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Policy Impact of Access to Rural Mental Health Care Services: A Legislative Analysis of TX SB 633

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Policy Impact of Access to Rural Mental Health Care Services: A Legislative Analysis of TX SB 633

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Abstract

Policy Impact of Access to Rural Mental Health Care Services: A Legislative Analysis of TX SB 633

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This professional report examined rural mental health care access in Texas based on a scientific literature review and analysis of SB 633. A legislative history of SB 633 will provide insights on how the state operationalized rural mental health access within an existing policy context. This policy context was influenced by the stakeholders who have been engaging with the state. Collaboration between mental health providers is a central strategy of the SB 633 process to increase rural mental health access and will be described in detail. When examined within the policyscape framework, this writer analysis finds collaboration to be a low-cost and highly effective form of policy maintenance. SB 633 uses cost savings and quality of service to measure the degree to which expanding services improved mental health access. This writer believes that cost savings are easy to understand but miss vital aspects of access to mental health care. This writer finds that Texas Statewide Behavioral Health Strategic plan and the NASW Code of Ethics better assess quality mental health access. This writer believes that both cost and these quality measures should be used to improve mental health access.

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Introduction

In 2019, the 86th Texas State Legislature passed legislation that addresses the lack of access to mental health services in certain rural counties. Although most people in Texas live in large urban areas, the majority of land is occupied by rural communities. Rural communities represent 85% of the land in Texas (Texas Rural Funder's Collaborative, 2018). Urban communities have greater levels of mental health access than rural communities in the United States (Myers, 2019; Wang et al., 2005; Kessler et al., 2003). Since 2013, the Texas Legislature passed a series of bills to improve mental health access through collaboration, which included several bills that emphasized rural mental health outcomes (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016). This writer believes that SB 633 86th is an important recent development in this project. The legislation seeks to improve rural mental health access in Texas through collaboration. This writer believes that SB 633 functions as a form of policy maintenance for SB 292 and HB 13. This writer believes that the implementation of SB 633 should provide an important opportunity to learn how the concept of rural mental health access has been operationalized in Texas.

This professional report will begin with a literature review. Chapter 1 will describe the definition of rural mental health access that has emerged in the scientific literature. This review will describe the unique characteristics of rural mental health outcomes. The concept of mental health access will be defined, and its factors described. Literature

applying this concept to a rural context will then be discussed along with the limitations of this definition of mental health access. The definition of rural mental health access will then be applied to Texas. The Texas context will be further developed by examining stakeholder groups in Chapter II. The stakeholder analysis will focus on mental health organizations, disability rights organizations, health provider groups, and community focused organizations. The stakeholder analysis will address the lack of organized opposition to SB 633's passage. Chapter III will consist of a legislative analysis that will describe how the Texas legislature developed the concept of mental health collaboration. The legislative analysis will also describe SB 633's relationship to previous mental health grant legislation and describe key legislators involved in the passage of SB 633. In the 83rd legislative session, SB 58 added community collaborations to the Texas Administrative Code governing the Health and Human Service Commission. Community collaborations were created that addressed the co-occurrence of mental illness and homelessness in urban communities. In the 85th Session, SB 292 established a grant program to reduce the number of people with mental illness in jails. In the same session, HB 13 provided grants to local mental health authorities that worked collaboratively. Senator Kolkhorst (R-Brenham), Representative Price (R-Amarillo), and Senator Perry (R-Lubbock) represent rural communities and played important roles in shaping Texas's approach to rural mental health collaboration. The legislative process in the Texas House and Senate will also be described in detail. The legislative history section will include a legislative history table. In Chapter IV, the implementation of SB 633 will be described.

Although implementation has not been completed, in this writer's opinion the implementation phase will address the question of how Texas operationalizes the definition of rural and how the state will define success. Chapter V will consist of a policy analysis that uses theory derived from public policy and social work to assess the strengths and limitations of SB 633's definition of successfully increasing rural mental health access. Systems theory, policyscape theory, and using cost and quality to measure success will be addressed. Chapter VI will use lessons from the previous sections of the professional report to suggest promising programs that could further the goal of SB 633 and concludes with a summary and suggestions of recommendations.

Chapter I: Literature Review

This section will use scholarship to describe the need for rural mental health access legislation and how this need can be used to understand SB 633. National scholarship will be used to highlight disparities in rural mental health outcomes, and the lack of mental health access in rural communities (Myers, 2019; Ziller, Anderson, and Coburn, 2010). The factors that make up the concept of mental health access will be described (Levesque, Harris and Grant, 2013). The concepts surrounding rural mental health access will be contextualized within Texas to better understand the legislation. The literature will then be used to describe how legislation like SB 633 would relieve strain on the wider support system that results from a lack of mental health access.

DEFINING RURAL

Many different definitions of rural are used in policy and the literature (Coburn et al., 2007). The federal government has two major definitions of rural (Health Resources & Services Administration, 2018). The US Census Bureau defines urban areas and considers all areas not included in an urban area as rural. The two types of urban areas are urbanized areas of 50,000 or more people and urban clusters of at least 2,500 people but less than 50,000 people. Thus, any area that does not have at least at cluster of 2,500 people would be considered rural by the U.S. Census. The Office of Management and Budget designates counties as metropolitan, micropolitan, or neither. A metropolitan area has a core urban area of 50,000 or more people. A micropolitan area has a population of

10,000 or more people but has less than 50,000 people. Any area not part of a metropolitan area is considered rural. Micropolitan areas are considered rural. The Census Bureau considers more areas urban than the Office of Management and Budget. The Federal Office of Rural Health Policy further modifies the Office of Management and Budget definition by creating a continuum of classifications on a scale of urban to rural. This measure is based on distance to urban areas, population, and open countryside (United States Department of Agriculture, 2019). The multiple definitions of rural have led to some confusion in the literature. The writer of this report noted that many research papers do not explicitly state what definition of rural they are using. In this report, the rural urban dichotomy used by the U.S Census and Office of Management and Budget definition will be adopted.

RURAL MENTAL HEALTH OUTCOMES

Nationally, rural communities (as defined by the U.S. Census Bureau) tend to have worse health outcomes than urban communities (Myers, 2019). This problem is particularly acute when rural behavioral health outcomes are compared to urban outcomes. Rural Communities have higher rates of suicide and overdose (Myers, 2019). People in rural areas tend to seek care later in their mental health trajectory (Wang et al., 2005). Mild mental illness often progresses into severe mental illness (Kessler et al., 2003). Kessler argues that severe mental illness has the greatest level of need and that preventing the progress to this high level of need may avoid intensive and expensive care. Both worse

outcomes and later care seeking can be tied to the issue of access to mental health services (Kessler et al., 2003; Myers, 2019). If mental health services are hard to obtain, people will seek care later. Unfortunately, this delayed care will often result in worse outcomes.

DEFINING HEALTHCARE ACCESS

Levesque, Harris, and Grant (2013) conceptualize health care access as a match between demand for services and the supply of services that are available. They further divide access into the following factors: approachability, acceptability, availability and accommodation, affordability, and appropriateness. A service is approachable to a person if they know it exists and they believe the service will match their needs. Acceptable services meet a person's cultural demands. For example, some breast cancer treatment providers will have offices that are in warm pastels, have photos of inspiring women in recovery, and feature slogans about a woman's journey on their website. Someone who does not identify with this rigid gender presentation may not feel comfortable using this provider because the environment does not signal that it is welcoming to all people. The service must also be available at a time and place that accommodates a person's needs (e.g. a dialysis provider who is a five-hour drive from a patient and is only open when that patient is working is not considered available or accommodating). Accessible services are also affordable. A person can only utilize a service if they can afford the service. The service must also be the appropriate service for a person's need. A person

who needs to see an oncologist, but can only see a primary care doctor, does not have access to cancer treatment.

Rural Mental Health Access

Nationally, rural communities tend to have less access to mental health services than urban communities (Ziller, Anderson, & Coburn, 2010). Myers (2019) argues that living in a rural community negatively impacts all the aspects of accessibility outlined in Levesque, Harris, and Grant's conceptualization of health care access. Higher poverty rates in rural communities also make services less affordable for many residents. Living in a rural community tends to increase the distance a person must travel to a provider making services more difficult to access when needed. There are fewer providers in rural communities making finding a provider that matches a person's medical and cultural needs more difficult. Rural residents tend to have greater concerns about confidentiality and stigma about help seeking (Wilson, Bangs, & Hatting, 2015). Providers often struggle to adapt services to rural cultural contexts, which tend to make services less culturally acceptable (SAMSHA, 2016).

The ability to measure disparities in rural-urban access to services is limited because potential access to services cannot be measured. Actual utilization can be measured by looking at the difference between the prevalence of mental health needs and actual mental health utilization. Large nationally representative studies have found rural and urban communities in the United States have similar rates of mental illness, but much

lower rates of mental health service utilization (Breslau, Marshall, Pincus, & Brown, 2014). This suggests a lower level of access to mental health services.

Access to mental health care in rural communities is also more difficult to measure because of a lack of specialized mental health providers. With so few providers, providers also tend to be less specialized in rural communities than urban communities. The same primary care provider may be providing mental health and physical health services in a rural community. This introduces an important question surrounding adequacy. If the primary care provider meets the needs and desires of the resident, then this form of care would be considered fulfilling a need for access. If the provider cannot fulfill this need, then it would not be considered to fulfill the need for access. Even if this provider meets the person's needs, a successful provider may go undetected in an evaluation measuring service access. Surveys of the number of psychologists, psychiatrists, and social workers provide a quick estimate of the number of people who specialize in providing mental health care. Counting the number of primary care doctors does not provide enough information to determine if they are effective resource people who want to access mental healthcare.

TEXAS CONTEXT

Rural Texas makes up 85% of the state's land and 234 of the 254 Counties are rural (Texas State Library and Archives, 2020; Texas Rural Funder's Collaborative, 2018). While most of the state lives in urban areas, 15.3% of the state still lives in rural areas

(Texas Demographic Center, 2017). The largest metropolitan areas account for most of the growth in population and small rural areas account for most of the reduction in population. As a result of these changes, when legislation does not directly address rural counties have lower funding for basic services (Brockman, 2020). The Texas legislature has been addressing the need for rural specific funding. Grant programs that address the need for rural specific funding will be discussed later in this paper. Texas has challenges relating to access to mental health professionals. 186 of the 254 Texas counties are federally designated as having a shortage of mental healthcare professionals (Hogg Foundation, 2018). Rural Texas has almost double the rate of uninsured people when compared to urban Texas (Texas Organization of Rural and Community Hospitals, 2017). Four of the five poorest counties in Texas are rural (Ura, 2016). This writer believes that rural communities in Texas tend to have greater challenges in regard mental health access.

LEGISLATION

The Texas legislature addressed rural mental health when it passed SB 633 (86th session) (Kolkhorst et al., 2019). The legislation focuses on reducing four outcomes resulting from a lack of rural mental health access: costs to local and state governments of serving people with mental illness, number of people transported experiencing a mental health crisis, number of people incarcerated in county jails with mental illness, and the number of emergency room visits by people experiencing mental health crises. The legislation

directs the Texas Health and Human Services Commission to work with local mental health authorities (LMHAs) to create regional plans to address these outcomes by expanding each region's capacity for needed services.

The legislation requires LMHAs to work together to plan, but it does not create a regional leader who is empowered to make decisions for the regional groups. This writer believes this is reflective of Texas's approach to mental health. The Texas Health and Human Services Commission directly controls state mental hospitals, but it gives LMHAs more autonomy to provide community mental health care. The state sets standards via state contracts and the Texas Administrative Code, which LMHAs must meet. This writer views the Texas Administrative Code as providing LMHAs with a high degree of freedom to form partnerships, obtain grants, and implement approaches to mental illness to meet these standards. (Texas Health and Safety Code). SB 633 does not require LMHAs to implement plans that lack funding. The regional plans will be presented to the legislature along with an analysis of how cost effective they are and an overall analysis of rural mental health access in Texas. It appears to this writer that this structure requires HHSC to use a bottom up approach to addressing rural mental health. Through community planning, each Texas region provides its understanding of what affects rural mental health outcomes. It appears to this writer that from a research perspective, bottom up planning provides more robust data that will capture regional differences than a top down initiative originating from a single planning source. In the opinion of this writer, the data will include each region's view of itself in addition to HHSC view of the region.

System Strain

In this writer's opinion, the four legislatively mandated outcomes are related to national trends in mental health access. Nationally, rural communities access mental health services later and at lower rates than their urban counterparts (Wang et al., 2005). Routine mental health providers are harder to access. Higher rates of poverty make paying for copays and regular travel to providers harder to afford. Rural communities experience longer travel time to resources like pharmacies. When pharmacies that fill prescriptions are hard to access, being diagnosed and prescribed a medication may not be enough to create access to the medication.

