Texas

UNIFORM APPLICATION
FY 2024/2025 Combined MHBGSUPTRS BG ApplicationBehavioral Health Assessment and Plan

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

OMB - Approved 04/19/2021 - Expires 04/30/2024
(generated on 08/31/2023 3.46.22 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

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

State Information

State Information

Plan Year

Start Year	2024
End Year	2025

State SAPT Unique Entity Identification

Unique Entity ID	G6JLG3FANUA9

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

Agency Name	Health and Human Services Commission
Organizational Unit	Mental Health and Substance Use Programs
Mailing Address	4601 Guadalupe, MC H101
City	Austin, Texas
Zip Code	78751

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

First Name	Sonja
Last Name	Gaines
Agency Name	Health and Human Services Commission
Mailing Address	
City	Austin
Zip Code	
Telephone	
Fax	
Email Address	SSA@hhs.texas.gov

State CMHS Unique Entity Identification

Unique Entity ID	G6JLG3FANUA9

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

Agency Name	Health and Human Services Commission
Organizational Unit	Mental Health and Substance Use Programs
Mailing Address	4601 Guadalupe, MC H101
City	Austin, Texas
Zip Code	78751

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

First Name	Sonja
Last Name	Gaines
Agency Name	Health and Human Services Commission
Mailing Address	
City	Austin

Zip Code	
Telephone	
Fax	
Email Address	SSA@hhs.texas.gov

III. Third Party Administrator of Mental Health Services

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

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

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

From	
To	

V. Date Submitted

Submission Date	8/31/2023 3:36:52 PM
Revision Date	8/31/2023 3:38:32 PM

VI. Contact Person Responsible for Application Submission

First Name	Corliss
Last Name	Powell
Telephone	(737) 704-9063
Fax	
Email Address	corliss.powell@hhs.texas.gov

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

GOVERNOR GREG ABBOTT

December 4, 2020

Ms. Wendy Pang
Grants Management Specialist
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-II09
Rockville, Maryland 20857

Dear Ms. Pang:

This letter concerns Texas' Substance Abuse Prevention and Treatment Block Grant (SABG), the Community Mental Health Services Block Grant (MHBG), and Projects for Assistance in Transition from Homelessness (PATH) grant.

Pursuant to federal regulations, I hereby delegate authority for all transactions required to administer the SABG, MHBG, and PATH grant to the Texas Health and Human Services Commission's Chief Program and Services Officer, or anyone officially acting in this role in the instance of a vacancy. This designation will last for the duration of my time in office.

If you have questions or need clarification concerning these grants, please contact Sonja Gaines, Deputy Executive Commissioner for Intellectual and Developmental Disability and Behavioral Health Services. She may be reached by phone at (512) 487-3417 or by email at Sonja.Gaines@hhs.texas.gov.

Sincerely,

Greg Abbott
Governor

GA:hfk

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Coastal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: _____

Name of Chief Executive Officer (CEO) or Designee: MIchelle Alletto

Signature of CEO or Designee[1]: _____

Title: Chief Program and Services Officer

Date Signed: _____

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

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

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

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

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

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

State: Texas

Name of Chief Executive Officer (CEO) or Designee: MIchelle Alletto

Signature of CEO or Designee[1]: 

Title: Chief Program and Services Officer

Date Signed: 8/30/2023

mm/dd/yyyy

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

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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b. Establishing an ongoing drug-free awareness program to inform employees about--
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   4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
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   1. Abide by the terms of the statement; and
   2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
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   1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
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The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that

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

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

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

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

5. Certification Regarding Environmental Tobacco Smoke

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

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

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

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

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

HHS Assurances of Compliance (HHS 690)

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

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

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964 (Pub. L. 88-352), as amended, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
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The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

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

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

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

Name of Chief Executive Officer (CEO) or Designee: Michelle Alletto

Signature of CEO or Designee[1]: _____

Title: Chief Program and Services Officer

Date Signed: _____

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

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

Fiscal Year 2024

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

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Section 1920	Early Serious Mental Illness	**42 USC § 300x-9**
Section 1920	Crisis Services	**42 USC § 300x-9**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**

Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the 19 statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply, as applicable, with provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to

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

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act Amendments of 1996 and OMB Circular No. A-133, "Audits of States, Local Governments, and Non-Profit Organizations."
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.
19. Will comply with the requirements of Section 106(g) of the Trafficking Victims Protection Act (TVPA) of 2000, as amended (22 U.S.C. 7104) which prohibits grant award recipients or a sub-recipient from (1) Engaging in severe forms of trafficking in persons during the period of time that the award is in effect (2) Procuring a commercial sex act during the period of time that the award is in effect or (3) Using forced labor in the performance of the award or subawards under the award.

LIST of CERTIFICATIONS

1. Certification Regarding Debarment and Suspension

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

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

2. Certification Regarding Drug-Free Workplace Requirements

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

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

3. Certifications Regarding Lobbying

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

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

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

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
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I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Michelle Alletto

Signature of CEO or Designee[1]: 

Title: Chief Program and Services Officer

Date Signed: 8/30/2023

mm/dd/yyyy

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

Please upload your state's Bipartisan Safer Communities Act (BSCA) – 2nd allotment proposal to here in addition to other documents. You may also upload it in the attachments section of this application.

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OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

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

Standard Form LLL (click here)

Name

Michelle Alletto

Title

Chief Program and Services Officer

Organization

Texas Health and Human Services Commission

Signature: Date:

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

State Information

Disclosure of Lobbying Activities

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Standard Form LLL (click here)

Name

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Signature:  Date: 8/30/2023

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Planning Steps

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

Narrative Question:

Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.

Further, in support of the **Executive Order On Advancing Racial Equity and Support for Underserved Communities Through the Federal Government**, SAMHSA is committed to advancing equity for all, including people of color and others who have been historically underserved, marginalized, and adversely affected by persistent poverty and inequality. Therefore, the description should also include how these systems address the needs of underserved communities. Examples of system strengths might include long-standing interagency relationships, coordinated planning, training systems, and an active network of prevention coalitions. The lack of such strengths might be considered needs of the system, which should be discussed under Step 2. This narrative must include a discussion of the current service system's attention to the MHBG and SUPTRS BG priority populations listed above under "Populations Served."

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Footnotes:

Mental Health Service System

Organization

HHSC's Mental Health Programs, Planning, and Policy (MHPPP) is part of the Mental Health and Substance Use Programs (MHSUP) section within the Behavioral Health Services (BHS) department. MHPPP is overseen by the MHSUP Associate Commissioner, who serves as the State Mental Health Authority and reports to the BHS Deputy Executive Commissioner.

MHPPP facilitates coordination and communication across multiple areas and teams, including substance use, prevention, peer and recovery services, contracts management, business operations and quality management. Additionally, MHPPP collaborates with the BHS' Office of Mental Health Coordination on initiatives designed to prevent suicide and promote veterans' services.

MHPPP oversees the provision of a range of services for persons with mental health and co-occurring psychiatric and substance use disorders (COPSD) across the state through contracts with 39 local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) for community-based outpatient mental health services. LMHAs and LBHAs serve as both the local authority and a local provider. For people in need of inpatient services, the Texas Health and Human Services Commission (HHSC) operates nine state hospitals and one residential youth center across the state. Each serves a different population, which may include adults, children and adolescents, and people involved with the criminal justice system. HHSC also contracts for 541 locally managed psychiatric hospital beds.

LMHAs and LBHAs collaborate with community stakeholders to develop local provider networks and some subcontract with other entities to provide a variety of services, including pharmacological management, counseling, and certain crisis services. HHSC contractually requires LMHAs and LBHAs to collaborate with community stakeholders to create Consolidated Local Area Service Plans. The plans ensure LMHAs and LBHAs and community members are working together and are responsive to the needs of the local community.

For the 2020-2021 biennium, Substance Abuse and Mental Health Services Administration's (SAMHSA) Mental Health Block Grant (MHBG) accounted for 7.5 percent of funding in Texas for mental health services for adults with a serious mental illness (SMI) and children and adolescents with a serious emotional disturbance (SED).

Texas Resilience and Recovery Model

In Texas, the service delivery system for community-based mental health services uses the Texas Resiliency and Recovery (TRR) model. The TRR model acknowledges that people experiencing SMI and SED need a continuum of care and have natural supports and strengths which should be built upon to foster resilience and recovery. The modern framework of the TRR system utilizes an intensity-based approach to

service delivery and recognizes the importance of continuity of care between service systems.

The TRR model includes the use of a Uniform Assessment (UA) to assess a person, provide recommendations for appropriate services, and monitor individual outcomes. The Children and Adolescent UA includes three sections: Texas Child and Adolescent Needs and Strengths Assessment (CANS), Community Data, and Authorized Level of Care. The Adult UA includes four components: Texas Adult Needs and Strengths Assessment (ANSA), Diagnostic Clinical Symptom Rating Scales, Community Data, and Authorized Level of Care.

The Texas CANS and ANSA are assessment tools to support decision-making, including eligibility for community mental health services, identification of the level of care (LOC) under TRR services, recovery and treatment planning, quality improvement initiatives, and monitoring of service outcomes. Each LOC contains assignment criteria determining the intensity of services. For children and adolescents, assignment criteria are based on diagnostic information and CANS scores. The assignment criteria for adults includes diagnostic information, ANSA scores, Identified Needs Threshold, and for LOC-2, considers scores on the Quick Inventory of Depressive Symptomology Scale.

An array of evidence-based practices (EBPs) and promising practices can be individualized in each LOC to meet the person's needs and build upon their unique strengths. Services and supports provided via the TRR model are expected to result in improved behavioral and emotional functioning.

Levels of Care: The TRR LOCs are the building blocks of a system of care built on the foundational elements of resiliency and recovery. Most LOCs allow for great flexibility in the types of services provided. Rather than changing the type of service offered, the frequency and location of service may change (e.g., weekly or daily, office- or community-based setting).

The person and family determine the supports they may or may not need. They may choose to refuse or not engage in one type of service and still be eligible for other services. This collaborative exchange between the person's or family's choice, the provider's clinical judgment, and the LOC-R (recommended) determines the LOC-A (authorized).

Continuity of Care

Continuity of care is an essential component of the TRR model and includes activities designed to ensure a person's seamless transition between systems of care. Continuity of care activities include:

- Assisting with admissions and discharges;
- Facilitating access to appropriate services and supports in the community;
- Coordinating the provision of services;
- Participating in developing and reviewing the person's recovery and treatment plan; and
- Promoting implementation of the person's recovery and treatment plan.

Training
HHSC offers coordinated trainings through the Centralized Training Infrastructure for Evidenced-Based Practices (CTI-EBP). The CTI-EBP promotes the use of evidence-based protocols for the provision of mental health services for children, adolescents, and adults by using nationally recognized experts to provide trainings for HHSC-funded providers and other service providers in the areas of: Cognitive Behavioral Therapy (CBT); Trauma-Focused Cognitive Behavioral Therapy; CBT for Psychosis; Cognitive Processing Therapy; Dialectical Behavior Therapy; Seeking Safety; Nurturing Parenting; Wraparound Process Planning; Motivational Interviewing; Illness Management and Recovery; Supported Employment; Supportive Housing; Assertive Community Treatment (ACT); CANS and ANSA; Crisis Response Planning, COPSDs, and Person-Centered Recovery Planning. The CTI-EBP also coordinates technical assistance (TA) calls and webinars in collaboration with HHSC and nationally recognized subject matter experts to support the use of EBPs and provide consultation to contractors.

Reaching the Rural Communities
Texas has 254 counties, of which 172[1] are considered rural. HHSC identified mental health and substance use service availability at the right time and right place as a high priority. Senate Bill 633, 86th Legislature, Regular Session, 2019, required HHSC to create Regional Groups with Centers in counties with populations under 250,000. Senate Bill 454, 87th Legislature, Regular Session, 2021, continues this work. In creating the Regional Groups with Centers, HHSC is focused on reducing:

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

Reduced capacity has required some adaptations to evidence-based services. For example, the ACT Program has both urban and rural models. The rural model uses a lower staff-to-client ratio to compensate for the added travel time necessary to reach people. Similarly, HHSC adjusted the Mobile Crisis Outreach Team (MCOT) requirements for rural areas to accommodate the needs in those communities. For, example, MCOT on-duty peak hours are set at eight hours per day in rural areas versus 12 hours per day in urban areas. The MCOT is on call in all areas 24 hours a day, seven days a week.

Additionally, HHSC established Rural Crisis Response and Diversion Programs to divert people in crisis from jails and emergency rooms to engage them in community mental health services. This program allows LMHAs and LBHAs to address the mental health and crisis needs of the rural communities they serve and strengthen the relationship and collaboration with law enforcement agencies.

[1] https://www.dshs.texas.gov/chs/hprc/counties.shtm

Telemedicine and Telehealth Services
To better serve people living in rural areas, some providers established the use of interactive communication technology to address critical levels of mental health workforce shortages in Texas and increase access to psychiatric services, substance use screening, assessment, and group education. Home telemonitoring services are available to Medicaid recipients who have one or more chronic illnesses, including SMI or SED, and have risk factors associated with frequent emergency department admissions and documented history of poor adherence to medications. Additionally, non-medical providers are approved to provide Medicaid-billable telehealth services. Finally, school-based services function as a patient site for telemedicine services.

Adult Services
HHSC contracts with providers to ensure mental health and substance use services are available to adults with SMI and people with COPSD. People who meet the definition for priority population include:

- Adults who have an SMI such as schizophrenia, major depressive disorder, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, anxiety disorder, attention deficit or hyperactivity disorder, delusional disorder, bulimia nervosa, and anorexia nervosa; or
- Adults with other severely disabling mental disorders which require crisis resolution or ongoing support and treatment.

The TRR model promotes the use of EBPs in the provision of services. For the adult population, the following EBPs are required: CBT; Illness Management and Recovery; SAMHSA's Supported Employment EBP Kit; SAMHSA's Supported Housing EBP Kit; and SAMHSA's ACT EBP Kit.

The HHSC TRR Utilization Management Guidelines assist LMHA and LBHA staff in determining the best possible course of treatment for the person. The TRR model for the adult population is comprised of the following LOCs:

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

The LOC is determined by the ANSA recommendation, but a clinician may override a recommended LOC based on clinical judgement. Adults are reassessed at least once every 180 days to ensure their recovery plan reflects their current needs and strengths.

Child and Adolescent Services
Services are available for children and adolescents ages three through 17 with a SED (excluding a single diagnosis of substance use, 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 childcare environment due to psychiatric symptoms, or
- Are enrolled in special education because of a SED.

HHSC employs a child-centered and family-driven system of care philosophy. A system of care is a spectrum of effective community-based services and supports for children, adolescents, and young adults (and their families) with, or at risk for, mental illness and related challenges. The Texas System of Care[2] is organized into a coordinated network, builds meaningful partnerships with families and children or adolescents, and addresses cultural and linguistic needs to help the child or adolescent function better at home, in school, in the community, and throughout life. Services are delivered through the LOC based on the TRR service delivery model for children and adolescents.

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

- LOC-0: Crisis Services
- LOC-1: Medication Management Services
- LOC-2: Targeted Services
- LOC-3: Complex Services
- LOC-4: Intensive Family Services
- LOC-5: Transitional Services
- LOC-EO: Early Onset Psychosis
- LOC-YC: Young Child Services (under age six)
- LOC-YES: Youth Empowerment Services
- LOC-RTC: Residential Treatment Center
- LOC TAY: Transition Age Youth

The CANS is used to assess a child's or adolescent's needs and strengths and recommend a LOC, but a clinician may override the recommended LOC based on clinical judgment. Children and adolescents are reassessed at least every 90 days to ensure their recovery plan is up-to-date to reflect their current needs and strengths. The LOC continuum for children and adolescents allows for movement to a different LOC based on progress made in treatment or increased emotional and behavioral needs. As treatment progresses, children and adolescents are expected to move down the continuum of care to a less intensive LOC until treatment is complete, or the need for services is minimal (e.g., medication maintenance). Crisis services are available for any LOC should a psychiatric crisis occur.

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

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

Children and adolescents and their families have access to three levels of case management services, depending on the intensity of the assessed LOC and specific needs. These include routine, intensive, and family case management. The mental health case manager works with other service providers to address additional needs of the child or adolescent, such as education, rehabilitation, employment, housing (for an older person transitioning to adulthood), juvenile justice, substance use disorder (SUD), and physical health issues. The most intensive LOC uses wraparound treatment planning based on the systems of care principles and philosophy. Wraparound is an ecologically-based process and approach to care planning that builds on the collective action of a committed group of family, friends, community, professional, and cross-system supports -- mobilizing resources and talents from a variety of sources that results in the creation of a plan of care that is the best fit between the family vision and story, team mission, strengths, needs, and strategies.[3]

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

Crisis Services

In Texas, LMHAs and LBHAs use a combination of federal block grant, local, and state funds to enhance mental health services provided to people experiencing mental health and substance use issues.

Crisis Hotline: In accordance with Texas Health and Safety Code Section 534.053 and 26 Texas Administrative Code §301.327, all LMHAs and LBHAs operate a crisis hotline, accredited by the American Association of Suicidology. Crisis hotline services are available 24 hours a day, 7 days a week, serving as the first point of contact for people experiencing a mental health or substance use crisis in the community. Qualified staff determine if mobile emergency services are required to further assess the caller's needs.

988 Suicide and Crisis Lifeline (988): 988 provides confidential support 24 hours a day, 7 days a week for people experiencing a mental health or suicide crisis, prevention services, and crisis resources at no cost. When a caller connects to one of the 988 crisis centers in Texas or national backup center, a trained crisis counselor is available to listen to the caller, provide support, and share resources or referrals as needed. The 988 network crisis centers offer support via phone, online chat and text.

[3] https://www.nwic.org/

MCOT: LMHAs and LBHAs are required to operate a MCOT. These services are available 24 hours a day, 7 days a week to respond in person to people in crisis. These are often the result of a referral obtained through the crisis hotline. MCOTs deploy to various sites in the community where a crisis has been reported. In some cases, MCOTs may accompany local law enforcement.

Community-Based Crisis Programs (CBCPs): CBCPs encompass facilities staffed with mental health, SUD, peer providers, and medical professionals offering assessment, support, and services to achieve psychiatric stabilization to people with mental health issues. These sites are alternatives to inpatient hospitalization and incarceration. Law enforcement is encouraged to use these services for crisis stabilization. CBCPs include:

- Crisis Respite Services – Crisis respite services provide short-term, community-based residential crisis treatment to people who have low risk of harm to self or others, may have some functional impairment, and may require direct supervision and care but do not require hospitalization. The recommended length of stay ranges from one to seven days. Texas has 15 sites.
- Crisis Residential Services – In contrast to crisis respite services, crisis residential services provide short-term community-based residential crisis treatment to people who may pose some risk of harm to self or others and may have minimal functional impairment. The recommended length of stay ranges from one to 14 days. There are seven sites.
- Extended Observation Units – Extended observation units are designed to provide emergency stabilization to people in a mental health crisis for up to 48 hours. There are eight sites.
- Crisis Stabilization Units – Crisis stabilization units provide short-term residential treatment designed to reduce acute symptoms of mental illness provided in a secure and protected clinically staffed, psychiatrically supervised, treatment environment that complies with crisis stabilization unit licensing requirements. There are three sites.
- Contracted Psychiatric Beds – Contracted psychiatric beds provide brief stays in licensed hospitals to relieve acute symptomatology and restore a person's ability to function in a less restrictive setting. There are 22 sites.
- Private Psychiatric Beds – Private psychiatric bed services are staffed with medical and nursing professionals who provide 24-hour monitoring, supervision, and assistance in an environment designed to provide safety and security during an acute mental health crisis. Currently, HHSC has 37 contracts with LMHAs and LBHAs to expand capacity for people on forensic and civil commitments for competency restoration or inpatient mental health treatment.

Crisis services include community-based services designed to stabilize crisis situations; minimize hospitalizations and re-hospitalizations; restore functioning; assist with adherence to medication regimens; promote integration into the larger community; and assist with linkage to other required community-based services. A person in crisis may be authorized to receive mental health services over the course of a seven or 90-day period, including transitional supports if not enrolled in longer-

term treatment. House Bill 1, Article II, Rider 52, 88th Legislature, Regular Session, 2023 appropriated funds to expand private psychiatric beds and crisis stabilization facilities, to include crisis respite services, crisis residential services, extended observation unites, and crisis stabilization units.
LMHAs and LBHAs provide or authorize the provision of assertive outreach to people who are more difficult to engage in ongoing care, including those who are chronically homeless and in need of substance use treatment. The TRR model includes access to intensive ongoing services, such as ACT, by those who have been successfully engaged in crisis transitional services over the 90-day period. Intensive, ongoing services for children and adolescents include team-based, wraparound services that are available in the most intensive LOC. By expanding its capacity to provide intensive ongoing services to people entering the mental health system because of a crisis, HHSC is working to prevent future hospitalizations or incarcerations. HHSC continues to expand the array of crisis projects, particularly in underserved communities.

Supportive Housing and Services Targeting People Who Are Unhoused
Housing for certain populations provide a critical intervention to avoid or reduce homelessness, institutionalization, and crisis costs to the state. The following programs target populations directly served by the LMHAs and LBHAs:

Supportive Housing Rental Assistance (SHRA) Program: Since its inception in 2014, over 32,000 people have been assisted financially by the SHRA Program. In 2019, HHSC began using MHBG funds to expand the SHRA Program from 20 to 36 programs. HHSC funds direct rental and utility assistance to 36 LMHAs and LBHAs across the state, in addition to the supportive housing and mental health services already provided to people with SMI or COPSD. There are four priority populations within the LMHAs and LBHAs for these funds:

- People who are homeless;
- People at-risk of homelessness;
- People at-risk or exiting a state hospital; and
- People who are frequent users of crisis services.

Each year since 2014, there has been a reduction in both crisis episodes and hospitalizations for those assisted with these funds. In state fiscal year 2022, the program served 1,618 people (i.e., 10 percent decrease compared to 2021).

Healthy Community Collaborative (HCC) Program: HHSC funds seven collaborative projects in the most populous urban municipalities (Austin, New Braunfels, San Antonio, Fort Worth, Dallas, and Houston) in Texas, as well as collaborative projects in six rural counties (Comal, Ellis, Hunt, Kaufman, Navarro, and Rockwall) to serve people experiencing homelessness and mental illness or COPSD. These projects promote community collaboration based on locally identified priorities. Projects are designed to creatively address homelessness, criminal recidivism, emergency room use, SUD, and unemployment rates.

Services provided include mental health treatment, substance use treatment, case management services, primary medical care, supported employment, supportive

housing, and other individualized services, as appropriate. The goal of HCC is to assist people experiencing homelessness in becoming independent and integrated into the community through a network of providers from all disciplines in the community.

Texas Government Code Section, Chapter 539, §539.002, requires HHSC to expand to rural communities. As a result, HHSC implemented a learning community to increase the capacity of rural organizations and thereby create a rural community collaborative. In 2019, statute changed the match by allowing in-kind match, or up to a 25 percent private cash match requirement, for rural communities.

Other Supportive Housing Resources

- Texas Interagency Council for the Homelessness: HHSC is a member of the Texas Interagency Council for the Homeless (TICH), which coordinates the state's resources and services to address homelessness. TICH serves as an advisory committee to the Texas Department of Housing and Community Affairs (TDHCA). Representatives from HHSC, Department of Family and Protective Services (DFPS), TDHCA, Texas Workforce Commission, Texas Veteran's Commission, Texas Education Agency, Texas Department of Criminal Justice (TDCJ), and Texas Juvenile Justice Department (TJJD) participate on the council along with members appointed by the governor, lieutenant governor, and Texas House of Representatives speaker.

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

- Project Access Pilot Program: This program is co-managed by HHSC and TDHCA. It is part of the larger, statewide Project Access program, which uses United States Department of Housing and Urban Development Housing Choice vouchers to help people with low-income and disabilities transition from institutional settings into their community. The pilot provides access to affordable housing and support services for people with low-income, SMI or COPSD who are in state-funded psychiatric hospitals and want to transition into the community.

- Housing and Urban Development 811 Project Rental Assistance Program:

TDHCA partners with HHSC to implement the 811 Project Rental Assistance program. This program provides project-based rental assistance and support services provided through LMHAs and LBHAs in the following metropolitan service areas:

- Austin and Round Rock
- Corpus Christi
- Dallas, Fort Worth, and Arlington
- El Paso
- Houston, The Woodlands, and Sugar Land
- McAllen, Edinburg, and Mission
- San Antonio
- Brownsville and Harlingen

HHSC trains LMHAs and LBHAs to become qualified referral agents and service coordinators who will identify eligible people and assist with ongoing housing needs. TDCHA is responsible for selecting multi-family properties applying to be in this program.

- HOME Tenant-Based Rental Assistance: LMHAs and LBHAs are encouraged to become federal HOME Tenant-Based Rental Assistance (TBRA) administrators through TDHCA, which allows them to access federal subsidies for housing and bridge to a permanent housing subsidy if needed. To date, seven of the LMHAs and LBHAs have become TBRA administrators. HHSC has an implementation plan to provide additional TA to LMHAs and LBHAs to increase capacity for rental administration and the likelihood an LMHA or LBHA would be approved for TBRA funds.

Criminal Justice
HHSC oversees programs that serve people who are justice-involved, including:

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

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

Mentally Ill Offender Screening and Coordination: When a person is booked into a county jail, the Texas Law Enforcement Telecommunications System matches the person's identifying information (last name, first name, date of birth, social security number, sex, ethnicity, and race) against the state's clinical case management system, CMBHS. If a partial or exact match is yielded, the jail receives a notification with the person's name and location of the last LMHA or LBHA that provided a service. The jail staff then contacts that LMHA or LBHA to conduct a screening and provide linkage to mental health services provided in the community via the LMHA or LBHA. Additionally, LMHAs and LBHAs receive notification of a match via email daily. In collaboration with DFPS, HHSC is working to build similar functionality and capacity in Texas Law Enforcement Telecommunications System to match children and adolescents in the juvenile justice system.

Mental Health Grant for Justice Involved-Individuals: HHSC contracts with 23 LMHAs and LBHAs throughout the state to engage in jail diversion activities, as well as to reduce recidivism rates, arrests, and incarceration among people with mental illness and the wait time for people on forensic commitments. These grants support community programs by providing behavioral health care services to people with a mental illness encountering the criminal justice system; and facilitating the local cross-agency coordination of behavioral health, physical health, and jail diversion services for people with mental illness involved in the criminal justice system. Senate Bill 1677, 88th Legislature, Regular Session, 2023 requires HHSC to make additional funding available to be open to new community collaboratives. HHSC will release a Needs and Capacity Assessment in state fiscal year 2024 to expand these services.

A licensed staff person screens child or adolescent referred to the juvenile justice system for mental health and SUD prior to adjudication, using an assessment tool approved by the TJJD. The youth is then referred to an LMHA or LBHA for further assessment and offered specialized services. HHSC uses the CANS to assess all people referred for mental health services. HHSC uses the substance use screening and assessment tool, which is based on the Assessment Screening Index for all people referred to SUD treatment. Both assessments are housed in CMBHS.

Outpatient Competency Restoration (OCR): HHSC funds an OCR Program that provides community-based restoration treatment to justice-involved people with SMI and COPSD who are deemed incompetent to stand trial. Aside from competency restoration treatment, a person in OCR receives the core psychiatric care and services afforded through the LMHAs and LBHAs. As of May 2023, seventeen of the 39 LMHAs and LBHAs operate OCR programs, most of which are in urban areas. In addition to OCR programs, Senate Bill 1475, 83rd Legislature, Regular Session, 2013 established a jail-based competency restoration (JBCR) pilot program and Senate Bill 1326, 85th Legislature, Regular Session, 2017, required county programs to provide mental health and COPSD services, as well as legal education, for these people. Eleven JBCR programs are in operated by largely urban LMHAs and LBHAs. Additionally, the state's most populous county, Harris County, launched a Jail Diversion Program in which the framework for treatment is guided by principles of Critical Time Intervention. OCR and JBCR are included in the Harris County Jail Diversion Program service array.

Other Forensic Services: Through state psychiatric hospitals and contracts with local community hospitals, inpatient services are provided to people on forensic commitments (i.e., not guilty by reason of insanity or incompetent to stand trial). These services are funded by state general revenue dollars. When a person on a forensic commitment no longer needs inpatient treatment, the court dismisses the commitment and the person transitions to the community where mental health services are provided by an LMHA or LBHA. These people are authorized to receive a LOC that may include, but is not limited to, the following services: case management, psychosocial rehabilitation, skills training, supported housing, supported employment, and CBT. Additionally, if these people are granted community supervision in the form of probation, mental health staff work closely with criminal justice agencies to provide support in the form of transportation to probation offices or court. All these services work to reduce the likelihood of recidivism. In 2015, the Texas Legislature directed HHSC to hire a forensic director responsible for statewide coordination and oversight of forensic mental health services and programs. This position oversees a forensic workgroup to make recommendations relating to the effective coordination of forensic services.

Special Needs and Populations

HHSC oversees efforts to address other special needs and populations, including:

Transition-Age Youth: Texas created a unique LOC to address the needs of people ages 18-20 in their transition towards independent living. This LOC allows a flexible array of services including supports to match the person's educational or vocational goals. Texas is continuing to expand this LOC to support people younger than 18.

Early-Onset Psychosis: The 10 percent set-aside requirement of the MHBG allowed Texas to implement a Coordinated Specialty Care program for people aged 15-30 years who are experiencing an early onset of psychosis. These programs focus on early identification and intervention to reduce the time between a first episode of psychosis and treatment for psychosis. The programs rely on team-based services, with each team maintaining a small caseload. Texas now has Coordinated Specialty

Care programs in 29 of 39 LMHAs and LBHAs, with plans to expand the programs to additional sites.

Older Adults: Starting in 2001, Texas pioneered a state policy known as Money Follows the Person, which enables Medicaid eligible adults leaving long term care institutions, such as nursing facilities, to access home and community-based services without respect to a waiting list. Texas also participates in the federal Money Follows the Person Demonstration (MFPD). Under the MFPD, Texas operates a Behavioral Health Pilot, which tested evidence-based behavioral health interventions from 2008 to 2017. The pilot test phase was successful in helping adults with SMI and long-term care needs transition from nursing facilities and live in the community. Since 2017, Texas focuses MFPD resources on sustaining and spreading pilot interventions. Texas provides TA and training through a university-based center for excellence to Medicaid Managed Care Organizations (MCOs) and providers throughout the state. Texas also received MFP-related funding for additional pilot projects. One pilot is designed to improve the capability of MCOs to transition adult members with SMI and long-term care needs from nursing facilities to community-based services. Another pilot will seek to divert people with similar needs who are leaving state psychiatric hospitals from nursing facilities to community-based services.

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

Cultural Competency: HHSC requires mental health and SUD providers to ensure culturally, linguistically, and developmentally appropriate services are provided in a non-discriminatory manner for people and their families or significant others. These considerations apply for physical disabilities as well as mental illnesses or disabilities. For those who are deaf or hard of hearing, HHSC-funded contractors have access to HHSC interpreter services. Contracts and rules require staff to receive training in cultural sensitivity.

Zero Suicide

The Zero Suicide Texas grant ended in 2016, and efforts to continue the work are underway with a new project entitled Suicide Care Initiative (SCI). SCI focuses on implementation of a zero-suicide framework in the public mental health system. Key partners in SCI include HHSC, four LMHAs, Texas Institute for Excellence in Mental Health (TIEMH) at The University of Texas at Austin, and the Texas Suicide Prevention Collaborative, a nonprofit organization which works to support local suicide prevention efforts. Zero Suicide is also instrumental, as part of a framework the Texas Legislature required in 2017, within the development and implementation of the Short Long-term Action Plan to Prevent Veteran Suicides as supported by HHSC.

SCI created two distinct projects to improve and expand on the safer care practices occurring through LMHAs across the state. Four LMHAs were selected to oversee the development, implementation, and evaluation of the projects. Together, they have been identified as Regional Suicide Care Support Centers (RSCSCs). The first

project focuses on the RSCSCs, serving as regional suicide care workforce development and TA hubs for LMHAs and LBHAs in their specified region by providing evidence-based instructor trainings, as well as TA via webinars and learning collaborative conference calls to support the continued implementation of the Zero Suicide initiative. The second project focuses on the improvement and enhancement of the Zero Suicide framework and its practices within the four RSCSCs.

HHSC is in year four of a five-year grant of over $3 million from SAMHSA for the Garrett Lee Smith State Tribal Youth Suicide Prevention and Early Intervention Grant Program. The grant, entitled Resilient Youth – Safer Environments, will create comprehensive Suicide Safer Early Intervention and Prevention systems aimed to support child and adolescent-serving organizations, including Texas schools, mental health programs, educational institutions, juvenile justice systems, substance use programs, and foster care systems. The target population, ages 10 through 24, are at an elevated risk of suicide and suicide attempts and will receive services, including best practice trainings, improved suicide care in clinical early intervention, and effective programming and treatment services. With increased capacity to serve and recognize this at-risk population, and enhanced infrastructure for strategy implementation, these Suicide Safer Early Intervention and Prevention systems will produce robust clinical and community services with collaborative networks to promote youth resiliency, recovery, and safety. Galveston County has been above the national average rate of suicide for the target population for several years. Those residents previously experienced the devastation of Hurricane Harvey in August 2017, and the Santa Fe, Texas school shooting in May 2018.

Veteran Mental Health Services

HHSC administers the Mental Health Program for Veterans (MHPV) in coordination with the Texas Veterans Commission (TVC) through an interagency contract. This program provides peer counseling services to service members, veterans, and their family members (SMVF) through contracts with 37 of the 39 LMHAs and LBHAs to employ or contract Peer Service Coordinators (PSC). PSCs provide peer-to-peer services and engage SMVF who experienced military-related trauma, are at risk of isolation from support services, and may not seek services through traditional channels. The MHPV also includes the Rural Veterans Counselor (RVC) program, in six LMHAs and LBHAs employing licensed mental health professionals trained in military-informed care to provide mental health services to veterans.

Additionally, through the MHPV, outreach and services are provided to special populations, such as women veterans, rural veterans and justice-involved veterans (JIVs). TVC provides PSCs and volunteer peers with training opportunities on how to incorporate the unique needs of women veterans into the peer support and intervention services they provide. Access to services for rural veterans and their families is not the same across the state. As such, PSCs are specially trained to meet the needs of rural SMVF in creative and dynamic ways leveraging all available resources and partnerships. To address the needs of JIVs, PSCs and volunteer peers are active in supporting JIV efforts in their local communities through

partnerships with law enforcement, veteran treatment courts, county jails, prisons, and community supervision.

HHSC contracts with Texas A&M University Health Science Center to operate the TexVet.org website (TexVet) website. TexVet serves as the resource directory in support of MHPV's PSCs, volunteer peers, and providers. This database also provides information about community-based services, resources with contact information, and eligibility criteria for SMVFs.

In state fiscal year 2022, LMHAs and LBHAs reported a sustained delivery of services and community member trained, including:

- 34,694 peer services delivered to SMVF;
- 1,453 PSCs and volunteer peers trained;
- 10,457 interactions with JIVs occurred; and
- 971 clinical mental health sessions conducted with an RVC.

The volume of peer services delivered and continued interactions with trusted, trained peers demonstrate the program successfully:

- Engages SMVF;
- Increases awareness of mental health service options; and
- Increases access to needed mental health care services.

In 2016, HHSC implemented the Texas Veterans + Family Alliance grant program. This community-matching grant program seeks to improve the quality of life of Texas veterans and their families by supporting local communities across the state to expand the availability of, increase access to, and enhance the delivery of mental health treatment and services. Grant awards are made to existing or developing community collaborations to support veterans and their families by connecting them with effective, responsive mental health and supportive service systems. At the end of state fiscal year 2022, the Texas Legislature will have appropriated more than $60 million to support this program for HHSC to provide awards to over 80 unique community collaborative projects.

Behavioral Health Medicaid Programs

MHPPP also oversees the following programs for people who are Medicaid-eligible with SMI or SED.

Home and Community-Based Services-Adult Mental Health (HCBS-AMH): This 1915(i) Medicaid program provides specialized supports through the provision of home and community-based services to adults diagnosed with an SMI and extended tenure in psychiatric hospitals, frequent arrests, or emergency department visits. The flexible array of services (e.g., host home, employment services, nursing) is designed to meet the needs of a person not currently addressed by other means, and to assist in the person's recovery—enabling people to live and experience successful tenure in their community of choice and improve their quality of life and functioning. In addition to a diagnosis of SMI, an person must be 18 years of age, have active eligible Medicaid coverage or determined to be Medicaid eligible if residing in a state hospital, not be dually enrolled or receiving

STAR+PLUS[4] or any other HCBS services by any other means, and must meet one of several needs-based criteria.

Youth Empowerment Services (YES): This 1915(c) Medicaid program serves children and youth with serious mental, emotional, and behavioral difficulties. The YES Waiver provides intensive services delivered within a strengths-based team planning process called Wraparound. Wraparound builds on family and community support and uses YES services to help build a family's natural support network and connection with their community. The YES program offers specialized therapies (e.g., music therapy), community living supports, minor home modifications, and other services. Participants must meet both demographic and clinical eligibility criteria.

[4] STAR+PLUS is a Texas Medicaid managed care program for adults who have disabilities or are age 65 or older. Adults in STAR+PLUS get Medicaid health-care and long-term services and supports through a health plan that they choose.

Substance Use Service System

Organization

HHSC's Substance Use Programs, Planning, and Policy (SUPPP) is part of the MHSUP section within the BHS department. SUPPP is overseen by the MHSUP Associate Commissioner, who serves as the Single State Authority representative and reports to the BHS Deputy Executive Commissioner.

SUPPP facilitates coordination and communication with internal department partners, including mental health, business operations, contracts, and quality management staff.

SUPPP includes the Substance Intervention and Treatment Programs and Prevention and Behavioral Health Promotion units that fund community-based and state-licensed treatment providers delivering substance use prevention, intervention, and treatment services. For the 2020-2021 biennium, SAMHSA's Substance Use Prevention, Treatment, and Recovery Services (SUPTRS) Block Grant (BG) accounted for 62 percent of substance use funding in the state. HHSC distributes SUPTRS BG funds through contracts with community-based providers, state licensed treatment providers, and other state agencies (e.g., TDCJ).

Contracted services are governed by the Texas Government Code, Texas Health and Safety Code, and Texas Administrative Code. All contracted providers are required to protect the people they serve and individual-identifying information and records from unauthorized disclosure. Confidentiality is also monitored during the annual peer reviews with remedies including TA, increased monitoring, or requirements to implement improvement or corrective action plans. Funded contractors use CMBHS as a confidential platform to report services and performance and outcome measures, and for billing.

Funding methodologies are used to determine the funding amounts allocated across the state. Contracts are procured in accordance with state and HHSC policy. Texas has a Medicaid benefit for outpatient, residential, and peer recovery services. Each of the state's 11 Health and Human Service (HHS) Regions has a continuum of care provided in accordance with the federal block grant guidelines, legislative direction, and the Texas Statewide Behavioral Health Strategic Plan, 2022-2026.[5] The state's fiscal year 2020 began a new five-year procurement term for prevention contracts and state fiscal year 2021 began a new procurement term for intervention, treatment and recovery support services.

HHSC currently uses SUPTRS BG funds to directly contract with one SUD entity, meeting the requirements of Charitable Choice. Charitable Choice requirements are included in the SUD provider performance contract, and a complaint process is in place for all people receiving services. The requirements follow the regulations outlined in 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (42 C.F.R. 54.8(c)(4) and

[5] https://www.hhs.texas.gov/reports/2022/11/texas-statewide-behavioral-health-strategic-plan-2022-2026

54.8(b)), Charitable Choice Provisions and Regulations. The contract provisions require providers to inform people of their choice options for treatment and offer alternatives prior to admission.

These requirements are further described as follows:

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

Prevention and Behavioral Health Promotion Services

HHSC funds a comprehensive array of prevention services, ranging from direct services in schools and communities to data collection and population-based strategies. HHSC funds five service types through end of fiscal year 2024: Youth Prevention Universal (YPU), Youth Prevention Selective (YPS), Youth Prevention Indicated (YPI), Community Coalition Partnerships, and Prevention Resource Centers (PRCs). Texas currently supports over 140 youth prevention programs, over 40 coalitions, and 11 PRCs across the state. HHSC uses data collected through its Regional Needs Assessments and statewide strategic planning processes as well as population health data analyses to determine prevention priorities for Texas that include alcohol (underage drinking), marijuana and cannabinoids, tobacco and nicotine products, and prescription drug misuse. The strategies implemented to address these priority areas promote behavioral health and wellness and address the underlying factors leading to substance misuse, including but not limited to, adverse childhood experiences, non-medical drivers of health, and building youth, family and community risk and protective factors. HHSC is currently implementing a statewide survey and community listening sessions across the state to help inform priorities and strategies moving forward. All programs are structured according to the Strategic Prevention Framework and incorporate the Center for Substance Abuse Prevention's six strategies to ensure a comprehensive continuum of prevention services.

Youth Prevention

The core strategy for these programs is prevention education to enhance wellness, social emotional development, relationship-building, and problem-solving skills. Youth Prevention programs use evidence-based curricula designated by the discontinued National Registry of Evidence-based Programs and Practices and proven effective with specific priority populations in school and community sites. Program types YPU, YPS, and YPI focus primarily on the youth population, though efforts are underway to expand reach to young adults, ages 18 to 25. These program types additionally serve a secondary adult population, including parents, guardians, and grandparents of the youth receiving services. YPU direct services are designed to reach the general population, between kindergarten and grade 12, without regard to individual risk factors, and are generally intended to reach a very

large audience. YPS direct services prioritize subgroups of the general population, between kindergarten and grade 12, determined to be at an elevated risk for substance use due to environmental risk factors. YPI direct services prioritize youth between kindergarten and grade 12 who are exhibiting early signs of substance use or other related behaviors associated with substance use. While typically delivered with fidelity to the model, the onset of COVID-19 required significant changes from standard delivery of services. All adaptations were approved by HHSC only after curriculum developers gave their approval. Under normal circumstances pre- and post-tests are given to the participants enrolled in the curriculum and measures are reported to HHSC. During the period of disruption from COVID-19, it was not possible to administer pre- and post-tests to all participants. HHSC is in the process of working with providers and model developers to enhance the pre- and post-test outcome measures to best assess the impact of programs.

Additionally, youth prevention programs provide Information Dissemination, Positive Alternatives, Community-Based processes, and Identification of Problems and Referral to Services. These services are substance-free and age-appropriate and are intended to promote behavioral health across the spectrum, provide skill-building opportunities, and help develop protective factors and mitigate risk factors facing individuals and communities.

Community Coalition Partnerships

Community Coalition Partnerships engage and mobilize various sectors of the community to implement evidence-based environmental strategies with a primary focus on changing policies, addressing environmental barriers to wellness, and influencing social norms related to substance use prevention and behavioral health promotion. Coalitions focus on the general community with an emphasis on adolescents and young adults ages 18-25 in colleges and universities. Coalitions are also strategically implementing services for people and communities impacted heavily by COVID-19, which includes implementing community-wide projects to promote wellness, trauma-healing and stress reduction activities, physical environmental and systematic changes to policies, ordinances, city priorities, and school policies.

Coalitions use the Strategic Prevention Framework, a five-step process to guide the selection, implementation, and evaluation of effective, culturally appropriate, and sustainable prevention and behavioral health promotion activities throughout the 11 HHS Regions of Texas. This includes conducting an initial needs assessment to identify the targeted county, zip code, neighborhood area, or community. Coalitions then assess capacity and mobilize coalition members and key stakeholder to begin discussing the needs assessment data and establish goals and priorities for their communities. The data collected determines the direction in which the members will contribute their time and effort in establishing written policy, attitude, and behavioral change.

PRCs, Synar Program, and Tobacco Prevention
Each of the 11 HHS Regions has a PRC, which functions as the central repository for collecting and analyzing data related to prevention and behavioral health promotion. Each PRC also supports the distribution of the statewide media campaign, monitors tobacco law compliance among the region's retailers, and helps to coordinate trainings for other providers in their region. Each PRC's data coordinator compiles federal, state, and local data into a Regional Needs Assessment (RNA) updated annually. The RNA analyzes key indicators to determine which of the region's populations, geographic areas, and risk and protective factors most need attention to support behavioral wellness. The data collection focuses on both the state's four prevention priorities--alcohol and underage drinking, marijuana and cannabinoids, tobacco and nicotine products, and prescription drug misuse—and social determinants of health that create the broader risk and protective factors for substance misuse.

Each PRC has a tobacco prevention coordinator (TPC) supporting the state's efforts to comply with the federal Synar Amendment and restrict youth access to tobacco and other nicotine products. The TPCs conduct on-site voluntary compliance checks with tobacco retailers in their region, ensuring, for example, that retailers display the most up-to-date signage from the Texas State Comptroller's Office, and conduct follow-up visits to retailers found out of compliance with Texas tobacco laws during a prior check. TPCs conduct retail merchant education and provide informational presentations for parents on the dangers of tobacco use by minors. HHSC's tobacco program promotes coordinated efforts to establish smoke-free policies, assist tobacco users to quit, reduce youth access to tobacco products, and prevent initiation of tobacco use. The use of media campaigns, control and cessation programs, and the implementation of smoke-free ordinances are examples of the tobacco prevention efforts in the state.

