Children's Behavioral Health Strategic Plan

December 2024

Fiscal Years 2025–2029

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Disclaimer

This report was developed by the Texas Statewide Behavioral Health Coordinating Council's (SBHCC) Children's Behavioral Health Strategic Plan Subcommittee. The recommendations were not authored by and do not reflect the views and opinions of the Texas Health and Human Services system, its component agencies, or staff.

Acknowledgements

Children’s Behavioral Health Strategic Plan Subcommittee Membership

The Children’s Behavioral Health Strategic Plan represents voices from across Texas, including mental health, substance use, and criminal justice professionals, people with lived experience and their families, community leaders, and program and policy subject matter experts across other stakeholder systems. Every effort was made to ensure the strategic plan for Texas children is reflective of the goals and priorities of diverse stakeholders.

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Mission, Vision, and Guiding Principles

The 88th Texas Legislature directed the Statewide Behavioral Health Coordinating Council (SBHCC) to establish a subcommittee to develop a strategic plan focused on the mental health and substance use [hereafter referred to as behavioral health][1] needs of children and offer a blueprint for understanding and meeting these needs over time.

Per the 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article IX, Health-Related Provisions, Sec. 10.04(g)) the plan must incorporate the full continuum of care needed to support children and families and include:

(1) descriptions of who provides what services to which children;
(2) strategies to identify and address gaps in care;
(3) discussion of workforce shortages;
(4) information on funding and reimbursement; and
(5) children-specific data and expenditure information.

The subcommittee met July 2023 through July 2024 to complete and submit the plan to the Legislative Budget Board and the Governor's Office by December 1, 2024.

VISION:
All Texas children have access to a comprehensive and equitable continuum of behavioral health care that is available, accessible, affordable, and improves their quality of life.

MISSION:
To strengthen the collaboration of state and local efforts to weave behavioral health supports and services into seamless systems of care for children and their caregivers.

[1] Per the American Medical Association, behavioral health generally refers to mental health and substance use disorders, life stressors and crises, and stress-related physical symptoms. Behavioral health care refers to the prevention, diagnosis and treatment of those conditions.

GUIDING PRINCIPLES:

1. Children and their caregivers have access to a range of developmentally appropriate services, provided in the least restrictive environment, that are culturally and linguistically responsive and address their emotional, behavioral, social, educational, and physical needs.

2. Children and their caregivers have access to services that are integrated at the system and practice levels, cross administrative and sustainable funding boundaries, and promote continuity of care with agreements between child-serving agencies and programs.

3. Children and their caregivers receive individualized treatment that is developed in partnership with them and recognizes their unique needs and strengths.

4. Prevent or lessen the impact of behavioral health conditions in children by investing in upstream initiatives that target the promotion, prevention, early identification, and intervention of behavioral health conditions.

5. Improve outcomes for children and their caregivers by investing in evidence-based, promising, and practice-based services and supports that are cost and clinically effective.

6. Develop and track outcomes at the system, practice, and child and family levels to assess the effectiveness of behavioral health services and incorporate continuous accountability and quality improvement processes to enhance service provision.

Executive Summary

According to the United States (U.S.) Census Bureau, one of every 10 people under the age of 18 in the U.S. lives in Texas.[2] In 2022, the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that of the 3.8 million children in Texas between the ages of 9 and 17, up to 500,000 had a serious emotional disturbance (SED)[3] causing moderate symptoms and/or functional impairment.[4] The 2021-2022 National Survey on Drug Use and Health (NSDUH) indicated that up to 7.8 percent of Texas children ages 12-17 had a substance use disorder in the past year (i.e., 2021 onward). [5]

Supporting children's recovery from mental and substance use conditions is possible and can be achieved through effective implementation of local and state-level Systems of Care.[6]

A system of care is a multi-sector partnership intended to provide a mechanism for planning, financing, evaluating, and ensuring the availability of and children's access to behavioral health services and supports. It is inclusive of behavioral health promotion, prevention, early identification and intervention, treatment, and recovery designed to meet the unique needs of children and their caregivers. The goal of systems of care is to help children thrive at home, school, communities, and adulthood.

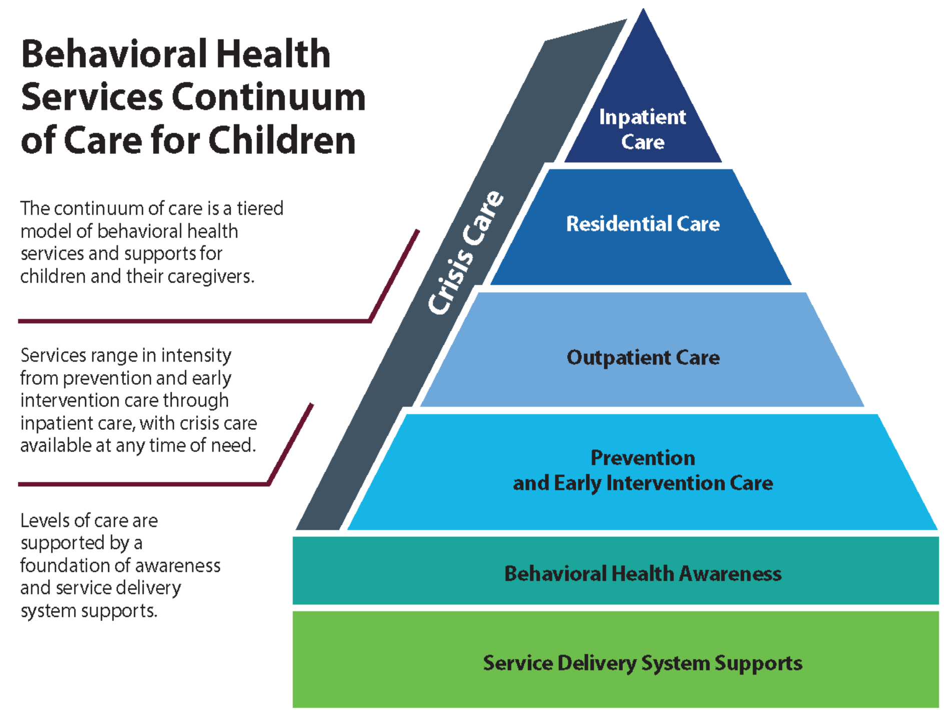
Meeting the behavioral health needs of children in Texas requires:

- Strengthening public-private partnerships at the state and local level;
- Strengthening insurance parity laws and enforcement;
- Strengthening the array of behavioral health services in the commercial insurance market to keep pace with the public sector;
- Braiding funding to support the total cost of care;

[2] Young Texans: Demographic Overview.
[3] Section 531.251, Texas Government Code, defines "Serious emotional disturbance" as a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits a person's role or ability to function in family, school, or community activities.
[4] https://www.samhsa.gov/data/sites/default/files/reports/rpt42790/adults-with-smi-and-children-with-sed-prevalence-estimates-in-2022.pdf.
[5] NSDUH State Estimates.
[6] The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.

- Increasing reimbursement rates for behavioral health services in commercial and public insurance markets to maintain and expand the capacity of the provider system to meet current and future demand for services; and
- Strengthening the behavioral health workforce recruitment, retention, and expertise.

Of note, it will require a multi-biennia strategy to enhance the **Children's Behavioral Health Care Continuum**. The Children's Behavioral Health Care Continuum is a tiered model of services and supports for children that increase in intensity, cost, and length of treatment based on the severity, complexity, and acuity of their needs. The tiers are fluid, meaning, children may move up or down these tiers at various stages of living with their condition.



The subcommittee developed recommendations that reflect solutions to the following gaps identified:

- Behavioral health parity;
- Rates of reimbursement for behavioral health services;
- Behavioral health workforce;
- Behavioral health data and health care information technology; and
- Crisis, outpatient, residential and inpatient care.

The table on the following page includes a summary of recommendations that could enhance access to behavioral health services, the delivery of timely, affordable, quality, and effective behavioral health services, continuity of care, and health and recovery outcomes for children and their caregivers. The recommendations are listed by category:

- **The System of Care Philosophy:** Framework for Children's Behavioral Health Governance, Funding, and Coordination of Care
- **Service Delivery System Supports:** Supports that shore up the availability, accessibility, affordability, efficacy, and outcomes of behavioral health services.
- **Behavioral Health Awareness:** Strategies that increase public knowledge about behavioral health to promote widespread understanding, reduce stigma, and foster positive help-seeking attitudes.
- **Behavioral Health Prevention and Early Intervention Care:** Care delivered to children in a community-based setting to facilitate early identification and initial connection to services that may reduce the incidence, prevalence, and severity of behavioral health conditions.
- **Behavioral Health Outpatient Care:** Care delivered to children in office or community-based settings that varies in frequency of contact and types of services based on the acuity of behavioral health conditions.
- **Behavioral Health Residential Care:** Care delivered to children in a non-hospital, residential setting that requires increased frequency of contact and services that respond to the acuity of behavioral health conditions.
- **Behavioral Health Inpatient Care:** Care delivered to children in a hospital-based setting that reduces imminent risk of harm to self or others, prevents deterioration of mental or physical health, and prepares for transition to less restrictive settings and long-term intensive treatment.
- **Behavioral Health Crisis Care:** Care delivered to children in an outpatient or crisis facility environment, or in the community, that reduces imminent risk of harm to self or others or deterioration of the child's mental or physical health.

Recommendations Summary

LEGEND Existing Program or Service Legislative Action Required $ Additional Funding Needed

The System of Care Philosophy	Implementation Action Required	Page Number
Amend Texas Government Code, Section 531.251, to establish a state multi-sectoral children's behavioral health advisory team to advance statewide implementation of the System of Care.		38
Establish a Texas Children's Behavioral Health Training and Technical Assistance Center.		38
Service Delivery System Supports	**Implementation Action Required**	**Page Number**
Amend Texas Insurance Code, Section 1355.001, to add a definition for Serious Emotional Disturbance.		42
Fund the Health and Human Services Commission (HHSC) to expand the number of Certified Family Partners and make Certified Family Partner services a Medicaid state plan benefit.		51
HHSC should expand the qualifications required to serve as a Qualified Mental Health Professional-Community Services.		51
Join the Counseling Compact and Social Work Compact, by amending Texas Occupations Code Chapters 503 and 505, respectively.		52

Amend Human Resources Code, Chapter 32, to authorize Licensed Marriage and Family Therapist Associates, Licensed Professional Counselor Associates, and Licensed Master Social Workers to provide and be reimbursed for counseling services under the Medicaid state plan.		55
Fund the Texas Child Mental Health Care Consortium to expand the Community Psychiatry Workforce Expansion Initiative to include other mental health professions.		56
Fund the Texas Higher Education Coordinating Board to implement the Behavioral Health Innovation Grant Program under Texas Education Code, Section 61.9991, Subchapter RR.		56
Establish a data governance committee for children's behavioral health.		59
Invest in modernizing data systems to strengthen data sharing, data collection, data storage, and data reporting to improve continuity of care for children served in the state system.		59
Strengthen data workforce capacity through human capital investment in data teams.		59
Behavioral Health Awareness	**Implementation Action Required**	**Page**
Amend Chapter 1001 Texas Health and Safety Code, Subchapter H, to permit HHSC to contract with Regional Education Service Centers (ESCs) in addition to LMHAs, LBHAs to deliver Mental Health First Aid (MHFA) training and fund HHSC to expand MHFA training infrastructure.		60

Behavioral Health Prevention and Early Intervention Care	Implementation Action Required	Page
Fund TEA to issue discretionary grants to school districts to replicate Project Advancing Wellness and Resiliency in Education (AWARE) Texas and deliver technical assistance with resources to increase student access to mental health services and supports aligned to statutory requirements for safe and supportive schools.	$	61
Establish a mental health allotment for schools separate from the school safety allotment.	$	62
Fund HHSC to expand the Children's System Navigator program.	$	63
Fund HHSC to expand substance use youth prevention programs.	$	64
Behavioral Health Outpatient Care	**Implementation Action Required**	**Page**
Fund HHSC to include Coordinated Specialty Care for First Episode Psychosis, Family Functional Therapy, and Multisystemic Therapy as Medicaid state plan benefits.	$	65
Fund HHSC to include Intensive Outpatient services and Partial Hospitalization services as Medicaid state plan benefits.	$	68
Fund HHSC to increase rates for the Youth Empowerment Services Waiver Program and address administrative barriers to serving children with complex needs.	$	68
Modernize Utilization Management Guidelines for the Texas Resilience and Recovery Treatment model to permit new evidence-based practices and broader curriculum usage.	$	69

Amend Chapter 531, Government Code, and fund HHSC to implement the Healthy Transitions: Improving Life Trajectories for Youth Grant program.		70
Fund HHSC to expand Outpatient Biopsychosocial Services statewide.		70
Fund the Supreme Court of Texas Permanent Judicial Commission on Children, Youth and Families (Children's Commission) to expand implementation of state and local dual status initiatives.		71
Behavioral Health Residential Care	**Implementation Action Required**	**Page**
Fund HHSC to establish Psychiatric Residential Treatment Facilities as a Medicaid state plan Benefit.		72
Fund HHSC to expand the Residential Treatment Center Project to include increasing rates for services.		73
Fund HHSC to expand youth substance use treatment programs and the resources available to the youth treatment provider network.		74
Behavioral Health Inpatient Care	**Implementation Action Required**	**Page**
Fund HHSC to increase rates for inpatient providers serving children with co-occurring mental health and Intellectual and Developmental Disabilities (IDD) and those with co-occurring complex medical conditions.		77

Behavioral Health Crisis Care	Implementation Action Required	Page
Fund HHSC to Expand Youth Crisis Outreach Teams as a statewide service available 24/7.		78
Fund HHSC to expand crisis respite units serving children with behavioral health conditions and/or IDD conditions.		79
Fund HHSC to cover crisis services such as in-home and out-of-home crisis respite, extended observation, and crisis stabilization services as a Medicaid state plan benefit, to the extent allowable under federal requirements.		80

Introduction

Behavioral health is one component of a child's overall well-being. Meeting children's behavioral health needs requires a multi-faceted approach, including supporting caregivers and families, ensuring safe and supportive schools, and increasing access to child-serving programs.[7] A child's development is influenced by caregiver capacity to foster a healthy environment, family interactions, child daycare and school environments, friendships, neighborhoods, and more.[8] Childhood development is also impacted by broader circles of community influence that shape a child's experiences and view of the world around them. These factors include economic circumstances, mass media, and available health care systems.

Adverse Childhood Experiences

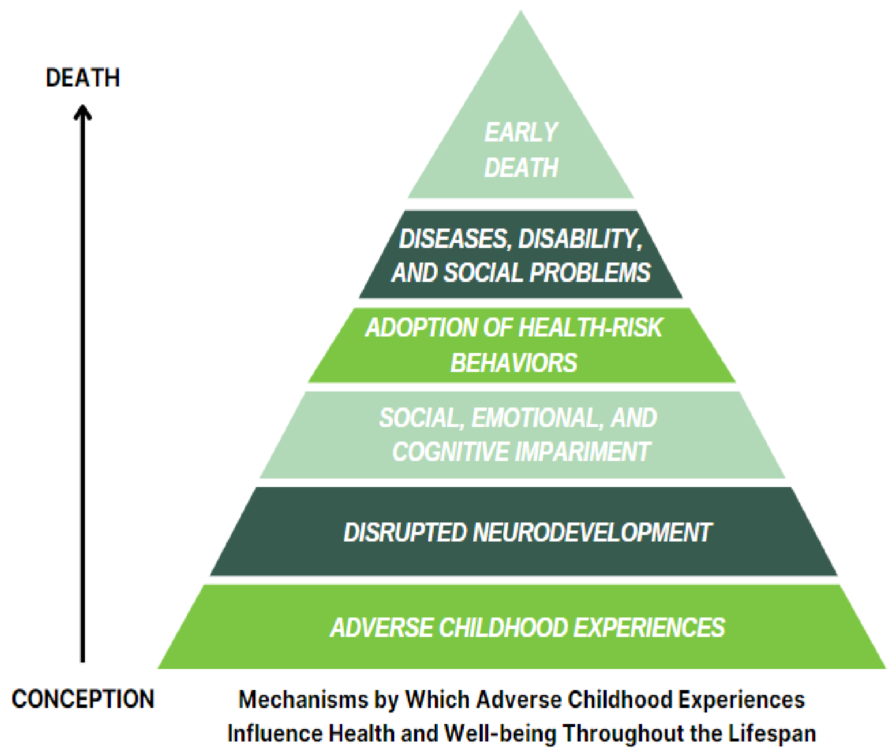
Childhood experiences shape the physical, mental, and emotional development that later influences the ability to enjoy secure relationships and physical and emotional well-being in adulthood. Adverse Childhood Experiences (ACEs), as described by Finkelhor (2020), are "a cluster of childhood experiences thought to be particularly damaging to healthy development" and have been shown to have long-term negative effects on health including behavioral health.[9] ACEs, when they occur before age 18, include the following: abuse, neglect, parental divorce, and other types of adversity, such as bullying, poverty, community violence, and natural disasters.[10]

In 2022, an estimated 19 percent of children in Texas experienced two or more ACEs by age 18.[11]

Figure 1 reflects the long-term impact of ACEs if the traumatic experiences are unacknowledged or left untreated.[12]

[7] American Psychological Association, Children's mental health.
[8] Ecology of the family as a context for human development: Research perspectives.
[9] Trends in Adverse Childhood Experiences (ACEs) in the United States.
[10] HHSC Texas Health Steps: Addressing ACEs During Texas Health Steps Checkups.
[11] Adverse Childhood Experiences (ACEs).
[12] Adverse childhood experiences.

Figure 1. Long-Term Impact of ACEs



Experiencing a higher number of ACEs is associated with both social-emotional deficits and developmental delay in early childhood. Positive parenting practices, however, demonstrate robust protective effects independent of the number of ACEs. This supports promotion of positive parenting practices at home, especially for children exposed to high levels of adversity.[13]

A 10 percent reduction in ACEs could equate to $56 billion in savings and other economic and health benefits, including a 15 percent reduction in the number of adults who are unemployed, a 44 percent reduction in adults with depression, and a 33 percent reduction in adults who smoke.[14]

ACEs can be preventable through caregiver, familial, and community-level interventions. Examples of these interventions include:

- Strengthening a family's financial stability through paid time off, flexible and consistent work schedules, and child tax credits;

[13] Positive Parenting in the Face of Early Adversity: Does it Really Matter?.
[14] We Can Prevent Childhood Adversity.

- Teaching healthy relationship skills, including appropriately managing conflict, developing emotional intelligence, and healthy dating practices; and
- Lessening immediate and long-term harms through interventions such as creating access to family-centered treatment for substance use conditions.[15]

ACEs do not have to determine a child's future. Prevention and early intervention strategies can reduce their prevalence and impact, increasing children's opportunities for healthy adulthood.

Collective Traumatic Experiences

Hirschberger (2018) defines collective trauma as "the psychological reactions to a traumatic event that affect an entire society; it does not merely reflect a historical fact, the recollection of a terrible event that happened to a group of people."[16] Texas children have faced collective traumatic experiences including the examples outlined below.

COVID-19 Pandemic

The COVID-19 pandemic profoundly shifted children's social realities. The isolation period created through lockdowns and social distancing did more than separate youth from their peers; it fostered a sense of loneliness and disconnect in children of all ages.[17] Children's emotional and psychological development happens through direct interactions with peers. School closures, suspension of extracurricular activities, and the shift to remote learning created a void for these social interactions. Isolation exacerbated children's feelings of loneliness, leading to a surge of behavioral health challenges. The inability to engage in face-to-face interactions and participate in shared experiences stunted the development of vital social skills, which intensified the sense of being alone.

The COVID-19 pandemic is an example of a collective traumatic experience with long-lasting impacts to communities, families, and children. Prior to the pandemic, the Centers for Disease Control and Prevention suggests that 1 in 5 American children, ages 3-17 had an emotional, developmental, mental, or behavioral health condition.[18] A review of several studies conducted between early 2020 and 2021 revealed that globally, the prevalence of anxiety and depression in youth doubled

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[15] We Can Prevent Childhood Adversity

[16] Collective Trauma and the Social Construction of Meaning.

[17] Loneliness and Well-Being in Children and Adolescents during the COVID-19 Pandemic: A Systematic Review.

[18] Protecting youth mental health: The U.S. Surgeon General's Advisory.

during the pandemic, with 25 percent of youth experiencing depressive symptoms and 20 percent experiencing anxiety. [19]

In Texas, more than 14,000 children lost a caregiver to COVID-19.[20] The loss of a caregiver can increase the likelihood of experiencing poverty, behavioral health conditions, abuse, neglect, exploitation, delayed development, reduced access to education, and institutionalization. Adverse experiences increase children's need for physical, behavioral, and health-related social services and supports.[21]

School Safety

The Texas School Safety Center reports that a safe school environment is "one free from bullying, violence, and substance use and one which promotes physical, mental, and behavioral health."[22] A 2018 survey conducted on behalf of the American Psychological Association (APA), which included youth ages 15-17, found that 56 percent experienced stress associated with school safety.[23] Data from the 2022 Texas School Survey of Drug and Alcohol Use reflected that 36 percent of students surveyed reported alcohol use, an increase from the 2020 survey. The 2020-2022 survey also noted increased tobacco and prescription drug use, while reported marijuana use remained steady.[24]

Incidences of mass violence, alcohol, and drug use, bullying, and other direct or secondary traumatic events may become a part of a child's collective memory and storytelling through their high degree of social media utilization. The APA reports U.S. teens spend an average of 4.8 hours a day on social media sites. [25] While there are benefits to the use of social media, such as forming online friendships and creative expression, there is also the opportunity for emotional harm. For example, 46 percent of adolescent girls ages 13-17 report that social media impacts their body image.[26] In a similar study, 75 percent of adolescents report that social media sites do a fair to poor job addressing cyberbullying.[27]

ACEs and collective traumatic experiences influence children's behavioral health and illuminate that behavioral health services and supports should not solely be those offered to an individual child, but should be inclusive of caregivers, broader support

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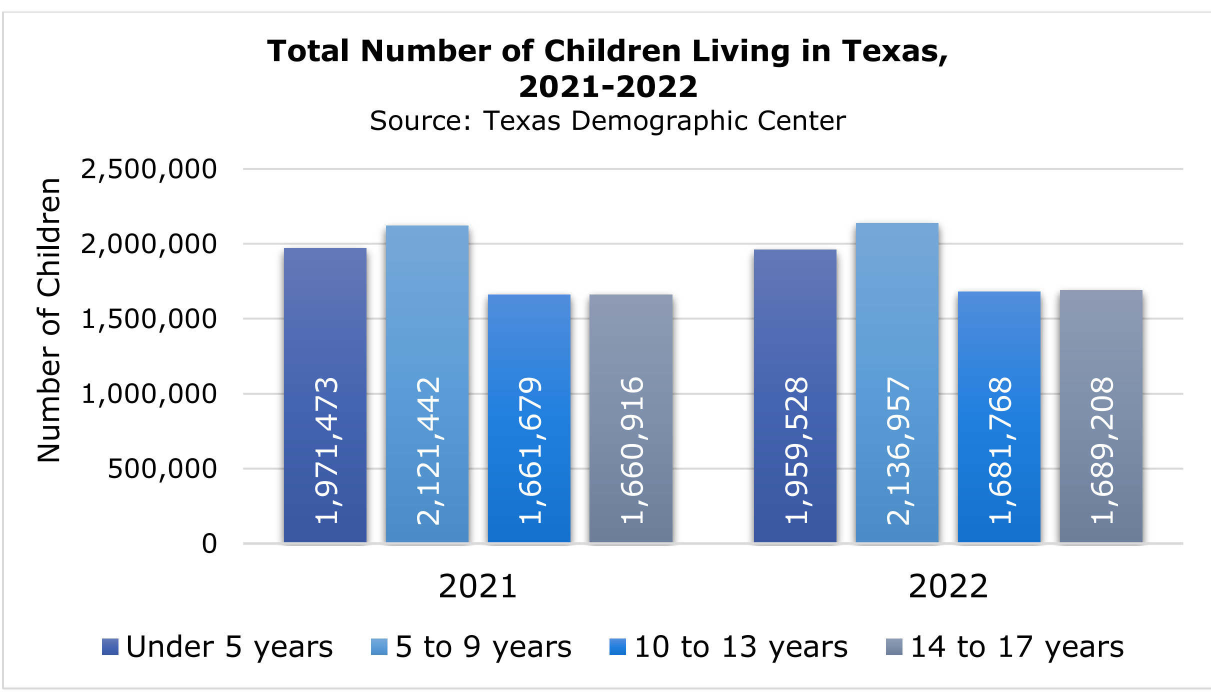
[19] Global Prevalence of Depressive and Anxiety Symptoms in Children and Adolescents During COVID-19.
[20] More than 14,000 Texas children have lost a caregiver due to COVID-19.
[21] COVID-19-Associated Orphanhood and Caregiver Death in the United States.
[22] A Parent's Guide to School Safety Toolkit.
[23] Stress in America Generation Z.
[24] Texas Health Data - Texas School Survey of Drugs & Alcohol Use.
[25] Teens are spending nearly 5 hours daily on social media. Here are the mental health outcomes.
[26] Social Media and Youth Mental Health.
[27] Social Media and Youth Mental Health.

systems, and community-and system-level interventions. In Texas, these upstream programs include Healthy Outcomes through Prevention and Early Support (HOPES), home visiting programs, Fatherhood EFFECT (Educating Fathers for Empowering Children Tomorrow), Family and Youth Success, and Help Me Grow. The recommendations in this strategic plan do not include these types of upstream interventions, as these programs do not typically provide children's behavioral health services. However, the subcommittee acknowledges that access to these types of services may prevent or mitigate behavioral health conditions in children downstream.