These barriers create incentives to access the most expensive and most intensive levels of care. An individual can access police, crisis service providers, and emergency room providers with a single phone call or showing up without an appointment. A call to 911 made by a person in crisis or a person interacting with a person in crisis will result in an individual in crisis interacting with law enforcement or other crisis responders. All local mental health authorities must operate crisis hotlines and Mobile Crisis Outreach Teams. Some counties have crisis intervention teams, which include law enforcement with mental health training.

Even with existing resources, law enforcement is often the only first responders; this is especially the case in rural areas. Law enforcement provides a wide range of services "as varied as paramedic, wildlife control, and plumber when trained professionals are

unavailable" (Yang, Gill, Kanewske, Thompson, 2018 citing Mohatt, Bradley, Adams, and Morris, 2006). Rural law enforcement professionals' roles additionally include being the first responder for mental health crises (Russell, 2016, July). The use of police as crisis mental health provider can result in people with mental illness being arrested and negatively impacts police officers.

Helping people in crisis results in strain on members of law enforcement. People experiencing mental health crises take up large amounts of time (Pogrebin, 1987). Members of law enforcement often feel more at risk of violence when working with people with mental illness (Yang, Gill, Kanewske, & Thompson, 2018). Further, members of law enforcement perceive people with mental illness as afraid of police officers (Yang, Gill, Kanewske, & Thompson, 2018). Time pressure and feelings of being at risk of violence have been tied to emotional exhaustion and burn out (Vuorensyrjä & Mälkiä, 2011). Burn out results in people performing worse and leaving their jobs, which adds additional costs to law enforcement budgets.

Members of law enforcement often do not want to arrest people experiencing mental health crises (Engel & Silver, 2001; Kisely et al., 2010). Rural members of law enforcement often are tasked with connecting people in crisis to services. Rural policing creates a greater emphasis on service provision than urban policing (Yang, Gill, Kanewske, &Thompson, 2018). This role as service connector includes being tasked with connecting people with mental illness to providers (Cordner & Scarborough, 2005;

Donnermeyer, DeKeseredy, & Dragiewicz, 2011 as cited by Yang, Gill, Kanewske, & Thompson, 2018). Yang, Gill, Kanewske, and Thompson (2018) found that 88.4% of the officers surveyed in Roanoke County, Virginia felt they had a duty to provide resources to people experiencing mental health crises, but that only 50.7% of the officers felt that they were satisfied with the mental health resources available. A lack of resources is emotionally difficult for members of law enforcement (Maslach & Jackson, 1981). Nationally, there is a lack of rural mental health professionals and much of Texas is also experiencing a mental health provider shortage (Hogg Foundation 2018; Mohatt, Bradley, Adams, & Morris 2006). When there are no mental health resources, jails are used to house people waiting for services (Sullivan & Spritzer, 1997). The literature suggests that incarcerating people in crisis and creating emotionally difficult work environments add costs and negatively impacts law enforcement retention.

The negative emotional impact of this lack of resources is amplified by a member of law enforcement's belief that they do not have the skills to help people experiencing a mental health crisis (Ruiz & Miller, 2004). In some areas, a call to 911 results in a mental health deputy engaging with an individual and helping to deescalate the situation or connect someone to a mental health professional. In other areas, a sheriff without extensive mental health training responds to a crisis. The crisis system is often the fastest and easiest to access form of mental health care.

Crisis services are much more expensive for the individual and the community than routine services (Kessler et al., 2003). They are also much more disruptive. In Texas, people in crisis are first taken to emergency rooms, crisis stabilization units, or extended observation units. Then, if additional stabilization is needed, law enforcement will need to transport a person to a state hospital. Texas has 10 state hospitals for people with the highest level of acute mental health crisis needs (Texas Health and Human Services Commission, N.D). Often law enforcement provides transportation to mental health crisis facilities. For the individual and law enforcement professional's safety, the person may be hand cuffed. Law enforcement in Texas varies in its degree of training on mental illness., Members of law enforcement in Texas are minimally required to complete the critical time intervention training, although may members of law enforcement receive more mental health training that the minimum requirement. (Texas Commission on Law Enforcement, 2019). The minimum requirement does not represent all training that members of law enforcement receive. Further, without extensive training, caring for someone who has high level of mental health needs can be emotionally difficult for the law enforcement professional (Maslach & Jackson, 1981).

LITERATURE REVIEW THEMES

Nationally, rural communities have greater mental health challenges than urban communities (Myers, 2019). Levesque, Harris and Grant (2013) provide factors to describe healthcare access. These factors provide a framework to describe the unique

barriers to mental healthcare in rural areas (Ziller, Anderson, and Coburn, 2010; Myers 2019). Like other rural areas, rural Texas has challenges relating to mental healthcare access. These challenges can result in greater use of the crisis system. Extensive use of crisis systems is costly and can be emotional difficult for crises responders who lack mental health training (Kessler et al., 2003; Yang, Gill, Kanewske, Thompson, 2018).

Chapter II: Stakeholders

In addition to government actors, non-government stakeholders play an important role in mental health policy development (Roy, Baker, & Kern 2017). This writer believes that the principles and stances of stakeholders provide important insight into the passage of SB 633. Mental health providers can describe the "on the ground experience" of implementing mental health policy. Groups representing mental health professionals can provide insight from direct service provision, while organizations representing provider organizations can describe the systemic effects of policy on organizations providing services. Healthcare consumer groups can articulate the experience of receiving services and describe important rights that should be supported by services and service providers. Broader community focused organizations can describe the views of people who are not directly involved with mental health policy, but care about mental policy as something that impacts broader community outcomes. The lack of organized stakeholder opposition to the legislation further describes the relationship between stakeholders and the legislation. SB 633's stakeholder support indicates to this writer that a policy consensus surrounding strategies to address mental health needs has emerged among mental health stakeholders. The principles of mental health stakeholders like NAMI Texas and The Texas Council of Community Centers emphasize local control. (National Alliance on Mental Illness Texas, 2013; Texas Council of Community Centers, 2016). It appears to

this writer that locally directed solutions based on collaboration and community input are favored by mental health stakeholders in Texas.

HEALTH CARE PROVIDERS

Mental Health Providers

In the Texas Senate Committee on Health & Human Services (86th ,2019), the Texas Council of Communities testified in Support of SB 633. The deputy director of Texas Council of Community Centers and the executive director of the rural LMHA Bluebonnet Trails Community Services publicly gave support to the legislation by testifying in favor SB 633. In addition to supporting SB 633, during the 85th session of the Texas legislature, they also supported HB 13 and SB 292 (House Research Organization, 2017). This writer believes that HB13 and SB 292 created collaboration focused grants that helped to define SB 633's approach to mental health access (SB 633's relationship to HB 13 and SB 292 will be discussed in more detail in the legislative analysis section of this paper). The Texas Council of Community Centers, which represents the local mental health authorities and local behavioral health authorities in Texas (Texas Council of Community Centers, 2016), has been operating since 1976 and generally works closely with HHSC to communicate the policy positions of LMHAs.

The Texas Council of Community Centers public policy principles are "strong communities," "local control," "public accountability," "proven performance," and

"personal independence" (Texas Council of Community Centers, 2016). They envision strong communities as

"Community Centers support[ing] essential networks of private and public providers that offer choice for people accessing services while addressing basic health and safety needs within Texas communities. Local government entities, community organizations and the business sector collaborate and blend resources to create enduring investments in strong communities" (Texas Council of Community Centers, 2016).

The Texas Council of Community Centers view LMHAs as working within a network of public private partnerships that address basic needs beyond mental health. The Texas Council of Community Centers envisions local control as important because "local officials and locally governed organizations are in the best position to understand and effectively address unique community needs. Broad geographic, economic, and cultural factors across Texas ‑ recognized as critical influences in local health and human service delivery ‑ preclude top down, one-size-fits-all delivery models." (Texas Council of Community Centers, 2016). Locally directed solutions allow for communities to respond to the unique factors influencing their individual communities. In this writer's opinion, SB 633 emphasizes locally directed solutions by allowing each regional group to do its own planning rather than creating a single statewide approach. Allowing planning at a local level and allowing individual regions to work with HHSC to identify sources of funding provides LMHAs an opportunity to support public private partnerships. HHSC 's

evaluation of the plans associated with SB 633 and HHSC's overall evaluation of rural mental health in the state in this writer's opinion allow for public accountability.

Mental Health Professional Organizations

Two mental professional organizations—the Federation of Texas Psychiatry and Texas Psychological Association—registered in support of SB 633 (Texas House Research Organization, 2019). Both organizations advocate for mental health professionals. Consequently, their support of expanding mental health capacity appears to this writer strongly align with their mission.

Healthcare Group that are not Focused on Mental Health

Broader health provider stakeholder groups also registered in support of SB 633 including the Texas Hospital Association, Texas e-Health Alliance, and Methodist Healthcare Ministries of South Texas (Coalition of Texans with Disabilities, 2020). The Texas e-Health Alliance advocates for improving health outcomes through technology (The Texas e-Health Alliance). Their members include universities, telemedicine companies, health insurers, hospital systems, telecommunication companies, and healthcare associations. The Texas Council of Community Centers, Texas Hospital Association, Texas Medical Association, and Texas Pain Society list themselves as members of the Texas e-Health Alliance (Texas e-Health Alliance, n.d.). SB 633 does not explicitly call for the expansion of telehealth. The Texas e-Health Alliance describes

electronic medical records as an important tool for coordinating systems. 97% of LMHAs provide some psychiatric services through telehealth and 33% of LMHAs provide telehealth counseling suggesting to this author that the Texas e-Health Alliance has a good reason to believe that expanding rural capacity through collaboration would involve the use of e-Health technologies (Texas Council of Community Centers, 2016), The Texas Council of Communities participates in the Texas e-Health Alliance which also suggests that Texas LMHAs support the expanded use of e-Health technologies. Community mental health providers have also expanded the use of telehealth during the COVID-19 pandemic to stay connected to the people they serve. Community providers have reported a significant decrease in their no-show rate. To this writer it appears that community mental health providers have obtained positive outcomes from the use of telehealth.

Healthcare Ministry

Methodist Healthcare Ministries of South Texas has a mission to increase access to healthcare for low-income and uninsured people in South Texas (Methodist Healthcare Ministries of South Texas Inc., 2014). The Ministry has a mission that is not explicitly focused on mental health. The organization's strategic imperatives include increasing access to primary care and increasing the role of churches in improving health. They also are seeking to strengthen the relationship between Methodist Healthcare and Methodist Healthcare Ministries. Methodist Healthcare Ministries currently owns a 50% share of the

Methodist Healthcare system. Methodist Healthcare systems is the “largest healthcare provider in San Antonio and 24 surrounding counties” Texas (Methodist Healthcare Ministries of South Texas Inc., 2014). Methodist Healthcare Ministries describes its role as advocating for greater community interests in the healthcare system. On a community level, they would like to improve collaboration, data capacity and influence healthcare policy. Their public policy advocacy objectives include increasing access to mental health services in the private and public sector (Methodist Healthcare Ministries of South Texas, Inc., 2019). In their advocacy objects they describe previous efforts to expand their state hospital and the expansion of mental health grants as effective strategies for improving mental health access. They have previously provided grants to support public private partnerships like providing grants to LMHAs in their service area. They have also described themselves as playing a large role in creating the Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas report (Methodist Healthcare Ministries of South Texas, Inc., 2019). The San Antonio redesign plan included regional collaboration between LMHAs the state hospital and law enforcement as a major component of an improved mental health system.

HEALTHCARE CONSUMER GROUPS

People with Lived Experience of Mental Illness.

The National Alliance on Mental Illness (NAMI) is a large and powerful organization that advocates for people with mental illness, caregivers, families and professionals supporting people with mental illness (The National Alliance on Mental Illness, 2016). The Texas chapter of the National Alliance on Mental Illness (NAMI Texas) was founded in 1984(National Alliance on Mental Illness Texas, 2013). NAMI Texas's public policy principles include supporting access to "strong community-based services", "elimination of stigma", "transparency of public mental health system", "choice and local control", and "reducing the population of persons with mental illness in jails and prisons" (National Alliance on Mental Illness Texas, 2013). The Texas chapter of NAMI supported SB 633 (Texas House Research Organization, 2019). NAMI Texas includes reducing the number of people with mental illness in jails and prisons as one of their policy principles (National Alliance on Mental Illness Texas, 2013). SB 633's stated goal of reducing the number of people with mental illness in jails aligns with this policy principle. NAMI Texas and The Texas Council of Community Centers share some principles that may explain their support of SB 633. Both groups emphasize strong community services, transparency, and locally directed solutions. NAMI Texas's emphasis on locally directed solutions has historically been part of its identity. Other Texas mental health organizations like the Texas Council of Community Centers have a

long history of emphasizing locally directed solutions. This suggests to this writer that locally directed solutions are a distinctly Texas feature of mental health advocates in the state.