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

Public Awareness and Training
HHSC funds a statewide public awareness campaign to promote individual wellness and inform local leaders about the conditions that best support their community's behavioral health. In collaboration with HHSC, the contracted vendor develops and distributes the campaign across a wide variety of media: a website, social media posts and ads, SMS (text) messaging, television and cable stations, radio, newspapers, billboards and more. Additional federal COVID-19 relief funding for fiscal years 2022 and 2023 expanded the scope of this campaign (temporarily through supplemental COVID-19 funding) by more than 15 times, allowing HHSC to address in a truly impactful way the state's collective trauma and resulting substance use issues. Major priorities include addressing the needs of communities historically underserved by the state health system and engaging youth across Texas as active participants in the campaign. HHSC held statewide community

listening sessions during summer 2021 that helped inform the direction of the current campaign.

HHSC also funds the Texas Prevention Training statewide training entity which works collaboratively with the PRCs to coordinate training on prevention and behavioral health promotion for other HHSC-funded providers and community partners. Texas Prevention Training coordinates trainings on the HHSC-approved evidenced-based prevention curricula and other required prevention trainings based on the training needs identified by providers and HHSC.

Substance Use Intervention

Outreach, Screening, Assessment, and Referral (OSAR): OSAR programs assist people to access substance use services in their community and across the state. OSAR programs located in all 11 HHS regions provide screenings, assessments, education, information dissemination, risk reduction education, case management coordination, referral to treatment, financial eligibility determination for SUPTRS BG-funded treatment services and other appropriate support services. OSAR programs assist people with transportation to and from treatment, if needed, and help them move through the substance use continuum of care by linking them to community-based support services. Beginning in 2017, each OSAR program received funding through the State Opioid Response (SOR) grant for a Priority Admission Counselor, whose role is to prioritize and assist people engaged in opioid use or diagnosed with an opioid use disorder. To optimize the use of state and local resources, each OSAR program operates out of an LMHA or LBHA.

Community Health Worker (CHW) Program: At the end of state fiscal year 2018 the Human Immunodeficiency Virus and Early Intervention (HIV and HEI) set aside requirement ended and as a result, HIV and HEI programs were phased out by the end of state fiscal year 2020. As of the state's last HIV Surveillance Report in 2019, Texas' case rate for AIDS was 6.5 percent remaining below the federal threshold of 10 percent.

In state fiscal year 2021, HHS began contracting with nine providers for the CHW programs redirecting funds formerly allocated to HIV and HEI services. The goal of CHW programs is to decrease gaps in access to behavioral health services and increase access to services for underserved communities by addressing non-clinical drivers of health in these communities. CHW programs are tasked with understanding how non-clinical drivers of health, which are often outside of the person's control, impact the person's health outcomes. The number of CHW program providers increased in state fiscal year 2022, from nine to 14 to serve the major metropolitan centers as well as the rural and frontier regions of the state.

Pregnant, Parenting Intervention (PPI): The PPI program provides community-based, gender-specific services for pregnant and parenting women diagnosed with an SUD. In state fiscal year 2021, the PPI program which previously served pregnant and postpartum women, expanded to serve pregnant and parenting women with children up to age six. The program also requires a woman to have been diagnosed with a SUD to be eligible for services. Previously, eligible women

included those at risk for developing a SUD. This change was made to focus on women who are at highest risk for a substance-exposed pregnancy and would benefit from harm reduction services and high-intensity case management.

Parenting Awareness and Drug Risk Education Services (PADRES): In state fiscal year 2021, PADRES expanded to serve males and females through brief intervention services. This program is available to parents, expectant parents, guardians and primary caretakers of a child under age six to decrease the impact of substance use. The purpose of the PADRES program is to provide community-based intervention services, case management, and education. PADRES is also available to eligible people who are at risk for involvement or are currently involved with DFPS.

Rural Border Intervention (RBI): The RBI programs provide community and home-based substance use intervention services in remote rural border[6] areas and Colonias[7]. People receiving in RBI services are provided case management, linkage to community resources and enhanced support services. The RBI programs develop and implement a comprehensive behavioral health model promoting and embracing culturally and linguistically competent intervention, and promote treatment for youth and adults in rural border communities. All three of the current RBI programs provide their services using community health workers or promotoras. These community health workers usually come from the communities they serve and often act as outreach workers providing information and education. They are also able to identify substance use, mental health and medical concerns and make appropriate referrals for eligible people. The RBI program works to create strong alliances among agencies and organizations to leverage existing resources, strengthen the local workforce and infrastructure, and increase access to health and social services in the rural border areas.

Comprehensive Continuum of Care (CCC): The CCC program, which began in state fiscal year 2020, seeks to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in long-term recovery by providing pregnant women and women with dependent children comprehensive case management services, community-based linkage services, and retention services from pre-admission services through post-treatment services. The program also provides financial assistance to help program participants with costs associated with supports necessary to facilitate long-term recovery, including housing, childcare, and transportation. Program participants are offered an array of services

[6] Per Section 321.55 (11), Texas Administrative Code Rural Border is the area that extends 62 miles north of the Texas-Mexico border and encompasses 32 counties as described in the United States-Mexico La Paz agreement of 1983.
https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=321&rl=55

[7] Per Section 321.55 (4), Texas Administrative Code Colonias are a residential area along the Texas-Mexico border that lacks basic living needs, such as potable water and sewer systems, electricity, paved roads, and safe and sanitary housing. Colonias, while frequently found in unincorporated areas of the counties, are also found within city limits.
https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=26&pt=1&ch=321&rl=55

tailored to their needs. Case management and service coordination help establish linkages with other services in the community, such as legal services, social services, and state and federal nutrition assistance. These services help to fill a gap within typical treatment services to help individuals enter and maintain long-term recovery.

Training and Resources: HHSC has historically contracted for training services for intervention statewide; however, starting in state fiscal year 2020, HHSC partnered with the CTI-EBP to provide regionally-specific educational training to HHSC contracted substance use providers.

SUD Treatment Services

HHSC SUD Treatment services for adults and adolescents (defined as ages 13-17) engage the person and their family in recovery efforts through the continuum of care. Treatment approaches are evidence-based, holistic in design, and emphasize coordination of care across the substance use service continuum. HHSC requires evidence-based Motivational Enhancement Therapy in all SUD treatment settings.

HHSC has established priority populations for treatment in accordance with SUPTRS BG requirements and state designation. Treatment contractors shall give preference for treatment services in the following order of priority:

Federal Priority Population Designations:

1. Pregnant people who report injecting substances will be admitted within 48 hours;
2. Pregnant people who report using substances will be admitted within 48 hours; and
3. People who report injecting substances will be admitted within 14 days.

State Priority Population Designations:

4. People identified as being at high risk for overdose will be admitted to requested services within 72 hours;
5. People referred by DFPS will be admitted to requested services within 72 hours;
6. People experiencing housing instability or homelessness will receive admission to requested services within 72 hours (effective 9/1/2021); and
7. All other populations.

HHSC requires contractors to adhere to the state-established screening procedures to identify members of the priority populations. When space is not available in a contractor's program service area, the contractor guarantees successful and timely referral to another suitable state-funded contractor (immediately for pregnant women or within 120 calendar days for people who inject drugs), or to HHSC's Waiting List and Capacity Management Coordinator, if a placement is not possible. Contractors accept applicants from every region in the state when space is available. If two applicants are of equal priority status, preference may be given to an applicant living in the contractor's program service area. Each OSAR and treatment contractor includes a statement in all its brochures and posts a notice in the provider's waiting room concerning the priority population admission requirements.

Infectious Disease: HHSC requires all treatment programs to conduct and document screening for HIV, tuberculosis, communicable diseases, and hepatitis B and C; and provide or make referrals for testing and treatment for these diseases. When a person is placed on a waiting list, a contractor documents referral of the person to an entity that provides testing, counseling, and treatment for HIV, tuberculosis, and sexually transmitted infections. HHSC also funds one residential SUD treatment facility to provide specialized services to people diagnosed with HIV.

Capacity and Waiting List: Contractors are required to document available capacity daily in CMBHS. Contractors must also hold and maintain a wait list if they have no available capacity.

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

Assessment and Levels of Care Designation: HHSC established the following Individual Placement Guidelines akin to the American Society of Addiction Medicine (ASAM) levels of care designation:

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

Specialized Female Set-Aside
Specialized female services promote recovery from a SUD for pregnant women and women with dependent children meeting clinical criteria. Treatment is designed to promote stable recovery from a SUD. Specialized female services provide gender-specific, evidenced-based, and trauma-informed services. The state offers residential and outpatient treatment services which provide specialized programming for pregnant women and women with dependent children. In state fiscal year 2023, the SUPTRS BG funded nine women and children's residential treatment facilities which allow women to bring children to treatment with them.

Co-occurring Psychiatric Disorder
COPSD programs provide adjunct services to adults and youth with co-occurring psychiatric and an SUD, emphasizing integrated treatment for both mental health needs and an SUD. These services target people who require specialized support because of their co-occurring diagnoses. COPSD services encourage people to participate in both mental health and substance use services. COPSD contractors can provide services to people whether they are enrolled in a substance use treatment program or on a wait list.

Pharmacotherapy Services
Pharmacotherapy services provide medications for opioid use disorder (MOUD) to adults, including women who are pregnant and post-partum, to alleviate the adverse physiological effects of withdrawal from the use of opioids as required to meet the individualized needs of the person. MOUD providers administer and dispense medications assisted treatment for opioid addiction along with providing counseling and behavioral therapy. MOUD providers also perform communicable disease testing and immunizations. Through additional funds provided by the SOR grant, MOUD providers can offer chronic disease prevention and treatment for comorbid conditions (e.g., abscesses due to injection drug use, hepatitis C, or co-occurring psychiatric disorders) giving people an opportunity to improve their health and overall quality of life.

Texas Group Homes-Recovery Housing
HHSC contracts with Oxford House of Texas to provide Level 1[8] recovery residences for people across the state. Often, eligible applicants transition from HHSC-funded SUD programs. Residents then follow the Oxford Housing model by living in a democratically run, self-supporting, and drug-free home. To date HHSC has assisted in the establishment in over 290 Oxford Houses throughout Texas. In addition, HHSC contracts with Oxford House of Texas to provide Outreach Workers that offer peer and recovery support services to more than 2,100 people and families in Texas.

[8] The National Association of Recovery Residences (NARR) divides recovery residences into four levels with Level 1 being democratically or pee run. National Association of Recovery Residences.

Cultural Competency
In accordance with the Texas Administrative Code, HHSC requires mental health and SUD providers to ensure the provision of culturally, linguistically, and developmentally appropriate services in a non-discriminatory (including physical disabilities) manner for people and their families or significant others. For people who are deaf or hard of hearing, HHSC-funded contractors have access to HHSC interpreter services. Contracts and rules require provider staff to receive training in cultural competency.

In accordance with their agreements with the state, HHSC requires all substance use contractors to adhere to Texas Cultural Competence Guidelines for Behavioral Health Organizations[9]. The guidance is comprised of a set of requirements, implementation strategies, and additional resources to help providers and programs establish and expand culturally and linguistically appropriate services.

Criminal Justice
SUD services for adults and adolescents involved with the criminal justice system are also provided statewide. Local providers work with county and state criminal justice agencies to address the substance use needs of people involved in a criminal justice system. A contract with TDCJ provides outpatient treatment for adult offenders through the Treatment Alternative to Incarceration Program, and a contract with TJJD provides intensive and moderate residential treatment services for youth who are confined in a secure facility operated by that department. HHSC will continue to explore opportunities to provide substance use services in county-based jails. Other initiatives related to the criminal justice system include coordination with specialized courts throughout the state. HHSC provides TA related to policy and assists with the development of specialized drug, mental health, and veteran courts. In addition to the 26 ongoing efforts of numerous LMHAs and LBHAs, four counties receive specific funding to provide mental health deputy training and staff to divert people with mental illness from the criminal justice system.

Texas Targeted Opioid Response (TTOR) Program
HHSC implemented the TTOR program in May 2017 supported by SAMHSA funding targeted to address the opioid crisis. SAMSHA awarded HHSC additional funding in September 2018, May 2019, and August 2020—this funding has been used to continue and expand the state's response to the opioid crisis. SAMHSA also awarded HHSC two discretionary grants in 2016 and 2017. Combined funding received to date is $280 million. The TTOR Program coordinates all opioid funds to maximize services without duplication. The TTOR program aims to address the opioid crisis by reducing unmet treatment needs and opioid overdose-related deaths through prevention, treatment, and recovery activities.

[9] Texas Cultural Competence Guidelines for Behavioral Health Organizations

Integrated Initiatives

The following services and initiatives impact both the mental health and substance use populations.

Peer Support and Recovery Services
The federal government's emphasis on promoting recovery support services, peer support, and peer-run organizations presents continuous opportunities for HHSC to enhance the delivery and expansion of these vital services.

In 2019, HHSC took a significant step by adding "peer services" to the list of covered Medicaid benefits. HHSC adopted rules that define responsibilities of peer specialists, describe training requirements, authorize the establishment of a supervisory position for experienced and qualified peer specialists, and actively promote adherence to best practices in peer support through ongoing education and peer supervision. This comprehensive approach ensures the effective implementation and fidelity to peer support standards in Texas.

Since the introduction of the peer services benefit in 2019, utilization has steadily increased, with 33,072 total encounters recorded in 2019 and a projected 68,810 encounters expected in 2022. The 2023 total encounters will not be available until after the submission deadline. The number of LMHA and LBHAs utilizing peer support codes has also grown from nine centers in 2016 to 27 in 2022, again, the increase in the 2023 number of centers participating in the peer services benefit will not be available until the submission deadline. These trends highlight the rising demand for peer support services and need for training and TA for LMHAs and LBHAs to address recruitment, career development, supervision, and implementation of peer support. Research emphasizes the importance of tailored support to maintain fidelity to the peer services model. Furthermore, pending policy decisions, including potential changes to the age of eligibility for peer services and the inclusion of services provided by certified family partners, may further influence demand. Final determinations on these matters are anticipated by year-end**.**

HHSC's Peer Support and Recovery (PSR) team is responsible for overseeing and coordinating various peer support and recovery programs and initiatives aimed at expanding the peer workforce, enhancing the capacity of peer support and recovery services, and improving data and research efforts. Within PSR, there are three dedicated programs focused on mental health support; and two programs dedicated to substance use recovery support services. These programs are implemented through 72 contracts funded by the SUPTRS BG, MHBG, and state general revenue. Recovery-based programs include**:**

Rural Mental Health and Peer Support Learning Community: PSR has partnered with HHSC's Rural Mental Health team through the All Texas Access initiative to provide targeted training and TA to six rural LMHAs to expand the utilization of peer support services. All Texas Access is a legislatively mandated initiative that focuses on increasing access to mental health services in rural communities.

Consumer Operated Service Provider (COSP): The 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 LMHAs and LBHAs. These entities provide a broad range of peer support and recovery services to people seeking assistance for mental health challenges. There are currently nine COSP contracts across the state.

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 quality of life in the community. Members are encouraged to participate in the operation of the Clubhouse by helping with various tasks, such as administrative duties, reception, food service, transportation and financial services. Members are also encouraged to participate in activities to promote outside employment, education, housing and meaningful relationships leading to an overall improved quality of life. HHSC supports six Recovery Clubhouse contracts.

Recovery Support Services (RSS): RSS are evidence-based services designed to increase long-term recovery and quality of life for people with an SUD. Services are provided by certified peer specialists who have lived experience with recovery from an SUD using an array of non-clinical services and supports to help people initiate, support, and maintain long-term recovery from an SUD. HHSC currently funds 24 RSS providers (treatment, community, and standalone peer-run organizations) responsible for integrating recovery support services throughout their local system of care, strengthening the alignment of treatment services with a recovery-oriented approach while expanding community supports available to assist individuals in successfully integrating into their communities.

Youth Recovery Communities (YRCs): YRCs provide RSS to adolescents ages 13-21 who may have an SUD or want a substance-free environment. The YRCs support adolescents and their families by providing peer support and recovery-oriented services. The YRCs also establish effective linkages between recovery support organizations, substance use treatment programs and other community resources that support efforts to initiate and sustain the recovery of young people and their families. HHSC currently funds 11 contracts.

Recovery-Oriented System of Care (ROSC): HHSC supports a non-funded statewide ROSC initiative to help ensure people affected by substance use and mental health

disorders are provided a continuum of care that continuously promotes a path to recovery. HHSC assists communities across the state with initiating and understanding the ROSC concept in their local area by conducting onsite informational trainings; providing ongoing TA to the local communities; and participating in both individual and local ROSC community meetings.

Related initiatives: HHSC partners with multiple universities to provide enhanced peer and recovery services training and technical support, research into the scope and impact of the current peer workforce, strengthen community collaboration and enhance the business health of community-based recovery organizations:

Enhancing Peer Support and Recovery Services: HHSC works with The University of Texas Health Science Center San Antonio (UTHSCSA) to pilot The Transformational Leadership Training project, designed to develop the capacity of peer leaders to create lasting change by shaping how systems adopt and utilize peer support, create cooperative relationships with other practitioners, and navigate resistance. A parallel project is the ongoing implementation of a centralized coordination hub in which certified peer specialists connect with training, job placements and certified peer supervisors to obtain required certification supervision hours. The hub serves as a clearinghouse for organizations seeking to hire peer specialists.

Enhancing Business Health: HHSC partners with TIEMH to implement the Leadership Fellows Academy (LFA) training. The LFA provides training in management and leadership to established community-based recovery organizations (CBROs), which include COSPs, Mental Health Clubhouses, and Recovery Community Organizations. The LFA enhances the business health of CBROs by focusing on topics like succession planning, building a sustainable organization, developing an effective board of directors, fundraising and grant writing.

Strengthening Collaboration: HHSC works with UTHSCSA to implement The Collaborative for Recovery Focused Change cohort, bringing together behavioral health agencies in Texas enabling ten to rise to the challenge of supporting the whole person, from service to systems levels. This multi-year program provides training and technical support within a collaborative community, preparing organizations to put person-centered, recovery-focused, and trauma-responsive principles into action. Community learning opportunities for cohort teams, as well as all-agency staff learning sessions, and site-specific training and informational events added much to the experience and success of this program.

HHSC supports the data and research of peer and recovery programs by integrating the work of its substance use and mental health research partners, The University of Texas, Center for Social Work Research Addiction Research Institute and TIEMH. This enables HHSC to make data-driven decisions regarding program development and implementation. HHSC is aligning program measures, research reports, and

other data tracking elements to enable coordinated data collection across programs.

Native American Tribes

HHSC has agreements with two of the three federally recognized Native American Tribes located in Texas. These agreements establish the roles and responsibilities of HHSC and the tribal authorities to promote and facilitate open communication, cooperation, and training to best serve tribe members' mental health and SUD needs. Tribal TA calls are conducted quarterly to share resources and identify ways to increase access to services and ensure services are delivered culturally appropriate.

HHSC began communications with the Texas Native Health center in Dallas to assess the needs of Native Americans throughout the state who may not be affiliated with one of the three federally recognized tribes in Texas. The goal is to reduce barriers to access to services while expanding the reach to over 100,000 natives throughout the state. HHSC recently hired a member of Alabama-Coushatta Tribe of Texas on the SUPPP team. As part of her role, this staff will advise the team to ensure that funded programs are culturally and appropriately implemented.

Texas Certified Community Behavioral Health Clinics (T-CCBHCs)

The federal CCBHC model integrates primary care screenings and SUD care into mental health care settings clinically, financially, and administratively, with the goal of improving overall health outcomes. The CCBHC model is comprised of the following services:

- Crisis behavioral health services, including 24-hour mobile crisis teams, emergency crisis intervention, and crisis stabilization;
- Screening, assessment, and diagnosis, including risk management;
- Patient-centered treatment planning;
- Comprehensive outpatient mental health and substance use services;
- Outpatient primary care screening and monitoring of key health indicators and health risk;
- Targeted case-management;
- Psychiatric rehabilitation services; and
- Development of comprehensive community recovery supports, including peer support, counseling services, and family support services.

HHSC launched the T-CCBHC initiative in 2016. T-CCBHC is based on the federal principles, with additional features designed to meet the needs of Texas' delivery system, using a modified payment methodology and requiring more stringent timelines for crisis service delivery, follow-up, and treatment planning. As of March 2023, HHSC has certified all 39 LMHAs and LBHAs in Texas and four non-profits.

The following table provides a list of HHSC's programs for people with SMI, SED, COPSD, or substance use issues and the associated funding source.

Program	State	Medicaid	MHBG	SUPTRS BG	Other Federal
Adult Mental Health Recovery Based Clubhouse Program	X		X		
Behavioral Health Mobile Crisis Outreach			X		
Community Coalitions Prevention	X			X	
Community Mental Health Grant Program	X				
Community Mental Health Hospitals	X				
Competency Restoration	X		X		
Comprehensive Continuum of Care Treatment Services for Females	X			X	
Consumer Operated Services			X		
Contingency Management and Motivational Reinforcement					X
Co-Occurring Psychiatric and Substance Abuse Disorders	X		X	X	
COVID-19 Harris County Statewide Call Center			X		
Crisis Stabilization Unit	X				
Education Service Center-Based Non-Physician Mental Health Professional	X				
Harris County Jail Diversion	X				
HCBS Provider Agreement	X	X			
Healthy Community Collaborative	X				
Healthy Community Collaborative Evaluation	X				
High Fidelity Supported Employment Program			X		
Home & Community Based Services-Adult Mental Health (HCBS-AMH)	X	X			
Home and Community Based Services	X				
HCBS-AMH Pre-Engagement Program	X				
HCBS-AMH Satisfaction Survey	X				
Hospital Transition Pilot Program	X		X		
Interagency Cooperation Contract with the Texas Veteran's Commission	X				
Jail-Based Competency Restoration	X		X		
Job Development Supported Employment Services	X		X		

Program	State	Medicaid	MHBG	SUPTRS BG	Other Federal
Local Behavioral Health Authority Contract	X			X	
Medication Assisted Therapy	X			X	X
Mental Health - Coordinated Specialty Care	X		X		
Mental Health - Mental Health Recovery and Resilience	X		X		
Mental Health - Residential and Transition Program Contract Management	X				
Mental Health Crisis	X		X		X
Mental Health Deputy Program	X				
Mental Health First Aid	X		X		
Mental Health Performance Contract Notebook	X		X		X
Mental Health Private Psychiatric Beds	X				
Mental Health Resource			X		
Mental Health Texas Homeless Network	X				
Mental Health and Outpatient Competency Restoration	X		X		
MH and Peer Counseling and Reintegration Services	X		X		
MHSA Provider Training, TA and Conference Planning	X	X	X		X
MH-YES Waiver Services Pre-Engagement	X				
MH-Youth Empowerment Services Training		X			
Modification to the http://mentalhealthtx.org website			X		
National Suicide Prevention Lifeline State Capacity Building Initiative			X		X
Neonatal Abstinence Syndrome Medication Assisted Therapy	X			X	
Office Based Treatment Services					X
Opioid Misuse Public Awareness Campaign					
Outreach, Screening, Assessment, and Referral	X			X	X
Overdose Prevention Education and Naloxone					X
Peer Support Re-Entry	X		X		
Post-Discharge Medications for Civil Commitments	X				

Program	State	Medicaid	MHBG	SUPTRS BG	Other Federal
Pregnant Post-Partum Intervention Program	X			X	
Prevention Media Campaign	X			X	
Prevention Resource Centers	X			X	
Texas Prevention Training	X			X	
Projects for Assistance in Transition from Homelessness	X				X
Promoting Integration of Primary and Behavioral Health Care					X
Recovery Support Services Community Based Organizations	X			X	
Recovery Support Services Recovery Community Organizations	X			X	
Recovery Support Services Treatment Organizations	X			X	
Residential Treatment Center	X				
Residential Treatment Center Integration	X				
Safe Drug Disposal and Community Awareness					X
Community Mental Health Services for Justice Involved Individuals	X		X		
Substance Abuse-Substance Use Disorder–Community Health Worker	X			X	
Texas Targeted Opioid Response (TTOR)-CJ Criminal Justice	X				
TTOR-PAX Good Behavior Game					X
Suicide Care Prevention Pilot			X		
Supportive Housing Project	X		X		
Survey – Treatment	X			X	
TDCJ Rider 39	X				
TTOR Extension for Community Healthcare Outcomes (ECHO)					X
TTOR Educate Before You Medicate					X
TTOR Houston Emergency Room Opioid Engagement System (HEROES) helpline					
TTOR Housing for Opioid Medication Assisted Recovery Expanded Services (Project HOMES)					X
TTOR Integrated Community Opioid Network (ICON)					X

Program	State	Medicaid	MHBG	SUPTRS BG	Other Federal
TTOR Medication-Assisted Recovery Services (MARS)					X
TTOR Overdose Prevention Drop-in Center					X
TTOR – Opioid Training Initiative					X
TTOR - Public Health					X
TTOR Recovery Housing					X
TTOR Support Hospital Opioid Use disorder Treatment (SHOUT)					X
TTOR University of Texas Recovery Support Services					X
Tobacco Special Program (Synar)	X			X	
Training Supports for Cognitive Behavioral Therapy	X		X		
Treatment Adult Services	X			X	
Treatment Alternative to Incarceration Program (TDCJ)	X				
Treatment Youth Services	X			X	
Treatment-Juvenile Correctional Facility (TYC)	X				
Veteran Counselor Program	X				
Veterans Services	X				
YES Waiver Provider Agreement		X			
Youth Prevention - Indicated	X			X	
Youth Prevention - Selective	X			X	
Youth Prevention - Universal	X			X	
Youth Recovery Community Services	X			X	

Planning Steps

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

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, **Behavioral Risk Factor Surveillance System (BRFSS)**, **Youth Risk Behavior Surveillance System (YRBSS)**, the **Uniform Reporting System** (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active SEOW.

This narrative must include a discussion of the unmet service needs and critical gaps in the current system regarding the MHBG and SUPTRS BG priority populations, as well as a discussion of the unmet service needs and critical gaps in the current system for underserved communities, as defined under **EO 13985**. States are encouraged to refer to the **IOM reports**, *Race, Ethnicity, and Language Data: Standardization for Health Care Quality Improvement* and ***The Health of Lesbian, Gay, Bisexual, and Transgender People: Building a Foundation for Better Understanding***[1] in developing this narrative.

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Footnotes:

Step 2: Unmet Needs and Services Gaps

Texas is a geographically expansive state with a population of 30 million people in 254 counties as of July 1, 2022 per census.gov. Texas has 82 metropolitan or urban counties with the remaining 172 counties classified as rural. Two metropolitan areas account for 54 percent of the population in Texas. The diversity of the urban and rural settings contributes to the contrasting needs, capability, and capacity of substance use services. Stated below are the unmet needs and gaps in services along with plans to mitigate the issues.

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

It is estimated that 5.68 percent of the total adult population in the state has an SMI during a given year. There are many more adults in need of services than currently served. In state fiscal year 2022--230,491 (or 38.45 percent of the estimated 599,426 adults with SMI living below 200 percent of the Federal Poverty Level (FPL)) were served by state-funded community mental health centers (Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021, Texas Demographic Center 2022 Population Projections by Single Year of Age, Vintage 2022, Texas HHSC BHS Decision Support Services, Mental and Behavioral Health Outpatient Warehouse (MBOW) 2022))

Estimates for Child and Adolescent Mental Health Treatment Needs in Texas
Two large national surveys conducted in the 1980s and 1990s serve as the basis for prevalence estimates for children and adolescents (Source: U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General, 1999). Approximately 18.41 percent of children and adolescents in Texas have some type of mental health disorder. Those children and adolescents diagnosed with a serious emotional disturbance (SED) represent approximately seven percent of the child and adolescent population. The prevalence estimates of SED in these studies are based on children and adolescents ages 12 to 17.

There are many more children in need of services than currently served. In fiscal year 2022--69,845 (36.30 percent) of the estimated 192,432 children with SED living below 200 percent of FPL were served by state-funded community mental health centers (Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021, Texas Demographic Center 2022 Population Projections by Single Year of

Age, Vintage 2022, Texas HHSC BHS Decision Support Services, MBOW 2022)

Intervention Needs

The COVID-19 pandemic continues to impact intervention services as many providers continue to struggle with workforce challenges. Individuals may also be reluctant to participate in face-to-face activities. Additionally, the long-term impact of the COVID-19 pandemic contributed to closures of partnering community agencies and businesses which served as adjunct resources to the intervention programs.

Texas's HIV designation and HHSC's Human Immunodeficiency Virus (HIV)-focused programs ended in fiscal year 2020 due to Texas no longer being considered a designated state (i.e., the rate of cases of acquired immune deficiency syndrome is 10 or more per 100,000 individuals[1]). However, the need remains for community-based outreach focusing on individuals who are living with or at risk of HIV.

HHSC pivoted HIV programs and developed the Community Health Worker (CHW) program. The CHW programs provides linkage and retention in substance use, mental health, and medical services for Texas residents who are marginalized or stigmatized, experiencing housing instability or homelessness, injecting substances, living with or are at risk of Hepatitis C Virus or HIV, and experiencing greater barriers to entering treatment or recovery services.

Data from national surveys on Drug Use and Health revealed about 1 in 8 children (8.7 million) aged 17 or younger lived-in households with at least one parent who had a past year substance use disorder (SUD).[2] In Texas substance use services for parents also continues to be a need. HHSC has substance use intervention programs specifically designed to assist parents. The Parenting Awareness Drug Risk Education Services program provides community-based intervention and evidence-informed education to parents and expectant parents to decrease the impact of substance use.

The Pregnant Parenting Intervention program supports the mother-child dyad through the provision of evidence-based education and case management services. These services are available to pregnant females and females with dependent children up to six years of age, who have been diagnosed with a substance use disorder.

HHSC implemented the Comprehensive Continuum of Care for Females (CCC) in 2021. The CCC program provides pregnant women and women with dependent children comprehensive case management services. These

[1] https://uscode.house.gov/view.xhtml?req=granuleid:USC-prelim-title42-section300x-24&num=0&edition=prelim

[2] Lipari, R.N. and Van Horn, S.L. Children living with parents who have a substance use disorder. The CBHSQ Report: August 24, 2017. Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration, Rockville, MD.

services aim to reduce barriers to treatment, encourage motivation, improve, and balance life situations, and promote engagement in long-term recovery.

Treatment Needs

HHSC funds a full treatment continuum of care (withdrawal management, residential, and outpatient services). However, due to a lack of providers, certain service types (e.g., withdrawal management) are not available in every region. This means individuals may have to travel out of region to access services. In addition, each service region spans a significant distance whereby transportation to and from a facility on a consistent basis is unreasonable to the indigent population served. However, recent flexibilities in state regulatory rules associated with COVID-19 allowed for treatment services to be conducted virtually, reducing barriers associated with distance and transportation.

The COVID-19 pandemic also brought new challenges for treatment providers and emphasized ongoing barriers, including service delivery. While treatment providers were able to shift to telehealth and telephonic service options, concerns were raised regarding the long-term impact of the pandemic on local service delivery systems and how changes to the service delivery system should be contemplated within the context of the long-term impacts of the pandemic.[4] HHSC continues to explore telehealth to serve the populations. HHSC is reviewing administrative rules, implementation cost, and reimbursement. Providers continue to report hiring and maintaining workforce and cost of providing treatment as issues impacting service delivery. Reduced capacity is now impacted by the lack of staff that includes licensed and non-licensed staff.

Youth treatment is underutilized due to a decrease in referral sources. To address this decrease in referrals, HHSC is currently exploring opportunities, including collaboration with the Texas Juvenile Justice Department, and developing a strategic approach to assist current contractors to strengthen their marketing and outreach plan.

Peer Services

The heightened emphasis at the federal level regarding expansion of recovery support services as an authorized activity, the ongoing focus on the peer workforce, peer run organizations and the integration of behavioral health creates opportunities to enhance the delivery of recovery supports to all parts of the public behavioral health system. The demand for adult and youth mental health and SED services continues to increase and is currently outpacing the capacity of the providers to provide recovery support. Providers are prevented by funding constraints from adding additional staff or incentivize existing staff, resulting in unfilled positions and turnover in the face of high demand. Research continues to indicate that sustained recovery is best facilitated when providers focus on a long-term recovery strategy by incorporating peer and community-based supports, addressing health

concerns, promoting life skills, and including families or other significant allies.

A recent report[3] examined the challenges faced and the strengths brought by peer run and peer allied organizations in the behavioral health system. Challenges include 1) the purpose and scope of work of these organizations is not fully recognized or understood by the systems with which they collaborate; 2) lack of understanding contributes to inappropriate funding structures and inadequate funding, which leads to 3) limiting the capacity of individual organizations and hindering system-wide scaling and sustainability.

The report shows that Clubhouses, consumer operated service providers and recovery community organizations are essential organizations that support recovery, wellness, and wellbeing for people, communities, and society. These organizations support the recovery and wellness journey for people with lived experience of mental health or substance use challenges. This is accomplished through peer support combined with a wide range of services to address people's needs. These organizations also support recovery, wellness, and wellbeing in communities and society through advocacy; cultural congruence with communities; training and technical assistance offered to community organizations; support for employment or employment opportunities; and policy and program development.

Thus, because these organizations address recovery, wellness, and wellbeing for individuals, communities, and society, their work extends beyond what most behavioral health service providers accomplish. These organizations know that these challenges are best managed by whole systems of support. Thus, they collaborate with hospitals, churches, Collegiate Recovery programs, workplaces, Federally Qualified Health Centers, courts, jails, and other settings. These collaborations foster resilient communities that are more responsive to the needs of all community members. Finally, these organizations can potentially alleviate the behavioral healthcare workforce and services shortage because as people heal, they use fewer services. As such, at this time HHS funds 39 peer-run and peer allied organizations, that are mostly centered in densely populated urban areas, leaving rural parts of the state largely unsupported.

Additionally, high demand for peer services can be found in the LMHAs and LBHAs. Services provided in these settings include the Medicaid-reimbursed peer services, mental health rehabilitation, and certain family partner services. However, these large organizations face similar staffing challenges as peer-run organizations, especially in rural areas.

[3] Acker, D., Bass, B., Carr, S., Earley, J., Estrada, E., Gray, A., Howell, J., Kuehnel, J., Lodge, A., Lowe, S., Manski, S., Mizell-Flint, A., Powell, J., Robles, E., Stevens Manser, S. (2023). The future of recovery, wellness, and wellbeing: Opportunities to enhance underutilized peer-run organizations and Clubhouses.

Youth

As with adult recovery support services, youth and family services are in high demand for both mental health and SUD. The demand has steadily increased for certified family partners (CFPs) and transition age youth support. There are currently 138 CFPs. As LMHAs and LBHAs continue hiring CFPs to meet demand, there is an increased need for certification training, technical assistance, and mentoring. To meet this expanding need, a formal family partner mentoring model has been developed along with a youth and young adult peer support endorsement so certified peer specialists can acquire training specific to youth and young adults. While this has been accomplished within existing resources, additional funding is necessary to increase the number of CFPs.

A needs assessment completed on the 11 Youth Recovery Communities in 2022[4] demonstrated the emergence and importance of the family liaison role in youth recovery. This finding, along with direct requests from stakeholders, has heightened the importance of placing family partners in substance use recovery organizations, again, increasing the demand for CFPs. Based on the increase of peer and family partner interactions with this population, a Youth and Young Adult peer support endorsement has been developed and will be available for training purposes. There is a demonstrated need to expand Youth Recovery Communities both in substance use and to begin piloting the model in mental health through the LMHA and LBHAs.

Prevention and Behavioral Health Promotion Needs in Texas

The Regional Needs Assessments (RNAs) developed by the 11 Prevention Resource Centers (PRCs) provide the data necessary to inform data-driven decision-making about prevention and behavioral health promotion for each region. The RNAs aggregate adult and youth substance use indicators as well as key non-medical drivers of health that shape behavioral health. Survey data, such as that collected using the Texas School Survey (TSS), Texas College Survey, the National Survey on Drug Use and Health, and the Texas Behavioral Risk Factor Surveillance System demonstrate the scope of substance use behaviors among the various age or ethnic groups and geographic areas. The RNAs also include some consequence data, such as substance-related crimes, hospital admissions and deaths to indicate the negative impact of substance use. HHSC is currently working with the PRCs to broaden the scope of the RNAs to include more data on non-medical drivers of health, and analyze data by race and ethnicity, so that our providers can better understand the primary risk and protective factors and health inequities affecting their constituencies.

[4] Mangrum, L; Kaviani, C.,Nichols, M., Achara, I.,Sears, J., Hutchison, B., Bruer, T.,(2022) Youth recovery Communities Needs Assessment

As part of its commitment to data-driven decision-making, HHSC plans to contract with a university in the state to strengthen surveillance data collection, data reporting, and program evaluation.

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

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

Mental Health Workforce Shortages in Texas

In 2019 the Statewide Behavioral Health Coordinating Council (SBHCC) established a Behavioral Health Workforce Subcommittee. The purpose of the subcommittee is to develop a plan for increasing and improving the workforce in Texas to serve people with mental health and substance use issues. The subcommittee includes representatives of state agencies, universities, professional organizations, providers, and advocates. Since establishment, the subcommittee published a meta-report in December 2020, *Strong Families, Supportive Communities: Moving our Behavioral Health Workforce Forward*, that looked at six pre-existing reports on the behavioral health workforce shortage and identified key next steps for Texas to address the problem. Most recently, the subcommittee produced a brief, *Texas Behavioral Health Workforce Shortage* Snapshot, that highlights key information on Texas' behavioral health workforce shortage. Non-state agency organizations represented on the subcommittee used the brief, paired with recommendations from the meta-report, in their information sharing and education efforts during the Texas 88th Legislative Session. The Texas Legislature passed several bills targeting the recruitment, retention, and growth of behavioral health professionals. Moving forward, the subcommittee plans to analyze the workforce related issues that did not receive attention during the Texas 88th Legislative Session in hopes to further educate policy makers about the state's behavioral health infrastructure and workforce needs. The meta-report is available at https://www.hhs.texas.gov/sites/default/files/documents/laws-

regulations/reports-presentations/2020/behavioral-health-workforce-workgroup-report-dec-2020.pdf, and the brief is available at https://mentalhealthtx.org/wp-content/uploads/2023/02/BH-WF-Shortage-Snapshot-Final_Jan-2023_1.17.23.pdf

Texas Statewide Behavioral Health Strategic Plan (TSBHSP)

To improve coordination between two branches of government (i.e., the executive and judicial branches) who receive state and federal appropriations to implement behavioral health training and services, in 2014, Texas lawmakers directed the establishment of the SBHCC. The SBHCC is directed to develop a five-year statewide behavioral health strategic plan, annually publish a progress report on the SBHCC's implementation of the behavioral health strategic plan, and annually publish a coordinated expenditure report which includes information on the amount of appropriated funds spent on behavioral health services. state agencies More information about the SBHCC and the published reports and presentations are available at: https://www.hhs.texas.gov/about-hhs/leadership/advisory-committees/statewide-behavioral-health-coordinating-council.

LMHA and LBHA Equity Funding

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

- LMHA or LBHA total baseline funding/(Local Service Area total population) + (Local Service Area population < 200% of FPL)

Data Sources for the Texas Needs Assessments Report

1. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2021. , Texas Demographic Center 2022 Population Projections by Single Year of Age, Vintage 2022, Texas HHSC BHS Decision Support Services, MBOW 2022
2. Kessler, R. C., Berglund, P. A., Zhao, S., Leaf, P. J., Kouzis, A. C., Bruce, M. L., Friedman, R. M., Grossier, R. C., Kennedy, C., Narrow, W. E., Kuehnel, T. G., Laska, E. M., Manderscheid, R. W., Rosenheck, R. A., Santoni, T. W., & Schneier, M. (1996). The 12-month prevalence and correlates of serious mental illness, in Manderscheid, R. W., & Sonnenschein, M. A. (Eds.), *Mental health, United States, 1996* (DHHS Publication No. (SMA) 96- 3098, pp. 59–70). Washington, DC: U.S. Government Printing Office.

3. White, W. (2008). Recovery Management and Recovery-Oriented Systems of Care: Scientific Rationale and Promising Practices. Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, and Philadelphia Department of Behavioral Health and Mental Retardation Services.
4. Expanding Capacity and Increasing Efficiency in Substance Use Disorder Services is submitted in compliance with the 2020-21 General Appropriations Act, House Bill (H.B.) 1, 86th Legislature, Regular Session, 2019 (Article II, Health and Human Services Commission, Rider 67).

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Prevention of Substance Use

Priority Type: SUP, MHS

Population(s): SMI, SED, PP, Other

Goal of the priority area:

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

Strategies to attain the goal:

Provide targeted technical assistance to providers so that strategies are centered on funded priorities; identify barriers to consumer access of prevention services and the challenges of service delivery; and provide technical assistance that allows contractors to concentrate their efforts on enrolling more youth and adults in prevention education while stabilizing their efforts of other prevention strategies.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Prevention of Substance Use Disorder

Baseline Measurement: Adults:400,654 Youth: 1,086,113

First-year target/outcome measurement: Return to Pre-Covid levels of Adults: 520,167 Youth: 1,636,415

Second-year target/outcome measurement: Return to Pre-Covid levels of Adults: 520,167 Youth: 1,636,415

Data Source:

CMBHS

Description of Data:

Number of youth and adults receiving substance abuse prevention services.

Data issues/caveats that affect outcome measures:

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

Priority #: 2

Priority Area: Substance Use Disorder Treatment and Intervention

Priority Type: SUT

Population(s): PWWDC, PWID

Goal of the priority area:

Focus on health care and services coordination. Integration efforts seek to increase access to appropriate high- quality intervention and treatment.

Strategies to attain the goal:

Maintain oversight of waitlist reporting and contact contractors to ensure coordination continues.
Provide oversight and communication with contractors not meeting Outcome Measures to ensure quality services are provided.
Continue to provide PADRE services across the state and provide ongoing technical assistance and on-site monitoring to support the PADRE programs.
Provide oversight to ensure contractors are not over-extending stays or not performing appropriate screenings which result in extended or shortened

lengths of treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Priority Population Admission

Baseline Measurement: Pregnant, injecting women and pregnant women who were immediately admitted (72 hours) into treatment services - 39%

First-year target/outcome measurement: FY2024 – Increase by 10% to, at least, 49%

Second-year target/outcome measurement: FY2025 – Increase by 10% to, at least, 59%

Data Source:

CMBHS

Description of Data:

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

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Intervention Services Number Served

Baseline Measurement: Numbers served in PADRE and RBI - 8,309

First-year target/outcome measurement: Return to Pre-Covid level of 9,217

Second-year target/outcome measurement: Return to Pre-Covid level of 9,217

Data Source:

CMBHS

Description of Data:

Contractual Performance Measures
PADRE
Number of adult clients screened for substance abuse risk factors
Number of youth clients screened for substance abuse risk factors.
RBI -
Number of adults served.
Number of youths served.

Data issues/caveats that affect outcome measures:

No known data issues.

Indicator #: 3

Indicator: Number of Adults served in Substance Use Disorder treatment services

Baseline Measurement: Number of adult treatment program services - 34,193

First-year target/outcome measurement: Return to Pre-Covid level of 34,450

Second-year target/outcome measurement: Return to Pre-Covid level of 34,450

Data Source:

CMBHS

Description of Data:

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

Data issues/caveats that affect outcome measures:

No known data issues.

Priority #: 3

Priority Area: Recovery Support

Priority Type: SUT, MHS

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

Goal of the priority area:

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

Strategies to attain the goal:

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

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number enrolled in long-term coaching

Baseline Measurement: Number of individuals enrolled in long-term coaching - 4,896

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBHS

Description of Data:

Performance Measure in contract
Number of individuals currently enrolled to receive long-term (12 months) coaching

Data issues/caveats that affect outcome measures:

No known data issues.

Indicator #: 2

Indicator: Youth Recovery

Baseline Measurement: Number of youth served - 8,852

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

CMBH

Description of Data:

Performance Measure in contract
Total number of participants with open cases for the reporting month.

Data issues/caveats that affect outcome measures:

None

Priority #: 4

Priority Area: Crisis Service Delivery

Priority Type: SUT, MHS

Population(s): SMI, SED, PP

Goal of the priority area:

Focus on the availability and accessibility of crisis services to individuals within the community.

Strategies to attain the goal:

1. Continue providing crisis residential facilities across the state focusing on special populations and rural areas. Provide ongoing technical assistance and on-site monitoring to support the crisis programs.
2. Increase access to crisis response services for persons waiting for access to ongoing mental health care.
3. Provide services within the community to meet the needs of individuals.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Persons Receiving Crisis Residential Services Per Year

Baseline Measurement: Individuals received crisis residential services: 12,827

First-year target/outcome measurement: Return to Pre-Covid level of 25,000

Second-year target/outcome measurement: Return to Pre-Covid level of 25,000

Data Source:

Consumer Analysis Data Warehouse/MBOW

Description of Data:

Number of individuals with SMI who received crisis residential services in a fiscal year

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of persons receiving crisis outpatient services

Baseline Measurement: Persons received crisis outpatient services - 83,317

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

Consumer Analysis Data Warehouse/MBOW

Description of Data:

Reflect the number of individuals who received crisis outpatient services in a fiscal year.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Percentage of individuals receiving crisis services who avoid psychiatric hospitalization

Baseline Measurement: Percent of individuals who avoid psychiatric hospitalization - 98%

First-year target/outcome measurement: Maintain baseline

Second-year target/outcome measurement: Maintain baseline

Data Source:

Consumer Analysis Date Warehouse/MBOW

Description of Data:

The percentage of individuals who received crisis service, but did not receive psychiatric hospitalization.