Profile of Texas Children

According to the U.S. Census Bureau, one of every 10 people under the age of 18 lives in Texas. In 2022, 24 percent of the 30 million people in Texas were children under the age of 18.[28] That same year, Texans experienced 12.9 live births per 1,000 people, seven percent higher than national rates.[29] Figure 2 reflects the total number of children in Texas in 2021 and 2022.

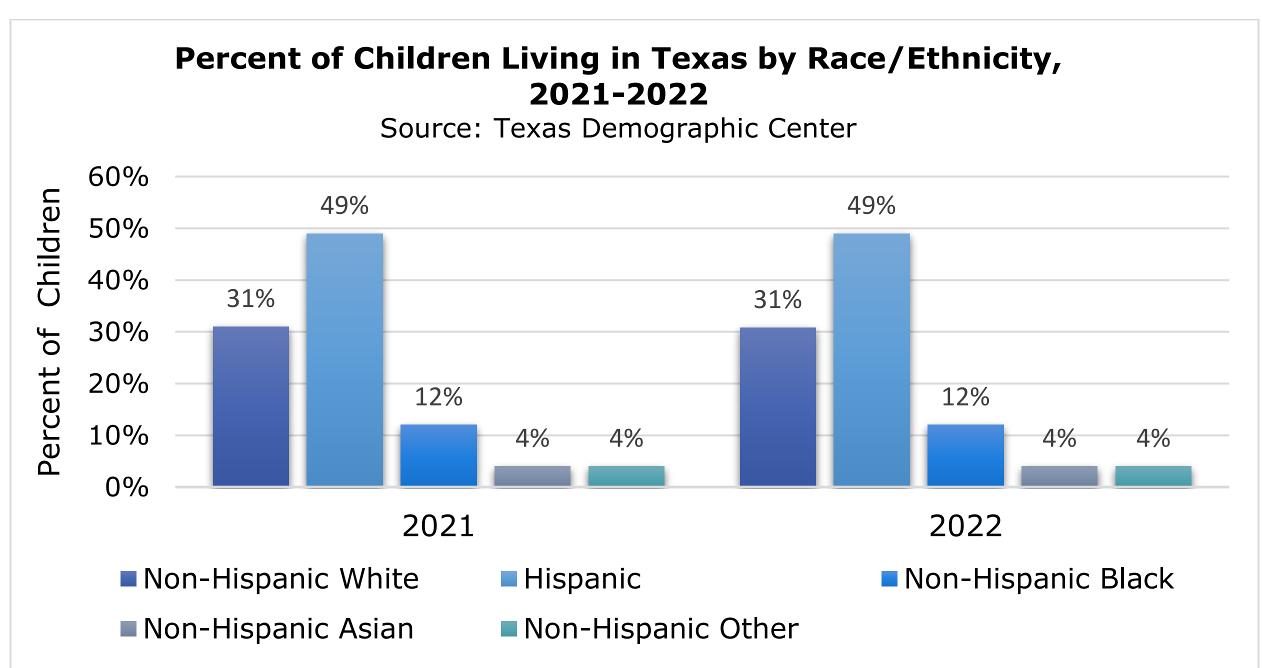
Figure 2. Total Number of Children Living in Texas



In 2022, of the seven million children in Texas, under 18, 51 percent were male and 49 percent were female. Figure 3 reflects the percentage of children in Texas under 18 by ethnic and racial category for 2021 and 2022.[30]

[28] Texas Demographic Center - 2022 Estimates.
[29] Centers for Disease Control and Prevention, National Center for Health Statistics. National Vital Statistics System, Natality on CDC WONDER Online Database. Data are from the Natality Records 2016-2022, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/natality-expanded-current.html on Jul 16, 2024, 10:30:57 AM.
[30] https://www.census.gov/data-tools/demo/saipe/#/?s_state=48&s_county=&s_district=&s_geography=us&s_measures=5_17_fam.

Figure 3. Percent of Children Living in Texas by Race/Ethnicity



The Texas Demographic Center (TDC) projects the Texas population will rise to about 47.3 million people by 2050. Across the state, TDC predicts a 43 percent rise in the under 18 population, or 3.2 million more children. That's more than seven times the 5.8 percent growth expected for the nation's child population. By 2050, 22.7 percent of Texas' population, or 10.7 million, will be under 18.[31]

Socioeconomic Status and Insurance Coverage

Poverty, lack of access to quality education, homelessness, and limited resources contribute to stress and mental health challenges in children. Economic differences can contribute to difficulties accessing behavioral health services and other supports.

If Texas were a country, it would be the eighth largest economy in the world, with a market value of all finished goods and services totaling $2.4 trillion.[32] Despite the thriving economy, some Texas families experience significant financial challenges. In 2022, 19 percent of children under the age of 18 were in poverty[33] and over 20 percent of Texas households with children voiced little to no confidence in their

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[31] Young Texans: Demographic Overview.
[32] https://comptroller.texas.gov/economy/fiscal-notes/economics/2024/big-map/.
[33] https://www.census.gov/data-tools/demo/saipe/#/?s_state=48&s_county=&s_district=&s_geography=us&s_measures=5_17_fam.

ability to pay the next rent or mortgage payment on time.[34] Table 2 reflects 2022 federal poverty thresholds.[35]

Table 2. 2022 Federal Poverty Thresholds

A family is in poverty if:	1 Adult	1 Adult + 1 Child	2 Adults + 1 Child	2 Adults + 2 Children
The yearly income for the family is at or below federal poverty level	$15,230	$20,172	$23,566	$29,678
Equivalent to hourly wage at or below federal poverty level (If one adult works full-time)	$7.32	$9.70	$11.33	$14.27

In addition to housing, childcare is a major driver of family financial stress. In 2021, the U.S. Department of the Treasury reported the average family with at least one child under the age of 5 would need to devote roughly 13 percent of family income to cover the cost of childcare,[36] which many families cannot afford. The same report noted fewer than 20 percent of eligible families received federal Child Care and Development Funds.

A 2019 study published by the Texas Alliance for Health Care, reported if Texas did not proactively address the issue of uninsured Texans, by 2040, over 6.1 million people will be uninsured, equating to an economic loss of $178.5 billion.[37] In 2022, 16.6 percent of Texans (4.9 million) had no health insurance. This is a decrease from 18 percent in 2021.[38] In 2022, most Texans with health insurance had employer-based coverage (51.4 percent), followed by Medicaid (16.9 percent), Medicare (14.2 percent), direct purchase (12.2 percent), TRICARE (3 percent), and Veterans Health Administration benefits (2.3 percent).[39]

In 2022, 10.9 percent of Texas children under 19 lacked health insurance coverage. Figure 4 reflects coverage by insurance type or no health insurance in 2021 and 2022.[40]

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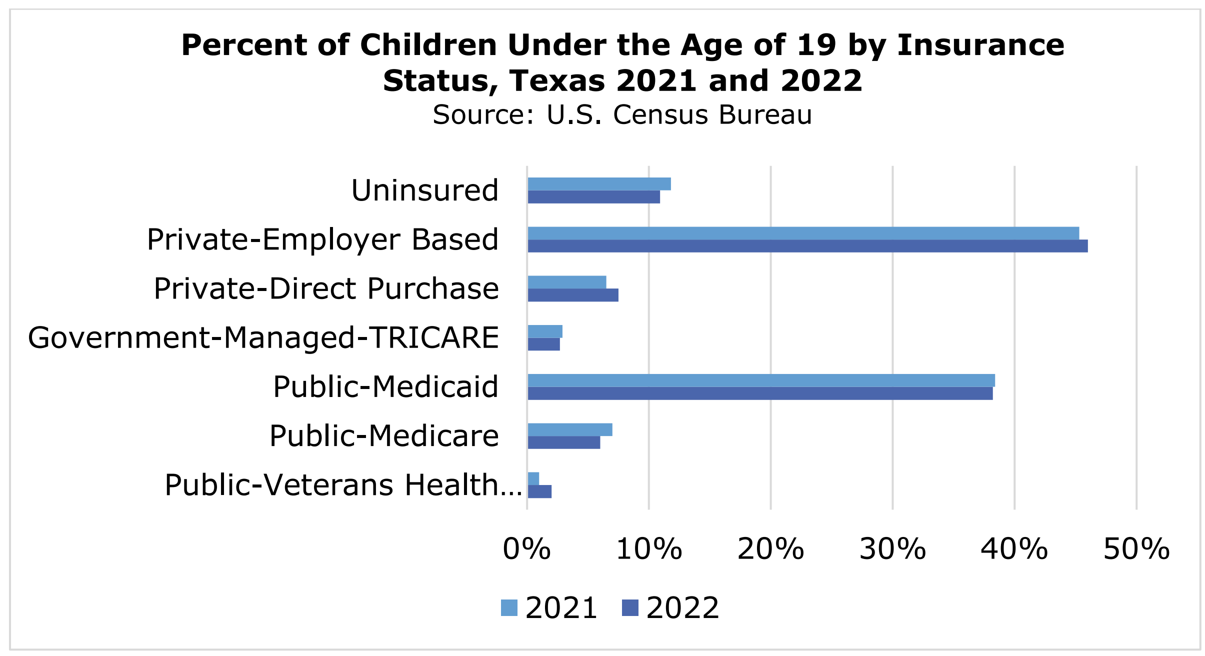
[34] Households with children where there was little or no confidence in ability to pay their next rent or mortgage payment on time | KIDS COUNT Data Center (aecf.org).
[35] Poverty Thresholds.
[36] The-Economics-of-Childcare-Supply-09-14-final.
[37] The_Impact_of_Uninsurance_on_Texas_Economy_20190108.pdf.
[38] Percentage of Population Without Health Insurance Coverage by State.
[39] Percentage and Type of Health Insurance Coverage by State.
[40] U.S. Census Bureau, 2008 to 2022 American Community Surveys (ACS).

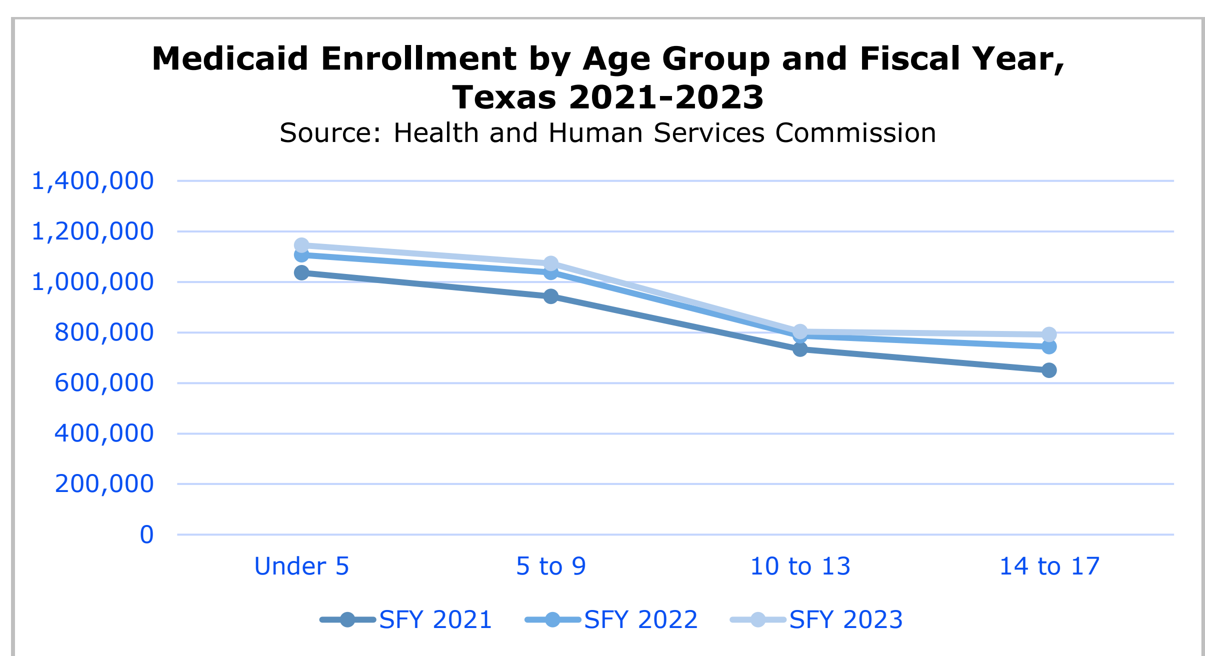
Figure 4. Percent of Children Under the Age of 19 by Insurance Status, Texas 2021 and 2022



In state fiscal year (SFY) 2023, 4.2 million children were enrolled in Children's Medicaid[41] and the Children's Health Insurance Program (CHIP). Figure 5 reflects children's enrollment in Texas by age group for SFY 2021 through 2023.

[41] Includes STAR Health, the Medicaid managed care program for children in state conservatorship.

Figure 5. Medicaid Enrollment by Age Group and Fiscal Year



In SFY 2021, 3,362,788 children were enrolled in Medicaid (i.e., 1,036,211 children under age five, 942,366 children ages 5-9, 733,973 children ages 10-13, and 650,238 children ages 14-17.) In SFY 2022, 3,674,370 children were enrolled in Medicaid (i.e., 1,106,656 children under age five, 1,037,132 children ages 5-9, 786,904 children ages 10-13, and 743,678 children ages 14-17.) In SFY 2023, 3,813,434 children were enrolled in Medicaid (i.e., 1,145,170 children under age five, 1,073,054 children ages 5-9, 803,412 children ages 10-13, and 791,798 children ages 14-17.)

The overall decrease in Medicaid enrollment may be attributed to children transitioning from Medicaid to CHIP. As children enrolled in Medicaid get older the Medicaid income limits decrease. However, older children and youth may qualify for CHIP which has a higher income limit of 201% of the Federal Poverty Level.

Public Education

In the 2022-23 academic school year, there were 5.5 million students enrolled in Texas public schools. Within this population, 703,058 students received special education services, an increase of 10.6 percent from the 2021-2022 academic year, and a 16 percent increase from the 2020-2021 academic year.[42]

[42] 2023 TEA Pocked Edition.

In SFY 2022, total public education spending was $80.64 billion, or $14,928 per student.[43] This includes one-time allotted funding the Texas Education Agency (TEA) received for 2022-25 to secure Texas schools. Figure 6 reflects the breakdown of these funds and annual funding for ongoing safety and mental health expenditures.

Figure 6. Funding to Secure Texas Schools and Ongoing Safety and Mental Health Expenditures 2022-2025

2022-25 Funding to Secure Texas Schools and Ongoing Safety and Mental Health Expenditures

Behavioral Health

In 2022, SAMHSA, estimated that of the 3.8 million children in Texas between the ages of 9 and 17, up to 500,000 had an SED causing moderate symptoms and/or functional impairment.[44] The 2021-2022 NSDUH indicated that up to 7.8 percent of Texas children ages 12-17 had a substance use disorder in the past year.[45]

[43] 2023 TEA Pocked Edition.
[44] https://www.samhsa.gov/data/sites/default/files/reports/rpt42790/adults-with-smi-and-children-with-sed-prevalence-estimates-in-2022.pdf
[45] NSDUH State Estimates.

In response to the 2021 Texas Youth Risk Behavior Surveillance (YRBS) System survey,[46] 29.7 percent of children 15 and under and 32 percent of 16-17 year-olds reported their mental health was not good most of the time or always.[47] Additionally, 8.3 percent of children 15 and under and 16.3 percent of 16-17 year-olds reported binge drinking.[48] In the same survey, children reported use of marijuana, cocaine, ecstasy, heroin, inhalants, methamphetamines, and pain medication.[49]

The rate of suicidal ideation, or seriously considering attempting suicide, is also an indicator of behavioral health concerns in children. Figure 7 outlines the percentage of Texas and U.S. high school students who seriously considered attempting suicide in the past 12 months. In 2021, 21.7 percent of high school students in Texas seriously considered suicide, up from 18.9 percent in 2019.[50]

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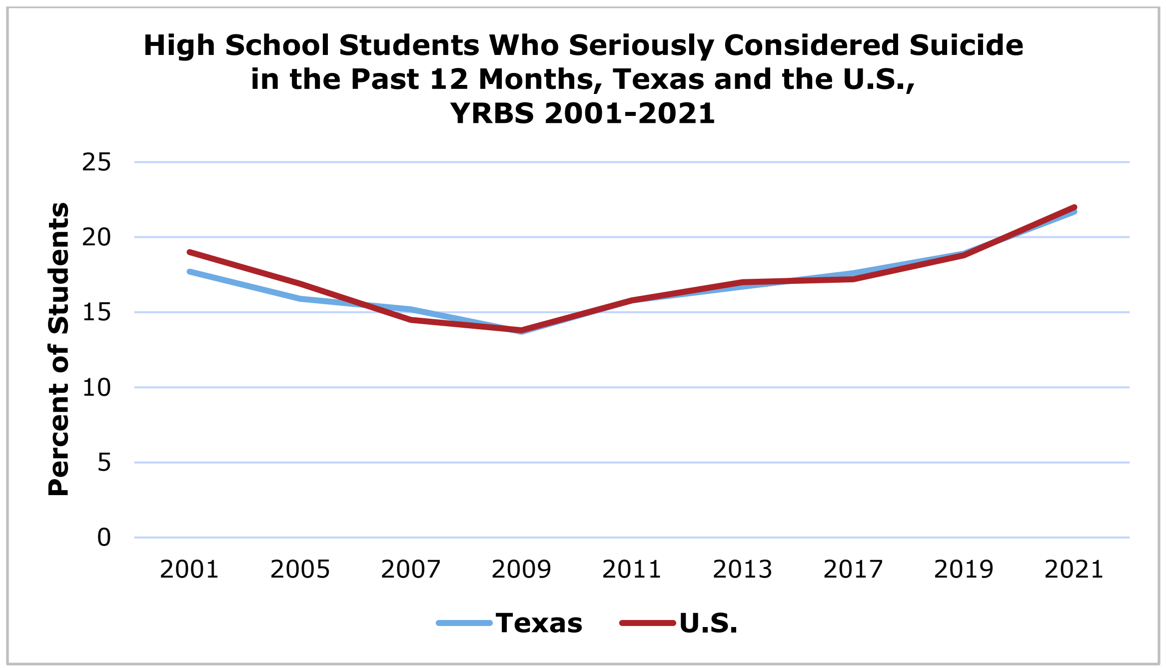
[46] The Texas Youth Risk Behavior Surveillance System survey, initiated in 1991, is a federally funded, classroom-based survey conducted every two years on odd years to monitor priority health risk behaviors that contribute substantially to the leading causes of death, disability, and social problems among youth and adults in the United States. 2021 data is the most current data available.
[47] Texas Health Data - Youth Risk Behavior Survey.
[48] Binge drinking was defined as having four or more drinks of alcohol in a row for female students or five or more drinks in a row for male students within a couple of hours, on at least 1 day during the 30 days before the survey.
[49] The sample size for the 2021 Texas Youth Risk Behavior Surveillance System survey was small. Reported results should be used with caution, but nonetheless provide a degree of insight into the health risk behaviors of high school students.
[50] Texas Health Data - Youth Risk Behavior Survey (YRBS)

Figure 7. High School Students Who Seriously Considered Suicide Within the Referenced Year in Texas and the U.S.



Females are nearly twice as likely as males to seriously consider suicide. The rate at which they considered suicide increased from 23.2 percent to 28.2 percent between 2001 and 2019, while the rate for males increased from 12.5 percent to 15.3 percent. Between 2000 and 2022 youth suicide mortality rates increased 30.4 percent, with rates rising from 9.2 deaths per 100,000 population to 12.[51]

Waitlists for Behavioral Health Services

Currently, Texas lacks a centralized method for collecting data on wait times to access behavioral health services, regardless of funding source, provided by independent practitioners, behavioral health practitioners, or those affiliated with healthcare organizations, residential treatment centers, hospitals, or many other types of treatment locations. Pockets of this information are available based on waitlists maintained by state agencies for the facilities or services they administer, trade associations that may collect this information from the organizations they represent, and locally maintained data, but there is no data available to provide a comprehensive picture of wait times across the state.

[51] Centers for Disease Control and Prevention, National Center for Health Statistics on CDC WONDER.

Children’s Community Mental Health Services Waitlist

HHSC is required to report on waiting lists for mental health services to the Legislative Budget Board and Governor.[52] Quarterly waitlists are point-in-time calculations of the total number of people waiting for community mental health services provided by the Local Mental Health Authorities (LMHAs) and Local Behavioral Health Authorities (LBHAs). For SFY 2023, quarters 3 and 4, and SFY 2024, quarters 1 and 2, there was no waitlist for children’s community mental health services.[53]

Though there was no waitlist for children’s community mental health services in quarters 1 and 2 of SFY 2024, 365 and 300 children, respectively, were underserved in that time. The term “underserved” is used to designate a person who received a lower level of care than recommended based on assessment scores. LMHAs and LBHAs report workforce shortages are a major factor in underserving children. These workforce shortages are exacerbated by competition for qualified staff employed with other child serving agencies, many of which can pay higher salaries than the public mental health system. Improved reimbursement rates could help address this concern.

