs. 2014; 33(4): 700-707

[38] TF Bishop. Acceptance of Insurance by Psychiatrists and the Implications for Access to Mental Health Care, JAMA Psychiatry. 2014;71(2):176-181; JR Cummings et al, Race/Ethnicity and Geographic Access to Medicaid Substance Use Disorder Treatment Facilities in the United States, JAMA Psychiatry. 2014; 71(2):190-196; JR Cummings et al. Geography and the Medicaid Mental Health Care Infrastructure: Implications for Health Reform. JAMA Psychiatry. 2013; 70(10):1084-1090; JW Boyd et al. The Crisis in Mental Health Care: A Preliminary Study of Access to Psychiatric Care in Boston. Annals of Emergency Medicine. 2011; 58(2): 218

[39] Hoge, M.A., Stuart, G.W., Morris, J., Flaherty, M.T., Paris, M. & Goplerud E. Mental health and addiction workforce development: Federal leadership is needed to address the growing crisis. Health Affairs, 2013; 32 (11): 2005-2012; SAMHSA Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, January 2013, **http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf**; Creating jobs by addressing primary care workforce needs, **https://obamawhitehouse.archives.gov/the-press-office/2012/04/11/fact-sheet-creating-health-care-jobs-addressing-primary-care-workforce-n**

[40] About the National Quality Strategy, **http://www.ahrq.gov/workingforquality/about.htm**; National Behavioral Health Quality Framework, Draft, August 2013, **http://samhsa.gov/data/NBHQF**

[41] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, **http://www.cms.gov/cciio/resources/letters/index.html**; Affordable Care Act, Indian Health Service, **http://www.ihs.gov/ACA/**

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

a) Co-occurring mental and physical health disorders are common in the general population but are significant for persons with serious mental illness (SMI) and require high quality integrated care from health care providers working together to treat all existing conditions at the same time. The term “integration” is widely used to describe the bringing together of healthcare components and has been used to reference everything from consultation to co-location to a setting of team-based approach around treating the whole person. The idea of integration occurring along a continuum of collaboration and integration is widely supported and adaptations have differed in the number of levels (from three to 10) and the categories used to differentiate or describe levels. SAMHSA and the Center for Integrated Healthcare Solutions (CIHS) propose six levels of integration framework representing a continuum of increasing collaboration and shared values between healthcare providers. The overarching framework has three main categories, coordinated, co-located, and integrated care, with two levels of degree within each category. The coordinated care category has Level 1 — Minimal Collaboration and Level 2 — Basic Collaboration at a Distance. The co-located care category has Level 3 — Basic Collaboration Onsite and Level 4 — Close Collaboration with Some System integration whereas the integrated care category refers to Level 5 — Close Collaboration Approaching an Integrated Practice and Level 6 — Full Collaboration in a Transformed/Merged Practice. This framework is designed to help organizations implementing integration to evaluate their degree of integration across several levels and to determine what next steps they may want to take to enhance their integration initiatives.

b) Texas has several Delivery System Reform Incentive Payment (DSRIP) projects focused on integrating primary and behavioral health care services. This includes both primary care services integrated into a behavioral health care setting and behavioral health care integrated into a primary care setting. DSRIP providers earn incentive payments based on achievement of project-specific metrics, not cost reimbursement. There are no standard requirements for implementation of these projects. Project plans were based on community needs assessments conducted by each of the Regional Healthcare Partnerships in DSRIP.

c) Select Local Mental Health Authorities (LMHAs) in Texas have received funds to support the creation or expansion of Certified Community Behavioral Health Clinics (CCBHCs). HHSC supports these efforts and has previously applied for CCBHC grants at the state level.

d) Similarly, the mental health and substance use disorder (SUD) clients are increasingly being provided with integrated care at community behavioral health centers (18 of 39 centers).

e) Senate Bill (S.B.) 200, 85th Legislature, Regular Session, 2017 requires the Texas Health and Human Services Commission (HHSC)

to research behavioral and physical health integration among Medicaid clients. A workgroup has been created to accomplish this task. S.B. 200 has two separate, but related, charges:
i. Establish performance measures that may be used to determine the effectiveness of the integration of behavioral health services, giving particular attention to Managed Care Organizations (MCO) that provide behavioral health services through a contract with a third party, and.
ii. Use performance audits and other oversight tools to improve monitoring of the provision and coordination of behavioral health services.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

a) The SUD unit provides Co-occurring Psychiatric Substance Use Disorder Services (COPSD) services with approximately $4.9 million of block grant funds allocated for the COPSD service type. Counseling and/or case management are provided depending on client needs. Contractors establish memorandums of understanding with funded treatment, prevention, intervention, mental health providers and other community service providers to define how services will be provided to client and their families. In addition, whenever possible inclusion of family in the clients' recovery plan is recommended.
b) Outreach, Screening, Assessment, and Referral (OSAR) involves screening for SUD as an outreach service and linking the individuals to the appropriate services. All OSAR services are administered through LMHAs/LBHAs. There is, at least, one OSAR in each of the state's 11 regions. Region 6 has two OSARs and in regions 3 and 4 there are two LBHAs assigned to specific counties along with a regional LMHA OSAR. The OSAR counseling staff conducts screenings and assessments to determine the level of care needed and provides the appropriate referral to treatment. The OSAR can also assist with transportation if needed. In addition, the OSARs help individuals move through the continuum of care and link to community-based support services after treatment. To guide referrals, priority populations are identified and mapped to specific levels of care are used at the time of screening and/or assessment. In addition to assisting individuals, OSARs work with treatment providers when individuals are waiting for treatment services by maintaining communication with individuals waiting for treatment and refer them to an appropriate level of care as soon as space becomes available. In fiscal year 2019 and 2020, the Human Immunodeficiency virus (HIV) early intervention and outreach programs will maintain service agreements with treatment providers and the regional OSARs to ensure that, the priority populations are prioritized for treatment services once identified.
c) Home and Community Based Services-Adult Mental Health (HCBS-AMH) is a state-wide 1915(i) state plan amendment program providing home and community-based services to adults with serious mental illness. The HCBS-AMH program provides an array of services, appropriate to each individual's needs, to enable him or her to live and experience success in their chosen community. Services are designed to support long term recovery from mental illness. HCBS-AMH care coordinators are called "recovery managers." The recovery manager is required to coordinate services with managed care organization (MCO) service coordinators, as well as other behavioral health providers involved in the individual's care. HCBS-AMH promotes integrated care by requiring an annual routine physical and providing a SUD benefit extending beyond the traditional state plan benefit, including providing services in the individual's home. Additionally, HCBS-AMH nursing provides care for chronic conditions related to both physical and behavioral health.
d) Though Texas was not awarded a demonstration grant for CCBHCs, the providers selected as part of the pilot have elected to continue moving forward in implementing the model. This CCBHC Initiative is continuing forward by creating a recertification process for pilot sites, certifying additional sites, and creating a process to allow for access to CCBHC certification statewide. This initiative has resulted in a transformed service delivery and continued efforts towards Alternative Payment Methodologies with MCOs.

3. **a)** Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

b) and Medicaid? ○ Yes ◉ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Texas currently has a federally-facilitated marketplace. Qualified Health Plans are not monitored by HHSC. The Texas Department of Insurance (TDI) monitors the Qualified Health Plans on a MCO, Health Management Organization (HMO) level.

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ◉ Yes ○ No

6. Do the M/SUD providers screen and refer for:

a) Prevention and wellness education ◉ Yes ○ No

b) Health risks such as

ii) heart disease ◉ Yes ○ No

iii) hypertension ◉ Yes ○ No

iv) high cholesterol ◉ Yes ○ No

v) diabetes ◉ Yes ○ No

c) Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based ◉ Yes ○ No

contractual relationships that advance coordination of care?

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? (●) Yes ( ) No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

a) Size. Despite efforts made to increase access to services through the introduction of telehealth and telemedicine, those in rural communities continue to lack access to appropriate integrated care, including substance abuse services, due to distance between geographical locations of service providers. Other issues facing Texas are billing and reimbursement guidelines, workforce shortage of primary care physicians and psychiatrists, and availability of space to house all needed employees for integrated care.
b) Integration. Integrated care in children's health and mental health is under-represented due to insufficient mental health education in primary care settings, insufficient allocation of child-focused resources and lack of integration-focused providers for children. More efforts need to be made to educate primary caregivers, pediatricians, and obstetricians on the importance of integrated care for children and the correlation between mental and physical health.
c) Access. Many individuals in Texas do not have access to Medicaid or private insurance and therefore may not be covered for most physical or behavioral health services. Lack of coverage can lead to individuals never receiving the screenings and subsequent care that they need.
d) Number of MCOs. Texas has 20 MCOs which have a fair amount of discretion over their NQTLs. Because of the large number, it is difficult for Texas to work closely with any MCOs in the way some other states are able to do with only a handful. Additionally, reviewing NQTL analyses from all MCOs and following up when necessary is time intensive and resource heavy.

10. Does the state have any activities related to this section that you would like to highlight?

a) Behavioral health providers screen and refer for prevention and wellness education and recovery supports as a result of individualized responses to the Adult Needs and Strengths Assessment (ANSA) and the Child and Adolescent Needs and Strengths (CANS). Physical and medical functioning is assessed in terms of general needs and would trigger referrals to health care providers should they be identified as needing professional healthcare. During psychiatric assessments for medications, general protocols typically include screening for chronic health conditions, as well as performing routine lab work, and referrals for health care providers would occur as needed.

b) A survey was conducted in April 2016 to assess Integrated Health Care (IHC) practices among Community Behavioral Health Centers including LMHAs and LBHAs. A total of 37 programs participated in the survey (100% participation) with following results in brief:
• Current level of IHC practices as per SAMHSA levels of integration framework – Level 3-5: 83 percent programs. Level 1-2: 14 percent programs, and None: 3 percent programs.
• Electronic Health Record (HER) Characteristics: 30 percent of programs have combined Primary Health (PH) and Mental Health EHR, 30 percent have separate PH and Mental Health, while 40 percent of programs have only Mental Health EHR.
• Major obstacles towards implementing IHC practices as shared by participating programs are lack of resources, lack of a collaborative EHR, featuring primary health and behavioral health in one package, and health care workforce shortage, recruitment, and retention issues. Other workforce issues include lack of experience or training in PH and barriers in credentialing and co-locating SUD providers. Other obstacles include billing and reimbursements issues, difficulty in finding primary health partners, MCO, and specialty care, and lack of infrastructure including space.

c) As the single state Medicaid agency, HHSC has comprehensive network adequacy requirements to ensure that MCOs deliver services to more than 85 percent of Texas Medicaid recipients. These requirements are monitored on an ongoing basis to ensure a provider network able to serve all Medicaid recipients enrolled in an MCO with primary and specialty care. Behavioral health and chemical dependency treatment facilities are among the specialty providers HHSC monitors. Health Plan Management (HPM) is a unit within the HHSC's Medicaid/CHIP department responsible for oversight and monitoring of MCOs delivering Medicaid services. HPM conducts readiness reviews with an MCO to ensure the operational readiness of the organization before executing a contract. HPM reviews MCO-provider contracts and monitors the MCO's provider network no less than quarterly. HPM also has staff to monitor Medicaid enrollee complaints and complaints related to access to care. HPM follows up on complaints to ensure there are no further barriers for enrollee's access to care.

d) HHSC is actively working to implement state legislative requirements. One requirement is to create two health home pilot sites for individuals with co-occurring serious mental illness and another chronic health condition. Texas will be using the Certified Community Behavioral Health Clinic model to implement this requirement. A second requirement is to put into place monitoring mechanisms to monitor MCO-level integration activities, such as data sharing, provider portal integration, and integration of care coordinators.

e) HHSC is working to implement new state legislative requirements for mental health parity. In addition to the creation of a parity ombudsman and parity workgroup made up of a diverse set of stakeholders, HHSC will complete a report on MCO's use of non-quantitative treatment limitations.

f) A state-wide 1915(i) state plan amendment program, HCBS-AMH uses a mixture of federal participation and state revenue (beyond the Medicaid state match), to provide an array of services, appropriate to each individual's needs and enable him or her to live and experience success in their chosen community. The HCBS-AMH recovery manager is required to coordinate services with MCO service coordinators as well as other behavioral health providers involved in the individual's care. HCBS-AMH promotes

integrated care by requiring an annual routine physical and providing a SUD benefit extending beyond the traditional state plan benefit, including providing services in the individual's home. Additionally, HCBS-AMH nursing provides care for chronic conditions related to both physical and behavioral health.

g) HHSC intends to administer an online survey to assess the behavioral health workforce shortage, inviting programs to share the problems encountered and possible solutions to build workforce capacity.

h) HHSC applied for and received a Promoting Integration of Primary and Behavioral Health Care grant, which will help develop integrated health care activities at the identified pilot sites.

i) HHSC promotes the use of telehealth services in both rural and urban areas in order to reduce the impact of workforce shortages throughout the state.