People with Intellectual and Developmental Disabilities

The Arc of Texas and Coalition of Texans with Disabilities registered in support of SB 633 (Texas House Research Organization, 2019). The Arc of Texas has been advocating for people with intellectual and developmental disabilities since 1951 (The Arc of Texas, 2020). People with intellectual and developmental disabilities (IDD) are served by local IDD Authorities, which have a distinct set of rules from local mental health authorities. Often a single organization will serve as both a local mental health authority and a local IDD authority. To this writer, the ARC's support indicates that they believe that SB 633 will strengthen the capacity of LMHAs in such a way that they are better able to function as local IDD authorities.

People with Lived Experience of Disabilities

The Coalition of Texans with Disabilities is a member driven disability rights organization (Coalition of Texans with Disabilities, 2020). They also supported SB 633 (Texas House Research Organization, 2019). Since 1978, they have focused on increasing the inclusion of people with disabilities in society (Coalition of Texans with Disabilities, 2020). Their legislative efforts have historically focused on improving state

programs medical coverage, increasing access to adaptive technology, and shifting services for people with disabilities into the community rather than institutions. Reducing the number of people receiving mental health services in institutions like jails and crisis facilities will increase the number of people who are able to stay in their community and stay in society. To this writer the stated goal of SB 633 aligns with The Coalition of Texans with Disabilities legislative efforts.

COMMUNITY FOCUSED ORGANIZATIONS

Some organizations that are not explicitly focused on healthcare also registered in support of the bill. The Texas Catholic Conference of Bishops, League of Women Voters of Texas, and the United Way of Texas all registered in favor of the bill (Texas House Research Organization, 2017). They appeared to this writer to back SB 633 because they believed the bill had community support.

The Texas Catholic Conference of Bishops represents the views of 8 million Catholics in Texas (Texas Catholic Conference of Bishops, 2019). They believe that "modern medicine should continually orient its work toward the dignity and transcendence of every human" (Texas Catholic Conference of Bishops, 2019). The Conference describes their legislative focus as including increasing healthcare access, respect for patient dignity and physician conscience, and increased access to addiction treatment. Their focus on the dignity of people seeking care has similarities to The Coalition of Texans with Disabilities. Both groups want healthcare to support patient dignity. The Coalition of

Texans with Disabilities focuses on the autonomy of patients, while the Conference of Bishops focuses on reducing pain and increasing patients' expression of faith. This focus does not explicitly include mental health, but the Conference's support of SB 633 suggests to this writer that they believe mental health is included in patient dignity. The Conference's support of mental health legislation like SB 633 indicates to this writer that expanding mental health access aligns with the spiritual beliefs of a large group of Texans.

The League of Women Voters of Texas lists increased funding for behavioral health services as an issue that they support (The League of Women Voters of Texas, 2018). The League of Women Voters is a nonpartisan organization that chooses issues based on member consensus. Their support of increasing behavioral health funding indicates that they believe the broader communities that the league members represent also support the legislation. The leagues members do not have to be mental health professionals or people with lived experience of mental illness. Generally, they are concerned citizens and represent the concerns of general citizens.

The United Way of Texas views its advocacy role as leveraging local and community knowledge to inform statewide policy decision-making. They view their role as "urging policymakers and stakeholders to set aside partisan differences, find common ground, and work together to advance the common good for all of our communities" (United Ways of Central Texas, 2020). During the 86th legislative session, United Way of Texas

viewed their community driven priorities as focusing on education, financial stability, nonprofits, and health. In their 86th Texas legislature public policy document, United Way of Texas described supporting SB 633 as part of their efforts to support health outcomes for communities. In this writer's opinion the United Way of Texas's support of SB 633 provides more evidence to support the argument that the bill aligns with community priorities and locally directed solutions.

MINIMAL OPPOSITION

Few people registered in opposition to the legislation. The writer of this report was unable to find evidence to suggest that the three people who opposed SB 633 represented a larger group of stakeholders. The fact that they registered but did not testify also limits this writer's ability to understand their reasons for opposition. The writer of this report could not find any articles in newspapers or websites describing the positions of these three people or anyone else who might have opposed the bill.

STAKEHOLDER THEMES

SB 633 had broad support including many nonpartisan organizations, the provider groups impacted by the bill, consumer rights groups, and community focused organizations. Expanded mental health access appears to this writer to be broadly popular with politically active mental health and non-mental health focused organizations. Mental health focused organizations support expanding mental health services. Trade groups in

healthcare and mental health care have been advocating for greater collaboration. Groups that represent physical health and intellectual disability providers appear to be in favor of the legislation. Based on the public policy principles of stakeholder groups, locally directed solutions appear to be important to key stakeholders including NAMI Texas and the Texas Council of Community Centers. Representing local beliefs is an important principle to the United Way of Texas and the League of Women Voters of Texas. Supporting community solutions is important to Disability Rights Texas, the Texas Council of Community Centers, NAMI, NAMI Texas, and Methodist Healthcare Ministries. Given their policy principles and support of SB 633, to this writer, the stakeholders appear to believe that SB 633 will expand mental health access and will be responsive to each community's unique vision.

Mental health provider and consumer groups supported SB 633. Disability rights and intellectual disability rights groups, healthcare provider groups, and community groups supported SB 633. This indicates support for the legislation beyond the world of mental health policy. SB 633 is also supported by organizations that emphasize patient dignity and organizations that emphasize locally directed solutions. Organizations representing the experiences and principles of mental health providers, mental health consumers, and the broader community support SB 633.

CHAPTER III: LEGISLATIVE ANALYSIS

SB 633 used a collaboration model developed in previous legislation to improve LMHA outcomes. The legislation quickly passed through the Texas House and Senate with minimal changes. This writer believes that was in part because SB 633 had very little negative fiscal impact and the legislation was built on existing legislation. Further, it was supported by experienced rural legislators. Table one provides an overview of the legislative history of SB 633.

Table 1 Legislative Timeline

November 9, 2012	House Speaker Joe Straus appoints the Select Committee on Mental Health to holistically examine behavioral health in Texas. Representatives: Price, Moody, Bonnen, Coleman, Davis, Galindo, Muñoz, Murr, Rose, and Sheets are appointed to service on the committee. Representative Price is appointed chair.
November 12, 2012	Senator Nelson files SB 58. SB 58 allocated funds for community collaboratives and inserted the definition of a community collaborative in the Texas Code governing Texas Health and Human Services.
December 29, 2016	The Select Committee on Mental Health submits its interim report to the 85th Texas Legislature. The report describes disparities in rural mental health outcomes and the value of collaboration.
June 9th, 2017	SB 292 authored by Senator Nelson, Huffman, and Schwert becomes law. SB 292 established a grant program to reduce the number of people with mental illness in jails. Representative Coleman and Price sponsor the bill in the Texas House.

Table 1 , continued

June 14, 2017	HB 13 becomes law. HB 13 is authored by Representative Price, Turner, White, Clardy, and Moody. The bill provides $20,000,000 in Grants to LMHAs that work collaboratively.
June 15, 2017	SB 1849 becomes law. The legislation, authored by Senator Whitmire and sponsored in the House by Representatives Coleman, Thompson, Moody, Hunter, and White, expanded the community collaborative model to rural communities. Additionally, the legislation required that a two or more rural counties work together to create a regional group
February 4th, 2019	Senator Kolkhorst files SB 633. SB 633 directed local mental health authorities servicing rural areas to create regional plans to expand mental access and reduce mental health costs.
December 1, 2020	The Final Report generated by SB 633 is due to be published.

Collaboration Concept

SB 633's collaborative model is based on a model developed in HB 13 and SB 292 (Texas Senate Committee on Health & Human Services, 86th Legislature). SB 292 establishes a grant program to reduce the number of people with mental illness in jails (Texas Legislature, 2017). SB 292 gives special grant dollars to communities where LMHAs collaborate with their hospital district and their county government. The

community collaborative must create community plans with outcomes that address SB 292's intended purpose.

The concept of a community collaborative was added to Texas Administrative Code to address mental illness and homelessness in urban communities (Texas Legislature, 2013). SB 58 83rd allocated funds for community collaboratives and inserted the definition of a community collaborative in the Texas Code governing Texas Health and Human Services. Like the planning procedure in SB 292, for a community to be eligible for SB 58 Healthy Community Collaborative grant dollars, the community must create a shared plan, raise matching grant dollars, and, when possible, include local mental health authorities. SB 58's model of collaboration originated from the approached used by Haven for Hope in San Antonio (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016). Haven for Hope is a public private partnership that works with their LMHA, local government, law enforcement, and UT Health San Antonio (which is the San Antonio University Health System). Haven for Hope co-locates 31 partners on their campus and works with 47 off-campus partners to provide services for people experiencing homelessness and people who may have behavioral health needs (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016).

In the interim between the 84th and 85th legislative session, the Select Committee on Mental Health was tasked with examining mental health in Texas and suggesting ways to

improve it (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016). Select Committees are appointed and directed by house speaker proclamations. Select committees have all the powers of a standing committee except where limited by a house speaker proclamation (Texas House, 2015). They also only exist if a proclamation says that they should exist. House Speaker Strauss (R, San Antonio) appointed the committee to complete the first holistic analysis of "every aspect of local and state mental health systems in Texas" (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016). The Texas Tribune noted that high profile mental health related deaths in 2015 made mental health a prominent issue in the 84th legislative session (Silver, 2015). In same Texas Tribune article, House Speaker Straus is quoted as saying

"We have taken some major steps to address the state's mental health needs [….] It's important not to look at these issues in isolation, but rather to take a comprehensive view of how to improve the system. Many legislators asked that we take a closer look at various issues related to mental health, and it became clear that one committee should look at all of those issues together."

Then House Speaker Strauss's letter to the select committee included instructions to focus on increasing coordination, reducing costs, and examining challenges associated with rural mental health services. The committee stated

"One recurring message or theme stood out to the Committee - communities and stakeholders who work in partnership and collaboration provide more effective mental

health/behavioral health services and in many cases to a greater number of persons and have the greatest successes" (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016, pp. 7).

The committee further highlighted the Haven for Hope model of collaboration. The Committee noted "that cooperation, coordination, planning, and provision of local matching funds by local stakeholders and assistance at the state level can successfully and effectively allow a community to identify and address its own unique mental health/substance abuse challenges" (Interim Report to the 85th Legislature House Select Committee on Mental Health, 2016, pp. 6). Community collaboration was an opportunity for locally directed mental health services. Requiring matching funds creates a requirement for partnerships between grantees and nonprofits. In community hearings, the committee highlighted a collaboration model for more effective statewide services and identified that the legislature's investment in mental health had made a large impact on local community collaboration. Additionally, in the community hearings, the committee highlighted a need for further coordination and mental health access.

The 85th Legislative session included two bills that expanded the concept of community collaboration. The first, SB 1849, expanded the community collaborative model to rural communities and required that two or more rural counties work together to create a regional plan (Texas Legislature, 2017). The second, HB 13, created a $20,000,000 mental health grant program that required an entity requesting grant money to obtain letters of support from all the LMHAs covered by the proposed mental health program

(Texas Legislature, 2017). Representative Price was both the author of HB 13 and the chair of the Select Committee on Mental Health. To this writer it appears that he brought ideas about community collaboration into his bill to expand mental health funding. Through SB 1849, community collaboratives had expanded to rural communities, while HB 13 provided $20,000,000 to communities with LMHAS that could work collaboratively

Bill Authors

Senate Bill 633 authored by Senator Kolkhorst (R-Brenham) was passed through the Texas Senate smoothly. The bill gained three additional co-authors: Senator Perry (R-Lubbock), Senator Lucio (D-Brownsville), and Senator Buckingham (R-Lakeway). Senator Kolkhorst's legislative district consists of 21 counties (Texas Legislative Council, 2015). Nineteen of the counties she represents have a population of less than 90,000 people. 60% of her constituents are in small rural communities. Senator Perry represented one moderately large county (Lubbock has a population of 278,831), one county of 110,224, and 49 counties with a population of less than 40,000 (Texas Legislative Council, 2015). Senator Lucio represents two urban counties and three small counties with a population of less than 40,000 people. Senator Buckingham represents 16 counties with a population of less than 90,000 and a small part of a large urban county (Texas Legislative Council, 2015). Thus, the bills authors represent many rural counties and both political parties.

The bill's author and coauthors appear to this writer to have substantial legislative experience serving important roles in crafting mental health policy and rural policy. SB 633 was sent to the Senate Health and Human Services Committee (Texas Senate, 2019). Senator Kolkhorst chaired. Senator Perry was the co-chair. Senator Perry is also the Chair of the Water and Rural Affairs Committee. Senator Buckingham is the chair of the Nominations Committee.

