Report on the 988 Implementation Study

As Required by
2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, HHSC, Rider 58)

Texas Health and Human Services Commission
September 2022

TEXAS
Health and Human Services

Table of Contents

Executive Summary

The 2022-23 General Appropriations Act, Senate Bill 1, 87th Legislature, Regular Session, 2021 (Article II, Health and Human Services Commission, Rider 58) directs the Health and Human Services Commission (HHSC) to study the adequacy and efficacy of the existing National Suicide Prevention Lifeline (NSPL) infrastructure in Texas to determine state preparedness to comply with the federal National Suicide Hotline Designation Act of 2020 (S. 2661, 116th Congress, 2019-2020).

Based on these goals and the evaluation completed as part of this study, HHSC identified recommendations within the following four categories:

Crisis Care and Behavioral Health Capacity

- Consider expansion of crisis services across the state, focusing on specific communities at-risk for suicide and regions with low resources as well as reducing unnecessary law enforcement involvement.
- Increase access to crisis services and resources among populations disproportionately impacted by suicide.
  - Leverage peer support specialists' expertise in crisis services.
  - Provide support and additional training guidance to NSPL centers on staff hiring, retention, and performance.
  - Align HHSC rules and contract standards with best practices endorsed by Vibrant Emotional Health (Vibrant) and the Substance Abuse and Mental Health Services Administration (SAMHSA).

Engagement and Communication

- Collaborate with the Commission on State Emergency Communications to provide joint training and education to Public Safety Answering Points (PSAPs).
- Execute communications plan and planned outreach activities to specific communities.

Data and Performance Management

- Gather additional data evaluation components to discern which services 988 callers are being referred to.
- Research the operational and fiscal ability to use Vibrant's unified platform, which will provide the following capabilities:
  - Assessment of immediate risks;

- Development of safety plans;
- Scheduling and tracking of follow-ups;
- Coordination and tracking of emergency rescues;
- Analytics and reporting;
- Secure data sharing with external entities; and
- Quality assurance reviews of completed contacts.[1]

- Implement a study to determine what it would cost to incorporate technology within HHSC's existing infrastructure that would allow NSPL contacts to be tracked through the crisis continuum.

Funding

- Diversify funding to ensure sustainability over time.

[1] SAMHSA. (2022). 988 Implementation Guidance Playbook for States, Territories, and Tribes. Retrieved from https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

1. Introduction

Rider 58 directs HHSC to complete a study to identify the adequacy and efficacy of existing NSPL infrastructure; strategies to improve linkages between NSPL infrastructure and crisis response services; and strategies to improve access to mental health crisis and suicide response. Rider 58 also requires the study to make recommendations for sources of sustainable funding for NSPL infrastructure and crisis response services.

In addition, Rider 58 requires HHSC to prepare and submit findings and recommendations to the Senate Committee on Finance, the House Committee on Appropriations, the Legislative Budget Board, the Governor, the Lieutenant Governor, the Speaker of the House, and permanent standing committees in the House of Representatives and the Senate with jurisdiction over health and human services by September 1, 2022.

This report provides an evaluation of the existing NSPL infrastructure in Texas including: center capacity, workforce, downstream resources, data collection and evaluation, and funding; strategies for improving linkages between NSPL and crisis response; funding recommendations for NSPL and crisis response services; and strategies to improve access to mental health crisis and suicide response.

2. Background

Suicide has remained a major contributor to premature mortality in the United States (U.S.) for over two decades. The overall age-adjusted suicide rate in the U.S. increased 30 percent between 2000 and 2020.[2] In 2020, suicide accounted for over 45,000 reported deaths in the U.S.[3] For Texas, on average, one person dies by suicide every two hours, equating to a total of 3,924 deaths by suicide in 2020. Suicide is the second leading cause of death for people aged 10-34, the fifth leading cause of death for people aged 35-44, and the eleventh leading cause of death for Texans across all age groups.[4]

While suicide is complex and rarely caused by a single factor, certain populations may disproportionately experience factors linked to suicide that increase both the rate and risk of suicide among these groups. Groups disproportionately impacted by suicide include military veterans, people living in rural areas, children and adolescents, adults over the age of 45, tribal populations and other marginalized communities.[5] Risk factors that increase the possibility of suicide include previous suicide attempts, mental health disorders, alcohol and other substance use disorders, and exposure to others who have died by suicide.[6]

The impacts of suicide are far reaching. According to the American Association of Suicidology, each death by suicide affects approximately 135 people.[7] This equates to as many as 526,000 new survivors of suicide loss in Texas each year. High rates of suicide and suicide attempts in the U.S. additionally represent a financial burden.

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[2] Centers for Disease Control and Prevention, National Center for Health Statistics. (CDC) (2022). Suicide Mortality in the United States, 2000-2020. Retrieved from https://stacks.cdc.gov/view/cdc/114217

[3] Centers for Disease Control and Prevention, National Centers for Health Statistics on CDC WONDER; *Note: This total likely underestimates the true prevalence of suicide due to unknown intent among certain types of deaths, for example, drug overdoses and car accidents.*

[4] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Retrieved from http://wonder.cdc.gov/ucd-icd10.html

[5] SAMHSA. (2022). People at greater risk of suicide. Retrieved from https://www.samhsa.gov/suicide/at-risk

[6] CDC (2022). Disparities in Suicide. Retrieved from www.cdc.gov/suicide/facts/disparities-in-suicide.html#

[7] American Association of Suicidology. (2021). Suicide in the US (2019 data). Retrieved from https://suicidology.org/facts-and-statistics/

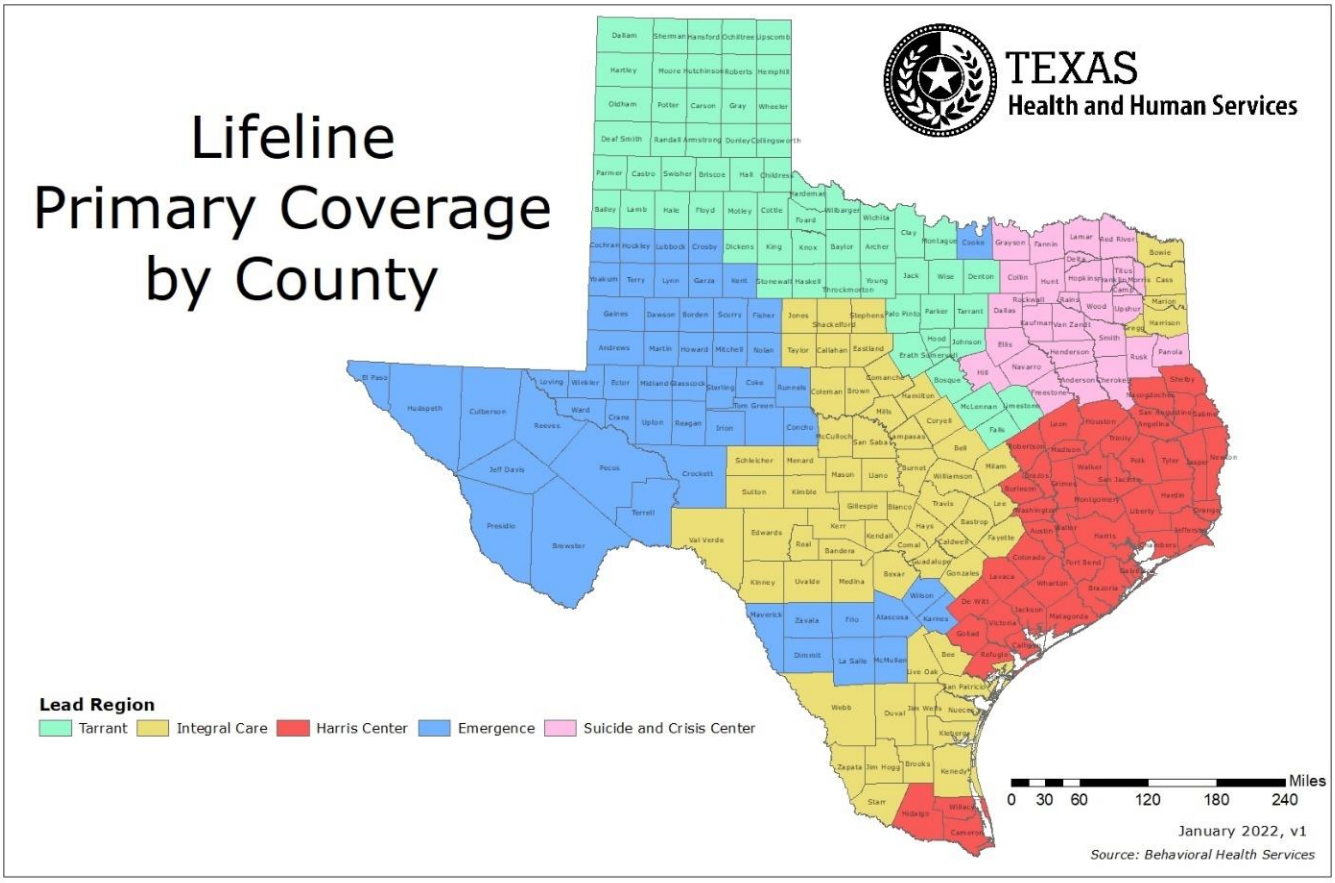
In 2020, suicide cost Texas approximately $42.2 billion in medical costs, work loss costs, value of statistical life, and quality of life costs.[8] There is a well-documented urgency to address the rising suicide mortality rates and ensure people receive the help they need.

The *National Guidelines for Behavioral Health Crisis Care* indicate that crisis call centers are an essential element of an effective suicide prevention strategy.[9] The NSPL provides confidential support for people in a suicide crisis or mental health-related distress, and is available through calls, chats, or texts at no cost, 24 hours a day, seven days a week (24/7). Research on the effectiveness of the NSPL show that after speaking with a trained crisis counselor, callers are significantly more likely to feel more hopeful, less depressed, less overwhelmed, and less suicidal.[10]

There are currently five NSPL centers operating in Texas: Suicide and Crisis Center of North Texas, The Harris Center, Integral Care, Emergence Health Network, and My Health My Resources (MHMR) of Tarrant County. Figure 1 shows the five NSPL centers' primary coverage regions by county.

[8] Centers for Disease Control and Prevention, National Center for Injury Prevention and Control. (2021). WISQARS Cost of Injury. Retrieved from https://wisqars.cdc.gov/cost/
[9] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care – A Best Practice Toolkit Knowledge Informing Transformation. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[10] SAMHSA. (2022). 988 PowerPoint Presentation Deck. Retrieved from https://www.samhsa.gov/sites/default/files/988-presentation-deck.pptx

Figure 1. Lifeline Primary Coverage by County



HHSC contracts with four of the five NSPL centers: MHMR of Tarrant County, Emergence Health Network, The Harris Center, and Integral Care. While the Suicide and Crisis Center of North Texas (SCC) also answers calls for NSPL, HHSC does not have a formal contractual relationship with SCC, however SCC and HHSC continue to work collaboratively to address needs related to the NSPL. All HHSC-contracted NSPL centers provide statewide crisis hotline services to Texas communities, which is notable given the unique challenges of the state's geography and the varying breadth and scope of the regions each center supports.

Designation of 988 for the NSPL

First introduced in May 2017 and enacted in August 2018, the National Suicide Hotline Improvement Act (H.R. 2345, 115th Congress, 2017-2018) directed the U.S. Federal Communications Commission and SAMHSA to study the feasibility of designating a three-digit dialing code for the NSPL.

In August 2019, the Federal Communications Commission (FCC) and SAMHSA submitted a report recommending 988 as the three-digit dialing code for the

NSPL.[11] In July 2020, the FCC officially designated 988 as the universal telephone number for the NSPL, requiring all U.S. telecommunication carriers to ensure nationwide accessibility by July 16, 2022.

In October 2020, Congress passed the National Suicide Hotline Designation Act (S. 2661), designating 988 as the universal telephone number for national suicide prevention and mental health crisis, incorporating 988 into statute, and directing the Department of Health and Human Services to develop a strategy to provide access to services for high-risk populations.

On October 17, 2020, the bill was signed into law by President Trump. In November 2021, the FCC issued a ruling requiring all U.S. telecommunication providers to also implement text messaging to 988 by July 16, 2022.

Appendix A provides additional background information.

[11] Federal Communications Commission. (2020). Report and Order in WC Docket No. 18-336, 85 FR 57767.

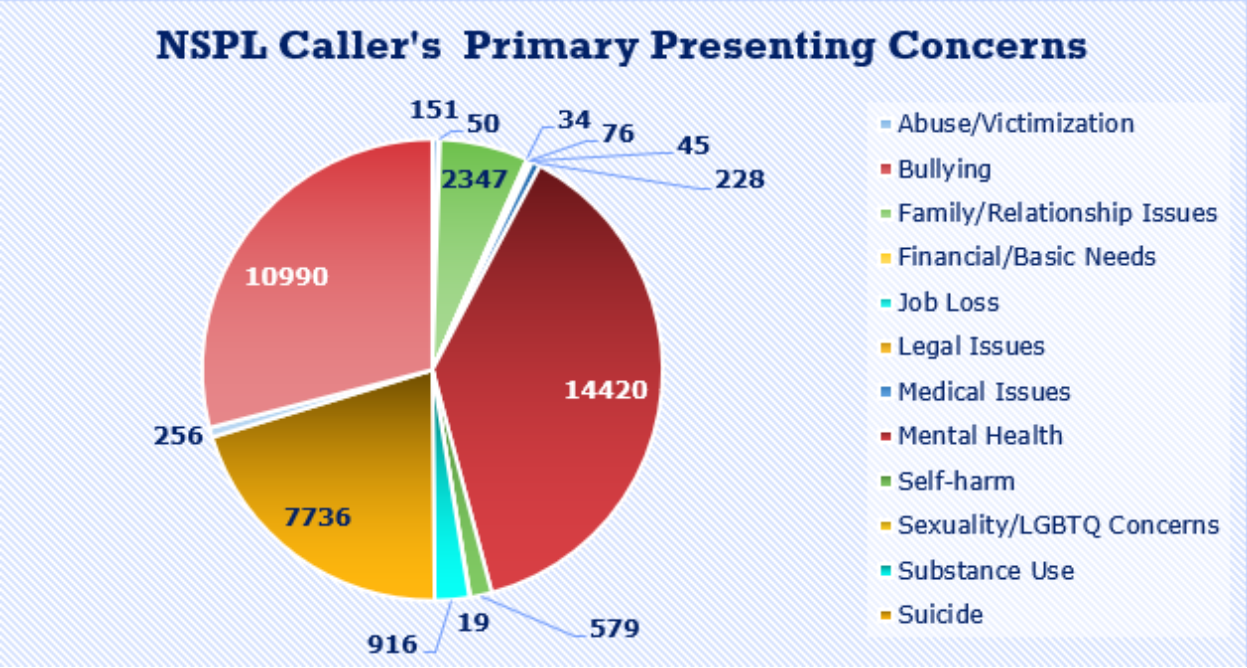
3. Adequacy of the Existing NSPL Infrastructure in Texas

Texas NSPL Center Capacity

Calls

NSPL calls range from basic information and referral needs to crisis counseling and de-escalation of severe distress. In federal fiscal year 2021, the HHSC-contracted NSPL centers collected data on 60,000 calls, including the primary presenting concern for 37,847 calls. As shown in Figure 2, mental health and suicide accounted for nearly 60 percent of callers' primary concerns.