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[42], **Healthy People, 2020**[43], **National Stakeholder Strategy for Achieving Health Equity**[44], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for **Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[45].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[46]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[47]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[48]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[42] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[43] **http://www.healthypeople.gov/2020/default.aspx**

[44] **https://www.minorityhealth.hhs.gov/npa/files/Plans/NSS/NSS_07_Section3.pdf**

[45] **http://www.ThinkCulturalHealth.hhs.gov**

[46] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[47] https://aspe.hhs.gov/basic-report/hhs-implementation-guidance-data-collection-standards-race-ethnicity-sex-primary-language-and-disability-status

[48] https://www.whitehouse.gov/wp-content/uploads/2017/11/Revisions-to-the-Standards-for-the-Classification-of-Federal-Data-on-Race-and-Ethnicity-October30-1997.pdf

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, sexual orientation, gender identity, and age?

a) Race	○ Yes ○ No
b) Ethnicity	○ Yes ○ No
c) Gender	○ Yes ○ No
d) Sexual orientation	○ Yes ○ No
e) Gender identity	○ Yes ○ No
f) Age	○ Yes ○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ○ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ○ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of M/SUD providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ○ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) Standards? ○ Yes ○ No

6. Does the state have a budget item allocated to identifying and remediating disparities in M/SUD care? ○ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, its purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ÷ Cost, (**V = Q ÷ C**)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state M/SUD authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. SAMHSA's Evidence Based Practices Resource Center assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. SAMHSA's Evidence-Based Practices Resource Center provides the information & tools needed to incorporate evidence-based practices into communities or clinical settings.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General,[49] The New Freedom Commission on Mental Health,[50] the IOM,[51] NQF,and the Interdepartmental Serious Mental Illness Coordinating Committee (ISMICC).[52]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[53] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[54] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[55] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

[49] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[50] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[51] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[52] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[53] **http://psychiatryonline.org/**

[54] **http://store.samhsa.gov**

[55] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? ○ Yes ○ No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** ☐ Leadership support, including investment of human and financial resources.
- **b)** ☐ Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** ☐ Use of financial and non-financial incentives for providers or consumers.
- **d)** ☐ Provider involvement in planning value-based purchasing.
- **e)** ☐ Use of accurate and reliable measures of quality in payment arrangements.
- **f)** ☐ Quality measures focus on consumer outcomes rather than care processes.
- **g)** ☐ Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** ☐ The state has an evaluation plan to assess the impact of its purchasing decisions.

3. Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed related to this section.

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4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP. The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a Coordinated Specialty Care (CSC) model, and have been shown to improve symptoms, reduce relapse, and lead to better outcomes.

State shall expend not less than 10 percent of the MHBG amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? (●) Yes ( ) No

2. Has the state implemented any evidence-based practices (EBPs) for those with ESMI? (●) Yes ( ) No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

Texas has implemented Coordinated Specialty Care (CSC) programs in twenty-three different cities across Texas to provide behavioral health services and supports to those experiencing an early onset of psychosis. Individuals are served via a team-based approach emphasizing their ability to lead a normal life within their community. This is a time-limited program with a maximum length of stay in the program of three years. After three years in the program, it is anticipated that individuals will be discharged or transitioned to the next most appropriate level of care (LOC).

3. How does the state promote the use of evidence-based practices for individuals with ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

Texas is focused on serving those with an early onset of psychosis. The CSC model has been proven to work with this population and Texas is dedicated to creating robust CSC programs for our constituents. CSC Programs provide education and outreach to their community to highlight the impact and availability of services to those who may be gatekeepers or potential consumers. This localized effort has been tremendous with individualizing both the promotion of the CSC programs as well as assisting with an

integrated team. As each program becomes more entrenched in their communities, they have seen even more integration of external supports within their programs. The use of person-centered recovery planning adds another layer of individualization to the programs to ensure each consumer is treated as a unique individual and given the ability to direct their path to recovery.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with ESMI? Yes No

5. Does the state collect data specifically related to ESMI? Yes No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? Yes No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Texas has implemented Coordinated Specialty Care (CSC) programs across Texas to serve those defined by the 10% set-aside for ESMI. The CSC team must provide several services related to the following roles: counseling, family education & support, supported employment/education, case management, peer support, and medication management. Within these roles, providers are expected to utilize the EBP (as applicable) designated to best serve individuals. Therefore, many EBPS are provided by the CSC including: Cognitive Behavioral Therapy (CBT), Individual Placement and Support (IPS), Illness Management & Recovery (IMR), Trauma-Focused CBT, and Preparing Adolescents for Young Adulthood (PAYA). In addition to these EBPs, providers may be granted the authority to utilize other EBPs if there is evidence the alternate EBP is a better treatment option for that individual.

8. Please describe the planned activities for FFY 2020 and FFY 2021 for your state's ESMI programs including psychosis?

In late spring 2019, Texas expanded the CSC programs to thirteen new locations for a total of twenty-three programs across the state. This expansion was made possible by the increase in the block grant funding approved in federal fiscal year 2018. Texas has chosen to allocate block grant funds beyond the required 10% set aside to support the continuation and expansion of CSC across the state. These new programs are in more rural areas which will present new challenges and opportunities. Fiscal years 2020 and 2021 will be dedicated to continuing to refine and improve all CSC programs with an emphasis on identifying best practices for rural implementation of the CSC model. It is expected that the current rural implementation of CSC programs will require flexibility and professional creativity to maximize the resources available within these geographically vast communities.

It is anticipated that in Texas' 87th legislative session in 2021, the state will propose an exceptional item to expand the CSC programs to full statewide implementation.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Texas collects assessment and encounter data for all programs. In addition to that data, the CSC programs are required to complete an additional quarterly report created to reflect the recommended fidelity measures listed by a national trainer in CSC. The data and measures collected are a mixture of processes and outcomes. Texas' goal with the CSC programs is to assist individuals with becoming independent and eventually discharging from services. Therefore, we focus our providers on the quarterly measures and assessment data from the Child and Adolescent Needs & Strengths (CANS) and Adult Needs & Strengths Assessment (ANSA) that shows an improvement in functioning and quality of life. Quality of life improvement will look different for each client. We also know that improvement in certain domains on our assessments are likely to correlate with self-reports of improvement. We are specifically looking at improvements within social relationships, job/school functioning, family functioning, and housing stability.

In addition to this data and analysis, we also have a university assisting with an evaluation of the programs across Texas. This evaluation has already identified methods of improving our data collection and outcome methodologies in addition to preliminary data showing CSC's effectiveness.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Enrollment in one of the CSC programs requires a psychosis diagnosis. We allow any diagnosis to qualify, including mood disorders, as long as psychosis is a presenting feature.

Substance or medically induced psychosis are exclusionary criteria.

Please indicate areas of technical assistance needed related to this section.

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5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person?s strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person?s goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, education, family relationships, and treatments are part of a written plan that is consistent with the person?s needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

N/A

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Texas' Mental Health Performance Contract Notebook states that the process of determining services to be provided must be conducted jointly by the contracted provider and the individual seeking services. The Texas Health and Human Services Commission (HHSC) has partnered with the Centralized Training Infrastructure for Evidence-Based Practices to provide ongoing educational support to providers on a variety of evidence-based practices in order to effectively engage clients and their caregivers. Available subjects include Motivational Interviewing, Person-Centered Recovery Planning, Illness Management and Recovery, Cognitive Behavioral Therapy, Individual Placement and Support, Permanent Supportive Housing and Co-Occurring Psychiatric and Substance Use Disorder.

Support for providers in developing person-centered planning models is also available through Via Hope: Texas Mental Health Resource. Via Hope is a Non-Profit which collaborates with HHS to promote the continuation of innovative, recovery-based, person-centered, and evidence-based programs and activities to enhance the public behavioral health system in Texas. Via Hope provides education and training for individuals in recovery (adult peers and family partners) and works with provider organizations to support the growth of recovery cultures and practices. Since 2011 Via Hope, in collaboration with national consultants, has worked with Local Mental Health Authorities (LMHAs) to assist in the spread of person-centered planning though learning communities, working with individual centers, and providing workshops to emphasize the critical involvement of individuals in service and their families, in the recovery planning process.

4. Describe the person-centered planning process in your state.

Texas adopted the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA) as the Uniform Assessment (UA). The CANS and ANSA are multi-purpose tools developed to support individualized care planning, including the application of evidence-based practices linked to identified assessment need. All individuals who have been screened and determined in need of assessment must have a UA completed to obtain and evaluate biopsychosocial histories, strengths, and needs that inform the specific services and supports for and with the individual served. CANS and ANSA scores are used for ongoing monitoring of the outcome of services.

In conjunction with the UA, a person-centered recovery plan is created through a collaborative partnership with the service provider and the individual receiving services. Every plan must reflect family or client choice and preference for items such as goals or desired outcomes, objectives, and services received. Providers are required to take into account cultural considerations and other unique needs. For children and adolescents with the highest level of need, the Wraparound Planning Process is implemented to assist with this process. The Wraparound Team ensures the recovery plan is child-centered and family driven to address the needs of the child and family. UAs must be reviewed and revised depending on the level of care, with a functional needs assessment, when circumstances or needs change, or when the client requests a review. Each client and/or their representatives are required to sign and be provided a copy of their person-centered recovery plan.

Please indicate areas of technical assistance needed related to this section.

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6. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of M/SUD benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? ○ Yes ○ No
2. Does the state provide technical assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards? ○ Yes ○ No
3. Does the state have any activities related to this section that you would like to highlight?

   Please indicate areas of technical assistance needed related to this section

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7. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[56] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state?s plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[56] **https://www.energy.gov/sites/prod/files/Presidential%20Memorandum%20Tribal%20Consultation%20%282009%29.pdf**

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

During State Fiscal Year 2017, HHSC conducted nine consultations with the three federally recognized tribes. These consultations initially consisted of 1:1 technical assistance (TA) calls to identify needs; followed by monthly TA calls, and finally quarterly calls and other calls, as requested. HHSC also conducted a site visit with two of the tribes.

2. What specific concerns were raised during the consultation session(s) noted above?

The Alabama Coushatta Tribe of Texas and Kickapoo Traditional Tribe of Texas raised similar concerns:
• Need for TA in grant writing for both federal and state funds
• Development of youth-specific prevention programs
• Development and implementation of community coalitions and services
• Development of behavioral health professionals and identification of funding to support workforce development
• Lack of tribal specific residential treatment facilities
• Lack of mental health and youth residential treatment facilities near the reservations as well as none specifically for tribal members
• Assistance with the development of a Tribal Action Plan

The Ysleta del Sur Pueblo reservation is located closer to a metropolitan area (El Paso) as well as near Albuquerque where they have access to the Native Epi Center, so their only concern was the need for additional funding for treatment services

3. Does the state have any activities related to this section that you would like to highlight?

Based on the consultations over the past year HHSC has conducted regular technical assistance (TA) calls with Tribes in Texas and provided TA that resulted in securing multiple federal grants.
- October, 2017: HHSC MOU with Alabama Coushatta was executed to address the needs they had identified during the site visit.

- May, 2018: HHSC Tribal Workgroup held its first call with all three federally recognized Tribes in Texas to discuss current funding opportunities (Native Connections, SPF-PFS, Suicide Prevention) and determine additional needs. Kickapoo Traditional Tribe of Texas expressed an interest in applying for the Native Connections Grant and the workgroup began providing TA as well as a Letter of Support for the Native Connections Grant. They were subsequently awarded the grant.
- June 6-13, 2018: HHSC conducted a site visit to Ysleta to provide TA and help establish a relationship. During the visit HHSC learned they were receiving $19,000 in treatment funds and advised them about HHSC's open enrollment process that could potentially increase their funding. The tribe then applied for additional funding during open enrollment thereby almost doubling their funding amount. They were able to provide additional services and expended 99 percent of funds ensuring their funding will not be de-obligated or reduced.
- July 16, 2018: HHSC began collaborations and planning for participation in the Red Ribbon Week Kickoff at the Capitol (SPF-PFS and SABG funds). There was representation from two of the three tribes with 14 tribal youth and three adults in attendance.
- August 2018: HHSC provided Kickapoo Traditional Tribe of Texas TA on grant-writing for the Tribal Opioid Response (TOR) Grant. They were later awarded the grant.
- September 2018: HHSC collaborated with Texas Department of State Health Services to develop maps showing Texas behavioral health centers and alcohol/substance abuse treatment facilities (a map specific to each of the three tribes and one collective map to include all three tribes). The map serves as a resource for the tribes when applying for funds to easily demonstrate the gaps in services due to access to services barriers.
- October 2018: HHSC created a tribal-designated position on the Behavioral Health Advisory Committee (BHAC); position was subsequently filled by Kickapoo Traditional Tribe of Texas with support and agreement of all three Texas tribes. As a result of being a BHAC member, the representative has begun conversation with the workgroup on how Texas can address the gap in service for tribal youth in need of behavioral health services.
- December 2018 to January 2019: HHSC Provided Alabama Coushatta with TA on the Native Connections Grant and they were later awarded the grant.

Please indicate areas of technical assistance needed related to this section.

While the representatives of tribes are eager to work with us, the state would benefit from TA to provide onsite TA to develop the Tribal Action Plan.