Youth Substance Use Treatment Services Waitlist

HHSC-funded substance use services available to children 17 years of age or younger include: Outpatient, Intensive Residential, Supportive Residential, and Co-Occurring Psychiatric and Substance Use Disorder (COPSD) treatment. The severity of the substance use disorder (SUD) determines the treatment needed.

Licensed facilities provide treatment services for children with SUD helping them learn, build, and practice skills for their recovery. Treatment services include counseling, case management, education, and recovery skills training. Treatment options are:

- **Intensive residential treatment** for children with high severity needs, provides at least 35 hours per week at a licensed treatment center while allowing youth to attend school while in treatment;
- **Supportive residential treatment** for children with moderate severity needs, provides at least six hours per week;
- **Outpatient treatment services** for children with lower severity needs, are provided in a community clinic setting for children who do not need a highly structured environment and can live at home; and

[52] 2024-25 General Appropriations Act, House Bill (H.B.) 1, 88th Legislature, Regular Session, 2023 (Article II, HHSC, Rider 45)
[53] Reporting of Waiting Lists for Mental Health Services.

- **COPSD** offers adjunct services provided to children where both mental health and substance use issues are addressed concurrently. [54]

Substance use treatment waitlists are point-in-time calculations of the total number of children who waited for substance use services during the respective quarter of the reporting period. Table 3 summarizes the number of children on the waiting list for these services during SFY 2023, quarters 3 and 4, and SFY 2024, quarters 1 and 2, and the average number of days on the waitlist.

Table 3. Number of Children Waiting for Substance Use Treatment Services for SFY 2023, Q3-Q4, and SFY 2024, Q1-Q2

Treatment Service	Waitlist, SFY 2023, Q3-Q4	Waitlist, SFY 2024, Q1-Q2	Average Days on Waitlist
Supportive Residential or COPSD	0	0	0
Intensive Residential	7	11	4.5
Outpatient	58	26	20

HHSC is the payor of last resort for substance use treatment, and many children are recipients of Medicaid. Youth with Medicaid benefits must use those state-federal funded services before accessing state-only funded services.

In addition, due to funding challenges, some HHSC-funded substance use service providers have been unable to continue providing services for youth, limiting access to services. There are 42 youth substance use treatment providers across the state. Of those, only five providers offer residential treatment. Additionally, only two of those residential providers accept females in addition to males.

Inpatient Care Waitlist

[54] COPSD services aim to offer an integrated, comprehensive, and coordinated approach to assisting individuals in managing both mental health and substance use issues simultaneously. Components such as case management and referrals are utilized to ensure access to the appropriate level of care.

HHSC created the Inpatient Care Waitlist (ICW)[55] as a centralized electronic record of individuals waiting for inpatient psychiatric hospital services in Texas.[56] The ICW is exclusively a civil waitlist, including children and adults with non-forensic commitments who need this level of care. LMHA and LBHAs provide ICW data to HHSC. Like all waitlists, the ICW data is a point-in-time calculation subject to daily fluctuations. For SFY 2023, quarter 3 through SFY 2024, quarter 4,296 children were on the ICW for an average of 43 days.

Child Welfare

The Texas Department of Family and Protective Services (DFPS) is the agency responsible for protecting children and youth whose safety has been compromised by abuse and/or neglect. DFPS serves approximately 18,000[57] children on any given day. Many DFPS-involved children have experienced considerable trauma which can significantly impact their overall health and well-being. To support their healing and recovery, DFPS is responsible for assuring both primary and behavioral healthcare is accessible to children and youth in conservatorship.

The needs of DFPS-involved children and families are multifaceted, complex, and often reflect unidentified or unmet needs, such as:

- Unemployment, or employment with insufficient income;
- Unsafe and/or unaffordable housing;
- Food insecurity;
- Unidentified or unmet mental health and substance use conditions; and
- Lack of familial or community support.

DFPS works with communities to promote safe and healthy families with the overarching goal to protect children from abuse, neglect, and exploitation. DFPS works with community partners to promote healthy child development and increase protective factors through the preservation of family and kinship relationships as well as community connections and supporting the caregiver’s capacity to meet the physical, behavioral, and educational needs of the child.[58]

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[55] This is not a waitlist for state hospital services exclusively, but it is for any child, adolescent, or adult with non-forensic commitments who requires an inpatient level of care but for whom no resource is available in the local service area.
[56] For more information, refer to Information Item F – ICW Helpful Information/FAQs, located at Community Mental Health Contracts | Texas Health and Human Services.
[57]DFPS Data Card FY2023, https://www.dfps.texas.gov/About_DFPS/Data_Book/documents/DFPS_Data_Card.pdf.
[58] https://acfmain-stage.acf.hhs.gov/sites/default/files/documents/cb/fact-sheet%202020.pdf.

Intake and Investigation and Child Protective Investigations

The role of DFPS Statewide Intake is to assess all reports of abuse, neglect, or exploitation and route them to the local office. In SFY 2023, Statewide Intake processed 814,091 contacts of which 310,539 were related to child protective reports of abuse and neglect. Intakes that met the legal definition of abuse and neglect [59] were referred to Child Protective Investigations for investigation of the allegations of abuse or neglect. While the investigation is occurring, children and families receive services in their home, or the child(ren) may be removed due to an immediate safety issue and placed with other family members, fictive kin, or in foster care. In SFY 2023, there were 163,855 completed investigations. Of these, 13,959 were referred to Family Preservation Services and 5,060 resulted in removals from the home.

DFPS Referrals as a Means to Access Behavioral Health Services

There are some instances in which families are referred to DFPS solely for the purpose of receiving children's behavioral health services. This scenario includes self-referrals by families who make the decision to give up custody of their child with the assumption that DFPS has a means to access needed services beyond those the family has access to.

Conservatorship relinquishment decisions are often made due to the escalation of the child's behavioral health needs as she or he grows older resulting in situations that may become untenable for the family as they consider the health and safety of the child, their family, home, and community. When a child enters foster care due to conservatorship relinquishment, the case is categorized as Refusal to Accept Parental Responsibility (RAPR). There are some situations which result in joint managing conservatorship to obtain mental health services the child needs – often residential treatment. If joint managing conservatorship is granted, the family must exhaust services available to them first and must be willing to work toward a goal of reunification.

Between four to five percent of youth placed into DFPS conservatorship are there because of RAPR. These children have unique, high needs and limited family support. As of December 31, 2023, 80 percent of children removed due to RAPR have emotional or mental disorders. Reasons for RAPR can include a lack of available behavioral health or IDD services, lack of medical services or solely to obtain behavioral health services. One of the reasons for prioritizing the prevention of RAPR situations is that custody relinquishment is a significant trauma for a young person who may have already experienced trauma in his or her past and many

[59] [59] Family Code Chapter 261. Investigation Of Report Of Child Abuse Or Neglect (Texas.Gov)

children in these situations, due to the impact of trauma on their behavioral health, may become Children Without Placement (CWOP). A CWOP event is when a child or youth is without placement for at least two consecutive, uninterrupted nights.[60]

Table 4 reflects the number of children at various stages of DFPS services in SFY 2023.

Table 4. Number of Children at Various Stages of DFPS services in SFY 2023

Stage of DFPS Service	SFY 2023 Totals
Contacts processed by Statewide Intake	814,091
Children and families received Family-Based Safety Services / Family Preservation Services	13,959
Children in Kinship Care Placement	6,088
Children in state conservatorship	18,812
Adoptions consummated	4,181

Juvenile Justice[61]

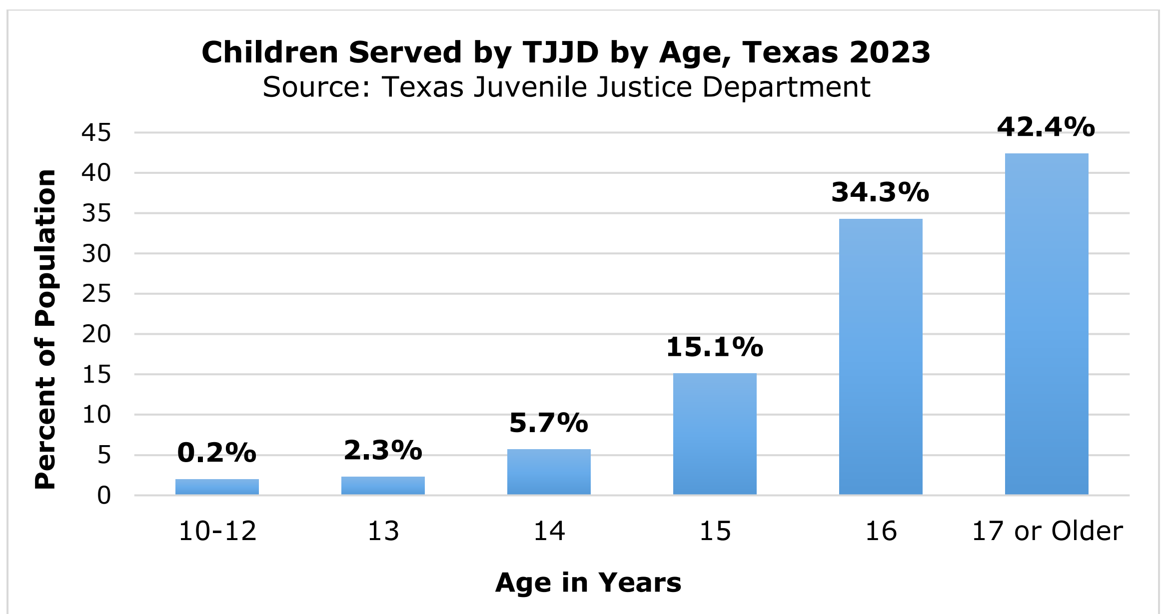
Since 2005, the state's juvenile secure facility population has decreased by 85 percent. However, there has been a six percent increase from the SFY 2021 average to SFY 2023, and the population continues to grow. Almost 99 percent of children in the Texas juvenile justice system are served at the county level, with only one percent referred for state-level services. County probation departments serve children adjudicated on misdemeanor and felony offenses, while the Texas Juvenile Justice Department (TJJD) just serves those adjudicated on felony offenses. The 164 juvenile justice probation departments are governed by Juvenile Boards with county contributions totaling 73 percent of funds and TJJD contributing the other 27 percent. TJJD is governed by a board appointed by the Governor and provides secure correctional facilities, halfway houses, contracted care, and parole services, as well as setting policy for state services and county level regulations.

[60] https://www.hhs.texas.gov/sites/default/files/documents/may-2024-hhsc-exec-council-agenda-item-1g.pdf.

[61] Information in this section derived from a formal presentation developed by TJJD and delivered to the Children's Mental Health Strategic Plan Subcommittee titled *TJJD State Secure Facilities: Programming Overview*.

Figure 8 reflects the ages of children served by TJJD in 2023.

Figure 8. Ages of Children Served by TJJD in 2023



In SFY 2023, 14.3 percent of children admitted to TJJD custody had an ACEs score [62]of 0 to 1, 27.7 percent had an ACEs score of 2 to 3, 27.7 percent had a score of 4 to 5, 17.7 percent had a score of 6 to 7, and 12.7 percent had a score of 8 to 10. The top five ACEs experienced were: separated or divorced parents (85.2 percent), an incarcerated household member (68 percent), household substance use (54.6 percent), history of family violence (42.3 percent), and history of emotional abuse (35.2 percent).

In 2023, 90 and 91 percent of children admitted to TJJD had identified mental health or substance use needs, respectively, with conditions including depression, anxiety, bipolar disorder, disruptive mood dysregulation disorder, and early onset psychosis. TJJD provides a variety of behavioral health programming, including the Mental Health Treatment Program, Crisis Stabilization Unit, Behavior Stabilization Unit, and substance use services. TJJD's licensed mental health professionals are trained in the following treatment modalities, including:

- Eye Movement Desensitization Reprocessing (EMDR);
- Trauma-Focused Cognitive Behavioral Therapy;
- Neurosequential Model of Therapeutics;

[62] The "ACE Score" Is the number of ACEs a person experienced. The ACE Score serves as a proxy for the level of adversity and has a "dose" relationship to adult health issues: The higher the ACE score, the more likely a person is to experience serious health challenges.

- Dialectical Behavior Therapy (DBT); and
- Attachment Based Family Therapy.

The Behavioral Health Continuum of Care for Children

Systems of Care: A Framework for Children's Behavioral Health Governance, Funding, and Coordination of Care

The core of the System of Care (SOC) approach is multi-sector collaboration at local and state levels, including, providers of behavioral health, early childhood, child welfare, education, juvenile justice, and recreational and vocational services to ensure individualized treatment for children and families is informed by their unique needs and strengths.

Outcomes of the SOC approach include decreases in behavioral and emotional symptoms, suicide rates, substance use, and juvenile justice involvement. Additional benefits include increased school attendance, improved grades, and more stable living situations. Families have reported reduced caregiver strain, improved family functioning and problem-solving skills, and increased capacity to handle their child's challenging behaviors.[63]

The SOC is a nationally recognized framework for the provision of children's behavioral healthcare. In Texas, the SOC is codified in Chapter 531, Texas Government Code, Section 531.251, and requires HHSC to partner with state agencies to implement at state and local levels. Implementation is targeted toward youth who have or are at risk of developing an SED, are receiving residential or inpatient mental health services, or are at risk of being removed from their home and placed in a more restrictive treatment setting. The state-level SOC, led by HHSC, is directed to identify local, state, and federal funding required to finance the infrastructure and provider system needed to support state and local SOC efforts.

Currently, no general revenue is allocated to HHSC to support state or local SOC infrastructure (e.g., personnel, behavioral health services and supports, and program evaluation). Since 1997, SAMHSA has awarded HHSC funding to implement the SOC in several communities. However, funding amounts, limitations on acceptable expenditures, and the focus of grants, have hindered local

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[63] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (2015). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbances, Report to Congress, 2015.

sustainability, effectiveness, and outcomes, ultimately limiting coordination of care and reducing access to care for children and families.

To strengthen state and local level implementation of the SOC approach, the subcommittee has the following recommendations.

Recommendations

Recommendation

Amend Texas Government Code, Section 531.251, to establish state level multi-sectoral children's behavioral health advisory team to advance statewide implementation of the SOC.

A state-level children's behavioral health advisory team composed of multi-sectoral representatives (including local agency, family, and youth perspectives) is intended to provide a mechanism for planning, financing, evaluating, and ensuring the availability of, and access to, behavioral health services and supports.

The advisory team, at a minimum, will be responsible for the following:

- Identifying and eliminating state policy barriers to coordination between child-serving entities;
- Determining ways in which agencies' funding streams and requirements can be streamlined and better coordinated;
- Supporting communities to operate and sustain local SOC and Community Resource Coordination Groups that operate under the SOC framework;
- Assisting communities with developing and implementing children's behavioral health service plans that align with and further implementation of the Children's Behavioral Health Strategic Plan;
- Partnering with local teams to identify and address state and/or local policy or administrative issues that interfere with the local implementation of the children's behavioral health service plan; and
- Providing biennial reports to the Legislature on implementation of the Children's Behavioral Health Strategic Plan.

Recommendation

Establish a Texas Children's Behavioral Health Training and Technical Assistance Center.

The Texas Children's Behavioral Health Training and Technical Assistance Center would serve as a centralized clearinghouse for disseminating children's behavioral health information through training and technical assistance for Texas-based individuals and organizations who care for and/or provide services and supports to children with behavioral health and co-occurring conditions.

The state Multi-Sectoral Children's Behavioral Health Advisory Team would collaborate to design and oversee the Center implementation, modeling it after the Texas School Safety Center, designated in Chapter 37, Subchapter G, of the Texas Education Code and the Governor's Homeland Security Strategic Plan.

Gaps in Services and Infrastructure

In order to better understand Texas' behavioral health care ecosystem, the subcommittee conducted a review of state and national literature, consulted with select organizations with expertise in health systems (both nationally and Texas-specific), disseminated surveys, interviewed youth and families with lived experience, and leveraged its own collective expertise.

Thematically, the following emerged as the most significant areas of need to enhance access to behavioral health services: the delivery of timely, affordable, quality, and effective behavioral health services; continuity of care in behavioral health services; and health and recovery outcomes for children and their caregivers.

Behavioral Health Parity

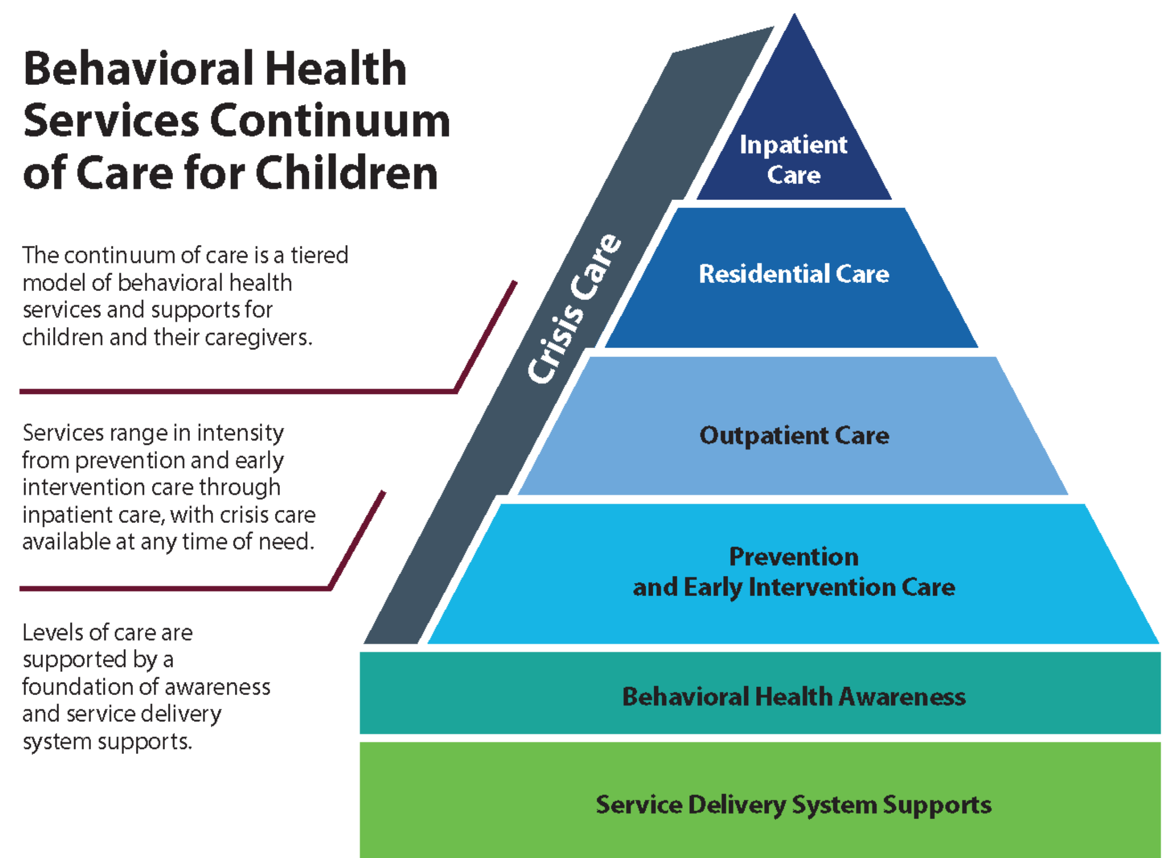
Rates of Reimbursement for Behavioral Health Services

Behavioral Health Workforce

Behavioral Health Data and Health Care Information Technology

Crisis, Outpatient, Residential, and Inpatient Care

Figure 1. The Children's Behavioral Health Care Continuum



Foundationally, the Behavioral Health Services Continuum of Care for Children begins with ***service delivery system supports*** that shore up service availability, accessibility, affordability, and efficacy. Service delivery system supports include:

- Compliance with and strong enforcement of state and federal parity laws;
- Reimbursement rates that reflect the rising costs of providing care for populations experiencing increased severity, complexity, and acuity of symptoms;
- A behavioral health workforce with sufficient capacity and expertise; and
- High-quality data and modernized data systems that inform program design and implementation, ensure continuity of care for children served by multiple systems, and improve health outcomes.

In the absence of this infrastructure, children and their caregivers are at risk of experiencing some of the issues highlighted earlier (e.g., ACEs, extended wait times for behavioral health services, juvenile justice involvement, and suicide).

The next layer of the continuum is ***behavioral health awareness***, which refers to strategies that increase public knowledge about behavioral health to promote widespread understanding, reduce stigma, and foster positive help-seeking attitudes.

The care section of the continuum consists of a tiered model of services and supports that increase in intensity, cost, and length of treatment based on severity, complexity, and acuity. These tiers are fluid, meaning, that children and their caregivers may move down and up these tiers at various stages of managing their behavioral health condition.

The continuum begins with ***prevention and early intervention***, delivered in a community-based setting to facilitate early identification and initial connection to services that may reduce the incidence, prevalence, and severity of behavioral health conditions. Most children who require some level of behavioral health intervention will not require care beyond this tier.

Outpatient care is delivered in office- or community-based settings that varies in frequency of contact and types of services based on the acuity of behavioral health conditions.

Residential care is delivered in a non-hospital, residential setting that requires increased frequency of contact and services that respond to the acuity of behavioral health conditions.

Inpatient care is delivered to children in a hospital-based setting that reduces imminent risk of harm to self or others, deterioration of mental or physical health, and prepares for transition to less restrictive settings and long-term intensive treatment.

Crisis care is delivered in a community or facility-based setting that reduces imminent risk of harm to self, others, or further deterioration of mental or physical health. Crisis care may be provided at any tier of the Continuum.

Service Delivery System Supports

Behavioral Health Parity

Parity[64] laws require health plans covering behavioral health services to provide the same level of coverage as offered for medical and surgical benefits, with respect to:

[64] Insurance coverage and parity for mental health and substance use disorder services.

- Annual and lifetime limits on coverage;
- Financial requirements including deductibles, copayments, coinsurance, out-of-pocket expenses;
- Quantitative treatment limitations including limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment; and
- Non-quantitative treatment limitations such as medical management standards, step therapy and fail-first requirements, formulary design, availability of coverage for services delivered by out-of-network providers and network tier design, standards for provider participation, payment methodologies, and other plan processes that limit or restrict coverage or access to treatment.

The behavioral health and well-being of children and their families requires investing in strategies to promote coverage and lower barriers to access, ensuring that insurance providers adhere to state and federal parity laws, and continuing to implement the strategies in the Texas Mental Health Condition and Substance Use Disorder Parity Strategic Plan. The subcommittee recommends the following action to advance behavioral health parity for children.

Recommendations

Recommendation

Amend Texas Insurance Code, Section 1355.001, to add a definition for Serious Emotional Disturbance.

Chapter 1355, Texas Insurance Code, Section 1355.001, includes a definition for serious mental illness (SMI) that lists applicable psychiatric illnesses defined by the APA in the *Diagnostic and Statistical Manual*. Federally, the term SMI is specific to people who are 18 or older, while the term SED refers to similar mental health challenges when experienced by children up to age 18. Currently, the Texas Insurance Code does not include an SED definition.