Figure 2. NSPL Callers' Primary Presenting Concerns, October 2020 – September 2021

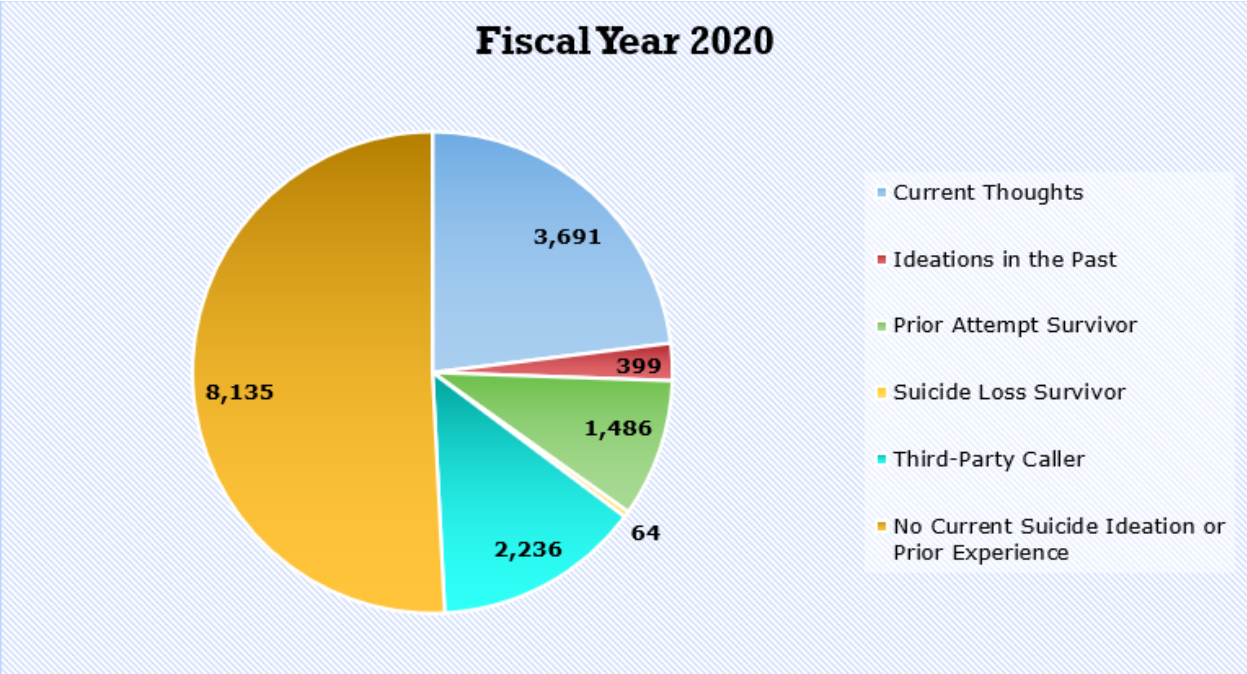


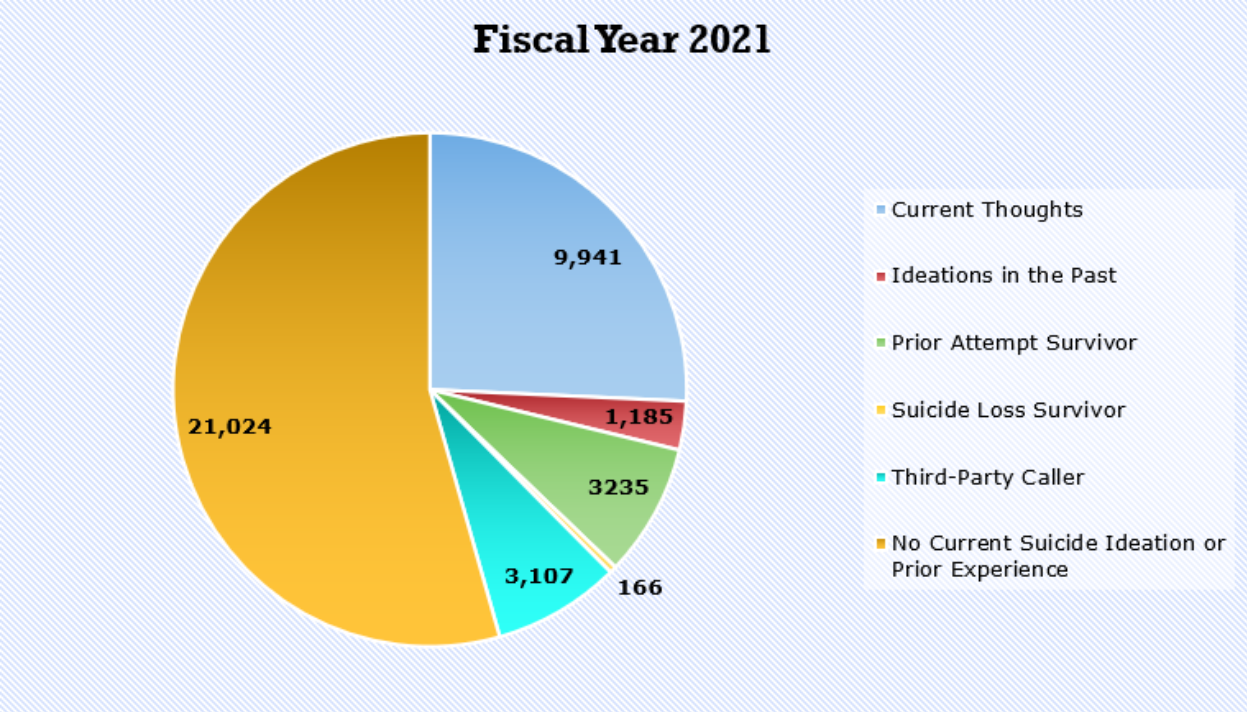
NSPL centers also receive calls from repeat or frequent callers, prank callers, verbally or emotionally abusive callers, as well as inappropriate or provocative callers. These types of calls can be very challenging to manage, both clinically and operationally. They can disrupt operations, exhaust the staff, and block access to services for others during the time of the call.

As shown by number of callers in Figure 3 below,[12] NSPL centers in Texas receive calls from people who are having thoughts of suicide at the time of the call; have experienced thoughts of suicide in the past; are suicide attempt survivors; are third-party callers concerned about another person's thoughts of suicide; or have no current thoughts of suicide or experience in the past.

[12] Fiscal year 2020 data began in December 2019 (nine months) and fiscal year 2022 data is thru April 2022 (eight months).

Figure 3. NSPL Caller Disposition and Experience





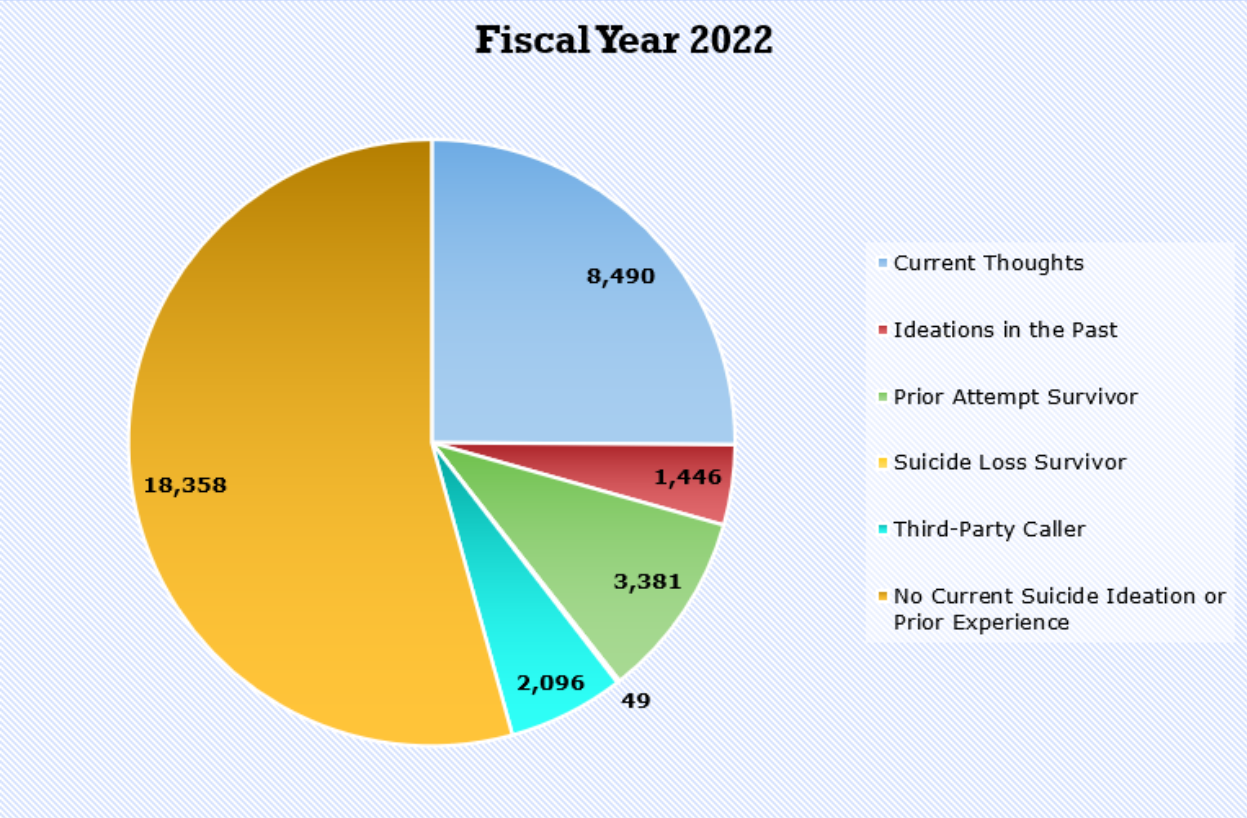
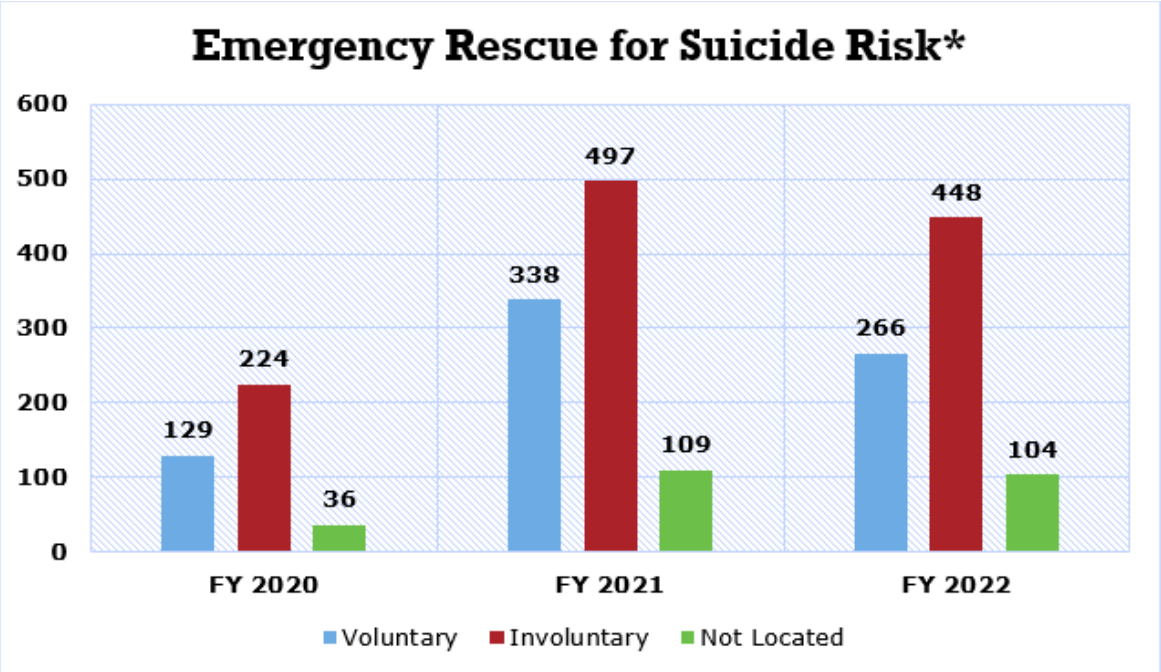


Figure 4[13] shows the number of callers referred to emergency rescue (e.g., police departments, fire departments, county sheriff offices, mobile crisis/psychiatric outreach teams, hospital emergency departments, PSAPs or 911 centers, and emergency medical services) due to imminent risk for suicide. NSPL centers determine if a caller is at imminent risk for suicide by conducting a suicide risk assessment, which includes questions on suicidal desire, intent, capability, and protective factors. Vibrant provides specific guidelines for assisting high-risk callers.[14]

[13] Fiscal year 2020 data began in December 2019 (nine months) and fiscal year 2022 data is thru April 2022 (eight months).
[14] National Suicide Prevention Lifeline (2011). Policy for Helping Callers at Imminent Risk of Suicide. Retrieved from https://suicidepreventionlifeline.org/wp-content/uploads/2016/08/Lifeline-Policy-for-Helping-Callers-at-Imminent-Risk-of-Suicide.pdf?_ga=2.141599611.810298458.1660162353-1403683451.1657819841

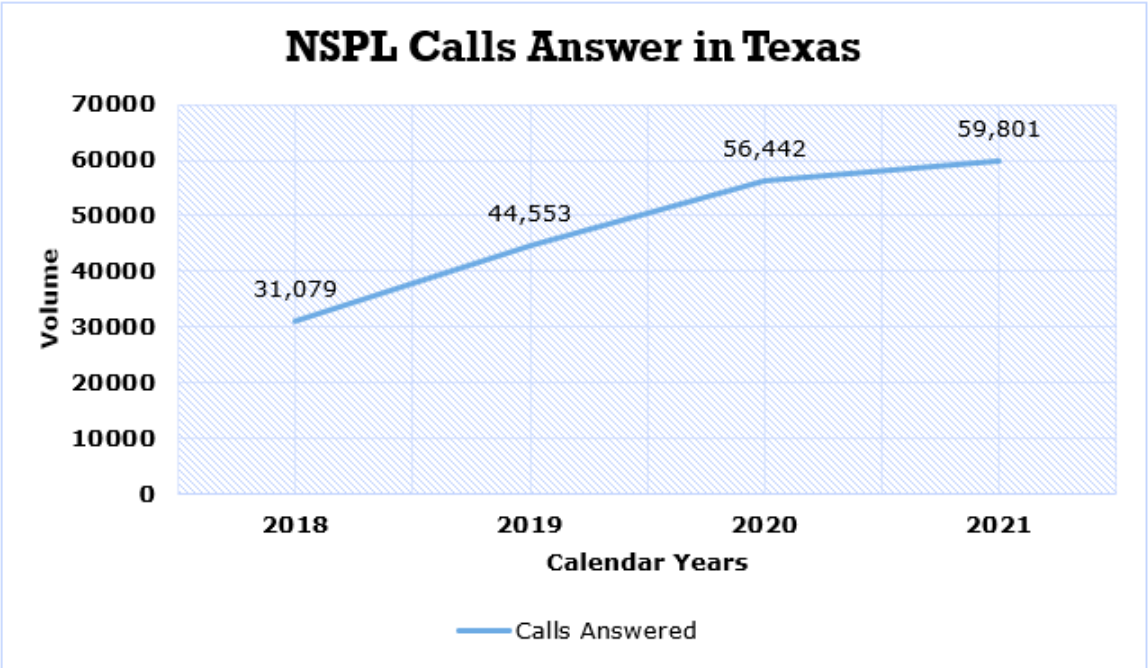
Figure 4. NSPL Call Metrics: Emergency Rescue for Suicide Risk*



* Refers to the need to provide potentially life-saving services.

Prior to SAMHSA awarding HHSC the NSPL Capacity Building Grant in October 2019, discussed later in the report, Texas NSPL centers provided coverage of NSPL calls for approximately 30 counties in Texas. Following receipt of the grant, HHSC-contracted NSPL centers have worked to expand primary coverage across Texas to regions where previously no NSPL calls were answered in-state. As of April 2022, Texas NSPL centers provide 24/7 primary coverage of calls for all 254 counties. With statewide primary coverage, fewer callers are routed to Vibrant's national backup centers, and more Texas callers are connected to state local resources providing community-based resources and assistance whenever needed. As shown in Figure 5, in calendar year 2021 Texas NSPL centers answered nearly 60,000 NSPL calls, resulting in a 92 percent increase from 2018.

Figure 5: NSPL Calls Answered in Texas, 2018-2021



While Texas has increased the volume of calls answered in-state, the total volume of NSPL calls initiated in Texas has also increased. Texas has the second highest number of NSPL calls in the U.S. According to Vibrant, 148,381 calls were generated from Texas in calendar year 2021. Of those, 59,801 were answered by Texas NSPL centers and 61,710 calls were answered by a NSPL national backup center. The remaining 26,870 calls were abandoned due to long wait times and callers not being able to connect with a NSPL center.

In-state Answer Rate

One of the key performance metrics used to evaluate NSPL centers is the in-state answer rate. Calls generated from a Texas area code are automatically routed to an assigned NSPL center based on county. Vibrant calculates the in-state answer rate by dividing the number of answered NSPL calls by the total number of calls routed to the state. For calendar year 2021, the Texas in-state answer rate was 40 percent. NSPL chats and texts are currently not routed by location, therefore, the in-state answer rate only reflects NSPL calls. In July 2022, a total of 15,736 calls were routed to Texas, of which 9,016 calls were answered in Texas for an in-state answer rate of 57 percent.