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8. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- **a)** ☑ Data on consequences of substance-using behaviors
- **b)** ☑ Substance-using behaviors
- **c)** ☑ Intervening variables (including risk and protective factors)
- **d)** ☑ Other (please list)

Legal consequences
Mortality
Hospitalization & treatment
Gaps in service
Gaps in data
Demographic data
Programmatic data
Pre/post-tests data
Coalition Monitoring System

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- ☑ Children (under age 12)
- ☑ Youth (ages 12-17)
- ☑ Young adults/college age (ages 18-26)
- ☑ Adults (ages 27-54)

Older adults (age 55 and above)

Cultural/ethnic minorities

Sexual/gender minorities

Rural communities

Others (please list)

U.S. - Mexico Border Region versus Non-Border

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

Archival indicators (Please list)

Mental Health and Substance Abuse Treatment
Local and Statewide Media Counts
Texas Education Agency
Office of Juvenile Justice and Delinquency Prevention
Texas Juvenile Justice Department
Centers for Disease Control
Texas Alcoholic Beverage Commission
Texas Department of Public Safety
Texas State Board of Pharmacy

National survey on Drug Use and Health (NSDUH)

Behavioral Risk Factor Surveillance System (BRFSS)

Youth Risk Behavioral Surveillance System (YRBS)

Monitoring the Future

Communities that Care

State - developed survey instrument

Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? Yes No

If yes, (please explain)

Texas currently uses Regional Needs Assessment (RNA) data to establish the capacity and need of each region and decides funding allocation for SABG primary prevention programs based on an algorithm giving weight to level of poverty, population, and need. A regional allocation is calculated for each of the 11 Texas Health & Human Service (HHS) regions. HHSC operationalizes need based primarily on information provided in the RNAs, which incorporates data sources described previously (in #4). A major contributor of data considered in assessing need is the Texas School Survey of Substance Use (TSS). The TSS identifies youth in need of selective prevention or indicated prevention, depending on the impact of risk and protective factors they experience. Additional data used to define need includes:

• annual dropout rates by grade (grades 7-12), high school graduation rate, gender, and ethnicity and number of dropouts among grades 7-12 by county;
• number of children of substance abusers by county of residence is obtained from HHSC data;
• the incident count of students with disruptive behaviors (including the discipline reasons of disruptive behavior, truancy, and possession of tobacco products) by school district/county, is obtained from Public Education Information Management System (PEIMS) data at the Texas Education Agency;
• the number of teenage (ages 13-17) pregnancy by county obtained directly from Texas Vital Statistics; and
• the number of juvenile substance-related arrests by county (raw data from Texas Department of Public Safety and analysis by HHSC).
• Number of children living in single-parent households

Future Plans
HHSC is working to improve Texas data collection capacity and process with guidance from the State Epidemiological and Outcomes Workgroup (SEOW). Renamed the State of Texas Epidemiological Workgroup (STEW) and comprised of state and national subject-matter experts (SMEs), the STEW will work closely with and include regional data coordinators, facilitating access to real-time and trending epidemiological issues. SEOW (aka STEW) is currently being funded under the Strategic Prevention Framework – Partnership For Success (SPF-PFS) grant and will focus on sustainability efforts beyond the funding period. HHSC and STEW will prioritize rural demographic needs in its pursuit of developing a sustainable epidemiological profile.

If no, (please explain) how SABG funds are allocated:

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? Yes No

If yes, please describe

The Texas Certification Board (TCB)1 is an autonomous arm of the Texas Association of Addiction Professionals. TCB certification upgrades and standardizes the qualifications of those working in areas of addiction counseling, clinical supervision, and prevention throughout Texas. These certifications are designed to be appropriate for those professionals currently working in counseling, supervision and prevention.
TCB offers Associate Prevention Specialist (APS) designation as well as Certified Prevention Specialist (CPS) and Advanced Certified Prevention Specialist (ACPS) certifications. Both certifications are recognized by the International Credentialing and Reciprocity Consortium (IC&RC) for the International Certified Prevention Specialist (ICPS) certification.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? Yes No

If yes, please describe mechanism used

The HHSC's Texas Prevention Training (TPT) contract provide a statewide coordinated system of prevention training and technical assistance services to support and enhance workforce development in Texas. TPT provides training on the latest prevention research, including best practice approaches; evidence-based prevention curricula addressing substance abuse prevention; six Center for Substance Abuse Prevention (CSAP) strategies; public health; Institute of Medicine (IOM) Continuum of Care model; coalition-building; cultural competency; staff competency; environmental strategies; prevention activities; the Strategic Prevention Framework (SPF); behavioral health approaches in prevention; and any other prevention-specific training directed by the state. The comprehensive prevention training is designed to support the effective implementation of evidence-based alcohol, tobacco, and other drugs (ATOD) prevention programs across the state.
Staff competencies are also developed and required part of all substance abuse prevention provider contracts. The prevention program director and all staff providing supervision must hold a CPS or APS working toward CPS certification. A prevention program director who does not possess a CPS certification must obtain a CPS certification within 12 months of employment in the position. The provider must ensure that the prevention program director and all prevention staff complete required trainings such as the cardiopulmonary resuscitation/First Aid, 15-hour Prevention Training within six months from the start date of the contract or the date of hire, whichever is later. The 15 hours must include a minimum of 3 hours in cultural competency, risk and protective factors/building resiliency, child development and/or youth development, strategies for strengthening families and prevention across the lifespan. The Prevention Program Director must provide documentation of their completion of the Substance Abuse Prevention Specialist Training (SAPST) training upon the date of hire. The provider must ensure all prevention staff employed with the organization complete the SAPST training within 18 months of employment.
The substance abuse prevention program staff must complete the required evidence-based curriculum training prior to service delivery. A minimum of 15 hours of prevention continuing education specifically related to prevention or job-related duties must be completed annually. These trainings may be obtained through the HHSC-funded TPT training contractor, HHSC's Behavioral

Health Institute, or other entities TCB-approved as continuing education providers. The contracted provider must maintain documentation of credentials and training certificates for all prevention staff in personnel files. These staff competencies apply to all employees, contracted labor, and volunteers that work directly with the program participants.
In addition, HHSC substance use and misuse prevention program specialists provide training and technical assistance to the prevention providers regarding programmatic issues surrounding the requirements in their statements of work which includes the service requirements, staffing requirements, staff competencies, and reporting requirements.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? Yes No

If yes, please describe mechanism used

The Behavioral Health Prevention Services Request for Applications (RFA) includes a section in the respondent's response regarding the Assessment of Community Needs and Organization Capacity (ACNOC). The respondent provides the following information as part of their response to the RFP section on the ACNOC:
• a description of the organization's capacity and experience in providing substance abuse prevention services;
• experience in networking and collaborating with other community partners;
• a description of the partnerships with agencies the respondent plans to work with to address gaps in services and provide support services for the target population of the proposed project;
• a description of the organization's experience providing prevention services to the identified target population;
• a description of the organization's experience and capacity in administrative functions, financial and contracts management, program oversight, staff retention and workforce development, a list of funding sources for the program type within the last five years, number of computers with minimum requirements, program staffing and staff competencies.
A community assessment section provides a description of the ATOD consumption patterns in the target schools and communities with a specific focus on the state's three priorities of alcohol, marijuana, and prescription drugs. Local data, such as the Texas School Survey, is used to support these items. In addition, a description of the intervening variables and underlying conditions that help explain local substance abuse problems, consequences, and consumption patterns. A description of who is affected by the identified problems or consequences is also provided.

Future Planning:
HHSC is working with the Department of State Health Services (DSHS) to build capacity for Tobacco Prevention and Cessation. The agencies are working to develop trainings to improve field capacity in response to the passing of Tobacco 21 in Texas. The focus on capacity development will be tobacco retailer education, community stakeholder education, and strengthening tobacco enforcement efforts.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

1. ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
2. ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
3. ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
4. ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

HHSC is using the Texas Behavioral Health Strategic Plan (TBHSP developed in June 2012 and recently updated for the state fiscal years 2017-2021. The TBHSP is in line with federal directives and has helped Texas create a coordinated data-driven substance abuse prevention system. The data collected and reviewed for the TBHSP supports the determination of the state's prevention priorities which include alcohol (underage drinking), marijuana and cannabinoids, tobacco and nicotine products, and prescription drug misuse. The TBHSP was used as a guide to develop the statements of work for prevention services programs to be procured through the Prevention Services RFP. This RFP which was issued November 5, 2012 with a five-year funding cycle that began in September 1, 2013 and was extended through August 31, 2019. The Substance Use and Misuse Prevention RFA will be used to procure services from September 1, 2019 through August 31, 2024.

Future Plans
HHSC will the work with the State of Texas Epidemiological Workgroup (STEW), the Texas Prevention Priorities Workgroup, and the Evidence-Based Practice Workgroup with funding through the SPF-PFS grant. These workgroups will play a vital role in the development of the prevention strategic plan. HHSC will evaluate the outcomes of the TBHSP in the development of future strategic plans.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) Yes No N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** Timelines
- **c)** Roles and responsibilities
- **d)** Process indicators
- **e)** Outcome indicators
- **f)** Cultural competence component
- **g)** Sustainability component
- **h)** Other (please list):
- **i)** Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary Yes No

prevention funds?

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? Yes No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Though the state does not have an active Evidence-Based Workgroup at this time, it has received technical assistance from the former Southwest Center Applied Prevention Technology and continues to receive technical assistance from the Prevention Technology Transfer Center.

Narratve Question

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In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** SSA staff directly implements primary prevention programs and strategies.
- **b)** The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** The SSA funds regional entities that provide training and technical assistance.
- **e)** The SSA funds regional entities to provide prevention services.
- **f)** The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** The SSA funds community coalitions to provide prevention services.
- **h)** The SSA funds individual programs that are not part of a larger community effort.
- **i)** The SSA directly funds other state agency prevention programs.
- **j)** Other (please describe)

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

- **a)** Information Dissemination:

  All of the HHS's primary prevention programs including;
  Community Coalition Partnerships (CCP),
  Texas Prevention Training,
  Statewide Prevention Media Campaign,
  Digital Text Messaging Campaign,
  Prevention Resource Centers (PRC), and
  All Youth Programs (Universal, Indicated and Selected)

- **b)** Education:

  All Youth Programs (Universal, Indicated, and Selected)

- **c)** Alternatives:

  All Youth Programs (Universal, Indicated, and Selected)

- **d)** Problem Identification and Referral:

  Prevention Resource Centers (PRC)
  Community Coalition Partnerships (CCP)

All Youth Programs (Universal, Indicated, and Selected)

e) Community-Based Processes:

All of HHS's primary prevention programs, including:
Community Coalition Partnerships (CCP),
Prevention Resource Centers (PRC),
Youth Programs (Universal, Selective, and Indicated),
Statewide Prevention Media Campaign, and
Texas Prevention Training

f) Environmental:

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? Yes No

If yes, please describe

The Block Grant Subcommittee of Texas' larger Behavioral Health Advisory Committee is responsible for reviewing the block grant plan. In addition, HHS's Budget and Contract offices ensure all contracts and funds are appropriately utilized as defined by the Block Grant rules and regulations.

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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5. ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
6. ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? Yes No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

Although HHS does not have a formal evaluation plan at present time, the development of an evaluation plan and the review of outcome measures is being discussed by the HHSC leadership, the HHSC Substance Abuse Prevention Team, and the Texas Prevention Priorities Workgroup (Advisory Council).

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** Includes evaluation information from sub-recipients
- **c)** Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** Establishes a process for providing timely evaluation information to stakeholders
- **e)** Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** Other (please list:)
- **g)** Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** Numbers served
- **b)** Implementation fidelity
- **c)** Participant satisfaction
- **d)** Number of evidence based programs/practices/policies implemented
- **e)** Attendance
- **f)** Demographic information
- **g)** Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** Heavy use

Binge use

Perception of harm

c) Disapproval of use

d) Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) Other (please describe):

Footnotes:

1. Information on the Texas Certification Board (TCB) can be found at www.tcbap.org.

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

The Texas Mental Health System is described as Texas Resilience and Recovery (TRR), a model relying on evidence-based practices and principles of recovery to obtain the best possible consumer outcomes and maximize available dollars. A uniform assessment is provided to evaluate the needs of consumers and recommend appropriate level of care (LOC) within which individual service plans are customized based on individual needs and preferences. LOCs for both adults and children have been developed to provide an appropriate array of evidence-based services for consumers in each level to meet identified needs. Each LOC is described in Texas Health and Human Services Commission's (HHSC) Utilization Management Clinical Guidelines. This document outlines the core services for each LOC (i.e. case management, physician services, and rehabilitation). The utilization guidelines also describe the array of add-on services available to meet individual consumer needs. These guidelines establish eligibility and discharge criteria and define the average expected hours of service recommended for each level of care.

2. Does your state coordinate the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	( ) Yes (•) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe or clarify the services coordinated, as needed (for example, best practices, service needs, concerns, etc.)

In Texas' community behavioral health centers, including local mental health authorities/local behavioral health authorities (LMHAs and LBHAs) provide integrated healthcare services to their clients. The nature, level, and extent of these services varies from referrals to offsite healthcare providers to collaboration with primary health provider's collocated in the same facility. The programs were asked to categorize the level of integrated healthcare being currently provided in a survey conducted in April 2016. Based upon the responses submitted and the levels of integration as detailed above, 97 percent of our programs provide integrated healthcare services ranging from Level 1 (3 percent), Level 2 (11 percent), Level 3 (35 percent), Level 4 (32 percent), and Level 5 (16 percent).