Fiscal Impact

Only a small cost was associated with the bill. While the bill itself did not allocate funds, the Legislative Budget Board noted that implementing the bill would require $659,248 to pay for staff and technology (Legislative Budget Board, 2019). Senator Kolkhorst framed SB 633 as preparation for LMHAs to efficiently use new funds. She noted,

"This session we will likely invest millions of new dollars into community mental health services and that means our rural LMHAs must be prepared, coordinated and able to expand their capacity by working with other LMHAs in their regions. When rural communities work together, Texas is better, and more people are served" (Kolkhorst, 2019)

The bill requires that any regional plans created as part of the implementation of SB 633 must be cost effective and focus on reducing costs to local governments. Senator Kolkhorst noted that the bill's rural language was created in part to complement language

in SB 292 85th (Texas Senate Committee on Health & Human Services, 2019) The SB 292 grant program requires each county with a population above 250,000 match every dollar of state grant money with a dollar of privately raised funds (SB 292, 2015). Counties of less than 250,000 must match every state dollar with 50 cents of private funds. SB 292 also requires that at least 20 percent of all funds must go to communities of less than 250,000 residents. The Legislative Budget Board (2017) estimated that the total cost of implementing SB 292 would be $18,801,600. The estimated fiscal impact of SB 633 was $659,248. Thus, in this writer's opinion, the existence of SB 292 allowed for the creation of SB 633 without creating any large additional costs. With the improved efficiency coming from regional planning, Senator Kolkhorst expressed her belief in a committee hearing that SB 633's true fiscal impact may even reduce costs to the state (Texas Senate Committee on Health & Human Services, 2019).

Senate Passage

With its authors and coauthors possessing an established history in positions where they were able to impact rural mental health legislation and extensive stakeholder support, SB 633 passed through the senate with only a small amendment and very little opposition. The bill passed the Health and Human Services Committee without an amendment. The only amendment to the bill was introduced on the floor of the Senate during regular session (Texas Senate, 2019). Senator Kolkhorst introduced an amendment to include

"Senator Nelson's Fiscal Responsibility language" and to correct a minor drafting error. The bill was passed in the senate with no objections.

House Passage

After being voted out of the Senate, SB 633 was considered in the house. The bill was considered in the House Committee on Public Health. Representative Price was the chair of the House Committee on Public Health when SB 292 85th and HB 13 85th were passed. When SB 633 was passed through the committee, he was no longer chair but he was a member. The committee unanimously voted in favor of the bill. When the bill was voted on in the full House, the only nay votes were from Representatives Cain, Flynn, Middleton, Schaefer, Tinderholt, and Zedler. Representative Cain also voted against SB 292 and HB 13. Representative Tinderholt voted against HB 13. The bill was passed in the House and signed by Governor Greg Abbott.

Conclusion

SB 633 passed through the Texas legislature with few modifications. The bill was crafted by experienced rural legislatures with a history of creating mental health policy. The collaboration concept in the bill was based on work in the Select Committee on Mental Health and previous legislation. To this writer it appears that existing grants allowed the bill to be implemented with existing resources, which eliminated another major hurdle to passage. The cost and concepts in SB 633 created a bill with little opposition.

Chapter IV: Implementation

As of the completion of this report, the implementation of SB 633 is not complete. This section will describe the implementation phase based on the most current data available. Very little of the implementation process is described in the legislation. The implementation process was developed as a collaboration between the LMHAs, HHSC, and stakeholders. Senator Kolkhorst's office provided HHSC with guidance on how to interpret the intention of the legislation

DEFINING REGIONAL GROUPS

An important part of implementing SB 633 is which LMHAs would be included in the planning process and how they would be divided into regional groups. Previous regional planning was completed as part of The Austin State Hospital Redesign and San Antonio State Hospital Redesign reports (The University of Texas at Austin Dell Medical School, 2018; Methodist Healthcare Ministries of South Texas Inc., 2019) Both of these state hospitals are part of a larger interconnected regional mental health system. The redesign reports provided recommendations that focused on how to improve their entire system of care and not just hospital providers. HHSC described how they defined regional groups in a meeting of the Joint Committee on Access and Forensics (Texas Health and Human Services Commission, 2019). In the October 23rd meeting, they noted that they used state hospital catchment areas to create regional groups. This resulted in 7 regional groups. They also described the role of urban LMHAs in regional planning. Urban LMHAs could

participate in regional planning as ex officio members. They described this role as acknowledging the interconnected relationship between urban and rural LMHAs. State hospital catchment areas would be used to define regions and both urban and rural LMHAs would have a role in planning. This writer believes that using state hospital catchment areas to define SB 633 regional groups allows data from previous planning efforts to be incorporated into the regional planning process. Data is also being collected through a community survey available on the SB 633 Website (Texas Health and Human Services Commission).

REGIONAL PLANNING

As of April 2020, the regional plans have not been completed and published.

Chapter V: Policy Analysis

POLICYSCAPE

As the legislative analysis included in this report demonstrated, SB 633 was dependent on existing laws like HB 13 and SB 292, nonprofit organization' successes like Haven for Hope, and the structure of the LMHA system in Texas. Existing grant programs meant that SB 633 did not introduce new large spending requirements but appears to this author to use funding already committed by HB 13 and SB 292. Mattler's (2016) policyscape framework describes laws existing within the context of a network of dynamic interconnected network of policies created by laws, regulations, tax codes, bureaucratic behavior, and decisions made by non-governmental organizations. SB 633 can be better understood by framing it within the policyscape.

Policy Environment

The outcomes being measured in SB 633 are also dependent on changing policies external to the actors within SB 633's control. Policy environments can shift dramatically over time. State economic conditions are influenced by policies and world events that can have dramatic effects on a community's mental health needs. The successes of community collaborations can be affected by a weakened economy or a natural disaster.

Policy Maintenance within the Policyscape

Given the dynamic nature of policy, Mattler argues that policies often need maintenance. If the world has changed, policies will need to change to match the environment. SB 633 can be conceived of as part of the policy maintenance for SB 292 and HB 13. By making more grant money available, the mental health policyscape in Texas shifted. In this writer's opinion, with greater funding, other aspects of improving the mental health system could more clearly be seen. Money would need to be paired with collaboration to be effective. As this professional report is being written, Texans has declared a state of emergency due to the COVID-19 outbreak. In 2019, Texas legislators passed SB 633 based on careful study of the results of previous efforts to improve mental health care in Texas. COVID-19's effects are unprecedented. There has never been a widespread virus emergency like this. The mental health system will likely have to respond to widespread anxiety, trauma, isolation, and worsening economic conditions that increase mental health strain (National Alliance on Mental Health, 2020; Meadows Mental Health Policy Institute, 2020). Laws must evolve to match the conditions that surround them, or they may lose relevance.

To this writer, viewing SB 633 as form of policy maintenance for SB 292 and HB 13 helps address an important question--why was SB 633's passage not controversial? Policy maintenance requires political support and governing expertise (Mattler, 2016). To maintain a policy, legislative actors must understand a policy well enough to see how it can be improved or maintained. Senators Kolkhorst and Perry and Representative Price

appear to have mental health governing expertise. SB 633 was designed by many of the same people who design the policies it sought to maintain. Senators Kolkhorst and Perry had long tenures in the Texas Legislature and a history of involvement in mental health legislation. In the Texas House, member Price participated in the Select Committee on Mental Health, the passage of SB 292 and HB 13. SB 633 was backed by a group of legislators with experience in creating the policies it was working to maintain.

The Interest Cycle and Stakeholders

Political support for SB 633 can be attributed to its alignment with the interest cycle and the structure of stakeholder groups. Groups supporting the legislation include long-standing and highly organized mental health stakeholders, health care provider groups, mental health focused nonprofits, and people with lived experience of mental illness.

To this writer SB 633 also appeared to only generate interest among mental health policy stakeholders. This writer could find no mention of SB 633 in any major Texas newspaper. Public interest is a limited resource. With so many bills considered by the Texas legislature during each session, the public cannot pay attention to every bill. Downs (1972) theorizes that public interest generally occurs in response to dramatic, attention-grabbing events. Dramatic events paired with a belief in the public's ability to solve the problem creates public enthusiasm for solving the problem, but it can eventually result in a backlash from people who do not want to pay the price needed to solve the problem. Improving mental health grant making through collaboration has been an

incremental in process. Planning is a slow process that is unlikely to grab headlines. It appears logical to this writer to presume people with lived experience of mental illness are likely to find mental health policy more interesting and mental health policy planning impactful for their lives. Without media coverage the general public would appear to this author to be less likely to be engaged with SB 633. The general public is unlikely to generate either marked enthusiasm or marked opposition. Without opposition, legislation is more likely to pass, and the organized voice of people with mental health can more easily be heard. Lack of community awareness may also limit the participation of nontraditional voices in the process. People in poverty or in rural communities with limited internet access may be unable to research issues that could impact them. The implementation phase alleviates this concern by engaging in additional assessment.

SYSTEMS THEORY

Systems theory is considered fundamental to social work (Payne, 2002). Systems theory is based on viewing a person within interconnected micro, mezzo, and macro systems to understand their experience in the world. Systems theory provides an important framework for understanding the strengths and limitations of SB 633. Social work applies systems theory to contextualize change within the context of micro and macro practice. Micro practice consists of change at a person-to- person level, such as direct practice (Bakalinsky, 1982). Macro practice consists of change at community or organizational levels. SB 633 measures individuals' interactions with larger systems through counting

the number and costs of individuals' interactions with healthcare, crisis response, and criminal justice systems. The legislation requires the level of intervention to be organizational. Organizations are instructed to plan how they will work together as members of a larger organizational system. Many aspects of mental health access must be addressed on a micro level. Systems contribute to services feeling acceptable to people but the actions and beliefs of individual people interacting with other individual people also plays a major role in determining the acceptability of services. A great organization can still have a single staff member who is not a good cultural fit for the client. If that single staff member interacts with the client, they will not feel accepted. The definition of mental health access has components of micro and macro systems. Mental health access emerges from how individuals conceptualize their needs and the larger healthcare system's ability to meet these needs. According this writer's analysis of the legislation, SB 633 primarily focuses on improving the macro system with the hope of improving the macro systems match with an individual and thus improving outcomes.

Systems and Political Perspective

The political perspective within Texas can provide insight into why the legislation emphasizes macro rather than micro change. In this writer's opinion, the legislative process that created SB 633 emphasized locally led solutions. Further, this writer believes that Texas politics have historically emphasized individualism. It appears to this writer that legislation that does not emphasize individualism is more politically difficult to pass.

The Texas Tribune noted that in effort to avoid a lack of consensus, the 86th legislature attempted to largely sidestep questions about individual freedoms (Ramsey, 2019). To this writer, forcing micro level change is less politically viable than macro level change.

The contracting approach with LMHA's utilized by HHSC is much less likely to impinge on personal freedoms than micro level changes from the Texas legislature. Local mental health authorities are an extension of the state government responsible for mental health coordination (Texas Health and Safety Code). The legislature has historically contracted with and regulated the behavior of LMHAs. Providing additional regulations of LMHAs is not novel. Stakeholders have emphasized that new regulations should maximize local direction of solutions. Instructing LMHAs to collaborate and thus improve their macro organizational system improves efficiency but does not remove their autonomy to make independent choices on how to interact with clients on a micro level. One of the stakeholder engaged in shaping SB 633 was the Texas Council of Community Centers. The Texas Council of Community Centers, which seeks to represent all LMHAs, views LMHAs as an independent but interconnected network of providers. The Texas Council of Community Centers already works with an interconnected group of providers. SB 633 is consistent with the view that LMHAs are an interconnected group.

Macro Systems Outside of the Scope of SB 633

Not all the macro systems that contribute to mental health outcomes are included in SB 633. Some macro systems are difficult to change through legislation. The legislation

focuses on LMHAs and organizations that might partner with them. Mental health access is impacted by many other systems. Affordability is a component of mental health access. LMHAs and their partners can alter the price of their services but have limited ability to change wider economic conditions. LMHAs do not have the capacity to alter a regional economic system. They do not have policy levers to regulate community wages or alter the supply of jobs that are available in their communities. Thus, to this writer they appear limited in their ability to alleviate an important exogenous factor associated with mental illness. Poverty and the stress associated with poverty are associated with mental illness (SAMSHA, 2016). Mental health providers are also limited in their ability to change transportation systems. LMHAs can pay for people to utilize public transit, or even pay people to transport clients to appointments, but LMHAs and their partners are not able to build roads or create new public transit systems. They may be able to make use or better use of existing systems, but creating wider systems is outside their control.

To this writer, focusing on macro level change has strengths and limitations regarding mental health access. Since individuals must interact with systems to access care, better systems have the potential to improve mental health outcomes. LMHAs and their partners can improve availability by creating an interconnected system with “no wrong door” for accessing services, but LMHAs cannot address the limitations in availability that come from wider transportation infrastructure limitations. Working together as a system can create economies of scale, which increase the affordability, but providers cannot address the elements of affordability that stem from larger economic factors. Providers working

together to identify the right partner to serve an individual can improve appropriateness of service. Working as a system can address some of the elements of mental health access.