H.B. 10, 85th Legislature, Regular Session, 2017, strengthened behavioral health parity laws, but did not add a definition for SED, limiting its effectiveness among children. Adding a definition for SED to the Insurance Code would provide the state a benchmark by which to measure compliance with federal parity standards as they relate to children. The definition for SED can be taken from Chapter 531, Texas Government Code, Section 531.251, "Serious emotional disturbance means a mental, behavioral, or emotional disorder of sufficient duration to result in functional impairment that substantially interferes with or limits a person's role or ability to function in family, school, or community activities." Leveraging of such a strategy may positively impact a family's ability to afford care for their children with

high acuity behavioral health needs perhaps diverting them from higher tiers of care and systems such as DFPS and TJJD.

Rates of Reimbursement for Behavioral Health Services

Providers on the subcommittee agreed that children served today often have significantly different clinical profiles than those served even a decade ago, noting many children with unstable family structures, significant histories of trauma, including human trafficking and physical and sexual abuse, substance use, and multi-system involvement (e.g., with child welfare, juvenile justice, and health and human services agencies).

Meeting these children's needs requires a high degree of service coordination involving multiple organizations. They often need an array of high-intensity services which current rates of reimbursement for services do not adequately support. Reimbursement rates should reflect the increasing severity, complexity, and acuity of the conditions being treated, and the rising costs of providing appropriate care. This is reflected in the workforce available and accessible to provide behavioral health services. For example, in 2023, the Texas Behavioral Health Executive Council (BHEC) surveyed psychologists, marriage and family therapists, professional counselors, and social workers licensed to practice in Texas. In response to the question "Do you or your employer accept or bill insurance (e.g., Blue Cross Blue Shield, United Healthcare) for services you provide?" 45 percent reported not accepting or billing insurance for services. When asked "Do you or your employer accept or bill Medicaid (e.g., CHIP, School Health and Related Services [SHARS]) for services you provide?" 65.5 percent responded no.

The *Texas Mental Health Condition and Substance Use Disorder Parity Strategic Plan* noted a significant disparity in reimbursement rates between mental health and medical providers. Mental health providers often received lower reimbursement rates compared to their medical counterparts for similar services. This financial imbalance has contributed to difficulties in attracting qualified professionals.

There is an abundance of literature that supports the data collected by the BHEC and the Texas Mental Health and Substance Use Disorder Parity Workgroup[65] and contextualizes the quantitative data on this matter. Often, examples of reasons cited for non-acceptance of insurance include low rates of reimbursement, workforce shortages, and the amount of time spent completing paperwork towards

[65] The authorizing statute for the Texas Mental Health and Substance Use Disorder Parity Workgroup expired September 1, 2021, and this workgroup is no longer operational.

billing for services rendered.[66,67] The subcommittee developed several recommendations for increasing rates of reimbursement for programs or treatment environments effective in helping children with complex trauma histories and behavioral health conditions.

Behavioral Health Workforce

Significant workforce shortages mean Texas' behavioral health providers lack sufficient capacity to deliver care to everyone who needs it. The shortage is felt throughout the system, among licensed, certified, and non-credentialed professionals. As the demand for services continues to rise, the shortage of qualified, skilled professionals presents a formidable barrier in access to timely and appropriate care. In December 2020, the SBHCC's Behavioral Health Workforce subcommittee published Strong Families, Supportive Communities: Moving Our Behavioral Health Workforce Forward which includes short, mid, and long-term action items to solutioning behavioral health workforce shortages.

During the strategic planning process, members of the subcommittee hosted focus groups with youth, young adults, and caregivers with lived experience receiving behavioral health services. Participants described access to behavioral health services and supports being impacted by workforce shortages, workforce expertise, and rates of reimbursement for these services.

Navigation and Access to Behavioral Health Services

Caregivers trying to meet their children's needs often find it overwhelming to navigate different service delivery systems. Caregivers in focus groups voiced a desire to be able to talk to someone who can help them understand what services are available, eligibility requirements, and how to access care. Helping caregivers navigate complex systems requires empathy, clear communication, and an understanding of the available services and supports, but does not require a licensed workforce. Certified Family Partners (CFPs), Mental Health Peer Specialists (MHPSs), Recovery Support Specialists (RSSs), and Community Health Workers (CHWs) or Promotoras, are among the professionals that could assist in this process. CFPs, MHPs, and RSSs are a group of professionals with lived experience having or supporting someone who has behavioral health conditions. These individuals have experience navigating and accessing behavioral health services. CHWs help people gain access to needed services and build individual, community, and system capacity through outreach, patient navigation and follow-up,

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[66] Frustrated You Can't Find A Therapist? They're Frustrated, Too : Shots - Health News:NPR.

[67] Acceptance of insurance by psychiatrists and the implications for access to mental health care.

community health education and information, informal counseling, social support, advocacy, and participation in clinical research.[68]

School-Based Behavioral Health Services

Focus group participants voiced a desire for more access to behavioral health services and supports provided in school settings. In 2019, the District Leadership Forum[69] reported that teachers lose an estimated average of 144 minutes per week managing student behavioral disruptions in the classroom, equating to 14.5 school days per year. In the 2023 Texas Teacher Poll: Listening to the Educator Experience, 94 percent of respondents felt they needed support in handling student discipline, and that having campus administrators address this need would create a positive work culture and environment.[70]

50% of teachers reported not having adequate training and support from their campus to respond to a student mental health crisis.

State investments in training and response would equip more schools and staff to recognize mental and behavioral health challenges and make a connection to services and supports when a need is identified, as necessary. Having a range of services and supports in schools is a strategy to support staff and reach children before they are in crisis by providing low-intensity, non-clinical support. For students who may need more support, available resources provide an opportunity to collaborate with parents in connecting youth and their family to mental health care.

For example, in 2019, through S.B. 11, the Texas Legislature created the Texas Child Mental Health Care Consortium (Consortium), to improve access to children's behavioral health services through collaboration among all 12 academic health related institutions, state agencies, and non-profit organizations. The Consortium operates the Texas Child Health Access Through Telemedicine (TCHATT). This school-based telehealth initiative is designed to identify needs early and provide assessments and short-term intervention. As of October 2024, TCHATT is available in 6,611 campuses, representing 860 school districts. Based on these numbers, 4.1 million children could potentially be served through TCHATT.

Youth focus group participants also reported that mental health and behavioral health stigma is present in schools. Due to this, students are apprehensive to speak about their behavioral health needs and confide in adults who may be able to help

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[68] Community Health Worker or Promotor(a) Training Certification Program | Texas DSHS.
[69] https://pages.eab.com/rs/732-GKV-655/images/BreakingBadBehaviorStudy.pdf.
[70] https://charlesbuttfdn.org/wp-content/uploads/2023/09/2023-teacher-poll.pdf.

them. Youth Mental Health First Aid (MHFA) is an 8-hour training course for adults who regularly interact with children between the ages of 12-18. The training introduces participants to the signs and symptoms of behavioral health concerns and gives an overview of common treatments and community-based resources. There are no degree requirements or other academic prerequisites to become certified to teach MHFA or be trained in MHFA. In Texas, the Legislature has invested in making MHFA available to all levels of professionals working in school settings. Similarly, the Consortium uses federal COVID-19 relief funds to provide Youth Aware of Mental Health (YAM) training in participating schools. YAM is an evidence-based mental health awareness curriculum for students from 8th to 12th grade.

Youth focus group participants voiced a need for suicide prevention resources. Caregivers and all levels of professionals working in school settings can obtain evidence-based suicide prevention training. Some trainings are free while others have a cost. Like MHFA, there are no degree requirements, or other academic prerequisites to become certified to teach these courses, or to receive the training. For example, the Texas Suicide Prevention Collaborative (TxSPC) and its coalition partners, LMHAs and LBHAs, some universities, and other organizations provide Applied Suicide Intervention Skills Training (ASIST) and Ask About Suicide to Save a Life training. TxSPC also developed the Texas Advancing Suicide Safer Schools Roadmap, free for Texas schools, with online resources for suicide prevention, intervention, and postvention planning.[71]

HHSC and TEA collaborate to identify and publish a list of evidence-based practices for suicide prevention, and other mental health promotion topics, pursuant to Chapter 38, Subchapter G, Texas Education Code. The list is reviewed and updated annually.[72]

As with any other entity or system across the state, there are varying needs from community to community and there is not a one-size-fits all approach for districts to support the mental health and well-being of its students and staff; needs may differ from campus to campus. Funding TEA to issue discretionary grants to school districts aligned to statutory requirements for safe and supportive schools and establishing a school mental health allotment could provide flexibility in assisting their efforts.

Behavioral Health Services for Special Populations

Caregivers participating in the focus groups voiced a need for providers who understand how to serve children and families with complex and intergenerational trauma histories and children with co-occurring behavioral health conditions and

[71] https://txspc.learnworlds.com/course/texas-advancing-suicide-safer-schools-roadmap.
[72] https://schoolmentalhealthtx.org/best-practices/.

IDD Assisting children and families with these needs requires initial and ongoing training for all levels of staff providing care.

Although some licensed professionals have received this in the course of earning their degree, not all programs include it, and training differs in quality and quantity. In 2019, The Arc and the Family Support Research and Training Center conducted focus groups with disability, mental health, and education professionals to explore their perceptions of training needs for serving individuals with co-occurring behavioral health conditions and IDD.[73] They identified the following major gaps:

- Misperceptions about the capabilities of people with IDD and mental health conditions;
- Uncertainty on how to effectively communicate with people with IDD and mental health conditions;
- No strength-based or keen understanding of the needs of people with IDD and mental health conditions;
- Lack of understanding of available programs and services and how service systems interact; and
- Uncertainty on how to collaborate across the disability, education, and mental health systems.

This lack of knowledge can impact wait times for services, decisions regarding admission to care in certain treatment environments, the treatment regimen, and ultimately, health outcomes of the children and families served. HHSC partners with the University of Texas Health San Antonio, Department of Psychiatry and Behavioral Sciences, to promote workforce development in understanding the needs of and how to treat individuals with co-occurring mental health conditions and IDD through the *Mental Health Wellness for Individuals with Intellectual and Developmental Disabilities* training hub.[74] Training modules are free and available to direct service workers and other healthcare professionals.

While some organizations require employees to receive training on trauma-informed care, human trafficking, and other issues involving special populations, that build awareness, knowledge, and skills to work with these special populations, the state lacks a centralized infrastructure to offer such courses. This is the type of training coordination the recommended Texas Children's Behavioral Health Training and Technical Assistance Center could offer.

Behavioral Health Services: Individual and Family Counseling

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[73] https://thearc.org/wp-content/uploads/2019/11/Training-Needs-of-Professionals-who-Serve-People-with-IDD-and-Mental-Health-Needs-and-their-Families.pdf.
[74] https://training.mhw-idd.uthscsa.edu/.

Caregivers participating in the focus groups voiced a need for individual and family counseling services. The behavioral health workforce comprises many professionals including primary care physicians, nurses, peers, licensed chemical dependency counselors, behavior analysts, occupational therapists, and more. However, counseling services in the treatment of mental health, substance use, or behavioral health conditions, are solely provided by the below categories of licensed professionals. Table 5 is a comparison of these professionals to include the minimum degree required for licensure, median salary, interstate licensure compacts, and if they are a reimbursable provider under Medicaid.

Table 5. Comparison of the Behavioral Health Workforce

Professional Type	Number of Professionals Statewide[75]	Minimum Degree Required	Median Salary[76]	Interstate Licensure Compacts	Services Medicaid Reimbursable and at What Percent	Eligible to Participate in the Mental Health Professionals Loan Repayment Program
Psychiatrists	2,651	Doctorate	$198,249	Yes[77]	Eligible for 100% of their Medicaid fee schedule	Yes
Psychologists	5,138	Doctorate	$84,855	Yes[78]	Eligible for 100% of their Medicaid fee schedule	Yes
Licensed Specialist in School Psychology (LSSP)	4,017	Doctorate	$75,438	No	Under SHARS	Yes
Licensed Psychological Associates	734	Masters	$52,360	No	70% of the rate paid to a psychiatrist and psychologist.	No
Licensed Clinical Social Workers	10,675	Masters	$44,099	No	70% of the rate paid to a psychiatrist and psychologist.	Yes

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[75] Data current as of 2023 and pulled from Texas Health Data - Health Profession Supply.
[76] Median salary information based on 2022 data pulled from Wages by MSA - Texas Wages and Employment Projections.
[77] The Interstate Medical Licensure Compact (IMLC) is a voluntary, expedited pathway to licensure for qualifying physicians who wish to practice in multiple states. On June 7, 2021, Governor Greg Abbott signed into law H.B. 1616 which was passed by the 87th Texas Legislature, making Texas the 33rd member state to join the Compact.
[78] The Psychology Interjurisdictional Compact (PSYPACT) is an interstate compact designed to facilitate the practice of telepsychology and the temporary in-person, face-to-face practice of psychology across state boundaries. Texas adopted PSYPACT pursuant to H.B. 1501 (86th Leg.) in 2019.

Licensed Master Social Workers	12,146	Masters	$59,190	No	No	No
Licensed Professional Counselors (LPC)	25,519	Masters	$51,798	No	70% of the rate paid to a psychiatrist and psychologist.	Yes
LPC Associates	5,903	Masters	N/A*	No	No	No
Licensed Marriage and Family Therapists (LMFT)	3,268	Masters	$66,275	No	70% of the rate paid to a psychiatrist and psychologist.	Yes
LMFT Associates	692	Masters	N/A*	No	No	No
Licensed Chemical Dependency Counselors	5,936	Associates	$55,776	No	No	Yes

*This information is not available in the U.S. Bureau of Labor Statistics website.

While these professionals can provide individual and family counseling services, more specialized therapeutic approaches such as Cognitive Behavioral Therapy, DBT, EMDR, and Functional Family Therapy (FFT) may require additional training, certification, and supervision. Simply increasing the number of these providers does not ensure a workforce skilled at delivering these types of evidence-based treatment approaches. In addition, training can be expensive and policy decisions limit the types of evidence-based approaches that may be provided in certain service delivery systems. Some therapies also may not be reimbursable under Medicaid or commercial insurance plans.

Recommendations

Recommendation

Fund HHSC to expand the number of Certified Family Partners and make Certified Family Partner services as a Medicaid state plan benefit.

Family partner services are provided to the family of a child receiving mental health services. Services are provided by a CFP or a family partner waiting to complete CFP training. A CFP is a person who has lived experience parenting a child with mental, emotional, or behavioral health conditions. They have navigated systems on behalf of their child and can articulate their experience. Services include providing emotional support, modeling advocacy skills, making referrals, providing skills training, and helping identify family supports. Access to family partner services can be instrumental in engaging families as active participants in the child's care.

Currently, HHSC's CFP initiative is implemented through contracts with 39 LMHAs and LBHAs, though there is no dedicated general revenue (GR) funding for this initiative. If GR is allocated to support this initiative, it would be used to expand the number of CFPs employed in a variety of settings through new or amended contracts with governmental entities; or a procurement to contract with governmental and non-governmental entities. Though family peer support services are reimbursable under Medicaid in the YES program at a payment rate of $6.25 per 15-minutes[79], these services may be provided by professionals other than CFPs, and CFP services are not reimbursable under the Medicaid state plan at this time. H.B. 1486 85th Legislature, Regular Session, 2017 established a Medicaid peer services benefit for adults with mental health and substance use conditions, and codified the framework for training, certification, and supervision. The infrastructure developed as a result of H.B. 1486 can be leveraged to implement CFP services as a Medicaid benefit.

Recommendation

HHSC should expand the qualifications required to serve as a Qualified Mental Health Professional-Community Services.

Qualified Mental Health Professional-Community Services (QMHP-CSs) deliver mental health rehabilitative and targeted case management services and must meet minimum credentialing requirements as described in Title 1, Chapter 353, Texas Administrative Code (TAC), §353.1415 and 26 TAC Chapter 306 Subchapter G.

Medicaid benefit policy and administrative code rule changes are underway to change the qualifications for QMHP-CS' for Mental Health Targeted Case

[79] Youth Empowerment Services (YES) Waiver Payment Rates Effective April 1, 2021.

Management and Mental Health Rehabilitative services to allow persons with a bachelor's degree in a non-human services field with at least one year of experience in a program within an organization that provides mental health and/or substance use disorder services to deliver these services.

Recommendation

Join the Counseling Compact and Social Work Compact, by amending Texas Occupations Code, Chapters 503 and 505, respectively.

Interstate licensure compacts create mutual professional licensing practices among joining states while ensuring quality and safety and safe-guarding state sovereignty.[80] As of 2023, Texas is a member of five professional compacts: the Nurse Licensure Compact (NLC), the Interstate Medical Licensure Compact (IMLC), the Physical Therapy (PT) Compact, the Emergency Medical Services (EMS) Compact, and the Psychology Interjurisdictional Compact (PSYPACT).[81] The counseling and social work compacts are the same in form and function to previously referenced compacts.

Effective September 2024, 37 states have joined the counseling compact and 21 have joined the social work compact.

Figure 9 and Figure 10 are two maps of states with enacted, filed, or no active legislation to join the counseling and social work compacts.

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[80] Compacts-and-Universal-Licensure-Laws-June-2022.pdf.

[81] https://compacts.csg.org/wp-content/uploads/2024/01/CompactChart2023.pdf.

Figure 9. States with Enacted, Filed, or No Active Legislation to Join the Counseling Compact

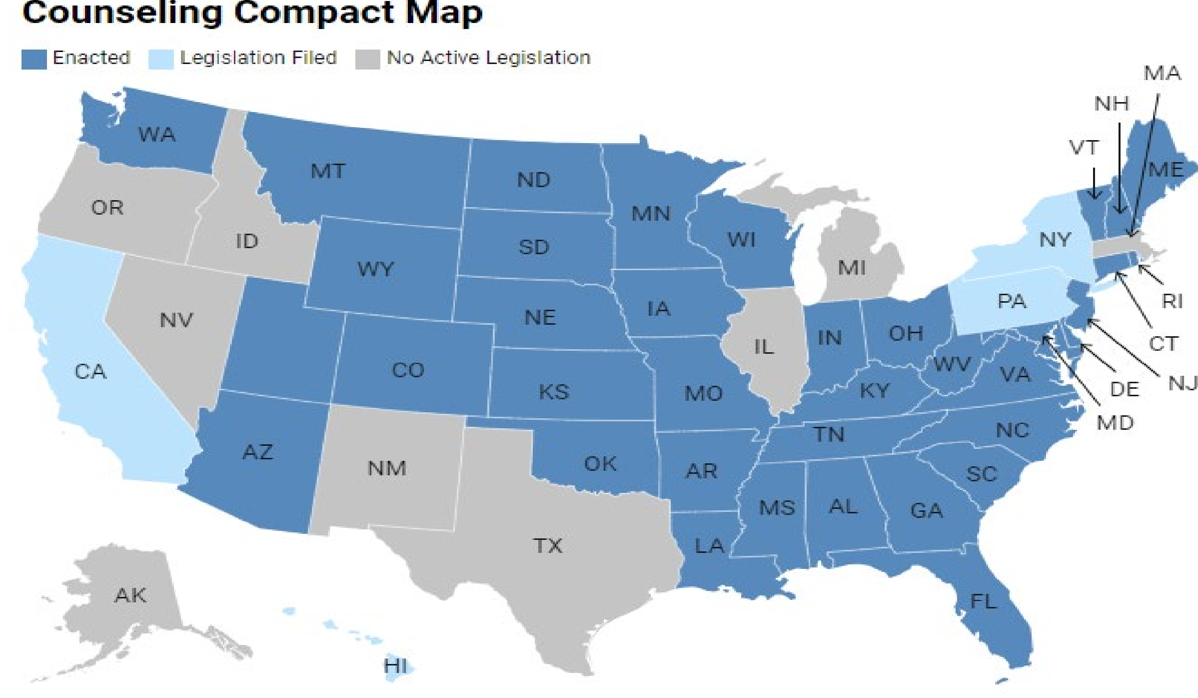
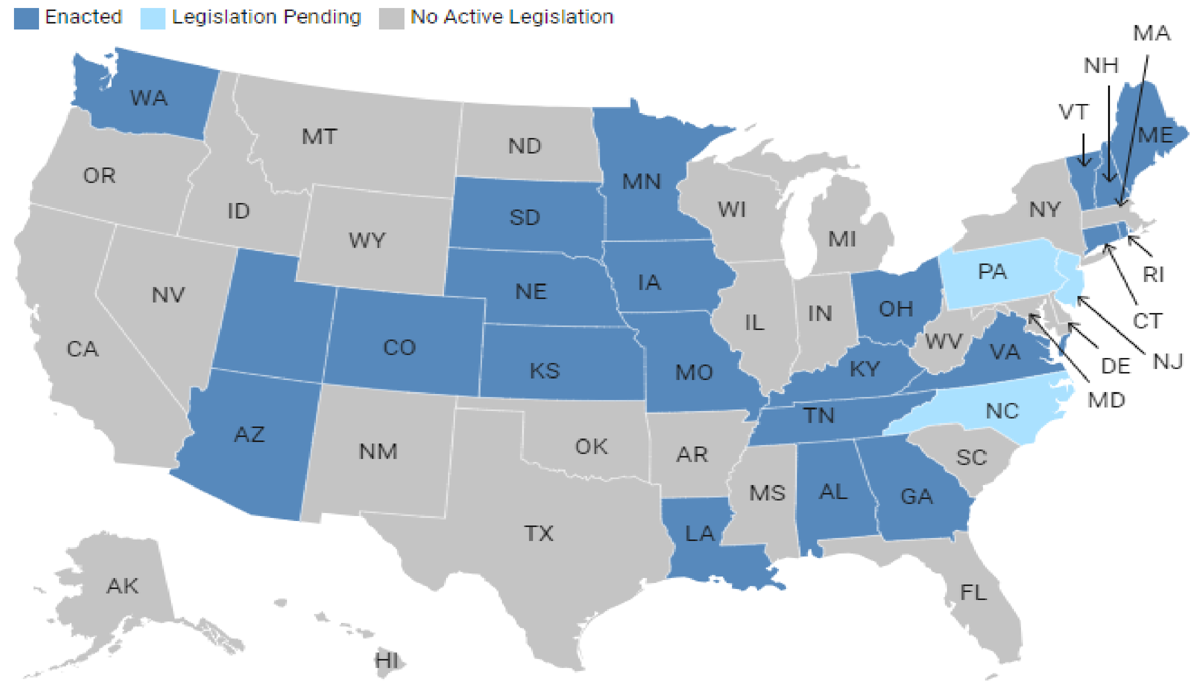


Figure 10. States with Enacted, Filed, or No Active Legislation to Join the Social Work Compact



In 2020, an advisory body to the Counseling Compact Commission approved counseling compact model legislation[82] which must be enacted by a state to officially join the compact. Conversely, there is also model social work compact legislation[83] that must be enacted by a state to officially join the social work compact.

The Counseling Compact Commission is not yet issuing compact privileges to practice. Throughout 2024, the Counseling Compact Commission is working with developers to create the necessary database to receive applications, provide interstate data communications, and issue privileges to practice. The Counseling Compact Commission anticipates they will begin issuing compact privileges to practice in 2025. The Counseling Compact Commission is enacted in some states, meaning those states have passed legislation to be part of the compact; however, the Counseling Compact Commission is not yet operationalized, meaning the

[82] Final_Counseling_Compact_3.1.22.pdf.
[83] Social-Work-Licensure-Compact-Model-Legislation.pdf.

process to apply for and receive compact privileges is in progress and will be available in 2025.