Data issues/caveats that affect outcome measures:

None

Priority #: 5

Priority Area: Community Mental Health Services

Priority Type: SUT, MHS

Population(s): SMI, SED, PP

Goal of the priority area:

Community mental health services should be available and provided to individuals regardless of age or geographic location within the state.

Strategies to attain the goal:

Maintain or increase access to community mental health services across the state.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults receiving community mental health services per year

Baseline Measurement: Adults served - 230,491

First-year target/outcome measurement: Maintain Baseline

Second-year target/outcome measurement: Maintain Baseline

Data Source:

Consumer Analysis Data Warehouse/MBOW

Description of Data:

This reflects the number of adults who received a mental health service in the fiscal year

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Number of children receiving community mental health services per year

Baseline Measurement: Children served - 69,845

First-year target/outcome measurement: Maintain baseline

Second-year target/outcome measurement: Maintain baseline

Data Source:

Consumer Analysis Data Warehouse/MBOW

Description of Data:

This reflects the number of children who received a mental health service in a fiscal year.

Data issues/caveats that affect outcome measures:

None

Priority #: 6

Priority Area: Mental Health Targeted Programs

Priority Type: SUT, MHS

Population(s): SMI, SED, PP

Goal of the priority area:

Guide the behavioral health system and promote individual, program, and system level approaches that foster health and resilience; increase housing to support recovery; reduce barriers to employment, education, and other life goals; and secure necessary social supports.

Strategies to attain the goal:

SHRA: Provide monthly supported housing technical assistance calls and conduct site visits as needed to support providers.

Certified Mental Health Peer Specialists and Recovery Support Peer Specialists; Continue to contract with providers to offer training and certification for MHPS and RSPS. Provide ongoing technical assistance to support Recovery Support Services provider (for persons with SUD) and LMHA/LBHA development and retention of certified MHPSs and RSPSs.

First Episode of Psychosis Program: Monitor and support current and future First Episode of Psychosis programs to establish and maintain access to integrated care for participants.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Reduce Crisis Services for individuals receiving Supportive Housing Rental Assistance (SHRA)

Baseline Measurement: Crisis Services Reduction - 64%

First-year target/outcome measurement: Maintain baseline

Second-year target/outcome measurement: Maintain baseline

Data Source:

CMBHS/MBOW

Description of Data:

Data compares crisis service utilization 180 days before clients' first SHR payment to utilization 180 days after first SHR payment.

Data issues/caveats that affect outcome measures:

None

Indicator #: 2

Indicator: Reduce Psychiatric Hospitalizations for individuals receiving Supportive Housing Rental Assistance (SHR)

Baseline Measurement: Psychiatric Hospitalization Reduction - 34%

First-year target/outcome measurement: Maintain baseline

Second-year target/outcome measurement: Maintain baseline

Data Source:

CMBHS/MBOW

Description of Data:

Data compares psychiatric hospital admissions 180 days before clients' first SHR payment to admissions 180 days after first SHR payment.

Data issues/caveats that affect outcome measures:

None

Indicator #: 3

Indicator: Number of individuals served in the First Episode of Psychosis program

Baseline Measurement: Individuals served- 1,218

First-year target/outcome measurement: Maintain baseline

Second-year target/outcome measurement: Maintain baseline

Data Source:

CMBHS/MBOW

Description of Data:

Number of persons served in the early onset psychosis level of care.

Data issues/caveats that affect outcome measures:

No known data issues.

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Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SUPTRS]

States must project how the SSA will use available funds to provide authorized services for the planning period for state fiscal years FFY 2024/2025.
SUPTRS BG – ONLY include funds expended by the executive branch agency administering the SUPTRS BG.

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2025

Activity (See instructions for using Row 1.)	Source of Funds									
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (SUPTRS BG)[b]
1. Substance Use Prevention[c] and Treatment	$226,250,540.00		$0.00	$119,078,946.77	$70,814,928.00	$0.00	$0.00		$30,866,517.00	$0.00
a. Pregnant Women and Women with Dependent Children[c]	$51,997,104.00		$0.00	$0.00	$10,419,748.00	$0.00	$0.00		$6,929,510.00	
b. Recovery Support Services	$7,792,178.00		$0.00	$6,500,000.00	$1,948,044.00	$0.00	$0.00		$568,420.00	
c. All Other	$166,461,258.00		$0.00	$112,578,946.77	$58,447,136.00	$0.00	$0.00		$23,368,587.00	
2. Primary Prevention[d]	$83,509,398.00		$0.00	$0.00	$22,451,056.00	$0.00	$0.00		$8,318,562.00	$0.00
a. Substance Use Primary Prevention	$83,509,398.00		$0.00	$0.00	$22,451,056.00	$0.00	$0.00		$8,318,562.00	
b. Mental Health Prevention										
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)										
4. Other Psychiatric Inpatient Care										
5. Tuberculosis Services	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
6. Early Intervention Services for HIV	$0.00		$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
7. State Hospital										
8. Other 24-Hour Care										
9. Ambulatory/Community Non-24 Hour Care										
10. Crisis Services (5 percent set-aside)										
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately	$16,303,154.00		$0.00	$6,267,312.00	$4,908,734.00	$0.00	$0.00		$2,062,372.00	
12. Total	**$326,063,092.00**	**$0.00**	**$0.00**	**$125,346,258.77**	**$98,174,718.00**	**$0.00**	**$0.00**	**$0.00**	**$41,247,451.00**	**$117,140,711.00**

[a] The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[b] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. Per the instructions, the planning period for standard MHBG/SUPTRS BG expenditures is July 1, 2023 – June 30, 2025. Please enter SUPTRS BG ARP planned expenditures for the period of July 1, 2023 through June 30, 2025

[c] Prevention other than primary prevention

[d] The 20 percent set-aside funds in the SUPTRS BG must be used for activities designed to prevent substance misuse.

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Footnotes:

1. Based on State Fiscal Year 2024 (9/1/2023 through 8/31/2024) and State Fiscal Year 2025 (9/1/2024 through 8/31/2025) allocations.

2. For the COVID-19 (H.R. 133) SABG award, projected expenditures are based on the No Cost Extension allocation of funds from 9/1/2023 through 3/14/2024.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Table 2 addresses funds to be expended during the 24-month period of July 1, 2023 through June 30, 2025. Table 2 now includes columns to capture state expenditures for COVID-19 Relief Supplemental and ARP funds. Please use these columns to capture how much the state plans to expend over a 24-month period (July 1, 2023 - June 30, 2025). Please document the use of COVID-19 Relief Supplemental and ARP funds in the footnotes.

Planning Period Start Date: 9/1/2023 Planning Period End Date: 8/31/2025

Activity (See instructions for using Row 1.)	Source of Funds										
	A. SUPTRS BG	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other	H. COVID-19 Relief Funds (MHBG)[a]	I. COVID-19 Relief Funds (SUPTRS BG)[a]	J. ARP Funds (MHBG)[b]	K. BSCA Funds (MHBG)[c]
1. Substance Use Prevention and Treatment											
a. Pregnant Women and Women with Dependent Children											
b. Recovery Support Services											
c. All Other											
2. Primary Prevention											
a. Substance Use Primary Prevention											
b. Mental Health Prevention[d]		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
3. Evidence-Based Practices for Early Serious Mental Illness including First Episode Psychosis (10 percent of total award MHBG)[e]		$18,932,842.00			$4,200,000.00			$2,327,790.00		$8,500,000.00	
4. Other Psychiatric Inpatient Care					$248,125,034.00						
5. Tuberculosis Services											
6. Early Intervention Services for HIV											
7. State Hospital				$9,985,498.00	$1,131,102,254.00		$26,904,806.00				
8. Other 24-Hour Care		$0.00	$0.00	$0.00	$0.00	$0.00	$0.00	$0.00		$0.00	
9. Ambulatory/Community Non-24 Hour Care		$108,750,871.00	$75,968,466.00	$37,520,362.00	$801,879,102.00			$14,554,762.00		$72,348,528.00	
10. Crisis Services (5 percent set-aside)[f]		$22,782,206.00		$7,947,124.00	$218,611,480.00			$3,026,607.00		$17,470,400.00	
11. Administration (excluding program/provider level) MHBG and SUPTRS BG must be reported separately[g]		$7,919,259.00	$3,086,252.00	$3,335,107.00	$4,712,892.00		$1,224,333.00	$437,715.00		$2,089,093.00	
12. Total	**$0.00**	**$158,385,178.00**	**$79,054,718.00**	**$58,788,091.00**	**$2,408,630,762.00**	**$0.00**	**$28,129,139.00**	**$20,346,874.00**	**$0.00**	**$100,408,021.00**	**$9,860,218.00**

[a]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states. Note: If your state has an approved no cost extension, you have until March 14, 2024, to expend the COVID-19 Relief supplemental funds.

[b]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Columns H should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[c]The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is from **October 17, 2022 thru October 16, 2024** and the expenditure for the 2nd allocation of BSCA funding will be from September 30, 2023 thru September 29, 2025 which is different from the expenditure period for the "standard" MHBG. Column J should reflect the state planned expenditure period of July 1, 2023– June 30, 2025, for most states.

[d]While the state may use state or other funding for prevention services, the MHBG funds must be directed toward adults with SMI or children with SED.

[e]Column 3 should include Early Serious Mental Illness programs funded through MHBG set aside.

[f]Row 10 should include Behavioral Health Crisis Services (BHCS) programs funded through different funding sources, including the MHBG set aside. States may expend more than 5 percent of their MHBG allocation.

[g]Per statute, administrative expenditures cannot exceed 5% of the fiscal year award.

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Footnotes:

*In prior years, there was no category for 'Other Inpatient Psychiatric Care' in Table 2. Previously these expenditures were reported under, 'Other 24 Hour Care'. These planned expenditures are now documented in Other Inpatient Psychiatric Care.

Planning Tables

Table 3 SUPTRS BG Persons in need/receipt of SUD treatment

To complete the Aggregate Number Estimated in Need column, please refer to the most recent edition of SAMHSA's National Survey on Drug Use and Health (NSDUH) or other federal/state data that describes the populations of focus in rows 1-5.

To complete the Aggregate Number in Treatment column, please refer to the most recent edition of the Treatment Episode Data Set (TEDS) data prepared and submitted to SAMHSA's Behavioral Health Services Information System (BHSIS).

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
1. Pregnant Women	55,180	574
2. Women with Dependent Children	18,143	8,488
3. Individuals with a co-occurring M/SUD	574,798	4,787
4. Persons who inject drugs	447,744	8,100
5. Persons experiencing homelessness	20,128	5,976

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

Aggregate number in treatment based on SFY22 CMBHS SAPT BG paid clients. Needs estimate for pregnant women and women with dependent children based on 2016-2017 NSDUH Texas SUD prevalence estimate for adults 18+, Texas total births 2018, Texas total fertility rate, and Texas State Demographer under 17 population. Co-occurring based on 2017 NSDUH nationwide percentage of SMI and SUD. Injection drug users on Lansky et al, 2014, Estimating the Number of Persons Who Inject Drugs in the United States by Meta-Analysis, PLoS One. 2014; 9(5): e97596. Persons experiencing homelessness based on HUD 2018 Annual Homeless Assessment Report and Fazel et al (2008) The Prevalence of Mental Disorders among the Homeless in Western Countries: Systematic Review and Meta-Regression Analysis, PLoS Med. 2008 Dec; 5(12): e225 .

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Footnotes:

Planning Tables

Table 4 SUPTRS BG Planned Expenditures

States must project how they will use SUPTRS BG funds to provide authorized services as required by the SUPTRS BG regulations, including the supplemental COVID-19 and ARP funds. Plan Table 4 must be completed for the FFY 2024 and FFY 2025 SUPTRS BG awards. The totals for each Fiscal Year should match the President's Budget Allotment for the state.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	FFY 2024		
Expenditure Category	**FFY 2024 SUPTRS BG Award**	**COVID-19 Award[1]**	**ARP Award[2]**
1 . Substance Use Disorder Prevention and Treatment[3]	$109,229,181.00	$30,298,097.00	$102,941,896.00
2 . Substance Use Primary Prevention	$41,754,699.00	$8,318,562.00	$7,647,044.00
3 . Early Intervention Services for HIV[4]	$0.00	$0.00	$0.00
4 . Tuberculosis Services	$0.00	$0.00	$0.00
5 . Recovery Support Services[5]	$3,896,089.00	$568,420.00	$694,736.00
6 . Administration (SSA Level Only)	$8,151,577.00	$2,062,372.00	$5,857,035.00
7. Total	**$163,031,546.00**	**$41,247,451.00**	**$117,140,711.00**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19

Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the FY 2024 "standard" SUPTRS BG, which is October 1, 2023 - September 30, 2024. The SUPTRS BG ARP planned expenditures for the period of October 1, 2023 - September 30, 2024 should be entered here in the first ARP column, and the SUPTRS BG ARP planned expenditures for the period of October 1, 2024, through September 30, 2025, should be entered in the second ARP column.

[3]Prevention other than Primary Prevention

[4]For the purpose of determining which states and jurisdictions are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance use disorder Prevention and Treatment Block Grant (SUPTRS BG); Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the AtlasPlus HIV data report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention (NCHHSTP). The most recent AtlasPlus HIV data report published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective SUPTRS BG allotments to establish one or more projects to provide early intervention services regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a “designated state” in any of the three years prior to the year for which a state is applying for SUPTRS BG funds with the flexibility to obligate and expend SUPTRS BG funds for EIS/HIV even though the state’s AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SUPTRS BG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance will be allowed to obligate and expend SUPTRS BG funds for EIS/HIV if they chose to do so and may elect to do so by providing written notification to the CSAT SPO as a part of the SUPTRS BG Application.

[5]This expenditure category is mandated by Section 1243 of the Consolidated Appropriations Act, 2023.

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Footnotes:

1. Based on SFY 2024 (9/1/2023 -8/31/2024) projected expenditures.

2. For the COVID-19 (H.R. 133) SABG award, projected expenditures are based on the No Cost Extension allocation of funds from 9/1/2023 through 3/14/2024.

Planning Tables

Table 5a SUPTRS BG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

A		B		
Strategy	IOM Target	FFY 2024		
		SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
1. Information Dissemination	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
2. Education	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
3. Alternatives	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
4. Problem Identification and Referral	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
	Universal			

5. Community-Based Processes	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
6. Environmental	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
7. Section 1926 (Synar)-Tobacco	Universal			
	Selected			
	Indicated			
	Unspecified	$1,010,516	$0	$0
	Total	**$1,010,516**	**$0**	**$0**
8. Other	Universal			
	Selected			
	Indicated			
	Unspecified			
	Total	**$0**	**$0**	**$0**
Total Prevention Expenditures		**$1,010,516**	**$0**	**$0**
Total SUPTRS BG Award[3]		**$163,031,546**	**$41,247,451**	**$117,140,711**
Planned Primary Prevention Percentage		**0.62 %**	**0.00 %**	**0.00 %**

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

1. Per 5b instructions and consistent with prior applications, HHSC completed 5b in lieu of 5a, excluding Section 1926 - Tobacco on Table 5a.

2. Based on SFY 2024 (9/1/2023 -8/31/2024) projected expenditures.

Planning Tables

Table 5b SUPTRS BG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Activity	FFY 2024 SUPTRS BG Award	FFY 2024 COVID-19 Award[1]	FFY 2024 ARP Award[2]
Universal Direct	$11,177,783	$0	$0
Universal Indirect	$10,853,520	$8,318,562	$7,647,044
Selected	$9,982,685	$0	$0
Indicated	$9,740,711	$0	$0
Column Total	**$41,754,699**	**$8,318,562**	**$7,647,044**
Total SUPTRS BG Award[3]	**$163,031,546**	**$41,247,451**	**$117,140,711**
Planned Primary Prevention Percentage	**25.61 %**	**20.17 %**	**6.53 %**

[1]The 24-month expenditure period for the COVID-19 Relief supplemental funding is **March 15, 2021 – March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 – September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

[3]Total SUPTRS BG Award is populated from Table 4 - SUPTRS BG Planned Expenditures

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Footnotes:

1. Based on SFY 2024 (9/1/2023 -8/31/2024) projected expenditures.

2. For the COVID-19 (H.R. 133) SABG award, projected expenditures are based on the No Cost Extension allocation of funds from 9/1/2023 through 3/14/2024.

Planning Tables

Table 5c SUPTRS BG Planned Primary Prevention Priorities (Required)

States should identify the categories of substances the state BG plans to target with primary prevention set-aside dollars from the FFY 2024 and FFY 2025 SUPTRS BG awards.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

	SUPTRS BG Award	COVID-19 Award[1]	ARP Award[2]
Prioritized Substances			
Alcohol	☑	☑	☑
Tobacco	☑	☑	☑
Marijuana	☑	☑	☑
Prescription Drugs	☑	☑	☑
Cocaine	☐	☐	☐
Heroin	☐	☐	☐
Inhalants	☐	☐	☐
Methamphetamine	☐	☐	☐
Fentanyl	☐	☐	☐
Prioritized Populations			
Students in College	☑	☑	☑
Military Families	☐	☑	☑
LGBTQI+	☐	☐	☐
American Indians/Alaska Natives	☑	☑	☑
African American	☐	☑	☑
Hispanic	☑	☑	☑
Persons Experiencing Homelessness	☐	☑	☑
Native Hawaiian/Other Pacific Islanders	☐	☐	☐
Asian	☑	☐	☐
Rural	☑	☑	☑

Underserved Racial and Ethnic Minorities	☑	☑	☑

[1]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[2]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 1, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the planned expenditure period of October 1, 2023 – September 30, 2025.

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Footnotes:

Planning Tables

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

Please enter the total amount of the SUPTRS BG, COVID-19, or ARP funds expended for each activity.

Planning Period Start Date: 10/1/2023 Planning Period End Date: 9/30/2024

Expenditure Category	FFY 2024				
	A. SUPTRS BG Treatment	B. SUPTRS BG Prevention	C. SUPTRS BG Integrated[1]	D. COVID-19[2]	E. ARP[3]
1. Information Systems	$0.00	$0.00	$1,007,936.30	$314,302.93	$890,373.29
2. Infrastructure Support	$0.00	$0.00	$3,224,644.12	$1,005,534.88	$2,848,530.20
3. Partnerships, community outreach, and needs assessment	$0.00	$0.00	$705,450.17	$219,979.24	$623,168.33
4. Planning Council Activities (MHBG required, SUPTRS BG optional)	$0.00	$0.00	$0.00	$0.00	$0.00
5. Quality Assurance and Improvement	$0.00	$0.00	$1,168,809.81	$364,467.82	$1,032,482.94
6. Research and Evaluation	$1,155,700.16	$0.00	$519,054.49	$745,028.81	$1,171,280.35
7. Training and Education	$0.00	$0.00	$4,490.67	$381,650.32	$468,716.89
8. Total	**$1,155,700.16**	**$0.00**	**$6,630,385.56**	**$3,030,964.00**	**$7,034,552.00**

[1]Integrated refers to non-direct service/system development expenditures that support both treatment and prevention systems of care.

[2]The 24-month expenditure period for the COVID-19 Relief Supplemental funding is **March 15, 2021 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG/SUPTRS BG. If your state or territory has an approved No Cost Extension (NCE) for the FY 21 SABG COVID-19 Supplemental Funding, you have until March 14, 2024 to expend the COVID-19 Relief Supplemental Funds.

[3]The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" SUPTRS BG. Per the instructions, the standard SUPTRS BG expenditures are for the federal planned expenditure period of October 1, 2023 - September 30, 2025. Please list ARP planned expenditures for each standard FFY period.

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Footnotes:

1. Based on SFY 2024 (9/1/2023 -8/31/2024) projected expenditures.

2. For the COVID-19 (H.R. 133) SABG award, projected expenditures are based on the No Cost Extension allocation of funds from 9/1/2023 through 3/14/2024.

Planning Tables

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

Please enter the total amount of the MHBG, COVID-19, ARP funds, and BSCA funds expended for each activity

MHBG Planning Period Start Date: MHBG Planning Period End Date:

Activity	FY Block Grant	FY [1] COVID Funds	FY [2] ARP Funds	FY [3] BSCA Funds
.	$	$	$	$
8. Total			**$**	**$**

Please wait while data loads...

[1] The 24-month expenditure period for the COVID-19 Rel **21 - March 14, 2023**, which is different from the expenditure period for the "standard" MHBG. Per the ins res captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for mo oved no cost extension, you have until March 14, 2024 to expend the COVID-19 Relief supplemental funds.

[2] The expenditure period for The American Rescue Plan Act of 2021 (ARP) supplemental funding is **September 1, 2021 - September 30, 2025**, which is different from the expenditure period for the "standard" MHBG. Per the instructions, the standard MHBG expenditures captured in Columns A - G are for the state planned expenditure period of July 1, 2023 - June 30, 2025, for most states.

[3] The expenditure period for the 1st allocation of Bipartisan Safer Communities Act (BSCA) supplemental funding is **October 17, 2022** thru **October 16, 2024** and for the 2nd allocation will be **September 30, 2023** thru **September 29, 2025** which is different from the expenditure period for the "standard" MHBG. Column D should reflect the spending for the state reporting period. The total may reflect the BSCA allotment portion used during the state reporting period.

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Footnotes:

Environmental Factors and Plan

1. Access to Care, Integration, and Care Coordination – Required

Narrative Question

Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports.

A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: **https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001**; **https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983**. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.[1]Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment.

Navigating behavioral health, physical health, and other support systems is complicated and many individuals and families require care coordination to ensure that they receive necessary supports in and efficient and effective manner. States should develop systems that vary the intensity of care coordination support based on the severity seriousness and complexity of individual need. States also need to consider different models of care coordination for different groups, such as High-Fidelity Wraparound and Systems of Care when working with children, youth, and families; providing Assertive Community Treatment to people with serious mental illness who are at a high risk of institutional placement; and connecting people in recovery from substance use disorders with a range of recovery supports. States should also provide the care coordination necessary to connect people with mental and substance use disorders to needed supports in areas like education, employment, and housing.

[1]Druss, B. G., Zhao, L., Von Esenwein, S., Morrato, E. H., & Marcus, S. C. (2011). Understanding excess mortality in persons with mental illness: 17-year follow up of a nationally representative US survey. Medical care, 599-604.Avaiable at: **https://journals.lww.com/lww-medicalcare/Fulltext/2011/06000/Understanding_Excess_Mortality_in_Persons_With.11.aspx**

1. Describe your state's efforts to improve access to care for mental disorders, substance use disorders, and co-occurring disorders, including detail on efforts to increase access to services for:

a) Adults with serious mental illness

b) Pregnant women with substance use disorders

c) Women with substance use disorders who have dependent children

d) Persons who inject drugs

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

f) Persons with substance use disorders in the justice system

g) Persons using substances who are at risk for overdose or suicide

h) Other adults with substance use disorders

i) Children and youth with serious emotional disturbances or substance use disorders

j) Individuals with co-occurring mental and substance use disorders

General Overview:
HHSC continuously works to improve access to care. The state has a pivotal role in coordinating and supporting initiatives to foster resilience and recovery among people with serious mental illnesses, serious emotional disturbances, substance use issues, or both. Through HHSC's partnership with local mental health authorities (LMHAs), local behavioral health authorities (LBHAs), and other providers Texas has established a robust service delivery system for adults with SMI based on evidence-based practices and interventions to promote positive outcomes.

HHSC orchestrates and facilitates efforts to enhance access to care through contract oversight, and by providing technical assistance and support to providers across the state. Those efforts help ensure providers are equipped to effectively and efficiently deliver timely services to people in critical need. HHSC is also committed to providing evidence-based practices with empirical support. By leveraging research-backed interventions, HHSC promotes recovery from mental health and co-occurring psychiatric and substance use disorders and resilience.

In response to the pressing need for improved access to mental health care for adults with SMI, Texas has undertaken significant efforts to strengthen and expand services. HHSC partners with LMHAs and LBHAs to ensure mental health and substance use disorder services are available to adults with SMI and people with co-occurring psychiatric and substance use disorders. LMHAs and LBHAs are responsible for providing services identified in the priority population as outlined in Health and Safety Code Section 534.054. Persons meeting the definition for priority population include:
• Adults with a SMI diagnosis of schizophrenia, bipolar disorder, or major depressive disorder; and
• Adults with a mental health diagnosis and significant functional impairment; or
• An adult who was served in children's mental health services and meet the children's mental health priority population definition prior to turning 18 is considered eligible for one year.

The adult priority population includes adults 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.

Initiatives to Improve Access to Care:
HHSC has successfully implemented both routine and targeted efforts to expand access to mental health care for children, families, and adults. Through a collaborative approach involving public and private stakeholders, these initiatives aim to address specific barriers to care and establish access for all eligible.

For example, HHSC provides contract monitoring and oversight to ensure Texans receive care when they need it most. Additional initiatives to improve access to care for children, families and adults are highlighted below:

• Quality Management (QM):
As part of Behavioral Health Services' Contract Management Unit, the QM team performs comprehensive quality management reviews of LMHAs and LBHAs every two to four years. QM initiates review activities in response to internal and external referrals; emergencies, critical incidents, complaints, and grievances; and internal projects, such as "mystery caller."

• Telehealth and Telemedicine Flexibilities:
The escalating situation of COVID-19 created a unique and difficult time for both providers and people receiving services. To ensure continuity of care during the COVID-19 pandemic, HHSC authorized the use of telemedicine, telehealth, and audio-only platforms to deliver a range of services. House Bill 4, 87th Legislature, Regular Session, 2021, required HHSC to expand the list of services eligible to be delivered via telemedicine, telehealth or other teleservice in any program, benefit, or service HHSC determines to be cost effective and clinically appropriate. It also required HHSC to implement audio-only benefits for behavioral health services and authorized HHSC to implement audio-only benefits in any program or services, if determined to be clinically appropriate and cost effective.

In order to ensure continuity of care after the end of the public health emergency declaration, HHSC worked in collaboration with providers, stakeholders, and Texas Medicaid to review the clinical appropriateness of the array of services being offered via telehealth and telemedicine. HHSC proceeded with efforts to make many of the flexibilities enacted under emergency rules permanent. HHSC continues to pursue the permanent addition of clinically appropriate telehealth and telemedicine flexibilities through state plan amendments, contract revisions, and rule revision projects.

• Behavioral Health: Office of the Ombudsman:
HHSC's Ombudsman for Behavioral Health Access to Care serves as a neutral third-party to help children, families, and adults, including people who are uninsured or have public or private health benefit coverage; and behavioral health care providers navigate and resolve issues related to consumer access to behavioral health care, including care for mental health conditions and substance use disorders. MHSUP and the Office of the Ombudsman implemented a protocol to ensure internal coordination among staff to prevent duplicative efforts and increase efficiencies in resolving access to care issues by children, families, adults, and Texas community partners. This protocol serves to create timely access to behavioral health services.

• Continuity of Care Liaison:
HHSC funds a Continuity of Care (COC) Liaison at each LMHA and LBHA. HHSC requires COC activities for LMHAs and LBHAs to ensure a person is provided uninterrupted services during a transition between inpatient and outpatient services and to help the

person, and any other person providing support as requested by the person, and the person's legally authorized representative, if applicable. COC activities assist children, families, and adults in identifying, accessing, and coordinating LMHA, LBHA, or local intellectual and developmental disability authority services, and other appropriate services and supports in the community. COC services must be provided by an LMHA- or LBHA-assigned COC worker as required under Title 26 of the Texas Administrative Code, Chapter 306, Subchapter D, or a designated alternate staff member, who may collaborate with a peer specialist or family partner to provide COC services.

• Outpatient capacity expansion:
In fiscal year 2020, LMHAs and LBHAs had capacity to serve only 44 percent of persons in need of ongoing care. Through the use of House Resolution 133 (H.R. 133) and American Rescue Plan Act (ARPA) funds, HHSC increased access to care for people living with mental disorders through a coordinated expansion of outpatient capacity resources. HHSC allotted $78.2 million of the H.R.133 and ARPA funds to expand outpatient mental health services by a total of 2,841 people statewide. The majority (38 of 39) of LMHAs and LBHAs accepted funds, with several using them for workforce recruitment and retention. By April 2022, LMHAs and LBHAs increased their number served to 188,804, which was 1.1 percent above the baseline target and 0.4 percent below the H.R. 133 target. In May 2023, LMHAs and LBHAs increased the number of people served by 3.04 percent above their baseline target of 186,724.

• Community Mental Health Grant (CMHG) Program:
The CMHG program is designed to foster community collaboration, reduce duplication of mental health services, and strengthen continuity of care for people receiving services for SMI through a diverse local provider network. The purpose of the grant program is to support community programs providing mental health care services and treatment to people with a mental illness; and coordinate mental health care services for people with a mental illness with other transition support services. The CMHG program served 36,140 unduplicated people in fiscal year 2020, 40,721 people in fiscal year 2021, and 43,096 people in fiscal year 2022.

• Coordinated Specialty Care for First Episode Psychosis (CSC-FEP):
The CSC-FEP program provides outpatient behavioral health services to people experiencing an early onset of psychosis. CSC-FEP services are for people ages 15–30. People are served via a team-based approach with the goal to empower their ability to lead a self-directed life within the community. The CSC team typically includes a psychiatrist, certified family partner, certified peer specialist, licensed therapist, supportive employment specialist, and education specialist. Since 2022, HHSC added six new providers to increase access to CSC-FEP services. CSC-FEP now operates in 29 LMHAs and LBHAs, across 154 counties in Texas. CSC-FEP served 928 people in fiscal year 2020, 1,059 people in fiscal year 2021, and 1,366 people in fiscal year 2022.

Additional initiatives to increase access to care for adults include:
• Assertive Community Treatment (ACT):
ACT is a team-based program that provides psychosocial rehabilitation and support services to people who have a history of multiple hospitalizations. ACT provides an integrated team approach, merging clinical and rehabilitation staff to support the person and reduce the likelihood of psychiatric inpatient care. People served have SMI and have experienced multiple psychiatric hospital admissions. Teams include psychiatry and support staff providing substance use, employment, peer, and housing services in a mobile service delivery design to support the person’s recovery in their home. ACT is available at all LMHAs and LBHAs across Texas.

In fiscal year 2022, ACT served 6,304 unduplicated adults in Texas. Due to the intensive intervention of ACT services, there was a 44.20 percent decrease in crisis episodes and 64.93 percent decrease of HHSC-funded hospitalizations before and after receiving ACT services.

• Counseling Services for Adults:
Texas aims to expand counseling services for adults with SMI to meet the growing demand for effective mental health interventions. Texas continues to place significant emphasis on evidence-based practices, including Cognitive Behavioral Therapy (CBT) and Cognitive Processing Therapy (CPT). CBT is an evidenced-based practice for the provision of individual, family, and group therapy focused on the reduction or elimination of a person’s SMI symptoms and increasing their ability to perform daily living activities. CPT is an adaptation of CBT used by practitioners to help people learn how to modify and challenge unhelpful beliefs related to trauma by exploring recovery. Moreover, HHSC continues to demonstrate our commitment to enhancing access to counseling by incorporating the flexibility of telehealth flexibilities when agreed upon by the person and clinically appropriate. As a result of these efforts, Texas has achieved progress in reaching and assisting adults with SMI through counseling services. In fiscal year 2021 37,185 people received counseling services and 39,630 people in fiscal year 2022. HHSC continues to encourage workforce retention and recruitment efforts to maintain growth in access to counseling for adults in need.

• State Hospital Step-Down Program:
The State Hospital Step-Down Program began in fiscal year 2020 and expanded from two to four sites by fiscal year 2023. The program identifies, assesses, and facilitates the successful transition of adults with SMI or a combination SMI and medical needs exceeding the supports available in traditional settings, but who are clinically appropriate for transition to community-based services with proper supports. The program works with people before and after leaving the state hospital to support their transition to step-down residences and community-based mental health services. Each step-down residence has a maximum occupancy of six to eight beds. There is a cost avoidance of $52,013 per person annually for people who would otherwise remain in a state hospital setting.
In fiscal year 2021 the program helped seven people transition from a state hospital to a community residence and one person

transition from a community residence to independent living. In fiscal year 2022 the number of people transitioned from a state hospital to a community residence grew to 23 while 12 people transitioned from a community residence to independent living.

• Home and Community-Based Services – Adult Mental Health (HCBS-AMH):
HCBS-AMH is a 1915(i) Medicaid State Plan Amendment program that provides specialized supports through the provision of home and community-based services to adults diagnosed with a SMI and extended tenure in psychiatric hospitals, frequent arrests, or emergency department visits. The flexible array of services offered by HCBS-AMH is designed to meet the unique needs of a participant which may not currently be addressed by other means and to assist in their recovery. The goal of the HCBS-AMH is to enable people to live and experience successful tenure in the community of choice and improve quality of life and functioning. The program began enrolling participants in October 2016. By September 1, 2020, the total enrolled increased to over 400, representing an 886 percent increase within the first three years. Monthly enrollment is forecasted to increase by at least 23 percent year over year.
HCBS-AMH has steadily increased the provider base and enrollment totals since inception. HCBS-AMH is currently able to serve eligible program participants across 18 LMHA and LBHA regions covering 76 Texas counties. Program growth may be attributed to continued cross department collaboration and program expansion efforts.
HCBS-AMH completes an annual evaluation of outcomes for program participants. Results show a reduction in repeat hospitalizations, incarcerations, and emergency department visits. Of people enrolled due to previous long-term psychiatric hospitals, most participants do not experience re-hospitalization. Of people enrolled due to frequent utilization of emergency departments, many have reduced emergency department utilization and, of people enrolled due frequent confinement in jail, many have reduced incarcerations.
HCBS-AMH has increased the number of people accessing its program from 328 people in fiscal year 2020, to 442 people in fiscal year 2021 and 508 people in fiscal year 2022.

b) Pregnant women with substance use disorders

• The QM oversight and review functions described in a) Adults with Serious Mental Illness also apply to providers contracted to provide services for pregnant women with substance use disorders and other substance use programs highlighted below.

• HHSC funds community programs for women who are pregnant and using substances. Pregnant and Parenting Intervention is for women with a past or present substance use disorder who either are pregnant or have a child up to six years old. The program allows the participant to receive community resources that can improve birth outcomes, parenting skills, and the home environment. A woman and her family members are eligible for these services, which include comprehensive case management, community-based linkage and retention services, evidence-based education, and peer support.

• The Comprehensive Continuum of Care program provides case management services, community-based linkage, and retention services through pre-admission service coordination to reduce barriers to treatment, enhance motivation, stabilize life situations, and facilitate engagement in long-term recovery. These additional services are available to pregnant and parenting women diagnosed with a substance use disorder and provide overdose prevention education, hygiene kits, financial assistance for basic needs such as housing, utilities, and transportation.

• The Parenting Awareness and Drug Risk Education services provide community-based intervention services for current and expectant parents. Services may include completing a needs assessment and case management services, such as referrals to community resources, home visits, and education to expectant parents who are at risk for developing a substance use disorder.

• Neonatal abstinence syndrome (NAS) is a group of symptoms that can occur in newborns exposed to certain substances, including opioids, during pregnancy. A variety of services are available for women using these substances.
The NAS-Recovery Residence Housing program provides stable and safe recovery housing for women who are pregnant or have dependent children who are co-enrolled or have completed
treatment for an opioid and other substance use disorder.
NAS-Recovery Support Service serves women who are pregnant or have dependent children and who have a history of opioid use or are seeking recovery, along with their family members, significant others, and supportive allies. The NAS-Medication for Opioid Use Disorders (MOUD) program meets the individualized needs of pregnant and postpartum women by providing access to all reimbursable Federal Drug Administration approved medications for opioid use disorder (OUD). The NAS-Pregnant and Parenting Women program provides trauma-informed treatment services for women who are pregnant and parenting who have been diagnosed with OUD.

• Treatment services for pregnant women are available throughout the state. Pregnant women can choose to attend residential treatment independently or with their dependent children in a Women and Children Residential Treatment facility. Both treatment service types are delivered in a licensed substance use treatment facility. This allows the family to remain together while the mother receives treatment including parenting skills and reproductive health education. Treatment for the child and family unit, includes education services as well as linkage to community resources (e.g., intervention, medical, services). Pregnant women may also elect to attend outpatient substance use treatment at a community-based licensed treatment facility.

• Integrated Family Planning Opioid Response services provide family planning program clients at risk for opioid overdose or OUD with initial medication, recovery support, and overdose prevention services. The four participating healthcare systems also arrange for long-term treatment and recovery through providers in the community. Services provided include overdose prevention education and naloxone, induction onto medications and coordinated treatment, peer recovery support, and family planning

follow-up and support.

These services are promoted through the Outreach, Screening, Assessment, and Referral (OSAR) program available to all persons seeking information about substance use services. The only eligibility requirement to receive OSAR services is that a person must be currently residing in the State of Texas. There are 14 OSAR program providers across the state. HHSC closely collaborates with other state agencies, like the Department of Family and Protective Services, so pregnant women may safely disclose substance use and receive linkage to the most appropriate service to meets their needs.

c) Women with substance use disorders who have dependent children

Please refer to the above narrative, as those programs are available to women who have dependent children. In addition, women with dependent children are also eligible for withdrawal management services in either a residential or ambulatory setting.

d) Persons who inject drugs

The substance use disorder Community Health Worker (CHW) program allows CHWs, also known as promotora(s), to increase linkage and retention in substance use, mental health, and medical services for Texas residents living with substance use disorders. CHW programs provide non-judgmental, non-coercive provision of services and resources to people who use substances by removing barriers to treatment and recovery. This includes people who are marginalized or stigmatized; experiencing housing instability or homelessness; injecting substances; or living with (or at risk of) Hepatitis C Virus or Human Immunodeficiency Virus. These programs focus on helping to engage people in mental health and substance use services, address their medical needs, and build a foundation for their recovery journey. Of note, these services are provided in the community wherever a person may be residing or staying. This increases the programs reach and allows those who may not seek care in more traditional settings.

e) Persons with substance use disorders who have, or are at risk for, HIV or TB

Please refer to the above narrative for the CHW program.

f) Persons with substance use disorders in the justice system

HHSC recognizes the importance of providing quality substance use services to people involved in the criminal justice system and work closely with our partner providers to ensure continuity of care while operating within the constraints of our funding streams.
• To enhance services to this population, HHSC leverages Maintenance of Effort funds for the Criminal Justice Opioid Response and Re-entry Support, a partnership with a county criminal justice system that aims to improve medication assisted treatment and recovery services for people preparing for release from Community Corrections Facilities. People receive intensive reach-in services for OUD and aftercare following release to ensure a seamless journey to recovery.

• Overdose Prevention Drop-in Centers Drop-in Centers, funded by State Opioid Response (SOR) dollars, expand the reach of block grant dollars by providing people at high risk for overdose with access to prevention education, overdose reversal medication, access to medication assisted treatment, and recovery support. HHSC supports walk-in centers as well as pre-arrest diversion facilities.

• The Mental Health Grant Program for Justice-Involved Individuals provides behavioral health services to people encountering the criminal justice system with a provision that includes substance use treatment not readily available in the community and local cross-agency coordination of behavioral health, physical health, and jail diversion services.

g) Persons using substances who are at risk for overdose or suicide

HHSC has a robust prevention program that aims to provide education and supports to those in the larger population who may be at risk for overdose or suicide.
• The safe Drug Disposal and Community Awareness Program helps Texans safely dispose of their unused or expired medication by providing safe drug disposal materials, in convenient locations throughout the state. The goal of the program is to reduce access, which is a major contributor to opioid misuse and overdose. The Overdose Prevention Education and Naloxone program provides overdose prevention education across the state and access to overdose reversal medication. Both programs are funded by the SOR grant. HHSC leads multiple prevention campaigns designed to reach a wide audience throughout the state through social media, traditional print media, TV and radio, and out of home ads (e.g., billboards, transportation). These aim to provide resources for healthy coping skills and access to life-saving resources such as naloxone.

• HHSC received grant funding for the 988 Suicide and Crisis Lifeline which is a network of over 200 independent local and state call centers aimed to provide 24/7, free and confidential support to people in suicidal crisis or mental health- or substance use-related distress via call, chat, or text. Through this effort, Texas' in-state answer rate had increased to 80% as of July 2023.

h) Other adults with substance use disorders

Substance use treatment for adults include withdrawal management (residential and ambulatory), residential (intensive and

supportive), and outpatient services. Services are available across the state and include a comprehensive assessment of strengths, weaknesses, problems, and needs. People are then connected to the most appropriate level of treatment and an individualized plan of care is developed with their input to address their goals. Services include education, individual and group counseling, and referrals as needed. Treatment services specific to OUD are also provided throughout the state.
• The Treatment in Clinic project increases access to all three U.S. Food and Drug Administration-approved medications for the treatment of OUD (methadone, buprenorphine, and extended-release naltrexone) by expanding capacity at new and existing clinics. This enables clinics to treat both primary OUD along with co-morbid conditions such as hepatitis C, psychiatric conditions, and wound care at a single clinic site.
• The Treatment in Office project funded by SOR increases access to medications for OUD, also known as MOUD, in a variety of settings outside of the traditional clinic by increasing the number of physicians providing both buprenorphine and extended-release naltrexone creating a professional peer mentoring network, and expanding the network of state-funded treatment providers.

i) Children and youth with serious emotional disturbances or substance use disorders

Substance Use Treatment for Youth programs provide adolescents ages 13-17 and their families with recovery and continuing care services for substance use disorder. Young adults ages 18-21 may be eligible if screening shows their needs, experiences, and behavior are like those of younger persons. These services include both residential and outpatient settings and are tailored to the unique needs of the adolescent and their families. All programs must focus on helping the adolescent learn recovery skills through counseling, case management, education, and recovery skills training.

Health and Safety Code 534.054 requires HHSC to identify and contract with an LMHA or LBHA for each service area to ensure services are provided to priority populations determined by HHSC. Additionally, Section 534.053 requires HHSC to ensure that specified services are available in each service area, including those that emphasize early intervention services for children, including adolescents, who meet HHSC's definition of being at high risk of developing SEDs.

Recognizing the urgent and increased demand for access to services for children and adolescents with SED, especially as children and families continue to recover from the impact of the COVID-19 pandemic, HHSC leveraged partnerships with LMHAs and LBHAs to support increased access to evidence-based services for children ages three through 17 who:

• Have a diagnosis of a mental illness (other than a diagnosis of a substance use disorder, intellectual disability, or autism spectrum disorder); and
• Exhibit serious emotional, behavioral, or mental disorders; and one of the following:
• Have a serious functional impairment;
• Are at risk of disruption of a preferred living or childcare.

Below are additional initiatives to promote access to care for children, adolescents, and families:

• Texas Child Mental Health Care Workforce Expansion:
HHSC remains dedicated to supporting the expansion of services to meet Texans' mental health needs through collaborative efforts between health-related institutions (HRIs) of higher education and mental health providers. Among other provisions, Senate Bill (S.B.) 11, 86th Legislature, Regular Session, 2019, created the Community Psychiatry Workforce Expansion project under the Texas Child Mental Health Care Consortium (TCMHCC), which provides funding for academic medical directors at HRIs to work in LMHAs and LBHAs; and provides educational opportunities in community mental health by supervising psychiatry residents who will rotate in LMHAs and LBHAs so they can consider that as a career path in the future. Academic medical directors and residents started working at LMHAs and LBHAs in mid-2020 and HHSC has worked with TCMHCC to create a method to track encounters delivered by academic medical directors and residents. The workforce expansion contributed to the reduction in the average length of time from intake appointment to first prescriber appointment from 35.32 days in fiscal year 2021 to 27.8 days in fiscal year 2022. The program served children at a ratio of 1.54 to 1.72 for every person served in fiscal year 2021 (1,975 served) and fiscal year 2022 (3,712 served).

• System Navigator:
The Children's Mental Health System Navigator (CMH-SN) and CMH-SN Plus Pilot are funded through the MHBG to provide services and treatment for children and adolescents with a single diagnosis of SED or a primary SED diagnosis and co-occurring diagnosis, including a substance use disorder or intellectual developmental disability. The goals of the CMH-SN are to:
o Enhance provision of services for high-needs children and adolescents enrolled in services at the LMHA or LBHA, including children and adolescents waiting to access inpatient care, residential treatment services, or those with co-occurring mental health and intellectual or developmental disabilities;
o Develop collaborative partnerships with other child-serving systems and coordinating resources to help facilitate access to appropriate services and supports in the community;
o Build LMHA and LBHA capacity through training and education efforts to direct care staff, including case managers, peers, counselors, therapists, agency liaisons, and supervisors;
o Educate community partners on the LMHA and LBHA's role in providing services to children and adolescents;
o Promote an integrated approach to care, coordination, and collaboration with schools, family courts, health care service coordinators, primary care providers, and other service providers; and
o Conduct outreach to community partners such as those agencies serving children and adolescents in juvenile justice, crisis facilities, local hospitals, school districts, etc. to ensure strong partnerships.

HHSC funded seven CMH-SNs to support children and families to access timely mental health services and increase access to care. Three of the seven CMH-SNs focus on increased support for children lacking placement in Department of Family and Protective Services (DFPS) conservatorship, and children that are at risk of relinquishment into DFPS conservatorship.

The overall goal of both pilot programs is to develop enhanced partnerships and resources with child-serving systems to promote greater understanding and collaboration to support enhanced provision of services and treatment for children and adolescents.
• Children's Crisis Respite Pilot:
HHSC funds four Children's Crisis Respite centers at LMHAs through MHBG funding to support the provision of services and treatment for children in a crisis respite facility with a single diagnosis of SED or a primary SED diagnosis and co-occurring diagnosis, including substance use disorder or intellectual development disability. The goals of Children's Crisis Respite are:
o Increase access to short-term, safe, and clinically appropriate placement for children who are in crisis, but do not meet inpatient care criteria; and
o Provide transition planning services to the child's family, adult caregiver, or Legally Authorized Representative prior to the child exiting the crisis respite facility.