Acceptability and Approachability

Acceptability and approachability are much more difficult to address through macro level interventions. Since acceptability centers on how an individual perceives a provider's ability to meet their cultural demands providers need to change how they interact with individuals to improve acceptability. Locally directed solutions provide an opportunity for each LMHA to adapt to its local community, but feedback from individuals through SB 633 has some limitations. During SB 633's implementation, feedback from individuals was obtain from surveys and from representatives of people with lived experience who participated in focus groups and planning meetings. Survey and focus group participants were sufficiently engaged with mental health systems to provide feedback. To this writer, this indicates a level of acceptability and approachability, i.e., participant knew the system existed and expected that their feedback would be valued to at least some degree. Since as noted by SAMSHA nationally providers struggle to meet the cultural demands of rural communities, it is possible that many people do not provide feedback about the mental health system because they believe the system is unresponsive to their cultural needs. For example, if someone in a rural community with a high school degree believes routine mental health care is only for college educated urban people, they

will not provide feedback on how to improve the system. Representing people with lived experience requires identifying with people with mental illness. Identifying with people with mental illness requires overcoming stigma. The people who are active in mental health policy have overcome stigma enough to say that mental health is meaningful to them. Both these limitations indicate to this writer that many people who would benefit from mental health supports are not providing the information LMHAs need to address their concerns about approachability and acceptability.

COST REDUCTION AS MEASURE OF SUCCESS

Business Approach to Social Services

The success of regional planning is based on two sets of outcomes, i.e., LMHAs' increased capacity to provide high quality services that result in reduced crisis service utilization and costs of service provision. The policy effects of focusing on performance will be discussed in the performance contracting section of this policy analysis. Using costs to governments as a measure of success allows the legislation to be more understandable to non-mental health professionals but appears to this writer appears to benefit from being paired with some other important aspects of success. The legislation combines both outcomes, in this writer's opinion this allows the legislation to benefit from the strengths of both fiscal and quality measures. Hypothetically from a strictly fiscal perspective, legislation that costs the state nothing but reduces costs is a success. A

hypothetical savings focused person does not need to know the minutia of mental health service delivery or even the mental health system to judge net cost saving. To this writer the political environment during the 86th legislative session made questions about costs to local governments particularly important. The 86th session included intense debate about property taxes and local government budgets. Property tax reform had the potential to change how much money local governments could raise and how quickly taxes could be increased. It would appear to this writer that reducing costs to local governments is likely popular in an environment where legislators expressed fear reduced property tax revenue resulting from new property tax formals would endanger local government funding in future. Outpatient mental health treatment is lower cost than inpatient crisis mental health treatment (Stensland, Watson, & Grazier, 2012). It appears to this writer that defining success based on dollars saved should capture the reductions resulting from increasing outpatient care.

Limitations of Measuring Success Using Cost

This writer believes that focusing on both costs and quality provides a more complete description of the success of the legislation. Acceptability can be indirectly measured by changes in service utilization. People who find that a service is a cultural fit for their needs are likely to use the service sooner, which should, in theory, reduce costs. Subtle shifts in a client's level of comfort with a provider may be more difficult to measure. Costs may be similar, but they may find the process easier to understand.

Measuring costs to local governments may not fully capture all successes of the legislation. A person who has recovered from a mental illness and is working and paying taxes not only puts less demand on local services but is providing a net increase in revenue to that government. Identifying increased net revenue from people with mental illness has the potential to be very difficult. Spending on mental health crisis services can be identified, but among people who pay their property taxes, there is no clear way to identify which of them has used mental health services and who has recovered from mental illness. Their money becomes part of the county's revenue without an indication of their recovery. Using research methods like surveys or modeling could potential capture some of these gains but sampling is unlikely to completely capture all gains. Research provides estimates of the cost saving associated with meeting a community's mental health needs, but this writer does not believe that research is not a substitute for policy makers measuring the success of individual programs in their own communities.

Performance Contracting

Since the 1980s, the structure of publicly supported programs has shifted. The number of federal grants for mental health services has been reduced (Anheier, 2014). With the shift towards block grants, the structure of contracts has also changed from reimbursement for specific services rendered to performance contracting (Anheier, 2014). Performance-based contracting "emphasizes efficiency and capacity" through focusing on outcomes rather than individual services delivered (i.e., inputs). In this writer's opinion, SB 633

utilizes this performance-based approach. SB 633 does not instruct local governments to provide a certain number of hours of services. The success of regional plans is measured in the offset of costs of specific services being utilized and specific costs incurred. Using a performance-based approach introduces more complexity into service delivery. When engaged in regional planning, LMHAs and HHSC must collaborate and try to understand how service delivery might impact outcomes. With greater freedom to decide on service delivery, there comes more responsibility for choosing the right service. This writer views effectiveness in a performance-based landscape as requiring LMHAs to be experts in their regions rather than simply providers of prescribed services. Since LMHAs participate in other performance-based contracting to provide routine services, they likely have made this shift already, but this approach may favor some LMHAs over others. Understanding a small homogeneous region with good data systems is easier than understanding a large complex region with little data available. This writer views HHSC as having the capacity to help LMHAs understand complex regions, but it appears to this writer that HHSC is also limited by available data and may lack the time needed to fully understand highly complex regions.

Lipsky and Smith highlight a danger in performance-based contracting that this writer believes may help explain stakeholder groups' continued emphasis on locally directed solutions. They view performance-based contracting as having the potential to make nonprofits feel "forced to conform to standards imposed by contracting policy at the expense of their homegrown notions of what constitutes effective service delivery"

(Lipskey and Smith as cited by Anheier, 2014,p. 638) It appears to this writer that when the legislature identifies the desired outcome, a local government may lose the ability to decide what an effective service is. Maintaining locally directed solutions allows communities to maintain a higher degree control in deciding what is effective. This degree of control is especially important when some aspects of mental health access like acceptability can be nebulous and difficult to measure. This writer believes that a LMHA will have more direct data and a more direct experience of what is acceptable to a community than any centralized government.

LMHAs have also requested supports that are not fully captured in performance contracting. LMHAs are already directed by the state to deliver certain evidence-based practices (Statewide Behavioral Health Coordinating Council, 2016). LMHAs have also expressed a desire to implement evidence-based practices that meet the needs of their communities and have requested additional training. Training on evidence-based practices adds additional supports that are not strictly based on monitoring outcomes.

CAPACITY AND QUALITY EXPANSION

In addition to the business-based definition of success, the legislature also requires that HHSC evaluate the success of SB 633 based on the degree to which plans improve care and align with the Statewide Behavioral Health Strategic Plan and the Comprehensive Inpatient Mental Health Plan. Measuring success based on care improvement and alignment with the Statewide Behavioral Health Strategic Plan supplements the business

measure of success with the opinion of mental healthcare experts. The Statewide Behavioral Health Strategic Plan was legislatively mandated by H.B.1 84th and was implemented by the Behavioral Health Coordinating Council Statewide (Behavioral Health Coordinating Council, 2016). The Behavioral Health Coordinating Council includes representatives from state agencies that provide mental health services, universities, and the Health Professional Council, which represents the licensing boards of an array of healthcare disciplines. The council's vision of quality care is that care must be person centered, culturally appropriate, recovery oriented, and delivered through a unified system that is trauma informed. The process should also "value peers, family, friends, behavioral health professionals, and other stakeholders and their vital roles in a person's journey" (Behavioral Health Coordinating Council, 2016, p.7). This writer views The Behavioral Health Coordinating Council's vision of success as more individualized than the business case for success. For example, valuing family and friends in a person-centered journey of recovery will mean recovery looks different for each person. Recovery is much more difficult to measure than dollars spent. As described in performance section of this paper, the mental health system assumes that quality care and recovery will lead to cost savings, but many aspects of success are person centered and more difficult to capture on paper. For example, the National Association of Social Work Code of Ethics (1996) states individual dignity and worth are two of the profession's values. Since individuals define their own journeys of recovery, an improved sense of dignity and worth are aspects of a successful recovery, but service delivery may not look

different among those who received services that support dignity and worth. Service recipients may feel better and be better supported but costs may not change.

In addition to addressing "Dignity and Worth of a Person," National Association of Social Work Codes of Ethics (1996) directly addresses other standards created by the Statewide Behavioral Health Strategic Plan, but it does not address cost. The guiding principles of the National Association of Social Work Code of Ethics are "Dignity and Worth of a Person" "Service", "Social Justice", "Importance of Human Relationships", "Integrity" and "Competence" (National Association of Social Workers, 1999). Aspects of Social Justice is expressed in the plan's commitment to culturally appropriate care. "The Importance of Human Relationships" align with the strategic plan's commitment to person centeredness and the value placed on personal supports like family and friends. The use of experts to define quality care aligns with the value of competence and integrity.

This writer's graduate education includes social work. His training in social work has centered on the principles outlined in The National Association of Social Work Code of Ethics. He believes that these principles play an important part in ethically engaging in improving behavioral health service delivery. Their inclusion in an analysis of the success of behavioral health outcomes is important.

Throughout the policy process, stakeholders have emphasized the voice of individual communities. To this writer, the voice of communities is needed to meet the vision of the

Statewide Behavioral Health Strategic Plan and provide quality care. In this writer's opinion, even the best top down solution will miss some unique characteristics of each person and each community. Policy needs to be crafted with enough room to adapt to individuals and communities. This is especially important in improving rural mental health access. Improvements in service acceptability require people to feel a sense of cultural match to services. This writer believes communities best understand their own culture. Allowing communities to adapt services to meet residents' needs seems to this writer to be vital for achieving this outcome.

POLICY ANALYSIS THEMES

The policyscape surrounding SB 633 allowed the legislation to function as policy maintenance for existing legislation. Mattler (2016) believes policy maintenance is a vital part of the policy process. Policy maintenance emerges when governing expertise and political support are available to address a changing environment (Mattler, 2016). Political support and controversy emerge out of the interest cycle (Downs,1972). SB 633 appeared to this writer to have generated interest among mental health stakeholders but did not appear to garner broader public interest. Without broader public interest, it was unlikely to generate controversy. The policy environment also influenced the systems changed by SB 633. System theory provides a framework to understand systems as macro, mezzo and micro (Payne, 2002). SB 633 primarily focused on macro level

change. Changing how systems of organizations interact is more politically feasible than changing the beliefs or culture of individuals. Focusing on organizational change can introduce limitations. Mental health access involves factors that must be addressed on the micro and macro level. Some macro factors are also outside of the scope of the legislation and may require action from other groups. Broad economic and transportation systems cannot be fully addressed by SB 633. The legislation is seeking to improve macro level outcomes and has developed two major ways of measuring success, quality and cost savings. Cost savings appear to this writer to be easier to understand than improvements in mental health quality, but improvements in mental health quality can provide a more nuanced picture of success. Measuring quality is supported by Statewide Behavioral Health Strategic Plan and NASW code of ethics. SB 633's approach to measuring mental health access emerged in a specific policy environment and can be measured by that environment's cost and quality tools.

Chapter VI: Promising Approaches and Next Steps

SB 633 is not the only effort to improve rural mental health access. Montana increased mental health access through an innovative peer telephone program (United States Department of Health and Human Services Administration, 2011). Texas already uses peers and operates hotlines. This writer believes Texas could implement multiple warm line programs that meet the cultural needs of the state's diverse communities. The Community Health Worker model has successfully been used to address behavioral health needs and increase the impact of each social worker (Rural Health Information Hub, 2019). In Texas, the model has been combined with telehealth to reduce barriers to mental health services. Texas has also been developing rural community collaboratives through the SB 1849 grant program. SB 1849 is described in the legislative timeline. The Resilient Bastrop County Initiative provides an example of the diverse approaches used to enhance mental health access in rural areas. Examples from Texas, Montana, and Massachusetts show that collaboration and technology provide opportunities to improve rural mental health access.

MONTANA WARM LINE

Montana operates a phone and web-based peer support hotline for people coping with mental illness (United States Department of Health and Human Services Administration, 2011). The service is designed for people with barriers to accessing mental health care or desire a high degree of anonymity. Given that many rural communities struggle with

stigma about mental health treatment, the Warm Line allows people who may want to access mental health services, but do not want their neighbors see them access care, to do so anonymously from their home. Like Texas, Montana has a mental health care provider shortage. The Warm Line allows people who cannot easily access services a quick and easy way to obtain support.

Texas already has Peer Support as a Medicaid benefit (Texas Health and Human Services Commission,). LMHAs operate mental health crisis hotlines (Texas Administrative Code Health). In Austin, the nonprofit Family Eldercare developed Lifetime Connections Without Walls, a telephone-based program for older adults to communicate and reduce their social isolation (Family Eldercare, 2020). The program offers older adults opportunities to take part in classes and connect with one another. Social isolation contributes to depression in older adults. Programs like Lifetime Connections Without Walls have helped reduce isolation and depression experience (Family Elder Care, 2012). This writer believes that expanding this model to rural communities in Texas would also allow younger people who felt alone to engage with people who have had a similar experience. The program has the potential to reduce crisis utilization by allowing people who feel isolated to engage with someone over the phone before a crisis or before they feel ready for more in-depth services. Montana is a much smaller state than Texas but was able to create the program using just 16 peers. The small number of peers needed to operate the Warm Lines suggests that there may be opportunities to create multiple Warm Lines that provide services in a variety of languages. In addition to English, the top three

languages spoken at home in Texas are Spanish, Vietnamese, and Chinese languages like Cantonese and Mandarin (The United States Census Bureau, 2015). This writer believes that creating Warm Lines staffed by small groups of peers from these communities could create statewide access to an empathetic voice, which can be especially important when people have moved to a rural community where very few people speak their preferred language. The Warm Line would also create an opportunity for referrals within large regional groups. Since a single phone line is used, an individual would not need to identify a provider before calling. Instead, they could call once they are ready for services and be referred to a provider in their region who can meet their needs.

RESILIENT BASTROP COUNTY INITIATIVE

The Resilient Bastrop County Initiative is a collaborative aimed at capacity building, reducing mental health stigma, and connecting people who have felt excluded from the community (Bastrop County Cares, 2020). This collaborative was supported by grant funding from the Hogg Foundation. Collaborative activities include the Healing History community conversation series about racial inequity, a youth summit, and supporting the work of other collaboratives. They support Faith Communities in Collaboration and the Bastrop County Veterans Collaborative. Their work also extends to fostering connections through unstructured events like the Bastrop Veteran Family Bowling Night. Working with existing communities and creating informal and formal events allows them to reach a wider group of people than only focusing on formal events. Using a broad range of

strategies also appears to this writer to be a good strategy to combat stigma. Mental health is being treated as part of broad continuum of community needs rather than something only discussed privately among or in separate mental health focused spaces. Focusing on the historical causes of mental health disparities is an important innovation for rural mental health. This approach acknowledges the historical environment as a root cause of mental health disparities and allows a community to openly grapple with it. The Resilient Bastrop County Initiative combines a diverse set of community level approaches to improve rural mental health outcomes.

COMMUNITY HEALTHCARE WORKER MODELS

Community Health Worker Model in The Outer Cape

The Outer Cape Health Services Community Resource Navigator Program addresses rural mental health access by improving coordination and approachability of services in The Outer and Lower Cape communities of Massachusetts (Rural Health Information Hub, 2019). These communities had high rates of behavioral health needs and service barriers such as limited transportation. People with low income and older adults struggled with access to services. Community health workers engage with people in their communities and help coordinate services. Referrals were made by police, family, friends, and primary care providers (Ward, 2018). One of the strengths of the Outer Cape model is that master's level social workers would assist navigators with coordination, but

the navigators would not need to be master's level social workers. The use of a social worker directing a group of navigators in this writer's opinion has the potential to increase the impact of each social worker and reduce the negative impacts of the mental health provider shortage in rural Texas. This model helps people learn about and connect with resources in their community and increase the effectiveness of each social worker.

Brazos Valley Care Coordination Program

Madison County Texas has developed its own community health worker program aimed at helping people access behavioral healthcare called the Madison Outreach and Services through Telehealth (MOST) Network (Rural Health Information Hub, 2018). A survey of Madison County found that 35% of people report not being able to easily access care. The program provides services in English and Spanish, with a focus on bring urban services to rural communities. MOST providers included county government, Brazos Valley Council on Alcohol and Substance Use, the Telehealth Counseling Clinic at Texas A&M, MHMR of Brazos Valley (the LMHA serving Madison County), and the St. Elizabeth Ann Seton Catholic Church. Community Health Workers provided culturally informed outreach, service coordination, home visits, classes, and transportation to appointments. The Telehealth Counseling Center provided telephone and televideo counseling services in English and Spanish. The MOST program increased rural mental health access by reducing transportation, language, cultural barriers to care.

Conclusion

Nationally, rural communities have greater behavioral health challenges than urban communities including higher rates of suicide and overdose, and rural residents seek care later in the course of their illness (Myers, 2019; Wang et al., 2005; Kessler et al., 2003). Levesque, Harris, and Grant (2013) conceptualize mental health access as a problem of supply and demand that can divided into the following factors: approachability, acceptability, availability and accommodation, affordability, and appropriateness. Myers (2019) argues that Levesque, Harris and Grant's definition fits with the barriers experienced by people in rural communities. Texas is largely made up of rural communities. 234 of Texas' 254 counties are rural and 85% of the state's land mass is in rural counties (Texas State Library and Archives 2020; Texas Rural Funder's Collaborative, 2018). Although the state has been working to address mental health needs most Texas counties have a mental health provider shortage (Department of State Health Services, 2014).

The Texas legislature has sought to address rural mental health access through collaboration. Collaboration first emerged as way of improving mental health services in urban communities. The Texas Legislature's Select Committee on Mental Health highlighted the success of using community collaboratives and the need to expand access to mental health services in rural areas. Grant programs emerged that increased mental

health funding on the condition that the funding was part of a collaborative mental health system effort.

SB 633 emerged as a piece of policy maintenance to improve the successes of these existing grant programs. It adapted the collaborative approach to the current policy environment. Regional planning had the potential the impact of existing grant programs by increasing collaboration. SB 633 instructed local mental health authorities serving rural communities to work with HHSC to create regional plans to improve mental health outcomes and reduce costs. SB 633 was authored and supported by people who were active in the Select Committee on Mental Health and the creation of mental health grant programs. The legislation had minimal opposition and widespread support from mental health provider groups, community groups, disability rights groups, and groups representing people with lived experience of mental illness. A collaborative approach to mental health matched the policy principles of major stakeholders because it allowed the LMHAs participating in regional groups to expand mental health access and continue to meet the unique needs of their communities through local decision-making. SB 633 garnered little media attention or opposition. To this writer the lack of media coverage appeared to have aided the bill's passage but introduced the limitation that people who were not already actively engaged with the mental health system were unlikely to hear about the bill and contribute new ideas to its approach. To increase participation, the bill's implementation phase included steps to gather additional data like surveys. Implementing SB 633 required taking the abstract concept of rural mental health access

and operationalizing it, the operationalized concept would need to be used by regional groups to create regional plans that address ER and jail utilization and transportation of people experiencing mental health crises. They also allowed large urban LMHAs to participate as ex officio members in regional planning. This approach appeared to this writer to acknowledge the interconnected nature of the mental health system. As of the writing of this professional report, regional plans have not been completed, but regional groups have been formed.

Systems theory supports using systemic collaboration to improve mental health care. Systems theory is central to social work and can be applied to SB 633 to understand its approach to improving the macro systems that affect rural mental health access. The theory also highlights the limitations of macro solutions. The legislation does not change all macro systems that influence mental health. For example, broad transportation and economic systems are not mentioned. Success is defined as cost reductions resulting from individuals receiving high-quality care that prevents them from needing crisis services. Mental health access includes micro and macro components. Regional plans have less direct effects on the micro components of approachability and acceptability. Acceptability focuses on how an individual perceives a provider's match with their needs including cultural needs. Approachability focuses on an individual's perception of whether a service exists and the person's belief that a service will meet their need. A service will seem unapproachable if the person does not understand that the service is meant to meet their needs. Both approachability and acceptability can be improved by

increasing an individual perception that providers are working together to create well-coordinated systems. Regional planning has the potential to result in improved coordination. However, unless these systems can create micro-levels interactions that make people feel welcome when interacting with staff, systems will be limited in their ability to improve access.

SB 633 specifies two sets of standards for improving rural mental health care access—improved quality of services and reduced costs. This writer believes that using reduced costs as a measure allows people outside mental health professions to easily see when mental health systems are succeeding in reducing costs. Focusing on performance to lower costs appears to this writer to also be in line with the shift in mental health services to performance contracting. Local organizations are given the freedom to define services if outcomes are achieved. Focusing on cost appears to this writer to introduce a substantial limitation, but many elements of successful mental health access are difficult to quantify. Pairing the cost perspective with quality measures creates a more well-rounded way of defining successful rural mental health access. This more rounded approach appears to this writer to comport with social work ethics and the state behavioral health systems' vision of success. In this writer's opinion SB 633 takes this approach.

Rural mental health providers in Texas and other states are using approaches that this writer believes the regional groups should consider adopting. Behavioral health

community health workers can improve micro interactions between people in need and mental health systems. These workers can also serve as experts who can help foster connection with providers to best fit a person's needs. Peer Warm Lines can increase access and engage individuals who were unlikely to be able to access in person services. Pairing technical solutions like telehealth and phone-based services with Community Health Worker models could improve rural mental health access.

LMHAs in Texas have been directed to increase rural mental health access using collaborations. This writer believes they have an opportunity to address Levesque, Harris, and Grant's (2013) conceptualization of mental health access through improving organizational collaboration while still valuing locally driven solutions. Local solutions must still align with the state's vision of quality mental health care. This writer believes that pairing local solutions and regional collaboration with state-wide quality measures can improve care while maintaining the unique approaches of individual communities.

NEXT STEPS

Implementation of regional planning of SB 633 has not been completed. This writer would like to see planning focused on creating long-term dynamic solutions. SB 633 was created in part to improve rural mental health access in a context where grant programs and collaboration already exist. New barriers to collaboration and new approaches to mental health care will emerge. It will be important for each region to view its regional plan as a jumping off point for further collaboration. HHSC has implemented a variety of

strategies to obtain community feedback. This writer believes that regional groups have an opportunity to design long-term strategies for obtaining community feedback. Regional plans are chance to begin a long-term commitment to collaboration.

Appendices

Appendix A: Description of the Bill

SB 633 86th instructs the Texas Health and Human Services Commission (HHSC) to work with rural local mental health authorities (LMHAs) to increase access to high quality mental health services (Texas Legislature, 2019). HHSC must create regional plans and its final report using existing resources. The plans must describe how to expand capacity to reduce: the cost to local governments of providing services to people experiencing a mental health crisis, transportation of people served by a LMHA to state hospitals and mental health facilities, incarceration of people with mental illness, and the number of emergency room visits by people with mental illness. Regional groups must be composed of at least two LMHAs serving counties with a population of 250,000 or less. HHSC is given the authority to assign LMHAs to regional groups and evaluate the quality of each regions plan. Each plan will be evaluated on whether it increases access and whether this increase in access offsets the cost of providing additional services. Plans will also be evaluated on alignment with the Statewide Behavioral Health Strategic Plan and the Comprehensive Plan for State-Funded Inpatient Mental Health Services. The regional plans and regional plan evaluations will be included in a final report published no later than December 1st, 2020. In additional to the regional plans and regional plan evaluations, the report will also contain a comprehensive analysis of mental health

services in rural Texas. Regional plans only need to be implemented if a source of funding has been found.

APPENDIX B: ENROLLED VERSION OF THE BILL

SB No. 633

AN ACT

relating to an initiative to increase the capacity of local mental health authorities to provide access to mental health services in certain counties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subchapter B, Chapter 531, Government Code, is amended by adding Section 531.0221 to read as follows:

Sec. 531.0221. INITIATIVE TO INCREASE MENTAL HEALTH SERVICES CAPACITY IN RURAL AREAS. (a) In this section, "local mental health authority group" means a group of local mental health authorities established under Subsection (b)(2).

(b) Not later than January 1, 2020, the commission, using existing resources, shall:

(1) identify each local mental health authority that is located in a county with a population of 250,000 or less or that the commission determines provides services predominantly in a county with a population of 250,000 or less;

(2) in a manner that the commission determines will best achieve the reductions described by Subsection (d), assign the authorities identified under Subdivision (1) to regional groups of at least two authorities; and

(3) notify each authority identified under Subdivision (1):

(A) that the commission has identified the authority under that subdivision; and

(B) which local mental health authority group the commission assigned the authority to under Subdivision (2).

(c) The commission, using existing resources, shall develop a mental health services development plan for each local mental health authority group that will increase the capacity of the authorities in the group to provide access to needed services.

(d) In developing a plan under Subsection (c), the commission shall focus on reducing:

(1) the cost to local governments of providing services to persons experiencing a mental health crisis;

(2) the transportation of persons served by an authority in the local mental health authority group to mental health facilities;

(3) the incarceration of persons with mental illness in county jails that are located in an area served by an authority in the local mental health authority group; and

(4) the number of hospital emergency room visits by persons with mental illness at hospitals located in an area served by an authority in the local mental health authority group.

(e) In developing a plan under Subsection (c):

(1) the commission shall assess the capacity of the authorities in the local mental health authority group to provide access to needed services; and

(2) the commission and the local mental health authority group shall evaluate:

(A) whether and to what degree increasing the capacity of the authorities in the local mental health authority group to provide access to needed services would offset the cost to state or local governmental entities of:

(i) the transportation of persons for mental health services to facilities that are not local providers;

(ii) admissions to and inpatient hospitalizations at state hospitals or other treatment facilities;

(iii) the provision of services by hospital emergency rooms to persons with mental illness who are served by or reside in an area served by an authority in the local mental health authority group; and

(iv) the incarceration in county jails of persons with mental illness who are served by or reside in an area served by an authority in the local mental health authority group;

(B) whether available state funds or grant funding sources could be used to fund the plan; and

(C) what measures would be necessary to ensure that the plan aligns with the statewide behavioral health strategic plan and the comprehensive inpatient mental health plan.