3. Describe your state's case management services

a. Routine Case Management is primarily site-based services assisting an adult, child or youth, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs.

b. Intensive Case Management is focused activities to assist an individual and caregiver/legally authorized representative in obtaining and coordinating access to necessary care and services appropriate to the individual's needs. An intervention consisting of management of a mental health problem and the rehabilitation and social support needs of the person concerned, over an indefinite period of time, by a team of people who have a fairly small group of clients. Twenty-four-hour help is offered, and clients are seen in a non-clinical setting.

4. Describe activities intended to reduce hospitalizations and hospital stays.

HHSC provides a continuum of crisis services intended to reduce hospitalization and number of hospital stays. Crisis services include community-based services assisting in stabilizing crisis situations, minimizing hospitalizations and re-hospitalizations, restoring functioning, assisting with adherence to medication regimens, promoting integration into the larger community, and assisting with linkage to other required community-based services. HHSC provides outpatient crisis intervention services such as Psychiatric Emergency Services Centers (PESC) which provides an array of outpatient residential based programs serving individuals from low to moderate risk of harm to self or others in a clinically supervised environment. The focus of the PESC is to provide appropriate treatment in the least restrictive environment to stabilize an individual's acute mental health symptoms and improve functioning. Intensive ongoing services for children and youth include team-based, wraparound services intended to keep the young person in the home with their family. These outpatient services provide an alternative to inpatient hospitalizations significantly. For individuals in need of inpatient psychiatric treatment, services are focused to stabilize crises and work towards discharge planning to a community setting to reduce readmissions to the hospital setting.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's M/SUD system.

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI		
2.Children with SED		

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

Criterion 3

Provides for a system of integrated services in order for children to receive care for their multiple needs. Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(•) Yes ( ) No
b)	Educational services, including services provided under IDE	(•) Yes ( ) No
c)	Juvenile justice services	(•) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(•) Yes ( ) No
e)	Health and mental health services	(•) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(•) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

a. Describe your state's targeted services to rural population.

In an effort to expand treatment which promotes recovery, House Bill 13, 85th Legislature, Regular Session, 2017, provided for the development of a community mental health grant program. This initiative seeks to establish a matching grant program to support community mental health efforts which provide services and treatment to individuals experiencing mental illness. Fifty percent of the total awarded is reserved for community mental health programs located in counties with a population of less than 250,000. In Texas' 86th Legislature, 2019, the matching grant program received continuous funding to support current and new programs. The goals of the community mental health grant program include the following:

• Provide mental health care services and treatment to individuals with mental illness; and

• Coordinate mental health care services for individuals with mental illness to other transition support services.

b. Describe your state's targeted services to the homeless population.

In an effort to expand community collaboratives into rural areas, Senate Bill 1849, 85th Legislature, Regular Session, 2017, aimed to establish or expand community collaboratives serving two or more counties with a population of less than 100,000. To assist rural providers, HHSC has contracted The University of North Texas to establish a learning community specifically to target rural communities and their community collaborative efforts. The learning community's goal is to help encourage participation in collaborative efforts around housing and homelessness and prepare providers to establish new community collaboratives. Services must be provided to persons experiencing homelessness, substance abuse issues, or mental illness.

c. Describe your state's targeted services to the older adult population.

1. HHSC Adult Mental Health Services has an internal workgroup on behavioral health issues in older adults age 60 and above. The group is assigned to study health care problems faced by elder adults, with a focus on behavioral health including Mental Health and Substance Use Disorder as well as primary care needs. The focus of the workgroup has been to:

a. Reach out to national associations and experts dedicated to behavioral health issues in older adults to seek input and guidance

b. Research available resources and literature to identify curricula, screening, and management protocols based on current evidence-based practices (EBP's) for older adults

c. Develop program for need assessment and gap analysis in provision of healthcare to older adults with emphasis on behavioral health disorders. The work group submitted Behavioral Health in Older Persons Program as an exceptional item. The objective was to implement a pilot study to document behavioral health needs in older adults in collaboration with University of Texas, School of Social Sciences, Aging services and other partners. The program was however discontinued due to competing priorities.

2. Behavioral Health and Aging (BHA) Workgroup in Texas is an ongoing collaboration between HHSC's Aging and Behavioral Health services divisions to promote the behavioral health of older adults by increasing awareness, training and outreach to service providers, professionals, and consumers. One of the desired objective of BHA is to build a coalition partnership between behavioral health, aging and other agencies providing support and services to older adults in Texas. This collaboration will enhance the alignment of services, build capacity, and foster care coordination to help people navigate across all systems of care with a no wrong door philosophy.

3. National Association of State Mental Health Program Director (NASMHPD) Older Persons Division (OPD) Coalition Group. The OPD is a coalition partnership of representatives designated from all the sates with interest in behavioral health and older adults. The coalition is an excellent platform to identify and prioritize behavioral health needs in older adults, share what the sates have done and how to improve service delivery system that respond to the older adults needs. The platform gives an opportunity to share success stories, educational resources, brain storm ideas as what can be done to plug gaps in service provision and encourage states to build a coalition partnership between agencies providing support and services to older adults with goal to improve provision of behavioral health care. The OPD executive committee prepare agenda on yearly basis with input from all the state representatives, prioritize behavioral health needs in older adults, and set targets to be accomplished for the calendar year. The target for 2019 is to encourage states to develop older persons peer support specialist services. Once agenda is approved, OPD coalition group hold monthly call-in meetings to discuss ways and means of accomplishing targets. For this purpose, subject matter experts and champions with interest in behavioral health and older adults from academia and from other states are invited to make presentations on targeting this population via Call-Me Webinar series. These webinars provide opportunity for state representatives to listen to national experts and success stories from other states. OPD is also in process of reaching out to legislatures in Washington DC through NASMHPD to lobby for legislative sponsorship for nationwide peer support specialist in older adults program. Representative from Texas is a Member at Large of the OPD executive committee and regularly participate in following scheduled activities:

a. Monthly 1.5-hour conference call every first Wednesday

b. Monthly 1-hour Meet-Me Call Webinar every third Thursday

c. Monthly 1-hour OPD executive committee conference call last Friday

d. Annual OPD meeting alongside NASMHPD commissioners conference

4. Internal work group at behavioral health services section has reached out in past to following National and Local

Agencies/Coalition Groups for input and guidance:
a. National Coalition on Mental Health and Aging (NCMHA) is a New York-based geriatric mental health alliance comprised of 80 diverse national organizations and New York State to achieve collaboration on Mental Health and Aging services through coalition building;
b. Georgia coalition on older adults and behavioral health works to improve the availability and quality of mental health preventative services, strategies and treatment for older adults in Georgia;
c. Illinois Coalition on Mental Health and Aging (ICMHA) is dedicated to improving Behavioral Health and Support Services for the elderly;
d. Substance Abuse and Mental Health Services Administration (SAMHSA)
e. National Academy of Sciences
f. School of Social Works, University of Texas at Austin (Prof. Namkee Choi)
g. Texas Medical Association (TMA), Texas Medical Foundation (TMF), Texas Association of Community Health Centers (TACHC).

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

The Centralized Training Infrastructure for Evidence Based Practices (CTI-EBP) supports online and in-person trainings and web-based technical assistance free to contractors and through partnerships with other state agencies. Providers from the LMHAs and LBHAs are eligible to sign up on www.centralizedtraining.com to access online trainings and a training calendar that lists upcoming in-person trainings. The login page will recognize approved email addresses.

The CTI-EBP is designed to aid development of a training infrastructure to support the delivery of behavioral health services for adult and youth Texans. It was developed to ensure contracted mental health service providers utilize scientific, evidence-based practices in contract service application. The infrastructure promotes and supports the utilization of evidence-based and promising practices to facilitate the TRR model of behavioral health care. CTI-EBP promotes recovery-based training for all behavioral health providers working with individuals having mental health and/or substance use disorders. E-Commerce is utilized to allow training access with private providers in promotion of evidence-based practices. The University of Texas Health Science Center – San Antonio (UTHSCSA), Department of Psychiatry, is contracted to implement this project.

The CTI-EBP manages all the logistical aspects for delivery of trainings across the state of Texas. In addition to procuring and contracting with proficient and competent trainers in accordance with HHSC requirements, the CTI-EBP tracks participants, offers continuing education units (CEUs) for practitioners, secures training locations, provides evaluation(s) of trainings, and develops a needs assessment to determine the ongoing training needs of the state mental health providers. The CTI-EBP may also serve to augment other identified training needs within the HHSC purview, such as training in the delivery of crisis services, the creation of evidence-based learning communities, supervision and/or coaching in evidence-based and promising practices, and/or the development of on-line trainings.

HHSC currently contracts with a Non-Profit organization to train peer specialists and certify family partners, provide leadership development learning series to peers, recovery coaches, family partners and other individuals in recovery and work with local mental health authorities to support the dissemination of person-centered practices and the value of peer support.

For the implementation and training on the System of Care approach for Child and Adolescent Services, HHSC contracts with the Texas Institute of Excellence in Mental Health (TIEMH) of the University of Texas at Austin. TIEMH provides training, technical assistance, learning communities, evaluation, consultation and experts in Systems of Care development and implementation including cultural and linguistic competency, the development of family and youth voice, cross-systems collaboration, and systems transformation. TIEMH provides supportive infrastructure for the implementation of a comprehensive strategic plan to address state and local policy and practice barriers to System of Care statewide expansion. This includes providing assistance to local communities implementing systems of care. HHSC was awarded a SAMHSA System of Care grant which supports this partnership with TIEMH.

Trainings and infrastructure for suicide prevention, intervention, and postvention coordination is supported by contracts or collaborations with TIEMH, the Texas Suicide Prevention Council, and the National Alliance on Mental Illness (NAMI) Texas. Through its contracts and collaborations, Texas ensures the continuity of trainings on evidence-based practices related to suicide prevention, intervention, postvention, and overall support of HHSC's Zero Suicide in Texas Initiative.

HHSC has developed Behavioral Health Services staff as trainers of Mental Health First Aid (MHFA) and Psychological First Aid to provide training throughout Texas. HHSC's Disaster Behavioral Health Unit supports the coordination of Psychological First Aid trainings. Since 2013, DSHS and HHSC provided training on Mental Health First Aid to behavioral health services providers and educators throughout school districts in Texas per legislative directive (83rd Legislature). Through legislative directives from the 83rd and 84th Legislatures, HHSC funds contracts with LMHAs to develop trainers and provide trainings throughout the state to any school personnel who interacts with children. The 85th Texas Legislature in 2017, expanded the legislation to fund MHFA to fund training for universities and higher education entities. In 2019, the 86th Texas Legislature, further required districts to provide access to MHFA, suicide prevention, and trauma as well as grief-informed trainings to school staff. These trainings are to become a documented part of school staff training record.

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	(•) Yes ( ) No
ii)	Education	(•) Yes ( ) No
iii)	Brief Intervention	(•) Yes ( ) No
iv)	Assessment	(•) Yes ( ) No
v)	Detox (inpatient/social)	(•) Yes ( ) No
vi)	Outpatient	(•) Yes ( ) No
vii)	Intensive Outpatient	( ) Yes (•) No
viii)	Inpatient/Residential	(•) Yes ( ) No
ix)	Aftercare; Recovery support	(•) Yes ( ) No

b) Services for special populations:

Targeted services for veterans?	( ) Yes (•) No
Adolescents?	(•) Yes ( ) No
Other Adults?	( ) Yes (•) No
Medication-Assisted Treatment (MAT)?	(•) Yes ( ) No

Criterion 2: Improving Access and Addressing Primary Prevention -See Narrative 8. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Does your state make prenatal care available to PWWDC receiving services, either directly or through an arrangement with public or private nonprofit entities? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Has your state identified a need for any of the following:

a) Open assessment and intake scheduling (●) Yes ( ) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, and custody issues? (●) Yes ( ) No

g) Providing employment assistance (●) Yes ( ) No

h) Providing transportation to and from services (●) Yes ( ) No

i) Educational assistance (●) Yes ( ) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The State requires contractors that receive block grant funds to give preference to pregnant women admissions to treatment. Contractors are required to use the web-based clinical record – Clinical Management of Behavioral Health Services (CMBHS). Weekly -Daily Capacity, Waitlist and Admission reports are generated from CMBHS to Program Services to assess adherence to federal and state priority populations.
All funded contractors ae required to adhere to currently applicable state federal rules specific to their programs and services. Based on the type of services (prevention, intervention or treatment) contractors are required to protect client and dependent children identifying information. Confidentiality is monitored through several mechanisms, peer review, programmatic review and quality management reviews. In addition, contractors providing treatment services, licensed staff are required to adhere to the guidelines as stated for each licensed type. The HHSC Quality Management unit conducts scheduled desk reviews, onsite reviews and investigations. Actions to address issues may include technical assistance, increased monitoring, reviewing and monitoring contractor progress on subsequent improvement or corrective action plans, sanctions, and contract termination.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

a)	90 percent capacity reporting requirement	(•) Yes ( ) No
b)	14-120 day performance requirement with provision of interim services	(•) Yes ( ) No
c)	Outreach activities	(•) Yes ( ) No
d)	Syringe services programs	( ) Yes (•) No
e)	Monitoring requirements as outlined in the authorizing statute and implementing regulation	(•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Electronic system with alert when 90 percent capacity is reached	(•) Yes ( ) No
b)	Automatic reminder system associated with 14-120 day performance requirement	( ) Yes (•) No
c)	Use of peer recovery supports to maintain contact and support	(•) Yes ( ) No
d)	Service expansion to specific populations (e.g., military families, veterans, adolescents, older adults)?	(•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