As of August 2023, 40 children were served in Children's Crisis Respite facilities across Texas through the Children's Crisis Respite Pilot.

• Multisystemic Therapy (MST):
HHSC was allotted $4.725 million in general revenue in response to the tragedy in Uvalde, Texas to implement MST in seven LMHAs and LBHAs. MST is a non-traditional, evidenced-based treatment model developed to treat children and adolescents with serious antisocial behavior and justice-involvement and their family systems. It is short-term (three to five months), intensive (available 24 hours a day), and delivered in the child or adolescent's community and home instead of an office setting. MST promotes pro-social behavior to prevent the child or adolescent's further involvement with the juvenile justice system. As of August 2023, 65 children were served through the MST pilot program.
• Youth Empowerment Services (YES) Waiver:
The YES Waiver is a 1915(c) Medicaid program that serves children and adolescents with serious mental, emotional, and behavioral difficulties. The YES Waiver provides intensive services delivered within a strengths-based team planning process called Wraparound. Wraparound builds on family and community support and uses YES to help build a family's natural support network and connection with their community.

A Wraparound facilitator works with the child or adolescent and family to create a Wraparound Team, which meets monthly and may include family, friends, neighbors, professionals, and others who are important to the child or adolescent and their family. The Wraparound Team helps the child or adolescent and family meet their goals by developing a Wraparound Plan, using YES and community resources, and identifying family strengths.

YES includes specialized therapies (animal-assisted therapy, art therapy, music therapy, recreational therapy, and nutritional counseling), community living supports, family supports, employee assistance and supported employment, paraprofessional services, respite services, nonmedical transportation, supportive family-based alternatives, adaptive aids and supports, minor home modifications, and transition services.

The total enrollment for fiscal year 2023 was 2,166 and this number is expected to increase in fiscal year 2024 as the program continues to work with LMHAs and LBHAs to address provider shortages. Telehealth has been a major focus of provider recruitment and retention, as providers outside of the immediate geographical region are now able to serve rural communities. YES Waiver data shows an overall decrease in crisis services after receiving YES Waiver services.

j) Individuals with co-occurring mental and substance use disorders

As research shows a high co-occurrence of both mental health and substance use in people seeking services, HHSC provides robust support specifically for this population. Within the continuum of substance use services, Co-Occurring Psychiatric and Substance Use Disorder (COPSD) programming includes case management, counseling, or both based on the needs of the person. A comprehensive assessment of needs and linkage to additional services required are a critical part of this program. Case management services can be provided in various settings, to increase access for those who may not otherwise engage in treatment or strengthen their recovery capital.

HHSC requires LMHAs and LBHAs to develop and implement written procedures to identify clients with COPSD, identify available resources, provide referrals and continuity of care for ongoing services as necessary to address the person's unmet substance-use treatment needs in accordance with 26 TAC Chapter 306, Subchapter A (Standards for Services to Individuals with Co-Occurring Psychiatric and Substance Use Disorder).

2. Describe your efforts, alone or in partnership with your state's department of insurance and/or Medicaid system, to advance parity enforcement and increase awareness of parity protections among the public and across the behavioral and general health care fields.

HHSC's Medicaid and the Children's Health Insurance Program (CHIP) completed an initial managed care mental health and substance use parity analysis in 2017, followed by a review of quantitative treatment limitations in Medicaid and CHIP policy and financial requirements in CHIP.

All Texas Medicaid and CHIP managed care organizations (MCOs) completed self-assessment tools regarding non-quantitative treatment limitations, including medical necessity criteria, prior authorization, concurrent review, and network admission and reimbursement, and these tools were reviewed by Medicaid and CHIP staff. When MCOs make relevant changes to mental health and substance use benefit policies, they must complete new analyses, which are also reviewed by MCS and CHIP staff.

HHSC also amended MCO contracts to add parity requirements concerning the availability of information for members and providers, including medical necessity criteria, when MCOs issue adverse determinations, and practice guidelines.

HHSC's Ombudsman for Behavioral Health investigates parity complaints from people receiving services and providers. The Ombudsman for Behavioral Health works with Medicaid and CHIP to review Medicaid managed care complaints and other types of parity complaints with the Texas Department of Insurance (TDI).

TDI also reviews Health Maintenance Organizations, Preferred Provider Organizations, and Exclusive Provider Organizations once every three years. Reviews include claims and utilization review data, as well as self-compliance tools. Additionally, TDI investigates complaints from people receiving services and providers through its complaint portal.

As part of House Bill 2595, 87th Legislature, Regular Session, 2021, TDI and the Ombudsman for Behavioral Health publish an annual report on the status of the rights and responsibilities for mental health condition and substance use disorder benefits and resolved and unresolved complaints submitted through the parity complaint portal.

3. Describe how the state supports integrated behavioral health and primary health care, including services for individuals with mental disorders, substance use disorders, and co-occurring mental and substance use disorders. Include detail about:

a) Access to behavioral health care facilitated through primary care providers

b) Efforts to improve behavioral health care provided by primary care providers

c) Efforts to integrate primary care into behavioral health settings

Texas supports integrated behavioral health and primary care in several ways.

• Among primary care providers, Texas Medicaid implemented the collaborative care model (CoCM) in 2022. This model allows primary care providers to work with a behavioral health case manager and psychiatric consultant to treat people with mild and moderate mental health and substance use needs. In May 2023, the Texas Legislature allocated $6 million to an acute care hospital in Jefferson County to implement an integrated care clinic using the CoCM. HHSC is currently working to implement this directive.

• Texas implemented SAMHSA's Certified Community Behavioral Health Clinic (CCBHC) model in 2016 and has since expanded the model statewide to include 43 state-certified provider organizations, known as Texas CCBHCs (T-CCBHCs). These organizations integrate physical health screenings and monitoring of key health indicators into behavioral health settings. Many of the T-CCBHCs go beyond the minimum requirements by co-locating with, or directly employing, primary care providers. In lieu of the federal prospective payment system model, starting two years ago Texas began using a unique funding mechanism for most T-CCBHCs through a Medicaid Directed Payment Program for Behavioral Health Services.

4. Describe how the state provides care coordination, including detail about how care coordination is funded and how care coordination models provided by the state vary based on the seriousness and complexity of individual behavioral health needs. Describe care coordination available to:

a) Adults with serious mental illness

b) Adults with substance use disorders

c) Children and youth with serious emotional disturbances or substance use disorders

a) Adults with serious mental illness
Texas ensures access to care coordination for adults with SMI and COPSD emphasizing the importance of integrating various services to meet their unique behavioral health needs. The needs are determined at an LMHA and LBHA intake through the Adult Needs and Strengths Assessment (ANSA) performed by a competent mental health professional or licensed practitioner of the healing arts to identify the person's behavioral health needs, which might include community-based as well as facility-based services. The ANSA is an assessment tool to support decision-making, including what level of care and recovery plan components to best fit the person's needs. The LMHA or LBHA completes the ANSA assessment every 180 days to continue to assess the person's needs, and identify what services are appropriate. Care coordination is required by contract for LMHAs and LBHAs delivering mental health services, substance use services, or both.

The LMHAs and LBHAs ensure coordination of services for adults with SMI and people with COPSD within the local service area. Such coordination ensures collaboration with other agencies, including local hospitals, nursing facilities, other health and human service agencies, criminal justice entities, nonprofit and for-profit housing providers, substance use community coalitions, local businesses, and community organizations. LMHAs and LBHAs also assist in gaining and coordinating access to necessary care and services appropriate to a person's needs, monitor services, and advocate for people experiencing ongoing mental health issues.

T-CCBHCs include, but are not limited to, LMHAs and LBHAs. In addition to the organization types listed above, T-CCBHCs coordinate care with primary care providers, including Federally Qualified Health Centers and rural health clinics, acute care

hospitals, substance use services providers, Indian Health Services, Veterans Affairs, and other veteran-serving organizations. T-CCBHCs also coordinate care within their respective organizations, particularly for people with COPSD and other conditions.

Care coordination is considered an activity (not a service) and as such, funding mechanisms vary. Some elements of care coordination are paid for through Medicaid targeted case management. Other elements are paid for through state general revenue allocated to LMHAs and LBHAs or the state's Directed Payment Program for Behavioral Health Services. Finally, several T-CCBHCs use SAMHSA's CCBHC expansion grants to fund certain elements of care coordination.

b) Adults with substance use disorders
. HHSC ensures that people with substance use disorders receive a comprehensive assessment and are connected with resources to meet all their identified needs, not just those directly related to their substance use. This includes, but is not limited to, mental health care, physical health care, housing, employment and education, and childcare. Specific programs, such as the Comprehensive Continuum of Care for Females and COPSD, include case management services to assist with care coordination. These supports are person-centered and based on identified needs.

c) Children and youth with serious emotional disturbances or substance use disorders
Texas ensures access to comprehensive care coordination for children and adolescents with SEDs by emphasizing the importance of integrating various services to meet their unique behavioral health needs. The needs are determined at an LMHA or LBHA intake through the Child and Adolescent Needs and Strengths Assessment (CANS) performed by a competent mental health professional or licensed practitioner of the healing arts to identify the person's behavioral health needs, which may include community-based or facility-based services. The CANS is an assessment tool to support decision-making on elements, such as the level of care and recovery plan components, that best fit the child's needs. The LMHA or LBHA completes the CANs assessment every 90 days to assess the child and family's needs and identify appropriate services. Care coordination is required by contract for LMHAs and LBHAs delivering mental health, substance use services, or both. This promotes a systemic approach via coordination with state mental health hospitals, recovery supports, and a broad range of other agencies (e.g., law enforcement agencies, juvenile justice entities, educational institutions, DFPS).

5. Describe how the state supports the provision of integrated services and supports for individuals with co-occurring mental and substance use disorders, including screening and assessment for co-occurring disorders and integrated treatment that addresses substance use disorders as well as mental disorders. Please describe how this system differs for youth and adults.

Texas supports provision of integrated services for people with COPSD through implementation of the T-CCBHC model, use of the Screening, Brief Intervention, and Referral to Treatment service, and funding of the COPSD service. Each of these efforts requires screening for both mental health and substance use conditions, as well as care coordination for people with co-occurring needs. HSHC funds these efforts for both youth and adults.

HHSC is working with T-CCBHCs on integration of mental health and substance use assessments. In Texas, while the assessment instruments are separate--both assessments use a biopsychosocial approach to capturing relevant information. HHSC's July 2023 Texas Institute, an annual conference hosted to provide continuing education for Texas mental health and substance use providers, included two sessions to discuss commonalities between the assessment instruments and how care coordination can be used to align the assessments within current technology systems. In addition, HHSC is working on multiple projects to enable providers to use their existing electronic medical records in a more integrated manner while still providing the state with the unique data required by SAMHSA.

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

None at this time.

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Footnotes:

Environmental Factors and Plan

2. Health Disparities - Required

Narrative Question

In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[1], **Healthy People, 2030**[2], **National Stakeholder Strategy for Achieving Health Equity**[3], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the **Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care** (CLAS)[4].

Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[5]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[6]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

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

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

[1] **https://www.minorityhealth.hhs.gov/assets/pdf/hhs/HHS_Plan_complete.pdf**

[2] **https://health.gov/healthypeople**

[3] **https://www.mih.ohio.gov/Portals/0/Documents/CompleteNSS.pdf**

[4] **https://thinkculturalhealth.hhs.gov/**

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

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

Please respond to the following items:

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

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

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

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

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

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

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

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

• Innovative Healing Centered Projects (IHCP): HHSC identified 15 underserved communities in Texas to participate in IHCP. These communities will use funds to promote mental health wellness and prevent substance use by providing interventions to support resilience, social and community connectedness, healing, and referrals for people who experienced Adverse Childhood Experiences, multigenerational trauma, or have emergent behavioral health needs due to COVID-19.
• "Turn To" Statewide Media Campaign: This multi-pronged public awareness campaign focuses on educating and promoting behavioral health by facilitating the connection between Texans and healthier alternatives to substance use, all while working to reduce the stigma surrounding those who face challenges with mental health or substance use issues. The campaign has two goals:
1. To provide Texas youth, young adults, parents, and legal guardians with resources to cope successfully with trauma, stress, and anxiety—escalated by COVID-19 and health disparities—thereby reducing the rate of substance use disorders that typically spike under adverse circumstances; and
2. To inform Texas community leaders about the risk and protective factors that contribute to substance use disorders and behavioral health issues so they can make decisions that best support their respective community's wellness.

• Community Coalition Partnerships – COVID 19 Program (CCP-COV): HHSC funds CCPs throughout Texas to address substance use and promote emotional and mental well-being at the local level through cross-sector partnerships and environmental change. In fiscal year 2022, HHSC allocated COVID-19 funds to existing CCPs across the state to expand their primary prevention work. CCP-COV focuses on improving health equity for communities disproportionately impacted by COVID-19, particularly people of color.

The CCP-COV program enhances environmental conditions and improves systemic processes through projects like revitalizing play-spaces and community gardens. CCPs additionally offer communities stress-reducing and trauma-healing activities such as yoga, mindfulness, exercise, and painting. These initiatives are rooted in research around substance misuse risk and protective factors, the social determinants of health, and behavioral health equity.

#3 Footnote: As part of the state's effort to address language barriers, HHSC requires contractors to provide services in a language either relevant to the service area or via translation services.
Contract language:
1. Local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) must ensure the availability of a telephone system and call center that allows people to contact the LMHA or LBHA through a toll-free number that must provide electronic call answering methods that include an outgoing message providing the crisis hotline telephone number, in languages relevant to the service area, for callers to leave a message outside of normal business hours.
2. LMHAs and LBHAs shall require providers to use a Level Three-certified sign language interpreter, if available, and if not, a Level Two or Level-One certified sign language interpreter, for people with hearing impairments who request sign language interpreter services.
3. Substance use disorder (SUD) providers ensure sign language services (telephone language services or interpreters) are available to people who are deaf or hard-of-hearing and receiving HHSC-authorized SUD treatment services. SUD providers:
a. Maintain a current list of sign language interpreters who are available to provide interpreter services and make available to HHSC upon request; and
b. Comply with Title III of the American with Disabilities Act of 1990 and have telecommunications devices for the deaf and hard-of-hearing in offices where the primary means of offering goods and services is by telephone.

SUD providers ensure sign language interpreter services are provided by an interpreter who possesses at least one of the following certification levels issued by Health and Human Services, Office for Deaf and Hard of Hearing Services:
a. Board for Evaluation of Interpreters - Level III/IV, Oral Certificate: Comprehensive, Oral Certificate: Visible, Comprehensive Skills Certificate; or
b. National Registry of Interpreters for the Deaf - IC/TC, CI/CT, Reverse Skills Certificate, and Certified Deaf Interpreter.
Sign language interpreter services are used in the delivery of SUD treatment services. This includes sign language interpreter services for a parent or guardian participating in a HHSC-funded, family-focused curriculum.

Training Requirements:
1. Title 26 Texas Administrative Code (TAC) Section 301.331 requires LMHAs and LBHAs to ensure staff members are competent in responding to a person's language and cultural needs through knowledge of customs, beliefs, and values of various racial, ethnic, religious, and social groups prior to providing services.
2. In alignment with 25 TAC Section 448.204 SUD providers are required to ensure staff members are competent in respond appropriately to "the individual's needs and circumstances, including age and developmental level, and should be culturally sensitive."

#4 Footnote:
HHSC requires LMHAs and LBHAs to follow the National Culturally and Linguistically Appropriate Services (CLAS) Standards, incorporated by reference and posted at: https://thinkculturalhealth.hhs.gov/clas, for all served populations in accordance with the most current version of "Texas Cultural Competence Guidelines for Behavioral Health Organizations," incorporated by reference and posted at: https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/lmha/tx-culutural-competence-guidelines-bh-orgs.pdf. This guidance document comprises a set of requirements, implementation strategies, and additional resources to help providers and programs establish and expand culturally and linguistically appropriate services.

HHSC requires SUD providers to document how they adhere to the National Standards for Culturally and Linguistically Appropriate Services in the Health and Health Care (The National CLAS Standards, 2013) for the proposed Population of Focus and demonstrate good-faith efforts to reach out to underserved populations. Underserved populations include, but are not limited to, people of color; people who have low socioeconomic status or limited English proficiency; members of federally recognized Native American tribes; and people living in Colonias.

Additionally, 25 TAC Section 448.204 requires services to "be appropriate for the individual's needs and circumstances, including age and developmental level, and should be culturally sensitive." SUD providers must "possess an understanding of the cultural norms of the individuals receiving services." The "services shall be respectful and non-exploitative." Additionally, SUD services must be provided in a culturally, non-threatening, respectful, and developmentally appropriate manner for clients, families, and/or significant others.

Please indicate areas of technical assistance needed related to this section

None at this time.

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Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

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

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

SAMHSA anticipates that the movement toward value-based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of M/SUD systems and services. The **National Center of Excellence for Integrated Health Solutions**[1] offers technical assistance and resources on value-based purchasing models including capitation, shared-savings, bundled payments, pay for performance, and incentivizing outcomes.

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

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

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions used with individuals with mental illness and substance use disorders, including youth and adults with substance use disorders, adults with SMI, and children and youth with SED. The recommendations build on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[2], The New Freedom Commission on Mental Health[3], the IOM, NQF, and the **Interdepartmental Serious Mental Illness Coordinating Committee** (ISMICC)[4].

One activity of the EBPRC[5] was a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[6] SAMHSA and other HHS federal partners, including the Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the M/SUD field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many innovative and promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, evidence is collected to determine their efficacy and develop a more detailed understanding of for who and in what circumstances they are most effective.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[7] are best practice guidelines for the SUD treatment. SAMHSA draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[8] was developed to help move the latest information available on effective M/SUD practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement M/SUD practices that work. Each KIT covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice

demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, for educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is interested with what additional information is needed by SMHAs and SSAs to support their and other purchasers' decisions regarding value-based purchase of M/SUD services.

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[1] **https://www.thenationalcouncil.org/program/center-of-excellence/**

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

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

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

[5] **https://www.samhsa.gov/ebp-resource-center/about**

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

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

[8] **https://store.samhsa.gov/?f%5B0%5D=series%3A5558**

Please respond to the following items:

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

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

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

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

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

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Footnotes:

Environmental Factors and Plan

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

Narrative Question

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

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

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

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

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

Please respond to the following items:

1. Please name the model(s) that the state implemented including the number of programs for each model for those with ESMI using MHBG funds.

Model(s)/EBP(s) for ESMI/FEP	Number of programs
Coordinated Specialty Care for First Episode Psychosis	23

2. Please provide the total budget/planned expenditure for ESMI/FEP for FY 24 and FY 25 (only include MHBG funds).

FY2024	FY2025
9466421	9466421

3. Please describe the status of billing Medicaid or other insurances for ESMI/FEP services? How are components of the model currently being billed? Please explain.

Coordinated Specialty Care for First Episode Psychosis is a cost reimbursement program. Providers will bill insurance or Medicaid as applicable and this cost is deducted from the invoice submitted by the provider. Enrolled individuals may have private insurance, Medicaid, Medicare, or have no health insurance at all. The program has a maximum length of stay of 36 months, after which an individual can be discharged or transitioned to the next most appropriate level of care.

4. Please provide a description of the programs that the state funds to implement evidence-based practices for those with ESMI/FEP.

The Coordinated Specialty Care for First Episode Psychosis model follows the OnTrack NY model to align with the established evidence for best practices in treatment of ESMI. The CSC sites in Texas are supported by staff from HHSC who provide technical assistance, organize training opportunities, and conduct virtual and/or on-site visits to ensure the model is implemented with fidelity.

HHSC has implemented Coordinated Specialty Care (CSC) programs in 23 local mental health authorities (LMHAs) across Texas. CSC serves young adults between ages 15-30 and meet the criteria for a psychotic disorder from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision (DSM-5-TR, regardless of the age of the individual at onset. All CSC programs in Texas follow the OnTrack NY model for first episode psychosis treatment, which is an evidence-based treatment model.

5. Does the state monitor fidelity of the chosen EBP(s)?

(●) Yes ( ) No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI/FEP?

(●) Yes ( ) No

7. Explain how programs increase access to essential services and improve client outcomes for those with an ESMI/FEP?

Each CSC site conducts local outreach and education about early onset psychosis and treatment options. CSC programs have partnered with independent school districts, public housing associations, community colleges and universities, psychiatric hospitals, emergency rooms, and private clinics to promote the CSC program and identify eligible individuals.

The CSC program uses a team-based care approach, which includes:

a. Team Lead who is a Licensed Professional of the Healing Arts (LPHA);
b. Supportive Employment/Supported Education Specialist (SEES)
c. Licensed Counselor if counseling is not provided by the Team Lead;
d. Case Manager or Skills Trainer;
e. Certified Peer Specialist;
f. Certified Family Partner (who is available for all enrolled in CSC-FEP); and
g. Psychiatrist, Psychiatric Advanced Practice Nurse, or Physician Assistant.

After the individual is enrolled, CSC program staff use a person-centered, strengths-based approach to care, which involves the individual's chosen family (with consent), support of peers, and an integration of school or work. Each CSC program tailors the implementation of the model based on factors such as primary language spoken, rural vs. urban locations, etc.

HHSC collects assessment and encounter data for all programs. In addition, the CSC programs are required to submit data related to fidelity measures established by the OnTrack NY program model. This data is submitted quarterly and includes measures like number of individuals who were: enrolled, competitively employed during the quarter, prescribed antipsychotic medications, and more. The measures are a combination of process and outcomes data.

A primary outcome goal for the CSC programs is to assist individuals with becoming independent and eventually discharging from services. HHSC, therefore, focuses on the quarterly measures and assessment data from the Child and Adolescent Needs and Strengths (CANS) and Adult Needs and Strengths Assessment (ANSA), which measure improvement in functioning and quality of life.

8. Please describe the planned activities for FY 2024 and FY 2025 for your state's ESMI/FEP programs.

HHSC intends to allocate block grant funds beyond the required 10 percent set aside to support the continuation of the existing 23 CSC programs across the state. Between March 2023 and 2025, the eight expanded sites will receive federal American Rescue Plan Act (ARPA) funding to sustain the expansion efforts begun under H.R. 133 funds. Three new FEP programs were funded through ARPA in fiscal year 2022 and these three programs will continue funding through fiscal year 2025.

Finally, HHSC staff will provide comprehensive technical assistance to all CSC programs throughout Texas during FFY2024 and FFY2025. HHSC staff conduct monthly technical assistance phone calls with each program to answer staff questions about the program model, troubleshoot issues with implementation, and discuss individual client cases as needed. Additionally, HHSC staff intend to conduct site visits to at least 12 sites between September 2023 and September 2024. When possible, the site visits will be conducted in person, although virtual site visits can be conducted as well. The purpose of the visits is to gain insight into the implementation of the CSC program to ensure it is implemented with fidelity and to provide specialized technical assistance to program staff.

9. Please list the diagnostic categories identified for your state's ESMI/FEP programs.

CSC serves young adults between ages 15-30 and meet the criteria for a psychotic disorder from the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition, Text Revision regardless of the age of the individual at onset.
Diagnostic categories include ICD-10 diagnosis code F20.0, F20.1, F20.2, F20.3, F20.81, F20.89, F20.9, F21, F 22, F 23, F 25.0, F 25.1, F 28, F 29, F 30.2, F 31.2, F 31.5, F 31.64, F32.3, F33.3.

10. What is the estimated incidence of individuals with a first episode psychosis in the state?

A first episode of psychosis can occur at almost any age, but the vast majority of FEP occurs between ages 12 and 35; roughly 3,000 Texans in that age group experience FEP in a 12-month period. This estimate represents a minimum expected number of new cases in a given 12-month period. Source: Meadows Mental Health Policy Institute, https://mmhpi.org/topics/policy-research/coordinated-specialty-care/

11. What is the state's plan to outreach and engage those with a first episode psychosis who need support from the public mental health system?

HHSC first episode psychosis program has a public facing website that lists resources for the individuals needing services. HHSC first episode psychosis program has published an educational brochure for outreach purpose. New provider training includes a manual for outreach and recruitment of clients from OnTrack New York, new team members also receive two-day onboarding training through OnTrack New York.

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

NA

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Footnotes:

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required for MHBG

Narrative Question

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

In addition to adopting PCP at the service level, for PCP to be fully implemented it is important for states to develop systems which incorporate the concepts throughout all levels of the mental health network. Resources for assessing and developing PCP systems can be found at the National Center on Advancing Person-Centered Practices and Systems **https://ncapps.acl.gov/home.html** with a systems assessment at **https://ncapps.acl.gov/docs/NCAPPS_SelfAssessment_201030.pdf**

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

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

NA

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

Since 2016, the Person-Centered Planning webpage has been available for providers supporting the planning process. The "Introduction to Person-Centered Planning" online training can be found at: https://learningportal.hhs.texas.gov/course/index.php?categoryid=7. Or at https://www.hhs.texas.gov/services/disability/person-centered-planning/person-centered-planning-waiver-program-providers.
Texas's Mental Health Performance Contract Notebook (PCN) for local mental and behavioral health authorities states that the determination of services to be provided must be done jointly by the person seeking services and the contracted provider. To support providers on implementing this approach, HHSC partners with the Centralized Training Infrastructure for Evidence-Based Practices to conduct relevant trainings. Training topics include but aren't limited to Motivational Interviewing, Person-Centered Recovery Planning, Illness Management and Recovery, Cognitive Behavioral Therapy, Individual Placement, and Support, Adults Needs and Strengths Assessment (ANSA) and Child and Adolescent Needs and Strengths Assessment (CANS) training and technical assistance, Permanent Supportive Housing, and Co-Occurring Psychiatric and Substance Use Disorder.

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

Health and Human Services utilizes peer support specialists to strengthen supports provided by people with lived experience. Texas engages persons with lived experience and their caregivers to drive change at all levels of the system. An example of this can be viewed in this HHSC employee training video that includes testimony from people with lived experience here https://youtu.be/CIl81TjIEdM.

The HHSC Person-Centered Strategic Planning Committee includes people with lived experience

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

HHSC has adopted the following approach to person-centered planning:

The person seeking services is to lead the planning of their treatment and involvement in services, whenever possible. The legally

authorized representative (LAR), legally authorized decision-maker, or the person's designee can provide the individual with assistance to help lead the team. When planning or discussing treatment options, the treatment team should support the individual to have ownership in decisions while also having a collaborative partnership with all service providers. Every treatment plan must identify the person's strengths, natural supports and reflect the person's or LAR's choices for needs, desired outcomes, treatment goals, and preferences regarding services to be received. For children and adolescents with the highest level of need, the Wraparound Planning Process is implemented to ensure that planning and treatment is child-centered and family-driven. Finally, providers are required to accommodate cultural preferences/priorities and incorporate plain language that is accessible to the person.

Another important aspect that facilitates the person-centered planning process is the use of Uniform Assessment tools. Texas has adopted the CANS and ANSA as the Uniform Assessment (UA). All individuals are screened with the appropriate UA to evaluate biopsychosocial histories, strengths, and needs. The findings inform the specific services and supports needed to help the person reach their desired outcomes. Each person or their LAR are required to sign the plan and be provided a copy. UAs must be reviewed and revised when circumstances or needs change, or when the individual or family requests a review.

In addition, HHSC collaborates with state and national partners to assess and improve organizational capacity to support person-centered behavioral health practices.

5. What methods does the SMHA use to encourage people who use the public mental health system to develop Psychiatric Advance Directives (for example, through resources such as SAMHSA's **A Practical Guide to Psychiatric Advance Directives**)?"

Texas law allows an option for the person's signature to be acknowledged by a notary instead of witness signatures and for digital or electronic signature on the Directive to Physicians, Out-of-Hospital Do Not Resuscitate Order, and the Medical Power of Attorney, if certain requirements are met.

The HHSC website includes a webpage on advance directives.The website includes the following documents: Declaration form Mental Health Treatment (DMHT), Directive to Physician's and Family or Surrogates (Living Will), Medical Power of Attorney (MPOA), Out-of-Hospital Do Not resuscitate (OOH-DNR) Order and Statutory Durable Power of Attorney (SDPOA). The advance directives webpage can be found at https://www.hhs.texas.gov/formas/advance-directives.

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

Technical assistance to ensure compliance with state and federal mandates and opportunities for consultation with The Learning Community for Person Centered Practices | TLCPCP.com and other resources including the National Center on Advancing Person-Centered Practices and Systems at https://ncapps.acl.gov would be beneficial.

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Environmental Factors and Plan

6. Program Integrity - Required

Narrative Question

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

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

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

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

Please respond to the following:

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

   NA

   Please indicate areas of technical assistance needed related to this section

   NA

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Footnotes:

Environmental Factors and Plan

7. Tribes - Requested

Narrative Question

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

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

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

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

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

Please respond to the following items:

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

During state fiscal year 2022 and 2023, the Health and Human Services Commission (HHSC) conducted 43 consultations, or technical assistance calls, with the three federally recognized tribes. These consultations consisted of regularly scheduled quarterly calls to identify needs and provide technical assistance and 1:1 technical assistance calls as needed to address identified needs and solutions for expanding collaborations.

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

- Limited broadband access creates challenges in delivering virtual services
- Development of behavioral health professionals and identification of funding to support workforce development
- Establishment of recovery support services for people returning to the community after receiving treatment services
- Additional support from the local mental health authority (LMHA) for assistance with crisis services
- Lack of mental health and youth residential treatment facilities near reservations or designed specifically to meet tribal members needs
- Replacement of the previous Behavioral Health Advisory Council tribal representative

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

During the past two years, HHSC continued facilitating quarterly technical assistance calls and 1:1 calls as needed with tribes in Texas. HHSC made recommendations to the Alabama-Coushatta Tribe of Texas (ACTT) for advertising open positions. The positions have since been filled. Through the quarterly technical assistance calls, ACTT conveyed the challenges with providing tele-health services due to COVID-19 and inquired about funding. They submitted a project proposal that is under review for possible funding. Continued consultation has laid the foundation for government-to-government contractual agreements. The proposal also addresses many of the needs mentioned above, including community development programs, workforce development, and increased collaborations with LMHAs and other community partners. Additionally, HHSC contracted with ACTT to implement the

Community Development program and the Virtual Behavioral Health Services program. HHSC conducted 21 technical assistance calls and conducted two site visits with the tribe to enhance relationships and improve the delivery of culturally appropriate services.

In fiscal year 2022, HHSC provided 12 monthly technical assistance calls with Ysleta Del Sur Pueblo (Ysleta) and their peer specialist staff, as they provided opioid and stimulant specific recovery support services. Additionally, four HHSC staff members visited Ysleta for the grand opening of their new Health and Human Services clinic. The purpose of the site visit was to develop better cultural understanding of their tribal needs and establish plans for future collaborations. Ysleta has been able to maintain behavioral health services with a reduction in HHSC funding for fiscal year 2023, which indicates their ability to strengthen their sustainability.

HHSC continues to provide technical assistance when requested to support the federal grants that were previously awarded, and discussion has begun to create a statewide consortia or coalition with the three federally recognized tribes. HHSC informed the tribes about the Addictions Technology Transfer Center's Advisory Council Meeting and one tribe attended.
In fiscal year 2022, an HHSC program specialist completed the Warrior Down – Recovery Coach training through the Wellbriety Training Institute. The purpose of the training was to learn how Native Americans can implement the curriculum, which provides a relapse prevention and recovery support program for Native Americans who are completing treatment, returning to the community from incarceration, or who have been working on their recovery journey using traditional method or 12 Step methods and who wish to provide support to others experiencing the same.

Lastly, HHSC provided an overview of the 988 Suicide and Crisis Lifeline (988) in two separate calls with ACTT and Ysleta to begin discussions pertaining to 988. HHSC and the tribes discussed working collaboratively to ensure people in tribal communities receive seamless support if they call 988. HHSC and the tribes plan to continue discussions to ensure the tribal communities are aware of 988 resources and fill any potential gaps.

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

None at this time.

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

8. Primary Prevention - Required SUPTRS BG

Narrative Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Assessment

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

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

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

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

- **a)** ☐ Children (under age 12)
- **b)** ☑ Youth (ages 12-17)
- **c)** ☑ Young adults/college age (ages 18-26)
- **d)** ☑ Adults (ages 27-54)
- **e)** ☐ Older adults (age 55 and above)
- **f)** ☑ Cultural/ethnic minorities
- **g)** ☐ Sexual/gender minorities
- **h)** ☑ Rural communities
- **i)** ☐ Others (please list)

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

- **a)** ☐ Archival indicators (Please list)
- **b)** ☑ National survey on Drug Use and Health (NSDUH)
- **c)** ☑ Behavioral Risk Factor Surveillance System (BRFSS)
- **d)** ☑ Youth Risk Behavioral Surveillance System (YRBS)
- **e)** ☐ Monitoring the Future
- **f)** ☐ Communities that Care
- **g)** ☑ State - developed survey instrument
- **h)** ☐ Others (please list)

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

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

  HHSC is developing a policy and procedure to evaluate evidence-based practices including curricula. A workgroup was convened to review evidence-based practices for the upcoming prevention procurement. The workgroup utilized the hexagon model/process, which evaluates existing strategies and interventions based on the following criteria: need, evidence, fit, usability, capacity, and supports. The select evidence-based curricula for Texas Youth Prevention Programs and strategic focus areas for Texas Community Coalition Partnership program are based on the results of the hexagon model/process.

- **b)** If no, (please explain) how SUPTRS BG funds are allocated:

6. Does your state integrate the National CLAS standards into the assessment step? ◉ Yes ○ No

- **a)** If yes, please explain in the box below.

  HHSC's contracts incorporate the National CLAS Standards into contract requirements for all substance use prevention providers. Thus, contractors are expected to integrate CLAS standards into their service delivery. Applicants for prevention funding are required to explain how they implement CLAS standards. Community Coalition Partnership providers must submit needs assessment, logic models, and sustainability plans, which are to incorporate the SPF (including CLAS).

- **b)** If no, please explain in the box below.

7. Does your state integrate sustainability into the assessment step? ○ Yes ◉ No

- **a)** If yes, please explain in the box below.

- **b)** If no, please explain in the box below.

  HHSC is taking steps to improve sustainability in the programs for which we contract. We are enhancing our training on sustainability, particularly for our Community Coalition Partnerships, and are continually looking to diversify funding at the state level. We area also refining our needs assessment process and aiming to launch a data contract for this purpose.

Narratve Question

SUPTRS BG statute requires states to spend not less than 20 percent of their SUPTRS BG allotment on primary prevention strategies directed at individuals not who do not meet diagnostic criteria for a substance use disorder and are identified not to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use primary prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SUPTRS BG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

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

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

Capacity Planning

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

a) If yes, please describe.

Texas Certification Board (TCB) is an autonomous arm of the Texas Association of Addiction Professionals. TCB certification upgrades and standardizes the qualifications of those working in areas of addiction counseling, clinical supervision, and prevention throughout Texas. These certifications are designed to be appropriate for those professionals currently working in counseling, supervision and prevention.

TCB offers Associate Prevention Specialist (APS) designation as well as Certified Prevention Specialist (CPS) and Advanced Certified Prevention Specialist (ACPS) certifications. Both certifications are recognized by the International Credentialing and Reciprocity Consortium (IC&RC) for the International Certified Prevention Specialist (ICPS) certification. Select staff at Agency-funded providers who do not possess certification at time of hire, must become Certified Prevention Specialists within 20 months of hire.

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

a) If yes, please describe mechanism used.

HHSC's Texas Prevention Training (TPT) contract provides a statewide coordinated system of prevention training and technical assistance services to support and enhance workforce development in Texas. TPT provides training on the latest prevention research, including best practice approaches; evidence-based prevention curricula addressing substance abuse prevention; six Center for Substance Abuse Prevention (CSAP) strategies; public health; Institute of Medicine (IOM) Continuum of Care model; coalition-building; cultural competency; staff competency; environmental strategies; prevention activities; the Strategic Prevention Framework (SPF); behavioral health approaches in prevention; and any other prevention -specific training directed by the state. The comprehensive prevention training is designed to support the effective implementation of evidence-based and promising programs across the state.

Staff competencies are also developed and required as part of all prevention and behavioral health promotion provider contracts. The provider must ensure that the prevention program director and all prevention staff complete required trainings within six months from the start date of the contract or the date of hire, whichever is later. Trainings are offered in domains including cultural competency, risk and protective factors/building resiliency, child development and/or youth development, strategies for strengthening families and prevention across the lifespan.

In addition, HHSC prevention and behavioral health promotion program specialists provide training and technical

assistance to the prevention providers regarding programmatic issues surrounding the requirements in their statements of work which includes the service requirements, staffing requirements, staff competencies, and reporting requirements.

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

a) If yes, please describe mechanism used.

The Request for Applications (RFA) includes a section in the respondent's response regarding the Assessment of Community Needs and Organization Capacity (ACNOC). The respondent provides the following information as part of their response to the RFA section on the ACNOC:
• a description of the organization's capacity and experience in providing substance abuse prevention services;
• experience in networking and collaborating with other community partners;
• a description of the partnerships with agencies the respondent plans to work with to address gaps in services and provide support services for the target population of the proposed project;
• a description of the organization's experience providing prevention services to the identified target population;
• a description of the organization's experience and capacity in administrative functions, financial and contracts management, program oversight, staff retention and workforce development, a list of funding sources for the program type within the last five years, number of computers with minimum requirements, program staffing and staff competencies.

4. Does your state integrate the National CLAS Standards into the capacity building step? (●) Yes ( ) No

a) If yes, please explain in the box below.

HHSC's contracts incorporate the National CLAS Standards into contract requirements for all substance use prevention providers. Thus, contractors are expected to integrate CLAS standards into their service delivery. Applicants for prevention funding are required to explain how they implement CLAS standards. Community Coalition Partnership providers must submit needs assessment, logic models, and sustainability plans, which are to incorporate the SPF (including CLAS).

5. Does your state integrate sustainability into the capacity building step? ( ) Yes (●) No

a) If yes, please explain in the box below.

b) If no, please explain in the box below.

HHSC is taking steps to improve sustainability in the programs for which we contract. We are enhancing our training on sustainability, particularly for our Community Coalition Partnerships, and are continually looking to diversify funding at the state level. We area also refining our needs assessment process and aiming to launch a data contract for this purpose.

Narratve Question

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Planning

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

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

HHSC is using the Texas Behavioral Health Strategic Plan 2022-2026, which includes a specific subset focused on prevention and behavioral health promotion. The initial plan assessed needs and gaps across the state in relation to mental health and wellness including an inventory of available programs.

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

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

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

4. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ( ) Yes (●) No

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

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

N/A

6. Does your state have an Advisory Council that provides input into decisions about the use of SUPTRS BG primary prevention funds? ○ Yes ◉ No

7. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SUPTRS BG primary prevention funds? ○ Yes ◉ No

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

N/A

8. Does your state integrate the National CLAS Standards into the planning step? ◉ Yes ○ No

a) If yes, please explain in the box below.

HHSC's contracts incorporate the National CLAS Standards into contract requirements for all substance use prevention providers per our planning process. Thus, contractors are expected to integrate CLAS standards into their service delivery, including their own planning. Applicants for prevention funding are required to explain how they implement CLAS standards. Community Coalition Partnership providers must submit needs assessment, logic models, and sustainability plans, which are to incorporate the SPF (including CLAS).

b) If no, please explain in the box below.

N/A

9. Does your state integrate sustainability into the planning step? ○ Yes ◉ No

a) If yes, please explain in the box below.

N/A

b) If no, please explain in the box below.

HHSC is taking steps to improve sustainability in the programs for which we contract. We are enhancing our training on sustainability, particularly for our Community Coalition Partnerships, and are continually looking to diversify funding at the state level. We area also refining our needs assessment process and aiming to launch a data contract for this purpose.

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Implementation

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

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

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SUPTRS BG primary prevention dollars in at least one of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

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

b) Education:

All Youth Programs (Universal, Indicated, and Selective)

c) Alternatives:

All Youth Programs (Universal, Indicated, and Selective)

d) Problem Identification and Referral:

All Youth Programs (Universal, Indicated, and Selective)

e) Community-Based Processes:

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

f) Environmental:

Community Coalition Partnerships (CCP)
Prevention Resource Center (PRC)
Statewide Prevention Media Campaign

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

a) If yes, please describe.

We partner with other state programs/systems to ensure non-duplication of services

4. Does your state integrate National CLAS Standards into the implementation step? (●) Yes ( ) No

a) If yes, please describe in the box below.

HHSC's contracts incorporate the National CLAS Standards into contract requirements for all substance use prevention providers. Thus, contractors are expected to integrate CLAS standards into their service delivery, including implementation. Applicants for prevention funding are required to explain how they implement CLAS standards. Community Coalition Partnership providers must submit needs assessment, logic models, and sustainability plans, which are to incorporate the SPF (including CLAS).

b) If no, please explain in the box below.

5. Does your state integrate sustainability into the implementation step? ( ) Yes (●) No

a) If yes, please describe in the box below.

N/A

b) If no, please explain in the box below

HHSC is taking steps to improve sustainability in the programs for which we contract. We are enhancing our training on sustainability, particularly for our Community Coalition Partnerships, and are continually looking to diversify funding at the state level. We area also refining our needs assessment process and aiming to launch a data contract for this purpose.

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

Evaluation

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

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

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

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

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

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

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

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

c) ☐ Binge use

d) ☐ Perception of harm

e) ☐ Disapproval of use

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

g) ☐ Other (please describe):

5. Does your state integrate the National CLAS Standards into the evaluation step? ◉ Yes ○ No

a) If yes, please explain in the box below.

HHSC's contracts incorporate the National CLAS Standards into contract requirements for all substance use prevention providers. Thus, contractors are expected to integrate CLAS standards into their service delivery, including implementation. Applicants for prevention funding are required to explain how they implement CLAS standards. Community Coalition Partnership providers must submit needs assessment, logic models, and sustainability plans, which are to incorporate the SPF (including CLAS).

b) If no, please explain in the box below.

6. Does your state integrate sustainability into the evaluation step? ○ Yes ◉ No

a) If yes, please describe in the box below.

b) If no, please explain in the box below.

HHSC is taking steps to improve sustainability in the programs for which we contract. We are enhancing our training on sustainability, particularly for our Community Coalition Partnerships, and are continually looking to diversify funding at the state level. We area also refining our needs assessment process and aiming to launch a data contract for this purpose.

Footnotes:

Environmental Factors and Plan

9. Statutory Criterion for MHBG - Required for MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

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

Please respond to the following items

Criterion 1

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

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

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

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

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

Local mental/behavioral health authorities (LMHAs and LBHAs) provide integrated healthcare services to individuals served. The nature, level, and extent of these services varies from referrals to offsite healthcare providers to collaboration with primary health provider's collocated in the same facility.

3. Describe your state's case management services

3. Routine Case Management is primarily a site-based service assisting an adult, child or adolescents, or caregiver in gaining and coordinating access to necessary care and services appropriate to the individual's needs.
Intensive Case Management is a focused activity with an individual and caregiver or legally authorized representative to help them obtain and coordinate access to necessary care and services. The services include coordinated management of a mental health problem or challenge and the rehabilitation and social support needs of the individual over an indefinite period. Services are provided by a team of people who have a small group of clients. Twenty-four-hour help is offered, and clients are seen in a non-clinical setting.

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

4. HHSC provides a continuum of crisis services to reduce hospitalization and number of hospital stays. Crisis services include

community-based services assisting in stabilizing crisis situations, restoring functioning, assisting with adherence to medication regimens, promoting integration into the larger community, and assisting with linkage to other required community-based services.

HHSC provides outpatient crisis intervention services such as community-based crisis programs, which serve individuals who have low to moderate risk of harm to self or others in a clinically supervised environment. Community-based crisis programs are designed to provide appropriate treatment in the least restrictive environment to stabilize an individual's acute mental health symptoms and improve functioning. Intensive ongoing services for children and adolescents include team-based, wraparound services intended to keep the individual in the home with their family while receiving treatment. These outpatient services provide an alternative to inpatient hospitalizations.

For individuals in need of inpatient psychiatric treatment, services are provided to stabilize crises and work towards discharge into a community setting to reduce readmissions to the hospital setting. HHSC provides a Hospital Transition Pilot Program for individuals who have been in the State Hospitals for an extended period. This program supports individuals with complex psychiatric and/or medical needs by facilitating transition from inpatient settings to appropriate community settings. The program is aligned with SAMHSA's strategic plan objective to "identify and promote evidence-based practices with the goal of reducing incidence and duration of psychiatric hospitalization, homelessness, incarcerations, and criminal justice system interactions."