(f) In each mental health services development plan produced under this section, the commission, in collaboration with the local mental health authority group, shall determine a method of increasing the capacity of the authorities in the local mental health authority group to provide access to needed services.

(g) The commission shall compile and evaluate each mental health services development plan produced under this section and determine:

(1) the cost-effectiveness of each plan; and

(2) how each plan would improve the delivery of mental health treatment and care to residents in the service areas of the authorities in the local mental health authority group.

(h) Not later than December 1, 2020, the commission, using existing resources, shall produce and publish on its Internet website a report containing:

(1) the commission's evaluation of each plan under Subsection (g);

(2) each mental health services development plan evaluated by the commission under Subsection (g); and

(3) a comprehensive statewide analysis of mental health services in counties with a population of 250,000 or less, including recommendations to the legislature for implementing the plans developed under this section.

(i) The commission and the authorities in each local mental health authority group may implement a mental health services development plan evaluated by the commission under this section if the commission and the local mental health authority group to which the plan applies identify a method of funding that implementation.

(j) This section expires September 1, 2021.

SECTION 2. The Health and Human Services Commission is required to implement a provision of this Act only if the legislature appropriates money specifically for that purpose. If the legislature does not appropriate money specifically for that purpose, the Health and Human Services Commission may, but is not required to, implement a provision of this Act using other appropriations available for that purpose.

SECTION 3. This Act takes effect immediately if it receives a vote of two-thirds of all the members elected to each house, as provided by Section 39, Article III, Texas Constitution. If this Act does not receive the vote necessary for immediate effect, this Act takes effect September 1, 2019.

_____ _____

President of the Senate Speaker of the House

I hereby certify that SB No. 633 passed the Senate on April 10, 2019, by the following vote: Yeas 30, Nays 0.

_____

Secretary of the Senate

I hereby certify that SB No. 633 passed the House on May 21, 2019, by the following vote: Yeas 141, Nays 6, one present not voting.

_____

Chief Clerk of the House

Approved:

_____

Date

_____

Governor

References

85(R) SB 292 - Senate Committee Report Version - Witness List (2017) Senate Health and Human Services Committee 85th legislature. Retrieved from: https://capitol.texas.gov/tlodocs/85R/witlistbill/pdf/SB00292S.pdf#navpanes=0

Alliance for Greater Works. (2018). ALLIANCE FOR GREATER WORKS™ RECEIVES $2.4 MILLION GRANT TO ADDRESS RURAL MENTAL HEALTH. Retrieved from https://allianceforgreaterworks.org/2018/07/11/alliance-for-greater-works-receives-2-4-million-grant-to-address-rural-mental-health/

Anheier, H. K. (2014b). State-nonprofit relations. In Nonprofit organizations: Theory, management, policy (Second Edition, pp. 429–454). Abingdon, Oxon: Routledge. Pp 440 DOI: https://doi-org.ezproxy.lib.utexas.edu/10.4324/9781315851044

Bakalinsky, R. (1982) Generic Practice in Graduate Social Work Curricula: A Study of Educators' Experiences and Attitudes, Journal of Education for Social Work, 18:3, 46-54, DOI: 10.1080/00220612.1982.10671613

Bastrop County Cares (2020) Resilient Bastrop County Initiative. Retrieved from https://www.bastropcares.org/community-resilience

Breslau, J., Marshall, G., Pincus, H., & Brown, R. (2014). Are mental disorders more common in urban than rural areas of the United States? Journal of Psychiatric Research, 56(1), 50–55. https://doi.org/10.1016/j.jpsychires.2014.05.004

Brock, J, (January 23, 2020) 2020 Census and the decline of rural Texas. Beeville Bee-Picayune Retrieved from: https://www.mysoutex.com/beeville_bee_picayune/news/census-and-the-decline-of-rural-texas/article_a191c4d8-3874-11ea-9666-f30d931df958.html

Coalition of Texans with Disabilities. (2020). ABOUT US Retrieved from https://www.txdisabilities.org/about-us

Coburn AF, MacKinney AC, McBride TD, et al. Choosing Rural Definitions: Implications for Health Policy. (Issue Brief #2). Omaha, NE: Rural Policy Research Institute Health Panel; March 2007.

Cordner, G. W., & Scarborough, K. E. (2005). Operationalizing community policing in rural America: Sense and nonsense. In Q. Thurman & E. F. McGarrell (Eds.), Community policing in a rural setting (2nd ed.). New York, NY: Routledge.

Decuir, W., Jr., & Lamb, R. (1996, October). Police response to the dangerous mentally ill. The Police Chief, pp. 99–106.

Department of State Health Services. (2014). The Mental Health Workforce Shortage in Texas. Retrieved from https://www.dshs.texas.gov/legislative/2014/Attachment1-HB1023-MH-Workforce-Report-HHSC.pdf

Downs, A., & Downs, A. (1972). Up and Down with Ecology--The "Issue-Attention Cycle." The Public Interest, 28, 38–50. Retrieved from http://search.proquest.com/docview/60883758/

Engel, R.S. and Silver, E. (2001), POLICING MENTALLY DISORDERED SUSPECTS: A REEXAMINATION OF THE CRIMINALIZATION HYPOTHESIS*. Criminology, 39: 225-252. doi:10.1111/j.1745-9125.2001.tb00922.x

Family Eldercare (2012). PHONE PROGRAM CONNECTS SENIORS TO SOCIAL LIFE. Retrieved from https://www.familyeldercare.org/phone-program-connects-seniors-social-life/.

Family Eldercare (2020). Lifetime Connections without Walls. Retrieved from https://www.familyeldercare.org/programs/lifetime-connections-without-walls/

Hammer, J. H., Vogel, D. L., & Heimerdinger-Edwards, S. R. (2013). Men's help seeking: Examination of differences across community size, education, and income. *Psychology of Men & Masculinity, 14*(1), 65–75. https://doi.org/10.1037/a0026813

Health Resource & Services Administration (2018) Defining Rural Population. Retrieved from https://www.hrsa.gov/rural-health/about-us/definition/index.html

Hogg Foundation for Mental Health (November 2018). A guide to understanding mental health systems and services in Texas. Retrieved from www.hogg.utexas.edu

Hogg Foundation for Mental Health (2018). Understanding Rural Communities. https://hogg.utexas.edu/podcast-mental-health-rural-communities

Hogg Foundation for Mental Health (2019). Five Rural Counties on a Mental Health Mission. Retrieved from https://hogg.utexas.edu/five-rural-counties.

Interim Report to the 85th Legislature House Select Committee on Mental Health (2016). Texas House of Representatives. Retrieved from: https://house.texas.gov/_media/pdf/committees/reports/84interim/Mental-Health-Select-Committee-Interim-Report-2016.pdf

Kisely, S., Campbell, L. A., Peddle, S., Hare, S., Pyche, M., Spicer, D., & Moore, B. (2010). A controlled before-and-after evaluation of a mobile crisis partnership between mental health and police services in Nova Scotia. The Canadian Journal of Psychiatry, 55(10), 662–668. doi:10.1177/070674371005501005

Kessler RC, Merikangas KR, Berglund P, Eaton WW, Koretz DS, Walters EE. 2003. Mild disorders should not be eliminated from the DSM-V. Arch. Gen. Psychiatry 60:1117–22 https://doi.org/10.1001/archpsyc.60.11.1117

Kolkhorst, Buckingham, Lucio, Perry (2019) 86(R) Enrolled SB 633. Texas Legislature retrieved 2/2/20 from https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB00633F.pdf#navpanes=0.

Kolkhorst, L. (2019). Senator Kolkhorst Files Legislation Promoting Coordination of Mental Health Services.

League of Woman Voters of Texas. Texas Positions (2018). Retrieved from https://my.lwv.org/texas/positions

Legislative Budget Board (2017) FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION RE: SB292 by Huffman (Relating to the creation of a grant program to reduce recidivism, arrest, and incarceration of individuals with mental illness.), As Passed 2nd House. Retrieved from https://capitol.texas.gov/tlodocs/85R/fiscalnotes/pdf/SB00292F.pdf#navpanes=0

Legislative Budget Board (2019) FISCAL NOTE, 86TH LEGISLATIVE REGULAR SESSION May 15, 2019 IN RE: SB633 by Kolkhorst (Relating to an initiative to increase the capacity of local mental health authorities to provide access to mental health services in certain counties.), Committee Report 2nd House, As Amended. Retrieved from: https://capitol.texas.gov/tlodocs/86R/fiscalnotes/pdf/SB00633H.pdf#navpanes=0

Levesque, J., Harris, M.F. & Russell, G. Patient-centred access to health care: conceptualizing access at the interface of health systems and populations. Int J Equity Health 12, 18 (2013). https://doi.org/10.1186/1475-9276-12-18

Lipsky, M., & Smith, S. (1989). Nonprofit Organizations, Government, and the Welfare State. Political Science Quarterly, 104(4), 625-648. Retrieved April 17, 2020, from www.jstor.org/stable/2151102

Maslach, C., & Jackson, S. E. (1981). The measurement of experienced burnout. Journal of Organizational Behavior, 2(2), 99–113. doi:10.1002/(ISSN)1099-1379

Methodist Healthcare Ministries of South Texas Inc. (2014) about. Retrieved from: http://www.mhm.org/about

Methodist Healthcare Ministries of South Texas Inc. (2019). Legislative Agenda. Retrieved from: http://www.mhm.org/library?task=document.viewdoc&id=101

Methodist Healthcare Ministries of South Texas Inc. (2019). Planning Report for the Redesign of San Antonio State Hospital and Reinvigoration of Behavioral Health Care in South Texas. Retrieved from http://www.mhm.org/library/policy-publications/san-antonio-state-hospital-report-2019.

Mohatt, D. F., Bradley, M. M., Adams, S. J., & Morris, C. D. (2006). Mental health and rural America: 1994-2005. Washington, DC: United States Department of Health and Human Services,
Health Resources and Services Administration, Office of Rural Health Policy. Retrieved from ftp://ftp.hrsa.gov/ruralhealth/RuralMentalHealth.pdf
Mettler, S. (2016). The Policyscape and the Challenges of Contemporary Politics to Policy Maintenance. Perspectives on Politics, 14(2), 369-390. doi:10.1017/S1537592716000074

Myers, Carole R. (2019) Using Telehealth to Remediate Rural Mental Health and Healthcare Disparities, Issues in Mental Health Nursing, 40:3, 233-239, DOI: 10.1080/01612840.2018.1499157

Meadows Mental Health Policy Institute (2020). MMHPI COVID Response Briefings Projected COVID-19 MHSUD Impacts, Volume 1: Effects of COVID-Induced Economic Recession (COVID Recession) – Appendix of State-Level Estimates. Retrieved from https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts-StateAppendix.pdf

National Alliance on Mental Illness (2020). Coronavirus: Mental Health Coping Strategies. Retrieved from https://www.nami.org/Blogs/NAMI-Blog/March-2020/Coronavirus-Mental-Health-Coping-Strategies

National Alliance on Mental Illness (2016). Public Policy Platform of the National Alliance on Mental Illness. Retrieved from https://www.NAMI.org/getattachment/Learn-More/Mental-Health-Public-Policy/Public-Policy-Platform-December-2016-(1).pdf

National Alliance on Mental Illness Texas. (2013). NAMI Texas Public Policy Principles Adopted 2013. Retrieved from: http://3394qh4fg22b3jpwm94480xg-wpengine.netdna-ssl.com/wp-content/uploads/sites/12/2015/01/NAMI-Texas-Public-Policy-Principles-2013-draft-revised-2_12_13.pdf

National Alliance on Mental Illness. (2016). NAMI Public Policy Platform Revised Twelfth Edition. Retrieved from https://www.nami.org/getattachment/Learn-More/Mental-Health-Public-Policy/Public-Policy-Platform-December-2016-(1).pdf

National Association of Social Workers. (1999). Code of ethics of the National Association of Social Workers. Washington, DC. NASW Press. Retrieved from https://www.socialworkers.org/about/ethics/code-of-ethics/code-of-ethics-english

Payne, M. (2002). The Politics of Systems Theory within Social Work. Journal of Social Work, 2(3), 269–292. https://doi.org/10.1177/146801730200200302

Peen, J., Schoevers, R.A., Beekman, A.T. and Dekker, J. (2010), The current status of urban-rural differences in psychiatric disorders. Acta Psychiatrica Scandinavica, 121: 84-93. doi:10.1111/j.1600-0447.2009. 01438.x

Ramsey, R. (2019) Analysis: Texas lawmakers haven't sworn off culture wars after all. Texas Tribune. Retrieved from https://www.texastribune.org/2019/04/01/texas-lawmakers-can-focus-on-meat-and-potatoes-or-chick-fil-a/

Roy, M. J., Baker, R., & Kerr, S. (2017). Conceptualizing the public health role of actors operating outside of formal health systems: The case of social enterprise. Social science & medicine (1982), 172, 144–152. https://doi.org/10.1016/j.socscimed.2016.11.009

Ruiz, J., & Miller, C. (2004). An exploratory study of Pennsylvania police officers' perceptions of dangerousness and their ability to manage persons with mental illness. Police Quarterly, 7(3), 359–371.