An analysis of the NSPL infrastructure in other states shows a potential correlation between in-state answer rates and the number of NSPL centers answering calls within the state. Other states comparable to Texas in terms of call volume have

more NSPL centers. For example, Florida has 12 NSPL centers with a population of 21 million, and an in-state answer rate is 77 percent. The 5 Texas NSPL centers have the capacity to answer approximately 50 percent of NSPL calls; however, HHSC is engaged in a multi-pronged effort to increase in-state answer rate. HHSC's plans to increase capacity include expanding in-state backup coverage, addressing crisis services workforce challenges, and continuing to leverage the state's robust crisis continuum. HHSC is conducting a comprehensive review of current statewide capabilities to inform future direction, which may include contracting or subcontracting with entities to expand in-state NSPL services capacity.

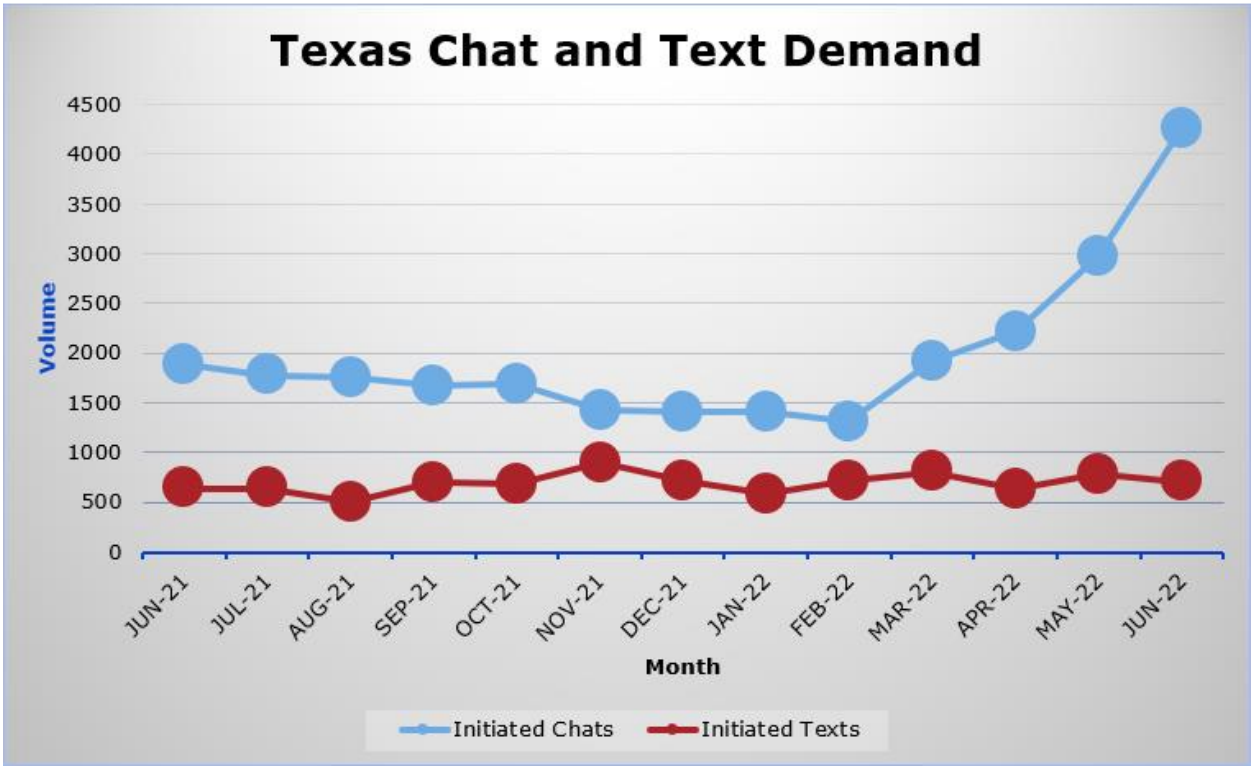
While primary NSPL coverage is statewide, only 25 of the 254 counties (10 percent) have assigned in-state backup coverage. If the NSPL center providing primary coverage for the remaining counties is unavailable, the call is rerouted to a national backup center. Expanding backup coverage will provide a greater opportunity to answer calls within the state and raise the in-state answer rate. HHSC and the HHSC-contracted NSPL centers plan to prioritize backup coverage to counties with the highest call volumes, including Travis, Harris, Tarrant, Bexar, El Paso, Dallas, and Denton counties.

In June 2022, HHSC began moving forward with a Needs and Capacity Assessment to solicit application(s) from a local mental health authority (LMHA) with experience contracting with a crisis hotline provider. This is a long-term solution that could dramatically increase the in-state answer rate.

Chats and Texts

Unlike NSPL calls, NSPL chats and texts currently are not routed by location. Instead, centers who participate in answering chats and texts are connected to the larger NSPL network, which sends chats and texts based on the availability of individual counselors within participating centers. Figure 6 shows chat and text demand within the state during the past 12 months. From April 2021 to April 2022, chat, and text demands both remained relatively constant, with an average of approximately 1,750 chats initiated from Texas per month and 680 texts initiated per month.

Figure 6: Texas Chat and Text Demand, June 2021 – June 2022



In May 2022, Vibrant began beta testing location-based response for chats and texts. Once implemented, Vibrant will route chats and texts to crisis centers equipped to respond in the state where the text or chat originated. The location will be determined by the area code of the phone number for text and either the internet protocol address or zip code for chat.

While chat and text interactions are similar to calls, some differences cause challenges in addressing the demand. The main difference is the interaction time length. NSPL calls tend to last approximately 10 minutes, whereas chat and text conversations last an average of 30 to 45 minutes.[15] Because crisis responders cannot use verbal communication to respond to chats and texts, guidance and support may require more thoughtful responses and attention to style and etiquette. Additional training and staff support may also be necessary due to the younger demographic of people contacting the NSPL through these modalities.

One NSPL center in Texas, Integral Care, has completed onboarding for the Vibrant chat/text subnetwork and began responding to chats and texts in April 2022. The

[15] Vibrant Emotional Health. (2022). 988 Chat and Text Webinar. Retrieved from https://www.youtube.com/watch?v=SK-Mj-5IDMQ&list=PLiP-eOwiHXLYkgSlZrY9-1DvnCgu_NNUv&index=4&t=1099s

remaining NSPL centers either do not have the infrastructure to support chat or text communications or do not have the staff to handle the added service due to time commitment without additional funding. With only one center answering chats and texts, there is a gap in services for communities the FCC identified as both at-risk and benefit from these services[16] For people in crisis, contacting a crisis counselor through chat or text may be easier than engaging in a phone conversation.

Increasing access to services for young people is especially important. Suicide is the second-leading cause of death for people aged 10-24, and far more adolescents attempt suicide and survive than those who die by suicide. From 2018 to 2020, suicide rates increased among the 10-14 and 15-24 age groups.[17] Further, suicide risk among Black adolescents is increasing, with Black children aged 5-12 dying by suicide at nearly twice the rate of their White peers. Black adolescents also have higher rates of past suicide attempts than their White counterparts.[18] Text and chat are the main forms of communication for people in these age groups. Increasing coverage of these services will allow children and adolescents in Texas to access the resources and assistance they need in a familiar mode of communication.

Workforce Challenges

The most significant challenge facing crisis services is the behavioral health workforce shortage. Almost all Texans live in a federally designated Mental Health Professional Shortage Area,[19] with fewer mental health providers than the minimum their population would need.[20] Due to the workforce shortage, people seeking treatment face limited options or long wait lists and mental health centers struggle to maintain a full staff load.

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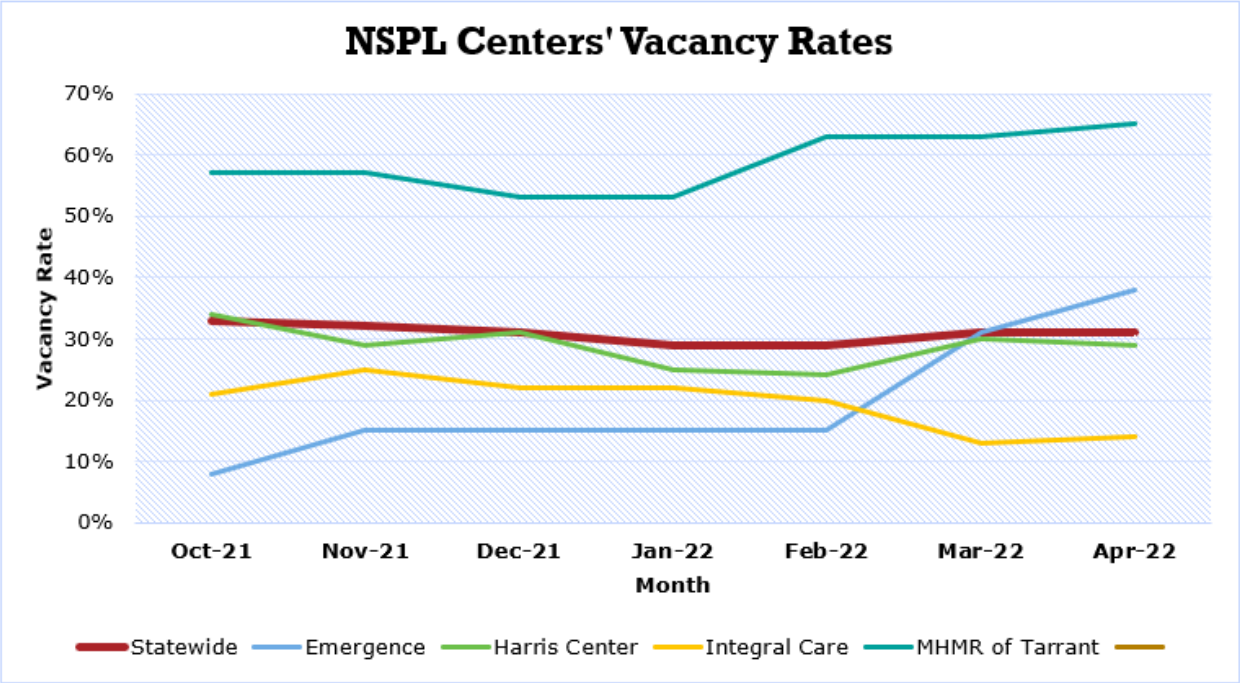
[16] Federal Communications Commission. (2021). Report and Order, 18-336, Enabling Text-to-988 Access to the National Suicide Prevention Lifeline.
[17] Centers for Disease Control and Prevention, National Center for Health Statistics. (2022). Suicide Mortality in the United States, 2000-2020. Retrieved from https://stacks.cdc.gov/view/cdc/114217
[18] SAMHSA. (2021). 988 Appropriations Report. Retrieved from www.samhsa.gov/sites/default/files/988-appropriations-report.pdf
[19] https://bhw.hrsa.gov/shortage-designation/what-is-shortage-designation
[20] The US Health Resources and Services Administration determines Health Professional Shortage Areas based on methodology that includes the population-to-provider ratio, percent of population below the Federal Poverty Level, travel time to the nearest source of care outside the HPSA designation area, percent of people over age 65, percent of people under age 18, and the prevalence of alcohol and substance use prevalence. Retrieved from https://data.hrsa.gov/topics/health-workforce/shortage-areas

Despite actively recruiting and interviewing new candidates, HHSC-contracted NSPL centers report struggling to fill weekend and overnight shifts, an inability to adequately compensate experienced candidates, unexpected turnovers, and new hires dropping out of training despite a sign-on bonus. Figure 7 shows the vacancy rates for the HHSC-contracted NSPL centers from October 2021 through April 2022.

Figure 7. NSPL Centers' Vacancy Rates, October 2021 – April 2022



Staffing Structure

Vibrant requires that anyone answering calls be trained on providing quality service before they begin taking calls, but does not require individual call center staff to be certified, accredited, or licensed by an external body. NSPL centers across the network utilize a combination of both paid and volunteer crisis counselors with various education levels. Because the NSPL centers in Texas operate both the NSPL and local crisis hotlines, they have faced challenges in using this combined staffing structure.

HHSC requires LMHA and local behavioral health authority (LBHA) crisis hotlines to comply with the Texas Administrative Code (TAC) requirements[21] and contract

[21] 26 TAC Chapter 301, Subchapter G (related to Mental Health Community Services Standards) Section 301.327

attachment Information Item V - Crisis Services Standards.[22] TAC outlines requirements for local crisis hotline operating hours, accessibility, average seconds to answer, and screening procedures. Information Item V provides more detailed guidance on local crisis hotline staffing, training, screening requirements, and the LMHA's or LBHA's role in activation of other crisis services. Texas has a robust set of existing local crisis hotline standards that differ from NSPL standards, which has required HHSC-contracted NSPL centers to integrate these differing set of standards.

Most HHSC-contracted NSPL centers have aligned NSPL staff hiring standards with crisis hotline hiring standards to ensure all call center staff can answer both lines. A challenge for the HHSC-contracted NSPL centers is balancing the expansion of NSPL coverage and answering calls, while complying with TAC and report metrics of the local crisis hotlines. TAC requires centers to transfer callers identified to be in a crisis to a credentialed Qualified Mental Health Professional-Community Services (QMHP-CS) within one minute.[23]

QMHP-CS, as defined in 26 TAC Section 301.303 is a staff member who has demonstrated and documented competency in the work to be performed and:

a. Has a bachelor's degree from an accredited college or university with a minimum number of hours equivalent to a major (as determined by the LMHA, LBHA, or Managed Care Organization in accordance with 26 TAC Chapter 301, Subchapter G of this title in psychology, social work, medicine, nursing, rehabilitation, counseling, sociology, human growth and development, physician assistant, gerontology, special education, educational psychology, early childhood education, or early childhood intervention;
b. Is a registered nurse; or
c. Completes an alternative credentialing process identified by the department.

At the time of this report, HHSC is exploring revising staffing qualification requirements for local crisis hotlines to align with NSPL staffing standards to reduce administrative burden and allow for more flexibility in hiring protocols.

This would allow NSPL centers to explore the potential of utilizing peer support, people with lived experience, and others who can answer 988 contacts and divert high acuity calls for clinicians and trained staff.

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[22] Texas Health and Human Services Commission. (2020). LMHA and LBHA Contract, Information Item V, Crisis Service Standards.
[23] 26 TAC Chapter 301, Subchapter G, Section 301.327

Training, Supervision, and Retention

Vibrant requires NSPL centers to provide basic crisis training to call center staff (new and active staff). Vibrant works with centers to ensure training consistently incorporates NSPL endorsed or developed training tools for staff responding to people in crisis, and provides the NSPL centers with supplemental training resources, including online modules, live webinars, simulation training, Lifeline Safety Assessment and Follow-up Matters training.

Vibrant and SAMHSA recognize the need for competency of all call center staff to address crisis and suicide needs of high-risk populations and continuously update training resources to help crisis counselors better address the needs of all callers. These training resources are designed with diversity, equity, inclusion, and cultural competency in mind. Vibrant is currently developing additional training modules that will be available to the NSPL centers starting November 2022.[24]

Vibrant also requires NSPL centers to participate in evaluation activities to promote quality assurance for NSPL operations. All NSPL centers are required by their network agreement with Vibrant to provide ongoing quality assurance call monitoring. Staff assigned to NSPL calls at each of the HHSC-contracted NSPL centers have at least one percent of their calls monitored by a supervisor who provides feedback.

HHSC is currently exploring the following options to support the NSPL centers in their efforts to hire, recruit, train, and expand crisis center staff and response structure:

- Explore adapting hiring requirements for crisis hotline staff to align with NSPL's minimum required standards;
- Explore utilizing peer support and people with lived experience to answer calls and divert high acuity calls for QMHP-CSs or trained staff;
- Explore methods of incorporating warm lines facilitated by peer specialists to divert low acuity calls;

[24] Vibrant Emotional Health. (2022). 988 Training Webinar. Retrieved from www.youtube.com/watch?v=SK-Mj-5IDMQ&list=PLiP-eOwiHXLYkgSlZrY9-1DvnCgu_NNUv&index=4&t=1099s

- Explore expanding the use of volunteers, interns, and Access Line and Customer Service Reps to triage calls and divert high acuity calls for QMHP-CSs or trained staff; and
- Provide ongoing support to NSPL centers through the Transformation Transfer Initiative's learning collaborative beginning in state fiscal year 2023.