In accordance with federal guidelines, the following are prioritized for HHSC block grant funded treatment services:
1. Pregnant injecting,
2. pregnant women, and
3. injecting drug users (IDU)
In addition, Texas added the following priorities:
4. High Risk for Overdose and Individuals involved with Department of Child and
5. Protective Services (DFPS), behind the federal priority populations.
The State monitors treatment contractors waitlist and daily capacity. Contractors include in the Daily Capacity report if there is a priority population individual in need of services. If a contractor is unable to provide immediate admission within their regional network, they are to contact the State's Waitlist Coordinator to ensure admission.
In fiscal year 2020 the state will implement a report to verify priority population of pregnant injecting and pregnant women are entered into services immediately.
If this is not happening, the subject matter expert (SME) will identify responsibility and request and provide:
Technical assistance
Request corrective action plan
Request sanction(s)

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? (•) Yes ( ) No

2. Has your state identified a need for any of the following:

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No
b)	Cooperative agreement/MOU with public health entity for testing and treatment	(•) Yes ( ) No
c)	Established co-located SUD professionals within FQHCs	(•) Yes ( ) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

All funded contractors are required to screen for infectious diseases and to either provide or assist in making available education or treatment for tuberculosis, HIV, or sexually transmitted diseases. For those providing substance use treatment or screening to determine the need for substance use services, these contractors are required to document the type of interim services based on individual need. For those individuals that are placed on waitlist for treatment services, the waitlist report requires contractors to

report if interim services were provided.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently have an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIV in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ○ No

2. Has your state identified a need for any of the following:

a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ○ No

b) Establishment or expansion of tele-health and social media support services ○ Yes ○ No

c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ○ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are NOT expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)(F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Workforce development efforts to expand service access — (•) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (•) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (•) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (•) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (•) Yes ( ) No
- **f)** Explore expansion of services for:
  - **i)** MAT — (•) Yes ( ) No
  - **ii)** Tele-Health — (•) Yes ( ) No
  - **iii)** Social Media Outreach — (•) Yes ( ) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person -centered and person-directed care? — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (•) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (•) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, such as FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (•) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449)? — (•) Yes ( ) No

2. Does your state provide any of the following:

- **a)** Notice to Program Beneficiaries — (•) Yes ( ) No
- **b)** An organized referral system to identify alternative providers? — (•) Yes ( ) No
- **c)** A system to maintain a list of referrals made by religious organizations? — ( ) Yes (•) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (•) Yes ( ) No

2. Has your state identified a need for any of the following:

- **a)** Review and update of screening and assessment instruments — (•) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (•) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (•) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Training staff and community partners on confidentiality requirements — (●) Yes ( ) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — (●) Yes ( ) No

c) Updating written procedures which regulate and control access to records — (●) Yes ( ) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — (●) Yes ( ) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

HHSC estimates that 6 contractors will be reviewed within the biennium.

3. Has your state identified a need for any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — (●) Yes ( ) No

c) Development of long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes ( ) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, such as the Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

While not required, HHSC has stated entities should be accredited by either CARF or the Joint Commission. Several current contractors have heeded the advice and have been accredited or are in the process of obtaining accreditation

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service (●) Yes ( ) No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing (●) Yes ( ) No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state (●) Yes ( ) No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services (●) Yes ( ) No

c) Preformance-based accountability (●) Yes ( ) No

d) Data collection and reporting requirements (●) Yes ( ) No

2. Has your state identified a need for any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs (●) Yes ( ) No

b) Addition of training sessions designed to increase employee understanding of recovery support services (●) Yes ( ) No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services (●) Yes ( ) No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort (●) Yes ( ) No

3. Has your state utilized the Regional Prevention, Treatment and/or Mental Health Training and Technical Assistance Centers (TTCs)?

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

d) State Targeted Response TTC? (●) Yes ( ) No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ( ) Yes (●) No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

b) Early Intervention Services Regarding HIV ( ) Yes (●) No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ( ) Yes (●) No

b) Professional Development ( ) Yes (●) No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations that govern the Mental Health and Substance Use Disorder Programs.

https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=2&ti=25

Chapter 140- Health Professional Regulation - Subchapter I- Licensed Chemical Dependency Counselors
Chapter 441- General Provisions
Chapter 442- Investigations and Hearings
Chapter 447- Department-Funded Substance Use Abuse Programs
Chapter 448 – Standard of Care

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2018-FFY 2019? ○ Yes ○ No

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

12. Trauma - Requested

Narrative Question

Trauma [57] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective M/SUD service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated M/SUD problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with. These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive M/SUD care. States should work with these communities to identify interventions that best meet the needs of these residents.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing ?business as usual.? These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[58] paper.

57 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
58 *Ibid*

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a plan or policy for M/SUD providers that guide how they will address individuals with trauma-related issues? (●) Yes ( ) No

2. Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers? (●) Yes ( ) No

3. Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care? (●) Yes ( ) No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight.

• The Behavioral Health Services (BHS) system for delivering services has policies in place requiring the provision of trauma-focused evidence-based practices when the initial assessment identifies trauma history. In community mental health services, the uniform assessment includes a trauma screening for children and adults, using the Child and Adolescent Needs and Strengths (CANS) assessment and the Adult Needs and Strengths Assessment (ANSA). Thus, every individual entering services is screened for trauma exposure. Depending on the need, the appropriate treatment or skills training protocol is provided. Acceptable protocols include: Trauma-Focused Cognitive Behavioral Therapy, Seeking Safety, Nurturing Parenting, or Cognitive Processing Therapy. Some Local Mental Health Authorities may have additional funding to provide treatments such as: Attachment, Self-Regulation and

Competency (ARC) or Trauma, Affect Regulation, Guided Education and Therapy (TARGET).

• All Rural Border Intervention, HIV Early Intervention, HIV Outreach and HIV Residential Treatment programs are encouraged to be trained in trauma-informed care. The annual HIV and Substance Abuse Conference provides opportunities to learn from national experts and obtain additional training on trauma and its impact on high-risk populations. The conference includes at least two presentations specific to trauma and all presenters are asked to address trauma within their sessions. Similarly, all training curriculum and presentations conducted through HHSC's subcontracted trainers contain information about the connection between trauma, high risk sexual behaviors and drug use.

• Crisis services staff are required to have training in trauma informed care. As part of the ongoing suicide safer care practices for LMHAs, based initially on the Zero Suicide framework, LMHAs had the opportunity to have staff trained in Cognitive Behavioral Therapy for Suicide Prevention (CBT-SP), Collaborative Assessment and Management of Suicidality (CAMS), Safety Planning Intervention (SPI), and the Columbia-Suicide Severity Rating Scale (C-SSRS). There is an intersection with CBT for Trauma and CBT-SP when practitioners applying CBT for Trauma employ skills to treat suicidality directly (as learned in CBT-SP) if and when suicidality would arise in a trauma informed care approach. LMHAs reported utilizing both trauma informed and suicide safer care approaches to improve overall client safety and systems integration

• In January 2019 Texas has taken on a new Trauma-informed Care Transformation initiative, the mission of which is to develop a coordinated statewide approach for building a person-centered, trauma-informed behavioral health system and providing quality supports, services, and care to Texans. The trauma transformation initiative includes a cross-agency workgroup whose focus is on building and strengthening a coordinated trauma-informed behavioral health system across Texas. Parallel to the cross-systems effort, HHSC has established a Trauma Transformation Workgroup to focus on internal policies and organizational framework. The objective is to build trauma-informed culture through awareness of trauma and it's impacts not only on clients and services, but on the broader organization, agency environments, and with a focus on staff wellness. Over the past few years Texas has made significant investments in building awareness about trauma-informed care (TIC) and implementing TIC practices.

• In addition, HHSC developed 2 different web-based training modules, Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities (MHWIDD), to address the needs of trauma-exposed individuals with comorbid mental health and IDD. The modules provide information about trauma, trauma- informed care, and tools for participants who work with individuals with IDD. One module is directed at direct services workers and the other, health care professionals. The trainings are free and available on www.mhwidd.com. Staff at intermediate care facilities for individuals with an intellectual disorder or related conditions (ICFs/IDD), including state supported living centers (SSLCs), are required to take this training before working with individuals with IDD. Over the past few years Texas has made significant investments in building awareness about trauma-informed care (TIC) and implementing TIC practices. HHSC has brought Karyn Harvey down on multiple occasions to provide TOT trainings across the state on trauma informed care for individuals with IDD. In 2018, HHSC partnered with SAFE Alliance, a non-profit organization whose mission is to stop abuse for everyone by serving the survivors of child abuse, sexual assault, trafficking, and domestic violence, to provide Road to Recovery trainings around the State. Finally, Texas' 13 State Supported Living Centers have all adopted Ukeru, which is a trauma-informed restraint-free crisis management technique based in the concepts of comfort vs. control.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

13. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[59]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[60]
A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or the Health Insurance Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[59] Journal of Research in Crime and Delinquency: : *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.*Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Ren?e L. Binder. **OJJDP Model Programs Guide**

[60] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to M/SUD services? (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, M/SUD provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? (●) Yes ( ) No

3. Does the state provide cross-trainings for M/SUD providers and criminal/juvenile justice personnel to increase capacity for working with individuals with M/SUD issues involved in the justice system? ( ) Yes (●) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

• Mental health services for adults and juveniles involved with the criminal justice system are provided statewide using the Texas Resiliency and Recovery (TRR) model. Local Mental/Behavioral Health Authorities in populated regions have contracts with the Texas Correctional Office on Offenders with Mental and Medical Impairment (TCOOMMI), which connect juvenile and adult offenders with special needs to a full array of psychiatric, medical services, and behavioral health services upon release and while on probation or parole and provides staff to support other re-entry initiatives. Additionally, TCOOMMI, in partnership with Texas Juvenile Justice Department (TJJD), collaborate on the Special Needs Diversionary Program (SNDP). TCOOMMI Juvenile and SNDP program collaboration focuses on reducing recidivism through coordinating and providing comprehensive mental health treatment and specialized supervision.

• Larger urban areas have Outpatient Competency Restoration (OCR) programs for individuals who have been found incompetent to stand trial (IST). In addition to OCR, legislation has passed allowing the establishment of a Jail-Based Competency Restoration pilot program and 'Jail-Based Competency Restoration Programs through Counties' which are allowed to provide mental health, co-occurring psychiatric and substance use treatment services, and legal education for these individuals. In the state's most

populous county, HHS launched a Jail Diversion Pilot Program in which the framework for treatment is guided by principles of Critical Time Intervention.

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

• Other initiatives related to the Criminal Justice system include coordination with specialized courts throughout the state. HHS provides technical assistance related to policy and assist with the development of specialized drug, mental health, and veteran courts. In addition to the ongoing efforts of numerous local mental health authorities (LMHAs), 12 counties receive specific funding to provide mental health deputy training and staff to divert individuals with a mental illness from the criminal justice system.

• The Texas law enforcement telecommunications system was established during the 80th Texas Legislative Session. This tracking system matches an individual booked into any county jail against the HHS Clinical Management for Behavioral Health Services System. If a partial or exact match is yielded, the jail receives a report with that individual's name and location of the last LMHA or local behavioral health authority (LBHA) in which a service was provided. The jail staff contacts the LMHA or LBHA to conduct a screening and provide linkage to mental health services provided in the community via the LMHA or LBHA.

• HHS contracts with LMHAs and LBHAs throughout the state to engage in jail diversion activities, as well as, activities to enhance continuity of care for incarcerated adults and youth with a mental illness. The Sequential Intercept Model is used as a conceptual framework for points to intervene and facilitate TRR services for individuals involved in the criminal justice system. HHS collaborates with TDCJ and the Texas Department of Public Safety-Bureau of Identification and Records to exchange real time data for individuals with a current or past history of state mental health care who are arrested and booked in to county jails.

• Through State Psychiatric Hospitals, HHS directly provides inpatient services for forensic patients on competency restoration and Not Guilty by Reason of Insanity commitments. LMHAs, LBHAs, and service providers link individuals with TRR services in the appropriate levels of care. In addition, they may receive transportation to the court, probation or parole office. These services frequently place special emphasis on readiness for court, understanding rules of probation, parole, or outpatient commitment, and prevention of recidivism.

• The State convened an advisory panel to make recommendations, monitor, and develop the implementation of updates to inpatient bed day allocation methodology for a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil, and forensic patients along with bed day utilization review protocol including a peer review process. HHS established a forensic work group made up of experts and stakeholders to make recommendations for a comprehensive plan for the coordination of forensic services.

Please indicate areas of technical assistance needed related to this section.

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14. Medication Assisted Treatment - Requested (SABG only)

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate.

SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? (●) Yes ( ) No

- **a)** ☐ Methadone
- **b)** ☐ Buprenophine, Buprenorphine/naloxone
- **c)** ☐ Disulfiram
- **d)** ☐ Acamprosate
- **e)** ☑ Naltrexone (oral, IM)
- **f)** ☐ Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

The SABG funds currently provide a percentage of the MAT services provided across the state. The Texas Targeted Opioid Response grant has coordinated with the SABG funded MAT services and in FY2021 the TTOR unit will manage all MAT services to provide a single voice and coordinated effort across the state.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

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15. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from M/SUD crises. SAMHSA has recently released a publication, Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies that states may find helpful.[61] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with M/SUD conditions and their families. According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[62],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response.