Although, the Social Work Licensure Compact has been enacted in at least seven states and has reached activation status, multistate licenses are not yet being issued. Texas' implementation process for the Social Work Licensure Compact would take an additional 12 to 24 months post passage of the compact law. Texas would also need to join the compact before multistate licenses are issued. Joining this compact may be a potential strategy in bolstering the workforce and attracting much needed talent to Texas in provisioning behavioral health services.

Recommendation

Amend Human Resources Code, Chapter 32, to authorize Licensed Marriage and Family Therapist Associates, Licensed Professional Counselor Associates, and Licensed Master Social Workers to provide and be reimbursed for counseling services under the Medicaid state plan.

Section 32.027, Human Resources Code, should be amended to add subsection (m), specifying that a recipient of medical assistance under this chapter may select from the following professionals to perform any health care service or procedure covered under the medical assistance program if the selected person is licensed and authorized by law to perform the service or procedure:

- An LMSW, as defined by Occupations Code, Section 505.002, who is actively pursuing the education and training required to be licensed as an LCSW, as defined by that section;
- An LPC Associate, as described by 22 TAC, Chapter 681, who is working toward fulfilling the supervised practice requirements to be licensed as an LPC, as defined by Occupations Code, Section 503.002; and
- An LMFT Associate, as described by 22 TAC, Chapter 801, who is working toward fulfilling the supervised practice requirements to be licensed as an LMFT, as defined by Occupations Code, Section 502.002.

In addition, Chapter 32, Human Resources Code, Subchapter B should be amended to add section 32.077, to direct professionals listed under Section 32.027(m), Human Resources Code, who are selected to provide a health care service or procedure covered under the medical assistance program be reimbursed at a rate equal to 70 percent of the reimbursement rate established for a licensed psychiatrist or psychologist providing a similar service.

The current mental health workforce in Texas lacks capacity to meet demand for individual, group, and family counseling services. Allowing Medicaid reimbursement for LMSWs, LPC Associates, and LMFT Associates training for further licensure under supervision may incentivize these professionals and their employing organizations

to become Medicaid providers. It may also encourage commercial insurance providers to authorize these professionals to be reimbursed through their plans.

Recommendation

Fund the Texas Child Mental Health Care Consortium to Expand the Community Psychiatry Workforce Expansion Initiative to Include Other Mental Health Professions.

The Texas Child Mental Health Care Consortium (TCMHCC) supports the expansion of the child and adolescent psychiatry workforce in Texas through two initiatives: the Community Psychiatry Workforce Expansion (CPWE) and the Child and Adolescent Psychiatric Fellowships.

The goals of the CPWE initiative are to:

- Collaborate and coordinate with community mental health providers to expand the amount and availability of mental health care resources by developing training opportunities for psychiatry residents and supervising residents at facilities operated by LMHAs and by other community mental health providers; and
- Increase the number of Texas-trained psychiatry residents who work in the public mental health system upon completion of their residencies.

In the Fall of 2021, during the third called special session of the 87th Texas Legislature, TCMHCC was appropriated $113 million in federal funds from the American Rescue Plan Act to enhance and expand initiatives in response to the impact of the COVID-19 pandemic. With these funds, CPWE expanded to deliver supervised training to students and recent graduates of accredited mental health care programs provided in specific health related institutions. Trainees assist in the delivery of effective child and adolescent mental health services in regional community-based mental health providers.

Mental health professionals supported through CPWEs expansion include psychology graduate students with child practicums and those with child and adolescent internships, LPCs, LCSWs, and nurse practitioners in training. Funds would be used to continue supervision training for mental health professionals.

Recommendation

Fund the Texas Higher Education Coordinating Board to implement the Behavioral Health Innovation Grant Program under Chapter 61, Education Code, Subchapter RR.

The Texas Higher Education Coordinating Board (THECB) was directed to implement the Behavioral Health Innovation Grant Program, however, no dedicated general revenue funding was allocated to support implementation, nor has THECB raised

funds to implement the program as statutorily authorized. Under the grant program, THECB may award incentive payments to institutions of higher education that administer innovative recruitment, training, and retention programs designed to increase the number of mental health professionals,[84] or professionals in related fields.

The current workforce crisis requires innovative recruitment and retention practices to graduate-level behavioral health programs, as well as new ways to incentivize licensure and direct behavioral health practice.

The behavioral health workforce recommendations included are intended to quickly help address critical shortages, as are current workforce efforts such as tuition and student loan reimbursement programs for mental health professionals. The recommendations may yield visible outcomes in three to five years due to implementation factors, such as recruitment and training.

Table 6 reflects workforce recommendations, high-level timeline for implementation, and when we could anticipate outcomes based on action by the 89th Legislative Session.

Table 6. Workforce Recommendations, Timelines, and Outcomes

Recommendation	Anticipated Implementation for State Agencies	Anticipated Implementation for Providers or Institutions	Outcomes Visibility
CFP Expansion and Compensation	GR allocation: 12 months: September 2026 Medicaid: 9-12 months: September 2025- September 2026	GR allocation: 12 months: September 2027 Medicaid: 12 months: September 2027	GR allocation: 12 months: September 2028 Medicaid: 12 months: September 2028

[84] Psychiatrists, psychologists, LSSPs, LCSWs, LPCs, LMFTs, Licensed Chemical Dependency Counselors, and Advance Practice Registered Nurses-Psychiatric or Mental Health Nursing specialties.

QMHP-CS Expanded Qualifications	Non-Medicaid: 12 months: September 2026 Medicaid: 12-24 months: September 2026- September 2027	Non-Medicaid: 12 months: September 2027 Medicaid: 12 months: September 2028	Non-Medicaid: 12 months: September 2028 Medicaid: 12 months: September 2029
Counseling Compact	12 months: September 2026	12 months: September 2026- September 2027	12 months: September 2027 - September 2028
Social Work Compact	12-24 months: September 2026- September 2027	12-24 months: September 2026- September 2027	12 months: September 2027 - September 2028
LMSW, LPC Associate, LMFT Associate Medicaid Reimbursement	18-24 months: September 2026- March 2028	12 months: March 2029	12 months: March 2030
Behavioral Health Innovation Grant Program	12 months: September 2026	12 months: September 2027	12 months: September 2028

Data and Health Information Technology

Strengthening pediatric behavioral health services within the broad scope and complexity of the current healthcare environment requires collection and analysis of large amounts of data. The data would be complicated and span many different provider sectors and stakeholders. Given this complexity, it will be important to have some controls in place, including clear guidelines for data collection, handling, storage, and analysis. The aggregate data could be used to ensure high-quality care, demonstrate areas for improvement, assess effectiveness of care, evaluate the state's return on investment, and streamline data reporting requirements. A centralized data clearinghouse of relevant data, managed by a governance committee, would provide oversight of the data usage and report to stakeholders as needed. The data collected and warehoused would be kept in accordance with national standards and best practices.

Recommendations

Recommendation
Establish a data governance committee for children's behavioral health.

This committee will be tasked with:

- Reviewing and reporting on statutes related to data collection and information sharing for child behavioral health programs and related supports;
- Reviewing and inventorying previously collected program information, metrics, and other data; and
- Communicating about trends or aggregate population data collected from state-funded programs to both internal and external stakeholders.

Recommendation
Invest in modernizing data systems to strengthen data sharing, data collection, data storage, and data reporting to improve continuity of care for children served in the state system.

State agencies often use different technology and software for data collection, storage, and reporting, making coordination and integration costly and/or challenging to accomplish. In addition, the existing data landscape hinders agencies' ability to easily determine the array of services children and caregivers receive and identify associated outcomes. Making it easier to safely share healthcare information would improve care coordination for children and families served by multiple agencies.

Recommendation
Strengthen data workforce capacity through human capital investment in data teams.

"Data literacy is when an individual possesses the skills necessary to understand, explore, use, make decisions with, and communicate using data."[85] Data specialists collaborate with program specialists to design measures of program success, interpret data to inform program design and re-design, understand return on investment, and more. The state invests billions of dollars to expand and create access to behavioral health services, but these investments do not always include robust data teams to support the infrastructure needed for the evaluation of ongoing implementation.

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[85] Data literacy is the key to better decisions, innovation, and data-driven organizations.

Behavioral Health Awareness

Stigma of behavioral health conditions continues to be a barrier to people seeking and receiving behavioral health care.[86] There is a need to invest in strategies that increase public knowledge about behavioral health to promote widespread understanding, reduce stigma, and foster positive help-seeking attitudes.

Recommendation

Recommendation

Amend *Chapter 1001, Texas Health and Safety Code, Subchapter H*, to permit HHSC to contract with Regional ESCs in addition to LMHAs, LBHAs, to deliver Mental Health First Aid (MHFA) training and fund HHSC to expand MHFA training infrastructure.

H.B. 3, 88th Legislature, Regular Session, 2023, requires school districts to ensure each district employee who regularly interacts with students completes an evidence-based training program regarding recognition and support of children and youth who experience a mental health or substance use issue that may pose a threat to school safety. TEA is directed to provide a funding allotment to school districts to help cover the costs of employees' travel, training fees, and compensation for the time spent completing the training, if state funding is appropriated to TEA for that purpose, and to adopt rules to implement the program. TEA in consultation with HHSC, agree that the primary evidence-based mental health training program identified that meets the specifications of the bill is Youth Mental Health First Aid (YMHFA). While an alternative training program to YMHFA has not been identified by the state agencies, school districts have flexibility to select an alternative mental health training program if it meets the requirements adopted in TEA's implementing rule.

HHSC and TEA promote the YMHFA training infrastructure available through the LMHAs and LBHAs, as funded by HHSC contracts, to deliver YMHFA training to school district employees. However, the LMHA and LBHA MHFA training capacity (e.g., number of trainers and funding) is currently insufficient to train the number of school district professionals that are anticipated to take the training between 2025-2029. It is estimated that the statutory requirements equate to a minimum of 24,834 trainings classes to be held across a 7-year span. This will require a minimum of 3,574 training classes be delivered each academic calendar year.

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[86] Patient and Health Care Professional Perspectives on Stigma in Integrated Behavioral Health: Barriers and Recommendations.

Chapter 1001, Texas Health and Safety Code, Subchapter H, relating to Mental Health First Aid Training, currently allows for LMHAs and LBHAs to contract with Regional ESCs to provide MHFA to school district employees. Due to Chapter 22, Texas Education Code, requiring most or all school district employees to be trained, statute should be amended to allow HHSC to contract directly with ESCs to provide the training if additional funding is available. Additional funding would be required to expand the number of professionals certified to teach YMHFA and deliver sufficient trainings to meet H.B. 3 training specifications for school district personnel.

Behavioral Health Prevention and Early Intervention Care

Prevention and early intervention strategies can promote earlier access to healthcare and prevent the onset or worsening of behavioral health conditions.[87] There is a need to invest in services and supports that include early identification and initial connection to services that may reduce the incidence, prevalence, and severity of behavioral health conditions.

Recommendations

Recommendation

Fund TEA to issue discretionary grants to school districts to replicate Project AWARE Texas and deliver technical assistance with resources to increase student access to mental health services and supports aligned to statutory requirements for safe and supportive schools.

The Safe and Supportive School Program (SSSP) is a coordinated, multi-tiered support system to address school climate, social and emotional learning, behavioral health and wellness, collaborate with community services and supports in conducting behavioral threat assessments, and implement a multi-hazard approach to prevent, prepare for, respond to, and recover from crisis situations.[88]

Under the SSSP, school districts implement a Multi-Tiered System of Supports (MTSS), a research-based framework for systemic alignment of school-wide practices, programs, and services to support student development, both academic and non (e.g., social and emotional needs and behavioral health and wellness) and address the physical and psychological safety of all individuals within the school community. The MTSS consists of three tiers providing evidence-based interventions, from Tier 1 universal supports (e.g., social and emotional skill lessons, mental health literacy, bullying and violence prevention programs), Tier 2 targeted interventions (e.g., social skills groups and mentoring), and Tier 3

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[87] Prevention and early intervention in youth mental health: is it time for a multidisciplinary and trans-diagnostic model for care?.
[88] Texas Education Code, Section 37.115.

intensive interventions (e.g., individual and family counseling and other specialized behavioral health services).

One way that TEA has implemented MTSS in school districts is through applying for and receiving competitive federal grants administered by SAMHSA to implement Project AWARE. The focus of Project AWARE is increasing awareness of mental health, increasing access to mental health screenings and assessments, and increasing access to mental health services and supports with parent/guardian permission and family engagement. TEA's initial Project AWARE grant was implemented from 2018-2023 with 15 schools receiving services. Project AWARE has resulted in 140,314 trainings to school community members, 16,405 Tier 1 supports provided to students, 16,569 Tier 2 and 3 services provided to students, and 46 policy changes.[89]

Federal funds for Project AWARE expire September 2026, and as a result, TEA will lose the two employees (i.e., school mental health program specialists) who lead project implementation. This will diminish TEA's capacity to provide statewide mental and behavioral health resources and technical assistance supports to schools in areas such as mental health promotion, human trafficking, child abuse prevention, and substance misuse prevention and intervention. If Project AWARE Texas is replicated with state funds, TEA could award additional school districts with competitive discretionary grants to increase access to mental and behavioral health services and supports. TEA could sustain its school mental health program specialists with capacity to deliver technical assistance resources that benefit grantees and all Texas schools to increase access to mental health services and supports like those successfully provided with federal funds.

Recommendation

Establish a mental health allotment for schools separate from the school safety allotment.

Beginning in 2020, TEA received three Elementary and Secondary School Emergency Relief (ESSER) funding grants totaling roughly $19 billion.[90] In 2022, the Collaborative Task Force for Public School Mental Health, issued a survey to school districts inquiring about funding sources used to fund behavioral health services. Of the respondents, 73 percent of school districts reported primarily using ESSER funds to cover the cost of behavioral health services that were provided, while 19 percent reported using funds from the School Safety Allotment.[91] Several other fund sources were reported used by school districts to support mental health

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[89] AWARE Texas - Texas School Mental Health.
[90] https://www.ncsl.org/in-dc/standing-committees/education/elementary-and-secondary-school-emergency-relief-fund-tracker.
[91] https://schoolmentalhealthtx.org/wp-content/uploads/2023/02/Collaborative-Task-Force-on-Public-School-Mental-Health-Services-Year-3-Report.pdf.

(e.g., local funds, Title 1, and State Compensatory Education). However, the largest fund source budgeted for mental health related services and supports that was reported by school districts in the 2022 Task Force survey (i.e., ESSER) expires September 30, 2025.

Schools are making critical expenditure decisions regarding increasing student and family access to behavioral health services and ensuring safe school environments. Establishing a separate mental health allotment would support continued focus in both critical areas. Allocating a dedicated mental health funding allotment for schools was also recommended by the House Bill 906 Collaborative Task Force on Public School Mental Health in their 2022 study and evaluation report submitted to the Texas legislature.[92]

Recommendation

Fund HHSC to expand the Children's System Navigator program.

HHSC uses Community Mental Health Services Block Grant funds to implement the Children's System Navigator Program[93] at six LMHAs and LBHAs. System Navigators specialize in enhancing access to mental health services for children and families by providing connections to local child-serving agencies, educating community partners, building and maintaining relationships with public and private providers, sharing information, resource system development, and case staffing.

The System Navigators developed memorandums of understanding with local ISDs to allow on-site access to mental health services, partnered with DFPS and other organizations to conduct over 60 case reviews, and provided over 60 trainings to LMHA, LBHA, and community partners on accessing children's mental health services. Currently, the six System Navigator programs cover 69 counties, leaving 185 Texas counties without intensive coordination for children and families.

Figure 11 is a map of current system navigator sites and counties served. If funded, a procurement will determine allocation to additional sites.

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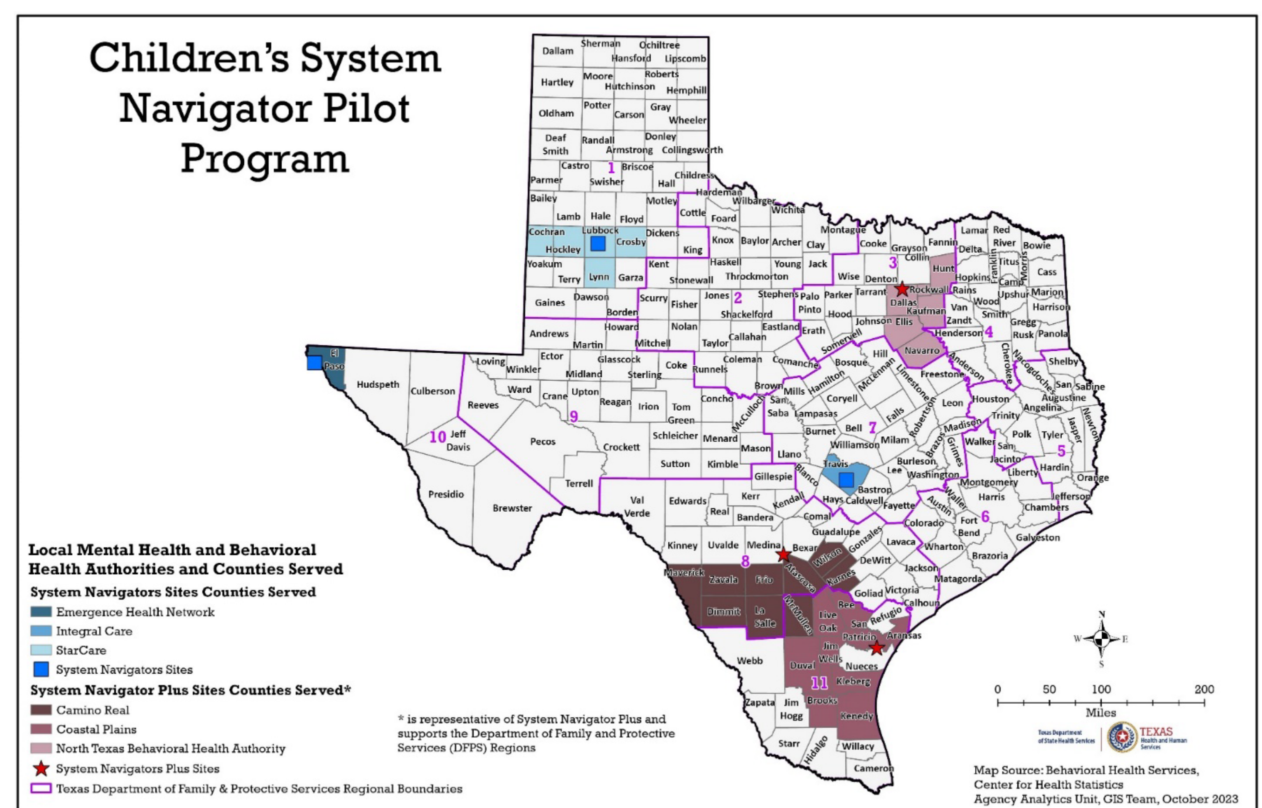
[92] Collaborative-Task-Force-on-Public-School-Mental-Health-Services-Year-3-Report.pdf (schoolmentalhealthtx.org)

[93] Population of focus includes children with intensive behavioral health needs, including children at risk of parental relinquishment and children under DFPS conservatorship.

Figure 11. Children's System Navigator Pilot Program Locations



Recommendation

Fund HHSC to expand substance use youth prevention programs.

Youth prevention programs use the Strategic Prevention Framework (SPF) to provide a comprehensive array of services to communities across Texas addressing behavioral health promotion and the dangers associated with alcohol, commercial tobacco and nicotine products, marijuana, and prescription drug misuse. Youth prevention programs focus on three categories of supports (i.e., Universal, Selective, and Indicated)[94] and provide evidence-based prevention activities and strategies from the Center for Substance Abuse Prevention in schools and other community sites, which address underlying factors that lead to substance use and

[94] Universal programs and practices take the broadest approach and are designed to reach entire groups or populations. Universal prevention programs and practices might target schools, whole communities, or workplaces. Selective programs and practices target individuals or groups who experience greater risk factors (and perhaps fewer protective factors) that put them at higher levels of risk for substance misuse than the broader population. Indicated programs and practices target individuals who show early signs of substance misuse but have not yet been diagnosed with a substance use disorder. These types of interventions include referrals to support services for young adults who violate drug policies. They also include screening and consultation for the families of older adults who are admitted to hospitals with potential alcohol-related injuries.

behavioral health challenges, including ACEs, non-medical drivers of health, or other youth, family and community risk and protective factors.

In fiscal year 2023, 1.8 million youth received universal program services, 1.8 million received selective program services, and 1.7 million received indicated program services. Currently, 48 providers, primarily non-profits, offer youth prevention program services in 187 of the 254 counties in Texas. Expanding substance use youth prevention programs would create greater access to behavioral health promotion services and the dangers associated with alcohol, commercial tobacco and nicotine products, marijuana, and prescription drug misuse.

Behavioral Health Outpatient Care

A robust array of outpatient services provided to children in office or community-based settings can prevent the need for out-of-home placement, residential treatment, or inpatient hospitalization.[95] There is a need to enhance the array of outpatient behavioral health services to help children develop coping skills, build resilience, accomplish personal goals, and prepare for adulthood.

Recommendations

Recommendation
Fund HHSC to include Coordinated Specialty Care for First Episode Psychosis, Family Functional Therapy, and Multisystemic Therapy as Medicaid state plan benefits.

Coordinated Specialty Care for First Episode of Psychosis

Coordinated Specialty Care for First Episode of Psychosis (CSC-FEP) is an evidence-based practice for children and young adults who have experienced an episode of psychosis. In HHSC's CSC-FEP program,[96] multi-disciplinary teams offer a variety of services and supports, including:

- Psychotherapy, including cognitive behavioral therapy for psychosis;
- Family education, support, and involvement;
- Support from peers in recovery from mental illness;
- Psychotropic medications prescribed by a psychiatrist; and
- Support for education and employment goals.

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[95] https://www.cmhnetwork.org/wp-content/uploads/2021/05/The-Evolution-of-the-SOC-Approach-FINAL-5-27-20211.pdf.
[96] Funded with General Revenue, Community Mental Health Services Block Grant, Coronavirus Response and Relief Supplemental Appropriations Act, and the American Rescue Plan Act.

Teams are typically composed of a psychiatrist, a Certified Family Partner or Peer Specialist, a licensed therapist, and a supportive employment and education specialist. CSC-FEP is a time-limited program with a maximum length of stay of three years.

Currently, there are 32 providers delivering CSC-FEP services, through 48 teams, across 171 counties. In fiscal year 2023, 1,289 people received CSC-FEP services of which 217 were children.[97] Among those served, there was a 39 percent decrease in the number of crisis encounters and a 65 percent decrease in admissions to HHSC-funded inpatient beds. 86.5 percent of participants had no psychiatric hospitalizations that fiscal year, and 98 percent had no arrests.

Texas Medicaid allows managed care organizations to cover CSC-FEP as an in-lieu-of service (ILOS) on a voluntary basis. ILOSs are services and settings offered by managed care organizations that substitute for Medicaid state plan services or settings, as allowed by 42 Code of Federal Regulations §438.3(e)(2). Per federal regulations, ILOSs must be a medically appropriate and cost-effective substitute for the covered service or setting under the state plan. Additionally, the Medicaid member must not be required by the MCO to use the ILOS and ILOSs must be optional for MCOs to provide.