Texas was awarded two Transformation Transfer Initiative grants from SAMHSA that will be funded starting in fiscal year 2023. The state will use one of these awards to fund learning collaboratives, eLearning modules, and a toolkit collaborative for LMHAs and LBHAs to address behavioral health workforce challenges related to 988 implementation and sustainability. With this funding, HHSC will work with the HHSC-contracted NSPL centers to improve recruitment and retention efforts, provide targeted training sessions on key workforce issues, foster peer-to-peer learning, and provide expert consultation to address specific challenges experienced by communities across the state. HHSC anticipates this work will inform the workforce pipeline strategy and support capacity building for NSPL centers statewide.

Crisis Care and Behavioral Health Care Capacity

The HHSC-contracted NSPL centers are required to have written procedures for providing access to resources, making referrals for services, and activating emergency services for callers outside of the grantee's catchment area. The HHSC-contracted NSPL centers are required to include the following items within their procedures:

- The requirement that NSPL calls are answered to NSPL standards prior to referring a person to another LMHA or LBHA for services; and
- Steps for how calls of people in crisis (requiring emergent or urgent crisis services) will be warm transferred to the LMHA or LBHA where the person resides. The HHSC-contracted NSPL center contacts the appropriate LMHA or LBHA crisis hotline or directly contacts the appropriate crisis service if that arrangement or contract exists.

LMHAs and LBHAs operate crisis programs, including crisis hotlines, mobile crisis outreach teams (MCOTs), mental health deputies (MHDs), various types of crisis facilities, and inpatient psychiatric beds. However, not every crisis service is available in every county, or every LMHA and LBHA. All 39 LMHAs and LBHAs provide crisis hotline and MCOT services. Although many contractors operationalize

various types of mental health crisis facilities to meet their local needs, crisis facilities do not exist in every area of the state.

Eight LMHAs do not have existing community-based crisis facilities, but they do receive funding for psychiatric inpatient beds making psychiatric hospitalization the only option for crisis stabilization in these designated local service areas.[25]

Additionally, while Crisis Hotlines and MCOTs are available 24/7 across all 254 counties in Texas, timely access to crisis response services is challenging at times due to the large and complex geography of Texas. In rural areas, law enforcement may be more likely to respond to crisis. The LMHAs and LBHAs in rural Texas report an increased number of suicide attempts among children and adolescents, as well as an increase in completed suicides. Limited resources exist within rural areas to support adolescent crisis respite to divert adolescents from inpatient psychiatric care and residential treatment.[26]

Vibrant requires all NSPL centers have and maintain resource and referral information. Through public and private entities, Texas has an array of mental health and substance use services currently available to serve Texans across the state. The four HHSC-contracted NSPL centers have access to resource listings provided by 211, Aunt Bertha, Network of Care, as well as resource listings developed within their specific regions. These listings are a foundation to providing referrals and linkages, but sustained efforts are needed to ensure listings are comprehensive beyond the immediate catchment areas of the four NSPL centers. Resource listings in Texas require special considerations, given the vast geography and scope of resources needed to support all demographics across the state's 254 counties. As part of the final 988 Implementation Plan, the 988 Stakeholder Coalition identified a list of available resources throughout the state.

Community-based behavioral health services are a critical component of a comprehensive crisis response system that support ongoing recovery. Per SAMHSA, harnessing the full potential of 988 to transform overall crisis care will require ensuring that states not only have the capacity to handle 988 contacts, but also sufficient capacity in the crisis care and behavioral health systems to meet the

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[25] Access, Andrews Center, MHMR of Brazos Valley, Central Counties Services Center, Lakes Regional Community Center, Coastal Plains Community Center, Gulf Bend Center, and PermiaCare.
[26] HHSC. (2020). All Texas Access Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf

ongoing needs of people and/or their families and allies in crisis who contact 988.[27] While there are existing services available, the current infrastructure finds it challenging to meet the demand for services. This is especially true regarding behavioral health services for higher risk populations.

At-Risk Populations

SAMHSA notes people at greater risk for suicide include veterans, people living in rural areas, children and adolescents, adults over the age of 45, tribal members and other vulnerable populations.[28] Although suicide is complex and rarely caused by a single factor, these populations may disproportionately experience factors linked to suicide. Risk factors that increase the possibility of suicide include but are not limited to previous suicide attempts, mental health disorders (particularly mood disorders, schizophrenia, anxiety disorders, and certain personality disorders), alcohol and other substance use disorders, and exposure to others who have died by suicide.[29] An overview of these populations and the available public behavioral health services are discussed below.

Veterans

Veterans had a higher death rate by suicide than most of the other categories examined in the *Report on Suicide and Suicide Prevention in Texas*, with a rate approximately two times higher than the overall Texas rate.[30] HHSC and the Texas Veterans Commission jointly administer the Mental Health Program for Veterans, through which providers deliver peer counseling services to service members, veterans, and their families (SMVF). People enrolled in the program receive peer services from trained and certified peer service coordinators and volunteer peers. HHSC contracts with 37 of 39 LMHAs and LBHAs for this program. HHSC also administers a veterans' counselor project in which licensed mental health professionals are trained in military-informed care and provide mental health

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[27] SAMHSA. (2022). 988 Implementation Guidance Playbook for States, Territories, and Tribes. Retrieved from https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

[28] SAMHSA. (2022). People at greater risk of suicide. Retrieved from https://www.samhsa.gov/suicide/at-risk

[29] CDC. (2022). Disparities in Suicide. Retrieved from www.cdc.gov/suicide/facts/disparities-in-suicide.html#

[30] HHSC. (2020). Report on Suicide and Suicide Prevention in Texas. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/suicide-prevention-texas-may-2020.pdf.

services. This project is funded through the Mental Health Program for Veterans and implemented at six LMHAs that serve rural communities.

HHSC oversees the Texas Veterans and Family Alliance grant and the *Long-Term Action Plan to Prevent Veteran Suicide*. Additional information on both is provided in Appendix B.

People Living in Rural Areas

Suicide rates for both males and females in rural counties are nearly two times higher than rates in urban counties, 1.6 and 1.7 times, respectively.[31] While an array of resources are available to Texans in urban areas, there are limited resources in the rural and frontier areas of the state, making it more difficult for these populations to receive the treatment and help needed. Limited access to health care and isolation are both known factors for increased risk of suicidal behavior.

Recommendations from the December 2020 *All Texas Access Report* included building upon the Broadband Development Council, evaluating innovations around telehealth in behavioral health services, increasing support and training for mental health professionals in these regions, and incentivizing mental health deputy programs to increase law enforcement collaboration with LMHAs and LBHAs.[32]

Children and Adolescents

All LMHAs and LBHAs offer services to children and their families. Children's community mental health services include counseling, skills training and development, routine and intensive case management (including Wraparound Planning Process), medication management, family partner services, crisis intervention, and other adjunct services such as support groups, and respite services to eligible children and adolescents through LMHAs and LBHAs.

HHSC conducted a Children's Crisis Service Needs Assessment Survey from November 2021 through January 2022 of community mental health providers,

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[31] Ivey, A., Crosby A., Jack, S., Haileyesus, T., Kresnow, M. (2017). Suicide Trends Among and Within Urbanization Levels by Sex, Race/Ethnicity, Age Group, and Mechanism of Death — United States, 2001–2015. MMWR Surveill Summ, 66(No. SS-18):1–16. DOI: http://dx.doi.org/10.15585/mmwr.ss6618a1external icon

[32] HHSC. (2020). All Texas Access Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf

school providers, other state agency staff (e.g., Texas Juvenile Justice Department, Department of Family and Protective Services), mental health advocates, family members, state and private inpatient providers, law enforcement personnel, and persons with lived experience.

Barriers to treatment identified include lack of access, funding, transportation, publicly available and accessible information, and lack of coordination between adjacent provider agencies.

Survey results identified programs and resources that could reduce the need for children's inpatient psychiatric care. Results included: specialized counseling; intensive outpatient programs or partial hospitalization programs; crisis respite/residential programs; and MCOTs. Additionally, stakeholders identified services that could be expanded in the community to reduce the need for children's inpatient psychiatric care. These services included counseling, family therapy, crisis services, case management, respite, and medication management.

Adults Over the Age of 45

Middle-aged people have the highest rate of suicide compared to other age groups. Eighty percent of all deaths by suicide in the U.S. are among men and women aged 45-54. Men ages 85 and older have the highest rate of any group in the country.[33] This section highlights the specific services dedicated to assisting adults with mental health and substance use disorders, both substantiated factors linked to suicidal behavior.

Mental Health Disorders

Most people with mental health conditions do not experience suicidal ideation; however, suicide rates among people with certain psychiatric disorders are more than 10 times higher compared to the general public. For example, researchers have found a 20-fold increased suicide risk among people with depressive and other mood disorders and a 15-fold increased risk among people with Bipolar I

[33] SAMHSA. (2022). People at greater risk of suicide. Retrieved from https://www.samhsa.gov/suicide/at-risk

Disorder.[34,35] Adult mental health programs and services are provided by LMHAs and LBHAs and based on evidence-based practices to help people manage mental illness via case management, counseling, and pharmacological management. Targeted case management (routine and intensive case management) and skills training and development services are also provided through Medicaid Managed Care Organizations.

Substance Use Disorders

Suicide is a leading cause of death among people with alcohol and substance use disorders.[36] HHSC contracts with providers to deliver substance use services for eligible adolescents and adults that encourage people to seek recovery parallel to prevention, intervention, and treatment. These services include detoxification services, intensive and supportive residential, outpatient, medication-assisted treatment, co-occurring psychiatric and substance use disorders services, and specialized female services. Outreach, screening, assessment, and referral (OSAR) services help people access substance use services, case management and peer support. An OSAR service provider will stay in touch with people waiting for treatment and refer them to community services while they are waiting.

Other High-Risk Populations

While the public behavioral health services discussed throughout this report are available to all Texans, there are gaps in dedicated services for certain high-risk populations. Suicide rates are highest among American Indian and Alaska Native populations compared to all other racial and ethnic groups.[37]

Data Collection and Evaluation

The HHSC-contracted NSPL centers submit monthly data reports which include monthly call summaries, staffing information, caller demographics, caller

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[34] Bachmann, S. (2018). Epidemiology of Suicide and the Psychiatric Perspective. International Journal of Environmental Research and Public Health, 15(7), 1425. doi:10.3390/ijerph15071425

[35] Baldessarini RJ, Tondo L. (2020). Suicidal Risks in 12 DSM-5 Psychiatric Disorders. J Affect Disord;271:66-73. doi: 10.1016/j.jad.2020.03.083. Epub 2020 Apr 15. PMID: 32312699.

[36] SAMHSA. (2020). Substance Use and Suicide: A Nexus Requiring a Public Health Approach. Retrieved from https://store.samhsa.gov/sites/default/files/d7/priv/sma16-4935.pdf

[37] CDC (2022). Disparities in Suicide. Retrieve at www.cdc.gov/suicide/facts/disparities-in-suicide.html#

deposition, suicide experiences, outcomes, and referrals. The specific metrics and definitions are provided in Table 1 below.

HHSC also receives a monthly report from Vibrant with call metrics, including total calls routed, calls answered, and the answer rate for all five NSPL centers in Texas. HHSC and the four contracted NSPL centers meet monthly to discuss progress and strategies related to capacity, funding, and communication. HHSC reviews quarterly county-level data on calls answered in and out of state to understand where answering efforts should be directed and make informed decisions on coverage rollout and implementation plans.

Monthly Data Report Metrics and Definitions

- Call Summaries
  - Calls Received: Total number of calls received
  - Calls Answered: Total number of calls answered
  - Average Speed to Answer: Average time taken to answer calls, in seconds
  - Center Answer Rate: Total calls answered divided by total calls received, as a percentage
- Staffing
  - Employees hired: Total number of employees currently hired and answering Lifeline contacts
  - Vacant positions: Total number of vacant positions
- Caller Demographics
  - Gender: Total number of callers who identify as male, female, total that preferred not to answer, and total that gender was unknown
  - Age: Total number of callers by age groups
  - Veteran Status: Total number of callers who identified as being a veteran or in active military service
- Caller Disposition and Suicide Experience
  - Suicidal Ideation Current: Total number of callers where suicidal ideation was present within the past 24 hours
  - Suicidal Ideation Recent: Total number of callers where suicidal ideation was present within the past 2 months, but not within the past 24 hours
  - No Suicidal Ideation: Total number of callers where suicidal ideation was not present

- Prior Attempt: Total number of callers who disclose a past suicide attempt
- Loss Survivor: Total number of callers who disclose losing someone to suicide
- Third-Party Caller: Total number of callers concerned about another person in crisis
- No Assessment: Total number of calls where an assessment of suicidal ideation and experience was not applicable

- Imminent Risk and Dispatch Outcomes[38]
  - Risk Imminent: Total number of calls where the caller was at imminent risk for suicide
  - Risk Not Imminent: Total number of calls where the caller was not at imminent risk for suicide
  - Risk Reduced: Total number of calls where imminent risk for suicide was reduced during the call
  - ER Dispatched Voluntary: Total number of calls when a voluntary emergency rescue was dispatched
  - ER Dispatched Involuntary: Total number of calls when an involuntary emergency rescue was dispatched
  - ER Dispatched Unknown: Total number of calls when emergency rescue was dispatched but the person could not be located
- Referral Outcomes
  - Referral MCOT: Total number of calls resulting in referrals to MCOT
  - Referral Crisis Unit: Total number of calls resulting in referrals to a crisis stabilization facility (Crisis Stabilization Units, Extended Observation Units, Crisis Residential Units, or Crisis Respite Units)

[38] Per Vibrant, a caller is determined to be at imminent risk of suicide if the center staff responding to the call believe, based on information gathered during the exchange from the person at risk or someone calling on his/her behalf, that there is a close temporal connection between the person's current risk status and actions that could lead to his/her suicide. The risk must be present in the sense that it creates an obligation and immediate pressure on the center staff to take urgent actions to reduce the caller's risk; that is, if no actions are taken, the center staff believe that the caller is likely to seriously harm or kill him/herself. Imminent Risk may be determined if an individual states (or is reported to have stated by a person believed to be a reliable informant) both a desire and intent to die and has the capability of carrying through his/her intent.

- Referral LMHA and LBHA: Total number of calls resulting in referrals to an LMHA or LBHA for outpatient services
- Referral Other: Total number of calls resulting in referrals to another resource or provider for outpatient services or counseling

Currently, the HHSC-contracted centers collect data through internal tracking software and submit monthly data to HHSC through an online survey. HHSC currently does not have the ability to monitor data in real time. With additional funding, HHSC's goal is to develop an automated, real-time tracking system with public-facing components. Additionally, Texas does not have the technology infrastructure to follow NSPL contacts through the crisis continuum to know if the person received a mental health or related service or not after the NSPL referral. To accomplish this, HHSC and the NSPL centers would need to develop protocols to track referrals and follow-up information, establish formal relationships with emergency response and mental health service providers, and develop data sharing agreements with entities across the crisis continuum.

Tracking Outcomes

In addition to the monthly NSPL report received from the HHSC-contracted NSPL centers, HHSC receives a monthly report from Vibrant with the state metrics for the previous month. This report includes NSPL center hours of operation; NSPL center coverage area, including primary and backup coverage; statewide demand for calls, chats, and texts; NSPL calls routed to Texas, answered in Texas, answered outside of Texas, and the in-state answer rate; and NSPL center-level in-state call metrics. The report provides the information on a rolling calendar year and reflects data for the most recent 13 months. HHSC uses this report to determine progress made towards increasing the in-state answer rate as well as tracking individual center-level volume. HHSC will use the key performance indicators in Table 2 to track progress under the 988 State and Territory Cooperative Agreement Grant.

Table 1: Key Performance Indicators

Key Performance Indicators	Definition	Target
Calls, chats, texts Received	Total number of contacts received	N/A
Calls, chats, texts answered	Total number of contacts answered	Greater than 90%
Phone, chat, text average speed to answer	Speed to answer contact	95% answered in 20 seconds

Key Performance Indicators	Definition	Target
Abandonment Rate	Percentage of contacts received versus disconnected prior to answer	Less than 5%
Direct/Rollover calls to backup centers	Total number of phone contacts sent to NSPL centers	Less than 10%

NSPL Funding

HHSC supports the contracted NSPL centers through federal Mental Health Block Grant (MHBG) funding. HHSC has committed over $18 million in MHBG funding through fiscal year 2024 for workforce expansion and increased responsiveness to 988 contacts.

The Texas Legislature has increased investment in an array of crisis services and behavioral health services that offer treatment when and where it is needed to support ongoing recovery. Since 2017, the Texas Legislature has invested more than $14 billion to improve the availability and quality of behavioral health services in Texas. This includes purchasing approximately 560 psychiatric beds operated by private providers across the state, allocating $775 million for expansion and replacement projects to improve the state psychiatric hospital system, and awarding $249.5 million in HHSC behavioral health matching grants for use by local partners to address their unique needs.[39]

NSPL Capacity Building and 988 Planning Grants

In October 2019, SAMHSA competitively awarded HHSC the NSPL Capacity Building Grant for federal fiscal years 2020 and 2021. The purpose of this grant was to enhance long-term state support for call centers and boost in-state answer rates.

In February 2021, Vibrant awarded HHSC the 988 Planning Grant to assist in planning for the implementation of the national 988 Suicide Prevention and Mental Health Crisis hotline. HHSC and the existing NSPL centers partnered to plan for the long-term improvement of the in-state answer rate for 988 contacts and address

[39] HHSC. (2021). Continuum of Care Workgroup Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/about-hhs/process-improvement/improving-services-texans/contiuum-care-workgroup-primer.pdf

key coordination, capacity, funding, and communication strategies that are foundational to the launching of 988.

The 988 Planning Grant required HHSC to assemble and host stakeholder coalition meetings, complete and submit a landscape analysis, and submit draft and final implementation plans using a template specified by Vibrant. Coalition members representing various agencies working on reducing suicide and mental health crises in Texas convened over several months to develop a roadmap for Texas' implementation of 988 and NSPL services. Per Vibrant's directive, the 988 implementation plan addresses challenges, gaps, and opportunities in eight core areas:

- Core Area 1: Statewide 988 Coverage
- Core Area 2: Funding for Call Centers
- Core Area 3: Capacity for Target In-State/In-Territory Answer Rates
- Core Area 4: NSPL Standards, Requirements, and Performance Metrics
- Core Area 5: 988 Stakeholder Coalition
- Core Area 6: Comprehensive Resource Listings and Plan for Expanded Services
- Core Area 7: Follow-Up Services
- Core Area 8: Marketing 988

HHSC submitted the final implementation plan to Vibrant in January 2022.

In April 2022, SAMHSA awarded HHSC the 988 State and Territory Cooperative Agreements Grant. The purpose of this funding is to improve state response to 988 contacts (including calls, chats, and texts) originating in the state by:

- Recruiting, hiring, and training behavioral health workforce to staff local 988/NSPL centers to respond, intervene, and provide follow-up to people experiencing a behavioral health crisis;
- Engaging NSPL centers to unify 988 responses across states/territories; and
- Expanding the crisis center staffing and response structure needed for the successful implementation of 988.

Through this opportunity, Texas will receive approximately $8 million over two years to support workforce capacity building and unification of 988 responses statewide. Table 3 outlines NSPL funding amounts.

Table 2: NSPL Funding Amounts by State Fiscal Year

State Fiscal Year	MHBG 5% Crisis Set Aside	Federal Grant Funding	Totals
2020	$0	$891,921	$891,921
2021	$0	$2,188,885*	$2,188,885
2022	$5,628,019	$0	$5,628,019
2023	$6,155,835	$4,183,940**	$10,339,775
2024	$7,042,941	$4,183,937**	$11,226,878

*NSPL Capacity Building Grant

**Notice of SAMHSA State and Territory Cooperative Agreement Grant received on April 14, 2022. These are approximate amounts.

NSPL Contact Volume and Cost Projections

To estimate 988 contact volume projections, Vibrant considered three potential sources, including baseline volume and growth trends, volume likely to be diverted toward 988 from 911 and other crisis lines, and estimated new user volume. Vibrant projects that Texas will receive 487,600 contacts (290,400 inbound and outbound calls, 10,900 texts, and 186,300 chats) within the first year of 988 operations.

Vibrant's estimated total projected costs of year one for 988 Implementation in Texas is $22,926,079. This figure reflects added costs for NSPL call centers, excluding costs for communication and technology related expenses and maintenance.

Volume and cost projections are based on national data and Vibrant's projection models. While historical data provides some of the inputs, there is uncertainty if models and projections could be higher or lower depending on assumptions used.

The state projections from Vibrant reflect each state's proportional share of the national projections based on population. While the national model reflects expert analysis, it cannot account for variation among individual states. Therefore, these projections may not accurately forecast activity in Texas since launching in July 2022.

For example, 2021 demand in Texas was about half of the state's proportional share of the national 2021 demand. Demand has been uneven, but largely stable in

Texas, while the national demand has been growing by seven percent per year.[40] Moreover, the state's chat volume is far lower than the national experience. HHSC anticipates better projections for subsequent years will be possible once specific data becomes available following the 988 launch.

[40] Vibrant Emotional Health (2020). 988 Serviceable Populations and Contact Volume Projections. Retrieved from https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443

4. Strategies to Improve Linkages Between NSPL and Crisis Response Services

Various strategies for improving linkages between NSPL and crisis response services provided by LMHAs and LBHAs include:

- Improving interoperability with Public Safety Answering Points (PSAPs)[41];
- Integrating NSPL systems;
- Improving NSPL connections with LMHA and LBHA crisis systems; and
- Integrating lived experience within the crisis systems.

Interoperability with PSAPs

There are approximately 600 PSAPs throughout Texas. Depending on the community, county, and municipality, dispatch services may be located at multiple 911 call centers. When a person calls 911, telecommunicators assess the situation and attempt to resolve it. If the 911 telecommunicator is unable to quickly resolve the situation by phone, they will dispatch first responders such as sheriff's deputies, police, emergency medical technicians, or firefighters to ensure public safety.

Because 911 telecommunicators may or may not be trained or equipped to identify people experiencing a behavioral health crisis, they frequently dispatch first responders and law enforcement officers to a behavioral health crisis. Without coordination and collaboration between law enforcement, 911 operators, and behavioral health providers, law enforcement is often the de facto responder for assisting people experiencing a behavioral health crisis.[42]

Integral Care and The Harris Center can divert mental health crisis calls from 911 through use of specialized programs working with their local PSAPs, reducing the likelihood law enforcement responds to people in behavioral health crisis through collaboration. Integral Care reports that 82 percent of the calls transferred to a behavioral health clinician are resolved without involving law enforcement or

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[41] FCC (2022). 911 Master PSAP Registry. Retrieved from https://www.fcc.gov/general/9-1-1-master-psap-registry; A primary PSAP is defined as a PSAP to which 9-1-1 calls are routed directly from the 9-1-1 Control Office, such as, a selective router or 9-1-1 tandem.
[42] HHSC. (2022). Integrating 911 and Behavioral Health Response. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/integrating-911-and-behavioral-health-response.pdf

emergency medical services personnel. The Harris Center diverted almost 7,500 calls from law enforcement response between March 2016 and March 2021, which saved resources for the police department.

While these initiatives exist in some urban communities in Texas, the capability to divert mental health crisis calls from 911 is not statewide. Of immediate need, PSAPs must be informed about the shift to 988 and its impact on their response and linkage to services.

Integrate NSPL Systems

Integration of systems across the crisis continuum would increase functionality, such as the monitoring of care provided, communication between NSPL contact centers and mobile crisis systems, mobile dispatch, appointment scheduling, and identifying the appropriate care for people using bed registries.[43]

Vibrant is developing a unified technological platform that is interoperable within and across crisis and emergency response systems. The unified platform is scheduled to go live in November 2022, and will support calls, chats, texts, and emails. The unified platform is comprised of two components: a Contact Center System and a Customer Relationship Management system. Through the unified platform, Vibrant plans to provide:

- Assessment of immediate risks;
- Development of safety plans;
- Scheduling and tracking of follow-ups;
- Coordination and tracking of emergency rescues;
- Analytics and reporting;
- Secure data sharing with external entities; and
- Quality assurance reviews of completed contacts.

When additional information about the fiscal and workforce implications of this unified platform is available, HHSC and the contracted NSPL centers will decide whether to integrate this platform into existing processes.

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[43] SAMHSA. (2022). 988 Implementation Guidance Playbook for States, Territories, and Tribes. Retrieved from https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

NSPL Connections with LMHA and LBHA Local Crisis Hotlines

Currently, there are differences in how some NSPL callers are linked to needed crisis services provided by LMHAs and LBHAs. If an NSPL center in Texas has an existing relationship with an LMHA or LBHA to provide crisis hotline services, that center can deploy that LMHA's or LBHA's MCOT team if needed due to existing agreements. This happens with 13 of the 39 LMHAs and LBHAs. However, if an NSPL center in Texas does not have an existing relationship with an LMHA or LBHA to provide crisis hotline services, that center must contact the LMHA's or LBHA's crisis hotline provider to make the referral for crisis services. Due to each LMHA's unique set of guidelines for deploying crisis services, the caller may receive a different response depending on the county or LMHA and LBHA local service area.[44]

A potential strategy to reduce these differences in service delivery is to streamline the ability for NSPL centers to connect with and deploy the LMHAs' or LBHAs' MCOTs and for LMHAs and LBHAs to take a unified approach for deploying MCOTs. Local needs and resources would have to be taken into account when implementing this strategy.

Integrate Lived Experience into Crisis Systems

SAMHSA emphasizes that a fundamental pillar of care includes peers as a vital part of a crisis program's service delivery system. This should include integrating peers within available crisis line operations, having peers serve as one of two mobile team members and ensuring a peer is one of the first people to greet a person admitted to a crisis stabilization facility.[45]

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[44] All LMHAs and LBHAs must adhere to the rules for accessing crisis services outlined in 26 TAC Chapter 301, Subchapter G, and Information Item V.
[45] SAMHSA. (2020). National Guidelines for Behavioral Health Crisis Care. Retrieved from https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf

Peer support is defined as the process of giving and receiving encouragement and assistance to achieve long-term recovery.[46,47] Peer specialists offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people.[48]

In Texas, a certified peer specialist is a peer specialist in the behavioral health field who completed the Texas Medicaid-approved peer support training and/or holds a certification in good standing from an HHSC-approved certifying entity.[49]

Peer specialists offer their unique lived experiences with recovery from mental health challenges and substance use disorders to provide support focused on advocacy, education, mentoring and motivation. Peer specialists provide peer support services in a myriad of environments, such as emergency departments, federally qualified health centers, community centers, integrated health care settings and criminal justice re-entry programs. Peers use their lived experience of recovery to build trust and a strong therapeutic alliance. This trusting relationship helps forge a connection from the person in crisis to the rest of the service team, which increases the likelihood of effective and comforting care. Their ability to remain objective and non-judgmental, and to relate to people who are suffering, is key to providing care.

Peer warmlines may also be used as a resource for NSPL centers. Currently there are two peer warmlines in Texas. These services offer emotional support, share knowledge and experiences, teach skills, and connect people to resources and support through the organization Hope[50]. Both warmlines offer bilingual services but are not available 24/7. There are additional peer service coordinators trained by the Texas Veterans Commission, funded by the Mental Health Program for Veterans.

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[46] Mead, Hilton, & Curtis. (2014). Peer Support: A Theoretical Perspective. Retrieved from https://www.intentionalpeersupport.org/wp-content/uploads/2014/02/Peer-Support_A-Theoretical-Perspective.pdf

[47] Mead & Hilton. (2014). Crisis and Connection: Speaking Out. Retrieved from http://www.intentionalpeersupport.org/wp-content/uploads/2014/04/CrisisAndConnection.pdf

[48] Solomon, P. (2012). Peer Support Peer Provided Services, Underlying Processes, and Critical Ingredients. Retrieved from https://numerons.files.wordpress.com/2012/04/6peer-support-peer-provided-services.pdf

[49] Texas HHS (n.d.). Peer Support Services. Retrieved from https://www.hhs.texas.gov/providers/behavioral-health-services-providers/peer-support-services

[50] Peer Support | Mysite (hopefamilyhealthcenter.org)

5. Funding Recommendations

Anticipated funding necessary to implement and sustain 988 calls, texts, chat, intervention services, follow-up, and other services will require funding considerations by the Legislature and pursuing other opportunities to create diversified funding sources. Limited information is publicly available about how each state plans to finance the 988 implementation. Federal block grants have supported initial planning efforts, but few states have passed legislation or made public a plan for financing 988 operations over the long term. The Biden-Harris administration increased federal investments from $24 million to $432 million towards building call center capacity and providing associated services. Congress provided the Department of Health and Human Services workforce funding through the American Rescue Plan Act (ARPA) and the Bipartisan Safer Communities Act.[51] The 988 State and Territory Cooperative Agreements Grant was also funded by ARPA. SAMHSA and Vibrant recommend states explore the following major funding sources:

- Federal grants
- ARPA of 2021 funding

ARPA authorizes states to provide community-based mobile crisis intervention services for a period of up to five years. Funding is available for implementing and administering these services. These costs include, but are not limited to:

- Systems in support of establishing and/or improving crisis call centers;
- Systems integration activities in support of the 988 activities;
- Providing cell phones or iPads to state-staffed MCOTs to facilitate telehealth services;
- Developing and implementing applications to facilitate communication between crisis call centers, mobile crisis providers, and supervisory clinicians with MCT staff; and
- Implementing text and chat technologies and other technologies for people with disabilities.[52]

[51] https://www.samhsa.gov/find-help/988/faqs#roles-and-funding
[52] SAMHSA. (2022). 988 Implementation Guidance Playbook for States, Territories, and Tribes. Retrieved from https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

Medicaid can cover a range of behavioral health services; however, the amount of financing available through Medicaid waivers varies by state. Other states have utilized Medicaid funding to advance crisis services by expanding benefits to cover crisis and rehabilitative services, increase access to home and community-based services, using managed care to organize delivery of services, strengthening service delivery through 1115 demonstration waivers, and financing crisis-related administrative spending.[53]

Although HHSC will continue to leverage existing federal dollars to continue funding Lifeline centers and priorities, the lack of dedicated funding for 988 may create difficulties if federal funding is reduced. In Texas, there is potential for the existing crisis infrastructure to become strained post-988 launch requiring funding support to meet the increased demand.

HHSC will continue to explore the availability of other additional MHBG funds beyond state fiscal year 2024 in an amount sufficient to sustain capacity and any increased volume in crisis, residential, outpatient, or inpatient services provided by LMHAs and LBHAs, to include training, recruitment, and retention needs for the workforce.

[53] SAMHSA. (2022). 988 Implementation Guidance Playbook for States, Territories, and Tribes. Retrieved from https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

6. Strategies to Improve Access to Mental Health and Suicide Crisis Services

Expanding Crisis and Behavioral Health Services

While LMHAs and LBHAs provide a variety of crisis services, not all are available in every county, or from every LMHA and LBHA. There is current need to expand community-based crisis services, including crisis facilities, to rural and border areas without existing community-based crisis services.

Community-based crisis services provide alternatives to costly inpatient hospitalizations by treating people in the least restrictive environment, reducing the use of local emergency departments, diverting people from the criminal justice system, and minimizing law enforcement time spent on transporting and assisting people in crisis.[54]

Expanding community-based crisis services to areas in the state through creative strategies where there is need will help fill the gaps in services. In the *Report on Suicide and Suicide Prevention in Texas*[55], the Statewide Behavioral Health Coordinating Council suggested the following strategies:

- Support and leverage the *All Texas Access Initiative* established by Government Code Section 531.0221[56] to improve access to mental health services in rural areas through state agency and legislative actions;
- Expand access to telehealth services and address issues, such as availability of technology, funding streams, and barriers to confidentiality, related to reimbursement among private insurance plans, and the need for training grants to help mental health providers bring telehealth services online and expanding its use to other services and supports;
- Integrate behavioral health into rural primary care clinics; and

[54] Comprehensive Review of Community-Based Crisis and Treatment Facilities for Persons with Mental Health and Substance Use Disorders in Fiscal Year 2016, Rider 80
[55] HHSC. (2020). Report on Suicide and Suicide Prevention in Texas. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/suicide-prevention-texas-may-2020.pdf
[56] As amended by Senate Bill 633, 86th Legislature, Regular Session, 2019

- Establish satellite community mental health offices.[57]

Follow-up and postvention services are critical aspects of a comprehensive crisis response system. These services act as a safety net for those at risk of suicide and aids in the transition to recovering from a crisis. Unfortunately, adequate resources identified by Vibrant as essential to service offerings for higher risk populations are limited.

Communication Strategy for Specific Populations

HHSC will develop and support targeted messaging to reach specific populations that have historically been marginalized as well as the organizations who serve them. These include outreach, test marketing, and other feedback mechanisms to refine messaging targeting marginalized groups including:

- Veterans
- People living in rural areas;
- Children and adolescents;
- Middle-aged adults;
- Tribal communities;
- People with language needs (e.g. American Sign Language and Spanish speaking populations);
- Black, Indigenous, and people of color (BIPOC);
- College age young adults;
- Chronically ill people and people with disabilities;
- People with lower incomes; and
- Other vulnerable populations.

Communicating with health professionals outside of crisis services will also be important. Current research on suicide prevention highlights the potential life-saving impact of healthcare systems on this devastating problem. A review of health system data from eight states showed that of 6,000 people who died by

[57] HHSC. (2020). Report on Suicide and Suicide Prevention in Texas. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/suicide-prevention-texas-may-2020.pdf

suicide, 83 percent received health care in the year before death, with 50 percent visiting a provider within one month of death.[58] Most of these people (64 percent) had no mental health diagnosis and saw a primary care or medical specialty physician before death. In an evaluation of health service utilization prior to a suicide attempt, researchers found that 70 percent of participants visited an emergency department and 42 percent had a hospitalization in the year prior.[59] Together, these results demonstrate the importance of prevention and intervention practices across healthcare settings, including inpatient and outpatient clinics and emergency departments.

Increase Support and Training for Mental Health Professionals

To help address workforce shortages, policymakers may consider additional incentives, training, and support for mental health professionals, to include encouraging people in BIPOC communities to become providers to ensure culturally competent care. Prioritizing opportunities for rural mental health professionals may result in more licensed mental health professionals practicing in rural areas, and prioritizing professionals who work at a state facility, agency, or LMHA and LBHA may help these entities with the challenge of recruiting and retaining a qualified mental health workforce.[60]

HHSC will provide opportunities for NSPL call center staff to receive annual education and training. The training will include information on current substance use intervention, treatment, and community services in each of the eleven health and human services regions. HHSC will ensure substance use services and education websites are current. A list of substance use resources can be found in Appendix D.

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[58] Ahmedani, B., Simon, G., Stewart, C. et al. (2014). Health Care Contacts in the Year Before Suicide Death. J GEN INTERN MED, 29, 870–877. https://doi.org/10.1007/s11606-014-2767-3

[59] Kammer, J., Rahman, M., Finnerty, M. et al. (2021). Most Individuals Are Seen in Outpatient Medical Settings Prior to Intentional Self-Harm and Suicide Attempts Treated in a Hospital Setting. J Behav Health Serv Res., 48(2), 306-319. doi: 10.1007/s11414-020-09717-1.

[60] HHSC. (2020). All Texas Access Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf

7. 988 Implementation Study Recommendations

In the Final 988 Implementation Plan, the 988 Stakeholder Coalition identified the following goals for the Rider 58 Workgroup:

- Identify strategies to address workforce shortage, recruiting, retention, support, and cultural competency;
- Identify, assess, recommend, and plan for funding expansion to meet the needs of 988 implementation and sustainability;
- Examine the development of a statewide, centralized resource base; and
- Identify strategic community partners who may have needs pertaining to revising and updating communications mechanisms outside of the scope of state agency entities.

Based on these goals and the evaluation completed as part of this study, HHSC and the Rider 58 Workgroup recommend the following considerations:

Crisis Care and Behavioral Health Capacity

- Expand crisis services across the state, focusing on specific communities at-risk for suicide and regions with low resources and reducing unnecessary law enforcement involvement;
- Improve access to crisis services and resources to rural and frontier communities, non-English speaking communities, tribal nations, BIPOC, Veterans, and other high-risk communities;
- Leverage peers' expertise in crisis services through warmlines and crisis receiving facilities, to include peer-run respite services;
- Provide support and additional training support to NSPL centers on staff hiring, retention, and performance (e.g., Transformation Transfer Initiative); and
- Align HHSC TAC and contract standards with Vibrant's and SAMHSA's best practices (e.g., 988 playbooks).

Engagement and Communication

- Collaborate with the Commission on State Emergency Communications to provide joint training and education to PSAPs; and

- Execute Communications Plan and planned outreach activities to specific communities;

Data and Performance Management

- Gather additional data evaluation components to identify to which services 988 callers are being referred to
- Based on the additional information received, research the operational and fiscal ability to utilize Vibrant's unified platform[61] in support of the following capabilities:
  - Assessment of immediate risks
  - Development of safety plans
  - Scheduling and tracking of follow-ups
  - Coordination and tracking of emergency rescues
  - Analytics and reporting
  - Secure data sharing with external entities
  - Quality assurance reviews of completed contacts
- Implement a study to determine what it would cost to incorporate technology within HHSC's existing infrastructure that would allow NSPL contacts to be tracked through the crisis continuum.

Funding

- Diversify funding to ensure sustainability over time.

[61] 988 Implementation Guidance Playbook for States, Territories, and Tribes https://www.nasmhpd.org/content/988-implementation-guidance-playbooks

8. Conclusion

HHSC studied the adequacy and efficacy of the existing NSPL infrastructure in Texas and determined that while there are existing services available, the infrastructure will face challenges in adequately meeting the increased demand resulting from the implementation of 988.

In this report, HHSC offers strategies to improve linkages between NSPL centers and crisis response services, access to mental health crisis and suicide response, and recommendations for sources of sustainable funding for the NSPL infrastructure and crisis response services.

These strategies entail expanding the existing workforce to include peers and people with lived experience; increasing support and training for the workforce; aligning local crisis hotline staffing standards with the NSPL staffing standards; improving interoperability with PSAPs; improving NSPL connections with LMHA and LBHA crisis systems; expanding the existing crisis infrastructure; securing sustainable funding for NSPL and additional crisis services through additional MHBG funds; and targeting communication efforts towards high-risk and specific populations.

List of Acronyms

Acronym	Full Name
ARPA	American Rescue Plan Act
BIPOC	Black, Indigenous, and people of color
CSU	Crisis stabilization unit
EOU	Extended observation unit
FCC	Federal Communications Commission
HHSC	Health and Human Services Commission
LBHA	Local behavioral health authority
LMHA	Local mental health authority
MCOT	Mobile crisis outreach team
MHBG	Mental Health Block Grant
MHD	Mental health deputy
NSPL	National Suicide Prevention Lifeline
OSAR	Outreach, Screening, Assessment, and Referral
PSAP	Public safety answering point
QMHP-CS	Qualified mental health professional-community services
SAMHSA	Substance Abuse and Mental Health Services Administration
SMVF	Service Members, Veterans, and their immediate family members
TAC	Texas Administrative Code
U.S.	United States
YES	Youth Empowerment Services

Appendix A. Additional Background

Suicide Prevalence and Burden

Although suicide rates declined slightly from 2018 to 2020, the overall age-adjusted suicide rate in the U.S. increased 30 percent between 2000 and 2020.[62] While death by suicide varies across demographic and socioeconomic classifications, there were significant increases across all racial and ethnic groups, genders, and geographical areas. Suicide accounted for over 45,000 reported deaths in the U.S. in 2020.[63] This total likely underestimates the true prevalence of suicide due to unknown intent among certain types of deaths, for example, drug overdoses and car accidents. Suicide mortality rates in Texas follow a similar trend. The age-adjusted suicide rate increased from 10.2 deaths per 100,000 population in 2000 to 13.3 deaths per 100,000 population in 2020.[64]

This highly preventable public health crisis impacts the family and friends of those who die and has a social and economic burden that extends into communities and the nation. Although people can be affected to varying degrees, those bereaved by suicide are likely to experience complicated grief reactions including post-traumatic stress disorder. Additionally, suicide loss survivors are at a higher risk of making a suicide attempt or dying by suicide themselves.

The numbers and rate of suicide attempts have continued to rise over the last several years. The Texas Department of State Health Services currently collects inpatient and outpatient data from hospitals and ambulatory surgical centers. From 2016 to 2019, there were over 18,000 emergency room visits each year for suicide attempt or non-suicidal self-injury where the person was treated and not admitted to the hospital.[65]

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[62] CDC. (2022). Suicide Mortality in the United States, 2000-2020. Retrieved from https://stacks.cdc.gov/view/cdc/114217

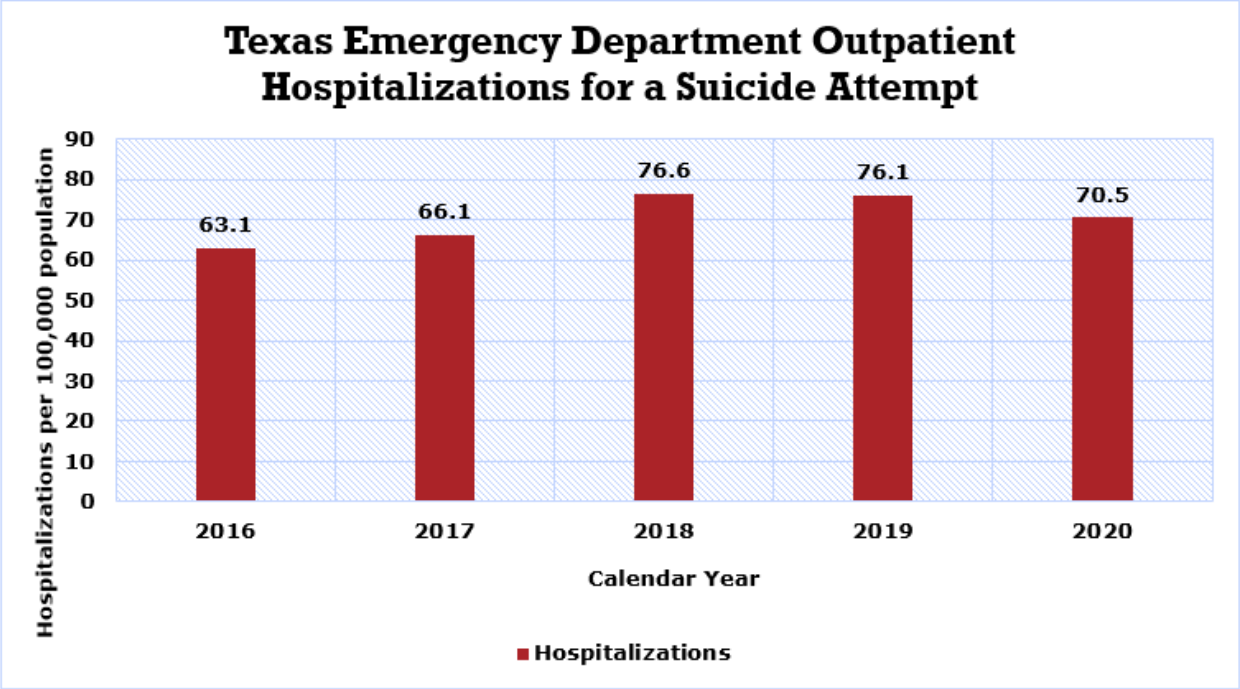
[63] CDC, National Centers for Health Statistics on CDC WONDER

[64] CDC, National Center for Health Statistics. National Vital Statistics System, Mortality 1999-2020 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999-2020, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/ucd-icd10.html

[65] HHSC. (2020). Report on Suicide and Suicide Prevention in Texas. Retrieved from: https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/suicide-prevention-texas-may-2020.pdf.

While these incidents only account for a small portion of emergency room visits each year, the number of visits in emergency departments for suicide attempts is more than five times the number of suicide deaths each year in Texas.

Figure 1. Texas Emergency Department Outpatient Hospitalizations for Suicide Attempt, 2016-2020[66]



High rates of suicide and suicide attempts in the U.S. additionally represent a financial burden of nearly $490 billion each year.[67] As mentioned, suicide cost Texas approximately $42.2 billion in medical costs, work loss costs, value of statistical life, and quality of life costs in 2020.[68]

Overview of National Suicide Prevention Lifeline (NSPL)

The NSPL is a network of over 200 independently operated and funded local and state crisis centers. The NSPL is funded by the federal Substance Abuse and Mental

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[66] Texas Health Care Information Collection (THCIC), Department of State Health Services
[67] CDC, Office of the Associate Director for Policy and Strategy. (2021). Health Topics – Suicide Prevention. Retrieved from www.cdc.gov/policy/polaris/healthtopics/suicide/index.html
[68] CDC, National Center for Injury Prevention and Control. (2021). WISQARS Cost of Injury. Retrieved from https://wisqars.cdc.gov/cost/

Health Services Administration (SAMHSA) and administered by Vibrant Emotional Health (Vibrant). The NSPL provides support for people in a suicide crisis or mental health-related distress, as well as suicide prevention and crisis resources, and best practices for professionals. The NSPL is available through calls, chats, or texts at no cost, 24/7. Calls to the NSPL are confidential and require a court order for disclosure.

In federal fiscal year 2021, the NSPL received approximately 2.4 million calls, 1.1 million chats, and 0.1 million texts.[69] SAMHSA expects the overall demand to increase, especially for chat and text services, with the transition to 988. The primary goal of all NSPL contacts is to work collaboratively with the person in crisis to determine the least-invasive intervention and keep them safe.

NSPL History and Federal Legislation

The NSPL launched with the number 1-800-273-8255 (TALK) in 2005 and received approximately fifty thousand calls in the first year.[70] The NSPL introduced a Spanish language subnetwork in 2006, partnered with Veterans Affairs to establish the Veterans Crisis Line in 2007, and incorporated the Disaster Distress Helpline into the NSPL in 2015. The NSPL initiated online chat services in 2013 and text services in 2020.

First introduced in May 2017 and enacted in August 2018, the National Suicide Hotline Improvement Act (H.R. 2345) directed the U.S. Federal Communications Commission (FCC) and SAMHSA to study the feasibility of designating a three-digit dialing code for the NSPL. In August 2019, the FCC and SAMHSA submitted a report recommending 988 as the three-digit dialing code for the NSPL.[71]

In July 2020, the FCC officially designated 988 as the universal telephone number for the NSPL, requiring all U.S. telecommunication carriers to ensure nationwide accessibility by July 16, 2022.

In October 2020, Congress passed the National Suicide Hotline Designation Act (S. 2661), designating 988 as the universal telephone number for national suicide prevention and mental health crisis, incorporating 988 into statute, and directing

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[69] SAMHSA. (2022). 988 Powerpoint Presentation Deck. Retrieved from https://www.samhsa.gov/sites/default/files/988-presentation-deck.pptx
[70] SAMHSA. (2022). Lifeline Timeline. Retrieved from https://www.samhsa.gov/find-help/988/lifeline-timeline
[71] Federal Communications Commission. (2020). Report and Order in WC Docket No. 18-336, 85 FR 57767.

the Department of Health and Human Services to develop a strategy to provide access to services for high-risk populations. Additionally, the legislation includes a provision allowing states to levy a fee for:

- Ensuring the efficient and effective routing of calls made to the 988 National Suicide Prevention and Mental Health Crisis Hotline to an appropriate crisis center; and
- Personnel and the provision of acute mental health, crisis outreach and stabilization services by directly responding to calls to the 988 National Suicide Prevention and Mental Health Crisis Hotline.

On October 17, 2020, the bill was signed into law by President Trump. In November 2021, the FCC ruled to require all U.S. telecommunication providers to also activate text messaging to 988 by July 16, 2022.

NSPL Contact Routing

When people call the NSPL, a greeting presents the caller with options to connect to the Veteran's Crisis Line or the Spanish subnetwork. If the caller does not make a selection, the NSPL phone system routes the call to a local crisis center in the NSPL network based on area code. If that center is unavailable to answer the call within 30 seconds, the caller is rerouted to a backup center in the NSPL network.

When a caller connects to a local crisis center or one of the many national backup centers, a trained crisis counselor is there to listen to the caller, provide support, and share resources or referrals as needed.

Regular quality assurance evaluations of the NSPL show that after speaking with a trained crisis counselor, callers are significantly more likely to feel more hopeful, less depressed, less overwhelmed, and less suicidal.[72]

While the processes and resources vary across the NSPL network, all centers have written procedures for providing access to resources, making referrals for services, and activating emergency services for callers outside the NSPL center's local service area. Currently, only two percent of NSPL calls require activation of the 911 system when there is imminent risk to someone's life that cannot be reduced during the

[72] SAMHSA. (2022). 988 PowerPoint Presentation Deck. Retrieved from https://www.samhsa.gov/sites/default/files/988-presentation-deck.pptx

call. In these cases, the crisis counselor shares information with 911 that is crucial to saving the caller's life.[73]

When someone texts the NSPL or uses the online chat, they first complete a short survey letting the crisis counselor know a little about their current situation. Both text and chat interactions are organized into one queue in Vibrant's PureConnect system. Unlike NSPL calls, NSPL chats and texts are not currently routed to the state the person is located in. Instead, centers who participate in answering chats and texts are connected to the larger NSPL network and receive texts/chats depending on the availability of individual counselors within participating centers. Vibrant is working to expand the network to allow local-based response for chat and text. In May 2022, Vibrant began beta-testing state routing. Once implemented, Vibrant will route chats and texts to crisis centers equipped to respond in the state where the text or chat originated. The location will be determined by the area code of the phone number for text and either the IP address or zip code for chat. Text and chat interactions typically take more time compared to phone interactions.

NSPL Operational Standards and Requirements

To be part of the NSPL network, a crisis center must be certified, accredited, or licensed by an external body; follow specific call answering standards; and participate in NSPL quality assurance evaluation activities. Specifically, the crisis center must provide proof of certification/accreditation from one of the following:

- American Association of Suicidology;
- CONTACT USA;
- Alliance of Information and Referral Systems;
- The Joint Commission;
- Commission on Accreditation of Rehabilitation Facilities;
- Council on Accreditation;
- Utilization Review Accreditation Commission;
- DNV Healthcare, Inc.; or

[73] Vibrant Emotional Health. (2021). 988 and the National Suicide Prevention Lifeline. Retrieved from https://suicidepreventionlifeline.org/wp-content/uploads/2021/01/988_two_pager_2021.pdf

- State/county licensure, as approved by the NSPL Administrator.

Vibrant requires crisis centers to have a distinctive call operation with the capacity to identify, receive and respond to calls from people in distress, preferably 24/7.[74] The crisis call operation must utilize its own policies, procedures, and training protocols and have identified staff and an administration that is responsible for the oversight of the operation. Additionally, the crisis center must be able to provide basic training of call center staff for both new and active staff members. During the onboarding process, Vibrant works with individual crisis centers to ensure the centers' procedures and training protocols align with NSPL policies.

Overview of Behavioral Health Services in Texas

In 2007, the 80th Texas Legislature appropriated $82 million to HHSC (formerly the Department of State Health Services) to improve the state's mental health and substance use crisis service delivery system[75]. In subsequent years, the Texas Legislature has continued to invest in an array of crisis and behavioral health services that offer treatment to support ongoing recovery. Past funding priorities have included treating people in the least restrictive environment, reducing use of local emergency departments, diverting people from the criminal justice system, minimizing law enforcement officer time, and enhancing community-based crisis alternatives in underserved communities.

Most recently, the 85th (2017)[76] and 86th (2019)[77] Texas Legislatures appropriated funds to expand outpatient and inpatient care for people in crisis. The investments by the Texas Legislature have allowed for significant improvements in behavioral health services, including:

- Increased access to 24/7 crisis hotlines and MCOTs;
- Increased alternatives to jail-diversion and inpatient psychiatric hospitalization;
- Redesign of select state hospitals;

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[74] Vibrant Emotional Health. (2017). Lifeline Requirements for Membership. Retrieved from https://suicidepreventionlifeline.org/wp-content/uploads/2017/07/Appendix-1-Lifeline-Requirements-for-Membership.pdf
[75] House Bill 1, General Appropriations Act, Regular Session, 2007.
[76] Senate Bill 1, General Appropriations Act, Regular Session, 2017; and Senate Bill 292, Regular Session, 2017.
[77] House Bill 1, General Appropriations Act, Regular Session, 2019.

- Increased funding for LMHAs and LBHAs to purchase private psychiatric beds; and
- Significant funding improvements, on a per capita basis, for rural-serving LMHAs and LBHAs.[78]

Publicly funded behavioral health services are mainly comprised of community mental health, substance use, and inpatient psychiatric services. Public mental health services are primarily provided through HHSC's contracts with 37 LMHAs and two LBHAs.

While the Texas legislature has demonstrated continued investment in community-based crisis services, the demand often exceeds available resources. Due to an increased demand, often "the only treatment options for people in behavioral health crises are in settings that do not adequately meet their needs despite being extremely costly, such as emergency departments and inpatient psychiatric units. Further, lack of appropriate and accessible behavioral health crisis response too frequently results in law enforcement being the only available first responders, which may lead to an increase in unnecessary arrest and incarceration for people with acute behavioral health needs."[79]

Services Provided by LMHAs and LBHAs

LMHAs and LBHAs provide crisis and substance use services, ongoing community-based behavioral health services, and connections to local resources. Every county in Texas is served by one of the 39 LMHAs and LBHAs throughout the state.

LMHAs and LBHAs provide services for children, adolescents, and adults meeting medically indigent criteria; people with a priority population diagnosis[80]; and

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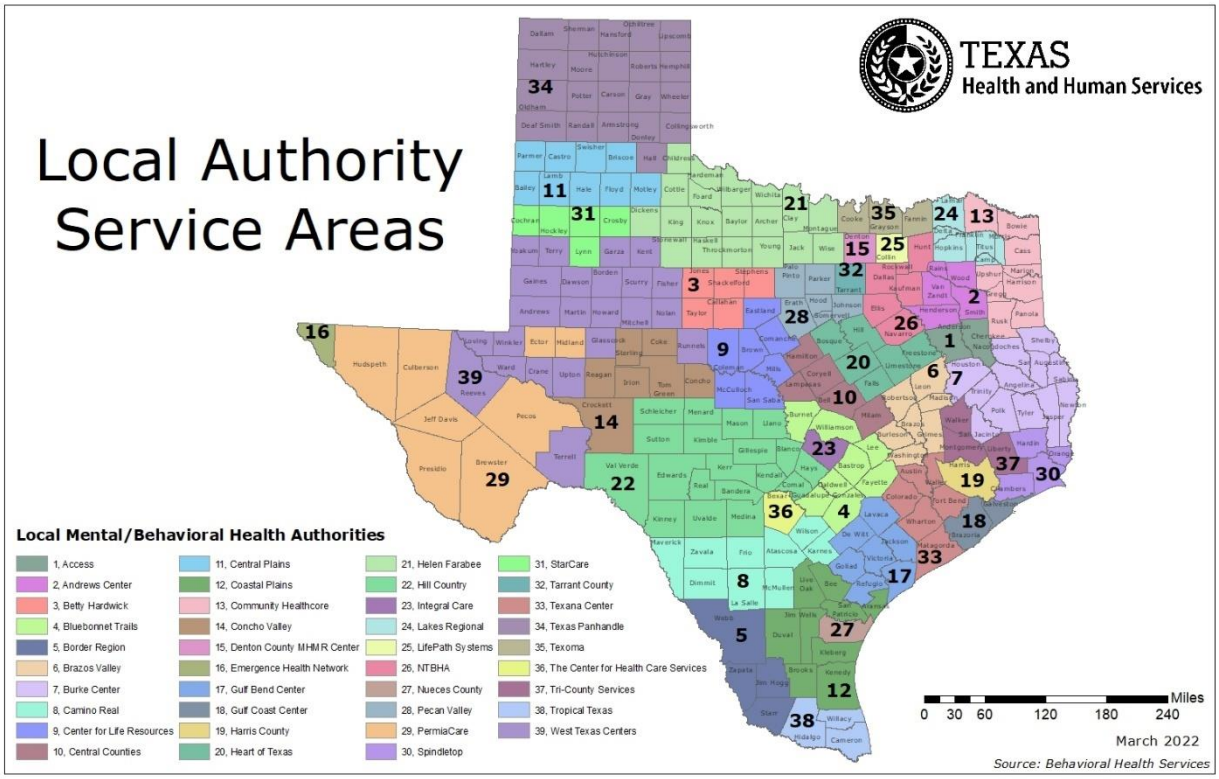
[78] HHSC. (2020). All Texas Access Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf

[79] National Council for Mental Wellbeing. (2021). Roadmap to an Ideal Crisis System. Retrieved from www.thenationalcouncil.org/wp-content/uploads/2022/02/042721_GAP_CrisisReport.pdf

[80] Per the Performance Contract Notebook, the priority population for adults are people who have severe and persistent mental illnesses such as schizophrenia, major depression, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, anxiety disorder, attention deficit/hyperactivity disorder, delusional disorder, bulimia nervosa, anorexia nervosa, or other severely disabling mental disorders which require crisis resolution or ongoing and long-term support and treatment. The priority population for

anyone eligible for Medicaid who resides in the LMHA's/LBHA's service area.[81] Figure 2 is a map of Texas counties by local authority service area.

Figure 2. Local Authority Service Areas



Each of the 39 LMHAs and LBHAs provides crisis services to all 254 counties in Texas 24/7. Of the 39 LMHAs and LBHAs:

- 9 only serve counties with a population over 250,000;
- 10 serve a mix of counties with a population under and over 250,000; and
- 20 serve counties with a population of 250,000 or less.

LMHA and LBHA staff aim to help people understand treatment options and address the challenges associated with their mental health and/or substance use disorders.

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children are people ages 3-17 with serious emotional disturbance (excluding a single diagnosis of substance abuse, intellectual or developmental disability, or autism spectrum disorder), who have a serious functional impairment, or who are at risk of disruption of a preferred living or children care environment due to psychiatric symptoms or are enrolled in special education because of a serious emotional disturbance.

[81] Hogg Foundation for Mental Health. (2018). Public Behavioral Health Services in Texas. Retrieved from https://hogg.utexas.edu/wp-content/uploads/2018/11/Public-Behavioral-Health-Services-in-Texas.pdf

LMHAs and LBHAs work with people to achieve stability of their symptoms, sufficient to continue to live in the community. Each person who requests LMHA and LBHA services is screened for eligibility and level of need; services are offered based on a person's level of need at any given time. LMHAs and LBHAs are contractually required to use evidence-based practices to provide counseling, peer support services, medication management, skills training, and psychosocial rehabilitation. HHSC estimates LMHAs and LBHAs served 282,911 unique people in fiscal year 2020 and 290,533 people in 2021. Of those people, 26 percent and 30 percent, respectively, received crisis services[82].

LMHAs and LBHAs collaborate with partners in the community, including mental health providers, schools, law enforcement, court systems, hospitals, and primary health care providers. Strong collaborative relationships with these community partners are critical to the ability of an LMHA and LBHA to provide mental health services to community members earlier and more effectively.

HHSC contracts with LMHAs and LBHAs to provide services in each of their local service areas. Through these contracts, HHSC allocates general revenue appropriated by the Texas Legislature along with federal grant money awarded to the state. LMHAs and LBHAs also receive Medicaid reimbursement when serving people enrolled in the state Medicaid program. In addition to these, LMHAs and LBHAs work to generate funding from a variety of sources to ensure that they can effectively meet the mental health needs of the population they serve. This often involves applying for federal, state, or private grant programs; working with private foundations; and partnering with other local organizations to develop or sustain specific programs or services.[83]

Texas Geography and Population

Texas has 268,597 square miles with 254 counties. According to the U.S. Census, in April 2020, Texas's population was 29.1 million people.[84] Much of the Texas population is clustered around metropolitan areas, including Houston, San Antonio, Austin, El Paso, and the Dallas-Fort Worth Metroplex. People in rural regions of the state sometimes must travel long distances to access services without access to public transportation compared to people located in urban regions. Due to a lack of

[82] Source: HHSC, Office of Decision Support, 2022
[83] HHSC. (2020). All Texas Access Report. Retrieved from https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf
[84] US Census. Retrieved from https://www.census.gov/quickfacts/TX

transportation in rural regions, some residents may go without mental health treatment until it becomes a crisis resulting in an emergency room visit or call to 911. Additionally, rural regions have an underdeveloped broadband infrastructure, so audio-visual synchronous services (i.e., telehealth or telemedicine) are not generally viable options for receiving services.[85]

The Texas Office of the State Demographer reports projected statewide population growth between 2019 (population 29,193,268) through 2029 (population 34,345,157) to be 5,151,889 and suggests most Texas counties will experience continued steady population growth. This is especially the case for suburban counties surrounding the large urban centers of Dallas-Fort Worth, Houston, San Antonio, and Austin. Other counties projected to experience rapid growth between now and 2029 are counties along the southern border and select counties in the Panhandle region.[86] Texas' population growth is rapidly outpacing psychiatric hospital capacity within state hospitals and private psychiatric facilities.

The 2018 U.S. Census Bureau data indicated that 5 million Texas residents (17.7 percent) did not have health insurance coverage in 2018, compared to the national rate of all insured people in the United States (8.9 percent) in 2018.[87] Projected population growth, coupled with the growing number of uninsured Texans, will impact the current statewide resource shortages that can limit availability of community-based mental health crisis services as an alternative to inpatient psychiatric care.

Crisis Continuum of Care

Crisis services include prompt face-to-face crisis assessment, crisis intervention services, and crisis follow-up and relapse prevention services. LMHAs and LBHAs operate crisis programs, including crisis hotlines, MCOTs, MHDs, various types of crisis facilities, and inpatient psychiatric beds. Crisis services are available statewide to everyone, regardless of if they are enrolled in ongoing mental health care. An overview of all crisis services can be found in Appendix B.

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[85] All Texas Access Report, 2020
[86] Texas Population Office of the State Demographer. https://demographics.texas.gov
[87] Fernández, S. (2019). Texas has Most People without Health Insurance. Retrieved from https://www.texastribune.org/2019/09/10/texas-has-most-people-without-health-insurance-nation-again/

Community-based crisis services reduce unnecessary stays in psychiatric hospitals, reduce the number and expenses of emergency department visits, and divert persons from inappropriate incarcerations while producing efficient outcomes.

Rider 58 Study and External Workgroup

HHSC established a Rider 58 external workgroup to assist in studying the adequacy and efficacy of existing NSPL infrastructure in Texas. Rider 58 workgroup members included HHSC staff and external stakeholders including representatives from the four HHSC-contracted NSPL centers and people representing diverse public and private organizations who bring experience in infrastructure development, suicide prevention, state policy and administration, advocacy, social services and support, and lived experience.

The study's findings and recommendations provide the necessary information to ensure a successful transition away from the current ten-digit 1-800 crisis number towards the new three-digit number in the state of Texas.

Appendix B. HHSC Resources

Crisis Services

Crisis Hotline

The Crisis Hotline is a 24/7 telephone service operated by trained crisis staff providing crisis screening and assessment, crisis intervention services, and referrals. The crisis hotline serves as an immediate point of contact for mental health and substance use crises in the community, providing confidential telephonic triage to determine the immediate level of need and to mobilize emergency services for the caller if necessary. The crisis hotline facilitates referrals to 911, MCOT, or other crisis services and conducts follow-up contacts to ensure callers successfully accessed the referred services. If crisis hotline staff's screening indicates a person is in crisis, they may choose to activate MCOT or emergency services like law enforcement or emergency medical services.

Mobile Crisis Outreach Teams (MCOTs)

MCOTs are qualified professionals deployed into the community to provide a combination of crisis services including emergent care (response within one hour), urgent care (response within eight hours), crisis follow-up, and relapse prevention to people of all ages. A team is comprised of two or more staff providing psychiatric emergency care that go into the community to begin the process of assessment and provide recommendations for the least restrictive treatment environment. MCOTs respond to calls in the community and collaborate closely with community partners, such as law enforcement and local emergency departments, to ensure behavioral healthcare needs are appropriately addressed.

Mental Health Deputies (MHDs)

Several LMHAs subcontract with local sheriffs' departments to deploy a certified MHD to address people in crisis. An MHD is an officer specially trained in crisis intervention who works collaboratively with the community and the LMHA's crisis response teams. MHDs help improve the crisis response system by diverting people in need of behavioral health crisis services from hospitals and jails to community-based alternatives providing effective behavioral health treatment. MHDs are not available statewide.

Non-facility Crisis Programs

HHSC also funds non-facility crisis programs, including the Continuity of Care program at Burke Center, substance use treatment within a crisis residential facility, the Mental Health Docket program at Texas Panhandle MHMR, and the Crisis Intervention Response Team program at Tri-County Behavioral Healthcare. These non-facility crisis programs are unique to specific local authorities and therefore not available statewide.

Crisis Facilities

Several LMHAs and LBHAs operate crisis facilities. Crisis facilities may be staffed with mental health professionals, medical professionals, or others (such as peer providers) offering assessment, support, and services to achieve psychiatric stabilization to people with behavioral health needs. The four types of crisis facilities are described below, ranging from the least restrictive to the most restrictive environment.

Crisis Respite

Crisis respite provides short-term, community-based crisis care for people who pose a low risk of harm to themselves or others and may have some functional impairment that necessitates direct supervision and care, but who do not require hospitalization. These services can occur in houses, apartments, group and foster homes, the person's own home, or other community living situations. Crisis respite services may serve people with housing challenges or assist caretakers who need short-term housing or supervision for the people for whom they care to help that person avoid a mental health crisis. Utilization of these services is managed by the LMHA or LBHA based on medical necessity. The availability of facility-based respite units is dependent on LMHA or LBHA funding. Facility-based crisis respite services have trained staff on-site 24/7. Some crisis respites are run by peer providers (People with at least one cumulative year of receiving mental health community services).

Crisis Residential

Crisis residential provides short-term, community-based residential crisis treatment to people experiencing a behavioral health crisis that cannot be stabilized in a less restrictive setting. Crisis residential services are provided to people presenting with increased risk of harm to self or others or moderately sever functional impairment.

Crisis residential facilities provide a safe environment with staff on site at all times. People must present on a voluntary basis and can participate in treatment and services at a minimum level of engagement, as defined by the person's treatment team.

Extended Observation Unit

Extended observation units (EOUs) provide people presenting on voluntary or involuntary status, with access to emergency psychiatric care 24/7. EOU services are provided in a safe and secure environment and staffed by medical personnel, mental health professionals, and trained crisis support staff. EOUs must have the ability to serve people with psychiatric symptoms ranging from moderate to severe, depending on the EOU's level of observation services, and coordinate a person's transfer to a higher level of care after 48 hours when clinically indicated and ordered by a physician, preferably a psychiatrist.

Crisis Stabilization Unit

Crisis stabilization units (CSUs) provide short-term, residential treatment designed to reduce acute symptoms of mental illness or serious emotional disturbance instead of admissions to an inpatient mental health facility in a secure and protected, clinically staffed and psychiatrically supervised treatment environment. CSUs[88] are the only facility type in the crisis array that requires licensure in accordance with 26 TAC Chapter 306, Section 306.47.[89]

Inpatient Psychiatric Beds

HHSC provides funding to LMHAs and LBHAs for inpatient psychiatric services in licensed private psychiatric hospitals[90] to people with acute symptoms in need of inpatient psychiatric treatment and stabilization. These services treat people on a voluntary admission, civil commitment, or forensic commitment. Civil commitments are for people receiving court-ordered treatment through a probate court. Forensic commitments are for people adjudicated incompetent to stand trial or not guilty by

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[88] https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/hospitals/hospital-csu-directory.pdf

[89] https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=26&pt=1&ch=306&sch=B&div=1&rl=Y

[90] https://www.hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/facilities-regulation/hospitals/hospital-psych-directory.pdf

reason of insanity by a criminal court. HHSC contracts with all 39 LMHAs and LBHAs for inpatient psychiatric beds.

Peer Services

Consumer Operated Service Provider Program

The Consumer Operated Service Provider (COSP) program is an evidence-based program offering recovery support services directed and managed by people who have lived experiences of recovery from mental health challenges.

The COSP program consists of peer-run organizations that have a sub-recipient relationship with local mental health and behavioral health authorities (LMHAs and LBHAs). These entities provide a broad range of peer support and recovery services to people seeking assistance for mental health challenges.

Recovery Focused Clubhouse

The Clubhouse Model is an evidence-based, recovery-oriented program for adults living with mental health challenges. The purpose of the program is to improve a person's ability to function successfully in the community through involvement in a peer-focused environment. Members are encouraged to participate in the operation of the Clubhouse by helping with various tasks, such as clerical duties, reception, food service, transportation, and financial services.

Mental Health Peer Support Community Re-Entry

The Mental Health Peer Re-Entry program enables mental health peer support providers with prior justice involvement, to provide reach-in and re-entry services to people with mental health challenges who are incarcerated in county jails. The program uses certified peer specialists employed by the LMHAs and LBHAs to support the successful transition of people from the county jail into clinically appropriate community-based care.

Family Partner Supports

Family partner support services are for the primary caregiver of a child who is receiving mental health services. These may include introducing the family to the

mental health treatment process, modeling advocacy skills, providing information, making referrals, providing skills training and helping to identify supports for the child and family. Services are not provided directly to the child. Services are provided by a certified family partner or a family partner waiting to complete approved training. In addition to their training, they have first-hand experience as primary caregivers of children with a mental health diagnosis. The family partner uses their experience to help primary caregivers learn how to help their child with a mental health diagnosis.

Substance Use Services

Outreach, Screening, Assessment, and Referral Services

OSAR services help people get substance use services, case management and peer support[91]. An OSAR service provider will stay in touch with people waiting for treatment and refer them to community services while they are waiting.

Texas residents can call one number to get information about substance use and mental health treatment services. Texans seeking services and information may qualify for services based on need.

OSAR programs can be the starting point for people who want help accessing substance use services if are unsure where to begin. Texans experiencing anxiety, stress, or emotional changes due to the pandemic can seek help from these resources. For immediate and confidential help, 24/7. OSAR may also be reached by calling 211 or searching online.

Opioid and Stimulant Community Support Services

Community resources span the behavioral health continuum of care including prevention, treatment, and recovery support services. These include medication-assisted treatment, peer recovery coaching, disposal of prescription drugs, and overdose-related emergency response services. Those who benefit from services include people with opioid use disorder, their family members, significant others,

[91] Outreach, Screening, Assessment & Referral | Texas Health and Human Services

and supportive allies who are affected by opioid and/or stimulant use. Relevant resources are listed below.

Texas Targeted Opioid Response

Opioid Misuse Public Awareness Campaign

The Texas Targeted Opioid Response opioid misuse public awareness campaign is a statewide health communication effort aimed at educating Texans about how to prevent prescription opioid misuse and overdose and protect themselves and their family. Community resources are listed on the Texas Takes Action and Get Help pages. [92]

Safe Drug Disposal

Unused medications from a past prescription can lead to misuse. This program provides free, single-use medication disposal pouches and increases access to safe disposal sites throughout the state. This program also provides an online map showing locations where these pouches may be picked up.[93]

Overdose Prevention Education and Access to Naloxone

Overdose prevention education and access to naloxone, an opioid overdose reversal medication, is free and available statewide. The program provides timely and effective community response to overdose while reducing overdose deaths. Information is available on the More Narcan Please website.[94]

Drop-in Centers

Drop-In Center programs offer more inclusive and comprehensive services for people experiencing crisis events or problems with substances. Drop-in Centers provide people at high risk for overdose with access to prevention education,

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[92] For additional information, please visit https://txopioidresponse.org/
[93] For additional information, please visit https://uh.edu/pharmacy/research/centers-and-institutes/the-premier-center/community-outreach/index.php
[94] For additional information, please visit https://www.morenarcanplease.com/
https://www.morenarcanplease.com/

overdose reversal medication, access to medication-assisted treatment induction, and recovery support. The centers reduce harms associated with substance use, individual overdose, and death, and increase recovery initiation.

Recovery Housing

Project HOMES provides housing for people in medication-assisted recovery from opioid and stimulant use disorders.

Heroes Helpline

Heroes Helpline offers free, telephone-based peer support, treatment navigation, and referral services for all first responders and healthcare workers in Texas.[95]

Recovery Support Services

Recovery Support Services is an evidence-based practice funded through SAMHSA that supports services to increase long-term recovery and recovery quality to people with a history of alcohol or drug problems, including co-occurring mental health disorders, who are in or seeking recovery, along with their family members and significant others.[96] Services are provided by peer specialists. Peer specialists help initiate services like counseling, sober housing, transportation, and medications. Peers provide support before, during and after treatment.

Youth Recovery Committees

Youth Recovery Communities (YRCs) provide recovery support services to adolescents and young adults ages 13-21 years that may have a substance use disorder or want a substance-free environment.

The YRCs support adolescents, young adults, and their families by providing peer support and recovery-oriented services in addition to hosting substance free activities. The YRCs also establish effective linkages between recovery support organizations, substance use treatment programs and other community resources

[95] For additional information, please visit https://heroeshelpline.org/
[96] For additional information, please visit https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/recovery-support-services

that support efforts to initiate and sustain the recovery of young people and their families.

Adult Intervention Services

Intervention services are designed to: work with people who have one or more risk factors for developing a substance use disorder; reduce the impact of substance use in families and communities; and connect people with appropriate community resources, including treatment services.

Parenting Awareness & Drug Risk Education

Parenting Awareness and Drug Risk Education Services (PADRES) provide community-based intervention outreach services and evidenced-based education to people who are childbearing age to decrease the impact of substance use.[97]

Pregnant & Parenting Intervention

Pregnant and Parenting Intervention (PPI) programs provide intervention services to reduce the impact, severity and cost associated with a substance-exposed pregnancy for the mother, child, and their families. PPI programs provide comprehensive case management services, community-based linkage and retention services, and evidenced-based education for mothers with a past or present substance use disorder diagnosis, while also providing support to their families and significant others.[98]

Rural Border Intervention

The Rural Border Intervention (RBI) program provides community and home-based substance use prevention and intervention services in remote rural border areas. People in RBI services receive education about community services, necessary services, and support with healthy behavior changes.[99]

Community Health Workers

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[97] For additional information, please visit https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/parenting-awareness-drug-risk-education
[98] For additional information, please visit https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/pregnant-parenting-intervention
[99] For additional information, please visit https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/rural-border-intervention-program

The substance use disorder community health worker (CHW) programs allow community health workers and promotor to increase linkage and retention in substance use, mental health and medical services for Texas residents living with substance use disorders. These CHW programs provide non-judgmental, non-coercive provision of services and resources to people who use substances and their communities to assist them in reducing harm. This includes people who are marginalized or stigmatized, experiencing housing instability or homelessness, injecting substances, live with or are at risk of Hepatitis C Virus or Human Immunodeficiency Virus, and are experiencing greater barriers to entering treatment or recovery services.[100]

Medication-Assisted Treatment

Medication-assisted treatment (MAT) is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.[101] Medications used in MAT are approved by the Food and Drug Administration and MAT programs are clinically driven and tailored to meet each patient's needs. Research shows that a combination of medication and therapy can successfully treat these disorders, and for some people struggling with addiction, MAT can help sustain recovery. MAT is also used to prevent or reduce opioid overdose.

MAT is primarily used for the treatment of addiction to opioids such as heroin and prescription pain relievers that contain opiates. The prescribed medication operates to normalize brain chemistry, block the euphoric effects of opioids, relieve physiological cravings, and normalize body functions without the negative and euphoric effects of the substance used.

Residential and Outpatient Services[102]

Adult and Youth Substance Use Outpatient Programs

[100] For additional information, please visit https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/community-health-workers
[101] SAMHSA (2022). Medication-Assisted Treatment (MAT). Retrieved from https://www.samhsa.gov/medication-assisted-treatment
[102] https://www.hhs.texas.gov/services/mental-health-substance-use

Outpatient treatment services are for people with substance use disorders who do not need to live at a facility to maintain sobriety. Outpatient treatment services provide counseling, education, and support services.

Adult and Youth Substance Use Supportive Residential Programs

Supportive Residential treatment is for people who receive lower intensity treatment services in a residential setting that facilitate recovery from substance use disorders. People remain in a structured setting but are able to participate in community offered services and transition into the community by participating in community offered services to support their recovery.

Adult and Youth Substance Use Intensive Residential Programs

Residential treatment services for substance use disorders are provided in licensed facilities where people live for a specific period. Treatment includes counseling, case management, education, and skills training. Eligible participants should expect to participate in a set number of hours per week.

Women and Children in Residential Treatment Program

Women and Children Residential Treatment Programs are specialized substance use treatment services designed for women and their accompanying children in a licensed residential facility. The services include counseling, parenting education, health education, skills training, and case management.

Adult Substance Use Detoxification Services

Withdrawal management services are provided in a structured residential environment for people who are physically dependent upon alcohol and other drugs to safely withdraw from those substances and people who are intoxicated to be medically monitored until achieving a non-intoxicated state. This environment prepares and engages people for ongoing treatment services.

Dual-Diagnosis

Dual-diagnosis or co-occurring services coordinate resources and care between behavioral health professionals or agencies. Coordinated care helps people with recovery, which can lead to improvement in their living situation, such as going back to work, finding new housing, or keeping existing housing. It also often means reconnecting to friends and family and restoring relationships so others in their life will understand.

Co-Occurring Psychiatric and Substance Use Disorder[103]

These services are adjunct services to people with Co-occurring Psychiatric Substance Use Disorders, emphasizing integrated treatment for both mental health needs and substance use disorder needs.

Veterans Suicide Prevention Initiatives

Texas Veterans + Family Alliance Grant Program

The Texas Veterans + Family Alliance (TV+FA) Grant program improves the quality of life of veterans and their families by expanding the availability of and access to, mental health treatment and services.

Grants are awarded to community collaboratives to implement new or existing mental health services and provide linkage to support services that increase response to mental health treatment such as employment services. TV+FA grants support a range of clinical mental health and non-clinical supportive services for SMVF that include:

- Evidence-based therapies and treatment;
- Person, group, and family peer support services;
- Individual and family counseling;
- Treatment of substance use disorders;
- Suicide prevention initiatives to help community members and SMVF develop skills in recognizing, assisting, and referring to mental health services; and
- Case-management and referral services.

Long-Term Action Plan to Prevent Veteran Suicides

Texas Government Code, Section 531.0925, requires HHSC to develop a comprehensive action plan to increase access to and availability of professional

[103] https://www.hhs.texas.gov/services/mental-health-substance-use/adult-substance-use/co-occurring-psychiatric-substance-use-disorder

health services to prevent veteran suicides in Texas. HHSC developed a long-term action plan for full implementation by September 1, 2027.[104] HHSC collaborates with the Texas Coordinating Council for Veteran Services (TCCVS), the U.S. Department of Veteran Affairs (VA), the SMVF Technical Assistance (TA) Center Implementation Academy of SAMHSA, veteran advocacy groups, medical providers, and other appropriate parties to develop a plan to address the following goals:

1. Identify opportunities for raising awareness and providing resources for veteran suicide prevention;
2. Identify opportunities to increase access to veteran mental health services;
3. Identify funding resources to provide accessible and affordable veteran mental health services;
4. Expand public and private partnerships to ensure access to quality and timely mental health services;
5. Provide proactive outreach measures to reach veterans needing care;
6. Provide peer-to-peer service coordination, including training, certification, recertification, and continuing education for peer coordinators; and
7. Address suicide prevention awareness, measures, and training regarding veterans involved in the justice system.

Additional information on these resources can be found in the Community Support Guide for Alternatives to Inpatient Mental Health Treatment (includes information on outpatient and community mental health services, peer support services, mobile crisis outreach teams, crisis respite units, crisis residential units, extended observation units, and crisis stabilization units).[105]

[104] https://www.hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2021/long-term-veteran-suicide-plan-report-sept-2021.pdf
[105] https://www.hhs.texas.gov/sites/default/files/documents/services/mental-health-substance-use/community-suport-guide-alt-inpatient-mh-treatment.pdf

Appendix C. Non-HHSC Resources in Texas

In addition to the resourced identified in Appendix B, the four HHSC-contracted NSPL centers have access to resource listings provided by 211, Aunt Bertha, Network of Care, and resource listings developed within their specific regions, to include the resources identified below.

- Substance use (including alcohol recovery) disorder treatment and support groups:
  - Community Support: Support groups within the community for people in recovery, which helps people connect with others who also struggle with addiction to form a network of peers working toward the same goal of sustained sobriety in recovery.
  - Local Alcoholic Anonymous and Narcotic Anonymous Support
  - Alternatives to 12 Step Recovery: LifeRing Secular Recovery; Moderation Management Self-Managed Alcohol Moderation; and Smart Recovery Addiction Support Groups
- Suicide loss and suicide attempt supports and groups facilitated by peers:
  - American Foundation for Suicide Prevention
  - NAMI Texas
- BIPOC:
  - American Civil Liberties Union of Texas
  - Mexican American Legal Defense & Educational Fund
  - Texas Civil Rights Project
  - Texas Workforce Commission, Civil Rights Division
- Gambling:
  - Texas Gamblers Anonymous offers a 24/7 hotline as well as meeting locations in Austin, Dallas, Houston and San Antonio. Others will be referred to the national hotline.
- Disability:
  - Disability Rights Texas
  - Relay Texas
- Domestic Violence/Sexual Assault:

- National Domestic Violence Hotline (24/7)
- Love is Respect (24/7)
- Texas Council on Family Violence
- FamilyTime Crisis and Counseling Services hotline (24/7)
- Family Violence Center- Northwest – Assistance Ministries (24/7)
- Texas Association Against Sexual Assault

- Social Services:
  - Public social services
  - Crisis receiving and stabilization units
  - Community Support Guide for Alternatives to Inpatient Mental Health Treatment[106] (includes information on outpatient and community mental health services, peer support services, mobile crisis outreach teams, crisis respite units, crisis residential units, extended observation units, and crisis stabilization units).
- Inpatient psychiatric unit services

[106] A Community Support Guide for Alternatives to Inpatient Mental Health Treatment (texas.gov)