[61] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[62] Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please check those that are used in your state:

1. Crisis Prevention and Early Intervention

- **a)** ☐ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☐ Psychiatric Advance Directives
- **c)** ☐ Family Engagement
- **d)** ☐ Safety Planning
- **e)** ☐ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☐ Peer Support/Peer Bridgers
- **b)** ☑ Follow-up Outreach and Support
- **c)** ☑ Family-to-Family Engagement
- **d)** ☐ Connection to care coordination and follow-up clinical care for individuals in crisis
- **e)** ☑ Follow-up crisis engagement with families and involved community members

f) ☐ Recovery community coaches/peer recovery coaches

g) ☐ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

The Texas Health and Human Services Commission (HHSC) serves individuals experiencing a mental health crisis on a continuum of care based on assessment and need in the least restrictive environment located within their community. HHSC offers Crisis Stabilization Units, Extended Observation Units (EOUs), and Rapid Crisis Stabilization Beds as alternatives to inpatient hospitalization. Crisis Stabilization services provide short-term, residential treatment to reduce acute symptoms of mental illness. Although less intensive than psychiatric hospitalization, the service is considered one of the most intensive facility-based crisis options. EOUs provide emergency services for up to 48 hours to individuals in a mental health crisis. Services are provided in a secure, clinically staffed, and supervised environment with immediate access to urgent or emergent medical and psychiatric evaluation and treatment. Individuals seeking treatment in an EOU may pose a moderate- to high-risk of harm to self or others. Rapid Crisis Stabilization Beds provide brief stays in licensed psychiatric hospitals to relieve acute mental health symptoms to restore an individual's ability to function in a less restrictive setting.

Please indicate areas of technical assistance needed related to this section.

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16. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life to the greatest extent possible, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system? (●) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (●) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Through consumer-informed, evidence-based and research driven development and implementation of policy and programs the state strives to support a variety of recovery-based services. The Texas Health and Human Services Commission (HHSC) is dedicated to the ongoing implementation of Person-Centered Recovery Planning as the foundation for providing recovery support services. Recovery support services may include:

- Evidence-based treatment options such as Cognitive Behavioral Therapy, Seeking Safety, Nurturing Parenting, Cognitive Processing Therapy, and Parent-Child Interaction Therapy
- Certified Mental Health Peer Specialist Services
- Certified Family Partners services
- Certified Recovery Support Specialists
- Appropriate referral and community options such as access to consumer operated service organizations

The state supports the use of person-centered recovery planning, self-direction, and participant-directed care through a number of initiatives. Person-Centered Recovery Planning is a fundamental component to the Texas Recovery and Resiliency (TRR) service delivery system. It is through placing an individual in the driver's seat of their recovery that strengths and natural supports are identified to support recovery. Formal supports such as evidence-based practices in treatment, housing, and employment offer the professional assistance a person may require to become or remain independent.

Peer support, family partners and recovery support coaching are available to individuals and their families to provide support from the perspective of someone who has been in a similar situation who can help guide the individual and their family towards their recovery goals. All peer services are recovery-oriented, person-centered, relationship-focused and trauma-informed. Peer driven activities may include: recovery and wellness support, which includes providing information on and support with planning for recovery; mentoring (serving as a recovery role model); assistance in finding needed community resources and services; advocacy, which includes providing support in stressful or urgent situation; making sure the individuals rights are respected; and many other daily activities that are sometimes complicated when an individual is also experiencing severe mental illness or several emotional disturbances. Consumer operated service providers represent a critical piece of the recovery supports continuum as described below.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

The substance use disorder (SUD) delivery system identifies that treatment and recovery supports must be intertwined within an integrate whole-system transformation designed to address the needs of the whole person. The 28 Recovery Oriented Systems of Care (ROSC) communities across Texas are connected through a consistent framework for coordinating multiple systems, services, and supports designed for adaptation to the individual's needs and chosen pathway of recovery.

Texas has developed multiple avenues to develop a recovery network that assists in identifying recovery strengths and gaps statewide. A statewide stakeholder group called the Texas Recovery Initiative (TRI) was developed in 2007 and continues to be a strong advocacy group to the state. The TRI includes members from criminal justice, community and faith-based service organizations and any other community organization with a focus to expand recovery support services statewide. In FY20-21 the focus of the TRI will be on the integration of SUD, MH and public health services.

HHSC supports a statewide recovery rally every September. HHSC helps with transportation costs, which allow individuals statewide to travel to the rally. The rally is in a different location each year allowing a new community to showcase their recovery efforts. In FY20 Houston, Texas will be the host of the National recovery rally.

The state has developed more than 25 recovery communities since 2011. These communities were developed through town hall meetings led by HHSC to expand services in their area. Most of these communities participate in the TRI meetings and workgroups. In FY20-21 HHSC plans to expand existing services to ensure public health is included.

HHSC expanded recovery services through a 4.4M procurement that funded 22 Recovery Support Services (RSS) projects in 2014. Recovery Support Services (RSS) includes a wide array of non-clinical services and supports to help individuals initiate, support, and maintain recovery from alcohol and other drug use problems. One of the key elements of RSS is the utilization of peer recovery coaches. HHSC will be re-procuring recovery support services to begin fiscal year 2021. The goals of the procurement will be to embed long-term recovery support services into community-based organizations and substance use disorder treatment programs in local communities across Texas and expand recovery supports that are available to individuals in their community environments. Prior to the procurement awards, recovery trainings will be provided to include: Trauma 101 for Recovery Coaches, Storytelling, and how to align treatment with a recovery management approach.

Finally, Texas implemented and developed a youth recovery project referred to as Youth Recovery Communities (YRC) Centers which resemble the RSS for adults. These programs assist youth transitioning from treatment back into the community with services supporting their recovery through a number of activities such as peer groups, sober activities, social activities in the community and a commitment to involve themselves with major community projects.

5. Does the state have any activities that it would like to highlight?

• The state supports a variety of approaches to peer-led recovery through seven consumer/peer led organizations (COSPs). The COSPs have benefited greatly through the fiscal year 2019 expansion funds. Prior to the expansion funding, the COSPs were flat funded for 8 years at below $400,000. The new funding has allowed for expansion in programming, additional staff and updated IT infrastructure desperately needed for employment searches, resume development and online classes. COSPs are a critical component to augment regional recovery.
• There are five Clubhouse organizations heavily focusing on job readiness and job procurement. In addition, there are another four clubhouses in the startup process in Texas that HHSC will support through an upcoming procurement based on expansion funding. This will broaden the reach of the International Clubhouse (IC) recovery model to rural portions of the state. Clubhouses, according to IC standard must build relationships with local employers, Non-Profit service organizations and the local mental health authority (LMHA), so they have a strong community footprint.
• HHSC currently contracts with a Non-Profit organization to train peer specialists and certify family partners, provide leadership development learning series to peers, recovery coaches, family partners and other individuals in recovery and work with local mental health authorities to support the dissemination of person-centered practices and the value of peer support. This contract will go for procurement, as required in Fiscal year 2021. The state will remain supportive of the recovery-based values and activities provided by this organization but may restructure the procurement to reflect the evolution in peer services and support in the last two years spurred by H.B. 1486, 85th Legislature (Regular Session).
• The state has supported data collection regarding the impact and the employment environment of peer workers annually since 2011 through The Texas Institute for Excellence in Mental Health (TIEMH), a part of the University of Texas Center for Social Work Research. TIEMH research work represents a significant contribution to the national peer research landscape. The Institute's annual compendium of peer certification programs across the nation has been widely received. As peer work becomes more integrated into the private sector and federally qualified health centers, it is vital that this research continue.

• H.B. 1486 mentioned above, requires expansion and continued integration of the role of certified peer specialists practicing in mental health and substance use in terms of service provision under Medicaid. The legislation requires HHSC to create rules regarding the definition of peer providers, eligibility criteria, scope of practice, training and certification criteria and an expansion of vendors approved the State to provide training and certification for certified peer specialists. The rules also allowed for the creation of a peer specialist supervisory role, formally introducing a career ladder for peer workers for the first time. The bill does not make peer workers providers, but rather pays a new benefit defined as "Peer Services" for individual and group support.

• Through collaboration with the University of Texas Addiction Research Institute, HHSC conducted an evaluation of the RSS project between May 2014 and August 2016 to primarily determine the benefit and value of recovery support services and the use of peer recovery coaches to the Texas service delivery system. A major benefit resulting from the evaluation was the reduction in estimated healthcare cost reported by participants one month prior to enrollment. Estimated healthcare costs dropped from $4,384,325 across all service categories to $1,284,397 at the three-month check-up resulting in an estimated reduction of $3,099,928.

• HHSC received a request from the National Association of State Alcohol and Drug Abuse Directors to participate in a State Agency Recovery Model case study by providing a summary description of Texas' recovery model with the intent of sharing what has been learned with other states.

• As HHSC worked to transform SUD organizations from an acute care model to a recovery management model it documented and developed Promising Practices. Through careful and thoughtful documentation HHSC identified the following as promising practices:
1) use focus groups to enhance and increase services,
2) to minimize role confusion ensure that staff monitoring and coaching roles are distinct and organizational structure support role delineation
3) use a strategic approach to assertive outreach and engagement based on the target population
4) develop a peer advisory council composed of service participants
5) promote a peer culture and leadership
6) create a sense of belonging and purpose
7) shift the locus of services from the agency to community context
8) invest sufficient time in training clinical staff about recovery services for a positive outcome in the integration of peer support services.

• HHSC has developed a data tracking system for participants who receive long-term recovery coaching. The data collection system will be fully functional in FY20-FY21. An enrollment form is filled out when a participant is first assigned a recovery coach and a unique ID number is automatically assigned to the participant. The participant completes an assessment of recovery capital scale that measures the participant's recovery capital. This is filled out at enrollment and can be reviewed every 3 months. The subscales are: substance use & sobriety, global health (psychological), global health (physical), citizenship / community involvement, social

support, meaningful activities, housing & safety, risk taking, coping & life functioning and their recovery experience. Through this evaluation process HHSC is able to measure a participant's quality of life.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

Please respond to the following items

1. Does the state's Olmstead plan include :

- Housing services provided. ○ Yes ○ No
- Home and community based services. ○ Yes ○ No
- Peer support services. ○ Yes ○ No
- Employment services. ○ Yes ○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Please indicate areas of technical assistance needed related to this section.

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18. Children and Adolescents M/SUD Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[63]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[64]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death.[65].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[66]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[67].

According to data from the 2015 Report to Congress[68] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

[63]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[64]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[65]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[66]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[67]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[68] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The public community mental health service delivery system, Texas Resilience and Recovery (TRR), provides integrated services within the system of care. The TRR system has a comprehensive service array based on the assessed intensity of needs of the child/adolescent and his/her family. During the Intake/Assessment of children and youth entering TRR services, each child or youth is assessed with the Child and Adolescent Needs and Strengths (CANS) assessment, which includes the history of trauma exposure, juvenile justice involvement involved, behavioral and emotional needs, caregivers' needs and strengths, child's needs and strengths, medical history, school functioning, involvement with child protective services as well as other risks or multi-system involvement history to better identify the needs of the child and the child-serving systems that impact the child and the family. The system of care philosophy, including the values and principles, guides the model of care which is family-driven, youth-guided, culturally and linguistically competent, and-community based, and considers the child and family's strengths and natural supports, as well as their needs and challenges. This model takes into consideration the involvement of the child in multiple child-serving systems and coordinates care along a continuum of need and intensity of services from stability to risk of out-of-home placement.

Community mental health providers coordinate care with other child-serving systems as a part of case management services and within the wraparound planning process. Furthermore, community mental health providers collaborate with child-serving systems such as juvenile justice, community resource coordination groups, education, child welfare, and primary care among others. The

following are specific collaborations and initiatives of community mental health services which includes Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs) within a system of care model:

• The Texas Law Enforcement Telecommunications System (TLETS) is a data system that allows local jails to identify whether or not newly incarcerated children and adolescents have a history of treatment at an LMHA/ LBHA. If there is a history, the jail contacts the LMHA/LBHA to ensure individuals are provided with any psychotropic medications that are prescribed, as well as to allow staff from the LMHA/ LBHA to provide services during the time the individual is incarcerated. The TLETS system is used in some outcome measures for community mental health services.

• Community Resource Coordination Groups (CRCGs) are available in 235 of the 254 counties in Texas. CRCGs provide interagency/interdisciplinary staffings to coordinate services for children, families, and adults needing multiagency services. CRCG membership consists of representatives from all relevant state agencies (Texas Education Agency, Texas Juvenile Justice Department, Health and Human Services Commission [LMHA/ LBHA], Department of State Health Services, Department of Family and Protective Services, Texas Correctional Office on Offenders with Medical or Mental Impairments, Texas Department of Criminal Justice, Texas Department of Housing and Community Affairs, and the Texas Workforce Commission.) When an individual is referred for a CRCG staffing, this standing group meets and invites any additional relevant people (local school district personnel, the family, mentors, therapists, substance use disorder providers, or other supportive community members, etc.). The case is discussed at length and an individualized service plan is developed to address the needs of the individual and the family. The referring agency coordinates the selected multiagency services, assesses with the child, family, or adult to determine whether the services are effective, and determines with the individual and family if adjustments in the service plan are needed.