Functional Family Therapy

Functional Family Therapy (FFT) is a family-centered, evidence-based practice for treating children with specific mental health needs, primarily related to externalizing behavioral issues impacting family dynamics. It is an intensive, short-term therapeutic model that offers in-home family counseling designed to address disruptive behaviors and juvenile delinquency from a relational, family-based perspective to improve family relationships. This model assesses family dynamics that have contributed to the youth's behavior, improves communication among family members, assists caregivers in learning new parenting skills, and supports positive reinforcement within community contexts and relationships. FFT is usually delivered through at least weekly sessions, for a duration of three to six months.

Multisystemic Therapy

Multisystemic Therapy (MST) is a proven family-and community-based treatment for at-risk youth with intensive needs and their families. It has been especially effective for treating youth who have committed violent offenses, have serious mental health or substance use concerns, are at risk of out-of-home placement, or who have experienced abuse and neglect. The 88th Texas Legislature invested

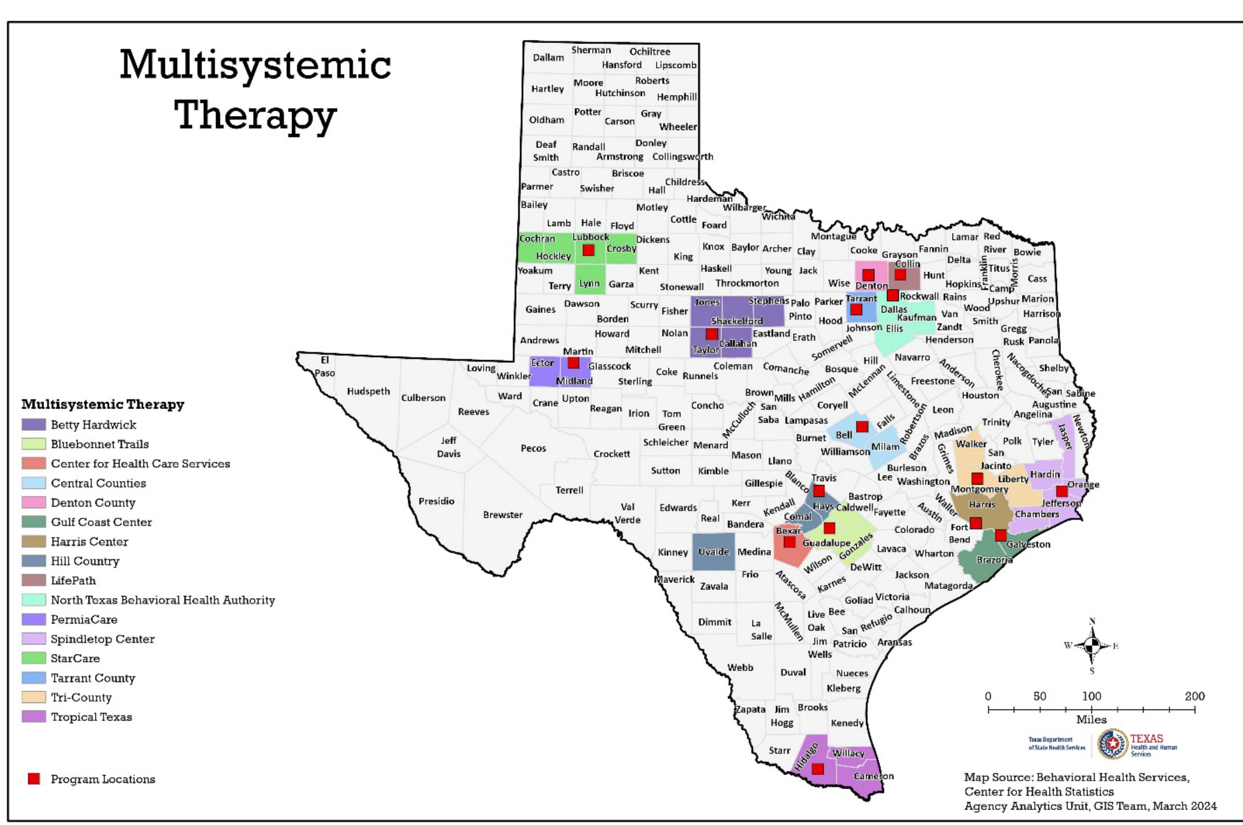
[97] From fiscal year 2015-2023, 896 children received CSC-FEP services.

almost $32.5 million in MST, with continued funding to sustain nine existing teams and establish 15 new teams.

Given that MST services typically last between three to six months and MST teams should serve at least 50 youth per year, Meadows Mental Health Policy Institute estimates that Texas would need approximately 140 teams to meet statewide need.[98] New Mexico has successfully implemented MST as a covered Medicaid benefit, finding savings by avoiding costs in other systems. 91 percent of youth were able to live at home after treatment, 85 percent reduced their substance use, and 64 percent had fewer drug related arrests. The state experienced $36.1 million in reduced Medicaid expenses and $124.7 million in reduced crime rate expenses totaling $73,382 saved per youth participant. Every dollar spent on MST resulted in $5.87 in community benefits.[99] In Texas, for SFY 2023, 85 children received MST services. 76 percent of children were living at home, 84 percent were in school or working, and 80 percent had no new arrests.

Figure 12 is a map of existing MST program locations.

Figure 12. Multisystemic Therapy Locations



98 Multisystemic-Therapy-MST-for-Texas-Youth_June-2024-2.pdf.
99 https://hsc.unm.edu/medicine/departments/psychiatry/cbh/docs/mstannualreport2005-2019.pdf.

Recommendation

Fund HHSC to include Intensive Outpatient and Partial Hospitalization services as Medicaid state plan Benefits.

Partial hospitalization (PHP) and intensive outpatient (IOP) services are designed for patients who do not need 24-hour residential hospitalization, but who do need more intensive services than traditional outpatient treatments offer. In PHP, patients can go home in the evening, but still receive many of the benefits of 24-hour hospitalization stays. IOP therapy programs offer more services than traditional outpatient therapy but are less intensive than PHP. Both are more cost-effective than 24-hour intensive inpatient hospitalizations and can help patients" step up" or "step down" from a hospital stay or prevent a stay altogether.

Currently, Texas Medicaid allows managed care organizations to cover partial hospitalization and intensive outpatient services as ILOSs on a voluntary basis. ILOSs are services and settings offered by managed care organizations that substitute for Medicaid state plan services or settings, as allowed by [42 Code of Federal Regulations §438.3(e)(2)]. Per federal regulations, ILOSs must be a medically appropriate and cost-effective substitute for the covered service or setting under the state plan. Additionally, the Medicaid member must not be required by the MCO to use the ILOS and ILOSs must be optional for MCOs to provide. With over five million Texans enrolled in Medicaid, there is an urgent need to provide additional mental health services to this population.

Recommendation

Fund HHSC to increase rates for the Youth Empowerment Services (YES) Waiver Program and address administrative barriers to serving children with complex needs.

The YES Waiver is a 1915(c) Medicaid Home and Community-based Services program designed to meet the needs of children with serious mental, emotional and behavioral difficulties in their home or community, rather than an institutional setting such as a residential treatment center or inpatient facility. The YES Waiver provides intensive services delivered within a strengths-based team planning process called Wraparound. Wraparound builds on family and community support and utilizes YES Waiver services to help build the family's natural support network and connection with their community. YES Waiver services are family-centered, coordinated and effective at preventing out-of-home placement, custody relinquishment, and juvenile justice involvement and promoting school success, lifelong independence, and self-defined success.

Providers report challenges with hiring staff or bringing subcontractors into the network due to inadequate reimbursement rates, which have remained the same for over a decade. Between SFY 2020 quarter 1 and SFY 2023 quarter 4, the

program lost 386 YES Waiver providers and the number of providers continues to decline due to financial or other challenges to providing care. Though YES Waiver's total slot allocation is 3,591 per waiver year, the program has not been able to serve at capacity due to provider shortage. In SFY 2017, 2,780 children were served with a steady decline in the numbers served. In SFY 2023, 1,933 children were served. This represents a 30 percent decrease in the number of children served between SFYs 2017 and 2023. Because the state saves an estimated $12,500 per child served in the YES Waiver, further investment in this program is vital and will ultimately conserve state resources.

In SFY 2023, 2,575 children were served in the YES Waiver program. There was a 48 percent decrease in crisis services before and after receiving YES, and 95 percent of children aged-out of the program, transitioned to other services, or graduated with a transition plan for on-going care.

Recommendation

Modernize Utilization Management Guidelines for the Texas Resilience and Recovery Treatment model to permit new evidence-based practices and broader curriculum usage.

In Texas, the service delivery system for community-based mental health services is the Texas Resiliency and Recovery (TRR) model. The TRR model is a framework for establishing eligibility for receiving services, determining a level of care to meet a child's needs, and authorizing a level of care.

To receive these services, children must be between the ages of 3 and 17, reside in Texas, have a diagnosis of SED or SMI (other than a single diagnosis of substance use or IDD), and be determined eligible based on the Child and Adolescent Needs and Strengths (CANS) Assessment. Each level of care has a distinct array of services that reflects the intensity of care needed based on the CANS assessment.

Though the TRR model is based on the provision of evidence-based practices, it was developed more than a decade ago and Texas children's and families' needs have changed, often requiring more intensive evidence-based therapies that are not currently reimbursable under TRR. The list of approved evidence-based practices should be expanded, as it has created a workforce challenge, and licensed providers are unable to fully use their training within the state-funded system. Providers report frustration and attribute leaving public practice due to the limited list of reimbursable services. Allowing the broadest array of evidence-based practices possible will allow individuals to receive the most up-to-date and individualized care and help retain providers in the public system.

Recommendation

Amend Government Code, Chapter 531, and fund HHSC to implement the Healthy Transitions: Improving Life Trajectories for Youth Grant program.

Youth with SED or SMI between the ages of 14 and 17, including those with IDD, face a myriad of challenges related to school and work. Some also experience homelessness and involvement in the juvenile justice system, increasing admissions to hospitals and mental health and correctional facilities. These youth are among the least likely to seek help and may "fall through the cracks" lacking the services and supports they need to become productive and healthy adults.

Evidence-based outreach and engagement practices are imperative to create access to effective behavioral health interventions and supports. The overall goal of this grant program will be to provide developmentally appropriate services and supports to youth to address their SMI, SED, and/or IDD needs and connect them to other supports that will be critical in readying them for self-sufficiency and transition into adulthood and adult systems of care. Services may include screening and assessment, evidence-based treatments such as dialectical behavior therapy (DBT) and cognitive behavioral therapy (CBT), wraparound services, and recovery support services (e.g., housing, transportation, peer and family support, and vocational and educational support and assistance).

Recommendation

Fund HHSC to expand Outpatient Biopsychosocial Services statewide.

Outpatient Biopsychosocial Services (OBI) is an existing pilot program at five Local IDD Authorities (LIDDA) sites providing mental health outpatient services for people with IDD who also have mental health or behavioral needs. The benefits of this program include unique services aimed at increasing self-awareness and emotional regulation, enhancing social skills, reducing anxiety and stress, and fostering greater independence, provided by staff who know and understand the IDD population. In SFY 2023, 44 percent of people who received OBI services were under the age of 18. Participants experienced a 37 percent decrease in the number of days spent in a hospital and a 62 percent decrease in the number of days spent incarcerated.

Only five LIDDAs currently offer specialized outpatient mental health services, they could be expanded to the rest of the 39 LIDDAs in Texas. No other publicly funded program offers mental health outreach from professionals trained to serve individuals with co-occurring behavioral health conditions and IDD, and the outcomes achieved by pilot sites demonstrate significant potential savings through avoidance of other systems. Expanding this important program could save state resources and help individuals stay healthy in their homes and communities.

Recommendation

Fund the Supreme Court of Texas Permanent Judicial Commission on Children, Youth and Families (Children's Commission) to expand implementation of state and local dual status initiatives.

Dual status initiatives are designed to improve practices that directly affect outcomes for children who are in child welfare and juvenile justice systems. Using a coordinated approach to serving dual status youth can improve the administration of justice for children and their caregivers. Having one judge familiar with the family can encourage a more holistic approach in both the child welfare and juvenile justice cases. With comprehensive information about a youth's family, behavior, and detention history as well as education, mental health, and other needs, judges can make better decisions about what services and supports are needed to meet the child's best interests while protecting the community against future delinquent conduct.

Behavioral Health Residential Care

There is a need to invest in residential behavioral health services for children with complex needs that are currently not being met through outpatient care. These services are provided in a non-hospital, residential setting that is a 24-hour treatment environment designed to better understand and respond to the needs of the child.

New Level of Residential Care

Currently, there is little to no viable residential treatment options for children with high acuity behavioral health needs, including those with complex needs such as co-occurring behavioral health conditions and IDD. Many of these children are denied admission into residential treatment environments due to a history of or current behaviors such as physical aggression, sexual aggression, bullying, elopement, emotional dysregulation, and social withdrawal. Additionally, some children who would clinically benefit from residential treatment require specialized services to address their complex traumatic experiences.

Often, these children do not meet medical necessity for inpatient hospitalization, but exhibit behaviors that pose a level of safety risk to themselves and others, and paired with their psychiatric status, require a more intensive residential treatment environment to address their needs. Often, caregivers of these children may be faced with a decision to relinquish their parental rights to DFPS solely to obtain behavioral health services for the child. Creating viable residential treatment options would provide an alternative to parental relinquishment, inability to find suitable kinship or foster care placements, or extended commitments to TJJD.

As a residential option to meet the needs of children with high acuity behavioral health conditions and co-occurring IDD does not exist in Texas, it is difficult to definitively identify this type of facility, though there are minimum specifications that should be a feature of the residential physical environment and treatment offered. The following are examples of considerations for operations:

- The residential environment should be operated within a trauma-informed model of care;
- The residential environment should be able to accommodate a comprehensive array of services meeting the behavioral health, and/or co-occurring IDD needs of children between the ages of 10-17;
- The residential environment should support providing developmentally appropriate daily living skills that will prepare children to live in the community upon discharge, either in a placement (e.g., kinship or foster care placement), or independently;
- The residential environment should be staffed with clinicians who are skilled at delivering evidence-based interventions that are diagnostically and behaviorally appropriate and effective at meeting the complex needs of children; and
- The residential environment should have effective admission, continuity, discharge, and follow-up standards.

Implementation would require a statutory and rule framework that clearly defines organizations eligible to make referrals to the residential facility, the population of focus or eligibility criteria, admission processes, licensure requirements, and more. In addition, implementation will require funding to operate the residential facility, comport with facility infrastructure requirements, and treatment standards. Some of the recommendations in this section are meant to provide options for a residential environment that could serve children with the needs described above.

Recommendations

Recommendation
Fund HHSC to establish PRTFs as a Medicaid state plan Benefit.

A Psychiatric Residential Treatment Facility (PRTF) is any non-hospital facility with a provider agreement with a State Medicaid Agency to provide the inpatient services benefit to Medicaid-eligible individuals under the age of 21 (psych under 21 benefit). The facility must be accredited by the Joint Commission or any other accrediting organization with comparable standards recognized by the state. PRTFs must also meet the requirements in §441.151 through 441.182 Title 42 of the Code

of Federal Regulations. HHSC would need to both create a PRTF license that meets these requirements and include PRTF as a Medicaid state plan benefit.

There are several states that have successfully implemented PRTF standards that can serve as valuable examples for Texas, including Alabama, Kansas, Kentucky, Louisiana, North Carolina, and Oklahoma.

Existing Residential Care

Recommendations

Recommendation

Fund HHSC to expand the Residential Treatment Center Project to include increasing rates for services.

The Residential Treatment Center (RTC) project is a partnership between DFPS and HHSC to provide intensive support for families who are at-risk of relinquishment to DFPS due to the acuity of their child's behavioral health needs. The goal of the RTC project is to prevent families from relinquishing their parental rights to DFPS by:

- Connecting families to behavioral health services available in their community through their LMHA or LBHA; and
- Providing state-funded residential placement to meet their child's mental health needs when families do not have the resources to access residential placement.

In SFY 2023, 249 referrals were made to the RTC project, 98 of which were received from DFPS. 42 percent of children referred to the RTC project were not receiving behavioral health services through the LMHAs or LBHAs at time of referral but were connected to these services through this process. The average length of stay in the RTC was 5 months. 22 percent of children referred to the RTC project were diverted from RTC placement due to being connected with community-based services.

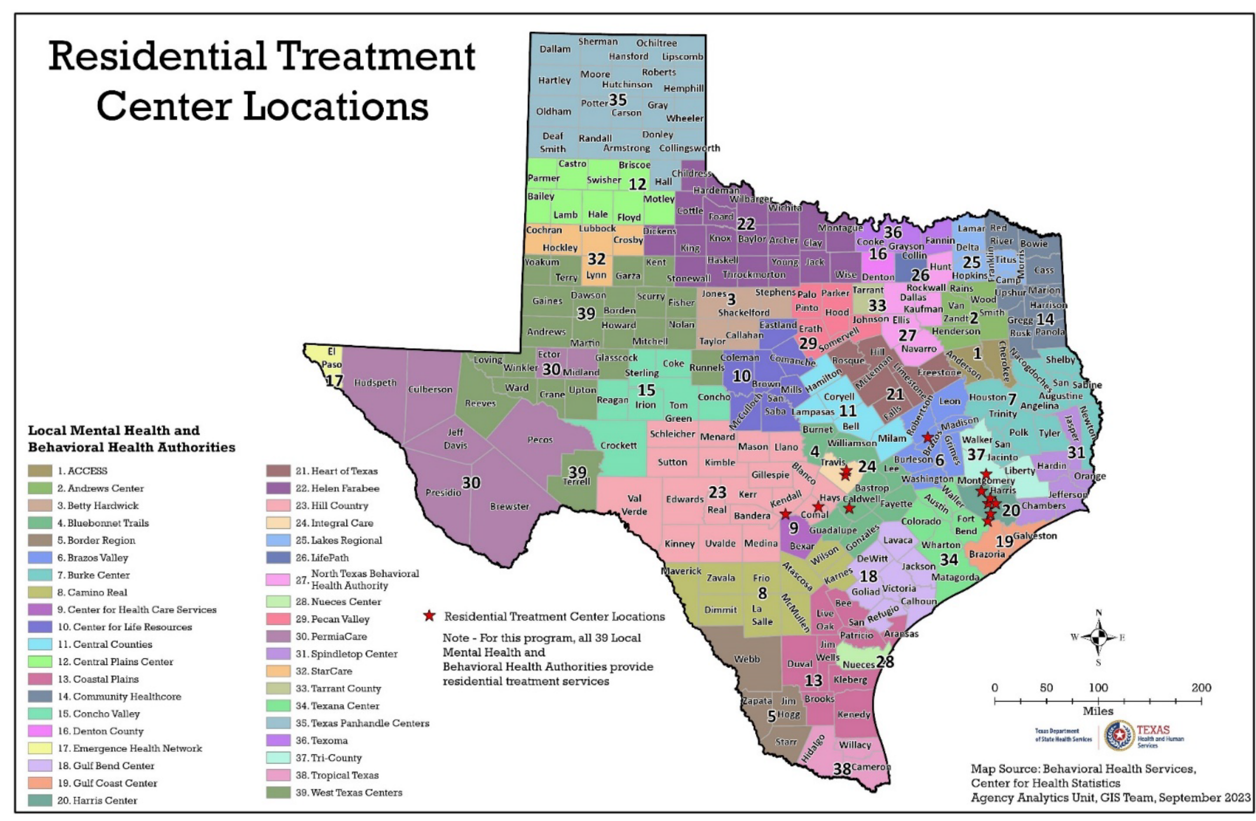
The mental health acuity of children being referred to the RTC project has increased since program inception. Children being referred now often have a history of human trafficking, substance use, and IDD, requiring RTC providers to hire a workforce skilled in serving children with these needs and modifying program operations to accommodate their admission and treatment.

In SFY 2023, the project increased its rate to align with the current DFPS rate structure and to ensure that the RTC project facilities received adequate payment based on the needs of children referred and to meet standards of effective service delivery. This rate change also increased the provider base from 11 to 19 providers

in SFY 2024. Reimbursement rates should reflect the needs of children referred to the RTC project and align with DFPS rates to prevent unintentional competition for RTC capacity due to rate differentials where one rate is less than another.

Figure 13 is a map of residential treatment center locations across the state.

Figure 13. Residential Treatment Center Locations



Recommendation

Fund HHSC to expand youth substance use treatment programs and the resources available to the youth treatment provider network.

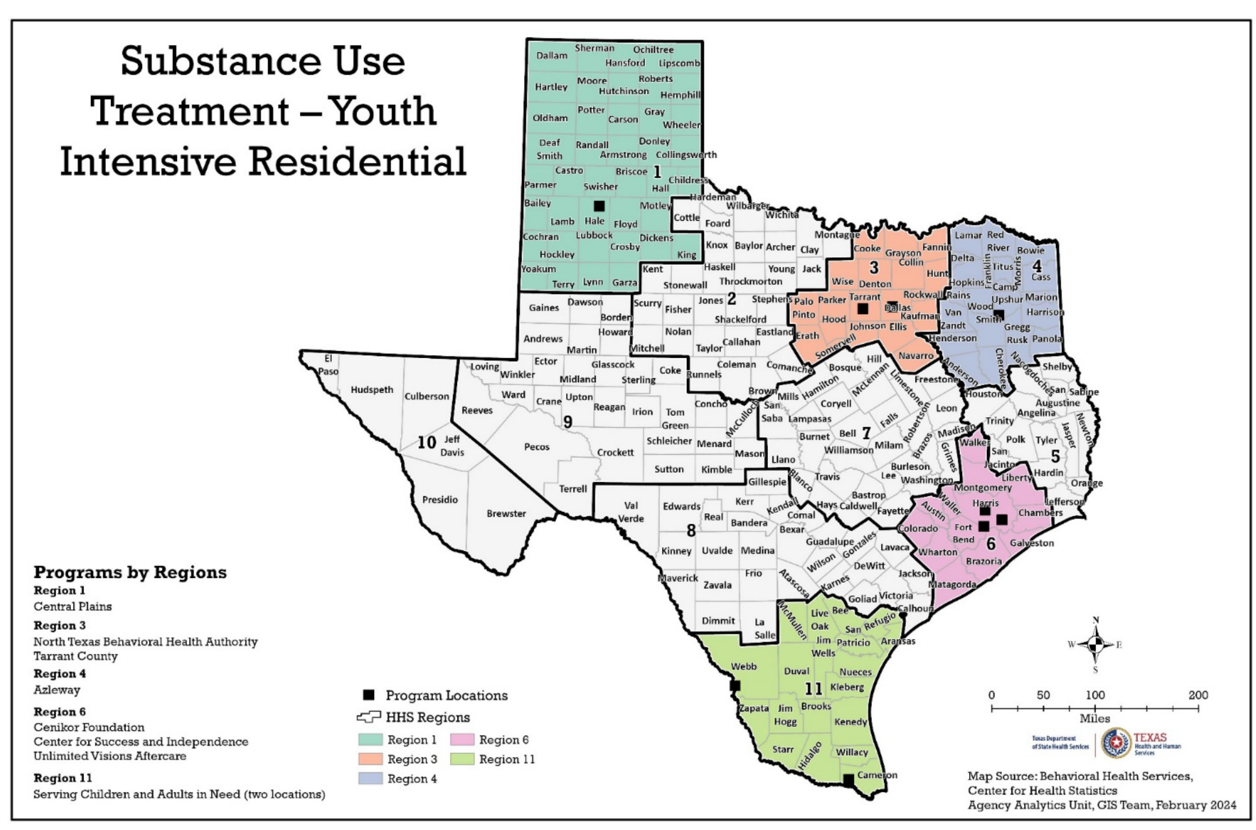
SUD youth treatment services engage the child and family in recovery efforts from outreach through treatment and continuing care. Treatment approaches are evidence-based, holistic in design, and emphasize coordination of care across the continuum. Evidence-based techniques and curriculums are required in all SUD youth treatment settings. Services include in-person and group counseling, life skills, and substance use education. Treatment for youth includes three service types:

- Intensive Residential;
- Supportive Residential; and
- Outpatient Treatment.