Rural Health Information Hub. (2018) Hub Madison Outreach and Services through Telehealth (MOST) Network. Retrieved from https://www.ruralhealthinfo.org/project-examples/856

Rural Health Information Hub. (2019). Outer Cape Health Services Community Resource Navigator Program. Retrieved from https://www.ruralhealthinfo.org/project-examples/911

SAMHSA. (2016). Rural behavioral health: Telehealth challenges and opportunities. In Brief, 9(2). Retrieved from https://store.samhsa.gov/shin/content/SMA16-4989/SMA16-4989.pdf

SAMHSA. (2016). SERIOUS MENTAL ILLNESS AMONG ADULTS BELOW THE POVERTY LINE. Retrieved from https://www.samhsa.gov/data/sites/default/files/report_2720/Spotlight-2720.html

Senate Bill 633. (2019). Texas Legislature 86th Session Retrieved from https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB00633F.pdf#navpanes=0

Silver, Johnathan (November 9, 2015) Straus Forms Select Committee on Mental Health. Retrieved from https://www.texastribune.org/2015/11/09/straus-forms-select-committee-mental-health/

Statewide Behavioral Health Coordinating Council. (2016). Statewide Behavioral Health Strategic Plan Fiscal Years 2017-2021. Retrieved from

https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf

Sullivan, G., & Spritzer, K. (1997). The criminalization of persons with serious mental illness living in rural areas. The Journal of Rural Health, 13(1), 6–13.

Stensland, M., Watson, P. R., & Grazier, K. L. (2012a). An examination of costs, charges, and payments for inpatient psychiatric treatment in community hospitals. Psychiatric Services (Washington, DC), 63(7), 666–671. https://doi.org/10.1176/appi.ps.201100402

Texas Administrative Code Health and Safety Code Title 7. Mental Health and Intellectual Disability Subtitle A. Services for Persons with Mental Illness or An Intellectual Disability Chapter 533. Powers and Duties of Department of State Health Services Subchapter A. General Powers and Duties Sec. 533.035 Retrieved from https://statutes.capitol.texas.gov/Docs/HS/htm/HS.533.htm

Texas Administrative Code Health and Safety Code Title 7. Mental Health and Intellectual Disability Subtitle A. Services for Persons with Mental Illness or An Intellectual Disability Chapter 533. Powers and Duties of Department of State Health Services Subchapter A. General Powers and Duties 534.0001 retrieved from https://statutes.capitol.texas.gov/Docs/HS/htm/HS.534.htm

Texas Catholic Conference of Bishops. (2019) 86th Legislative Session Agenda. Retrieved from https://txcatholic.org/86th-legislative-agenda-priorities/

Texas Catholic Conference of Bishops. About. Retrieved from https://txcatholic.org/about/.

Texas Commission Law Enforcement. (2019). TCOLE Licensee Training Mandates (09/01/2017- 08/31/2021). Retrieved from https://www.tcole.texas.gov/sites/default/files/documents/LTM%2001.008%20Licensee%20Training%20Mandates%2003.21.19.pdf

Texas Council of Community Centers (2016). About Us. Retrieved from https://txcouncil.com/about-us/

Texas Council of Community Centers (2016). Public Policy. Retrieved from https://txcouncil.com/public-policy/

Texas Council of Community Centers (2016). COMMUNITY CENTER TELEMEDICINE AND TELEHEALTH SURVEY retrieved from https://txcouncil.com/wp-content/uploads/2016/09/Telemedicine_Telehealth_Survey_Summary_July2016_Final.pdf

Texas Demographic Center (2017). Urban Texas Migration could become the most important phenomenon shaping Texas in the 21st century. Retrieved from: https://demographics.texas.gov/Resources/publications/2017/2017_08_21_UrbanTexas.pdf

Texas e-Health Alliance. About TeHA. Retrieved from http://txeha.org/about-teha/

Texas e-Health Alliance. Members. Retrieved from http://txeha.org/members/

Texas Freedom Caucus (2020). Members. Retrieved from https://www.freedomfortexas.com/members/

Texas Health and Human Services Commission (n.d) All Texas Access. Retrieved from : https://hhs.texas.gov/about-hhs/process-improvement/improving-services-texans/all-texas-access .

Texas Health and Human Services Commission (2019). October 23, 2019 Joint Committee on Access and Forensic Services. Retrieved from http://texashhsc.swagit.com/play/10232019-1317/

Texas Health and Human Services Commission (n.d) State Hospitals. Retrieved from https://hhs.texas.gov/services/mental-health-substance-use/state-hospitals.

Texas Health and Human Services Commission. Peer Support Services. Retrieved from: https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/peer-support-services

Texas House. (2015). Texas House Rules Retrieved from: https://tlc.texas.gov/docs/legref/HRules.pdf

Texas House Research Organization. Bill Digest SB 633 (2nd reading) Kolkhorst, et al. (Lambert) (2019). Retrieved from https://hro.house.texas.gov/pdf/ba86r/sb0633.pdf#navpanes=0

Texas House Research Organization. HB 13 Price (2017). Retrieved from https://hro.house.texas.gov/pdf/ba85r/hb0013.pdf#navpanes=0

Texas Legislative Council. District Population Analysis with County Subtotals SENATE DISTRICT 18 - PLANS172 (2015). Retrieved from https://wrm.capitol.texas.gov/fyiwebdocs/PDF/senate/dist18/r4.pdf.

Texas Legislative Council. District Population Analysis with County Subtotals SENATE DISTRICT 24 - PLANS172 (2015). Retrieved from: https://wrm.capitol.texas.gov/fyiwebdocs/PDF/senate/dist24/r4.pdf

Texas Legislative Council. District Population Analysis with County Subtotals SENATE DISTRICT 28 - PLANS172 (2015). Retrieved from https://wrm.capitol.texas.gov/fyiwebdocs/PDF/senate/dist28/r4.pdf

Texas Legislature, House Bill 13. 85th Legislature (2017), Retrieved from https://capitol.texas.gov/tlodocs/85R/billtext/pdf/HB00013F.pdf#navpanes=0

Texas Legislature, Senate Bill 1849. 85th Legislature (2017), Retrieved from https://capitol.texas.gov/tlodocs/85R/billtext/pdf/HB00013F.pdf#navpanes=0

Texas Legislature, Senate Bill 292. 85th Legislature (2017), Retrieved from https://capitol.texas.gov/tlodocs/85R/billtext/pdf/SB00292F.pdf#navpanes=0

Texas Legislature, Senate Bill 58. 83th Legislature (2013), Retrieved from https://www.capitol.state.tx.us/tlodocs/83R/billtext/html/SB00058F.htm

Texas Legislature, Senate Bill 633, 86th Legislature (2019), Retrieved from https://capitol.texas.gov/tlodocs/86R/billtext/pdf/SB00633F.pdf#navpanes=0

Texas Organization of Rural and Community Hospitals. (2017). Twenty-Five Things to Know About Texas Rural Hospitals. Retrieved 2/2/20 from https://capitol.texas.gov/tlodocs/85R/handouts/C2102017030910301/be43111d-e0d4-4de3-bc7d-935d111daced.PDF

Texas Rural Funder's Collaborative. (2018). The Future of Rural Texas: A Texas Tribune Symposium. Retrieved 2/2/20 from https://www.edtx.org/getattachment/Get-Involved/Texas-Rural-Funders-Collaborative/The-Future-of-Rural-Texas-2018_Spreads.pdf?lang=en-US

Texas Senate Committee on Health & Human Services, 86th Legislature (2019) (Testimony of Andrea Richardson). Retrieved from: https://tlcsenate.granicus.com/MediaPlayer.php?view_id=45&clip_id=13889

Texas Senate Committee on Health & Human Services, 86th Legislature (2019) (Testimony of Lee Johnson) Retrieved from: https://tlcsenate.granicus.com/MediaPlayer.php?view_id=45&clip_id=13889

Texas Senate Committee on Health & Human Services, 86th Legislature (2019). Retrieved from: https://tlcsenate.granicus.com/MediaPlayer.php?view_id=45&clip_id=13889

Texas State Library and Archives (2020). Population Estimates for Texas Counties, 2010-2017: Arranged in Descending Order. Retrieved 2/2/2020 from https://www.tsl.texas.gov/ref/abouttx/popcnty201011.html

The Arc of Texas. (2020). Mission, History, And Achievements. Retrieved from https://www.thearcoftexas.org/who-we-are/

The Promotor(a) or Community Health Worker Training and Certification Advisory Committee. (2019) 2018 Annual Report 25 Texas Administrative Code, Section 146.3 Promotor(a) or Community Health Worker Training and Certification Advisory Committee. Retrieved from https://www.dshs.texas.gov/legislative/2019-Reports/CommunityHealthWorkerAnnualReport2018.pdf

The Texas Senate. (2019) Senate Committee on Health & Human Service. Retrieved from https://senate.texas.gov/cmte.php?c=610

The Texas Senate. (2019) Senate Session. Retrieved from https://tlcsenate.granicus.com/MediaPlayer.php?view_id=45&clip_id=14194

The Texas Senate. (2019) Senator Charles Perry: District 28. Retrieved from https://senate.texas.gov/member.php?d=28&lang=en

The United States Census Bureau. (2015). Detailed Languages Spoken at Home and Ability to Speak English for the Population 5 Years and Over: 2009-2013. Retrieved from: https://www.census.gov/data/tables/2013/demo/2009-2013-lang-tables.html

The United States Department of Agriculture. (2019) Rural Classifications. Retrieved from https://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/

The University of Texas at Austin Dell Medical School. (2018). AUSTIN STATE HOSPITAL ASH Brain Health System Redesign. Retrieved from https://static1.squarespace.com/static/5bec7c0a1137a6f21d74e0ee/t/5c531f2ecd83669b42

f99056/1548951346445/Austin+State+Hospital+-+ASH+Brain+Health+System+Redesign+-+Report.pdf

The University of Texas at Austin Steve Hicks School of Social Work (2020). Lailea Noel, Ph.D. Retrieved from https://socialwork.utexas.edu/directory/lailea-noel/

United States Department of Health and Human Services Administration. (2011). Rural Behavioral Health Programs and Promising Practices. Retrieved from https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/ruralbehavioralmanual05312011.pdf.

United Ways of Texas. (2020). Raising Awareness Through Advocacy United Ways and Public Policy. (2020) Retrieved from https://www.uwtexas.org/public-policy.

United Ways of Texas. TEXAS COMMUNITIES AND THE 86TH LEGISLATIVE SESSION: A Recap Report by United Ways of Texas. Retrieved from https://www.uwtexas.org/sites/uwtexas.org/files/TX%20UWs%20Session%20Recap%20Report%20-%20FINAL.pdf

University of Wisconsin Population Health Institute, & Robert Wood Johnson Foundation. (2019). Health Factors Uninsured. Retrieved from https://www.countyhealthrankings.org/app/texas/2019/measure/factors/85/data.

Ura, Alexa. (2016). Data: Texas' top 5 poorest counties all located in the Rio Grande Valley. Texas Tribune republished in CBS Valley 4 Retrieved 2/2/2020 from https://valleycentral.com/news/local/data-texas-top-5-poorest-counties-all-located-in-the-rio-grande-valley

Vuorensyrjä, M., & Mälkiä, M. (2011). Nonlinearity of the effects of police stressors on police officer
burnout. Policing: An International Journal of Police Strategies & Management, 34(3), 382–402.

Wang PS, Berglund P, Olfson M, Pincus HA, Wells KB, Kessler RC. (2005). Failure and Delay in Initial Treatment Contact After First Onset of Mental Disorders in the National Comorbidity Survey Replication. Arch Gen Psychiatry. 2005;62(6):603–613. doi:10.1001/archpsyc.62.6.603

Ward, K. (January 21,2018) Professional navigators, fighting the winter blues. Provincetown Banner

Wilson, W., Bangs, A., & Hatting, T. (2015). The future of rural behavioral health. National Rural Health Association Policy Brief. Retrieved from https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Policy%20documents/The-Future-of-Rural-Behavioral-Health_Feb-2015.pdf

Yang, Sue-Ming & Gill, Charlotte & Kanewske, L. & Thompson, Paige. (2018). Exploring Police Response to Mental Health Calls in a Nonurban Area: A Case Study of Roanoke County, Virginia. Victims & Offenders. 13. 1132-1152. 10.1080/15564886.2018.1512540.

Ziller, E.C., Anderson, N.J. and Coburn, A.F. (2010), Access to Rural Mental Health Services: Service Use and Out-of-Pocket Costs. The Journal of Rural Health, 26: 214-224. doi:10.1111/j.1748-0361.2010.00291.x