• Each LMHA/ LBHA and each state hospital (including the Waco Center for Youth residential treatment center for adolescents) has an identified Continuity of Care Officer to ensure that individuals transition between community and inpatient services as seamlessly as possible.

• Many LMHAs provide Co-Occurring Psychiatric and Substance Use Disorder (COPSD) treatment programs for individuals with both mental health and substance use treatment needs. Furthermore, the TRR service array in all LMHAs incorporates screening for substance use in its uniform assessment, and evidence-based practices to treat substance use and the impact of trauma in youth. The uniform assessment also incorporates the Screening, Brief Intervention and Referral to Treatment (SBIRT) as part of the initial services all children and adolescents receive. All children and adolescents are screened for the need of early intervention or a referral for substance use treatment. Depending on the findings, children and adolescents may receive prevention or early intervention services, or be recommended substance use treatment services. In the case where the child or adolescent is found to have only a substance use disorder, the child or adolescent is referred to substance use treatment center inside the LMHA/LBHA (if the service is available) or outside the LMHA/LBHA to a community partner organization.

• The Health and Human Services Commission (HHSC) and the Department of Family and Protective Services (DFPS) collaborate on the Residential Treatment Center (RTC) Parental Relinquishment Prevention Project Initiative. This project, with a current RTC bed capacity of 50 and funded by the state legislature, allows DFPS to refer children and adolescents with a serious emotional disturbance to HHSC who are at risk for parental relinquishment of custody to DFPS to solely obtain RTC services. HHSC then coordinates RTC admission and funds room and board for children and adolescents meeting clinical need for RTC services. The family maintains full custody and is highly involved in treatment, including weekly family therapy. Eligible families will have a completed DFPS investigation that resulted in no findings of abuse or neglect. The child must not have been adopted in the state of Texas as post-adoption services are available to those families. The typical length of stay in an RTC for children and adolescents served through this project is six to nine months.

• HHSC staff worked with DFPS Child Protective Services (CPS) staff to develop a new version of the Texas CANS that can be used across child-serving systems (child protective services and community mental health services). DFPS started implementing the Texas CANS 2.0 version that was developed on September 1, 2016. HHSC plans to start implementing the new Texas CANS 2.0 version. Currently, 30 percent of all LMHAs are implementing both CANS versions as they are serving children in foster care services, as well as children in mental health services. The expansion of the Texas CANS from community mental health services to child protective services has allowed for better cross-agency collaboration with DFPS and HHSC, and at the community level for LMHA/ LBHA providers and CPS providers to better coordinate and provide services to children in both child-serving systems.

The 85th Texas Legislature, Regular Session, 2017 reinstated the system of care framework and initiative in statute. In addition, in May 2017 HHSC was awarded SAMHSA funding for the system of care cooperative agreement, Sustaining a Texas System of Care, which is a statewide initiative to improve behavioral health outcomes for children and adolescents with serious emotional disturbances and their families by expanding utilization of high-fidelity wraparound to engage children and adolescents in the juvenile justice system, child welfare, and residential treatment center placement. The initiative is also developing youth peer support services, expanding family partner services to young adults 18 through 20 years old, expanding the use of Building Bridges Initiative best practices in additional Texas RTCs, and providing outreach and education about early onset psychosis to child-serving agencies, including schools. For service provision, the Texas System of Care is partnering with and expanding the system of care to 12 counties in east Texas, served by one LMHA, and to Collin County, served by another LMHA and the seventh-most populous county in Texas. In addition, the Texas System of Care will be expanding to two additional communities in federal fiscal year 2020. In April 2018, six state agencies entered into a Memorandum of Understanding to support the implementation of

a comprehensive plan to deliver mental health services and support to children, youth, young adults, and their families using a system of care framework.

7. Does the state have any activities related to this section that you would like to highlight?

The 86th Texas Legislature, Regular Session2019 expanded the HHSC/DFPS Parental Relinquishment Prevention Project Initiative, which provides RTC services to children and adolescents with a serious emotional disturbance who are at risk for parental relinquishment of custody to DFPS due solely to a need for RTC services. As a result of this legislation, capacity for this program has expanded from 40 to 50 beds.

Additionally, to ensure that culturally and linguistically competent services are provided to children, adolescents, and families receiving services at the LMHAs/ LBHAs, in 2017 the Texas System of Care reviewed HHSC's contract with the LMHAs for compliance with the Culturally and Linguistically Appropriate Services Standards and issued recommendations that are under review by the Behavioral Health Services Cultural and Linguistic Competency Workgroup.

Please indicate areas of technical assistance needed related to this section.

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Footnotes:

Environmental Factors and Plan

19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

In an ongoing effort to build on National Strategy for Suicide Prevention (NSSP) recommendations, the state goals were aligned with the NSSP goals and strategic direction. These goals were then further broken out into strategies to serve as a "road map" for stakeholders, suicide prevention workers, mental health, education, military, veteran groups, agencies serving people with mental illness, behavioral health agencies, counselors, media, higher education, and local suicide prevention coalitions across the state with links to resources and specific strategies to accomplish the goals. The areas of strategic direction include: 1) Healthy and Empowered Individuals, Families, and Communities; 2) Clinical and Community Preventive Services; 3) Treatment and Support Services; and 4) Surveillance, Research, and Evaluation. This strategic direction translated into the following activities intended to reduce the incidents of suicide in Texas:

Healthy and Empowered Individuals, Families, and Communities

• The Suicide Care Initiative (SCI) created three distinct projects to improve and expand on the suicide safer care practices occurring throughout all the local mental health authorities (LMHAs) across the state. Three of the LMHAs were chosen to oversee the development, implementation and evaluation of all three projects, and one LMHA was chosen to oversee two of the projects. Together, they have been identified as Regional Suicide Care Support Centers (RSCSCs). The first project focuses on the RSCSCs serving as regional suicide care workforce development and technical assistance (TA) hubs for the LMHAs in their specified region by providing evidence-based suicide specific instructor trainings as well as TA via webinars and learning collaborative conference calls to support the continued implementation of the Zero Suicide initiative. The second project focuses on the improvement and enhancement of the Zero Suicide framework and its practices within the four RSCSCs. The third project focuses on the enhancement and increase of hotline services at three of the RSCSCs to answer calls from within the state for the National Suicide Prevention Hotline. A baseline for their call rate was set and strategies to improve sustainable outcomes and quality improvement were created.

• In addition to providing critical support to empower and sustain healthy communities through the aforementioned efforts, HHSC provides consultation and support to local suicide prevention coalitions and educational service centers across the state, as well as development, coordination and participation in several suicide prevention-specific initiatives for service members, veterans, and their families (SMVF). There are collaborative efforts with SAMHSA, the Department of Defense, and the Veterans Administration, along with HHSC as the lead in mental health and suicide prevention programs at the Mayoral and Governor's Challenges to end Veterans Suicide, as well as all of the workgroups springing from these initiatives. There is further collaboration around implementation of Texas legislation that supports a plan for suicide prevention in the SMVF population. Ongoing coordination of local suicide prevention coordinators/programs and suicide coalitions with faith groups and peer groups as protective factors is another priority and service coordinated through HHSC.

Clinical and Community Preventive Services

• HHSC worked with the Governor and his office in the Governor's Challenge to Prevent Suicide among SMVF to develop and implement the National Strategy for Preventing Veteran Suicide. Additionally, HHSC has been instrumental in the Mayor's Challenge to Prevent Suicide among SMVF occurring in Austin and Houston, Texas.

• The Suicide Safer Schools project has created a state-of-the-art toolkit for Texas Schools (K-12) applying the best practices for suicide prevention while integrating Texas laws and resources. Early data shows excellent results and improvements for student and school safety.

• HHSC worked with the SAMHSA Best Practices in Suicide Prevention Policy Academy to create a plan with the National Guard, Veterans Administration, SAMHSA Regional Administrator, Veterans Affairs Office, state Suicide Prevention Coordinator to support behavioral health of Veterans Service Members and their family's needs in Texas.

• HHSC is working to ensure Military Veteran Peer Specialists are connected with the Zero Suicide Teams at LMHAs and coordinating with the Military Veterans Peer Network (MVPN) to provide suicide prevention trainings for all Military Veterans Peer

Specialists.
• HHSC will continue to engage with the community stakeholder groups to provide suicide prevention evidence-based trainings and information for the Texas Veterans and Families Alliance programs that support veterans and their families in Texas.
• The Texas Targeted Opioid Response (TTOR) program (funded by other SAMHSA grants) enables HHSC to expand prevention and treatment efforts that promote recovery and early intervention for populations identified as high risk for opioid use disorders (OUD). A critical issue among persons with OUD is the high correlation between OUD and suicide. The goal of this contract is to train OUD treatment providers and recovery support staff in suicide prevention training such as ASK and ASIST.
• The HHSC suicide prevention team collaborated with the HHSC Disaster Behavioral Health Services implementation administrators after they were awarded the SAMHSA SERG grant to support Hurricane Harvey affected areas through the provision of suicide prevention training and the establishment of LOSS teams to enhance healing and recovery for families and communities in postvention services past suicide and mass disasters (both natural and man-made acts of mass violence) that Texas suffered in 2018.
• HHSC also worked with the Texas Education Agency (TEA) after being awarded SAMHSA's AWARE grant to develop and enhance the utilization of best practices that effectively address mental health challenges in schools.
• HHSC's suicide prevention team is part of the Board of Directors for the Texas School Safety Center, responsible for all school safety prevention efforts. Coordinated efforts for suicide prevention, bullying prevention, first responders, school policy and more are coordinated with trainings, products and services impacting all youth-serving providers engaging in violence prevention with school-aged youth.

Surveillance, Research, and Evaluation
• Part of the suicide prevention efforts include collaboration and the use of data gathered by the newly established Injury Prevention Department at the Texas Department of State Health Services shows trends and patterns in youth violent deaths and identify communities to target for additional education and prevention efforts. HHSC uses the Youth Risk Behavior Surveillance reported data to investigate other risky youth behaviors that impact injury data for self-harm, such as overdose and motor vehicle accidents. Overall, the data shows a need for the collaboration of professionals working in prevention, intervention, epidemiology, research, data analysis, and program development towards the advancement of violence prevention.
• In addition to this data, HHSC engages with the Child Fatality Review Teams (CFRTs) in order to provide education and training CFRTs about suicide prevention and postvention services available through the LMHAs.
• Surveillance efforts are critical to understanding the challenges and resources communities may have. Surveillance in Texas has included tracking real-time death data in communities with medical examiners, tracking youth suicide attempt data using the Texas Youth Risk Behavior Survey Data, and tracking adult suicide attempt and morbidity data using the Behavior Risk Factor Surveillance Survey. In addition, Texas has begun tracking the number of people dying by suicide within the public mental health system and cross-walking that data with Texas Vital Statistics Data to examine prevalence of people dying in the public mental health system by suicide deaths.
• Texas DSHS was just awarded the National Violent Dealth Registry grant from the Centers for Disease Control (CDC) in 2018 and has begun infrastructure building. HHSC's suicide prevention team is collaborating with DSHS.
• The HHSC Suicide Prevention team participated in focus group and workgroup with the CDC to advance the understanding of the states by conducting an environmental scan of suicide prevention in state activities. Texas' experience and HHSC's implementation of suicide prevention was useful in the study for the year, culminating in a joint presentation for a conference.

3. Have you incorporated any strategies supportive of Zero Suicide? Yes No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? Yes No

5. Have you begun any targeted or statewide initiatives since the FFY 2018-FFY 2019 plan was submitted? Yes No

If so, please describe the population targeted.

These efforts, while statewide and community-based in approach, are also targeted in the following manner:
• Suicide Care Initiative (SCI) focuses on enhancing suicide safer care policies and practices in the LMHAs to more appropriately serve and provide effective pathways to care for children and adults experiencing a suicidal crisis.
• Postvention education addresses capacity building for staff at LMHAs.
• Training of trainers initiative for suicide prevention best practice trainings are provided to LMHAs and schools
• Connecting trauma informed care and suicide care by engaging LMHAs in Zero Suicide
• Suicide prevention trainings (ASK & ASIST) will be provided to OUD treatment providers and recovery support staff.
• Veteran service members and their families are a specific population of focus among suicide prevention initiatives.

Please indicate areas of technical assistance needed related to this section.

N/A

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Footnotes:

Environmental Factors and Plan

20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in M/SUD needs and/or impact persons with M/SUD conditions and their families and caregivers, providers of M/SUD services, and the state's ability to provide M/SUD services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in M/SUD.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Children's Mental Health
New partnerships have been developed with various entities regarding the training, intervention, and prevention of suicide. These new partnerships include:

• Emergency Rooms/Community Hospitals – Coordination of community hospitals with local and state entities to insure delivery and screening for suicide prevention/trauma informed care/substance abuse prevention and treatment services.
• Coroners/Medical Examiners – training and conversations regarding the ICD-10 coding regarding deaths related to suicide/drug overdose/self-inflicted injury.
• Police Officers and Emergency Responders – working to provide training and use of evidence base screening tools and interventions for suicide prevention and substance use for youth and families. Training partnerships between local mental health authorities, HHSC and law enforcement agencies on Mental Health First Aid for law enforcement.
• Pharmacies – coordination with several state agencies to increase awareness/education/interventions for drug use and suicide services.
• Schools- Coordination with LMHAs and school entities to enhance youth suicide prevention and intervention training and best practices. Additionally, coordination with state agencies working with schools and school personnel to ensure children's mental health and suicide prevention practices are woven into school-based mental health programs and prevention services.