There are 32 providers of SUD youth treatment programs including LMHAs, LBHAs, non-profit organizations, for profit organizations, and other governmental entities.

In SYF 2023, the Youth Intensive Residential Treatment program served 674 children, with 48 percent successfully completing treatment. 97 percent of children were abstinent at discharge, 91 percent were admitted and involved in on-going treatment, 98 percent had no arrest since admission, and 86 percent were enrolled in school or vocational training at discharge. Figure 14 is a map of youth intensive residential treatment locations and counties served. Expanding youth substance use treatment programs and the resources available to the youth treatment provider network could increase the number of providers or existing provider capacity to serve more youth in geographical areas where care is difficult to access.

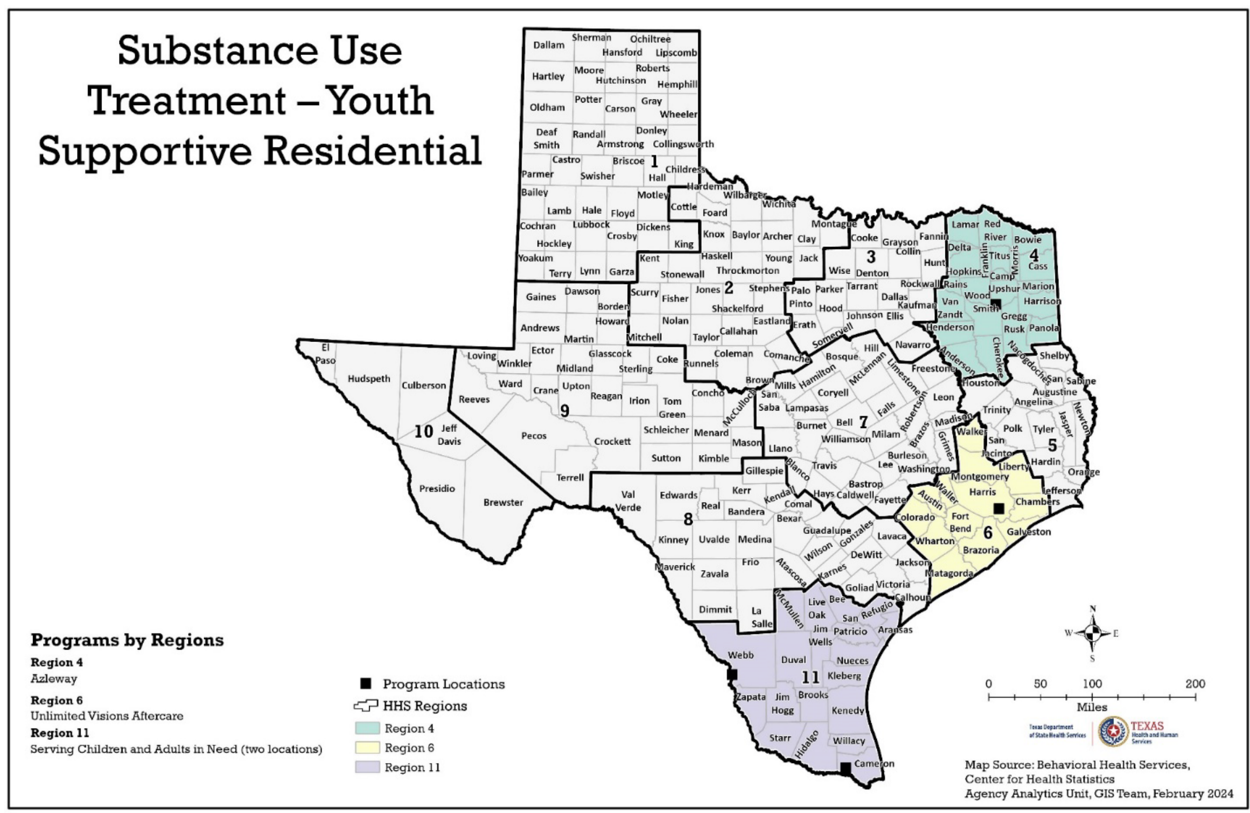
Figure 14. Substance Use Treatment – Youth Intensive Residential Locations



In SFY 2023, the Youth Supportive Residential Treatment program served 81 children, with 85 percent successfully completing treatment. 99 percent of children were abstinent at discharge, 100 percent were admitted and involved in on-going treatment, 100 percent had no arrest since admission, and 74 percent were enrolled in school or vocational training at discharge.

Figure 15 is a map of youth supportive residential treatment locations and counties served.

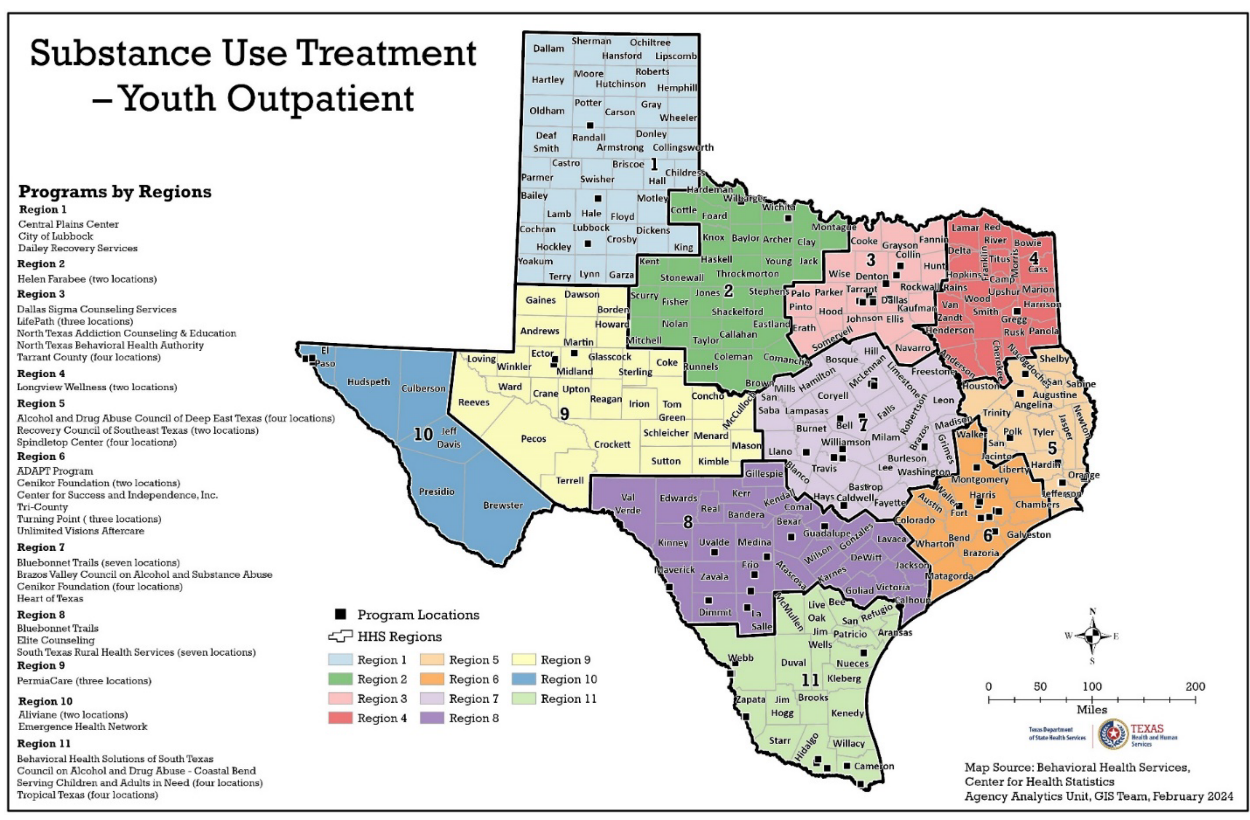
Figure 15. Substance Use Treatment – Youth Supportive Residential Locations



In SYF 2023, the Youth Outpatient Treatment program, served 1,956 children, with 40 percent successfully completing treatment. 90 percent of children were abstinent at discharge, 57 percent were admitted and involved in on-going treatment, 98 percent had no arrest since admission, and 88 percent were enrolled in school or vocational training at discharge.

Figure 16 contain maps of youth outpatient treatment locations and counties served.

Figure 16. Substance Use Treatment – Youth Outpatient Locations



Behavioral Health Inpatient Care

Behavioral Health Inpatient Care is care delivered to children in a hospital-based setting that reduces imminent risk of harm to self or others, prevents deterioration of mental or physical health, and prepares for transition to less restrictive settings and long-term intensive treatment. The subcommittee recommends that, in making decisions regarding inpatient bed capacity, consideration be given to the findings from the Texas A&M University System Health Science Center, Article III Study on Mental Health Services for Children and Adolescents.

Recommendations

Recommendation
Fund HHSC to increase rates for inpatient providers serving children with co-occurring mental health conditions and IDD and those with co-occurring complex medical conditions.

Capacity limitations mean children are often waiting for an inpatient admission in crisis, juvenile detention facilities, emergency rooms, and other places unsuitable to meet their needs. In addition, youth with IDD are often denied services from private psychiatric hospitals due to potential disruption of the treatment environment, or due to diagnostic overshadowing attributed more to their IDD than to mental health diagnoses. This population needs increased access to inpatient

psychiatric beds to ensure appropriate evaluation to address diagnostic overshadowing, care, and treatment that addresses co-occurring conditions. Increasing funding would incentivize more inpatient facilities to serve these complex children.

Behavioral Health Crisis Care

Behavioral Health Crisis care is care delivered to children in an outpatient or crisis facility environment, or in the community, that reduces imminent risk of harm to self or others or deterioration of the child's mental or physical health.

Recommendations

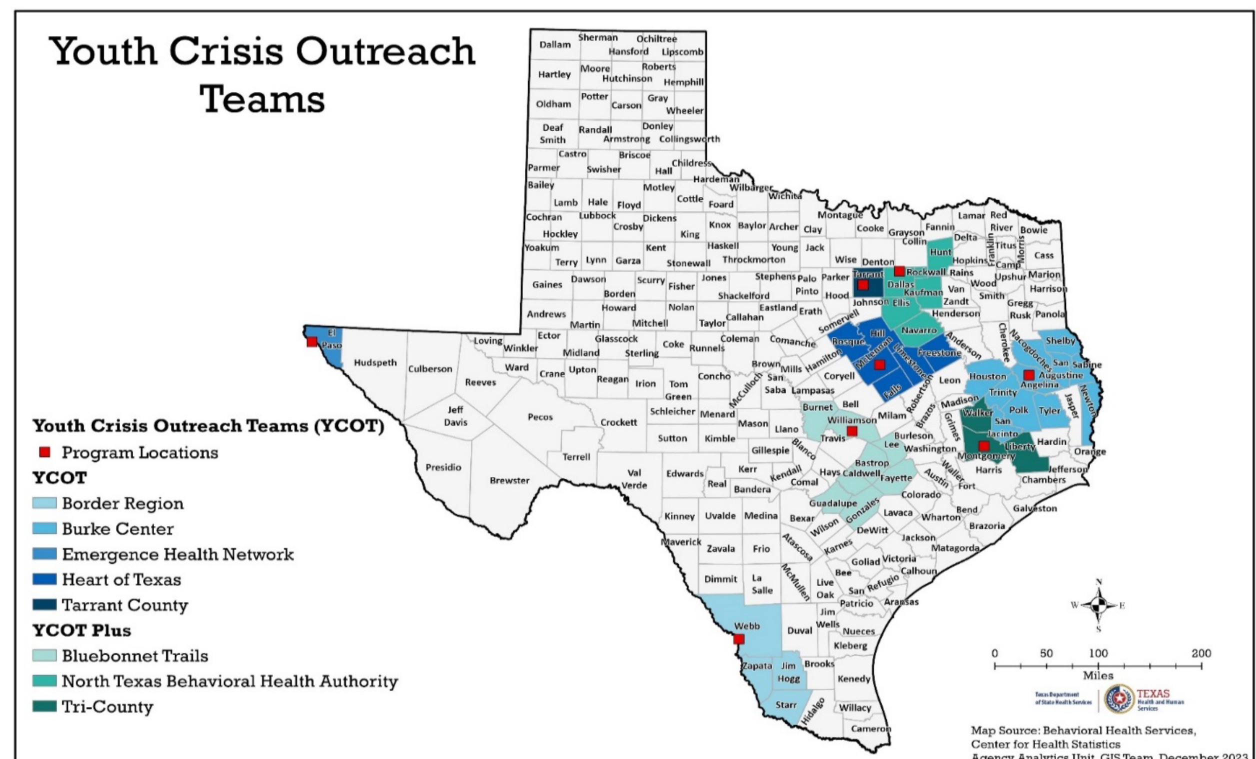
Recommendation
Fund HHSC to Expand Youth Crisis Outreach Teams as a Statewide Service Available 24/7.

The Youth Crisis Outreach Team (YCOT) pilots are intended to provide in-person community-based stabilization and support 24 hours a day, seven days a week, for a child in crisis. The diversionary goal aligns with the current statewide Mobile Crisis Outreach Team model, but YCOTs focus on enhancing child response and providing extended follow-up and linkage to resources.

During the 88th Legislative Session, HHSC received funding and awarded contracts to 8 providers to deliver YCOT services across 32 counties. Current funding does not support a full-time 24/7 response, however, and sites are limited. Significant investment would be required to ensure capacity for 24/7 statewide coverage, and it is unclear that this is what Texas requires. Increasing funding to expand to new sites and/or enhance capacity at current sites will help YCOT achieve its great potential to significantly benefit Texas children and families.

Figure 17 is a map of the counties served by YCOT teams.

Figure 17. Youth Crisis Outreach Teams Locations



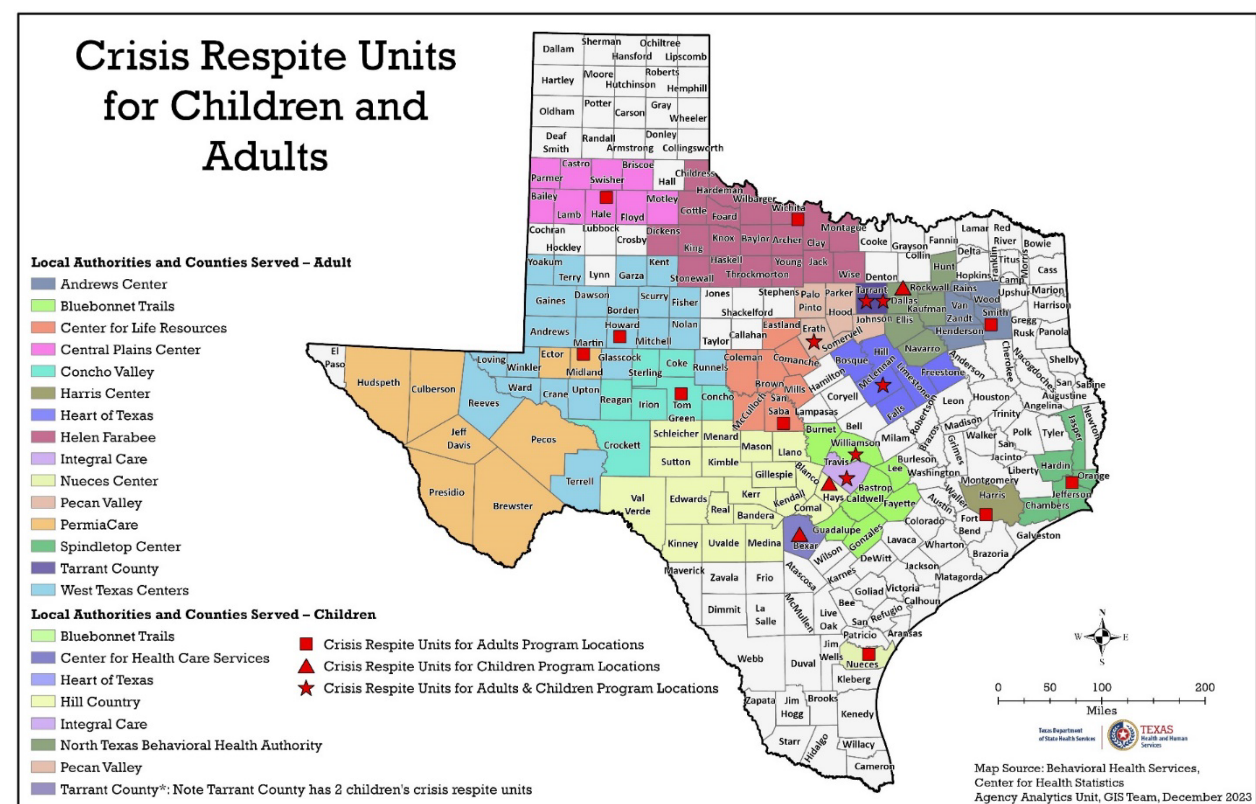
Recommendation

Fund HHSC to expand crisis respite units serving children with behavioral health conditions and/or IDD.

Crisis respite programs provide short-term, community-based crisis care for people who pose a low risk of harm to themselves or others and do not require hospitalization but may have functional impairment that necessitates direct supervision and care. This is the least intensive, facility-based crisis option. Services may be provided for a few hours or up to seven days. Many of the people served in these programs have experienced an event causing significant distress, are having housing challenges, or have loved ones or caretakers seeking temporary support or supervision. Facility-based crisis respite services have trained staff on-site 24 hours per day, seven days per week. Some crisis respites are run by peers (people who have at least one cumulative year of receiving mental health community services).

There are 28 crisis respite units across the state, but only 11 that exclusively serve children, and one that serves children and adults. In SFY 2023, 77 children were served in children's crisis respite units. The average age of the child was 14 with an average length of stay of nine days. There was a 48 percent decrease in crisis encounters before and after receiving treatment in the children's crisis respite unit. Figure 18 is a map the existing crisis respite unit locations.

Figure 18. Crisis Respite Units for Children and Adults Locations



Recommendation

Fund HHSC to cover crisis services such as in-home and out-of-home crisis respite, extended observation, and crisis stabilization services as a Medicaid state plan benefit, to the extent allowable under federal requirements.

National guidelines identify three core crisis services that should be accessible to anyone who is experiencing a behavioral health crisis: regional crisis call centers or crisis hotlines, crisis mobile team response, and crisis receiving and stabilization facilities.[100] While MCOT services are typically reimbursable by Medicaid, more nuanced and robust services such as crisis stabilization are not covered by the Medicaid state plan. Crisis stabilization allows for better matching of the right service for the person's need with the appropriate type of mental health professional. Crisis stabilization is critical to closing the gap in coverage for children enrolled in Medicaid and ensuring children with higher behavioral health needs get appropriate care, preventing unnecessary and costly emergency room visits or hospital stays. These services would benefit youth with IDD, many of whom receive or are eligible to receive Medicaid because of their eligibility for Supplemental

[100] https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-services-executive-summary-02242020.pdf.

Security Income or certain Medicaid programs. Existing state and local resources to fully meet the crisis stabilization needs of youth with IDD are limited. Crisis respite provides critical short-term relief for family or other caretakers struggling to care for a loved one with a behavioral health condition and/or IDD. Twenty states cover crisis stabilization services as a Medicaid state plan benefit, while 10 states cover crisis respite.

Conclusion

In the last 20 years the number of children who need behavioral health services has increased. Caregivers experience unique strains in meeting these children's needs and managing life circumstances (e.g., employment, housing, and childcare) that foster safe and healthy environments for their children.

The Children's Behavioral Health Strategic Plan subcommittee developed a plan focused on children's behavioral health needs, offering recommendations that would take multiple biennia to implement. Successful implementation will require ongoing commitment from all branches of government, as well as local, state, and federal multi-sector partnerships.

The Behavioral Health Continuum of Care operated by the state should serve as a safety net and be flexible and responsive to the evolving and unique needs of children and caregivers. The Children's Behavioral Health Strategic plan is a living document that the SBHCC is committed to adapting based on the evolving landscape of Texas and the needs of the most vulnerable children and caregivers.

The plan is intended to foster an environment in which Texas children and their caregivers, based on identified need, have access to compassionate, comprehensive, and innovative behavioral health care, that will help develop their resilience and enable them to thrive emotionally, mentally, and socially.

During the Texas Mental Health Creative Arts contest, middle schooler Zoey Ramteke wrote a poem about mental health and its importance for all. In parts, she wrote: "Family and friends are there to help you sustain. We'll lend a hand, don't worry about fear. People who struggle with mental health…Together, we can stay strong and get through this."

Together we can support healthy Texas families for a healthy Texas.

APPENDIX A: Coordinated Expenditure Report

Article I – Office of the Governor

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Specialty Courts Program	Substance Use Disorder Services - Intervention	B.1.1. Criminal Justice	Provides grant funding to specialty courts as described in chapters 121-126 and 129-130 of the Texas Government Code.	GR	$0	$0
				GR-D	$629,848	$630,000
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$629,848	$630,000
Residential Substance Abuse Treatment	Substance Use Disorder Services - Intervention	B.1.1. Criminal Justice	Provides grant funding to states and local governments in the development and implementation of substance use treatment programs in correctional and detention facilities.	GR	$0	$0
				GR-D	$0	$0
				FF	$160,277	$160,000
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$160,277	$160,000
Juvenile Justice & Delinquency Prevention	Mental Health Services - Other	B.1.1. Criminal Justice	Provides grant funding to units of local government and non-profit corporations to improve the juvenile justice system through increased access to mental health and substance abuse services.	GR	$0	$0
				GR-D	$729,723	$750,000
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$729,723	$750,000
			Office of the Governor, Total		**$1,519,848**	**$1,540,000**

Article II – Department of Family Protective Services

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Post-Adoption/ Post-Permanency Purchased Services	Mental Health Services - Other	B.1.5	Provide payments to contractors for short-term residential behavioral health services to provide families with critical supports to promote permanency and reduce re-entry into the foster care system and dissolution of consummated adoptions.	GR	$752,289	$752,289
				GR-D	$0	$0
				FF	$518,053	$518,053
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$1,270,342	$1,270,342
Substance Abuse Prevention and Treatment Services	Substance Use Disorder Services - Intervention	B.1.7	Provide payments to contractors for substance abuse prevention and treatment services (education, counseling, and treatment) delivered to individuals to meet their needs, where not met by HHSC funded services or other community services. Services may include: • Substance abuse assessment and diagnostic consultation. • Individual, group and/or family substance abuse counseling and therapy, including home-based therapy.	GR	$3,744,847	$3,744,847
				GR-D	$0	$0
				FF	$107,813	$107,813
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$3,852,660	$3,852,660
Other CPS Purchased Services	Counseling and Therapeutic Services	B.1.8	Provide payments to contractors for counseling and therapeutic services delivered to individuals to meet their service plan needs, where not met by STAR Health or other services. Services may include: • Psychological testing, psychiatric evaluation, and psychosocial assessments. • Individual, group, and/or family counseling and therapy, including home-based therapy.	GR	$10,228,365	$10,228,365
				GR-D		
				FF	$14,028,814	$14,028,814
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$24,257,179	$24,257,179

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
APS Emergency Client Services	Mental Health Services - Other	D.1.3	Provide payments to contractors for mental health services to individuals to assess capacity and meet their service plan needs where services are not already provided through HHSC or other funding sources.	GR	$28,959	$28,959
				GR-D	$0	$0
				FF	$159,037	$159,037
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$187,996	$187,996
Prevention and Early Intervention Services	Service Coordination/Crisis Intervention	C	Fund family-strengthening programs and initiatives that support healthy parenting relationship and positive conflict resolution while promoting positive outcomes for children, youth, and families to: • Mitigate the need for more intensive interventions. • Make referrals and offer complementary auxiliary support to families.	GR	$3,542,151	$3,542,151
				GR-D	$0	$0
				FF	$15,735,923	$15,735,923
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$19,278,074	$19,278,074
Increase SSCC's for Kinship Behavioral Health Services	Mental Health Services - Other	B.1.1	Contracted SSCC providers currently leverage their existing infrastructure and provider networks to ensure youth in their respective regions have access to care. DFPS data reflects the SSCC's ability to address the behavioral health needs of youth as intended by this model. This strategy intends to expand the behavioral health funding for SSCC's to specifically service children in kinship care and the families supporting them.	GR	$1,500,000	$1,500,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$1,500,000	$1,500,000
Sustain Intensive Psychiatric	Mental Health Services - Other	B.1.9, E.1.4, F.1.1	DFPS has identified a gap in the service delivery system for youth exiting inpatient psychiatric treatment. Once the acute	GR	$10,752,192	$10,309,550
				GR-D	$0	$0
				FF	$67,873	$3,955

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Stabilization Program (IPSP)			phase has been stabilized, private psychiatric hospitals are discharging subacute youth who lack readiness to return to existing placements or another option such as residential treatment centers (RTC). This gap has exacerbated the children without placement issue that the system is currently experiencing. This strategy proposes to maintain this initiative to continue offering an option in the continuum of care that meets the behavioral health needs of youth in the subacute stage of their recovery while also mitigating placement issues for youth.	IAC	$0	$0
				Other	$0	$0
				Subtotal	$10,820,065	$10,313,505
Behavioral Health Strategy Team	Mental Health Services - Other	E.1.1, E.1.4, F.1.1	To ensure a coordinated and outcome-based approach to meeting the behavioral health needs for youth in DFPS conservatorship, this strategy proposes funding a dedicated team at DFPS solely focused on addressing the strategic, coordinated care of youth in conservatorship. This inaugural team will work closely with DFPS leadership and other child-serving institutions, stakeholders, and partners to strengthen service delivery for youth and families engaged with the DFPS system or those at risk of coming into conservatorship -5 FTE's.	GR	$459,231	$459,231
				GR-D	$0	$0
				FF	$172,931	$172,931
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$632,162	$632,162
			Department of Family Protective Services, Total		**$61,798,478**	**$61,291,918**

Article II – Department of State Health Services

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Center for Health Statistics	Research	A.1.5 Health Data and Statistics	Texas Youth Risk Behavior System (YRBS): Survey of a sample of Texas high school students that collects information on behaviors, including suicide ideation and alcohol and substance use.	GR	$0	$14,430
				GR-D	$0	$0
				FF	$0	$33,670
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$0	$48,100
Ryan White HIV/AIDS Program, Part B Grant, and State Services	Mental Health Services - Outpatient	A.2.2. HIV/STD Prevention	Mental Health (MH) Services are the provision of outpatient psychological and psychiatric screening, assessment, diagnosis, treatment, and counseling services offered to clients living with HIV.	GR	$0	$0
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$0	$0
Ryan White HIV/AIDS Program, Part B Grant, and State Services	Substance Use Disorder Services - Outpatient	A.2.2. HIV/STD Prevention	Substance Abuse Outpatient Care is the provision of outpatient services for the treatment of drug or alcohol use disorders for clients living with HIV. Services include screening, assessment, diagnosis, and treatment.	GR	$0	$0
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$0	$0
Specialized Health and Social Services	Mental Health Services - Other	B.1.1. Maternal and Child Health	Service 1: Regional case management staff are active members of the Community Resource Coordination Groups (CRCG) and provide evidence-based technical assistance to families and organizations in need of behavioral health	GR	$0	$0
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
			/ disability services. Service 2: Regional case management staff coordinate with local mental health authorities & parents to conduct risk assessments if client shows signs of need. Regional THSteps staff educate providers on importance of conducting risk screenings per periodicity schedule for Medicaid recipients. Service 3: Regional case management/Texas Health Steps staff recruit for new behavioral health providers in underserved areas and coordinate with providers in populated areas to assist in underserved area via Telehealth or in-person.	Subtotal	$76,273	$76,273
			Department of State Health Services, Total		**$76,273**	**$124,373**

Article II – Health and Human Services Commission

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
System of Care Expansion and Sustainability Cooperative Agreement	Mental Health Services - Outpatient	D.2.2. Community Mental Health Services - Children	The purpose of this program is to improve behavioral health outcomes for children and youth (birth-21) with serious emotional disturbances (SED) and their families. This program will support the widescale operation, expansion, and integration of the System of Care (SOC) approach by creating sustainable infrastructure and services that are required as part of the Comprehensive Community Mental Health Services for Children and their Families Program (also known as the Children's Mental Health Initiative).	GR	$0	$0
				GR-D	$0	$0
				FF	$2,585,775	$2,585,775
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$2,585,775	$2,585,775
Community Mental Health Services - Children (Outpatient)	Mental Health Services - Outpatient	D.2.2. Community Mental Health Services - Children	Outpatient Services include an array of community-based services to support recovery and resilience of children and families. Examples include medication-related services, skills training, counseling, case management, family support services, and crisis intervention services.	GR	$71,223,952	$71,223,952
				GR-D		
				FF	$23,748,415	$23,748,415
				IAC		
				Other		
				Subtotal	$94,972,367	$94,972,367
Community Mental Health Services - Children (Inpatient)	Mental Health Services - Inpatient	D.2.2. Community Mental Health Services - Children	This strategy supports the purchase of psychiatric bed days from local, general or private psychiatric hospitals using funds in the Children's Mental health Services Strategy. These funds are not specifically designated for inpatient services, but local authorities may use them to facilitate access to needed	GR	$761,210	$761,210
				GR-D		
				FF		
				IAC		
				Other		

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
			inpatient care for individuals experiencing acute psychiatric crises.	Subtotal	$761,210	$761,210
Community Mental Health Services - Children (All Other)	Mental Health Services - Other	D.2.2. Community Mental Health Services - Children	Other funded activities support the mental health service delivery system, including community center training, contracted activities that directly relate to mental health community services, statewide claims processing, centralized program support, and performance contract management and quality management support costs.	GR	$6,672,390	$6,672,390
				GR-D		
				FF	$2,438,540	$2,438,540
				IAC		
				Other	$0	$0
				Subtotal	$9,110,930	$9,110,930
DFPS Relinquishment Slots	Mental Health Services - Outpatient	D.2.2. Community Mental Health Services - Children	Relinquishment Slots (DFPS) - Intensive residential treatment for children and youth referred to DFPS who are at risk for parental relinquishment of rights to solely to a lack of mental health resources to meet the needs of children with severe emotional disturbance whose symptoms make it unsafe for the family to care for the child in the home.	GR	$5,118,481	$5,118,481
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$5,118,481	$5,118,481
Community Mental Health Services - Children Administration	Staff	D.2.7 Community Behavioral Health Administration	The purpose of this strategy is to support HHSC's administrative support needs to oversee the implementation of the state’s Community Mental Health services for children as described in strategy D.2.2.	GR	$2,929,396	$2,973,981
				GR-D		
				FF	$554,022	$554,022
				IAC	$1,396,212	$1,403,909
				Other	$0	$0
				Subtotal	$4,879,630	$4,931,912

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Child Advocacy Programs (Child Advocacy Centers)	Mental Health Services - Outpatient	F.3.2 Child Advocacy Programs	Children's Advocacy Centers (CAC) provide assistance, advocacy, and coordination of multidisciplinary teams to serve child survivors of physical abuse, sexual abuse, and neglect and their families.	GR	$23,942,802	$23,942,802
				GR-D	$4,013,500	$4,013,500
				FF	$2,779,225	$2,779,225
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$30,735,527	$30,735,527
Youth Empowerment Services (YES) Waiver	Mental Health Services - Outpatient	D.2.5 Behavioral Health Waivers	Mental Health Services for Children YES Waiver - This program provides intensive wrap-around services for children at risk of hospitalization or parental relinquishment due to a need for services to treat serious emotional disturbance. Children enrolled in YES are eligible for all Medicaid behavioral health services as well as those that are specific to the YES service array, such as adaptive aids and supports, specialized therapies, and minor home modifications.	GR	$7,545,276	$7,545,276
				GR-D		
				FF	$6,135,584	$6,135,584
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$13,680,860	$13,680,860
Community Health Crisis Services (All Other)	Mental Health Services - Other	D.2.3 Community Health Crisis Services	Child Crisis Respite	GR	$5,700,000	$5,700,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$5,700,000	$5,700,000
			YCOT	GR	$7,000,000	$7,000,000

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Community Health Crisis Services (All Other)	Mental Health Services - Other	D.2.3 Community Health Crisis Services		GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$7,000,000	$7,000,000
Children with Special Needs	Mental Health Services - Other	L.1.2 IT Oversight & Program Support	Children with special needs are children that have complex or chronic conditions that require a variety of services for the children and their families. Most of their daily needs are in the form of supports and services that are provided separately from their medical care. Note: Program area provides strategic planning and coordination. No clients served.	GR	$65,551	$65,551
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$65,551	$65,551
Substance Abuse Prevention	Substance Use Disorder Services - Prevention	D.2.4 Substance Abuse Prevention/ Intervention/ Treatment	Substance Use Youth Prevention Programs	GR	$39,042,306	$39,042,306
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$39,042,306	$39,042,306
Substance Abuse Treatment	Substance Use Disorder	D.2.4 Substance Abuse	Substance Use Treatment for Youth (TRY)	GR	$20,066,973	$20,066,973
				GR-D	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
	Services - Treatment	Prevention/ Intervention/ Treatment		FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$20,066,973	$20,066,973
Substance Abuse Intervention	Substance Use Disorder Services - Recovery	D.2.4 Substance Abuse Prevention/ Intervention/ Treatment	Youth Peer Program	GR	$3,200,000	$3,200,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$3,200,000	$3,200,000
			Health and Human Services Commission, Total		$236,919,610	$236,971,892

Medicaid

Program	Summary Description	Fund Type	FY 2024	FY 2025
Medicaid	Mental Health Cost Estimate – Medical and Drug – Age 0 to 17	General Revenue	$345,454,073	$375,562,345
		All Funds	$889,029,891	$947,766,439

CHIP

Program	Summary Description	Fund Type	FY 2024	FY 2025
CHIP	Mental Health Cost Estimate – Medical and Drug – Age 0 to 17	General Revenue	$8,775,567	$14,282,194
		All Funds	$31,911,153	$51,026,059

Article III – Texas Education Agency

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Rider 85-Fentanyl Contamination Training	Education and Training	Strategy B.2.2 Health and Safety	As specified in the rider, funds from the Opioid Abatement Account No. 51894 are to provide training developed by The University of Texas Health Science Center at San Antonio utilizing Education Service Center (ESC) staff to train school district employees regarding the dangers of fentanyl contamination.	GR		
				GR-D	$2,611,722	$0
				FF	$0	$0
				IAC	$0	$0
				Other		$0
				Subtotal	$2,611,722	$0
Rider 88- Mental Health Services in Out of School Time	Mental Health Services - Other	Strategy A.2.1 Statewide Educational Programs	As specified in the rider, funding to support the TexasPartnership for Out of School Time to implement mental health programs in community-based out of school time (OST) and statewide intermediary infrastructure to support OST programs and professionals.	GR	$2,500,000	$2,500,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$2,500,000	$2,500,000
			Texas Education Agency, Total		**$5,111,722**	**$2,500,000**

Article III – University of Texas Health Science Center at San Antonio

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
				GR	$10,263,401	$10,263,401

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Texas Child Mental Health Care Consortium	Mental Health Services - Other	Statewide Behavioral Health Strategic Plan	Improving mental health care and systems of care for the children and adolescents of Texas.	GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$10,263,401	$10,263,401
University of Texas Health Science Center at San Antonio, Total					**$10,263,401**	**$10,263,401**

Article III – Texas Higher Education Coordinating Board

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Texas Child Mental Health Care Consortium - CPAN	Mental Health Services - Other	D.1.7.	Child Psychiatry Access Network. A network of child psychiatry access centers that will provide consultation services and training opportunities for pediatricians and primary care providers operating in the center's geographical region to better care for children and youth with behavioral health needs.	GR	$18,539,674	$18,539,674
				GR-D	$0	$0
				FF	$17,045,044	$17,045,044
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$35,584,718	$35,584,718
Texas Child Mental Health Care Consortium - TCHATT	Mental Health Services - Other	D.1.7.	Texas Child Health Access Through Telemedicine. Creates or expands telemedicine or telehealth programs to identify and assess behavioral health needs and provide access to MH services. Prioritizes	GR	$80,380,971	$80,380,971
				GR-D		
				FF	$24,653,978	$24,653,978
				IAC	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
			the MH needs of at-risk children/youth and maximizes the number of school districts served in diverse regions of Texas.	Other	$0	$0
				Subtotal	$105,034,949	$105,034,949
Texas Child Mental Health Care Consortium - CPWE	Workforce Development	D.1.7.	Community Psychiatry Workforce Expansion. Funds community psychiatric workforce expansion projects through partnerships between health-related institutions of higher education and community mental health providers. Develops training opportunities for residents and supervising residents.	GR	$16,993,045	$16,993,045
				GR-D	$0	$0
				FF	$13,426,717	$13,426,717
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$30,419,762	$30,419,762
Texas Child Mental Health Care Consortium - CAP Fellowships	Workforce Development	D.1.7.	Child and Adolescent Psychiatry Fellowships. Funds additional child and adolescent psychiatry fellowship positions at health-related institutions of higher education.	GR	$5,567,228	$5,567,228
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$5,567,228	$5,567,228
Texas Child Mental Health Care Consortium - Research	Research	D.1.7.	Research; Development of two research networks focused on mental health research in the areas of childhood depression and childhood trauma with the goal of improving systems of care.	GR	$14,790,355	$14,790,355
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$14,790,355	$14,790,355
Texas Child Mental Health Care Consortium - COSH	Mental Health Services - Other	D.1.7.	Centralized Operations Support Hub. The COSH provides centralized comms and data management systems to health-related institutions providing CPAN and TCHATT services. The COSH provides high level coordination and facilitates collaboration	GR	$1,833,979	$1,833,979
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
			between physicians providing CPAN and TCHATT consultations through a Medical Director position.	Subtotal	$1,833,979	$1,833,979
Texas Child Mental Health Care Consortium - External Eval	Mental Health Services - Other	D.1.7.	External Evaluation. An independent evaluation of the programs under the TCMHCC. The evaluation centers on a systematic approach to planning with program-specific comprehensive evaluations. Focus is on implementation science, quality improvement, and health economics.	GR	$400,000	$400,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$400,000	$400,000
Texas Child Mental Health Care Consortium - Administration	Mental Health Services - Other	D.1.7.	Administration of the Texas Child Mental Health Care Consortium including contract management, financial management, program oversight and monitoring, coordination of executive committee meetings, program evaluation, etc.	GR	$1,772,706	$1,772,706
				GR-D	$0	$0
				FF	$1,415,703	$1,415,703
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$3,188,409	$3,188,409
			Texas Higher Education Coordinating Board, Total		**$196,819,398**	**$196,819,398**

Article IV – Supreme Court of Texas

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Texas Judicial Commission on Mental Health	Education and Training	B.1.4 Judicial Commission on Mental Health	Annual Judicial Summit on Mental Health - Youth Track Education and Workshops	GR	$254,060	$264,060
				GR-D	$0	$0
				FF	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$254,060	$264,060
Texas Judicial Commission on Mental Health	Information Technology	B.1.4 Judicial Commission on Mental Health	Judicial Commission on Mental Health - Youth Resources on a Youth Tab of the Texas County Innovations in Mental Health Map.	GR	$40,414	$50,414
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$40,414	$50,414
Texas Judicial Commission on Mental Health	Staff	B.1.4 Judicial Commission on Mental Health	JCMH staff works to create (i) judicial training, both in-person and online, (ii) tools and resources for judges such as a Bench Book and a Court Improvement Guide, (iii) juvenile law peer to peer support through correspondence from a Jurist in Residence, (iv) guidance on judicial leadership, and (v) increased collaboration among the many legal stakeholders.	GR	$674,906	$674,906
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$674,906	$674,906
Texas Judicial Commission on Mental Health	Workforce Development	B.1.4 Judicial Commission on Mental Health	Youth Systems Sequential Intercept Model (SIM) Mappings - SIM Mappings bring a community of youth serving organization together to identify their resources, gaps, and processes for all the agencies and courts that involve youth with mental illness, substance use disorder, or intellectual and developmental disabilities.	GR	$116,560	$116,560
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
				Subtotal	$116,560	$116,560
			Supreme Court of Texas, Total		**$1,085,940**	**$1,105,940**

Article V – Texas Department of Criminal Justice

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Special Needs Programs and Services/TCOOMMI - Juvenile	Mental Health Services - Outpatient	B.1.1.	Provide grants for community-based treatment programs, funding a continuity of care program and responsive system for local referrals from various entities for juvenile offenders with special needs (serious mental illness, intellectual disabilities, terminal/serious medical conditions, physical disabilities).	GR	$3,863,995	$4,073,987
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$3,863,995	$4,073,987
			Texas Department of Criminal Justice, Total		**$3,863,995**	**$4,073,987**

Article V – Texas Juvenile Justice Department

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
Special Needs Diversionary Program	Mental Health Services - Other	A.1.3. Community Programs	Provides grants to probation departments for mental health treatment and specialized supervision to rehabilitate	GR	$1,895,175	$1,895,175
				GR-D	$0	$0
				FF	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
			juvenile offenders and prevent them from penetrating further into the criminal justice system.	IAC	$0	$0
				Other	$0	$0
				Subtotal	$1,895,175	$1,895,175
Community Programs	Mental Health Services - Other	A.1.3. Community Programs	Provides assistance to local juvenile probation departments for community-based services for misdemeanors, enhanced community-based services for felons, and other behavioral health programs.	GR	$36,706,104	$36,706,104
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$1,150,000	$1,150,000
				Subtotal	$37,856,104	$37,856,104
Commitment Diversion Initiatives	Mental Health Services - Other	A.1.5. Commitment Diversion Initiatives	Funding to local juvenile probation departments for community based and/or residential alternatives to commitment to state residential facilities.	GR	$19,492,500	$19,492,500
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$19,492,500	$19,492,500
Mental Health Services Grants	Mental Health Services - Other	A.1.7 Mental Health Service Grants	Provide grants and technical assistance to local juvenile probation departments for mental health services.	GR	$14,178,353	$14,178,353
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$14,178,353	$14,178,353
Regional Diversion Alternatives	Mental Health Services - Other	A.1.8. Regional Diversion Alternatives	Provide discretionary grants to local juvenile probation departments to build additional mental health resources.	GR	$4,875,000	$4,875,000
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
				Subtotal	$4,875,000	$4,875,000
Psychiatric Care	Mental Health Services - Other	B.1.1. Orientation and Assessment and B.1.7 Psychiatric Care	Psychiatric services provided by contract psychiatric providers for services to youth who are assigned to intake and assessment unit or to youth who later develop a mental health need while in TJJD residential facilities.	GR	$2,720,734	$2,720,734
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$2,720,734	$2,720,734
General Rehabilitation Treatment	Mental Health Services - Other	B.1.8. Integrated Rehabilitation Treatment	Supports all rehabilitation treatment services to target population including case management, correctional counseling, ongoing assessment of risk and protective factors, case planning, review by multi-disciplinary team (MDT), crisis intervention and management, reintegration planning and family involvement.	GR	$8,568,615	$8,008,951
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0
				Other	$0	$0
				Subtotal	$8,568,615	$8,008,951
Specialized Rehabilitation Treatment	Mental Health Services - Other	B.1.8. Integrated Rehabilitation Treatment	TJJD administers four specialized treatment programs: sexual behavior, capital and serious violent offender, alcohol/other drug, and mental health programs. 97% of youth entering TJJD have a need for one or more of these programs. Services include assessment, group and/or individual counseling, MDT collaboration, re-integration planning and are provided by licensed individuals.	GR	$6,732,483	$6,292,747
				GR-D	$0	$0
				FF	$0	$0
				IAC	$691,000	$691,000
				Other	$0	$0
				Subtotal	$7,423,483	$6,983,747
Parole Programs and Services	Mental Health Services - Other	C.1.2. Parole Programs and Services	Youth who have completed specialized treatment in residential placements required aftercare services in those areas as a condition of their parole to improve outcomes.	GR	$1,317,127	$1,317,127
				GR-D	$0	$0
				FF	$0	$0
				IAC	$0	$0

Program	Service Type	Agency Budget Strategy	Summary Description	Fund Type	FY 2024 Appropriated	FY 2025 Appropriated
				Other	$0	$0
				Subtotal	$1,317,127	$1,317,127
			Texas Juvenile Justice Department, Total		**$98,327,091**	**$97,327,691**

APPENDIX B: Cover Art

The cover of the Children's Behavioral Health Strategic Plan features original artwork created by young Texans for the Texas Mental Health Creative Arts Contest.

Front cover:

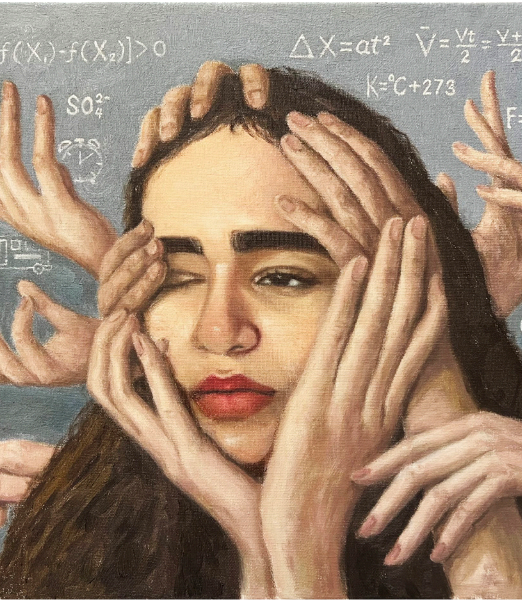
> "Mental Health Matters" by Dev J. – First place; middle school original artwork (2021).

Back cover (left to right):

> "Brave" by Baylee H. – Second place; elementary original artwork (2022).
>
> "High-Schooler to Be" by Vanessa Q. – First place; middle school original artwork (2022).
>
> "Mental Health Matters Guiding Light" by Nicole A. – Honorable mention; high school artwork (2021).

The annual contest aims to raise awareness of mental health experiences and challenge mental health stigma through open discussions with the Texas Community.

To learn more and view the full gallery, visit https://gallery.txsystemofcare.org/



Supporting Healthy Texas Families for a Healthy Texas

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