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

NA

Criterion 2: Mental Health System Data Epidemiology

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

Criterion 2

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

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

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

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	5.68%	1.00%
2.Children with SED	18.41%	2.74%

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

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

Criterion 3

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

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

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

NA

**A system of care is: A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.*
https://gucchd.georgetown.edu/products/Toolkit_SOC_Resource1.pdf

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

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

Criterion 4

a. Describe your state's targeted services to rural population. **See SAMHSA's Rural Behavioral Health page for program resources**

In 2017, the Texas Legislature directed the development of a community mental health grant program in order to expand recovery focused treatment options. This initiative sought to establish a matching grant program to support community mental health efforts providing services and treatment to individuals experiencing mental illness. Fifty percent of funding awarded is reserved for community mental health programs located in counties with a population of less than 250,000. In 2019, the Texas Legislature provided continuous funding to the matching grant program to support current and new programs. The goals of the community mental health grant program include the following:
-Provide mental health services and treatment to individuals with mental illness; and
-Coordinate mental health services for individuals with mental illness to other transition support services.

b. Describe your state's targeted services to people experiencing homelessness. **See SAMHSA's Homeless Programs and Resources for program resources**

The Supportive Housing Rental (SHR) Assistance program provides funding to local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) to enhance their ability to provide: rental and utility assistance to individuals with mental illness who are either homeless or at imminent risk of becoming homeless, while also providing supportive housing and mental health services to individuals in need.
SHR programs are implemented in 36 of the 39 LMHA/LBHAs in Texas. Funds may be used for rent, utility assistance, deposits, move-in costs, and other one-time/time-limited expenses needed to obtain and maintain housing. SHR funds used for rental assistance may be used for up to 12 months, based on the individual's identified need. Participants are required to develop a transition plan to address barriers for housing and employment with the goal of being self-sufficient.

c. Describe your state's targeted services to the older adult population. **See SAMHSA's Resources for Older Adults webpage for resources.**

HHSC Adult Mental Health Services internal workgroup:
HHSC Adult Mental Health Services has an internal workgroup focused on behavioral health issues in older adults aged 60 and above. The group is assigned to study health care problems faced by older adults, with a focus on mental health and SUD as well as primary care needs. The tasks of the workgroup include:
-Reach out to national associations and experts dedicated to behavioral health issues in older adults to seek input and guidance;
-Research available resources and literature to identify curricula, screening, and management protocols based on evidence-based practices (EBP) for older adults; and
-Develop programs for need assessment and gap analysis in the provision of healthcare to older adults with an emphasis on behavioral health disorders.
Behavioral Health and Aging (BHA) Workgroup:
Behavioral Health and Aging (BHA) Workgroup in Texas is an ongoing collaboration between HHSC's Aging and Behavioral Health services divisions to promote the behavioral health of older adults by increasing awareness, training, and outreach to service providers, professionals, and consumers. One of BHA's desired objectives is to build a coalition partnership between behavioral health, aging, and other agencies providing support and services to older adults in Texas. This collaboration will enhance the alignment of services, build capacity, and develop care coordination to help people navigate across all systems of care with a "no wrong door" philosophy.
The BHA Workgroup identified focus areas and identified three main priorities include social isolation, peer support and suicide prevention. Sub-workgroups were developed for each of the priority areas with projects that include: resource sheets, trainings, an issue brief and resources on best practices, and partnerships/collaborations for outreach and bridging identified gaps.
National Association of State Mental Health Program Director (NASMHPD) Older Persons Division (OPD) Coalition Group:
The National Association of State Mental Health Program Director (NASMHPD) Older Persons Division (OPD) Coalition Group is a partnership of representatives from states with an interest in behavioral health and older adults. Coalition members identify trends in behavioral health needs among older adults and share practices adopted by respective members to improve service delivery systems. The platform also provides an opportunity to build a coalition partnership between agencies. The OPD executive committee prepares an annual agenda with input from its state representatives and sets targets to be accomplished for the calendar year. After the agenda is approved, OPD coalition group holds monthly call-in meetings to discuss ways and means of accomplishing targets. For this purpose, subject matter experts and champions with interest in behavioral health and older adults are invited to present via the OPD's Call-Me Webinar series.

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

NA

Criterion 5: Management Systems

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

Telehealth is a mode of service delivery that has been used in clinical settings for over 60 years and empirically studied for just over 20 years. Telehealth is not an intervention itself, but rather a mode of delivering services. This mode of service delivery increases access to screening, assessment, treatment, recovery supports, crisis support, and medication management across diverse behavioral health and primary care settings. Practitioners can offer telehealth through synchronous and asynchronous methods. A priority topic for SAMHSA is increasing access to treatment for SMI and SUD using telehealth modalities. Telehealth is the use of telecommunication technologies and electronic information to provide care and facilitate client-provider interactions. Practitioners can use telehealth with a hybrid approach for increased flexibility. For instance, a client can receive both in-person and telehealth visits throughout their treatment process depending on their needs and preferences. Telehealth methods can be implemented during public health emergencies (e.g., pandemics, infectious disease outbreaks, wildfires, flooding, tornadoes, hurricanes) to extend networks of providers (e.g., tapping into out-of-state providers to increase capacity). They can also expand capacity to provide direct client care when in-person, face-to-face interactions are not possible due to geographic barriers or a lack of providers or treatments in a given area. However, implementation of telehealth methods should not be reserved for emergencies or to serve as a bridge between providers and rural or underserved areas. Telehealth can be integrated into an organization's standard practices, providing low-barrier pathways for clients and providers to connect to and assess treatment needs, create treatment plans, initiate treatment, and provide long-term continuity of care. States are encouraged to access, the SAMHSA Evidence Based Resource Guide, **Telehealth for the Treatment of Serious Mental Illness and Substance Use Disorders**.

Criterion 5

a. Describe your state's management systems.

• The Centralized Training Infrastructure for Evidence Based Practices (CTI-EBP) supports online and in-person trainings and web-based technical assistance. Services are free to contractors and through partnerships with other state agencies. Providers from the LMHAs and LBHAs are eligible to register at www.centralizedtraining.com to access online trainings and a training calendar of upcoming in-person trainings. The login page recognizes approved email addresses.
• The CTI-EBP is a training infrastructure system that supports the delivery of behavioral health services for adult and adolescents in Texas. It was developed to ensure contracted mental health service providers use scientific, evidence-based practices in the implementation of the TRR model of behavioral health care. Additionally, CTI-EBP promotes recovery-based training for all behavioral health providers working with individuals with mental illness or SUD.
• E-Commerce is used to give access to private providers. HHSC contracts with The University of Texas Health Science Center – San Antonio, Department of Psychiatry, to implement this project.
• The CTI-EBP manages all the logistical aspects for delivery of trainings across the state of Texas. In addition to procuring and contracting with competent trainers in accordance with HHSC requirements, the CTI-EBP tracks participants, offers continuing education units (CEUs) for practitioners, secures training locations, evaluates trainings, and conducts a needs assessment to identify the ongoing training needs of mental health service providers. The CTI-EBP may also serve to augment other identified training needs within the HHSC purview, such as training in the delivery of crisis services, the creation of evidence-based learning communities, supervision and/or coaching in evidence-based and promising practices, and/or the development of online trainings.
• HHSC has also worked with CTI to develop a centralized coordination hub in which certified peer specialists can connect with placements and supervisors to obtain required certification supervision hours. The hub will serve as a clearinghouse for organizations seeking to hire peer specialists. CTI provides continuing education opportunities for peer specialists and family partners as well as training and technical assistance to support the successful implementation of peer and family services.
• For the implementation of and training on the system of care approach for child and adolescent services, HHSC contracts with the Texas Institute of Excellence in Mental Health (TIEMH) of The University of Texas at Austin. TIEMH provides training, technical assistance, learning communities, evaluation, and consultation. Services are focused on cultural and linguistic sensitivity, the development of family and youth voice in services, cross-systems collaboration, and systems transformation. TIEMH also supports the implementation of a comprehensive strategic plan to address state and local policy and practice barriers related to statewide expansion of the system of care. This includes providing assistance to local communities implementing systems of care. HHSC was awarded a SAMHSA system of care grant, which supports this partnership with TIEMH.
• Trainings and infrastructure for suicide prevention, intervention, and post-intervention coordination is supported by contracts or collaborations with TIEMH, the Texas Suicide Prevention Council, and the National Alliance on Mental Illness (NAMI) Texas. Through its contracts and collaborations, Texas ensures continuity of training on evidence-based practices related to suicide prevention, intervention, postvention, and overall support of HHSC's Suicide Care Initiative (formerly the Zero Suicide in Texas Initiative).
• HHSC employs staff who provide statewide training for Psychological First Aid and Mental Health First Aid (MHFA). HHSC's Disaster Behavioral Health Services team supports the coordination of Psychological First Aid trainings. MHFA trainings have been provided to behavioral health service providers within school districts since 2013, in accordance with the 83rd Texas Legislature. In 2013 and 2015, The Texas Legislature directed HHSC to fund contracts with LMHAs/LBHAs to provide trainings and trainers to any school personnel interacting with children throughout the state. In 2017, the Texas Legislature expanded funding for MHFA training for universities and institutes of higher education. In 2019, the 86th Texas Legislature required districts to provide school staff with trainings related to MHFA, suicide prevention, trauma-informed care, and grief-informed care. In 2023, the 88th Texas

Legislature required any school personnel interacting with children throughout the state to complete evidence-based mental health training.

b. Describe your state's current telehealth capabilities, how your state uses telehealth modalities to treat individuals with SMI/SED, and any plans/initiatives to expand its use.

• HHSC has developed guidance on telehealth and telemedicine flexibilities to allow many services to be provided via audiovisual and audio-only technology, including outpatient mental health services (psychiatric diagnostic evaluation, psychotherapy, psychological/neuropsychological testing, and pharmacological management), mental health case management, mental health rehabilitation, physician evaluation and management services, intake services, and non-Medicaid services such as supported employment and supportive housing.

• House Bill 4 (87th Legislature, Regular Session, 2021) requires HHSC to ensure that individuals have the option to receive behavioral health services as telemedicine and telehealth services to the extent it is clinically-effective and cost-effective. HHSC has provided guidance to all LMHAs and LBHAs on the services that are able to be provided via audiovisual or audio-only technology, as well as direction related to clinical appropriateness, person-centeredness, documentation, confidentiality, and the need to establish an existing clinical relationship prior to the delivery of certain services using audio-only technology.

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

NA

Footnotes:

Environmental Factors and Plan

10. Substance Use Disorder Treatment - Required SUPTRS BG

Narrative Question

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

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

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

b) Services for special populations:

i)	Prioritized services for veterans?	(•) Yes ( ) No
ii)	Adolescents?	(•) Yes ( ) No
iii)	Older Adults?	(•) Yes ( ) No

Criterion 2

Criterion 3

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

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

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

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

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

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

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

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

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

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

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

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

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

i) Educational assistance (●) Yes ( ) No

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

HHSC employs the following strategies to ensure compliance with Block Grant requirements:
1. HHSC uses a risk-based approach to evaluate and score a contractor's level of risk. The annual risk assessment identifies contractors for the Quality Management (QM) review schedule. QM uses a monitoring tool based on contractual, state, and federal requirements to analyze and review the contractor's individual client delivery and program services.
Texas Administrative Code (TAC) 448.504 Quality Management requires Texas HHSC licensed facilities to maintain quality management procedures, processes and plans to monitor compliance with contractual, state, and federal requirements. SUPTRS – funded programs are monitored by HHSC Quality Management Unit to ensure compliance with contractual requirements, as well as state and federal laws. Quality Management reviews result in monitoring reports with additional actions which can include technical assistance, corrective action plans, increased contract and performance monitoring, or contract termination.

2. PWWDC programs are required to comply with federal and state priority population criteria and are required to ensure the pregnant women injecting individuals and pregnant individuals are prioritized and admitted within 48 hours in treatment services. Contractors use the web-based clinical record Clinical Management of Behavioral Health Services (CMBHS). Weekly-Daily Capacity, Waitlist, and Admission reports are generated from CMBHS for HHSC to review and determine adherence to federal and state priority populations.

3. Substance Intervention Treatment Program (SITP) staff review a monthly report on Outcomes to ensure contractors are meeting the requirements.
If any of these strategies identify compliance issues SITP may perform technical assistance, initiate a corrective action plan, or perform a deeper analysis to identify a possible systemic issue requiring additional input and broader scope solution.
HHSC conducts performance measure reviews, contractor calls and distributes statewide Broadcast Messages to address requirements and systemic issues.
HHSC staff meet regularly to address contract issues, identify opportunities for improvement and make recommendations to address areas of noncompliance. Actions and recommendations resulting from these meetings may require technical assistance or additional monitoring of contractors.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

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

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

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

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

1. HHSC uses a risk-based approach to evaluate and score a contractor's level of risk. The annual risk assessment identifies contractors for the Quality Management (QM) review schedule. QM uses a monitoring tool based on contractual, state, and federal requirements to analyze and review the contractor's individual client delivery and program services.
Texas Administrative Code (TAC) 448.504 Quality Management requires Texas HHSC licensed facilities to maintain quality management procedures, processes and plans to monitor compliance with contractual, state, and federal requirements. SUPTRS – funded programs are monitored by HHSC Quality Management Unit to ensure compliance with contractual requirements, as well as state and federal laws. Quality Management reviews result in monitoring reports with additional actions which can include technical assistance, corrective action plans, increased contract and performance monitoring, or contract termination.

2. PWID programs are required to comply with federal and state priority population criteria and are required to ensure the pregnant women injecting individuals and pregnant individuals are prioritized and admitted within 48 hours in treatment services. Contractors use the web-based clinical record Clinical Management of Behavioral Health Services (CMBHS). Weekly-Daily Capacity, Waitlist, and Admission reports are generated from CMBHS for HHSC to review and determine adherence to federal and state priority populations.

3. SITP runs a weekly Wait List report to ensure contractors are complying with federal requirements to admit priority populations, including pregnant women who inject drugs.

4. SITP runs a monthly report on Outcomes to ensure contractors are meeting requirements.
If any of these strategies identify compliance issues SITP may perform technical assistance, initiate a corrective action plan, or perform a deeper analysis to identify a possible systemic issue requiring additional input and broader scope solution.
HHSC conducts performance measure reviews, contractor calls and distributes statewide Broadcast Messages to address requirements and systemic issues.
HHSC staff meet regularly to address contract issues, identify opportunities for improvement and make recommendations to address areas of noncompliance. Actions and recommendations resulting from these meetings may require technical assistance or additional monitoring of contractors.

Tuberculosis (TB)

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

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

a)	Business agreement/MOU with primary healthcare providers	( ) Yes (•) No

b) Cooperative agreement/MOU with public health entity for testing and treatment (●) Yes ( ) No

c) Established co-located SUD professionals within FQHCs (●) Yes ( ) No

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

HHSC employs the following strategies to ensure compliance with Block Grant requirements:
1. HHSC uses a risk-based approach to evaluate and score a contractor's level of risk. The annual risk assessment identifies contractors for the Quality Management (QM) review schedule. QM uses a monitoring tool based on contractual, state, and federal requirements to analyze and review the contractor's individual client delivery and program services.
If this strategy identifies compliance issues SITP may perform technical assistance, initiate a corrective action plan, or perform a deeper analysis to identify a possible systemic issue requiring additional input and broader scope solution.
HHSC conducts performance measure reviews, contractor calls and distributes statewide Broadcast Messages to address requirements and systemic issues.
HHSC staff meet regularly to address contract issues, identify opportunities for improvement and make recommendations to address areas of noncompliance. Actions and recommendations resulting from these meetings may require technical assistance or additional monitoring of contractors.

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

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

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

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

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

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

Syringe Service Programs

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

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

3. Do any of the programs use SUPTRS BG funds to support elements of a Syringe Services Program? ( ) Yes ( ) No

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

Criterion 8,9&10

Service System Needs

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

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

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

Service Coordination

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

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

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

Charitable Choice

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

2. Does your state provide any of the following:

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

Referrals

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

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

- **a)** Review and update of screening and assessment instruments — (•) Yes ( ) No
- **b)** Review of current levels of care to determine changes or additions — (•) Yes ( ) No

c) Identify workforce needs to expand service capabilities — (●) Yes ( ) No

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

Patient Records

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

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

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

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

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

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

Independent Peer Review

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

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

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

HHSC Quality Management Unit (QM) conducts an annual Independent Peer Review of the SUPTRS-funded providers. QM has policies and procedures to ensure the Contractors identified as peer reviewers are independent and qualified to conduct the review. Additionally , QM policies and procedures ensure the client sample selection, tool development, data quality, data analysis, and conclusions developed by peer reviewers meet contractual, state, and federal requirements. The scope of the fiscal year 2023 Independent Peer Review began on June 15, 2023. The six independent reviewers evaluated five SUTPRS-funded on the following:
(1) Admission criteria/intake process.
(2) Assessments.
(3) Treatment planning, including appropriate referral, e.g., prenatal care and tuberculosis and HIV services.
(4) Documentation of implementation of treatment services.
(5) Discharge and continuing care planning; and
(6) Indications of treatment outcomes.

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

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

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

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

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

If Yes, please identify the accreditation organization(s)

i) ☐ Commission on the Accreditation of Rehabilitation Facilities

ii) ☐ The Joint Commission

iii) ☐ Other (please specify)

Criterion 7&11

Group Homes

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

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

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

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

Professional Development

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

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

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

c) Performance-based accountability: (●) Yes ( ) No

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

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

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

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

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

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

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

a) Prevention TTC? (●) Yes ( ) No

b) Mental Health TTC? (●) Yes ( ) No

c) Addiction TTC? (●) Yes ( ) No

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

Waivers

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

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

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

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ( ) Yes (●) No

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

3. Additional Agreements

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

b) Professional Development ○ Yes ◉ No

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

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

1.Title 25, Part 1 of the Texas Administrative Code:
CHAPTER 140 HEALTH PROFESSIONS REGULATION Subchapter I - LICENSED CHEMICAL DEPENDENCY COUNSELORS
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=140&sch=I&rl=Y
CHAPTER 229 Subchapter J MINIMUM STANDARDS FOR NARCOTIC TREATMENT PROGRAMS
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=229&sch=J&rl=Y
CHAPTER 441 GENERAL PROVISIONS
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=441
CHAPTER 448 STANDARD OF CARE
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=25&pt=1&ch=448

2. Title 26, Part 1 of the Texas Administrative Code:
CHAPTER 321 SUBSTANCE USE SERVICES
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=321
CHAPTER 564 TREATMENT FACILITIES FOR INDIVIDUALS WITH SUBSTANCE-RELATED DISORDERS
https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=4&ti=26&pt=1&ch=564
3. Health and Safety Code §464.019 concerning administrative penalty against a CDTF for a violation.
CHAPTER 464. FACILITIES TREATING PERSONS WITH A CHEMICAL DEPENDENCY §464.019
https://statutes.capitol.texas.gov/Docs/HS/htm/HS.464.htm

If the answer is No to any of the above, please explain the reason.

Footnotes:

Environmental Factors and Plan

11. Quality Improvement Plan- Requested

Narrative Question

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

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2022-FFY 2023? ○ Yes ○ No

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

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12. Trauma - Requested

Narrative Question

Trauma[1] is a common experience for adults and children in communities, and it is especially common in the lives of people with mental and substance use disorders. For this reason, the need to address trauma is increasingly seen as an important part of effective behavioral health care and an integral part of the healing and recovery process. It occurs because of violence, abuse, neglect, loss, disaster, war, and other emotionally harmful and/or life-threatening experiences. Trauma has no boundaries regarding age, gender, socioeconomic status, race, ethnicity, geography, ability, or sexual orientation. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in M/SUD services. People in the juvenile and criminal justice system and children and families in the child welfare system have high rates of mental illness, substance use disorders and personal histories of trauma. Similarly, many individuals in primary, specialty, emergency, and rehabilitative health care also have significant trauma histories, which impacts their health and responsiveness to health interventions. Also, schools are now recognizing that the impact of traumatic exposure among their students makes it difficult for students to learn and meet academic goals. As communities experience trauma, for some, these are rare events and for others, these are daily events. Children and families living in resource scarce communities remain especially vulnerable to experiences of trauma and thus face obstacles in accessing and receiving M/SUD care. States should work with these communities to identify interventions that best meet the needs of their residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink how practices are conducted. These public institutions and service settings are increasingly adopting a trauma-informed approach distinct from trauma-specific assessments and treatments. Trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues with a focus on equity and inclusion. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[2] paper.

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

[2] *Ibid*

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

1.	Does the state have a plan or policy for M/SUD providers that guides how they will address individuals with trauma-related issues?	Yes No
2.	Does the state provide information on trauma-specific assessment tools and interventions for M/SUD providers?	Yes No
3.	Does the state provide training on trauma-specific treatment and interventions for M/SUD providers?	Yes No
4.	Does the state have a plan to build the capacity of M/SUD providers and organizations to implement a trauma-informed approach to care?	Yes No
5.	Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations?	Yes No
6.	Does the state use an evidence-based intervention to treat trauma?	Yes No
7.	Does the state have any activities related to this section that you would like to highlight.	
	Please indicate areas of technical assistance needed related to this section.	

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13. Criminal and Juvenile Justice - Requested

Narrative Question

More than a third of people in prisons and nearly half of people in jail have a history of mental health problems.[1] Almost two thirds of people in prison and jail meet criteria for a substance use disorder.[2] As many as 70 percent of youth in the juvenile justice system have a diagnosable mental health problem.[3] States have numerous ways that they can work to improve care for these individuals and the other people with mental and substance use disorders involved in the criminal justice system. This is particularly important given the overrepresentation of populations that face mental health and substance use disorder disparities in the criminal justice system.

Addressing the mental health and substance use disorder treatment and service needs of people involved in the criminal justice system requires a variety of approaches. These include:

- Better coordination across mental health, substance use, criminal justice and other systems (including coordination across entities at the state and local levels);
- Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups;
- Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system;
- Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community;
- Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems);
- Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, at booking, jails, the courts, at reentry, and through community corrections);
- Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system;
- Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met;
- Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges;
- Partnering with the judicial system to engage in cross-system planning and development at the state and local levels;
- Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system; and
- Supporting court-based programs, including specialty courts and diversion programs that serve people with M/ SUD.
- Addressing the increasing number of individuals who are detained in jails or state hospitals/facilities awaiting competence to stand trial assessments and restoration.

These types of approaches can improve outcomes and experiences for people with M/SUD involved in the criminal justice system and support more efficient use of criminal justice resources. The MHBG and SUPTRS BG may be especially valuable in supporting a stronger array of community-based services in these and other areas. SSAs and SMHAs can also play a key role in partnering with state and local agencies to improve coordination of systems and services. This includes state and local law enforcement, correctional systems, and courts. SAMHSA strongly encourages state behavioral health authorities to work closely with these partners, including their state courts, to ensure the best coordination of services and outcomes, especially in light of health disparities and inequities, and to develop closer interdisciplinary programming for justice system involved individuals. Promoting and supporting these efforts with a health equity lens is a SAMHSA priority.

[1]Bronson, J., & Berzofsky, M. (2017). Indicators of mental health problems reported by prisoners and jail inmates, 2011–12. Bureau of Justice Statistics, 1-16.

[2]Bronson, J., Stroop, J., Zimmer, S., & Berzofsky, M. (2017). Drug use, dependence, and abuse among state prisoners and jail inmates, 2007–2009. Washington, DC: United States Department of Justice, Office of Juvenile Justice and Delinquency Prevention.

[3]Vincent, G. M., Thomas Grisso, Anna Terry, and Steven M. Banks. 2008. "Sex and Race Differences in Mental Health Symptoms in Juvenile Justice: The MAYSI-2 National Meta-Analysis." Journal of the American Academy of Child and Adolescent Psychiatry 47(3):282–90.

Please respond to the following items

1. Does the state (SMHA and SSA) engage in any activities of the following activities:

- [x] Coordination across mental health, substance use disorder, criminal justice and other systems
- [x] Data sharing and use of data to identify individuals in need of services, improve service delivery and coordination, and/or address disparities across racial and ethnic groups
- [x] Improvement of community capacity to provide MH and SUD services to people involved in the criminal justice system, including those related to medications for opioid use disorder
- [x] Supporting the ability of law enforcement to respond to people experiencing mental illness or SUD (e.g. Crisis Intervention Teams, co-responder models, and coordinated police/emergency drop-off)
- [x] Partnering with other state agencies and localities to improve screening and assessment for MH and SUD and standards of care for these illnesses for people in jails and prisons;
- [x] Supporting coordination across community-based care and care in jails and prisons, particularly upon reentry into the community
- [x] Building crisis systems that engage people experiencing a MH or SUD related crisis in MH or SUD care instead of involvement with law enforcement and criminal justice (including coordination of 911 and 988 systems)
- [x] Creating pathways for diversion from criminal justice to MH and SUD services throughout the criminal justice system (before arrest, booking, jails, the courts, at reentry, and through community corrections)
- [x] Coordination with juvenile court systems and development of programs to improve outcomes for children and youth involved in the juvenile justice system
- [x] Developing interventions during vulnerable periods, such as reentry to the community from jail or prison, to ensure that MH, SUD, and other needs are met
- [x] Addressing other barriers to recovery for people with M/SUD involved in the criminal justice system, such as health insurance enrollment, SSI/SSDI enrollment, homelessness and housing insecurity, and employment challenges
- [x] Partnering with the judicial system to engage in cross-system planning and development at the state and local levels
- [x] Providing education and support for judges and judicial staff related to navigating the mental health and substance use service system
- [x] Supporting court-based programs, including specialty courts and diversion programs that serve people with M/SUD
- [x] Addressing Competence to Stand Trial; assessments and restoration activities.

2. Does the state have any specific activities related to reducing disparities in service receipt and outcomes across racial and ethnic groups for individuals with M/SUD who are involved in the criminal justice system? If so, please describe.

○ Yes ◉ No

3. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address M/SUD and other essential domains such as employment, education, and finances?

◉ Yes ○ No

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

Effective 9/1/23, due to the growth of several initiatives authorized by the 88th Texas Legislature, additional staffing support will be made available to HHSC's Forensic and Jail Diversion Services team within the Mental Health and Substance Use Programs area of HHSC Behavioral Health Services.

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

N/A

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14. Medications in the Treatment of Substance Use Disorders, Including Medication for Opioid Use Disorder (MOUD) – Requested (SUPTRS BG only)

Narrative Question

In line with the goals of the Overdose Prevention Strategy and SAMHSA's priority on Preventing Overdose, SAMHSA strongly request that information related to medications in the treatment of substance use disorders be included in the application.

There is a voluminous literature on the efficacy of the combination of medications for addiction treatment and other interventions and therapies to treat substance use disorders, particularly opioid, alcohol, and tobacco use disorders. This is particularly the case for medications used in the treatment of opioid use disorder, also increasingly known as Medications for Opioid Use Disorder (MOUD). The combination of medications such as MOUD; counseling; other behavioral therapies including contingency management; and social support services, provided in individualized, tailored ways, has helped countless number of individuals achieve and sustain remission and recovery from their substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based, or non-medication inclusive, treatment for these conditions. The evidence base for medications as standards of care for SUDs is described in SAMHSA TIP 49 Incorporating Alcohol Pharmacotherapies Into Medical Practice and TIP 63 Medications for Opioid Use Disorders.

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to offer MOUD and medications for alcohol use disorder or have collaborative relationships with other providers that can provide all FDA-approved medications for opioid and alcohol use disorder and other clinically needed services.

Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs. States should use Block Grant funds for the spectrum of evidence-based interventions for opioids and stimulants including medications for opioids use disorders and contingency management.

In addition, SAMHSA also encourages states to require equitable access to and implementation of medications for opioid use disorder (MOUD), alcohol use disorder (MAUD) and tobacco use disorders within their systems of care.

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

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding the use of medications for substance use disorders? ○ Yes ○ No

2. Has the state implemented a plan to educate and raise awareness of the use of medications for substance disorder, including MOUD, within special target audiences, particularly pregnant women? ○ Yes ○ No

3. Does the state purchase any of the following medication with block grant funds?

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

4. Does the state have an implemented education or quality assurance program to assure that evidence-based treatment with the use of FDA-approved medications for treatment of substance use disorders is combined with other therapies and services based on individualized assessments and needs? ○ Yes ○ No

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

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15. Crisis Services – Required for MHBG, Requested for SUPTRS BG

Narrative Question

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. The statutory language outlines the following for the 5 percent set-aside:

> *....to support evidenced-based programs that address the crisis care needs of individuals with serious mental illnesses and children with serious emotional disturbances, which may include individuals (including children and adolescents) experiencing mental health crises demonstrating serious mental illness or serious emotional disturbance, as applicable.*
>
> *CORE ELEMENTS: At the discretion of the single State agency responsible for the administration of the program, the funds may be used to expend some or all of the core crisis care service components, as applicable and appropriate, including the following:*
>
> - *Crisis call centers*
> - *24/7 mobile crisis services*
> - *Crisis stabilization programs offering acute care or subacute care in a hospital or appropriately licensed facility, as determined by such State, with referrals to inpatient or outpatient care.*
>
> *STATE FLEXIBILITY: In lieu of expanding 5 percent of the amount the State receives pursuant to this section for a fiscal year to support evidence based programs as required a State may elect to expend not less than 10 percent of such amount to support such programs by the end of two consecutive fiscal years.*

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. Given the multi-system involvement of many individuals with M/SUD issues, the crisis system approach provides the infrastructure to improve care coordination, stabilization service to support reducing distress, promoting skill development and outcomes, manage costs, and better invest resources.

SAMHSA developed **Crisis Services: Meeting Needs, Saving Lives**, which includes "**National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit**" as well as an **Advisory: Peer Support Services in Crisis Care** and other related National Association of State Mental Health Programs Directors (NASMHPD) papers on crisis services. SAMHSA also developed "**National Guidelines for Child and Youth Behavioral Health Crisis Care**" which offers best practicies, implementation strategies, and practical guidance for the design and development of services that meet the needs of children, youth and their families experiencing a behavioral health crisis. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are swiftly identified and are engaged in the core crisis care elements.

1. Briefly narrate your state's crisis system. For all regions/areas of your state, include a description of access to the crisis call centers, availability of mobile crisis and behavioral health first responder services, utilization of crsis receiving and stabilization centers.

HHSC serves people experiencing a mental health crisis on a continuum of care based on assessment and need in the least restrictive environment located within their community. HHSC funds crisis services for people of any age, regardless of insurance. These services are available 24 hours/7 days a week (24/7) and include prompt face-to-face crisis assessment, crisis intervention services, and crisis follow-up and relapse prevention services.
• The Crisis Hotline is a 24/7 telephone service operated by trained crisis staff providing crisis screening and assessment, crisis intervention services, mental health and substance use referrals, and general mental health and substance use information to

2. In accordance with the guidelines below, identify the stages where the existing/proposed system will fit in.

*a) The **Exploration** stage: is the stage when states identify their communities' needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.*
*b) The **Installation** stage: occurs once the state comes up with a plan and the state begins making the changes necessary to implement the crisis services based on the SAMHSA guidance. This includes coordination, training and community outreach and education activities.*
*c) **Initial Implementation** stage: occurs when the state has the three-core crisis services implemented and agencies begin to put into practice the SAMHSA*

guidelines.

*d) **Full Implementation** stage: occurs once staffing is complete, services are provided, and funding streams are in place.*

*e) **Program Sustainability** stage: occurs when full implementation has been achieved, and quality assurance mechanisms are in place to assess the effectiveness and quality of the crisis services.*

Other program implementation data that characterizes crisis services system development.

1. Someone to talk to: Crisis Call Capacity

- *a. Number of locally based crisis call Centers in state*
  - *i. In the 988 Suicide and Crisis lifeline network*
  - *ii. Not in the suicide lifeline network*
- *b. Number of Crisis Call Centers with follow up protocols in place*
- *c. Percent of 911 calls that are coded as BH related*

2. Someone to respond: Number of communities that have mobile behavioral health crisis mobile capacity (in comparison to the toal number of communities)

- *a. Independent of first responder structures (police, paramedic, fire)*
- *b. Integrated with first responder structures (police, paramedic, fire)*
- *c. Number that employs peers*

3. Safe place to go or to be:

- *a. Number of Emergency Departments*
- *b. Number of Emergency Departments that operate a specialized behavioral health component*
- *c. Number of Crisis Receiving and Stabilization Centers (short term, 23-hour units that can diagnose and stabilize individuals in crisis)*

a. Check one box for each row indicating state's stage of implementation

	Exploration Planning	Installation	Early Implementation Less than 25% of counties	Partial Implementation About 50% of counties	Majority Implementation At least 75% of counties	Program Sustainment
Someone to talk to	☐	☐	☐	☐	☑	☐
Someone to respond	☐	☐	☐	☐	☐	☑
Safe place to go or to be	☐	☐	☐	☐	☑	☐

b. Briefly explain your stages of implementation selections here.

Someone to talk to: HHSC-funded Lifeline centers continue to build upon the workforce in order to respond to the volume of Lifeline contacts initiated in Texas.
Someone to respond: HHSC continues to sustain MCOT services since originally allocated in 2008.
Place to go: While HHSC continues to sustain crisis facilities since originally allocated and expanded upon in the last 14 years, crisis facilities have challenges with hiring and retaining staff which has been exacerbated recently due to the COVID-19 pandemic. Most HHSC-funded crisis facilities remain open, but have had temporary closures due to staffing constraints. A few have permanently closed

3. Based on SAMHSA's National Guidelines for Behavioral Health Crisis Care, explain how the state will develop the crisis system.

HHSC's crisis system is developed, but HHSC will continue to make improvements to standards to align with national guidelines.

4. Briefly describe the proposed/planned activities utilizing the 5 percent set aside.

The five percent set aside will be used to expand existing services.

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

None at this time.

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

None at this time.

Footnotes:

Environmental Factors and Plan

16. Recovery - Required

Narrative Question

Recovery supports and services are essential for providing and maintaining comprehensive, quality M/SUD care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals. Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders.

Recovery is supported through the key components of: health (access to quality health and M/SUD treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery- guided the approach to person-centered care that is inclusive of shared decision-making, culturally welcoming and sensitive to social determinants of health. The continuum of care for these conditions involves psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder, and services to reduce risk related to them. Because mental and substance use disorders can become chronic relapsing conditions, long term systems and services are necessary to facilitate the initiation, stabilization, and management recovery and personal success over the lifespan.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

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

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.**

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Technical assistance and training on a variety of such services are available through the SAMHSA supported Technical Assistance and Training Centers in each region. SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a)	Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care?	(•) Yes ( ) No
b)	Required peer accreditation or certification?	(•) Yes ( ) No
c)	Use Block grant funding of recovery support services?	(•) Yes ( ) No
d)	Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?	(•) Yes ( ) No

2. Does the state measure the impact of your consumer and recovery community outreach activity? (•) Yes ( ) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Through consumer-informed, evidence- and research-based development and implementation of policy and programs, the state strives to support a variety of recovery-based services. HHSC is dedicated to the ongoing implementation of person-centered recovery planning as the foundation for providing recovery support services. Recovery support services may include:
• Evidence-based treatment options such as Cognitive Behavioral Therapy, Seeking Safety, Nurturing Parenting, Cognitive Processing Therapy, and Parent-Child Interaction Therapy;
• Certified Mental Health Peer Specialist Services;
• Certified Family Partners services;
• Certified Recovery Support Specialists; and
• Appropriate referral and community options, such as access to consumer operated service organizations, recovery community organizations, and recovery Clubhouses.

The state supports the use of recovery focused person-centered recovery planning, self-direction, and participant-directed care through several initiatives. Person-centered recovery planning is a fundamental component of the Texas Recovery and Resiliency service delivery system. By placing an individual or family in the driver's seat of recovery, strengths and natural supports are identified to support recovery. Formal supports such as evidence-based practices in treatment, housing, and employment offer the professional assistance a person may require to become, or remain, independent.

Certified mental health and recovery services peer support and certified family partners are available to provide people and their families support from the perspective of someone who has been in a similar situation and who can help guide the person and their family towards their recovery goals. All peer services are recovery-oriented, person-centered, relationship-focused, and trauma-informed.

Peer- driven activities may include: recovery and wellness support, which includes providing information on and support with planning for recovery; mentoring (serving as a recovery role model); assistance in finding needed community resources and services; advocacy, which includes providing support in stressful or urgent situations; making sure the individuals' rights are respected; and other daily activities that are sometimes complicated when an individual is also experiencing severe mental illness or several emotional disturbances. 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 LMHAs and LBHAs. These entities provide a broad range of peer support and recovery services to people seeking assistance for mental health challenges. There are nine COSP programs in the state. 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. Members are also encouraged to participate in activities to promote outside employment, education, meaningful relationships, housing, and an overall improved quality of life. There are six HHSC-contracted Clubhouses.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state. i.e., RCOs, RCCs, peer-run organizations

The substance use delivery system recognizes that treatment and recovery supports must be intertwined within an integrated system transformation designed to address the needs of the whole person. Recovery Support Services (RSS) are evidence-based services designed to increase long-term recovery and quality of life to people with substance use disorders. Services are provided by certified peer specialists who have lived experience with recovery from substance use disorders and use a wide array of non-clinical services and supports to help people initiate, support and maintain long-term recovery from substance use disorders.

HHSC currently funds 24 RSS providers (treatment, community, and standalone peer-run organizations) responsible for integrating recovery support services throughout their local system of care, strengthening the alignment of treatment services with a recovery-oriented approach while expanding community supports available to assist individuals in successfully integrating into their communities.

Youth Recovery Communities (YRCs) provide recovery support services to youth and young adults ages 13-21 years who may have a substance use disorder or want a substance-free environment. The YRCs support youth, 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 that support efforts to initiate and sustain the recovery of young people and their families. HHSC currently funds 11 contracts.

HHSC values stakeholder input and recognizes people in the field understand their needs. To that end, HHS facilitates monthly Peer and Recovery Statewide stakeholder group information calls, monthly calls for each program (community re-entry, RSS, YRC, Clubhouse, COSP), participates in the Behavioral Health Advisory Committee and Peer and Family Partner Sub-committees.

Texas has developed multiple avenues beyond traditional contracts to create a recovery network that assists in identifying recovery strengths and gaps statewide. HHSC implemented a non-funded statewide Recovery-Oriented System of Care (ROSC) initiative to help ensure individuals affected by substance use and mental health disorders are provided a continuum of care that continuously promotes a path to recovery. HHSC assists communities across the state with initiating and understanding the ROSC concept in their local area by conducting onsite informational trainings; providing ongoing technical assistance to the local communities; and participating in individual and local ROSC community meetings. HHSC facilitates monthly calls to strengthen ROSC communities. HHSC also funds statewide recovery rallies every September. HHSC has historically supported one rally in a metropolitan area, but based upon stakeholder feedback, in fiscal year 2023 HHS piloted the support of five rallies across the state, thus reducing travel costs and building support for recovery locally. This approach was highly successful and in fiscal year 2024 HHSC will support ten rallies across the state. Further, HHSC developed The Leadership Fellows Academy a cohort-based learning collaborative that focuses on developing individual and organizational leadership within mental health and substance use recovery organizations. The purpose of the program is to provide executive leadership with the skills and knowledge base they need to build the business health and sustainability of their organizations.

5. Does the state have any activities that it would like to highlight?

• Implementation of the Rural Mental Health Learning Community – six organizations received training and technical assistance in a collaborative environment to enhance the integration of peer specialists and family partners and increase and improve the delivery of recovery support services.
• Expansion of the Statewide Recovery Rally from one to ten rallies across Texas.
• Curriculum revisions to update materials and increase the effectiveness of new peer specialists;
• Implementation of a train the trainer curriculum for training entities;
• Implementation of PeerForce, a centralized hub to assist prospective peers and family partners connect with training, certification and potential employees https://peerforce.org/ . PeerfForce was cited as a best practice by SMI Advisor.
• Increase in the number of peer specialists certified between July 2022 and July 2023:
- RSPS from 628 to 806
- MHPS: from 592 to 727
- MHPS-Intern: from 2 to 3
- PSS from 264 to 300
- Training Entities: from 26 to 36
- Certified Family Partners: from 91 to 135

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

None at this time.

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17. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with M/SUD conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with M/SUD needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Does the state's Olmstead plan include:

Housing services provided	○ Yes	○ No
Home and community-based services	○ Yes	○ No
Peer support services	○ Yes	○ No
Employment services.	○ Yes	○ No

2. Does the state have a plan to transition individuals from hospital to community settings? ○ Yes ○ No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

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

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18. Children and Adolescents M/SUD Services –Required for MHBG, Requested for SUPTRS BG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.[1]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[2]. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.[3].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[4].

Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs.[5].

According to data from the 2017 Report to Congress[6] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system.
2. improve emotional and behavioral outcomes for children and youth.
3. enhance family outcomes, such as decreased caregiver stress.
4. decrease suicidal ideation and gestures.
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious M/SUD needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and

employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[1]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[2]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593-602.

[3]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[4]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

[5]Department of Mental Health Services. (2011) The Comprehensive Community Mental Health Services for Children and Their Families Program: Evaluation Findings. Annual Report to Congress. Available from **https://store.samhsa.gov/product/Comprehensive-Community-Mental-Health-Services-for-Children-and-Their-Families-Program-Evaluation-Findings-Executive-Summary/PEP12-CMHI0608SUM**

[6] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery of children and youth with SED? (●) Yes ( ) No

b) The resilience of children and youth with SED? (●) Yes ( ) No

c) The recovery of children and youth with SUD? (●) Yes ( ) No

d) The resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address M/SUD needs:

a) Child welfare? (●) Yes ( ) No

b) Health care? (●) Yes ( ) No

c) Juvenile justice? (●) Yes ( ) No

d) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? (●) Yes ( ) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult M/SUD system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

c) Is the child serving system connected with the FEP and Clinical High Risk for Psychosis (CHRP) systems? (●) Yes ( ) No

d) Does the state have an established FEP program? (●) Yes ( ) No

Does the state have an established CHRP program? (●) Yes ( ) No

e) Is the state providing trauma informed care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

The Texas system of care model in use is a spectrum of effective community-based services and supports for children, youth, and young adults with or at risk for mental health and related challenges and their families that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs in order to

help them function better at home, in school, in the community, and throughout life. HHSC also supports collaborative and multi-system planning for youth across all domains to ensure the most appropriate evidence-based care is provided.

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

NA

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

NA

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19. Suicide Prevention - Required for MHBG

Narrative Question

Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following:

1. Have you updated your state's suicide prevention plan in the last 2 years? (●) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

In an ongoing effort to build on National Strategy for Suicide Prevention (NSSP) recommendations, the state goals were aligned with the NSSP goals and strategic direction. These goals were then further broken out into strategies to serve as a "road map" for stakeholders, suicide prevention workers, mental health, education, military, veteran groups, agencies serving people with mental illness, behavioral health agencies, counselors, media, higher education, and local suicide prevention coalitions across the state with links to resources and specific strategies to accomplish the goals. The areas of strategic direction include: 1) Healthy and Empowered Individuals, Families, and Communities; 2) Clinical and Community Preventive Services; 3) Treatment and Support Services; and 4) Surveillance, Research, and Evaluation. This strategic direction translated into the following activities intended to reduce the incidents of suicide in Texas:

Healthy and Empowered Individuals, Families, and Communities

• The Suicide Care Initiative created two distinct projects to improve and expand on the suicide safer care practices occurring through local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) across the state. Four LMHAs were chosen to oversee the development, implementation, and evaluation of both projects].. Together, they have been identified as Regional Suicide Care Support Centers (RSCSCs). The first project focuses on the RSCSCs serving as regional suicide care workforce development and technical assistance (TA) hubs for the LMHAs and LBHAs in their specified region by providing evidence-based suicide specific instructor trainings as well as TA via webinars and learning collaborative conference calls to support the continued implementation of the Zero Suicide framework. The second project focuses on the improvement and enhancement of the Zero Suicide framework and its practices within the four RSCSCs. T

• In addition to providing critical support to empower and sustain healthy communities through the aforementioned efforts, HHSC provides consultation and support to local suicide prevention coalitions and educational service centers across the state, as well as development, coordination, and participation in several suicide prevention-specific initiatives for service members, veterans, and their families (SMVF). There are collaborative efforts with SAMHSA, the Department of Defense, and the Veterans Administration, along with HHSC as the lead in mental health and suicide prevention programs at the Mayoral and Governor's Challenges to end Veterans Suicide, as well as all of the workgroups springing from these initiatives. There is further collaboration around implementation of Texas legislation that supports a plan for suicide prevention in the SMVF population. Ongoing coordination of local suicide prevention coordinators/programs and suicide coalitions with faith groups and peer groups as protective factors is another priority and service coordinated through HHSC.

• HHSC collaborates with the Texas Suicide Prevention Council (TxSPC) to advance community-based suicide prevention programs. As the conduit linking statewide community-based prevention through its 38 local coalitions, as well as other non-profit and public sector agencies interested in suicide prevention, TxSPC is a vital partner for statewide comprehensive suicide prevention infrastructure.

Clinical and Community Preventive Services

• In September 2019, Vibrant Emotional Health (Vibrant) awarded HHSC a two-year grant of over $3 million for the National Suicide Prevention Lifeline's State Capacity Building Initiative. With this grant, HHSC contracted with four LMHAs to increase the state's capacity to provide free and confidential emotional support and services to people calling the National Suicide Prevention Lifeline (NSPL).

• In February 2021, Vibrant awarded HHSC a nine-month 988 Planning Grant award of $180,261.63. The grant's goal was to develop clear roadmaps for how Texas will address key coordination, capacity, funding, and communication strategies foundational to the launching of 988 and plan for the long-term improvement of in-state answer rates for 988 calls. Through this grant, HHSC's Behavioral Health Services, Crisis Services Unit, formed a 988 Stakeholder Coalition to assist in identifying key planning considerations pertaining to 988 Implementation in Texas. The 988 Stakeholder Coalition met monthly to discuss these topics and inform the final implementation plan, submitted in December 2021.

• SAMHSA awarded HHSC approximately $10 million over two years through the 988 State and Territory Cooperative Agreements Grant in April 2022 and the 988 State and Territory Supplemental Award in December 2022. The purpose of this funding is to improve state response to 988 contacts (including calls, chats, and texts) originating in Texas by:

o 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;
o Engaging NSPL centers to unify 988 responses across states and territories; and
o Expanding the crisis center staffing and response structure needed for the successful implementation of 988.
HHSC has utilized this funding to support workforce capacity building and the unification of 988 responses statewide.
• HHSC worked with the Governor and his office in the Governor's Challenge to Prevent Suicide among SMVF to develop and implement the National Strategy for Preventing Veteran Suicide. Additionally, HHSC has been instrumental in the Mayor's Challenge to Prevent Suicide among SMVF occurring in Austin and Houston, Texas.
• The Suicide Safer Schools project has created a state-of-the-art toolkit for Texas Schools (K-12) applying the best practices for suicide prevention while integrating Texas laws and resources. Early data show excellent results and improvements for student and school safety. In June 2021, the Suicide Safer Schools workshop was presented to several school districts in the Hurricane Harvey affected region, including Santa Fe Independent School District.
• HHSC is working to ensure Military Veteran Peer Specialists are connected with the Zero Suicide Teams at LMHAs and coordinating with the Military Veteran Peer Network to provide suicide prevention trainings for all Military Veterans Peer Specialists.
• HHSC will continue to engage with the community stakeholder groups to provide suicide prevention evidence-based trainings and information for the Texas Veterans and Families Alliance programs that support veterans and their families in Texas.
• The Texas Targeted Opioid Response program (funded by other SAMHSA grants) enables HHSC to expand prevention and treatment efforts that promote recovery and early intervention for populations identified as high risk for opioid use disorders (OUD). A critical issue among persons with OUD is the high correlation between OUD and suicide. The goal of this contract is to train OUD treatment providers and recovery support staff in suicide prevention training such as AS+K About Suicide to Save a Life and Applied Suicide Intervention Skills Training.
• HHSC also worked with the Texas Education Agency (TEA) after TEA was awarded SAMHSA's AWARE grant to develop and enhance the utilization of best practices that effectively address mental health challenges in schools.
Surveillance, Research, and Evaluation
• HHSC is strengthening its ability to analyze and synthesize suicide prevention data. Targeted in-house data analysis will continuously inform HHSC's next steps in administering current programs and future initiatives involving suicide prevention efforts. HHSC's Behavioral Health Services (BHS) Section hired a full-time epidemiologist with an extensive background in suicide prevention and health data analysis. HHSC utilizes the following data sources for analysis and informing the direction of suicide prevention programs:
o Hospital discharge data;
o Hospital emergency room data
o Mortality data;
o Behavioral Risk Factor Surveillance System data;
o Texas Poison Control Network;
o Electronic Surveillance System for the Early Notification of Community-based Epidemics;
o Youth Risk Behavior Survey data; and
o Veterans Administration data.
• Through the work of the epidemiologist, the suicide prevention program can assist localities with ensuring a more data driven approach to community-level suicide prevention and state level programs. The epidemiologist completes analysis of Department of State Health Services (DSHS) datasets and will coordinate with DSHS on the National Violent Death Reporting System data once it becomes available.
• House Bill 3980, 86th Legislature, Regular Session, 2019 established suicide as a public health crisis and required the development of a legislative report. HHSC and the Statewide Behavioral Health Coordinating Council implemented House Bill (H.B.) 3980. The report provided policy makers with a better understanding of the prevalence of suicide rates, regional needs, and populations at high risk for suicide to determine the appropriate efforts necessary to decrease suicide rates in Texas. The report addressed the impact of state laws, policies, programs, and efforts that are currently being utilized to address suicide, underscoring the need for a more strategic and comprehensive approach. H.B 3980 was implemented in two phases: a summary report and a legislative report. Senate Bill 1, 87th Legislature, Regular Session 2021, and Senate Bill 1, 88th Legislature, Regular Session 2023 required an update to report required by H.B. 3980.
• HHSC is in the fifth year of a five-year grant of over $3 million from SAMHSA, short title, the Garrett Lee Smith State/Tribal Youth Suicide Prevention and Early Intervention Grant Program. The grant, entitled Resilient Youth – Safer Environments will create comprehensive Suicide Safer Early Intervention and Prevention (SSIP) systems aimed to support youth-serving organizations, including Texas schools, mental health programs, educational institutions, juvenile justice systems, substance abuse programs, and foster care systems. The target population, youth 10 to 24 years old at elevated risk of suicide and suicide attempts, will receive enhanced services through best practice trainings, improved suicide care in clinical early intervention, and effective programming and treatment services. With increased capacity to serve and recognize youth at risk, and enhanced infrastructure for strategy implementation, these SSIP systems will produce robust clinical and community services with collaborative networks to promote youth resiliency, recovery, and safety. Galveston County (GC) has been above the national average rate of suicide for the target population for several years. Additionally, GC residents experienced the devastation of Hurricane Harvey in August 2017 and the Santa Fe school shooting in May 2018. Therefore, activities will begin with youth, 10 to 24 years old, living in Galveston County, and specifically in Santa Fe, attending schools in the Santa Fe Independent School District (ISD).
• The goals of the grant are to: (1) improve SSIP systems with development of a Suicide Prevention Community Collaborative to support community planning, workforce development and oversight; (2) increase early identification and referral of youth ages 10 to 24 years at risk of suicide; (3) provide evidence-based interventions to enhance protective factors, promote mental health and reduce suicide risk; and (4) enhance postvention strategies to reduce risk following exposure to suicide attempts or deaths in the community. Collaboration with the LMHA, Gulf Coast Center, and Educational Service Center Region 4 that serves Galveston County will be strengthened by hiring additional subject matter experts to work for these agencies with students, their families,

and staff of Santa Fe ISD.

• Part of the suicide prevention efforts include collaboration. The use of data gathered by the Injury Prevention Department at DSHS shows trends and patterns in youth violent deaths and identifies communities to target for additional education and prevention efforts. HHSC uses the Youth Risk Behavior Surveillance reported data to investigate other risky youth behaviors that impact injury data for self-harm, such as overdose and motor vehicle accidents. Overall, the data shows a need for the collaboration of professionals working in prevention, intervention, epidemiology, research, data analysis, and program development towards the advancement of violence prevention.

• In addition to this data, HHSC engages with the Child Fatality Review Teams (CFRTs) to provide education and training to CFRTs about suicide prevention and postvention services available through the LMHAs.

• Surveillance efforts are critical to understanding the challenges and resources communities may have. Surveillance in Texas has included tracking real-time death data in communities with medical examiners, tracking youth suicide attempt data using the Texas Youth Risk Behavior Survey Data, and tracking adult suicide attempt and morbidity data using the Behavior Risk Factor Surveillance Survey. In addition, Texas has begun tracking the number of people dying by suicide within the public mental health system and cross-walking that data with Texas Vital Statistics Data to examine prevalence of people dying in the public mental health system by suicide deaths.

• DSHS was awarded the National Violent Death Registry grant from the Centers for Disease Control (CDC) in 2018 and has begun infrastructure building. HHSC's suicide prevention team is collaborating with DSHS.

• The HHSC Suicide Prevention team participated in focus group and workgroup with the CDC to advance the understanding of the states by conducting an environmental scan of suicide prevention in state activities. Texas's experience and HHSC's implementation of suicide prevention was useful in the study for the year, culminating in a joint presentation for a conference.

3. Have you incorporated any strategies supportive of Zero Suicide? (●) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (●) Yes ( ) No

If yes, please describe how barriers are eliminated.

The Suicide Care Initiative focuses on the implementation of the seven tenets of the Zero Suicide framework into the LMHAs and LBHAs in Texas. One of the tenets is Transition. HHSC provides TA regarding best practices in care transitions from emergency departments, inpatient hospitalizations, and between levels of care in outpatient settings. LMHAs and LBHAs are encouraged to using caring contacts in between appointments.

5. Have you begun any prioritized or statewide initiatives since the FFY 2022 - 2023 plan was submitted? (●) Yes ( ) No

If so, please describe the population of focus?

The State Suicide Prevention Team has increased training opportunities in evidence-based trainings for higher education and other state agency partners to include AS+K About Suicide to Save a Life, Applied Suicide Intervention Skills Training, and Safety Planning Intervention.

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

None at this time.

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20. Support of State Partners - Required for MHBG

Narrative Question

The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations.
- The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults.
- The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions.
- Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities.
- SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with their integration efforts. The collaborations will be critical among M/SUD entities and comprehensive primary care provider organizations, such as maternal and child health clinics, community health centers, Ryan White HIV/AIDS CARE Act providers, and rural health organizations. SMHAs and SSAs can assist SMAs with identifying principles, safeguards, and enhancements that will ensure that this integration supports key recovery principles and activities such as person-centered planning and self-direction. Specialty, emergency and rehabilitative care services, and systems addressing chronic health conditions such as diabetes or heart disease, long-term or post-acute care, and hospital emergency department care will see numerous M/SUD issues among the persons served. SMHAs and SSAs should be collaborating to educate, consult, and serve patients, practitioners, and families seen in these systems. The full integration of community prevention activities is equally important. Other public health issues are impacted by M/SUD issues and vice versa. States should assure that the M/SUD system is actively engaged in these public health efforts.
- SAMHSA seeks to enhance the abilities of SMHAs and SSAs to be full partners in implementing and enforcing MHPAEA and delivery of health system improvement in their states. In many respects, successful implementation is dependent on leadership and collaboration among multiple stakeholders. The relationships among the SMHAs, SSAs, and the state Medicaid directors, state housing authorities, insurance commissioners, prevention agencies, child-serving agencies, education authorities, justice authorities, public health authorities, and HIT authorities are integral to the effective and efficient delivery of services. These collaborations will be particularly important in the areas of Medicaid, data and information management and technology, professional licensing and credentialing, consumer protection, and workforce development.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (●) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? (●) Yes ( ) No

If yes, with whom?

Children's Mental Health:

New partnerships within Children's Mental Health have been developed with various entities regarding the training, intervention, and prevention of suicide. These new partnerships include:

* Emergency Rooms and Community Hospitals – Coordination of community hospitals with local and state entities to ensure delivery and screening for suicide prevention, trauma informed care, and substance abuse prevention and treatment services.
* Coroners and Medical Examiners – training regarding the ICD-10 coding related to deaths caused by suicide, drug overdose, and self-inflicted injury.
* Police Officers and Emergency Responders – working to provide training and use of evidence-based screening tools and interventions for suicide prevention and substance use for youth and families; Training partnerships between LMHAs/LBHAs,

HHSC, and law enforcement agencies on Mental Health First Aid for law enforcement.
* Pharmacies – coordination with several state agencies to increase awareness, education, and interventions for drug use and suicide services.
* Schools - coordination with LMHAs/LBHAs and school entities to enhance youth suicide prevention and intervention training and best practices. Additionally, coordination with state agencies working with school personnel to ensure children's mental health and suicide prevention practices are woven into school-based mental health programs and prevention services.

After the passage of new legislation in the 86th Legislature (2019), the Texas Education Agency (TEA) and HHSC have collaborated to improve the mental health of school-aged children in the following ways:

* annually developing a list of best practices in school-mental health for educators;
* developing a statewide mental health resource document for schools;
* partnering to develop a toolkit for educators on how to implement a comprehensive school-mental health system;
* providing guidance to 20 LMHA/LBHAs and their regional Education Service Center(ESC) in implementing House Bill 19, 86 (R) that provides for a full-time Non-Physician Mental Health Professional (NPMHP) hired by the LMHA/LBHA who offices in the ESC. The NPMHP serves as a mental health and substance use and misuse prevention resource person to the school communities in the ESC catchment area.
* participating in the school legislation coordination workgroup to streamline efforts in implementing multiple bills impacting schools.

Additionally, TEA and HHSC are working together on a grant to support schools in implementing a comprehensive mental health system, including providing training on social emotional learning, trauma-informed care, suicide prevention, and mental health first aid. This is done in collaboration with the regional educational service centers and LMHAs.

Texas Juvenile Mental Health and Intellectual Disabilities Law Bench Book: HHSC works with The Judicial Commission on Mental Health (JCMH) to identify areas of training education, service awareness, resource distribution, and pilot programs for innovative ideas. This partnership, including HHSC's Crisis Services, Forensic and Jail Diversion Services, Adult Mental Health, Children's Mental Health, and the Forensic Policy Office, partnered with JCMH to develop the Texas Juvenile Mental Health and Intellectual and Developmental Disabilities Law Bench Book.

This Bench Book's first edition covers 2020-2021. Currently, the second edition is being edited. These documents provide guidance to personnel of the judiciary system, community mental health providers, law enforcement agents, and others who work with youth with mental health and intellectual and developmental disabilities. The goal of the book is to increase awareness of Texas laws and services and assist each youth's support system in making appropriate, person-centered decisions that may divert children and adolescents from entering the juvenile justice system.

Partnership with Texas Juvenile Justice Department:
Forensic and Jail Diversion Services and Children's Mental Health (CMH) of HHSC have begun meeting regularly with the Texas Juvenile Justice Department to identify areas of collaboration and service improvement for justice-involved juveniles in need of mental health services. CMH has established a formal process for TJJD to submit staffing requests for support with youth who are transitioning back into their communities and need access to services. CMH is specifically focusing on children who have acute needs for which they require referral to higher levels of service through the LMHA/LBHA and who do not need to go through Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI). During the staffing process, HHSC/CMH and TJJD reach out to the CMH director assigned at the LMHA and include the probation department on the email.

HHSC CMH leadership has also identified a need for a Memorandum of Understanding (MOU) to facilitate an exchange of confidential information between the Texas Correctional Office on Offenders with Medical or Mental Impairments (TCOOMMI) and Health and Human Services (HHSC). At this time, there is no direct way of getting reports on TJJD clients for LMHAs through CMBHS or any other tool. The purpose of the proposed MOU will be to enhance interagency collaboration and cooperation by protecting information and enabling parties to exchange confidential and sensitive information to effectuate their respective powers and duties.

More specifically, the MOU will facilitate the goal of identifying people who are justice-involved and have mental health and/or intellectual disabilities in order to connect them with local, post-booking jail diversion programs and services. Benefits of this collaboration include:

* Supporting juvenile clients as they transition back into the community
* Reducing the amount of time spent among providers and jail staff
* Increasing the reliability and usability of the data available at the state-level
* Reducing the amount of time spent by providers to locate their juvenile client's information
* Enhancing communication between BHSO and LMHAs

Forensic and Jail Diversion Services has partnered with the Texas Commission on Jail Standards to streamline and facilitate improved identification of individuals with mental health issues booked into county jails. This partnership allows for increased jail

diversion and community based mental health services.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilities Education Act.

Foster new and strengthen existing partnerships through exemplary customer and public service, transparency, and integrity to build public trust. Ongoing collaboration across agencies and systems will ensure the capability and capacity of our partners to respond to evolving local, regional, and statewide needs. Collaboration and coordination will use data and evidence-driven policy to drive program decisions.

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

NA

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Environmental Factors and Plan

21. State Planning/Advisory Council and Input on the Mental Health/Substance use disorder Block Grant Application- Required for MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council to carry out the statutory functions as described in 42 U.S. C. 300x-3 for adults with SMI and children with SED. To meet the needs of states that are integrating services supported by MHBG and SUPTRS BG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as an Advisory/Planning Council (PC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a PC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[1]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with M/SUD problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[1] **https://www.samhsa.gov/grants/block-grants/resources [samhsa.gov]**

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

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc.)

The Behavioral Health Advisory Committee (BHAC) receives information and presentations throughout the year regarding behavioral health in the state, as well as current or planned programs, services, and initiatives. BHAC members review and provide input and feedback on the services, policies, and rules that inform the development of the block grant plan. BHAC members provide suggestions in the form of recommendations, which the Health and Human Services Commission (HHSC) incorporates where feasible.

2. What mechanism does the state use to plan and implement community mental health treatment, substance misuse prevention, SUD treatment, and recovery support services?

HHSC collaborates with various internal and external stakeholders to plan and implement community mental health treatment; substance use prevention, treatment, and intervention services; and peer and recovery support services as directed by the Texas Legislature and in accordance with applicable federal grant requirements.

HHSC offers external stakeholders, such as contracted providers, provider and advocacy organizations, the BHAC, and the Statewide Behavioral Health Coordinating Council, the opportunity to provide input on HHSC's behavioral health programs and services funded by block grant, competitive grants, general revenue, and Medicaid. These opportunities occur via routine and ad hoc meetings and informal and formal solicitation of comments on rulemaking.

HHSC contracts with over 700 providers, including local mental health authorities, local behavioral health authorities, substance use providers, prevention providers, and peer recovery support services providers, to implement behavioral health services for new or expanded programs to serve Texans. These formal contracts reflect the expectations for service provision across the state, based upon the input provided and alignment with current evidence-based and emerging practices.

3. Has the Council successfully integrated substance misuse prevention and SUD treatment and recovery or co-occurring disorder issues, concerns, and activities into its work? (●) Yes ( ) No

4. Is the membership representative of the service area population (e.g. ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)? (●) Yes ( ) No

5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

BHAC provides customer, consumer, and stakeholder input to the Health and Human Services (HHS) system in the form of recommendations regarding the allocation and adequacy of behavioral health services and programs within the State of Texas. In accordance with federal requirements, the BHAC's duties include:

1. Reviewing the MHBG and SUPTRS BG Plan making recommendations;
2. Serving as advocates for adults with a SMI, children/adolescents with an SED, and other persons with mental illnesses or emotional problems; and
3. Monitoring, reviewing, and evaluating at least once each year the allocation and adequacy of mental health services within the state.

The BHAC also may make recommendations to HHS system agencies regarding behavioral health services that include:
• The promotion of cross-agency coordination, state/local and public/private partnerships in the funding and delivery of behavioral health services;
• The promotion of data-driven decision-making;
• The prevention of behavioral health issues and the promotion of behavioral health wellness and recovery;
• The integration of mental health and substance use services in prevention, intervention, treatment, and recovery;
• The integration of behavioral health services and supports with physical health service delivery;
• Access to services and supports in urban and rural areas of the state;
• Access to services and supports to special populations;
• Rules, policies, programs, initiatives, and grant proposals/awards for behavioral health services; and
• The five-year behavioral health strategic plan, progress reports, and coordinating expenditure plan.

Nominated members must have interest in mental and substance use disorders health systems from a broad perspective and a working knowledge of mental and substance use disorder health issues.

Prior to each scheduled quarterly BHAC meeting, HHSC posts the meeting agenda online. Meetings are open to the public, allowing for public comment. The public may attend in person or view the meeting via webcast. Subject matter experts not on the BHAC are often invited to participate in subcommittees to provide meaningful input.

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

None at this time

OMB No. 0930-0168 Approved: 04/19/2021 Expires: 04/30/2024

Footnotes:

Behavioral Health Advisory Committee
APPROVED: Meeting #26 Minutes
Friday, February 11, 2022
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Texas Department of State Health Services
Robert Bernstein Building
Public Hearing Room, K-100, 1st Floor
1100 w. 49th Street
Austin, TX 78756

Agenda Item 1: Welcome, Opening Remarks and Introductions

The twenty-sixth Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:01 a.m. by Mr. Doug Beach, Chair. Mr. Beach welcomed committee members and members of the public in attendance. Mr. Beach announced that Agenda item #4 – Subcommittee updates would be reorganized to facilitate public comment as recommendations are brought forth.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted roll of members and noted that a quorum was present for the meeting.

Mr. Beach, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations. Mr. Beach thanked the outgoing members for their ongoing support of the committee and announced that the current members are looking forward to welcoming the new members at the May meeting.

Table 1: The BHAC member attendance at the Friday, February 11, 2022 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Beach, Doug	X		Reed, Gabriella M. (joined late)	X	
Carson, Chris, M.D.		X	Richardson, Angela	X	
Curtis, Amy, Ph. D	X		Vale Saenz, Vanessa	X	
Fagan, Donna	X		Sanchez, Eric		X
Gray, Anna	X		Smelley, Jordan	X	
Gilmore, Rev. Robert, EdD		X	Soto, Javier (joined late)	X	
Hicks, Tracy, Dr.	X		Uga, Aghaegbulam, M.D.		X
Hoffman, Shannon	X		Walker, Paul, Dr.	X	
Rasmussen, Jolene	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 2: Consideration of November 15, 2021 meeting minutes
Mr. Doug Beach, Chair, referred members to the draft minutes emailed by the committee liaison. Mr. Beach requested for any edits from the members and a motion to approve the minutes from the November 15, 2021 committee meeting.

MOTION: Dr. Tracy Hicks moved to approve the minutes from the November 15, 2021 committee meeting as presented in the meeting. Mr. Jordan Smelley seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Beach, Curtis, Gray, Hicks, Hoffman, Rasmussen, Richardson, Val Saenz, Smelley, and Walker), no nays and no abstentions.

Agenda Item 3: Health and Human Services Commission updates
Mr. Doug Beach, Chair, introduced HHSC Staff Ms. Britney Rohsner, Ms. Sarah Melecki, Dr. Courtney Harvey, Ph.D, Mr. Philander Moore and Ms. Mariah Ramon, to provide updates to the committee.

a. Behavioral Health Services – Ms. Britney Rohsner, Manager, Crisis Services, referenced presentation titled *National Suicide Prevention and 988 Planning Grant Overview.* Highlights of the update included:

- **Background**: The National Suicide Prevention Lifeline (Lifeline) is a network of independent local and state call centers. It is not one large national call center. Lifeline is funded by the federal Substance Abuse and Mental Health Services Administration and administered by Vibrant Emotional Health. Lifeline provides 24/7, free, and confidential support for people in distress, suicide prevention and crisis resources, and best practices for professionals. On July 16, 2022 the national three digit number for mental health crisis and suicide response (988) will launch. 988 will be routed to Lifeline's current 1 800 number.
- Vibrant requires a follow up with callers with current thoughts of suicide 24 to 72 hours after they have contacted Lifeline.
- Texas Lifeline centers (currently there are 5) have access to various resource listings: 2-1-1, Aunt Bertha/findhelp.org, and Network of Care. Additional work is needed to ensure listings are comprehensive across all 254 counties in Texas.
- To be part of the Lifeline network, a center must - be certified, accredited, or licensed by an external body; follow specific standards for answering Lifeline calls; and be willing to participate in Lifeline evaluation activities.
- **How is 9-8-8 different than 9-1-1?** 9-88- is designated as the universal telephone number within the U.S. for the purpose of the national suicide prevention and mental health crisis hotline system operated through Lifeline.
- **9-8-8 and Diversion**: 9-8-8 may easily divert from law enforcement involvement in mental health emergencies due to the ease of remembering a three digit number.
- **9-8-8 Grant Planning**: eligible applicants for this grant are state mental health and public health agencies. The purpose of this grant was to assist agencies in planning for the implementation of a new, national, three digit number for mental health crisis and suicide response. Goal 1: Develop a clear roadmap to address key coordination, capacity, funding, and communication strategies that

are foundational to the launching of 988, which will occur on or before July 16, 2022. Goal 2: Plan for the long term improvement of in state answer rates of 988 contacts.

- **9-8-8 Planning and Implementation Considerations**: stakeholder coalition meetings began in April 2021 and HHSC priorities for implementation were developed (8 core considerations).
    - Ensure statewide 24/7 coverage for 9-8-8 calls, chats, and texts
    - Secure adequate, diversified, and sustained funding streams for Lifeline member centers.
    - Expand and sustain center capacity to maintain target in state answer rates for current and projected call, text, and chat volume.
    - Support crisis centers in meeting Lifeline's operational standards, requirements, and performance metrics.
    - Convene a coalition of key stakeholders to advise on 9-8-8 planning and implementation.
    - Maintain a comprehensive, updated listing of resources, referrals, and linkages; plan for expanded services.
    - Ensure all state centers can provide best practice follow up to 9-8-8 callers/chatters/texters.
    - Plan and implement marketing for 9-8-8.

Ms. Sarah Melecki, Director, Integrated Care Strategy, referenced presentation titled *Certified Community Behavioral Health Clinics 101.* Highlights of the update included:

- **Background:** Certified Community Behavioral Health Clinics (CCBHC) are a model of care integrating substance use treatment and primary care screenings into mental health care settings. Care coordination is the focal point of the CCBHC model.
- Currently in Texas, 32 CCBHC's are certified by HHSC in 187 counties providing services to more than 89% of Texans.
- **Requirements and Expectations**: staffing, service availability and accessibility, care coordination, scope of services, quality and reporting (assessments) and governance.
- **CCBHC Impact**: consistent set of organization expectations for service delivery; targeted primary care screenings as a minimum requirement; treatment and recovery plans must be coordinated across mental health and substance use for all clients when applicable; requires use of electronic health records and data sharing and SAMHSA model that aligns with current and upcoming funding opportunities.

b. Office of Mental Health Coordination – Dr. Courtney Harvey, Associate Commissioner, HHSC, and Chair, Statewide Behavioral Health Coordinating Council, and Mr. Philander Moore, Statewide Opioid Coordinator, provided an update to the committee. Highlights of the update included:

- **Providers in Texas receiving federal and state funds to address the Opioid Crisis** – HHSC reaching out to providers to identify areas of needs, provide technical assistance and to allow the agencies to receive data. Working

on developing a program "report" card to represent who is providing treatment and prevention services and where in the state of Texas. HHSC is providing data information to the Texas Opioid Abatement Council. Meeting quarterly with the Statewide Opioid Coordinating Council to share and receive national information. Member expressed comments to include recovery programs in the service coordination plans as funding becomes available.

- **Statewide Suicide Prevention Symposium** will be held March 1 -3, 2022.
- **IDD Strategic Plan** was released in January 2022 (intentional focus on how we talk about and develop services for those diagnosed with IDD and Behavioral Health). Implementation of plan will be led by the Office of Disability Services Coordination.
- **Texas Statewide Behavioral Health Strategic Plan (5 year**): BHAC is interested in the gaps, goals and strategies of the plan to determine how BHAC recommendations can be integrated with the intention of enhancing the plan. Continue to collaborate with mental health partners, advocates, behavioral health agencies and advisory committees/subcommittees to develop recommendations. The statewide strategic plan is focused solely on Diversion, Community Integration and Forensic Services.
- Member comments agreed on the need to include advocacy in the plan and continued development of strategies to address peer workforce issues.

c. Medicaid – Mariah Ramon, Senior Policy Advisor, Medicaid, provided an update and referenced the presentation *House Bill 4 – Medicaid and CHIP Teleservices.* Highlights of the update included:

- **HB 4, 87th Legislative Session, 2021 –** allowed use of telemedicine, telehealth, and audio-only for many new Medicaid services during the COVID-19 Public Health Emergency (PHE). HB4 requires HHSC to allow more services to be delivered using telemedicine, telehealth, and audio-only methods on a permanent basis after the PHE ends if clinically appropriate and cost-effective.
- **SB 670, 86th Legislative Session, 20H19** – guidance for Managed Care Organizations regarding responsibility to determine which services can be delivered through telemedicine, telehealth, and audio-only methods.
- **HB 4 Teleservice Requirements include**: rural health clinic reimbursement: preventive, wellness, case management, behavioral health and assessment services; occupational/speech therapy and nutritional benefits; home telemonitoring services: improved access to care in managed care; managed care service coordination and member assessments and CHIP Telehealth.
    - Framework for assessing services criteria – clinical and cost effectiveness, health and safety, member choice and access, and federal/state laws.
    - Anticipated outcomes – increased client access, expanded access to care for Medicaid members especially in rural areas, and continued access to services via telecommunications after the PHE.
- HB 4 Timeline:
    - Phase 1 – Analysis: Winter 2021
    - Phase 2 – Analysis: Spring 2022
    - Phase 3 – Rule making: Summer 2022

- Phase 4 – Finalizing Policy: Fall 2022
- Dedicated email to submit stakeholder comment regarding policy - HHSC_MCS_HOUSE_BILL_4@hhs.texas.gov and HHS site outlining ways to provide input - https://www.hhs.texas.gov/services/health/medicaid-chip/provider-information/medicaid-chip-teleservices

Agenda Item 4: Behavioral Health Advisory Committee Subcommittee updates
Mr. Doug Beach, Chair, asked for subcommittee updates. Highlights of the update included:

d. Peer and Family Partner Services Subcommittee – Subcommittee Co-Chair Anna Gray provided the update to members. Highlights of the update included:

- Recommendations address the need for Certified Family Partners to have effective curricula for all ages and curricula that is Medicaid billable.
- **Draft Recommendation #1**: Part 1 of the recommendation requests the HHSC, Children's Mental Health Unit, CMH, HHSC, Evidenced Based Practice, EBP Unit and HHSC Peer Services Unit to collaboratively work with stakeholders to identify and approve additional family skills training materials for use as rehab billable services for families of children and youth. Recommendation requests for HHSC to develop a workgroup including Master Level Certified Family Partners who have experience using family skills training materials (billable as rehab services) in the field of children's mental health and representatives from Local Mental Health Authorities, LMHAs and other agencies who may benefit from such collaboration (such as DFPS) and other children's system of care stakeholders who utilize family skills training materials or who can provide information on informed, promising or evidenced based materials which can be utilized by Certified Family Partners. Part 2 of the recommendation requests HHSC work with stakeholders to adopt a list of suggested skills training materials for use by Certified Family Partners and adopt a procedure by which recommended materials will come under review, are approved, and adopted for use and that education on those materials be provided to Community Mental Health Agencies, Certified Family Partners and other child serving systems including procedures for updating the Texas DSHS TRR UM Guidelines Child and Use Services Manual with those recommended rehab billable, Family Skills Training materials.
- **Draft Recommendation #2** – Part 1 of the recommendation requests HHSC provide immediate approval of the Preparing Adolescents and Youth for Adulthood (PAYA) curriculum for use by Certified Family Partners as a rehab billable service to the families of adolescents transitioning to Adult Mental Health Services. This curriculum will be extremely beneficial to families whose youth are transitioning from Children's Mental Health Services to Adult Mental Health Services by meeting a particularly important need of youth in Level of Care Transition Age Youth. There is significant misunderstanding among providers if the PAYA Curriculum can be used by Certified Family Partners as family skills training materials, whether it is billable by Certified Family

Partners as a rehab service and whether or not it can be used singularly as a rehab service or as adjunct family skills training materials. Part 2 of the recommendation includes HHSC develop a "decision tree" specifically for PAYA such as exists within the Children's Mental Health Utilization Management for Nurturing Parenting Program that provides direction as to when the use of certain skills training materials may be appropriate for the child/youth and their family. Also requests that HHSC promptly publish this decision tree for immediate use and include it in the UM Guidelines. Part 3 of the recommendation requests HHSC make every effort to identify, educate and provide CFPs, LMHAs and other parties with written directives, utilizing "decision trees" and issuing written directives and alerts, both in person, webinar or virtual presentations to inform providers of these expanded services.

- **Draft Recommendation #3** - Part 1 of the recommendation requests HHSC provide training through Centralized Training by Dr. Russell Barkley and his associates on the use of Barkley's Defiant Child/Teen. To ensure fidelity and make this training opportunity available to all Certified Family Partners and some LMHA staff in support of the use of this material by Certified Family Partners. Part 2 of the recommendation requests HHSC develop a "decision tree" specifically for Barkley's Defiant Child/Defiant Teen skills training material such as exists within the Children's Mental Health Utilization Management Guidelines for Nurturing Parenting Program that provides direction as to when the use of certain skills training materials may be appropriate for the use with families of children and youth in children's mental health services. Also requests that HHSC promptly publish this decision tree for immediate use and include it in the UM Guidelines. Part 3 of the recommendation includes HHSC shall make every effort to identify, educate and provide CFPs, LMHAs and other parties with written directives utilizing "decision trees" and issuing written directives and alerts, both in person, webinar or virtual presentations to inform providers of these expanded services.
- **Draft Recommendation #4** - Part 1 of the recommendation requests HHSC review and provide immediate approval of the Families Thrive curriculum as supported through Texas Institute of Excellence Mental Health (TIEMH) and Texas Family Voice Network (TxFVN) for training and use by Certified Family Partners, both singularly and as adjunct material with other family skills training materials. Also requests that the use of Families Thrive be approved as a rehab billable service as provided to the families of children and adolescence by Certified Family Partners. Families Thrive is a Youth in Focus Curriculum from the Center for the Study of Social Policy and there are currently trainers in Texas to support this need. Part 2 of the recommendation includes HHSC develop a "decision tree" specifically for Families Thrive skills training material such as exists within the Children's Mental Health Utilization Management Guidelines for Nurturing Parenting Program that provides direction as to when the use of certain skills training materials may be appropriate for the use with families of children and youth

in children's mental health services. Also requests that HHSC promptly publish this decision tree for immediate use and include it in the UM Guidelines. Part 3 of the recommendation includes HHSC make every effort to identify, educate and provide CFPs, LMHAs and other parties with written directives utilizing "decision trees" and issuing written directives and alerts, both in person, webinar or virtual presentations to inform providers of these expanded services.

MOTION: Ms. Anna Gray moved to approve the four recommendations brought forth by the Peer and Family Partner Services Subcommittee as presented in the meeting. Ms. Shannon Hoffman seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 11 yeas (Beach, Curtis, Fagan, Gray, Hicks, Hoffman, Rasmussen, Reed, Richardson, Smelley, and Walker), no nays and no abstentions.

a. **Access to Care and Community Engagement Subcommittee** – Member Jolene Rasmussen provided the update to members. Highlights of the update included:
- Members continue to meet monthly focusing on workforce shortage and access to service issues.
- Members received a presentation from the Office of the Ombudsman – reported greatest complaint is access to inpatient psychiatric services and challenges for individuals understanding eligibility for all the wavier services.
- Workforce crisis shortages are requiring out of the box solutions.
- Importance of community members involvement in community engagement to address gaps and needs. Looking at specific local communities.

b. Children & Youth Behavioral Health Services Subcommittee –No report given.

c. Housing Subcommittee — Chair Beach provided the update to members. Highlights of the subcommittee update included:
- Subcommittee met twice since the November committee meeting.
- Received a presentation from the University of Texas Health Housing Pilot (HOME). Nation's largest housing project focused on individuals recovering from opioid use disorder.
- Continued review of HHSC Recovery Housing and Housing rental assistance policy.
- Continued review of the "Money follows the person" requirements and policy.
- Housing Choice Plan – still under HHSC review and hoping to provide more information at May meeting. Member comments focused on what the hold up is and what are the challenges and barriers from the report being released. Dr. Harvey shared that HHS Government Relations is following up with the agencies involved to determine the impact. Will be important for the report to be released prior to the next Legislative session.
- Requesting a BHAC member to join the Housing subcommittee.

e. Policy and Rules Subcommittee – Danielle Kailing, Committee liaison provided the update to members. Highlights of the subcommittee update included:

- Request to have several BHAC members join the Policy and Rules subcommittee.
- Rule amendment project to make needed modifications to the BHAC member roster is open. Member comments focused on the importance of input from this subcommittee in governance of the services to the individuals who receive behavioral services. Members Rasmussen and Hicks volunteered to join subcommittee. Shannon Hoffman is interested in participating on subcommittee as a subject matter expert.

Agenda Item 5: Public Comment
Ms. Kayla Cates-Brown announced that written public comment was submitted and that Danielle Kailing, Committee liaison, forwarded the public comment to all members for review prior to the meeting. There were no oral registrations or on-site public comment.

Agenda Item 6: Review of action items and agenda items for next meeting
Mr. Doug Beach, Chair, opened the floor for action items and agenda topics for the next meeting. Danielle Kailing announced that the next meeting is scheduled for Friday, May 6, 2022 at 9:00 am and BHAC new members will be joining the meeting. Items discussed included:

- Committee liaison will provide members with registration information for the Suicide Prevention Symposium.
- Next meeting agenda items -
  - Strategic Plan presentation
  - Workforce presentation
  - Housing Choice presentation – Dr. Harvey to provide current status
  - Office Election Procedure – Chair
- Add Dr. Hicks, Shannon Hoffman, and Jolene Rasmussen to the Policy & Rules Subcommittee.
- Add Dr. Hicks to the Access to Care and Community Engagement Subcommittee.

Agenda Item 7: Closing Remarks
Mr. Doug Beach, Chair, thanked the members and presenters for their attendance and adjourned the BHAC meeting at 11:54 a.m.

Below is the link to the archived video of the February 11, 2022 Behavioral Health Advisory Committee meeting that will be available for viewing approx. two years from date meeting was posted on website and based on the HHSC records retention schedule.
(To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee Meeting

Behavioral Health Advisory Committee
APPROVED Meeting #27 Minutes
Friday, May 6, 2022
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Health and Human Service Commission
John H. Winters Building
Public Hearing Room, 1st Floor
701 W. 51st Street
Austin, TX 78751

Agenda Item 1: Welcome, Opening Remarks and Introductions

The twenty-seventh Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:00 a.m. by Mr. Doug Beach, Chair. Mr. Beach welcomed committee members and members of the public in attendance. Mr. Beach provided a special welcome to the newly appointed BHAC members – Elias Diaz, Melissa Ann Luna, Olawale Adio-Oduola, Jennifer Reed, Victoria Rodriguez and Nasruddin Rupani.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted roll of members and noted the absence of quorum for the meeting. Mr. Beach announced that several agenda items would be moved to later in the agenda when a quorum of members would be present to conduct member voting.

Mr. Beach, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations.

Table 1: The BHAC member attendance at the Friday, May 6, 2022 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Adio-Oduola, Olawale	X		Rodriguez, Victoria	X	
Beach, Doug	X		Rupani, Nasruddin		X
Curtis, Amy, Ph. D	X		Vale Saenz, Vanessa		X
Diaz, Elias	X		Smelley, Jordan	X	
Gray, Anna		X	Soto, Javier (joined late)	X	
Hicks, Tracy, Dr.		X	Walker, Paul, Dr.	X	
Luna, Melissa Ann		X	VACANT		
Rasmussen, Jolene	X		VACANT		
Reed, Jennifer	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 3: Health and Human Services Commission updates
Mr. Doug Beach, Chair, introduced Mr. Noah Abednour, Director of Peer and Recovery Services, HHSC to provide and update on Behavioral Health Services.

a. Behavioral Health Services – Highlights of the update included:

- Background: House Bill 1486, 85th Legislature, Regular Session, 2017, authorized the creation of a new Medicaid benefit "Peer Services". To support implementation of this legislation and highlight the importance of peer support, HHSC established the Peer and Recovery Services Programs, Planning, and Policy (PRSPPP) unit.
- Peer support is defined as the process of giving and receiving encouragement and assistance to achieve long-term recovery. Peer specialists offer emotional support, share knowledge, teach skills, provide practical assistance, and connect people with resources, opportunities, communities of support, and other people.
- PRSPPP unit objectives –
    - Workforce Development
    - Services Capacity Expansion
    - Data and Research Alignment
- Workforce development team focused on Medicaid benefit, PeerForce and working with Texas Credentialing Board and administration of aligned certifications, where possible.
- Service capacity team focuses on programs and projects serving individuals directly. These include peer run community organizations and other substance use services providers.
- Data and research work closely with university partners to align contracts to harmonize data and research efforts. This team also takes on special projects like HR133 and American Rescue Plan funds.

Mr. Doug Beach, Chair, introduced Dr. Courtney Harvey, Associate Commissioner, and Chair of the Statewide Behavioral Health Coordinating Council (SBHCC), HHSC to provide an update from the Office of Mental Health Coordination and Statewide Behavioral Health Services.

b. Office of Mental Health Coordination – Highlights of the update included:

- **SBHCC Background:** 2016-17 General Appropriations Act, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015 created the SBHCC and required the participation of 18 state agencies receiving state funding for behavioral health services.
- Some of the state agencies with member representatives on the SBHCC include the Court of Criminal Appeals (CCA), Texas Commission on Jail Standards, Texas Workforce Commission (TWC), Texas Department of Housing and Community Affairs (TDHCA), Texas Education Agency (TEA), Judicial Commission on Mental Health (JCMH), Texas Indigent Defense Commission (TIDC), Texas Child Mental Health Care Consortium (TCMHCC), Texas Commission on Law Enforcement and the Texas School for the Deaf.

- SBHCC was charged with developing a five-year strategic plan for behavioral health services for fiscal years 2017 through 2021 and submitting an expenditure proposal each fiscal year.
- Dr. Harvey announced that the Housing Choice Plan has been approved and will be released soon for public viewing.

Mr. Doug Beach, Chair, introduced Ms. Kathi Montalbano, Director, Federal Coordination, Rules and Committees, Medicaid/CHIP, HHSC to provide the Medicaid update.

c. Medicaid – Highlights of the update included:

- **Youth Empowerment Services** (YES) waiver is required to be renewed every 5 years. Upcoming critical dates:
    - Web Posting: September 2022
    - Public Comment Period: September to October 2022
    - Submission to CMS: December 2022
    - Renewal Effective Date: April 1, 2023

Agenda Item 2: Consideration of February 12, 2022 meeting minutes

Mr. Doug Beach, Chair, referred members to the draft minutes emailed by the committee liaison. Mr. Beach requested for any edits from the members and a motion to approve the minutes from the February 12, 2022 committee meeting.

MOTION: Mr. Jordan Smelley moved to approve the minutes from the February 12, 2022, committee meeting as presented in the meeting. Ms. Joleen Rasmussen seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Adio-Oduola, Beach, Curtis, Diaz, Rasmussen, Reed, Rodriguez, Smelley, Soto, and Walker), no nays and no abstentions.

Agenda Item 4: Officer Elections

Mr. Beach turned the meeting over to Ms. Cates-Brown to conduct the Officer Election Procedure and the Chair/Co-Chair Election Process. Ms. Cates-Brown read the Officer Election Procedure aloud for the record and responded to member questions.
Highlights of the Office Election Procedure:

- Per the officer election procedure, the BHAC nominating subcommittee comprised of 3 – 5 members met to discuss potential candidates.
- The nominating subcommittee members contacted the recommended candidates to determine if they would accept the nomination.
- The nominating subcommittee brough forth a list of recommended candidates for a vote by the full committee membership.
- At the full committee meeting, members were also given the opportunity to nominate themselves and to provide additional nominations from the floor for Chair/Co-Chair.
- Nominees were given two minutes to share their qualifications.
- Due to the hybrid meeting virtual setting is it required for a roll call vote to be conducted and the nominee receiving the most votes is elected as the Chair/Co-Chair.

Ms. Cates-Brown announced that two candidates had been recommended for the Chair position – Dr. Tracy Hicks and Ms. Jolene Rasmussen. Both candidates accepted the nomination and Ms. Cates-Brown read a brief statement from Dr. Tracy Hicks as she was not able to attend the meeting. Ms. Rasmussen briefly shared her qualifications for the Chair position. No other nominees were received. Following a roll call vote of the members, the motion passed with 10 approval votes for Ms. Rasmussen (Adio-Oduola, Beach, Curtis, Diaz, Rasmussen, Reed, Rodriguez, Smelley, Soto, and Walker), no nays, and no abstentions. Ms. Rasmussen was elected as the BHAC Chair.

Ms. Cates-Brown announced that one candidate had been recommended for the Co-Chair position – Ms. Anna Gray. Ms. Gray accepted the nomination and Ms. Cates-Brown read a brief statement from Ms. Gray as she was not able to attend the meeting. No other nominees were received. Following a roll call vote of the members, the motion passed with 10 approval votes for Ms. Gray (Adio-Oduola, Beach Curtis, Diaz, Rasmussen, Reed, Rodriguez, Smelley, Soto, and Walker), no nays, and no abstentions. Ms. Gray was elected as the BHAC Co-Chair.

Member Break
After a member break, Mr. Beach reconvened the meeting. Ms. Cates-Brown conducted member roll call and announced the absence of quorum.

Agenda Item 5: Behavioral Health Advisory Committee Subcommittee updates:
Mr. Doug Beach, Chair, opened the floor BHAC subcommittee updates.

a. Access to Care and Community Engagement Subcommittee – Ms. Jolene Rasmussen provided the update to members. Highlights of the update included:
- 988 implementation and resources (211 informational line) are available to the general public to connect with community-based services.
- Workforce shortages – recommendations included individual level engagement, reviewed underrepresented groups and the importance of community health workers as an outreach in a harm reduction model for substance use.
- Access for special populations including co-occurring needs

b. Children and Youth Behavioral Health Services Subcommittee – Ms. Jennifer Reed provided the update to members. Highlights of the update included:
- Subcommittee members heard a compelling story related to family voice and how support looks for families.
- Subcommittee members received updates on Mental Health Awareness month and a tool kit that is an available resource.

c. Housing Subcommittee— Chair Beach provided the update to members. Highlights of the update included:

- Subcommittee member received a presentation on a survey of LMHAs on housing issues.
- Formal recommendations will be brought to the August meeting for review by the full committee.
- Requests for more BHAC members to join the Housing subcommittee.

d. Peer Specialists and Family Partner Services Subcommittee – Ms. Donna Fagan provided the update to members. Highlights of the update included:

- An increase in funding for peer services and hiring of peer support specialists is improving.
- Subcommittee members plan to bring forth additional recommendations to upcoming meetings for review by the full committee.

e. Policy and Rules Subcommittee – Ms. Adriana Flores, HHSC, provided the update to members. Highlights of the update included:

- New membership, monthly schedule initiated, reviewed purpose and goals
- Subcommittee given list of behavioral health rules projects currently in process.

Agenda Item 6: Public Comment

Ms. Kayla Cates-Brown announced that written public comment was submitted and that Danielle Kailing, Committee liaison, forwarded the public comment to all members for review prior to the meeting. There were no oral registrations or requests on-site to provide public comment.

Agenda Item 7: Review of action items and agenda items for next meeting

Mr. Doug Beach, Chair, opened the floor for action items and agenda topics for the next meeting. Mr. Beach, Chair, announced that the next meeting is scheduled for Friday, August 6, 2022 at 9:00 am. Items discussed included:

- Committee liaison staff to email members the Final Statewide Behavioral Health Coordinating Council Strategic Plan.
- Committee liaison staff to email members YES Waiver slides – include timeline for requesting public comment.
- Committee liaison staff to extend subcommittee meeting invite several members to attend the next Access to Care and Community Engagement Subcommittee meeting to provide input on recommendations for gaps in care as it relates to IDD.
- Policy and Rules Subcommittee – notification of two rule changes regarding advisory committee quorum.

Agenda Item 8: Closing Remarks

Mr. Doug Beach, Chair, offered closing remarks and thanked members for their attendance and continued participation to move forward the work of the committee. Mr. Doug Beach, Chair, offered thanks to HHSC staff for their dedication to assisting with the work of the committee. Dr. Courtney Harvey offered thanks to Mr. Beach for his service and commitment to behavioral health work. Mr. Doug Beach, Chair, encouraged members to attend committee meetings in person and adjourned the BHAC meeting at 11:37 a.m.

Below is the link to the archived video of the May 6, 2022 Behavioral Health Advisory Committee meeting that will be available for viewing approx. two years from date meeting was posted on website and based on the HHSC records retention schedule.
(To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee

Behavioral Health Advisory Committee
APPROVED: Meeting #28 Minutes
Friday, August 5, 2022
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Texas Health and Human Services Commission
North Austin Complex
Public Hearing Room, 1st Floor
4601 Guadalupe Street
Austin, TX 78751

Agenda Item 1: Welcome, Opening Remarks and Introductions

The twenty-eighth Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:02 a.m. by Ms. Joleen Rasmussen, Chair. Ms. Rasmussen, Chair, welcomed committee members and members of the public in attendance. Ms. Rasmussen, Chair, provided opening remarks and turned the meeting over to Ms. Kayla Cates–Brown.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted roll of members and noted the presence of quorum for the meeting.

Ms. Rasmussen, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations. Ms. Rasmussen, Chair, introduced HHSC staff Danielle Kailing, Helen Esiert, Dr. Chris Laguna, Associate Commission Trina Ita, Philander Moore , Samm Zachary, and Dr. Courtney Harvey.

Table 1: The BHAC member attendance at the Friday, August 5, 2022 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Adio-Oduola, Olawale		X	Rodriguez, Victoria	X	
Beach, Doug – joined late	X		Rupani, Nasruddin	X	
Curtis, Amy, Ph. D	X		Vale Saenz, Vanessa – joined late	X	
Diaz, Elias	X		Smelley, Jordan	X	
Gray, Anna	X		Soto, Javier (joined late)	X	
Hicks, Tracy, Dr.	X		Walker, Paul, Dr.		X
Luna, Melissa Ann		X	VACANT		
Rasmussen, Jolene	X		VACANT		
Reed, Jennifer	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 2: Consideration of May 6, 2022 meeting minutes
Ms. Rasmussen, Chair, referred members to the draft minutes emailed by the committee liaison and requested for any edits from the members, Hearing none, Ms. Rasmussen, Chair, requested a motion to approve the minutes from the May 6, 2022 committee meeting.

MOTION: Dr. Tracy Hicks moved to approve the minutes from the May 6, 2022, committee meeting as presented in the meeting. Ms. Jennifer Reid seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Curtis, Diaz, Gray, Hicks, Rasmussen, Reed, Rodriguez, Rupani, Smelley, and Soto), no nays and no abstentions.

Agenda Item 3: New Chair Updates
Ms. Rasmussen, Chair, provided members with a committee wide update.
Highlights of the update:

- New Member appointments have been approved and hopefully the new members will be able to attend the next meeting.
- The annual BHAC report will include two years of recommendation content.
- Bylaw revisions will an agenda item for the November meeting (potential to remove policy and rules subcommittee).
- Interim feedback is requested from members regarding proposed recommendations.

Agenda Item 4: Behavioral Health Advisory Committee Subcommittee updates:
Ms. Rasmussen, Chair, opened the floor for BHAC subcommittee updates.

a. **Access to Care and Community Engagement Subcommittee** – Ms. Jolene Rasmussen provided the update to members. Highlights of the update included:
   - Members focused on a timely draft of subcommittee recommendations and were in favor of including two years of activities in annual report.
   - Subcommittee is looking at ways to receive interim feedback and informal comments from partners and HHS staff to facilitate drafting efficient and impactful recommendations. (i.e., agency narrative input; faith-based community partners addressing recovery gaps).

b. **Children and Youth Behavioral Health Services Subcommittee** – Ms. Danielle Kailing provided the update to members. Highlights of the update included:
   - Subcommittee members met on July 13, 2022. Recording and formal agenda will be posted soon to the Texas System of Care website.
   - Subcommittee members plan to meet next on October 12, 2022 and will provide a more detailed update at the November BHAC meeting.
   - Ms. Rasmussen inquired about receiving a children services update from the 88th Legislature Regular Session.

c. **Housing Subcommittee –** Ms. Helen Eisert and Ms. Tanya LaVelle, HHSC, provided the update to members. Highlights of the update included:
   - Formal recommendations were brought by the subcommittee for review and approval by the full committee.
     - **Recommendation 1** - HHSC fund a housing coordinator at each local mental health facility that will implement the requirements laid out in the HHSC Performance Contract. The Housing Coordinator shall work collaboratively with local staff and the state housing program staff to improve access to safe, decent, affordable housing and an array of voluntary pre-tenancy and tenancy support services
     - **Recommendation 2** – Increase funding for the SHR program to each LMHA by increasing GR investment in the program a further $6 million per fiscal year. At the end of every FY '24, collapse all unspent funds into a statewide pot of funding available to LMHAs with illustrated need for more SHR funding. Edit Form H (LMHA reporting document) to add reporting for SHR to include amount of funds expended, the timeline for funds expended, and how they were expended (include reportable data points).

d. **Peer Specialists and Family Partner Services Subcommittee** – Ms. Anna Gray provided the update to members. Highlights of the update included:
   - Subcommittee members plan to bring forth additional recommendations to upcoming meetings for review by the full committee. Draft recommendations:
     - Additional extended curricula.
     - Family partners be Medicaid reimbursable.
     - Barrier of interactions between Peer family partners and behavioral health
     - Topic nomination moving forward – changing client per services age from clients from 21 years and up to 16 years of age up.
     - Peer services provider curriculum training expanding from 6 – 8 hours to 3 full days of training.

Ms. Rasmussen, Chair, referred members to the draft recommendations brought forth by the Housing Subcommittee and requested for any edits from the members. Members discussed several edits. On consensus, Ms. Rasmussen, Chair, requested a motion from the members to approve the recommendations brought forth by the Housing Subcommittee.

MOTION: Mr. Doug Beach moved to approve the Housing Subcommittee recommendations as presented with edits in the meeting. Ms. Anna Gray seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 11 yeas (Beach, Curtis, Diaz, Gray, Hicks, Rasmussen, Reed, Rodriguez, Saenz, Smelley, and Soto), no nays and no abstentions.

Member Break

After a member break, Ms. Rasmussen, Chair, reconvened the meeting. Ms. Cates-Brown conducted member roll call and announced the absence of quorum.

Agenda Item 5: Health and Human Services Commission updates
Ms. Rasmussen, Chair, introduced Ms. Trina Ita, Associate Commissioner of Behavioral Health, HHSC to provide an update on Behavioral Health Services.

a. **Behavioral Health Services –** Highlights of the update included:
- Agency activities in preparation for the 88th Legislative Session – internal discussions for what will be included in the LAR.
- Budget execution order – agency implementing additional mental health initiatives. "Coordinated specialty care" expansion from three to twenty-seven sites across Texas.
- Multi systemic family therapy funding.
- Funding to implement a needs assessment focused on the mental health needs for the Uvalde community.

Ms. Rasmussen, Chair, introduced Dr. Courtney Harvey, Associate Commissioner, and Chair of the Statewide Behavioral Health Coordinating Council (SBHCC), HHSC to provide an update from the Office of Mental Health Coordination and Statewide Behavioral Health Services. Mr. Philander Moore and Ms. Samm Zachary provided an update on the state Opioid Office and Suicide Prevention Network.

b. **Office of Mental Health Coordination** – Highlights of the update included:
- SBHCC was charged with developing a five-year strategic plan for behavioral health services for fiscal years 2017 through 2021 and submitting an expenditure proposal each fiscal year.
- Dr. Harvey announced that a reiteration of the Strategic Plan for Behavioral Health has been approved and will be released soon for public viewing.
- Brief overview of statewide Opioid Coordination.
- Brief overview of Opioid Settlement and Texas Abatement Council.
- Statewide Opioid report card for 2022.
- National statewide opioid network coordination.

Agenda Item 6: Public Comment
Ms. Kayla Cates-Brown announced that written public comment was submitted and forwarded to all members for review prior to the meeting by the Committee liaison. No oral registrations were received there were no requests on-site to provide public comment.

Agenda Item 7: Review of action items and agenda items for next meeting
Ms. Rasmussen, Chair, opened the floor for action items and agenda topics for the next meeting. Ms. Rasmussen, Chair, announced the next meeting is scheduled for Friday, November 4, 2022 at 9:00 am. and stated the importance of potential votes on the annual recommendation report and the bylaw revisions at the November meeting.

Agenda Item 8: Closing Remarks
Ms. Rasmussen, Chair, offered closing remarks and thanked members and the public for their participation. Ms. Rasmussen, Chair, adjourned the BHAC meeting at 12:28 p.m.

Below is the link to the archived video of the August 5, 2022 Behavioral Health Advisory Committee meeting that will be available for viewing approx. two years from date meeting was posted on website and based on the HHSC records retention schedule.
(To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee

Behavioral Health Advisory Committee
DRAFT Meeting #25 Minutes
Monday, November 15, 2021
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Texas Health and Human Services Commission
John H. Winters Building
Public Hearing Room, 125, 1st Floor
701 West 51st Street
Austin, TX 78751

Agenda Item 1: Welcome, Opening Remarks and Introductions

The twenty-fifth Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:01 a.m. by Mr. Doug Beach, Chair. Mr. Beach welcomed committee members and members of the public in attendance.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted roll of members and noted that a quorum was present for the meeting.

Mr. Beach, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations.

Table 1: The BHAC member attendance at the Monday, November 15, 2021 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Beach, Doug	X		Reed, Gabriella M.		X
Carson, Chris, M.D.		X	Richardson, Angela	X	
Curtis, Amy, Ph. D	X		Vale Saenz, Vanessa D'Lise	X	
Fagan, Donna	X		Sanchez, Eric		X
Gray, Anna	X		Smelley, Jordan	X	
Gilmore, Rev. Robert, EdD		X	Soto, Javier		X
Hicks, Tracy, Dr.	X		Uga, Aghaegbulam, M.D.		X
Hoffman, Shannon		X	Walker, Paul, Dr.	X	
Rasmussen, Jolene	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 2: Consideration of May 7, 2021 meeting minutes

Mr. Doug Beach, Chair, referred members to the draft minutes emailed by the committee liaison. Mr. Beach requested for any edits from the members and a motion to approve the minutes from the May 7, 2021 committee meeting.

MOTION: Mr. Jordan Smelley moved to approve the minutes from the May 7, 2021 committee meeting as presented in the meeting. Ms. Anna Gray seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas, no nays and no abstentions.

Agenda Item 3: Consideration of August 6, 2021 meeting minutes
Mr. Doug Beach, Chair, referred members to the draft minutes emailed by the committee liaison. Mr. Beach requested for any edits from the members and a motion to approve the minutes from the August 6, 2021 committee meeting.

MOTION: Mr. Jordan Smelley moved to approve the minutes from the August 6, 2021 committee meeting as presented in the meeting. Ms. Jolene Rasmussen seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas, no nays and no abstentions.

Agenda Item 4: Health and Human Services Commission updates
Mr. Doug Beach, Chair, introduced HHSC Staff Reilly Webb, Ms. Veronica Martinez, Dr. Courtney Harvey, Ms. Keisha Ledlow and Dr. Jennie Simpson, to provide updates to the committee.

a. **Behavioral Health Services –** Reilly Webb, Director, Mental Health Programs, Planning and Policy, and Ms. Veronica Martinez, Director, Adult and Children's Mental Health referenced presentation titled *Residential Treatment Center Project SB 642.* Highlights of the update included:
    - An overview of the Residential Treatment Center Project (RTC) and Senate Bill 642. Link - www.texashhs.org/residentialtreatmentcenterproject
    - As of June 2021, a local mental or behavioral health authority (LMHA/LBHA) or DFPS can refer families interested in receiving support through the RTC Project.
    - A review of HHSC policies, implementation and public outreach activities related to the implementation of S.B. 642.

b. **Office of Mental Health Coordination** – Dr. Courtney Harvey, Associate Commissioner, HHSC, and Chair, Statewide Behavioral Health Coordinating Council, and Ms. Kiesha Ledlow, Director, Texas System of Care, HHSC, provided an update to the committee. Highlights of the update included:
    - An overview of the Statewide Behavioral Health Coordinating Council (SBHCC) and highlights of the Council's recent work.
    - Progress of the 5-year Behavioral Health Strategic Plan, the Substance Use sub-plan, and the Jail Diversion sub-plan.
    - As a result of H.B. 4574, a Suicide Prevention subcommittee was established on the SBHCC.
    - Behavioral Workforce Subcommittee report publication.
    - Member Donna Fagan suggested a certified family representative be invited to serve on the SBHCC Behavioral Workforce subcommittee.
    - An overview of the Texas System of Care 2.0.
    - HHSC was recently awarded a four year SANSA grant ($11.5 million) to support system of care mental health services.

Texas System of Care 2.0 - BHAC Updates
- Texas System of Care (TxSOC) is a statewide framework and approach to strengthen state and local efforts to weave mental health supports and services

into seamless systems of care for children, youth, young adults, and their families. This will ensure all Texas children and youth have access to high quality mental health care that is family- and youth-driven, community-based, culturally responsive, and sustainable.

- Texas Government Code, Chapter 531, Section 531.251, requires the Texas Health and Human Services Commission (HHSC) to implement a system of care framework to develop local mental health SOCs in communities for minors who are receiving residential mental health services and supports or inpatient mental health hospitalization, have or are at risk of developing a serious emotional disturbance, or are at risk of being removed from the minor's home and placed in a more restrictive environment to receive mental health services and supports. It also tasks HHSC with identifying appropriate local, state, and federal funding sources to finance infrastructure and mental health services and supports needed to support state and local SOC framework efforts.
- HHSC was recently awarded a new four-year cooperative agreement from SAMHSA for SOC implementation. The current four-year TxSOC grant funding from SAMHSA totaling $11.5 million began on August 31, 2021.
- Through this grant funding, HHSC hopes to accomplish the following goals: o Increase state and local leadership support for the system of care approach;
  - Increase community awareness of behavioral health challenges and available resources;
  - Increase access to culturally responsive and developmentally appropriate school- and community-based behavioral health services and supports;
  - Build on strengths of students, families, and communities to support wellness and promote success at home, in school, and in the community; and
  - Develop and implement capacity-building strategies to sustain the system of care infrastructure once grant funding has ended.
- To implement the grant, HHSC will continue to partner with the Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin to assist with state infrastructure efforts, implementation, provision of training and technical assistance to system of care sites, and evaluation of the development and effectiveness of the system of care framework at state and local levels.
- TIEMH will continue to house a team of subject matter experts to support Texas System of Care efforts. One change, however, will be in the location of the Youth Engagement Specialist and Family Engagement Specialist positions. Previously, these two positions were housed within TIEMH's Texas System of Care team. However, with the new grant, these positions will be moved into the Office of Mental Health Coordination as HHSC employees. With these positions located in HHSC, we are hopeful to further promote family and youth/young adult voice within the Office of Mental Health Coordination, other areas of HHSC, and other state partners.
- In addition to partnering with UT Austin, HHSC will partner with three Local Mental Health Authorities (LMHAs) for local system of care implementation and service provision. Those LMHAs are Emergence Health Network in El Paso County, Integral Care in Travis County, and Pecan Valley Centers in a six-county region in north central Texas. o Each of these LMHAs will develop local governance boards consisting of cross-system stakeholders to identify local gaps and barriers in accessing behavioral services for young people and their families and work collectively to fill those gaps and remove those barriers.
  - Regarding service provision, each LMHA will employ a team consisting of a local project director, school-based interventionist, school-based therapist, youth peer support specialist, and certified family partner. These teams will be embedded in local school districts and will partner with school mental

health teams to address local youth mental health needs across a continuum of care.

c. **Forensic Services –** Dr. Jennie Simpson, State Forensic Director HHSC, provided an update and referenced the presentation *Well and Safe_Forensic Services_BHAC_update.* Highlights of the update included:
   - An overview of the Well and Safe: The Texas Strategic Plan for Diversion Community Integration and Forensic Services.
   - Well and Safe Plan purpose - To lay out a vision and a coordinated, clear, actionable, and achievable plan for improving forensic services reducing justice involvement for Texans with mental health, substance use disorders and intellectual and developmental disabilities by ensuring all Texans receive care in the right place at the right time.
   - An overview of the Texas Behavioral Health and Justice Technical Assistance Center.
     - Key Partnerships– The Judicial Commission on Mental Health and more than 20 other leaders representing behavioral health and justice systems across Texas.
     - Initiatives - Eliminate the Wait strategies; Community Diversion Coordinator Pilot; Council of State Governments Housing Community of Practice; and Study of Challenges to the use of Diversion Programs.

Agenda Item 5: Consideration of BHAC Annual Report
Mr. Doug Beach, Chair, opened the discussion regarding the BHAC annual committee report and introduced Ms. Danielle Kailing, BHAC Liaison, to provide an overview of the FY2020 report for consideration. Highlights of the update included:
- A reminder of the timeline and requirements of the annual committee report.
- An overview and status of the draft report for approval and committee feedback received.
- A status chart of recommendations is included as an appendix to the report.
- The Peer Specialist and Family Partner Services Subcommittee's work was included in the report.
- Ms. Anna Gray suggested an edit in the executive summary of the report (stand-alone paragraph).

MOTION: Ms. Anna Gray moved to approve the BHAC FY2020 annual committee report with the edit as noted in the meeting. Drs. Paul Walker and Amy Curtis seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas, no nays and no abstentions.

MEMBER BREAK
After a member break, Mr. Beach, Chair reconvened the meeting and Ms. Cates-Brown conducted member roll call and announced the absence of quorum.

Agenda Item 6: Behavioral Health Advisory Committee Subcommittee Updates
Mr. Doug Beach, Chair, asked for subcommittee updates. Highlights of updates included:

a. **Access to Care and Community Engagement Subcommittee** – Member Jolene Rasmussen provided the subcommittee update to committee members. Highlights of the update included:
   - A recap of monthly subcommittee presentations from HHSC and other entities.

- Specific subcommittee emphasis - attention to children services, specifically school initiatives, as a result of legislation passed during the 87th Regular session.
- H.B. 19 – Texas Education Agency – LMHA link to school education/resources
- Over-arching TEA recommendations to assist school districts.
- Texas Child Health Access – TCHAT.

b. **Children & Youth Behavioral Health Services Subcommittee** – Member Donna Fagan provided a subcommittee update to committee members. Highlights of the update included:
   - Focus has been on school based mental health resources – presentations from parents and care givers. Topics - what it looks like today, changes that are happening, need for grief and trauma training for teachers and school support staff.
   - System of Care grant - awards to 6 county region areas. Collaboration with school based teams and community based care teams.
   - Trauma training – the need for this topic of training greatly increased as a result of the pivot to virtual learning.

c. **Housing Subcommittee—** Chair Beach provided an update on the Housing Subcommittee to members. Highlights of the subcommittee update included:
   - Subcommittee focuses on housing related outcome data to assist with the development of recommendations to enhance housing programs.
   - Texas State Affordable Housing Corporation (TSAHC) presentation on the "Money follows the person". TSAHC programs target the housing needs of low-income families and other underserved populations who do not have acceptable housing options through conventional financial channels.
   - Presentations on the Healthy Community Collaborative and Recovery Housing programs funded by HHS.
   - Housing Choice Plan is still under review by HHS (high interest of subcommittee).
   - Next meeting is November 30, 2021. Topic of interest will be supportive housing rental assistance programs and outcomes in the recovery home program.

d. **Peer Specialist and Family Partner Services Subcommittee** – Subcommittee Co-Chair Anna Gray provided the update to members. Highlights of the update included:
   - Meeting monthly with good stakeholder and subject matter expert attendance.
   - Variety of recommendations are forth coming – action item for next meeting agenda (BHAC members review and take action on recommendations brought forth by subcommittee).
   - Member Donna Fagan provided an update on family partner services:
     - Recommendation to increase family skills training and materials.
     - Currently, family skills training is a service that is Medicaid reimbursable. (strategies around parenting children with mental health challenges, helping parents identify their selfcare needs).
   - Peer service recommendations:
     - Focus on peer service organizations (recovery community organizations) where services are provided by peer specialists to support individuals dealing with substance abuse issues, especially groups facing re-entry.

        - On the mental health side, you have Consumer Operated Services Providers (COSP) providing these services through peer specialists.
        - Recommendation to HHSC to have the COSP and peer service organizations be added to the Medicaid Provider List so they can bill Medicaid services.
        - Recommendation for the role of peer providers to be monitored by HHSC. Providers providing peer support services in Certified Community Behavioral Health Clinics (CCBHC) are able to bill to Medicaid for their services.
        - A rate hearing for Medicaid peer support services billing is scheduled for November 19, 2021. Request for BHAC to provide written testimony to provider finance at the rate hearing to increase the Medicaid peer support services reimbursement rate to a minimum of $15 per 15 minute increments with a proportional increase for group services.
    - TX Medicaid Topic Nomination Peer Services Forms – peer services forms were vetted and are currently in que for review. The forms will be assigned to a policy development analysist.
        - The peer services nomination topic form (Certified Family Partners) is scheduled for discussion at the February 2022 Governance Review meeting.

MOTION: Ms. Anna Gray moved to approve the recommendation brought forth by the Peer Specialist and Family Partner Service Subcommittee (BHAC to provide written testimony to provider finance at the rate hearing to increase the Medicaid peer support services reimbursement rate to a minimum of $15 per 15 minute increments with a proportional increase for group services). Mr. Jordan Smelley seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas, no nays and no abstentions.

e. **Policy and Rules Subcommittee** – Ms. Danielle Kailing, BHAC liaison, provided the subcommittee update to members. Highlights of the update included:
    - Rule amendment project to make needed modifications to the BHAC member roster has been completed. Several organizational comments were received. Rules will be published for formal comment in March.

Agenda Item 7: Public Comment
Ms. Kayla Cates-Brown read the public comment announcement. Ms. Cates-Brown coordinated with the ACCO production team to conduct the oral registered public comments and any requests for public comment received in person at the public hearing room.

In person public testimony: Ms. Sonja Burns, advocate and sister of a brother in Austin State Hospital. Ms. Burns was encouraged by the reimbursement rate discussion at today's meeting and the need for peer support services. She recommended exit interviews by conducted with LMHA staff. She also advocated for increased services to assist clients in the jail system with re-entry and step-down opportunities.

Agenda Item 8: Review of action items and agenda items for next meeting
Mr. Doug Beach, Chair, opened the floor for action items and agenda topics for the next meeting. The next meeting is scheduled for Friday, February 11, 2022 from 9:00 am - 4:00 pm. Items discussed included:

- BHAC liaison to request presenter resource list from Dr. Jennie Simpson and presenter talking points from Ms. Keisha Ledlow (agenda item #4 -HHSC updates).
- BHAC liaison to email members the Peer Specialist and Family Partner Services Subcommittee peer services rate documents.
- Send Anna Gray and Doug Beach's contact information to Dr. Jennie Simpson.
- BHAC members and HHS staff to draft written letter to provide written testimony to provider finance at the November 19, 2021 rate hearing.
- New member appointments are schedule to attend the next BHAC meeting on February 11, 2022.

Agenda Item 9: Closing Remarks
Mr. Doug Beach, Chair, thanked the members and presenters for their attendance and adjourned the BHAC meeting at 12:30 p.m.

Below is the link to the archived video of the November 15, 2021 Behavioral Health Advisory Committee meeting that will be available for viewing approx. two years from date meeting was posted on website and based on the HHSC records retention schedule.
(To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee Meeting

Behavioral Health Advisory Committee
APPROVED Meeting #29 Minutes
Friday, November 4, 2022
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Texas Health and Human Services Commission
North Austin Complex
Public Hearing Room, 1st Floor
4601 Guadalupe Street
Austin, TX 78751

Agenda Item 1: Welcome, Opening Remarks and Introductions

The twenty-nineth Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:06 a.m. by Ms. Joleen Rasmussen, Chair. Ms. Rasmussen, Chair, welcomed committee members and members of the public in attendance. Ms. Rasmussen, Chair, provided opening remarks and turned the meeting over to Ms. Kayla Cates–Brown.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted roll call of members and noted the presence of quorum.

Ms. Rasmussen, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations. Ms. Rasmussen, Chair, introduced HHSC staff.

Table 1: The BHAC member attendance at the Friday, November 4, 2022 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Adio-Oduola, Olawale	X		Rupani, Nasruddin	X	
Beach, Doug		X	Vale Saenz, Vanessa (joined late)	X	
Curtis, Amy, Ph. D	X		Smelley, Jordan	X	
Diaz, Elias	X		Walker, Paul, Dr.	X	
Gray, Anna	X		VACANT		
Hicks, Tracy, Dr.		X	VACANT		
Rasmussen, Jolene	X		VACANT		
Reed, Jennifer	X		VACANT		
Rodriguez, Victoria	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 2: Consideration of August 5, 2022 meeting minutes
Ms. Rasmussen, Chair, referred members to the draft minutes emailed by the committee liaison and requested for any edits from the members, Hearing none, Ms. Rasmussen, Chair, requested a motion to approve the minutes from the August 5, 2022 committee meeting.

MOTION: Dr. Paul Walker moved to approve the minutes from the August 5, 2022, committee meeting as presented in the meeting. Mr. Jordan Smelley seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Adio-Oduola, Curtis, Diaz, Gray, Rasmussen, Reed, Rodriguez, Rupani, Smelley, Soto), no nays and no abstentions.

Agenda Item 3: Consideration of BHAC annual report to HHSC and Legislature as required by Title 1, Part 15, Texas Administrative Code, Sections 351.807
Ms. Rasmussen, Chair, led the member discussion of the BHAC annual report to be submitted to the HHSC Executive Commissioner and the Legislature.
Highlights of the update:

- Ms. Rasmussen referred members to the table of recommendations and informed members of the request to have HHSC review the recommendations semi-annually.
- Ms. Gray asked if there was a feedback loop from the Legislature to help address their questions or points of clarification. Ms. Rasmussen shared that the process is for the Legislature to submit questions and concerns to HHSC. HHSC will provide the committee with the feedback if submitted by the Legislature.
- Ms Gray asked if there is a need for the committee to submit a request for additional funding to the Legislature. Ms. Rasmussen stated this would be addressed in the LAR presentation later in the meeting.

Ms. Rasmussen, Chair, requested a motion to approve the BHAC annual report to be submitted to the HHSC Executive Commissioner and the Legislature.

MOTION: Dr. Amy Curtis moved to approve the BHAC annual report to be submitted to the HHSC Executive Commissioner and the Legislature as presented in the meeting. Mr. Olawale Adio-Oduola seconded the motion. The vote was suspended until quorum was met later in the meeting. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Adio-Oduola, Curtis, Diaz, Gray, Rasmussen, Reed, Rodriguez, Rupani, Smelley, Soto), no nays and no abstentions.

Ms. Rasmussen, Chair, requested a motion to give staff authority to make any non-substantive edits to the report before submission.

MOTION: Ms. Anna Gray moved for approval to give staff authority to make any non-substantive edits to the report before submission. Mr. Smelley requested clarification on non-substantive edits. Ms. Kailing responded the edits would be template formatting, spelling and grammar edits. Mr. Jordan Smelley seconded the motion. The vote was suspended until quorum was met later in the meeting. After conducting a roll call vote of

the members, the motion unanimously passed with 10 yeas (Adio-Oduola, Curtis, Diaz, Gray, Rasmussen, Reed, Rodriguez, Rupani, Smelley, Soto), no nays and no abstentions.

Agenda Item 4: Behavioral Health Advisory Committee Subcommittee updates: Ms. Rasmussen, Chair, opened the floor for BHAC subcommittee updates. Ms. Rasmussen reminded members of previous discussions regarding transitioning the Policy and Rules subcommittee from a standing subcommittee to an ad hoc subcommittee which would require a member vote for approval.

a. **Access to Care and Community Engagement Subcommittee** – Ms. Joleen Rasmussen provided the update to members. Highlights of the update included:
   - There is an everchanging landscape in behavioral health, especially the crisis continuum, and 988 has an increased focus on crisis in the community.
   - The 211 Texas network resource will be reviewed.

Ms. Rasmussen, Chair, requested a motion to approve transitioning the Policy and Rules subcommittee from a standing subcommittee to an ad hoc subcommittee.

MOTION: Ms. Anna Gray moved for approval to transition the Policy and Rules subcommittee from a standing subcommittee to an ad hoc subcommittee. Mr. Elias Diaz seconded the motion. After conducting a roll call vote of the members, the motion unanimously passed with 10 yeas (Adio-Oduola, Curtis, Diaz, Gray, Rasmussen, Reed, Rodriguez, Rupani, Smelley, Soto), no nays and no abstentions.

b. **Children and Youth Behavioral Health Services Subcommittee** – No update was given.

c. **Housing Subcommittee –** Ms. Jolene Rasmussen provided the update to members. Highlights of the update included:
   - Ms. Rasmussen, Chair, led the member discussion regarding dissolvement of the Housing subcommittee due to vacant member positions.
   - Housing recommendations will continue to be discussed in the other subcommittees and potentially in the future when the member positions are filled the Housing subcommittee could be revisited.
   - Possibly a boarder development of social determinates of health subcommittee.
   - Member inquired about moving the housing topics under the access to care and community engagement subcommittee.

After member discussion concluded, Ms. Rasmussen, Chair, requested a motion to dissolve the Housing subcommittee.

MOTION: Mr. Jordan Smelley moved to dissolve the Housing subcommittee. Ms. Victoria Rodriguez seconded the motion. The vote was suspended until quorum was met later in the meeting. After conducting a roll call vote of the members, the motion unanimously passed

with 10 yeas (Adio-Oduola, Curtis, Gray, Rasmussen, Reed, Rodriguez, Rupani, Sanez, Smelley, Soto), no nays and no abstentions.

d. **Peer Specialists and Family Partner Services Subcommittee** – Ms. Anna Gray provided the update to members. Highlights of the update included:
   - Promoting peer and family partner services in the state.
   - Ensuring competitive compensation to attract and retain a well-qualified workforce.
   - Promote continued paid training and development opportunities for peers and family partners so they can be informed of developments in their professions.
   - Promote recovery services in all mental health and substance use programs in the state.
   - Ensure fidelity to peer run program practices.
   - Promote the development of peer run programs.
   - Address the specific peer and family partners needs of rural communities.
   - Reduce barriers to full peer integration in services.

Member Break
After a member break, Ms. Rasmussen, Chair, reconvened the meeting.

Agenda Item 5: Health and Human Services Commission updates
Ms. Rasmussen, Chair, introduced Ms. Robyn Strickland who provided the Behavioral Health update on behalf of Associate Commissioner Trina Ita, HHSC.

a. **Behavioral Health Services –** Highlights of the update included:
   - Organizational changes at HHSC – previously, Intellectual and Developmental Disability and Behavioral Health Services (IDD-BHS) provided a unified and coordinated approach to the delivery of appropriate and cost-effective IDD and behavioral health services. With the organizational changes, IDD and BH will be separated out and under Deputy Executive Commissioner Gaines.

Ms. Rasmussen, Chair, introduced Dr. Courtney Harvey, Associate Commissioner, and Chair of the Statewide Behavioral Health Coordinating Council (SBHCC), HHSC to provide an update from the Office of Mental Health Coordination and Statewide Behavioral Health Services. Mr. Will Krueger and Mr. Brent Whitaker provided an update from the Stakeholder and Government Relations Office.

b. **Office of Mental Health Coordination** – Highlights of the update included:
   - The Statewide Behavioral Health Strategic Plan Fiscal Years 2022-20226 has been published. There is a new focus on substance use. Ms. Kailing will email members the link to the report.
   - Mr. Whitaker and Mr. Krueger provided information on the Legislative Appropriations Request (LAR) development process.
     - In fall 2021, the Health and Human Services Commission (HHSC) solicited and received feedback from the public and stakeholders regarding the 2024 25 Legislative Appropriations Request (LAR).

- The agency received more than 200 emails containing 572 funding and programmatic requests by the submission deadline (November 19, 2021).
- Most requests, or 54 percent, concerned programmatic or funding changes for Medicaid, including Medicaid Waiver Programs, and Community Behavioral Health Services.
- Additionally, 28 percent of replies concerned mental health, either community services, state psychiatric hospital services, addiction services or housing, with feedback on addiction services making up more than half of all mental health comments.

Ms. Rasmussen, Chair, introduced Ms. Leslie Smart and Ms. Tamara Boyd-Ostrout who provided the Medicaid update.

c. **Medicaid** – Highlights of the update included:
- HB 4, 87th Legislature, Regular Session, 2021 - requires HHSC to allow more services to be delivered using telemedicine, telehealth, and audio-only methods on a permanent basis after the PHE ends if clinically appropriate and cost-effective
- SB 670, 87th Legislature, Regular Session 2021 – under SB670: MCO's can't deny reimbursement to health care providers for a Medicaid service or procedure just because it was delivered via telemedicine or telehealth; and or reduce reimbursement for a covered health care service or procedure based upon the network provider's choice of platform. MCO's must ensure that telemedicine and telehealth services promote and support patient-centered medical homes.
- Behavioral Health Rule Update

Agenda Item 6: Public Comment

Ms. Cates-Brown read the public comment announcement and coordinated the registered oral public comment. No written public comment was submitted and there were no in person requests to provide public comment.

- **Registered oral public comment** – Ms. Linda Litzinger, representing Texas Parent to Parent provided testimony that parents are prepared for guardianship when their child turns 18. Parents are not prepared for what happens regarding guardianship at age 17. Ms. Litzinger recommended that parents should be informed and prepared to have legal guardianship established by the child's 17th birthday. Ms. Litzinger encouraged the BHAC to help parents with establishing guardianship correctly and by the right date.

Agenda Item 7: Review of action items and agenda items for next meeting

Ms. Rasmussen, Chair, opened the floor for action items and agenda topics for the next meeting. Ms. Rasmussen, Chair, announced the next meeting is scheduled for Friday, February 3, 2023 at 9:00 am.

Action and Agenda Items discussed:

- Bylaw revisions – members will be emailed the revisions prior to the meeting for their review
- School interface with the SBHCC – expanded section to include in report
- Email reminder to members in the months leading to the next BHAC meeting that recommendations can be submitted to the program area to facilitate discussion and potential approval at the February meeting.
- Program liaison will email members HHSC new organizational chart
- Program liaison will email member more information on the Behavioral Health Rule project

Agenda Item 8: Closing Remarks

Ms. Rasmussen, Chair, offered closing remarks and thanked members and the public for their participation. Ms. Rasmussen, Chair, adjourned the BHAC meeting at 12:41 p.m.

Below is the link to the archived video of the November 4, 2022 Behavioral Health Advisory Committee meeting that will be available for viewing approx. two years from date meeting was posted on website and based on the HHSC records retention schedule.
(To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee

Behavioral Health Advisory Committee
APPROVED Meeting #30 Minutes
Friday, May 5, 2023
9:00 a.m.

Virtual: Teams Meeting Platform
In Person Meeting Site: Texas Health and Human Services Commission
North Austin Complex
Public Hearing Room, 1st Floor
4601 Guadalupe Street
Austin, TX 78751

Agenda Item 1: Welcome, Opening Remarks and Introductions

The thirty Behavioral Health Advisory Committee (BHAC) meeting was called to order at 9:01 a.m. by Ms. Joleen Rasmussen, Chair. Ms. Rasmussen, Chair, welcomed committee members and members of the public in attendance. Ms. Rasmussen, Chair, provided opening remarks and turned the meeting over to Ms. Kayla Cates–Brown.

Ms. Kayla Cates-Brown, Advisory Committee Coordination Office (ACCO), HHSC, provided meeting logistics and announced the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Cates-Brown conducted member roll call and announced the initial absence of quorum. Quorum was met later in the meeting when an additional member joined.

Ms. Rasmussen, Chair, reviewed the purpose and charge of the BHAC. The purpose of the committee is to provide customer, consumer, and stakeholder input to the Texas Department of Health and Human Services system in the form of recommendation regarding the allocation and adequacy of behavioral services and programs within the state of Texas. In addition, the Statewide Behavioral Health Coordinating Council (SBHCC) Strategic Plan was adopted by the BHAC membership as the strategic plan for the BHAC and to assist with implementation of strategic plan recommendations. Ms. Rasmussen, Chair, introduced HHSC staff.

Table 1: The BHAC member attendance at the Friday, May 5, 2023, meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Adio-Oduola, Olawale	X		Rupani, Nasruddin	X	
Beach, Doug		X	Vale Saenz, Vanessa		X
Curtis, Amy, Ph. D	X		Smelley, Jordan	X	
Diaz, Elias	X		Walker, Paul, Dr.	X	
Gray, Anna	X		VACANT		
Hicks, Tracy, Dr. (joined late)	X		VACANT		
Rasmussen, Jolene	X		VACANT		
Reed, Jennifer		X	VACANT		
Rodriguez, Victoria	X		VACANT		
			VACANT		

Yes: Indicates attended the meeting No: Indicates did not attend the meeting

Agenda Item 2: Consideration of November 4, 2022, meeting minutes
Ms. Rasmussen, Chair, announced the approval vote regarding the draft minutes was tabled due to lack of quorum and would be revisited if quorum is met later during the meeting.

Agenda Item 3: Behavioral Health Advisory Committee subcommittee updates
Ms. Rasmussen, Chair, opened the floor for BHAC subcommittee updates.

a. **Access to Care and Community Engagement Subcommittee** – Ms. Joleen Rasmussen provided the update to members. Highlights of the update included:
   - Members identified the "Turn To" Campaign as a valuable and effective resource designed to reach the target audience. The campaign development included focus groups and initiatives to identify what was important to individuals and Texas and realizing that family and community rated very high. Several focus areas of the campaign were reaching out to someone to let them know they are not alone in feeling this way, that you can contact someone you care about and that you can take back control, understanding the connection between physical and mental health. Members were encouraged to review the website and share the resource with partners.
   - **Office of Rural Health – All Access Texas.**
     - Current pilot focused on understanding and bringing rural community resources and organizations together. The subcommittee talked about rural areas tend to utilize crisis services at a higher rate (150%-400%) than average. Speaks to importance of having preventive services and community resources. There will be a statewide toolkit so other communities can replicate the pilot.
   - **Non-Medical Determinants of Health/Social determinants of health.**
     - The Texas Consortium of Non-Medical Drivers of Health, to engage providers and stakeholders in the communities. Consortium looking for opportunities that providers can address individuals needs and be able to get reimbursed to obtain sustainability for initiatives. Consortium comprised of four affinity groups: food, community safety net providers, medical systems, evaluation. Important to identify the outcome is anticipated to improve because the needs are being addressed.
   - **SAMHSA has updated their certification criteria for the certified community behavioral health clinics (CCBHCs).**
     - One of the outcome measures that changed is the social determinants of health: transportation, food, housing, utilities, and personal safety. The subcommittee discussed that any assessment tool used explain why the information is being collected. SAMHSA recommends the American Academy for Family Physicians, which includes a question asking the individual if they want assistance with any of their needs. This question gives the person a choice to get their needs addressed now or later.

b. **Children and Youth Behavioral Health Services Subcommittee** – Ms. Josette Saxton provided the update to members. Highlights of the update included:
   - Newly elected subcommittee Co-Chair Marilyn Johnson (family representative).

- Focused on crisis continuum for children and families (best practices, barriers, family testimonies).
- Dr. Rishi Sawhney provided the subcommittee information about a survey/report on the availability of crisis services.
    - Top five services identified that should be prioritized were specialized counseling, intensive outpatient/partial hospitalization, crisis respite, mobile crisis outreach teams, and residential treatment centers.
    - Services that should be expanded: counseling, family therapy, crisis services, case management, and psychological assessments.
    - Common barriers: lack of timely access to mental health treatment, lack of knowledge about what services are available, cost associated with mental health care, and difficulty navigating mental health systems.
    - Children younger than 13 years of age have the greatest difficulty accessing services.
- Heard from DFPS staff about addressing youth that have the most difficulty maintaining a placement. DFPS created positions for Community Coordinators and Clinical Liaisons who work with children that are without placement. They do not manage a caseload but work with other caseworkers and help troubleshoot placements. Focus on youth who have behaviors that may be challenging. Subcommittee talked about the value of providing peer support services to the teens. The Harris Center has a peer support specialist who participates in a mobile outreach team. Increase access and availability of youth peer support.
- HHSC's Community Resource and Coordination Groups (CRCGs).
    - Bring stakeholders from various public and private agencies together to brainstorm options, along with a family, to identify the needs of the child and family, what are the strengths and what services area availability to come up with a plan for the family.
    - CRCGs do not get funding at the local level and are mainly voluntary. HHSC has built up support provided to CRCGs.
    - Subcommittee looking at how to maximize the information local CRCGs are sharing with HHSC about the needs and gaps of the families they are serving, and what are the outcomes. Use the data CRCGs collect to better inform activities at the state level.
- It was suggested for the subcommittee to discuss substance use and legislation in their future meetings.

c. **Peer Specialist and Family Partner Services Subcommittee –** Ms. Anna Gray provided the update to members. Highlights of the update included:
    - **Subcommittee brought forth recommendations for review and approval vote by the full committee centered on the unwinding of Medicaid:**
        - Recommend HHSC provide special focus on notifying people with lived experience of mental health issues as they roll out their efforts to reach Medicaid recipients. Includes language on the Medicaid website that will minimize adverse reactions/fear response. Make sure all communication is trauma informed in a way to avoid eliciting a traumatic stress response.

    - Recommend HHSC work collaboratively with organizations that have initiatives to reach people on Medicaid, especially those who work with people with lived experience of mental health issues and support them by providing up-to-date and accurate information as the initiative moves forward.
    - Recommend HHSC encourage/ask LMHAs and LBHAs to have a point person responsible for educating staff about this to get the word out to everyone that is served. Have point person be included in information disseminated to collaborating organizations.
    - Recommend HHSC put specific language on Medicaid website about mental health (ex: "If you are on Medicaid because of MH know that this includes you.")
    - Recommend all material that is produced by HHSC about the unwinding of Medicaid include a QR code that directs people to up to date information.
    - Recommend having information disseminated in different formats to accommodate various learning styles.
- Looking at increasing the peer support and family partner workforce. A focus is growing peer run/peer-directed programs. Have been looking at legislation that would define peer-directed programs and how they work. Will work to clarify, in code, what a peer directed program is – an organization that provides peer support for people with lived experience of mental health and/or substance use issues. Organizations focusing on mental health are known as Consumer Operated Service Programs, while those focusing on substance use are Recovery Community Organizations (RCOs).
- Had a presentation on the role of HHSC and the legislature and how the agency advises on these matters.
- Received an update from All Texas Access Peer Learning Collaborative.
    - Started looking at concerns peers have in relation to provision of peer services: disconnection from supervisors, integrating peers as part of the team, hiring peers, extent in which centers are prepared to support peer specialists, and a need to expand social support for service recipients.
- Mr. Jordan Smelley noted that House Bill 4702, regarding IDD peer support is on the floor for vote today, May 5, 2023.

After member discussion concluded, Ms. Rasmussen, Chair, shared support for the recommendations on behalf of the Access to Care and Community Engagement subcommittee.

MOTION: Ms. Anna Gray moved to approve the Peers Specialist and Family Partner Services subcommittee recommendations as presented in the meeting. Ms. Rasmussen seconded the motion. After conducting a roll call vote of the members, the motion failed due to lack of quorum. Member approvals (Adio-Oduola, Curtis, Diaz, Gray, Hicks, Rasmussen, Rodriguez, Smelley, Walker), no nays and no abstentions.

d. **Policy and Rules (ad hoc) Subcommittee** – Ms. Anna Gray provided the update to members. Highlights of the update included:

- Discussed the Mental Health Community Crisis Hotline rule project.
    - Roll out 988 and push to have large majority of the 988 calls answered locally. Workforce shortage challenge - Rule change would allow for Business of Arts graduates without the training hours to answer phones while receiving the training.

Member Break
After a member break, Ms. Rasmussen, Chair, reconvened the meeting at 10:30 a.m. Ms. Cates-Brown conducted member roll call and announced the absence of quorum.

Agenda Item 4: Health and Human Services Commission updates
Ms. Rasmussen, Chair, introduced Acting Associate Commissioner, Reilly Webb, HHSC to provide an update from the Mental Health and Substance Use Programs section.

a. **Mental Health and Substance Use Programs –** Highlights of the update included:
    - **Legislative updates:** Behavioral Health Services tracked over 370 bills, took lead in reviewing more than half.
        - **Budget:** expansion of community inpatient beds with funding adding 234 community beds; funding for up to 150 competency restoration beds; expanding the budget for 6 crisis service units serving individuals at risk for admission into a psychiatric hospital; considering establishing youth mobile crisis teams; expansion of youth crisis respite; expanding current grant programs and creating new grant programs, for example child diversion facilities, mental health grant for justice involved individuals, and community mental health grant program.
        - **Bills:**
            - House Bill 2072 modified mental health grant justice involved individuals program in the Harris County jail diversion program to expand to non-profits.
            - House Bill 4173 require HHSC to develop an overdose mapping and response system to allow law enforcement to report and map an overdose within 24 hours.
            - Senate Bill 1228 is a grant program that would assist LMHAs to build mental health facilities.
            - Senate Bill 26 establishes a grant program for youth and families targeting children at risk for relinquishment; it codifies requirements for transitional support services for individuals being discharged from the state hospital system, and expands publicly available metrics regarding LMHAs and LBHAs.
            - House Bill 1359 is a rewrite of Chapter 55 of the family code, referencing the outpatient competency restoration programs for youth.

Ms. Rasmussen, Chair, introduced Associate Commissioner and State Forensic Director, Dr. Jennie Simpson, to provide an update from the Office of Forensic Coordination.

b. **Office of Forensic Coordination** – Highlights of the update included:

- **Spoke on four key metrics that guide the work of the Office of Forensic Coordination:** number of people booked into county jails using the TLETS continuity of care query, increase in competency restoration services, state geography and how it affects reducing justice involvement, and the forensic waitlist.
- **Office of Forensic Coordination focuses on five pillars:** state and local planning, policy and staffing to the Joint Committee on Access and Forensic Services, training and technical assistance, research and data analysis, as well as engagement, education, and coordination.
    - **State and local planning**: Sequential Intercept Mapping (SIM) and Eliminate the Wait.
        - Sequential Intercept Mapping Workshops to assist communities set strategic communities based on identified gaps. Priorities across communities include lack of diversion centers, establishing behavioral health leadership teams, increase data collection, enhance training on behavioral health and IDD for justice systems stakeholders, housing options for people who are justice involved, and enhanced jail-based services. Early outcomes after SIM mappings include county funding secured for diversion, identification of existing resources, and new community partnerships. Launching Youth SIM mapping in September [2023].
        - Eliminate the Wait is a statewide campaign to eliminate the wait for inpatient competency restoration services. There is a toolkit to support LMHAs/LBHAs, treatment providers, law enforcement, and the judiciary in their role as it relates to competency restoration.
- **Launched the Texas Behavioral Health and Justice Technical Assistance Center in April 2023.** Centralized source of information for the public, professionals, anyone involved in the intersection of behavioral health and criminal justice. The center has local expert network, expert consultation, SIM mapping workshops, and resources. Will be launching a pre-arrest collaborative through the TA center and will have a re-entry collaborative in the fall.
- **Committee feedback:** include resources for people with co-occurring mental health/substance use and IDD; provide services for people before there is a reason to interact with the justice system; and include TA for people being served.

Ms. Rasmussen, Chair, introduced Associate Commissioner Dr. Courtney Harvey, Chair of the Statewide Behavioral Health Coordinating Council (SBHCC), HHSC to provide an update from the Office of Mental Health Coordination and Statewide Behavioral Health Services. Mr. Philander Moore, Sr., Director, provided an update from the State Opioid Response Program.

c. **Office of Mental Health** Coordination and Statewide Behavioral Health – Highlights of the update included:
    - There are currently around 13 organizations receiving federal funds to address the opioid crisis across the state; this number can change based on available grants.
    - Texas Abatement Council is developing an online application to procure services with settlement dollars; voted to publish the proposed rules related to the grants and peer reviewed process that will be used to put out funds. HHSC does not have control of funds, but does have a level of coordination with the Comptroller office. The Comptroller has a website with information regarding the settlement dollars and who receives them.
    - Statewide Opioid Report Card gives a snapshot about what the 13 organizations receiving federal funds to address the opioid crisis are doing. Draft will be ready in July 2023.
    - National Statewide Opioid Coordination Network has frequent calls to discuss how state are addressing the crisis; state learn from each other and provide technical assistance. Will work on creating a national report card to note what is happening in states receiving settlement dollars.
    - **Committee feedback:** use some funding to scale up recovery organizations; GIS mapping of resources compared to where problems are.
    - The Statewide Behavioral Health Coordinating Council has been meeting monthly since February tracking over 200 bills with a behavioral health focus that might have an impact to the council as a body or w or more organizations that service on the Statewide Behavioral Health Coordinating Council. In late June will start implementation meetings to talk through implementation plans for the legislation.
    - One new possible deliverable is the development of a children's mental health strategic plan that would be due December 1, 2024. The Statewide Behavioral Health Coordinating Council will be directed to develop a subcommittee to develop the plan. The BHAC can help identify organizations that should be a part of the strategic plan development process. Transitional aged youth and making the plan available are points of conversation. Consideration of using the System of Care framework as the framework for the strategic plan.
    - **Committee feedback:** include more content related to substance use and peer support, and highlight what children and families need to keep them out of the system.
    - Texas Christian University is seeing students with a need above what college counseling services have been trained or expected to treat. Dr. Wood with the Texas Christian University Counseling Center will be providing a presentation to the Statewide Behavioral Health Coordinating Council at their meeting later in May. Posed question if committee would like Dr. Wood to present on array of services at Texas Christian University and the landscape of services at colleges.
    - Young Invincibles published the report *More than Self Care: Student Speaking Out on Mental Health*, which reflects landscape of mental health and substance use services offered at college and university campuses. Data collected during COVID-19 when colleges and universities were shut down.
    - Children's Mental Health Acceptance Day – event at capital on May 6, 2023. Hosting Texas System of Care and Community Coordination Group joint

conference in July. June 13-15 HHSC is hosting a Texas Suicide Prevention Symposium in collaboration with the Texas Suicide Prevention Council.

Ms. Rasmussen, Chair, introduced Mr. Noah Abdenour, Director, to provide an update from Peer Support and Recovery Section.

d. **Peer Support and Recovery Section** – Highlights of the update included:
- Peer Support and Recovery Section focused on fidelity to the model of peer support work.
- Act as technical support, manage different programs and projects, act as policy consultants, and the voice of lived experience in the state and nationally.
- One team focuses on workforce development – certification administration, PeerForce, leadership training, stakeholder engagement, and curriculum development. Another team focuses on services and capacity – programs delivering direct services like recovery support services, youth recovery services, peer-run organizations, Clubhouses, and capacity expansion projects. The research and strategic planning area oversee university contracts, alignment of technical assistance, contract strategy alignment, and program development and strategic planning.

Ms. Rasmussen, Chair, introduced Mr. Jimmy Blanton, Director, Value-Based Initiatives and Ms. Noelle Gaughen, Director, Quality and Evaluation to provide an update from the Medicaid and CHIP Services Office.

e. **Medicaid and CHIP Services** – Highlights of the update included:
- **Non-Medical Drivers of Health** are the conditions the places where people live, learn, work, and play that affect a wide range of health risks and outcomes. The Non-Medical Drivers of Health Action Plan is a strategic plan for Medicaid and CHIP Services to better coordinate work, set priorities, support managed care organizations and providers, and create successful collaborations.
  - **Action plan priorities:** food insecurity, housing, and transportation
  - **Plan goals and actions:**
    - Build data infrastructure – have screening tools and quality measures, plan for collecting member data, and evaluate trends.
    - Coordinate services – more coordinated referral systems, look for coordination in areas within the agency like SNAP, WIC and 2-1-1.
    - Develop policies and programs – reimbursement options for healthcare providers, MOC incentives and requirements, incorporate recommended measures based on data, explore options to test new models of care delivery.
    - Support collaboration – have internal HHS staff workgroup, have external learning collaboratives, and Look for ways to engage Medicaid members
- **Alternative Payment Model Performance Framework:** payments based on measure of quality and outcomes, moving away from fee for service. It does not add dollars in premiums paid to MCOs but encourages flexibility of how they are

allocating the funds. Texas uses contract targets to promote the alternative payment model.

- Close to 50% of overall APM achievement in the three major programs (STAR, STAR-PLUS, and STAR Kids). One indicator that model is working is how dollars are being allocated, specifically incentives.
- **Updated APM framework:** MCO earn points in five APM domains
  - APM Achievement level: maintain APM achievement, increase APMs, and successful increase in payment to high performing providers in APM.
  - Quality: award MCOs with high performance in quality metrics.
  - APM Priorities: rural providers, non-medical drivers of health, primary and behavioral health integration, pharmacists, and home community-based services.
  - APM Pilots/Initiatives: looking at current pilots but also at opportunities for pilots currently not in place.
  - APM Support: deepening relationship between MCOs and providers, ensure MCOs have a strategic plan in place with annual updates, point to MCOs performing evaluations and putting forth what they learned.
- **Committee feedback:** provide incentives for medication coverage, tie following to Texas Administrative Code around specialty drug lists to an incentive, look at return on investment as part of the evaluation (where was investment made and where the return is showing).

Agenda Item 5: Public Comment

Ms. Cates-Brown announced that written public comment was submitted and shared with the members. No one registered to provide oral public comment and there were no in person requests to provide public comment.

- **Written public comment submitted** – Ms. Marilyn Hartman and Ms. Pamela Cann, Members and Advocates, National Alliance on Mental Illness (NAMI) Central Texas.

Agenda Item 6: Review of action items and agenda items for next meeting

Ms. Rasmussen, Chair, opened the floor for action items and agenda topics for the next meeting.

- **Action and Agenda Items discussed:**
  - Next scheduled committee meeting – Friday, August 4, 2023
  - Children's Mental Health Acceptance Day – Saturday, May 6th
  - Mental Health Awareness Webinar: Take Care of Yourself - Suicide Prevention, Compassion, Fatigue and Self-Care – Tuesday, May 16th
  - Mental Health Creative Arts Banquet
  - Peer Support and Recovery Section Webinar: Peer Support In Texas and What We Do - Tuesday, May 30th
  - Committee liaison will provide information for members to participate in the SAMSHA mental health grant review process.

- Committee liaison will follow up with members to provide the dates and times for the upcoming subcommittee meetings.

Agenda Item 7: Closing Remarks
Ms. Rasmussen, Chair, and Ms. Anna Gray, Co-Chair offered closing remarks and thanked members and presenters for their participation.

Agenda Item 8: Adjourn
Ms. Rasmussen, Chair, adjourned the BHAC meeting at 1:25 p.m. CST.

Below is the link to the archived video of the May 5, 2023, Behavioral Health Advisory Committee meeting will be available for viewing approximately two years from the date the meeting was posted on the HHS website and based on the HHSC records retention schedule. (To view and listen to the entirety of the meeting click on the link below)

Behavioral Health Advisory Committee

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
State Information, Funding Agreements, Disclosure of Lobbying Activities			
Planning Steps			
Step 1: Assess strengths and organizatioal capacity of service system to address the specific populations	*Provide an overview of the state's M/SUD prevention (description of the current prevention system's attention to individuals in need of substance use primary prevention), early identification, treatment, and recovery support systems, including the statutory criteria that must be addressed in the state's Application. Describe how the public M/SUD system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SMHA, the SSA, and other state agencies with respect to the delivery of M/SUD services. States should also include a description of regional, county, tribal, and local entities that provide M/SUD services or contribute resources that assist in providing the services. In general, the overview should reflect the MHBG and SUPTRS BG criteria detailed in "Environmental Factors and Plan" section.*	Anna H. Gray, Elias Diaz, Jolene Rasmussen, Victoria Rodriguez	Do not define CMBHS as an electronic medical record or electronic health record. It is a data repository that should not be misrepresented in the application. Recommend modifying CMBHS description by removing the term “electronic health record” and limiting to terms used such as the "state’s electronic data system" or a "web-based data management system".
		Jolene Rasmussen and Anna H. Gray	Expand RSS funding and contracts to more organizations that are already providing, or are able to provide, SUD recovery support, including peer-run organizations.
		Victoria Rodriguez and Jolene Rasmussen	Increase funding for OSARs to allow some type of assistance while people are waiting for services, especially for those who do not have a payor.
		Elias Diaz	Expand funding to smaller/rural organizations. Grants are going to urban areas that serve rural communities, but it is weakening the rural infrastructure.
		Anna H. Gray, Elias Diaz, Jolene Rasmussen, Victoria Rodriguez	Instead of using number served as a metric, focus on realitic accessiblity of services (i.e. using local buildings, telehealth, local collaborations, etc.). Rural areas often can't meet the number served required due to lower population, which leads to services and programs concentrating on urban areas where the
		Anna H. Gray	Trauma training for pediatricians and family physicians to identify reasons for behavior instead of quickly medicating children.
		Anna H. Gray, Elias Diaz, Jolene Rasmussen, Victoria Rodriguez	Flexibility onevidence-based and promising practices for rural areas. Incoporate some of te practices SAMHSA and the NIH have approved but HHSC has not adopted.
		Anna H. Gray	Greater support for non-clinical community recovery support services
		Elias Diaz	Greater support for community collaboration. Prioritize projects that are collaborative efforts with local governments/communities.

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
Step 2: Identify the unmet service needs and critical gaps within the current system	*This step should identify the unmet service needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state's behavioral health system, including for other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps. The state's priorities and goals must be supported by data-driven processes. This could include data that is available through a number of different sources such as SAMHSA's National Survey on Drug Use and Health (NSDUH), Treatment Episode Data Set (TEDS), National Survey of Substance Use Disorder Treatment Services (N-SSATS), the Behavioral Health Barometer, Behavioral Risk Factor Surveillance System (BRFSS), Youth Risk Behavior Surveillance System (YRBSS), the Uniform Reporting System (URS), and state data. Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States with current Partnership for Success discretionary grants are required to have an active*		
Planning Tables			
Table 1: Priority Areas and Annual Performance Indicators		Jordan Smelley, MHPS	It should be a priority of Texas HHSC Mental Health and Substance Use Programs staff to set specific expectations of what is required to provide peer support services with block grant money that peers with MH must be served by a certified MHPS and peers with SUD must be served by certified RSPS as that is within the Medicaid Statute for MHPS/RSPS certifications as well as within the ethics MHPS and RSPS sign off on following. Currently when block grant funds are being used by Agencies that employ certified MHPS and/or RSPS the agencies feel that they do not have to follow Medicaid statute because Medicaid dollars aren't being used. This approach completley goes against the evidenced based practice of peer support in general because the biggiest requirement to provide ethically sound peer support is Peer Support Specialist having the same personal lived experience as the peer. This means peers with just MH should be supported by certified MHPS and peers with just SUD should be supported only by certified RSPS and peers that are co-
Table 2: State Agency Planned			
Table 2: State Agency Planned			
Table 3: SUPTRS BG Pesons in need/receipt of SUD treatment			
Table 4: SUPTRS BG Planned			
Table 5a: SUPTRS BG Primary			
Table 5b: SUPTRS BG Primary Prevention Planned Expenditures by IOM category			
Table 5c: SUPTRS Planned Primary			
Table 6: Non-Direct Services/System Development (SUPTRS)			
Table 6: Non-Direct Services/System Development (MH)			
Environmental Factors and Plan			

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
1. Access to Care, Integration, and Care Coordination	*Across the United States, significant percentages of adults with serious mental illness, children and youth with serious emotional disturbances, and people with substance use disorders do not access needed behavioral health care. States should focus on improving the range and quality of available services and on improving the rate at which individuals who need care access it. States have a number of opportunities to improve access, including improving capacity to identify and address behavioral needs in primary care, increasing outreach and screening in a variety of community settings, building behavioral health workforce and service system capacity, and efforts to improve public awareness around the importance of behavioral health. When considering access to care, states should examine whether people are connected to services, and whether they are receiving the range of needed treatment and supports. A venue for states to advance access to care is by ensuring that protections afforded by MHPAEA are being adhered to in private and public sector health plans, and that providers and people receiving services are aware of parity protections. SSAs and SMHAs can partner with their state departments of insurance and Medicaid agencies to support parity enforcement efforts and to boost awareness around parity protections within the behavioral health field. The following resources may be helpful: https://store.samhsa.gov/product/essential-aspects-of-parity-training-tool-for-policymakers/pep21-05-00-001; https://store.samhsa.gov/product/Approaches-in-Implementing-the-Mental-Health-Parity-and-Addiction-Equity-Act-Best-Practices-from-the-States/SMA16-4983. The integration of primary and behavioral health care remains a priority across the country to ensure that people receive care that addresses their mental health, substance use, and physical health problems. People with mental illness and/or substance use disorders are likely to die earlier than those who do not have these conditions.1Ensuring access to physical and behavioral health care is important to address the physical health disparities they experience and to ensure that they receive needed behavioral health care. States should support integrated care delivery in specialty behavioral health care settings as well as primary care settings. States have a number of options to finance the integration of primary and behavioral health care, including programs supported through Medicaid managed care, Medicaid health homes, specialized plans for individuals who are dually eligible for Medicaid and Medicare, and prioritized initiatives through the mental health and substance use block grants or general funds. States may also work to advance specific models shown to improve care in primary care settings, including Primary Care Medical Homes; the Coordinated Care Model; and Screening, Brief Intervention, and Referral to Treatment. Navigating behavioral health, physical health, and other support systems is complicated and many individuals and*	Jordan Smelley, MHPS	It should also be a priority for Texas HHSC Behavioral Health and Substance Use Program staff to makie it clear to certified CCBHCs orgnaizations that if someone comes in the door with SUD and/or MH but they or a person with them raises concerns or makes statements that implies the person seeking support potentially has IDD to at the very least require the CCBHs to offer a referal to testing to determine if the person seeking support does have IDD. If the person comes in alreday with a diagnosis of IDD then CCHBC's at the very least should be required to identify the needed supports and if the CCBHCs can not provide the needed support then they are required to refer the person to resrouces that can or contact Texas HHSC Behavioral Health and Substance Use Program staff for support reffering the person if the CCBHC has exhausted all other potential avenues to find a provider that offers the needed support(s) and cant find one so that the person with IDD can start getting the co-occuring IDD support that they need to not only enter long term recovery but
		Jolene Rasmussen	Increase the number of CHW program providers from 14 to 20 to serve the major metropolitan centers as well as the rural and frontier regions of the state. The focus should include outreach, engagement of underrepresented communities and should also address CORSD
2. Health Disparities	*In accordance with Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (Executive Order 13985), Advancing Equality for Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex Individuals (Executive Order 14075), the HHS Action Plan to Reduce Racial and Ethnic Health Disparities1, Healthy People, 20302, National Stakeholder Strategy for Achieving Health Equity3, and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and M/SUD outcomes among individuals of all cultures, sexual orientations, gender identities, races, and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (e.g., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the Behavioral Health Implementation Guide for the National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)4. Collecting appropriate data are a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status5. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations6. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBTQI+ populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide M/SUD services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve. In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or*		

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
4. Evidence-Based Practices for Early Interventions to Address Early SMI	*Much of the mental health treatment and recovery service efforts are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcomes across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis. SAMHSA's working definition of an Early Serious Mental Illness is "An early serious mental illness or ESMI is a condition that affects an individual regardless of their age and that is a diagnosable mental, behavioral, or emotional disorder of sufficient duration to meet diagnostic criteria specified within DSM-5 (APA, 2013). For a significant portion of the time since the onset of the disturbance, the individual has not achieved or is at risk for not achieving the expected level of interpersonal, academic or occupational functioning. This definition is not intended to include conditions that are attributable to the physiologic effects of a substance use disorder, are attributable to an intellectual/developmental disorder or are attributable to another medical condition. The term ESMI is intended for the initial period of onset."* *States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode (RAISE) initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). RAISE was a set of NIMH sponsored studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons*		
5. Person Centered Planning [MHBG]	*States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP team may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a*		

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
6. Program Integrity	*SAMHSA has a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for M/SUD services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SUPTRS BG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SUPTRS BG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds. The MHBG and SUPTRS BG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SUPTRS BG funds are allocated to support evidence-based, culturally competent programs, substance use primary prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.* *States traditionally have employed a variety of strategies to procure and pay for M/SUD services funded by the MHBG and SUPTRS BG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan;*		
7. Tribes: Requested	*The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation56 to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications. Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues. In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal*		
8. Primary Prevention (SUPTRS) -			
9. Statutory Criterion for MHBG			
Criterion 1: Comprehensive Community-Based Mental Health Service Systems			
Criterion 2: Mental Health System Data Epidemiology			
Criterion 3: Children's Services			
Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults			
Criterion 5: Management Systems			
10. Substance Use Disorder Treatment (SUPTRS) - Includes 11			
15. Crisis Services: Required for MHBG, Requested for SUPTRS			
16. Recovery		Jolene Rasmussen	Increase the number of funded RSS contracts from 24 to 30. Increase the number of YRCs from 11 to 15.

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments
18. Children and Adolescents M/SUD Services: Required for MHBG, Requested for SUPTRS BG	*MHBG funds are intended to support programs and activities for children and adolescents with SED, and SUPTRS BG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community.1. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.2. For youth between the ages of 10 and 14 and young adults between the ages of 25 and 34, suicide is the second leading cause of death and for youth and young adults between 15 and 24, the third leading cause of death.3. It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.4. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services. Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in*		
19. Suicide Prevention [MHBG]	*Suicide is a major public health concern, it is a leading cause of death overall, with over 47,000 people dying by suicide in 2021 in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges M/SUD agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide using MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the M/SUD agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.*		
20. Support of State Partners -MHBG	*The success of a state's MHBG and SUPTRS BG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include: The State Medicaid Authority agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations. The state's agency on aging which provides chronic disease self-management and social services critical for supporting recovery of older adults. The state's intellectual and developmental disabilities agency to ensure critical coordination for individuals with ID/DD and M/SUD conditions. Strong partnerships between SMHAs and SSAs and their counterparts in physical health, public health, and Medicaid, Medicare, state and area agencies on aging and educational authorities are essential for successful coordinated care initiatives. While the State Medicaid Authority (SMA) is often the lead on a variety of care coordination initiatives, SMHAs and SSAs are essential partners in designing, implementing, monitoring, and evaluating these efforts. SMHAs and SSAs are in the best position to offer state partners information regarding the most effective care coordination models, connect current providers that have effective models, and assist with training or retraining staff to provide care coordination across prevention, treatment, and recovery activities. SMHAs and SSAs can also assist the state partner agencies in messaging the importance of the various coordinated care initiatives and the system changes that may be needed for success with*		
21. State Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application			
22. Public Comment on the State			
23. Syringe Services Program			
BiPartisan Community Safety Plan	*Develop a proposal for the 2nd allotment of BSCA funds with the FY2024-25 Application as an attachment. Based on the guidance issued on October 11th, 2022, states should submit a proposal that includes a narrative describing how the funds will be used to help individuals with SMI/SED, along with a budget for the total amount of the second allotment. The proposal should also explain any new projects planned with the second allotment and describe ongoing projects that will continue with the second allotment. Both set asides- 10% for ESMI and 5% for Crisis Services are required for the BSCA-2nd Allotment. The performance period for the second allotment is from September 30th, 2023, to September 29th, 2025, and the proposal should be titled "BSCA Funding Plan 2024. The proposed plans are due to SAMHSA by September 1, 2023."*	Jolene Rasmussen	Since this does not include the provision of services, how is the program evaluated?

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Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments

Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments

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Section	SAMHSA Guidance	BHAC Member	Aug 2023 Comments

Environmental Factors and Plan

Advisory Council Members

For the Mental Health Block Grant, **there are specific agency representation requirements** for the State representatives. States MUST identify the individuals who are representing these state agencies.

State Education Agency
State Vocational Rehabilitation Agency
State Criminal Justice Agency
State Housing Agency
State Social Services Agency
State Health (MH) Agency.
State Medicaid Agency

Start Year: 2024 End Year: 2025

Name	Type of Membership*	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Olawale Adio-Oduola	Others (Advocates who are not State employees or providers)			
Doug Beach	Family Members of Individuals in Recovery (to include family members of adults with SMI)			
Brooke Boston	State Employees			
Amy Curtis	Others (Advocates who are not State employees or providers)			
Elias Diaz	Providers			
Anna Gray	Providers			
Courtney Harvey	State Employees			
Tracy Hicks	Providers			
Trina Ita	State Employees			
Jolene Rasmussen	Others (Advocates who are not State employees or providers)			
Jennifer Reid	Others (Advocates who are not State employees or providers)			
Victoria Rodriguez	Others (Advocates who are not State employees or providers)			
Nasruddin Rupani	Others (Advocates who are not State employees or providers)			
Vanessa Saenz	Others (Advocates who are not State employees or providers)			
Jonas Schwartz	State Employees			
Jordan Smelley	Youth/adolescent representative (or member from an organization serving young people)			
Paul Walker	Others (Advocates who are not State employees or providers)			

Julie Wayman	State Employees			
April Zamora	State Employees			

*Council members should be listed only once by type of membership and Agency/organization represented.

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Footnotes:

Environmental Factors and Plan

Advisory Council Composition by Member Type

Start Year: 2024 End Year: 2025

Type of Membership	Number	Percentage of Total Membership
Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	0	
Family Members of Individuals in Recovery (to include family members of adults with SMI)	1	
Parents of children with SED	0	
Vacancies (individual & family members)	3	
Others (Advocates who are not State employees or providers)	8	
Total Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services), Family Members and Others	**12**	**52.17%**
State Employees	6	
Providers	3	
Vacancies	1	
Total State Employees & Providers	**10**	**43.48%**
Individuals/Family Members from Diverse Racial and Ethnic Populations	0	
Individuals/Family Members from LGBTQI+ Populations	0	
Persons in recovery from or providing treatment for or advocating for SUD services	0	
Representatives from Federally Recognized Tribes	0	
Youth/adolescent representative (or member from an organization serving young people)	1	
Total Membership (Should count all members of the council)	**23**	

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Footnotes:

Environmental Factors and Plan

22. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

https://www.hhs.texas.gov/business/grants/behavioral-health-services-grants

If yes for the previous plan year, was the final version posted for the previous year? Please provide that URL:

https://www.hhs.texas.gov/business/grants/behavioral-health-services-grants

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

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

N/A

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Footnotes:

Environmental Factors and Plan

23. Syringe Services Program (SSP) - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act**, 2018 (P.L. 115-141) signed by President Trump on March 23, 2018[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of an SSP other than to purchase sterile needles or syringes. States interested in directing SABG funds to SSPs must provide the information requested below and receive approval from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when developing its Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016, the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs**,

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.samhsa.gov/sites/default/files/grants/ssp-guidance-for-hiv-grants.pdf ,**

2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**

3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above and follow the steps below when requesting to direct FY 2021 funds to SSPs.

- **Step 1** - Request a Determination of Need from the CDC
- **Step 2** - Include request in the FFY 2021 Mini-Application to expend FFY 2020 - 2021 funds and support an existing SSP or establish a new SSP
  - Include proposed protocols, timeline for implementation, and overall budget
  - Submit planned expenditures and agency information on Table A listed below
- **Step 3** - Obtain State Project Officer Approval

Future years are subject to authorizing language in appropriations bills.

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-23(b)) and 45 CFR § 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2020-2021 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit a request via its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan request is applicable to the FY 2020-2021 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2] Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.§ 300x-31(a)(1)(F)) and 45 CFR § 96.135(a)(6) explicitly prohibits the use of SABG funds to provide PWID with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2018 (P.L. 115-141)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(a)) and 45 CFR § 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. § 300x-24(b)) and 45 CFR 96.128 requires "designated states" as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes an SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a **description of the elements of an SSP** that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);
- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and

HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;

- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing an opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

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Footnotes:

N/A for Texas

Environmental Factors and Plan

Syringe Services Program (SSP) Information – Table A - Required if planning for approved use of SUBG Funding for SSP in FY 24

Planning Period Start Date: 7/1/2023 Planning Period End Date: 6/30/2024

Syringe Services Program (SSP) Agency Name	Main Address of SSP	Planned Dollar Amount of SUBG Funds to be Expended for SSP	SUD Treatment Provider (Yes or No)	# of locations (include any mobile location)	Naloxone Provider (Yes or No)
No Data Available					

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Footnotes:
N/A for Texas

BSCA Funding Plan 2024

The Bipartisan Safer Communities Act (BSCA) grant provides supplemental Community Mental Health Services Block Grant (MHBG) funds to enable states to expand access to mental health care. The Texas Health and Human Services Commission (HHSC) proposes to fund activities as described in SAMHSA's recommendation #1:

- "Describe any plans to utilize the BSCA supplemental funds to develop and enhance components of your state's mental health emergency preparedness and response plan that addresses behavioral health. Please include in your discussion how you plan to coordinate with other state and federal agencies to leverage crisis and mental health emergency related resources."

HHSC's proposal will continue the implementation and maintain focus on creating Readiness, Response, Resiliency Toolkits to:

(1) Assist our 39 local mental health authorities (LMHAs) and local behavioral health authorities (LBHAs) in the development of comprehensive mass violence incidents (MVI) readiness and response plans; and
(2) Provide LMHAs and LBHAs with a set of guidelines to initiate the establishment of a multidisciplinary community action plan (MCAP)

The community action plan will:

(1) Identify and establish collaborative partnerships with local and state emergency planning leadership;
(2) Develop strategies to integrate mental health and victim services into an emergency operation plans; to include emergency preparedness and planning considerations for persons with serious emotional disturbance (SED), serious mental illness (SMI), or first episode of psychosis/early serious mental illness (FEP/ESMI); and
(3) Identify existing community gaps, available resources, as well as training and workforce development gaps.

Because every community is different, the planning process will address the specific needs and resources of that community. The toolkits will provide a foundation for the LMHAs and LBHAs and their community partners to identify the most effective means of providing supportive services for victims and their families. HHSC will implement the program with a phased approach.

Phase One will include designing and developing well-defined, evidence-based, and best practices-based toolkits that are universal, easily implemented, and can be disseminated broadly. The second part of this phase would consist of implementation of the toolkit components. This would include generalized education for all 39 LMHAs and LBHAs related to specific aspects within the toolkit, specifically MCAP development, purpose, limitations, and implementation of the toolkit's components. During this phase, Continuity of Operations Planning (COOP) will

provide the LMHAs and LBHAs with a framework to begin building COOP plans and assembling COOP respite teams for MVIs.

Phase Two would include the continuation of individualized technical assistance for the initiation of multidisciplinary community planning, keys to components to meeting facilitation, and strategies for integrating into local emergency operation plans (EOP).

Grant activities link to HHSC's guiding principles as follows:

1. This program proposal will support fidelity to HHSC's mission "We serve Texas". By providing LMHAs and LBHAs with the tools to help their communities prepare for MVI events, HHSC is working towards protecting the state's mental health assets and aligning outcomes with agency expectations.
2. A major component of this project is to develop a communications plan that is universal in approach and can be used throughout the LMHA and LBHA network as a standard practice. This communications plan will be responsive to our stakeholders and provide them with readily accessible information to aid in their response to an MVI.
3. Creating toolkits will enable the LMHAs and LBHAs to remain agile. Having a set of preparedness guidelines will enable the LMHAs and LBHAs to anticipate challenges and adjust accordingly.

Proposal Goals

1. Develop toolkits and templates for all 39 LMHAs and LBHAs to use when planning for a mass violence incident.
2. Develop guidelines for LMHAs and LBHAs to develop an MCAP to effectively respond to victims, including people with SMI, SED, or FEP/ESMI, of MVI throughout the lifecycle of the event.
3. Provide a framework for COOP.

Fiscal Year 2024

The budget for fiscal year 2024 is funded by the initial BSCA allocation.

Proposed Budget for Fiscal Year 2025 by Category

Category	FY25 Budget
Personnel	$ 899,850
Fringe	$ 292,631
Travel	$ 159,080
Equipment	$ -
Supplies	$ 43,890
Other	$ 42,800
Contractual	$ -

Category	FY25 Budget
Total Direct Charges	$ 1,438,251
Indirect Charges	$ 495,388
Total Project Costs	**$ 1,933,639**

Phase One Objectives Summary:

1. DBHC designs and develops toolkits.
2. DBHC distributes toolkits.
3. DBHC holds workshops to educate LMHAs and LBHAs; and schedules individualized site visits.
4. DBHC holds individualized planning sessions with LMHAs and LBHAs to discuss components of the MCAP.
5. Each LMHA and LBHA:
   a. Gathers info and solicits community participants;
   b. Conducts internal briefings about the workshop's purpose and importance of developing emergency operations plans that includes members of the community; and
   c. Plans MCAP sessions.

Objectives	Action Plans
Design and Develop	**Phase One** • Design and develop comprehensive Readiness, Response, Resiliency Toolkits • Develop guidelines for LMHAs to develop an MCAP to effectively respond to victims of MVI
Distribution	**Phase One** • Conduct four educational workshops outlining specific elements of pre-planning including the development of MVI Response and Recovery toolkits and an MCAP. Additionally, these workshops will provide LMHAs and LBHAs with instructional material as it relates to identified vulnerable populations (i.e., SMI, SED, and FEP/ESMI), along with the elements of COOP. These will be formatted and delivered by the temporary FTEs funded by this grant as well as current DBHC staff. • Disseminate resource to the 39 LMHAs and LBHAs • Begin scheduling planning sessions with the 39 LMHAs and LBHAs
Planning Sessions	**Phase One** • Coordinate with the LMHAs and LBHAs to craft adaptable resources for individualized community action plans – prioritizing those LMHAs or LBHAs with limited capabilities • Utilize a regional approach to conduct work sessions that will focus on Readiness, Response, Resiliency and COOP • Provide the framework and educational component for COOP development

Objectives Explained

HHSC contracts with 37 LMHAs and two LBHAs to deliver mental health services in communities across Texas. LMHAs and LBHAs evaluate the mental health needs of communities in their area and plan, develop policy, coordinate services, and use resources to address those needs.

Developing universal easily implemented, and evidence- and best practices-based disaster behavioral health toolkits that can be disseminated broadly is the overarching objective for this grant proposal. HHSC's DBHC has a wide range of experience with the response and recovery aspects of the MVI that have impacted Texas. During the past decade, Texas has been affected by several mass violence and or criminal incidents: Fort Hood Shooting in 2014, South by Southwest Car Rampage in 2014, Sutherland Springs Church Shooting in 2017, Santa Fe School Shooting in 2018, HHSC Regional Office Shootings in 2011, 2017, and 2019, El Paso Walmart Shooting in 2019, Midland-Odessa Spree Shooting in 2019, White Settlement Church Shooting in 2020, and the Uvalde School Shooting in 2022. What is known is that no two MVIs are the same; community response and recovery will vary and according to LMHAs and LBHAs that have responded to MVI over the past five years, the state's network of LMHAs and LBHAs is not as prepared as it could be with an effective mental health response. While almost everyone exposed to a MVI will experience the expected fear and distress response, the nature or intensity of exposure should inform behavioral health responses (Schultz, 2014).

DBHC plans to design, develop, and disseminate comprehensive Readiness, Response, Resiliency Toolkits to fill this long-standing gap. This toolkit would include:

- Readiness – Conduct four educational conferences for specific elements of pre-planning. These will be formatted and delivered by temporary staff funded by this grant as well as some of the DBHC permanent state-funded staff. Workshop topics will include:
    - Incident Command System (ICS) - Organizational structure used by emergency responders to assist in managing resources during response to incidents. LMHAs and LBHAs should be trained in ICS in order to understand the framework, lines of reporting, and their role within ICS. The ICS environment can reduce chaos during the response and allow non-traditional responders, like the LMHAs and LBHAs, to integrate into an existing response framework.
    - Community Capacity – Focus on the importance of knowing community and LMHA or LBHA capacity to provide quality mental health services following an MVI.
    - MCAP – Identify key partners able to be activated as leadership in their respective roles during an MVI, with the authority to make decisions and allocate resources and help develop the MCAP.

- Family Assistance Centers versus Family Resiliency Centers – Provide distinctions, key partners and their role in each.
- Overview of MVI Trauma and its Impact – Address the prevalence and impact of MVI-related trauma and how it differs from generalized trauma-informed care. Provide information related to establishing MVI specific trauma-informed service systems.
- Fiscal Considerations – Focus on an array of financial issues important to consider as part of preparing for an MVI (e.g., coding and billing).
- COOP - Focus on conceptualization and education of both MVI COOP and COOP Team type.

Readiness Specialists will use a regional approach to conduct work sessions that will focus on the topics below:

- Readiness – Implementation to assist the LMHAs and LBHAs in the individualization of their toolkits.
  - Multidisciplinary Committee Identification and Engagement – How to assemble a multidisciplinary planning committee that represents systems and community-based agencies and organizations
  - Development of a Community Action Plan – Discuss components of the plan and why they are important. Emphasize the importance of generating a contact list of key responding agencies and their points of contact with backups
  - Determine an activation notification process that includes the triggering mechanism and method of notification. Who needs to be contacted? By whom? When?
- Response – Emphasizes cross agency collaboration when responding to an MVI.
  - Establishing an ICS, clarifying the interagency roles and delineating the roles and responsibilities of LMHA and LBHA personnel
  - Establishing and clarifying role in Family Assistance Centers
  - Challenges in immediate response
  - Identifying and addressing the immediate mental health needs of victims and the community
  - Establishing public information and crisis communications protocol
  - Fiscal Considerations – Addressing financial issues and concerns that arise in the wake of an MVI, including tips on how to manage donations, information about crime victims' compensation, financial resources, and general information about Antiterrorism and Emergency Assistance Program grants.

- Resilience – Addresses key considerations in the transition from the response to resilience and recovery phase of an MVI.
    - Identify and address the short and long-term needs of a community
    - Core components of a community needs assessment.
    - Identify effective strategies for community outreach that reflect the community's diversity, culture, and demographics.
    - Establishing a Family Resiliency Center – Key community components, professionals, and organizations necessary for a collaborative FRC and the role of Antiterrorism and Emergency Assistance Program grants in financially supporting a Resiliency Center.
    - Effective strategies to increase community resiliency to include identifying the long-term needs of victims and survivors and their communities, managing memorials and commemorative events, and the importance of inclusivity.
- Specialty Care Coordinator will coordinate and take the lead on conducting educational sessions in the workshops to discuss the specific elements of planning and preparedness for the SMI, SED, and FEP/ESMI populations. These will be formatted and delivered by temporary staff funded by this grant and some DBHC general revenue-funded staff. Workshop topics will provide:
    - An overview of emergency preparedness and planning considerations for these populations throughout the disaster cycle
    - Guidance on the examination of current EOP to ensure evidence-based practices and components for these populations are included
    - Resources and linkages to augment their EOPs with the appropriate components (e.g., population specific plan for annual training, test drills and exercises)
- COOP – Highlights internal effort of the LMHA or LBHA to assure their capability to continue essential functions and services in response to an MVI.
    - Identify the elements of the COOP
    - Business Impact Analysis (BIA) - Determine and evaluate the potential effects of an interruption to critical business operations because of a disaster, accident, or emergency
    - Provide education and a general framework on the four phases of COOP
    - COOP team type (Respite)- To include deployment parameters and demobilization
    - Implementation of both MVI COOP and COOP team type

In addition to continuing to assist with the individualization of the LMHA and LBHA toolkits, DBHC would like to lay the foundation for the LMHA's or LBHA's COOP work.

Phase Two Objective Summary

1. DBHC continues holding individualized planning sessions to discuss components of community action plans.
2. Each LMHA and LBHA:
   a. Gathers information and solicits community participants;
   b. Returns to help facilitate development of MCAP, share purpose, develop session plans, and reinforce the importance of having community planning sessions;
   c. Begins COOP work for both MVI COOP and COOP Teams;
   d. Conceptualizes and educates; and
   e. Develops component work (i.e., framework) for:
      i. BIA – MVI COOP
      ii. Phases – MVI COOP

Objectives	Action Plans
Planning Sessions	**Phase Two** • Continue utilizing a regional approach to conduct work sessions focusing on Readiness, Response, Resiliency, and COOP • Provide technical assistance to LMHAs and LBHAs on the development of Community Action Plans
COOP Activities	**Phase Two** • Contextualize both MVI COOP and COOP Team type (Respite) • Initiate the build-out of COOP Teams (Respite) to ensure the LMHA or LBHA has a consistent relief plan during the initial response and respite during the initial stages of recovery

Objectives Explained

Experience has taught the state that when an MVI occurs, the LMHA's or LBHA's daily operations can be severely disrupted. Because LMHAs and LBHAs tend to be a trusted mental health entity within the community, there is a strong likelihood their services will be in higher demand. For this reason, a COOP that includes BIA needs to be conducted. COOP is an effort within individual executive departments and agencies to ensure that primary mission-essential functions continue to be performed during emergencies and are not disrupted.

Another lesson learned from previous MVI is that COOP may not be a primary concern for most LMHAs and LBHAs unless they are a Texas Certified Community Behavioral Health Clinic. Using the same framework required by the Department of Health and Human Services and SAMHSA could ensure that all 39 LMHAs and LBHAs have consistent COOP practices throughout the life of the MVI.

Given the depth and breadth of COOP planning, the two COOP Planners and two Specialty Care Coordinators will utilize the four regions created for preparedness with the intent to mirror the Texas Division of Emergency Management's disaster districts. Their scope will be relegated to providing education and a general framework to begin developing their plans within the four phases of COOP:

- Readiness and Preparedness – COOP planning, to include BIA development**,** and drills and exercise coordination
- Activation – Plans and procedures for COOP/COOP Team activities,
- Operations Continuity – Execution of plans when an emergency occurs, and
- Reconstitution – Termination of continuity operations and resuming normal operations.

Since DBHC recognizes respite teams must be an essential part of any COOP, this foundation will provide a framework to begin establishing respite teams or Continuity of Operations Teams among the network of LMHAs and LBHAs. The two COOP Planners will assist LMHAs and LBHAs with building teams that will provide support to the LMHAs and LBHAs by providing resources and culturally appropriate skillsets to mitigate the effects of the MVI on the LMHA or LBHA. These teams will also provide the LMHA and LBHA with relief during the initial response and respite during the initial stages of recovery. This strategy will ensure that the best practice of "no closed door" for victims is supported and maximize the contribution to the overall continuity of operations response effort.

It is important to note employees of the LMHA or LBHA can be affected by a tragedy as much as any other community member. It is their community as well. Working in a community mental health center does not negate or minimize the trauma or emotional toll. Having a respite COOP in place is a best practice in self-care as well as an investment in the human capital that provides services and support and ensures the continuity of day-to-day mission essential functions of the organization. To this end, BSCA-funded staff may also deploy to the impacted communities in support of community action coordination to implement toolkit activities in real time. BSCA-funded staff deployment will be in support of their service region, respectively. However, aligning with DBHC recovery, respite, and COOP best practices, additional BSCA-funded staff rotations may be augmented to ensure continuity of BSCA activities, if the incident is of a protracted nature.
To support these services, Disaster Behavioral Health Coordination (DBHC) proposes a staff of 10 to operationalize the phased approaches. During the program development stage, the 88th Texas Legislature passed Senate Bill 30, authorizing the pay increase for state employee to include a five percent increase of each classified employees' base pay. The pay increase will be effective in phase two. In addition, Texas Government Code authorizes state agencies to grant merit salary increases or make one-time merit payments to eligible employees whose job performance and productivity are consistently above the normal or expected levels.

New for Fiscal Year 2024 and 2025: BSCA Proposal for Community Resource Coordination Groups

In addition to the continued implementation and creation of the Readiness, Response, Resiliency Toolkits, HHSC proposes to use BSCA funds to help build collaborations by providing regional support to Texas' Community Resource Coordination Groups (CRCGs).

Per SAMHSA's letter to Commissioners dated October 1, 2022, BSCA grant funding provides a unique opportunity for policymakers to develop improved and sustainable public mental health systems that are more adept at meeting the needs of vulnerable people, including those with more complex presentations. Texas HHSC proposes to fund activities in alignment with this call from SAMHSA by supporting our local CRCGs to advance community-based mental health services in their local communities for persons with complex needs.

CRCGs are county-based groups of local partners and community members who work with parents, caregivers, children, youth, and adults with complex needs to identify and coordinate services and supports. The intent of the CRCG is to make available, a diverse network of community providers, who together, staff cases of people with the most complex clinical and social needs, such that their needs cannot be met by one provider or organization.

Collectively, they do not deliver services to these individuals, but they make a recommendation on a level of care and services and supports required to address the individual's needs.

Objectives Explained

There are currently 146 CRCGs across Texas, each serving their local community by helping to identify and coordinate services and supports to help people whose needs can't be met by one single agency and who would benefit from interagency coordination.

CRCGs stive to meet the person's and family's needs with community-based solutions whenever possible, and by being culturally and linguistically responsive to the needs of their local community.

HHSC proposes to use BSCA funds to support the 146 CRCGs operating locally by providing targeted outreach, engagement, training, and technical assistance to help support CRCGs in helping coordinate community mental health services for children and adults with SED, SMI, or FEP/ESMI. This project will support the development of public, community mental health systems for adults and children with complex needs.

Proposed Budget for Fiscal Year 2024 by Category

Category	FY24 Budget
Personnel	$ 262,387.50
Fringe	$ 85,328.35
Travel	$ 78,716.25
Equipment	$ -
Supplies	$ 42,890.00
Other	$ 42,800.00
Contractual	$ 986,113.04

Category	FY24 Budget
Total Direct Charges	$ 1,423,324.14
Indirect Charges	$ 74,911.00
Total Project Costs	**$ 1,498,235.14**

Proposed Budget for Fiscal Year 2025 by Category

Category	FY25 Budget
Personnel	$ 262,387.50
Fringe	$ 85,328.35
Travel	$ 78,716.25
Equipment	$ -
Supplies	$ 42,890.00
Other	$ 42,800.00
Contractual	$ 986,113.04

Category	FY25 Budget
Total Direct Charges	$ 1,423,324.14
Indirect Charges	$ 74,911.00
Total Project Costs	**$ 1,498,235.14**