The state education agency (SEA) and State Mental Health Agency collaborate in several areas to address improving the mental health of school-aged children. SEA and HHSC:
- Annually develop a list of best practices in school-mental health for educators;

- Developed a statewide mental health resource document for schools;
- Partnered to develop a toolkit for educators on how to implement a comprehensive school-mental health system.

Further, the SEA and State Mental Health Agency are working together on a grant to support schools in implementing a comprehensive mental health system, including providing training on social emotional learning, trauma-informed care, suicide prevention, and mental health first aid. This is done in collaboration with the regional educational service centers and LMHAs.

Veterans
The Texas Veterans + Family Alliance grant program seeks to improve the quality of life of Texas Veterans and their families by supporting local communities across the state to expand the availability of, increase access to, and enhance the delivery of mental health treatment and services. Grant awards are made to community collaboratives to fund implementation of new or improved systems which coordinate and deliver mental health services; supportive services essential to the provision of mental health services; and development of and/or support for community collaboratives with the goal of self-sustainment by the end of the grant period.

The Mental Health Program for Veterans (MHPV) is jointly administered by the HHSC and the Texas Veterans Commission (TVC). Through the MHPV, peer-to-peer counseling services are provided to service members, veterans and their families through local mental health authorities and local behavioral health authorities across the state. HHSC contracts with 37 local mental health and behavioral health authorities to hire or contract for Peer Service Coordinators who provide direct peer-to-peer services to engage veterans and family members who have experienced military trauma, are at risk of isolation from support services and don't seek services through traditional channels.

HHSC contracts with Texas A&M University Health Science Center to provide online information and resources through the TexVet program and TVC to provide training and technical assistance to peer service coordinators, community-based partners and mental health providers. Services are also coordinated for justice-involved veterans.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

Behavioral Health Advisory Committees

Statewide Behavioral Health Coordinating Council

Since 2013, Texas lawmakers have taken steps to improve coordination between state agencies and to create a strategic approach to providing behavioral health services. As a result, the Texas Legislature directed HHSC to dedicate one full-time employee, known as the State Mental Health Coordinator, to coordinate behavioral health services as provided by the 23 state agencies that receive general revenue for behavioral health services. This collaboration is codified the Statewide Behavioral Health Coordinating Council (SBHCC) and this coordinating body is responsible for several key deliverables that must be submitted to the Texas Legislature to include the following:
• Developing a five-year strategic plan for the delivery of behavioral health services which may be located here: Texas Statewide Behavioral Health Strategic Plan 2nd Edition;
• Developing an annual progress report on the implementation of the behavioral health strategic plan to include a behavioral health programs and services inventory;
• Developing an annual coordinated statewide expenditure proposal;
• Receiving biannual reports from certain community collaborative grant programs on population served, project implementation, and mental health outcomes; and
• Reviewing an annual report on the collection of emergency room data published by DSHS.
In addition, the 86th Texas Legislature (i.e., January 8, 2019-May 27, 2019) directed the SBHCC to develop and submit a legislative report on suicide rates in Texas and state efforts to prevent suicides; develop and submit as part of the update to the strategic plan a subplan regarding strategies for addressing substance abuse issues; and provide consultation to HHSC on the development of a proposal to improve the efficiency of administering substance abuse treatment services and expand the capacity of substance use treatment services.

Behavioral Health Advisory Committee

HHSC established the Behavioral Health Advisory Committee (BHAC) as the state mental health planning council in accordance with the state's obligations under 42 U.S.C. §300x-3. The purpose of the committee is to provide customer/consumer and stakeholder input to the Health and Human Services system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within the State of Texas. The BHAC considers and makes recommendations to the HHS Executive Commissioner consistent with the committee's purpose.

Broad recommendations to Health and Human Services system agencies regarding behavioral health services include:
• The promotion of cross-agency coordination, state/local and public/private partnerships in the funding and delivery of behavioral health services;

• The promotion of data-driven decision-making;
• The prevention of behavioral health issues and the promotion of behavioral health wellness and recovery;
• The integration of mental health and substance use disorder services in prevention, intervention, treatment, and recovery services and supports;
• The integration of behavioral health services and supports with physical health service delivery;
• Access to services and supports in urban, rural, and frontier areas of the state;
• Access to services and supports to special populations; and
• Rules, policies, programs, initiatives, and grant proposals/awards for behavioral health services.

Joint Committee on Access and Forensic Services

HHSC established the Joint Committee on Access and Forensic Services (JCAFS) in accordance with S.B. 1507, 84th Legislature, Regular Session, 2015. The purpose of the committee is to provide customer/consumer and stakeholder input to the Health and Human Services system in the form of recommendations regarding access to forensic services within the state of Texas. The JCAFS considers and makes recommendations to the Legislature consistent with the committee's purpose. Recommendations to the Texas Legislature regarding access to forensic services include:
• Monitoring the implementation of updates to the bed day allocation methodology for allocating to each designated region a certain number of state-funded beds in state hospitals and other inpatient mental health facilities for voluntary, civil and forensic patients.
• Implementing a bed day utilization review protocol, including a peer review process.
• Planning for the coordination of forensic services.

Children's Mental Health
Services for Texas children focus on providing the necessary care in the least restrictive setting possible while also keeping families together. In order to keep to these ideals, Texas' state agencies have MOUs and/or contracts to assist with providing cross-functional services to a family. One of these efforts is highlighted in the Community Resource Coordination Groups (CRCGs) which allow for local communities and agencies to assist with coordination of services to children and families with multiagency needs without duplication or delay of services. Through these groups and programs such as the Residential Treatment Center (RTC) project which helps find RTC placements for children at risk of being relinquished to state custody, Texas is committed to keeping children with their families and out of permanent long-term treatment/residential facilities when possible. The expansion of the Texas System of Care through the cooperative agreement awarded in 2017 and the accompanying coordination of agencies at both the state and local levels is anticipated to result in shorter lengths of stay in out-of-home placement and decreased recidivism. In April 2018, six state agencies entered into a Memorandum of Understanding for the implementation of a comprehensive plan to deliver mental health services and supports to children, youth, young adults, and their families using a system of care framework.

Adult Mental Health
Adults with severe mental illness typically desire to live independent lives with as little intrusion as possible. Texas understands this goal and works to provide every opportunity for adults to live their life of recovery with dignity and purpose. This requires HHSC to ensure individuals with criminal backgrounds, disabilities, co-occurring challenges, and employment issues all have a means to live the life they deserve. Coordinating services among the state agencies and local community providers requires a focus on helping individuals find treatment, employment, and stable housing with a "no-wrong-door" policy. From partnerships with the Texas Department of Criminal Justice to the Preadmission Screening and Resident Review, Texas is committed to providing individuals with the supports they need.

Substance Use Disorder Services
Substance use disorders (SUD) often co-occur with a mental health diagnosis creating a greater need for coordination and support from other local or state agencies. In addition to the services for children and adults referred to above, there are programs specific to SUD treatment that emphasize coordination. The Treatment Alternative to Incarceration Program is an example of how HHSC has implemented a recovery focused cross-agency program specific to keeping individuals out of jails due strictly to their substance use. On the youth side, treatment programs such as Alcohol and Other Drug have been allowed to work within specific state schools and juvenile centers to ensure youth in these settings have the treatment they need. With the assistance from external tasks forces such as the Texas Recovery Initiative and the statewide Recovery Oriented Systems of Care groups, HHSC will continue to maximize the efficiency, effectiveness, and quality of services provided to our constituents.

Taking into account the aforementioned strategies, the behavioral health strategic plan creates a framework for gaps and challenges to be addressed. The state agencies on the Statewide Behavioral Health Coordinating Council are invested in the implementation of the five-year strategic plan and affecting long-term change. While this plan will not solve every behavioral health problem or remedy every challenge, implementation of the strategic plan is a step in the right direction and offers a hopeful path to wellness and recovery.

https://hhs.texas.gov/reports/2016/05/statewide-behavioral-health-strategic-plan

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC).SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[69]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[69] **https://www.samhsa.gov/sites/default/files/manual-planning-council-best-practices-2014.pdf**

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council involved in the development and review of the state plan and report? Please attach supporting documentation (meeting minutes, letters of support, etc.) using the upload option at the bottom of this page.

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

The Behavioral Health Advisory Committee (BHAC) and the Statewide Behavioral Health Coordinating Council provide input and feedback in the development and review of the Block Grant (BG) plan. Throughout the year, the committee and council members review and provide input and feedback on the services, policies, and rules that inform the development of the block grant plan.

The BHAC BG subcommittee, which meets between quarterly full BHAC meetings, is charged with close monitoring and oversight of the block grant planning process. This subcommittee is supported by a dedicated HHSC staff person who participates as a resource for the subcommittee, providing information, and resources to facilitate receipt of feedback.

During the review process, HHSC gathers members' comments and incorporates their feedback in the final response, where feasible. BHAC BG subcommittee members provide feedback and suggestions specifically related to behavioral health services. The BG subcommittee chair provides a summary of BG subcommittee work to the full BHAC and solicits additional feedback in the upcoming meeting.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

3. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

BHAC provides customer, consumer, and stakeholder input to the Health and Human Services (HHS) system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within the State of Texas. In accordance with federal requirements, the BHAC's duties include:
1. Reviewing the Mental Health Block Grant Plan and making recommendations;
2. Serving as advocates for adults with a serious mental illness, children with a serious emotional disturbance, and other individuals with mental illnesses or emotional problems; and
3. Monitoring, reviewing, and evaluating at least once each year the allocation and adequacy of mental health services within the state.

In addition, the BHAC may make recommendations to HHS system agencies regarding behavioral health services that include:
• The promotion of cross-agency coordination, state/local and public/private partnerships in the funding and delivery of behavioral health services;
• The promotion of data-driven decision-making;
• The prevention of behavioral health issues and the promotion of behavioral health wellness and recovery;
• The integration of mental health and substance use disorder services in prevention, intervention, treatment, and recovery services and supports;
• The integration of behavioral health services and supports with physical health service delivery;
• Access to services and supports in urban and rural areas of the state;
• Access to services and supports to special populations;
• Rules, policies, programs, initiatives, and grant proposals/awards for behavioral health services; and
• The five-year behavioral health strategic plan and coordinating expenditure plan.

BHAC membership includes:
o two adult consumers of mental health and/or substance use disorder services;
o one youth/young adult consumer of mental health and/or substance use disorder services
o two family representatives of consumers of mental health and/or substance use disorder services, one of which must be a parent of a child with serious emotional disturbance;
o one adult certified peer provider;
o one representative nominated by the Texas Council of Community Centers;
o one representative nominated by the Association of Substance Abuse Programs (ASAP);
o two independent community behavioral health service providers;
o two behavioral health advocates or representatives of behavioral health advocacy organizations;
o one representative nominated by the Interagency Coordinating Group for faith and community-based organizations;
o one representative of a managed care organization that contracts with the Commission;
o two representatives of local government; and
o up to three additional members who have demonstrated an interest in behavioral health systems and a working knowledge of behavioral health issues.

A member of the Statewide Behavioral Health Strategic Plan and Coordinated Expenditure Coordinating Council, representing state agencies providing behavioral health services or funding, will serve as a non-voting ex-officio member.

Nominated members must have interest in mental and substance use disorders health systems from a broad perspective and a working knowledge of mental and substance use disorder health issues.

Before each scheduled BHAC meeting, HHSC posts the meeting agenda online. Meetings are open to the public, allowing for public comment. The public may attend in person or view the meeting via webcast.

The BHAC held three committee meetings during State FY 2019. BHAC focused on and provided input on an array of areas. The BHAC provided HHS executive leadership and legislative bodies' recommendations on housing, consumer services providers and supports, substance use treatment, peer services, suicide prevention, and mental health first aid.

Please indicate areas of technical assistance needed related to this section.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[70]

[70]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

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Footnotes:

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, there are specific agency representation requirements for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.

Start Year: 2020 End Year: 2021

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
No Data Available				

*Council members should be listed only once by type of membership and Agency/organization represented.
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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2020 End Year: 2021

Type of Membership	Number	Percentage of Total Membership
Total Membership	**0**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	0	
Parents of children with SED/SUD*	0	
Vacancies (Individuals and Family Members)	0	
Others (Advocates who are not State employees or providers)	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Total Individuals in Recovery, Family Members & Others	**0**	**0.00%**
State Employees	0	
Providers	0	
Vacancies	0	
Total State Employees & Providers	**0**	**0.00%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	0	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**0**	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations or include individuals with substance misuse prevention, SUD treatment, and recovery expertise in their Councils.

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a)	Public meetings or hearings?	(•) Yes ( ) No
b)	Posting of the plan on the web for public comment?	(•) Yes ( ) No
	If yes, provide URL:	
c)	Other (e.g. public service announcements, print media)	( ) Yes (•) No

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Footnotes: