TEXOMA

Behavioral Health Community Needs Assessment

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MEADOWS MENTAL HEALTH POLICY INSTITUTE

tbhlt | Texoma Behavioral Health LEADERSHIP TEAM

Contents

Acknowledgements

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Executive Summary

In this Executive Summary, we highlight key findings and recommendations from our assessment. This final report integrates feedback that we received on the draft reports in March and December 2020 and incorporates the latest available prevalence data.

In addition to the data analysis described in the report, we interviewed nearly 80 leaders and other community members in the course of our assessment. These individuals included stakeholders from the criminal justice system, health systems, behavioral health services providers, school districts, philanthropic organizations, the local public college, the court system, and the juvenile justice system; county and city elected officials; and people with lived experience of mental illness. In every case, we found people to be forthcoming about gaps in services and opportunities to improve mental health care in Fannin and Grayson counties.

Organization of the Report and Summary of Key Findings and Recommendations

This Executive Summary is designed to provide the reader with a succinct overview of our key findings and recommendations.

Our guiding principle is that the traditional approach of treating the mind and body separately has led to inadequate and often inappropriate care for people with mental illnesses; an overuse of jails, emergency departments, and hospital beds; and a treatment approach for adults with serious mental illnesses and children and youth with serious emotional disturbances that stands in sharp contrast to the integrated care provided to people with complex physical health needs. Care for mental illness should be the same as care for physical illness, unless clinical needs or public safety warrants a specialty approach, with integration of care as the norm and not simply a goal. In Fannin and Grayson counties, as in communities throughout Texas, care for mental illnesses remains fragmented, but we provide strategies throughout our report that can lead to integrated care.

We begin with a discussion of the advantages in Grayson and Fannin counties, particularly through the leadership of the Texoma Behavioral Health Leadership Team, and important contextual factors that are shaping the future of mental health care in each county. Then, to understand the size of the population in need, we provide prevalence figures and comments regarding opportunities to target the relatively small population of people in each county who require the most intensive services, while noting that most people in each county can be treated in primary care settings.

Critical Advantages and Contextual Factors in Fannin and Grayson Counties

Through the leadership of the Texoma Behavioral Health Leadership Team, Grayson and Fannin counties have a unique opportunity to continue transforming the mental health systems in both

counties and throughout the region. The COVID-19 pandemic, and its impact on the region's health system and the mental health of the residents of each county, adds to the urgency of taking advantage of this opportunity. To do so will require a commitment to treating mental illness like a physical illness.

This report is designed to a provide a framework for the Texoma Behavioral Health Leadership Team to take concrete steps to continue its transformational work. We strongly believe that the best mental health care is provided in an integrated health care system and that, as with all illnesses, the earlier we can identify and treat mental illnesses, the better. This will require continued changes in the response to mental health crises by expanding and, in some cases, creating services that evidence shows can reduce hospitalizations and jail bookings. It requires continued leadership by the Texoma Behavioral Health Leadership Team; clinical leadership is essential to making this transformation, and it also requires attention and support across systems.

Although both Fannin and Grayson counties have gaps in treatment capacity (discussed in detail in the report), they also have critical advantages that create opportunities for continued improvement. These advantages include the following:

- There is strong leadership from the Texoma Behavioral Health Leadership Team, which recognizes that mental health care is a major issue and has championed this issue since its inception. The two counties also benefit from the leadership and support of the Texoma Health Foundation.
- Resources such as the University of Texas Southwestern Medical Center can play a major role in advancing integrated care, particularly for children and youth, through initiatives such as the Texas Child Health Access Through Telemedicine (TCHATT) program and the Child Psychiatry Access Network (CPAN) created by the Texas Legislature during the 86th Regular Session in 2019.

Scope of Assessment

We conducted a behavioral health needs assessment of Fannin and Grayson counties – and their local capacity to meet identified needs – from April 2019 through November 2019. We were asked to provide a targeted and focused assessment that included analysis of the following factors:

- Review of the current literature on behavioral health best practices,
- Collection and analysis of data gathered through stakeholder interviews and other methods and sources,
- Analysis of sample service providers' interactions with people with behavioral health disorders to identify barriers to accessing services at different parts of the service delivery system,

- Analysis of resident need compared to system capacity in various sectors of the service delivery system,
- Analysis of the quantity/capacity and quality of existing services compared to state and national data, and
- Development of quantified and practical recommendations prioritized for implementation.

In addition to the general review of current capacity, gaps in services, and opportunities for system integration and improvement, we focused, as requested, on the behavioral health needs of the area's adults, youth, and children and the intersection of the criminal justice and behavioral health care systems. Our findings and recommendations are organized into two areas of focus: (1) Needs and Services for Adults, including the Crisis and Justice Systems; and (2) Needs and Services for Children and Youth. The scope of this assessment did not include a detailed review of specific systems such as child welfare and juvenile justice.

Methodology

For this report, we interviewed nearly 80 leaders and community members in key positions who had important perspectives to share on the functioning of the current behavioral health care system. These interviews included stakeholders from the criminal justice system, health systems, behavioral health services providers, school districts, philanthropic organizations, the local public college, the court system, and the juvenile justice system; county and city elected officials; and people with lived experience of mental illness.

Our analysis of community demographics relied on several publicly-available data sets. We obtained demographic and population data from the U.S. Census Bureau's 2017 American Community Survey. Data on the number of veterans in Fannin and Grayson counties, and future growth projections for this population, came from the U.S. Department of Veterans Affairs. Population growth projections for adults, children, and youth were obtained from the Texas Demographic Center.

Summary of Findings and Recommendations

Our findings regarding the adult population include the following:

- With an estimated 3,700 adults with serious mental illness (SMI) living in poverty in the region, of whom many may not have the resources to obtain behavioral health care, there are adults in the region who are not receiving adequate treatment.
- There is a need to increase high-quality intensive outpatient services such as Assertive Community Treatment (ACT), with fidelity to the cutting-edge Tool for Measurement of Assertive Community Treatment, for adults with complex needs in Fannin and Grayson counties.

- Supporting the previous finding, adding intensive outpatient capacity such as ACT for people with severe needs may further reduce the need for additional inpatient or residential psychiatric treatment beds.
- Based on the availability of inpatient psychiatric beds on most days in the year, and the use of many of the current beds by residents of counties outside the region, it does not appear that there is a shortage of inpatient capacity in Fannin and Grayson counties. Very few residents of Fannin and Grayson counties are sent to state hospitals.
- Despite the general availability of inpatient beds, people without insurance may not be able to access them.

Our findings and recommendations for crisis, law enforcement, and the justice systems include the following:

- Texoma Community Center (the local mental health authority) leadership noted that one significant limitation for people with mental illnesses who are involved with the criminal justice system is that those who are placed in forensic beds might be better treated in the community with enhanced services such as Forensic Assertive Community Treatment (FACT). Although a full FACT team may not be feasible for Texoma Community Center at this time, additional steps should be taken to help the team integrate a FACT model component within the ACT team. This would include closely coordinating services with community supervision and implementing Risk-Need-Responsivity principles,[64] which would entail assessing and reducing various aspects of criminogenic risk – criminal thinking, substance use, and associating with criminal companions, for example – by matching interventions to each person's specific constellation of risk factors.
- With further specificity and agreement between Grayson County and Texoma Community Center, realigning the dedicated jail coordinator and the ACT team would provide more optimal pre- and post-booking case management services.
- As the next step beyond Grayson County Sheriff's Office and Texoma Community Center's project funded by the Texas Health and Human Services Commission's Community Mental Health Grant (House Bill 13, 85th Regular Session, consider integrating mobile telehealth into first responder vehicles that would be connected to Texoma Community Center's mobile crisis outreach team, in lieu of adding law enforcement officers to stabilize mental health crises. Find ways to encourage more medically-facing interventions for mental health crises.
- There is an opportunity (and need) for local law enforcement agencies to substantially improve their use of data.
- Law enforcement officers should continue to receive more advanced mental health training.
- County and city dispatch centers should provide mental health training for call takers.

- A community stakeholder group should identify and provide appropriate resource materials for law enforcement officers and the community.
- Communities should capitalize and expand on innovative programs.

Our findings regarding services for children and youth include the following:

- Based on our stakeholder interviews, it appears that there is a shortage of mental health service providers for children, youth, and their families in Fannin and Grayson counties.
- In addition to a shortage of mental health providers, there is also a lack of other needed providers. In Fannin County, in particular, the Texas Department of State Health Services reported that in 2018, there were no pediatricians in the county.
- There is a gap between the number of children and youth who need intensive services and the number who receive them.
- Universally, stakeholders we interviewed identified stigma as a barrier to accessing mental health treatment or support.

Across the five components of a comprehensive framework of care for children and youth – based on current system realities combined with tangible opportunities to strengthen the reach and quality of services – we offer the following recommendations:

- Life in the Community, Component 0
  - Fannin and Grayson counties have undertaken initiatives to address stigma, including the Okay to Say campaign. Although this campaign has increased awareness of mental health needs and resources, the region should build upon these efforts to increase its reach.
  - Ensure that school districts obtain the knowledge to effectively recognize the signs and symptoms of mental health needs and crises, which will help students access appropriate services and supports more quickly.
- Integrated Behavioral Health Care, Component 1
  - Fannin and Grayson counties should take full advantage of the opportunity to establish and expand integrated care efforts by expanding the use of psychiatric consultation through the regional Child Psychiatry Access Network's hub at the University of Texas Southwestern Medical Center, which was established by Senate Bill (SB) 11 (86th Regular Session).
  - Improve early detection and support for emerging and low-to-moderate pediatric mental health needs by establishing pediatric integrated care programs (cross-system recommendation).
- Specialty Behavioral Health Care, Component 2
  - Continue the intentional efforts to improve the referral process to better match children, youth, and their families to needed services through efforts such as Here for Texas.

  - Improve access to providers by forming strategic partnerships between child serving systems (cross-system recommendation).
- Rehabilitation and Intensive Services, Component 3
  - Expand the availability of intensive, evidence-based services and supports to prevent inpatient hospitalizations and crisis events (cross-system recommendation).
- Crisis Care Continuum, Component 4
  - After approval from the Sherman City Council in February 2019, Carrus Behavioral Hospital opened a new 28-bed child and adolescent behavioral health treatment facility that provides 24-hour inpatient behavioral care for children and youth ages five through 17. As the region integrates Carrus Behavioral Hospital into the service delivery system, it will be important to develop relationships between this provider and other providers to facilitate needed step-down services as children and youth transition from inpatient care back to their homes and communities.

Behavioral Health Needs Assessment for Fannin and Grayson Counties

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- Review of the current literature on behavioral health best practices,
- Collection and analysis of data gathered through stakeholder interviews and other methods and sources,
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- Analysis of resident need compared to system capacity in various sectors of the service delivery system,
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In addition to the general review of current capacity, gaps in services, and opportunities for system integration and improvement, we focused, as requested, on the behavioral health needs of the area's adults, youth, and children and the intersection of the criminal justice and behavioral health care systems. Our findings and recommendations are organized into two areas of focus: (1) Services for Adults, including the Crisis and Justice Systems; and (2) Services for Children and Youth Services. The scope of this assessment did not include a detailed review of specific systems such as child welfare and juvenile justice.

Framing Our Findings and Recommendations

Several principles guided our needs assessment:

- Identification and treatment of mental illness should occur as soon as possible after symptoms emerge and should be provided, whenever possible, in the general health care system, from the initial response to a crisis through the use of outpatient and inpatient care, with specialty care reserved for those whose needs cannot be addressed by the general health care system. In practice, this means that traditional reliance on law enforcement response to mental health crises should be shifted, to the degree possible, to the medically-facing response used for all other health crises.
- Many people with diagnoses of mental illnesses have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses such as depression that can compromise care. Given this, emergency

assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and treat both physical and mental health conditions.

- It is particularly important to identify and provide treatment for children, youth, and families as soon as possible because untreated mental illnesses and emotional disturbances can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.

No community in Texas or the nation has a system that seamlessly incorporates all of these principles. Like most communities, the need for mental health care in Fannin and Grayson counties is often identified by law enforcement at the point of crisis and delivered primarily by specialists responding to a crisis. This reliance on law enforcement occurs routinely only with mental health crises, and not with physical health crises. Mental health care is fragmented and segregated in many instances from the health care system. Too often, the mental health system in Fannin and Grayson counties, as in much of Texas, looks like the system depicted in the current mental health system diagram in the following figure (Figure 1), when it should look as much as possible like the system depicted in the second – and ideal – mental health system diagram (Figure 2).

Figure 1: The Current Mental Health Care System

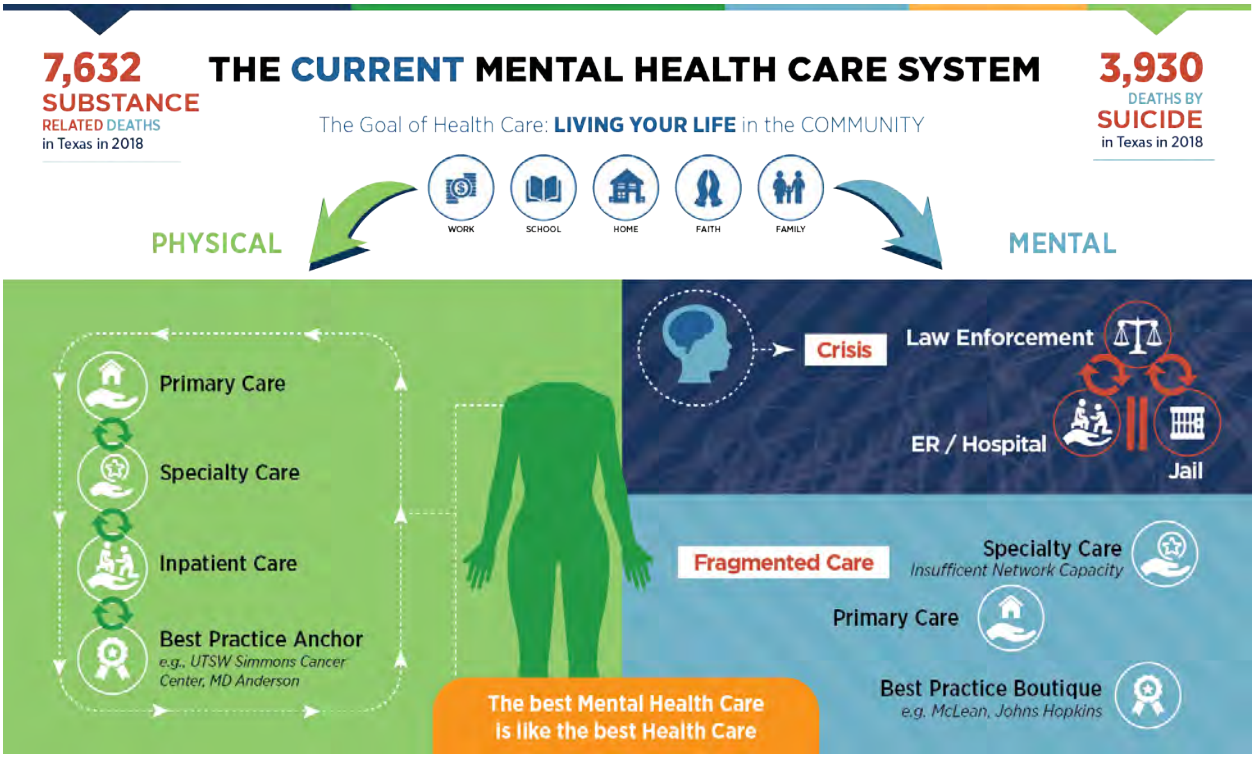
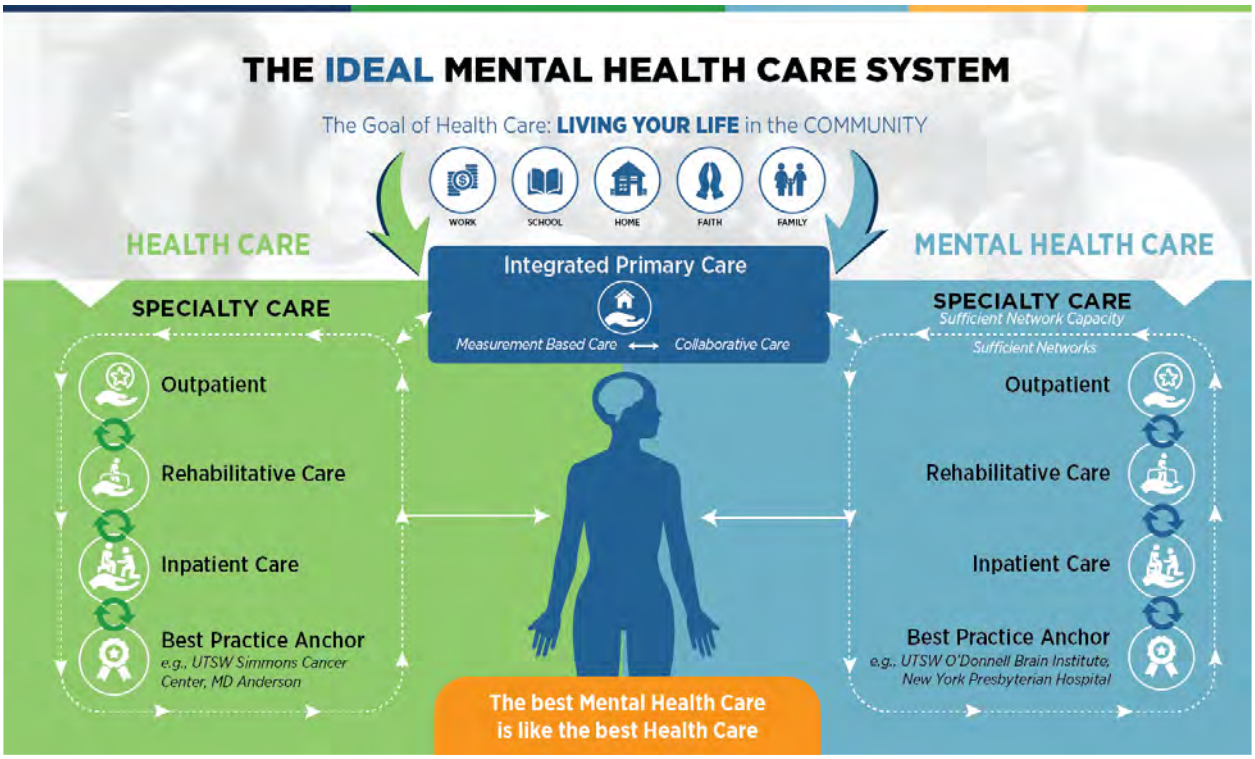


Figure 2: The Ideal Mental Health System



Contextual Issues Affecting Mental Health Care in Fannin and Grayson Counties

Community leadership is committed to transforming mental health care in Fannin and Grayson counties

As noted in the Executive Summary, Fannin and Grayson counties have several important advantages as they examine mental health care for its residents. None is more important than the Texoma Behavioral Health Leadership Team. In our interviews with stakeholders, many respondents expressed strong appreciation for the work that the Texoma Behavioral Health Leadership Team has done in working to improve mental health care in Fannin and Grayson counties. The two counties also benefit from the leadership and support of the Texoma Health Foundation, which has launched and encouraged a number of initiatives: Mindfulness at Work Initiative, Youth Aware of Mental Health (YAM, University of Texas Southwestern Medical Center) in the Bonham Independent School District, the Hope Squad (a peer-to-peer suicide prevention program for students), and the Texoma Health Foundation Park.[1]

Social Determinants of Health in Fannin and Grayson Counties

Traditionally, communities often have looked at health care, including mental health care, as a function of the resources available to provide care. Although those resources are critically

[1] Texoma Health Foundation. (2019). *Some of our favorite things: July 2018–June 2019*. https://texomahealth.org/wp-content/uploads/2020/02/FINAL-2018-2019-Annual-Report-email.pdf

important, the social determinants of health and the community context in which people live also have an impact on health, development, and morbidity. The social determinants of health are the conditions in which people are born, grow, live, work, and age.[2]

One way to capture data about these social determinants of health is through the County Health Rankings and Roadmaps (CHRR), a collaboration between the University of Wisconsin Population Health Institute and the Robert Wood Johnson Foundation. The CHRR uses a model of community health that is based on the factors that influence how long and well people live, and uses more than 30 measures that examine health outcomes (length of life and quality of life) and the health factors (health behaviors – 30%, clinical care – 20%, social and economic factors – 40%, and physical environment – 10%) that will affect health in the future.[3]

On overall health outcomes, Fannin County ranked in the bottom third (173rd) of the 244 Texas counties that have rankings in the CHRR.[4] The county's more favorable CHRR rankings compared to other Texas counties included social and economic factors (52nd), quality of life indicators (67th), health factors (103rd), and physical environment (118th). Its CHRR rankings that may warrant attention compared to other Texas counties included length of life (222nd), health behaviors (160th), and clinical care (158th).[5] The CHRR also provided "areas of strength" and "areas to explore" for Fannin County. The most notable areas to explore included (1) preventable hospital stays, which is the rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees – this was 6,735 per 100,000 people for Fannin County, compared to 5,011 per 100,000 for the state of Texas and 2,761 for the top performing counties in the United States; and (2) the ratio of population to primary care physicians, which was 4,920:1 for Fannin County compared to 1,640:1 for the state of Texas and 1,030:1 for the top performing counties in the United States[6]

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[2] World Health Organization. (n.d.). *About social determinants of health*. http://www.who.int/social_determinants/sdh_definition/en/

[3] University of Wisconsin Population Health Institute. (2020). *County health rankings model*. https://www.countyhealthrankings.org/explore-health-rankings/measures-data-sources/county-health-rankings-model

[4] University of Wisconsin Population Health Institute. (2020). *Fannin (FAN) County, Texas. County health rankings & roadmaps*. Retrieved June 5, 2020, from https://www.countyhealthrankings.org/app/texas/2020/rankings/fannin/county/outcomes/overall/snapshot

[5] University of Wisconsin Population Health Institute. (2020). *Fannin (FAN) County, Texas. County health rankings & roadmaps*.

[6] University of Wisconsin Population Health Institute. (2020). *Fannin (FAN) County, Texas. County health rankings & roadmaps*.

On overall health outcomes, Grayson County ranked at the bottom of the top half (120th) of the 244 Texas counties that have rankings in the CHRR.[7] The county's more favorable CHRR rankings compared to other Texas counties included social and economic factors (55th), clinical care (89th), health factors (90th), and quality of life indicators (93rd). Its CHRR rankings that may warrant attention compared to other Texas counties included physical environment (174th), length of life (157th), and health behaviors (134th).[8] The CHRR also provided "areas of strength" and "areas to explore" for Grayson County. The most notable area to explore was preventable hospital stays, which is the rate of hospital stays for ambulatory care-sensitive conditions per 100,000 Medicare enrollees – this was 7,234 per 100,000 people for Grayson County compared to 5,011 per 100,000 for the state of Texas and 2,761 for the top performing counties in the United States. [9]

Demographics and Prevalence Data for Fannin and Grayson Counties

The populations of adults, veterans, and children and youth each have distinct but overlapping behavioral health needs and systems of care that address those needs. The capacity needed in each system is determined by the number of people with behavioral health needs, which in turn changes with the size of each population. For this reason, we begin our analysis with demographic descriptions of the adult, veteran, and children and youth populations and the projected growth rates for each. Because people living in poverty often have higher rates of behavioral health needs and are dependent on the publicly-funded behavioral health care system, we provide additional data on the number of people living in poverty within each group, and the number of these people with the most severe mental illnesses.

Our analysis of community demographics relied on several publicly-available data sets. We obtained demographic and population data from the U.S. Census Bureau's 2018 American Community Survey. Data on the number of veterans and future growth projections for this population came from the U.S. Department Veterans Affairs. Population growth projections for adults, children, and youth were obtained from the Texas Demographic Center. We organized these tables to align with the order of this report's chapters, with Tables 1 through 7 presenting data on adults, Tables 8 through 10 covering veterans, and Tables 11 through 15 summarizing the data on children and youth.

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[7] University of Wisconsin Population Health Institute. (2020*). Grayson (GRY) County, Texas. County health rankings & roadmaps*. Retrieved June 5, 2020, from https://www.countyhealthrankings.org/app/texas/2020/rankings/grayson/county/outcomes/overall/snapshot

[8] University of Wisconsin Population Health Institute. (2020). Grayson (GRY) County, Texas. *County health rankings & roadmaps*.

[9] University of Wisconsin Population Health Institute. (2020). Grayson (GRY) County, Texas. *County health rankings & roadmaps*.

The Adult Demographics Tables (1-7, on the following pages) detail 2018 population estimates from both the Texas Demographic Center and the American Community Survey,[10] by demographic group, for Fannin and Grayson counties. All Texas population estimates were rounded to reflect uncertainty in the underlying population estimates from the Texas Demographic Center and the American Community Survey. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Table 1 includes a summary of these estimates for both counties and, for comparison, aggregated estimates for the state of Texas (see Table A in Appendix F for a breakdown of demographic percentages for Fannin and Grayson counties separately). In 2018, there were more than four times as many adults in Grayson County (about 100,000) as there were in Fannin County (about 25,000). To maintain consistency throughout this report, we will refer to the total adult population of Fannin and Grayson counties as 125,000, and the total population of children and youth as 25,000 (totaling 150,000 residents in 2018).

As compared to Texas in aggregate, the region's age distribution skewed towards an older population, with nearly one quarter of all adults over the age of 64. Half of the adults in the region were between the ages of 35 and 64, and 11% were young adults between the ages of 18 and 24. In contrast, for Texas in aggregate, only 17% of the adult population was over the age of 64 and 6% were between the ages of 18 and 24.

The vast majority of the population in the region was non-Hispanic White (80%) compared to a smaller non-Hispanic White population (43%) in Texas overall. About 11% of the population was Hispanic or Latino, with smaller populations of adults from other race and ethnicity categories (including Black/African American, Asian American, and those identifying as multiple races). Texas in aggregate had a larger Black/African American and Hispanic or Latino population (11% and 34%, respectively).

[10] The U.S. Census combined Fannin and Grayson counties in order to perform demographic sampling. Therefore, we provide population data from both the American Community Survey and the Texas Demographic Center, the latter of which can distinguish between Fannin and Grayson counties. The population estimates often differ between these two data sources. The two data sources were in agreement about the total child population.

Table 1: Demographics of Adults in Fannin and Grayson Counties (2018)[11,12]

Adult Population	Texas	Fannin	Grayson
Total Adult Population	20,600,000	25,000	100,000
Age			
18–20	1,200,000	1,000	5,000
21–24	1,600,000	2,000	6,000
25–34	4,100,000	4,000	15,000
35–44	3,750,000	4,000	15,000
45–54	3,500,000	4,000	15,000
55–64	3,100,000	5,000	20,000
65 and older	3,350,000	6,000	25,000
Sex			
Male	10,150,000	15,000	50,000
Female	10,450,000	15,000	55,000
Race / Ethnicity			
Non-Hispanic White	9,500,000	20,000	80,000
Black/African American	2,450,000	1,000	5,000
Asian American	1,000,000	300	1,000
Multiple Races	360,000	500	2,000
Hispanic/Latino	7,350,000	3,000	10,000

Among all adults in Fannin and Grayson counties, just under one in three lived in poverty in 2018. However, as Table 2 shows, these rates differed among demographic groups, which provides important information regarding potential need of services from the public behavioral health system. Among all adults in Fannin and Grayson counties, slightly more females than males lived in poverty. About one quarter (26%) of all non-Hispanic White residents lived in poverty, compared to about half of Black/African American and Hispanic residents at 46% and 48% respectively. In Fannin and Grayson counties, nearly 40% of young adults ages 18 to 24 lived in poverty in 2018, which was slightly lower than the Texas poverty rate for this same age range. Additionally, approximately one third of adults in Fannin and Grayson counties over the

[11] All Texas population estimates were rounded to reflect uncertainty in the underlying Texas Demographic Center population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[12] Population estimates from Texas Demographic Center. (2018) *Texas Population Estimates Program – age, sex, and race/ethnicity for state and counties [excel file].* https://demographics.texas.gov/Data/TPEPP/Estimates/

age of 25 experienced poverty (ranging from 24% for people between the ages of 55 to 64 to as high as 39% for people between the ages of 21 and 24).

Table 2: Demographic Comparison of Adults Living in Fannin and Grayson Counties Compared to Texas Statewide (2018)

Population	Texas			Fannin and Grayson Counties		
	Percentage of Total Population	Percentage of Total Poverty	Poverty Rate[13]	Percentage of Total Population	Percentage of Total Poverty	Poverty Rate
Age						
18–20	6%	8%	42%	5%	6%	34%
21–24	8%	11%	44%	6%	9%	39%
25–34	20%	22%	34%	16%	19%	36%
35–44	18%	18%	31%	15%	16%	30%
45–54	17%	14%	25%	17%	14%	25%
55–64	15%	12%	25%	18%	15%	24%
65 Years and Older	16%	15%	30%	23%	21%	27%
Sex						
Male	49%	44%	28%	49%	42%	25%
Female	51%	56%	34%	51%	58%	33%
Race / Ethnicity						
Non-Hispanic White	47%	31%	21%	80%	70%	26%
Black/African American	12%	14%	37%	5%	8%	46%
Asian American	5%	4%	24%	1%	1%	29%
Native American	0%	0%	30%	1%	1%	31%
Multiple Races	1%	1%	29%	2%	2%	26%
Hispanic/Latino	35%	50%	45%	11%	18%	48%
Total Population			**31%**			**29%**

Compared to statewide estimates, Fannin and Grayson counties had slightly lower rates of poverty overall, and the distribution of poverty rates by age and sex were equal to—or lower than—statewide estimates. Most racial and ethnic groups in Fannin and Grayson counties had

[13] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

slightly higher rates of poverty than in Texas statewide, but because the population of non-Hispanic Whites (which also had one of the lowest poverty rates) made up the majority of the population, the overall poverty rate for the region was lower than the statewide rate. Black/African Americans living in Fannin and Grayson counties appeared to be particularly vulnerable, as more than half (46%) of this population was living in poverty compared to only 37% of Black/African Americans in Texas statewide.

Tables 3 and 4 below provide the estimated number of people, by category, in Fannin and Grayson counties separately, broken out by total population, population with serious mental illness (SMI), poverty, and both poverty and SMI in 2018. Across both Fannin and Grayson counties, an estimated 6,000 adults are living with SMI, with 3,700 of these individuals additionally living in poverty. There are more female adults living with SMI compared to males in both counties (total of 3,700 compared to 2,600, respectively). Although the age distribution was skewed toward older populations, because the rate of SMI varied by age, the number of people with SMI was disproportionately lower at each end of the age distribution (18–24 years and 65 years and older). This association was true for both Fannin and Grayson counties.

Table 3: Population of Adults with Serious Mental Illness (SMI) in Fannin County (2018)[14,15]

Fannin County	Total Adult Population	Total Adult Population with Serious Mental Illness (SMI)	Total Adult Population in Poverty[16]	Total Adult Population with SMI in Poverty
Adult Population	25,000	1,000	8,000	700
Age				
18–20	1,000	30	400	10
21–24	2,000	90	600	50
25–34	4,000	300	1,000	200
35–44	4,000	300	1,000	200
45–54	4,000	300	1,000	100
55–64	5,000	200	1,000	90
65 and older	6,000	100	2,000	50

[14] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[15] The U.S. Census combined the two counties in order to perform demographic sampling. Therefore, the two counties had the same estimated proportions for poverty, age, race, and sex, even though in Grayson County's adult population was about four times as large as Fannin County's population in 2019 (100,000 compared to 25,000).

[16] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

Fannin County	Total Adult Population	Total Adult Population with Serious Mental Illness (SMI)	Total Adult Population in Poverty[16]	Total Adult Population with SMI in Poverty
Sex				
Male	15,000	600	3,000	200
Female	15,000	700	4,000	500
Race / Ethnicity				
Non-Hispanic White	20,000	1,000	5,000	500
Black/African American	1,000	100	600	60
Asian American	300	<10	100	<6
Native American	200	10	70	<10
Multiple Races	500	20	100	10
Hispanic/Latino	3,000	200	1,000	100

Table 4: Population of Adults with Serious Mental Illness (SMI) in Grayson County (2018)[17]

Grayson County	Total Adult Population	Total Adult Population with SMI	Total Adults in Poverty[18]	Total Adults with SMI in Poverty
Adult Population	100,000	5,000	30,000	3,000
Age				
18–20	5,000	100	2,000	50
21–24	6,000	300	2,000	200
25–34	15,000	1,000	6,000	600
35–44	15,000	1,000	4,000	600
45–54	15,000	1,000	4,000	500
55–64	20,000	600	4,000	300
65 and older	25,000	400	6,000	200
Sex				
Male	50,000	2,000	10,000	800
Female	50,000	3,000	15,000	2,000

[17] Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.
[18] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

Grayson County	Total Adult Population	Total Adult Population with SMI	Total Adults in Poverty[18]	Total Adults with SMI in Poverty
Race / Ethnicity				
Non-Hispanic White	80,000	4,000	20,000	2,000
Black/African American	5,000	400	2,000	200
Asian American	1,000	30	400	20
Native American	900	50	300	30
Multiple Races	2,000	90	500	50
Hispanic / Latino	10,000	600	5,000	400

Projected Population Growth Among Adults in Fannin and Grayson Counties

Tables 5 and 6 show the projected population of adults who will be living in Fannin and Grayson counties through 2050. Although the overall population is expected to decrease slightly by 2050 (–5%), this is mostly due to a decrease in the population of adults ages 18 to 64 years, whereas the population of older adults ages 65 and older is expected to increase. Although the Fannin County population ages, fewer people in younger age groups are remaining or moving to the area to replace the aging cohort of adults.

Table 5: Estimated Population of Adults in Fannin County (2020–2050)[19]

Year	All Adults		Adults Ages 18 to 64		Older Adults Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**26,103**		**19,829**		**6,274**	
2025	26,308	1%	19,265	-3%	7,042	12%
2030	26,158	0%	18,606	-6%	7,551	20%
2035	25,999	0%	18,371	-7%	7,627	22%
2040	25,743	-1%	18,328	-8%	7,414	18%
2045	25,344	-3%	18,223	-8%	7,122	14%
2050	24,897	-5%	17,977	-9%	6,920	10%

[19] Texas Demographic Center. (2018).

In Grayson County (Table 6), the adult population is expected to grow by 17% through 2050. The population of older adults ages 65 and older is expected to grow by 35%, whereas the population of adults ages 18 to 64 years is expected to grow by just 11%.

Table 6: Estimated Population of Adults in Grayson County (2020–2050)[20]

Year	All Adults		Adults Ages 18 to 64		Older Adults Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**99,985**		**75,921**		**24,064**	
2025	103,902	4%	76,223	<1%	27,679	15%
2030	107,446	7%	76,886	1%	30,560	27%
2035	110,433	10%	78,852	4%	31,581	31%
2040	113,047	13%	81,013	7%	32,034	33%
2045	115,249	15%	83,393	10%	31,856	32%
2050	117,176	17%	84,649	11%	32,527	35%

Although Fannin and Grayson counties will have a much slower population growth overall than Texas statewide (Table 7),[21] the counties will experience demographic shifts toward an older population from now until the year 2050, just as we expect throughout the rest of the state. The need for behavioral health services for older adults is likely to increase disproportionately, compared to other age groups.

Table 7: Estimated Population of Adults in Texas (2020–2050)[20]

Year	All Adults		Adults Ages 18 to 64		Older Adults Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**21,385,556**		**17,759,807**		**3,625,748**	
2025	23,404,336	9%	18,997,244	7%	4,407,092	22%

[20] Texas Demographic Center. (2018).

[21] The United States Census Bureau (2010–2019) cumulative estimates of resident population change indicate that Fannin and Grayson counties have experienced positive population growth in the past, with Grayson County, in particular, experiencing substantial population growth over the past decade. However, the U.S. Census Bureau does not maintain projection algorithms that would allow us to anticipate what the populations of counties may be several decades from now. Therefore, we relied on the Texas Demographic Center's population projections to assess growth.

Year	All Adults		Adults Ages 18 to 64		Older Adults Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2030	25,473,652	19%	20,305,247	14%	5,168,405	43%
2035	27,638,868	29%	21,852,605	23%	5,786,263	60%
2040	29,959,393	40%	23,556,041	33%	6,403,352	77%
2045	32,477,496	52%	25,490,926	44%	6,986,570	93%
2050	35,226,196	65%	27,527,399	55%	7,698,797	112%

Veteran Demographics

Table 8 shows the overall population of Fannin County, Grayson County, and Texas statewide in 2018, with breakouts for the population of veterans by age and sex. The table shows that three times as many veterans lived in Grayson County compared to Fannin County (9,000 versus 3,000, respectively), which is due to the variation in populations between these two counties. The population of veterans in Fannin and Grayson counties are predominantly older (ages 65 to 84) and male.

Table 8: Demographics of Veterans in Fannin and Grayson Counties (2018)[22]

Population Demographics	Fannin County	Grayson County	Texas Statewide
Total Veteran Population	3,000	9,000	1,500,000
Population by Sex			
Male	2,700	9,000	1,500,000
Female	200	700	200,000
Population by Age			
17–44	400	1,800	400,000
45–64	800	3,000	550,000
65–84	1,300	4,000	550,000
85 Years and Older	300	600	100,000

[22] National Center for Veterans Analysis and Statistics. (2019). *Veteran population by county*. https://www.va.gov/vetdata/veteran_population.asp

Projected Population Growth of Veterans

The National Center for Veterans Analysis and Statistics provides actuarial population projections through the next 30 years. Tables 9 and 10 show projected populations of veterans living in Fannin and Grayson counties through the year 2045. The overall veteran population in Fannin and Grayson counties is expected to decline by more than 30% by the year 2045.

Projections by age and sex are also included as sub-categories. The population of male and female veterans under the age of 65 is expected to decline. Similarly, the population of male veterans at or above age 65 is also expected to decline – with 46% fewer male veterans in Fannin County and 37% fewer male veterans in Grayson County ages 65 and older.

However, unlike all other demographic groups in this analysis, the population of older female veterans (ages 65 and older) is expected to substantially increase relative to the 2018 population. In Fannin County, the population is expected to double (a 108% increase) and the population in Grayson County is expected to increase by 79%. Although the percentage of female veteran populations is expected to increase substantially, this increase does not represent a large population since the overall population of female veterans in these counties is small to begin with; it is expected that there will be about 70 more female veterans in Fannin County and 100 more female veterans in Grayson County in the oldest cohort by the year 2045.

Table 9: Estimated Population of Veterans in Fannin County (2020–2045)[23,24,25]

Fannin County	All Ages		Veterans Ages 17 to 64		Veterans Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
Male Veterans						
2020	3,000	—	1,000	—	2,000	—
2025	2,000	-8%	1,000	-12%	1,000	-5%
2030	2,000	-8%	900	-7%	1,000	-8%
2035	2,000	-9%	900	-5%	1,000	-12%
2040	2,000	-9%	800	-1%	1,000	-16%
2045	2,000	-9%	800	0%	900	-17%

[23] Texas Demographic Center. (2018).

[24] Veteran population estimates were rounded to reflect uncertainty in the Texas Demographic Center estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[25] All percentages were based on unrounded values.

Fannin County	All Ages		Veterans Ages 17 to 64		Veterans Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
Female Veterans						
2020	200	—	100	—	80	—
2025	200	10%	100	2%	100	23%
2030	200	8%	100	3%	100	14%
2035	300	5%	100	-2%	100	12%
2040	300	2%	100	-2%	100	6%
2045	300	0%	100	-5%	100	5%
Total Veterans						
2020	3,000	—	1,000	—	2,000	—
2025	3,000	-6%	1,000	-10%	2,000	-4%
2030	3,000	-7%	1,000	-6%	1,000	-7%
2035	2,300	-7%	1,000	-4%	1,000	-10%
2040	2,000	-8%	1,000	-1%	1,000	-14%
2045	2,000	-8%	1,000	-1%	1,000	-14%

Table 10: Estimated Population of Veterans in Grayson County (2018–2045)[26, 27, 28]

Grayson County	All Ages		Veterans Ages 17 to 64		Veterans Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
Male Veterans						
2020	9,000	—	4,000	—	4,000	—
2025	8,000	-6%	4,000	-10%	4,000	-2%
2030	7,000	-7%	3,000	-6%	4,000	-9%
2035	7,000	-8%	3,000	-6%	4,000	-9%
2040	6,000	-8%	3,000	-4%	3,000	-12%
2045	6,000	-8%	3,000	-2%	3,000	-13%

[26] Texas Demographic Center. (2018).

[27] Veteran population estimates were rounded to reflect uncertainty in the Texas Demographic Center estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[28] All percentages were based on unrounded values.

Grayson County	All Ages		Veterans Ages 17 to 64		Veterans Ages 65 and Older	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
Female Veterans						
2020	700	—	600	—	200	—
2025	700	0%	500	-11%	300	32%
2030	700	-1%	500	-8%	300	12%
2035	700	-2%	400	-10%	300	10%
2040	700	-4%	400	-10%	300	4%
2045	700	-5%	300	-8%	300	-2%
Total Veterans						
2020	9,000	—	5,000	—	5,000	—
2025	9,000	-5%	4,000	-10%	5,000	-1%
2030	8,000	-7%	4,000	-6%	4,000	-7%
2035	8,000	-7%	4,000	-7%	4,000	-8%
2040	7,000	-8%	4,000	-5%	3,000	-10%
2045	6,000	-7%	3,000	-3%	3,000	-12%

Children and Youth Demographics

Table 11 provides a high-level summary of the overall demographic breakdown (including age, sex, race, and ethnicity) of children and youth in Fannin and Grayson counties, compared to aggregated estimates for Texas statewide (see Table B in Appendix F for a breakdown of demographic percentages).[29] As with adults, the child and youth population of Grayson County (nearly 20,000) in 2018 was nearly four times that of Fannin County (approximately 5,000).

In 2018, the child and youth population of Fannin and Grayson counties was predominantly non-Hispanic White (66%) and split between male (49%) and female (51%) children and youth. When compared to Texas overall, the two counties in 2018 had a higher proportion of non-Hispanic White children and youth (75% versus 32% statewide), less than half the proportion of Black/African American children and youth (5% versus 12% statewide), and half the rate of Hispanic children and youth (25% versus 49% statewide).

[29] Because the prevalence of behavioral health care needs for young children is poorly understood, we do not provide population data for children under the age of six.

Table 11: Demographics of Children and Youth in Fannin and Grayson Counties (2018)[30, 31]

Children and Youth Population	Texas	Fannin County	Grayson County
Total Children and Youth Ages 6–17	4,900,000	5,000	20,000
Age			
Ages 6–11	2,450,000	3,000	10,000
Ages 12–17	2,450,000	3,000	10,000
Sex			
Male	2,500,000	3,000	10,000
Female	2,400,000	3,000	10,000
Race/Ethnicity			
Non-Hispanic White	1,600,000	4,000	15,000
Black/African American	570,000	200	800
Asian American	200,000	70	300
Multiple Races	130,000	300	1,000
Hispanic/Latino	2,400,000	1,000	5,000

The overall poverty rate in Fannin and Grayson counties was slightly lower than that of Texas. Among all children and youth in the two counties, slightly less than half lived below 200% of the federal poverty level in 2018 (full results provided in Table 12). More than one third of non-Hispanic White children and youth in Fannin and Grayson counties lived in poverty, compared to the majority of children of color: half of Black/African American children and more than two thirds of Hispanic, Latino, and multi-racial children and youth living in poverty. Asian American children and youth had the lowest rate of poverty (18%). Although non-Hispanic White children made up three fourths of the Fannin and Grayson County population, they only made up half of the population in poverty, indicating that non-Hispanic White children in Fannin and Grayson counties were less affected by poverty than Black/African American, Hispanic, Latino, and multi-racial children and youth.

However, across each race and ethnicity category, children and youth in Fannin and Grayson counties had higher rates of poverty than Texas statewide – this was especially true for children and youth of multiple races (61% versus 29% statewide).

[30] Texas Demographic Center (2018).

[31] Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Table 12: Description of Children and Youth in Poverty in the Texoma Region Compared to Texas Statewide (2018)[32]

Population	Texas			Fannin and Grayson Counties		
	Percentage of Total Population	Percentage of Total Poverty	Poverty Rate	Percentage of Total Population	Percentage of Total Poverty	Poverty Rate
Age						
Ages 6–11	50%	53%	47%	49%	54%	47%
Ages 12–17	50%	47%	44%	51%	46%	40%
Sex						
Male	51%	51%	45%	52%	50%	42%
Female	49%	49%	46%	48%	50%	45%
Race/Ethnicity						
Non-Hispanic White	33%	17%	24%	66%	53%	35%
Black/African American	12%	14%	53%	4%	5%	53%
Asian American	4%	2%	25%	1%	1%	18%
Native American	0%	0%	39%	1%	1%	37%
Multiple Races	3%	2%	33%	6%	8%	61%
Hispanic/Latino	49%	65%	61%	22%	33%	65%

Projected Population Growth for Children and Youth in Fannin and Grayson Counties

Tables 13 and 14, below, show the projected population change for children and youth in Fannin and Grayson counties. The population of children and youth is expected to *decrease* by nearly 7% in Fannin County by 2050, whereas the opposite is expected to happen in Grayson County – the child and youth population is expected to grow by 10% by 2050. Because Grayson County has a higher population than Fannin County, the overall area is expected to see a slight growth of about 7% of children and youth by the year 2050. This is a much slower growth rate than Texas overall (Table 15), which shows that the population of children and youth is expected to nearly double by 2050.

Based on these projections, the underlying need for behavioral health care for children and youth should show very modest regional growth through 2050. This does not imply additional services are unneeded – see the section on the system of care for children and youth for a description of how well the current system of care addresses the needs of children and youth.

[32] American Community Survey. (2018).

Table 13: Estimated Population of Children and Youth in Fannin County (2020–2050)[33]

Year	All Children and Youth		Children Ages 6 to 11		Youth Ages 12 to 17	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**5,433**		**2,706**		**2,726**	
2025	5,307	–2%	2,774	2%	2,533	–7%
2030	5,383	–1%	2,744	1%	2,639	–3%
2035	5,312	–2%	2,658	–2%	2,654	–3%
2040	5,171	–5%	2,579	–5%	2,592	–5%
2045	5,063	–7%	2,559	–5%	2,505	–8%
2050	5,071	–7%	2,591	–4%	2,480	–9%

Table 14: Estimated Population of Children and Youth in Grayson County (2020–2050)[34]

Year	All Children and Youth		Children Ages 6 to 11		Youth Ages 12 to 17	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**20,914**		**10,337**		**10,577**	
2025	21,568	3%	10,723	4%	10,844	3%
2030	22,169	6%	11,045	7%	11,125	5%
2035	22,560	8%	11,046	7%	11,514	9%
2040	22,593	8%	11,084	7%	11,509	9%
2045	22,714	9%	11,200	8%	11,514	9%
2050	22,994	10%	11,393	10%	11,601	10%

[33] Texas Demographic Center. (2018).

[34] Texas Demographic Center. (2018).

Table 15: Estimated Population of Children and Youth in Texas (2020–2050)[35]

Year	All Children and Youth		Children Ages 6 to 11		Youth Ages 12 to 17	
	Population	Percentage Change from 2020	Population	Percentage Change from 2020	Population	Percentage Change from 2020
2020	**4,976,236**		**2,476,699**		**2,499,537**	
2025	5,205,016	5%	2,643,413	7%	2,561,603	2%
2030	5,549,839	12%	2,841,328	15%	2,708,511	8%
2035	5,957,752	20%	3,040,091	23%	2,917,661	17%
2040	6,350,942	28%	3,218,611	30%	3,132,331	25%
2045	6,726,601	35%	3,394,446	37%	3,332,155	33%
2050	7,119,003	43%	3,595,652	45%	3,523,351	41%

Children and Youth System and Data Analysis

In 2018, there were approximately 2,000 children and youth in Fannin County and 8,000 children and youth in Grayson County with any mental health needs. The regional data described above are disaggregated for Fannin and Grayson counties separately in Tables 16 and 17 below.

Table 16: Demographics of Children and Youth in Fannin County (2018)[36]

Fannin County	Total Child and Youth Population	Total Child and Youth Population with SED	Total Child and Youth Population in Poverty[37]	Total Child and Youth Population with SED in Poverty
Children and Youth Ages 6–17	5,000	400	2,000	200
Age				
Ages 6–11	3,000	200	1,000	100
Ages 12–17	3,000	200	1,000	100
Sex				
Male	3,000	200	1,000	100
Female	3,000	200	1,000	100

[35] Texas Demographic Center. (2018).

[36] All Texas prevalence estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[37] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

Fannin County	Total Child and Youth Population	Total Child and Youth Population with SED	Total Child and Youth Population in Poverty[37]	Total Child and Youth Population with SED in Poverty
Race/Ethnicity				
Non-Hispanic White	4,000	300	1,000	100
Black/African American	200	20	100	10
Asian American	70	<6	10	<6
Native American	70	<6	30	<6
Multiple Races	300	30	200	20
Hispanic/Latino	1,000	100	800	70

Table 17: Demographics of Children and Youth in Grayson County (2018)[38]

Grayson County	Total Child and Youth Population	Total Child and Youth Population with Serious Emotional Disturbances (SED)	Total Child and Youth Population in Poverty[39]	Total Child and Youth Population with SED in Poverty
Children and Youth Ages 6–17	20,000	2,000	9,000	800
Age				
Ages 6–11	10,000	800	5,000	400
Ages 12–17	10,000	800	4,000	400
Sex				
Male	10,000	800	5,000	400
Female	10,000	800	4,000	400
Race/Ethnicity				
Non-Hispanic White	15,000	1,000	5,000	400
Black/African American	800	70	400	40
Asian American	300	20	50	<6
Native American	200	20	90	<10

[38] All prevalence estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[39] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

Grayson County	Total Child and Youth Population	Total Child and Youth Population with Serious Emotional Disturbances (SED)	Total Child and Youth Population in Poverty[39]	Total Child and Youth Population with SED in Poverty
Multiple Races	1,000	100	800	70
Hispanic/Latino	5,000	400	3,000	300

System-Level Findings: Adults and the Crisis and Criminal Justice Systems

In this detailed overview, we present system-level findings and recommendations as well as findings and recommendations specific to adults and people involved with the criminal justice system. We provide select data tables as necessary to illustrate main points.

Adult Services Systems and Data Analysis

The majority of adult behavioral health needs are best served in integrated primary care settings. Although these are the most effective settings for the majority of people, few people receive integrated primary care in most local systems. Instead, individuals often receive no care at all, or they are served in specialty care settings or through the crisis services system. Our description of the adult system of care in Fannin and Grayson counties will first provide details on how many adults have behavioral health needs, broken out by the type of need. Then, we will describe the current capacity of the system to address those needs.

Adult Behavioral Health Conditions

Our description of community demographics, above, included an estimate of the number of people with serious mental illnesses (SMI). In this next section, we provide an overview of the estimated prevalence of a broader range of behavioral health conditions and disorders in Fannin and Grayson counties and in Texas statewide in 2018. Table 18 shows the estimated prevalence of mental health conditions among adults in Fannin and Grayson counties, while Table 19 shows the estimated prevalence of substance use disorders (SUD).

Overall, there were about 125,000 adults living in Fannin and Grayson counties in 2018, the majority of whom resided in Grayson County. We estimated that just over 30,000 adults in the region had any mental illness and that eight in ten of these adults living with mental illness had conditions that were mild to moderate in severity, which could be treated in integrated primary care clinics.[40] We estimated that the rest, about 6,000, had a serious mental illness (SMI) and

[40] Meadows Institute experts estimate that the proportion of the adult population with mental health needs who are best treated in integrated primary care settings is approximately equal to the proportion with mild or moderate severity. Although some portion of people with serious mental illnesses, such as some people with major

more than half (62%) of these people were living in poverty. These people had mental health conditions that would have benefited from treatment in a specialized behavioral health setting such as treatment provided by the local mental health authority, Texoma Community Center. We also estimated that the rate of suicides per 100,000 residents was higher among Fannin County adults than Grayson County adults (33.4 versus 23.5 per 100,000 residents, respectively). The suicide rate for both counties from 2013 to 2018 exceeded the rate of suicides statewide (16.5 per 100,000 residents).

The most serious cases of SMI cause a level of impairment that leads to frequent use of crisis resources such as hospitals, emergency rooms, and jails. Often, these people can benefit from intensive outpatient practices such as Assertive Community Treatment (ACT).

ACT is a well-established, evidence-based practice for people with serious mental illnesses and substance use disorders whose needs have not been well met by traditional approaches to delivering services. At the heart of ACT is a transdisciplinary team of 10 to 12 practitioners who provide services to about 100 people.[41] These multidisciplinary teams of clinicians persistently work to engage clients in treatment and directly provide services and support in the community around the clock. Although ACT reduces hospitalizations and improves other clinical outcomes, it does not necessarily reduce police contacts and arrests. For this reason, offenders with moderate to high risk of recidivism should be assigned to Forensic Assertive Community Teams (FACT) teams, which add a probation officer to ACT's standard multidisciplinary clinical team.

FACT, a derivative of ACT designed for people with mental illnesses with higher risk for criminal recidivism, has been shown by research to reduce jail recidivism rates for people with serious mental illnesses and high risk for recidivism who frequently cycle through the criminal justice system and local emergency and hospital services.[66] Best practice FACT is based on best practice ACT principles (Tool for Measurement of ACT), but the Forensic ACT team also includes a forensic specialist and all staff are specially trained to focus on factors that increase a person's risk for recidivism (called "criminogenic risk"). Currently, people involved in the criminal justice system receive the same treatment as those who are not involved in the criminal justice system, which is not best practice for forensic services. Without the specialized forensic component of FACT, the program's participants are likely to experience reincarceration as ACT has not been shown to be effective in reducing arrests and jail time.[67]

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depression, can be effectively treated in integrated primary care, a proportion of people with moderate mental illness need care at specialty settings. These are offsetting forces and approximately cancel each other.

[41] Substance Abuse and Mental Health Services Administration. (2008). *Assertive Community Treatment: Building your program* [DHHS Pub. No. SMA-08-4344]. Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services. https://store.samhsa.gov/shin/content/SMA08-4345/BuildingYourProgram-ACT.pdf.

Although FACT studies are sparse and methodologically limited, the soundest experiment found that FACT reduced jail bookings and hospitalizations over a two-year follow-up period.[42] Although the evidence for FACT is sparser and therefore more tentative at this point, results of a rigorous randomized controlled trial conducted in California showed that, at both 12 and 24 months, FACT clients had more outpatient contacts, significantly fewer jail bookings, and fewer hospital days than clients who received treatment as usual.[43] FACT can also implement Risk-Need-Responsivity (RNR) principles; the RNR model has a well-developed literature.[44, 45]

In summary, there is compelling evidence that ACT and RNR-infused FACT will have sizable effects on utilization rates for these populations of interest. We estimated that in Fannin and Grayson counties in 2018, there were about 100 adults who could have benefited from services such as ACT. About half of these people would have been involved in the criminal justice system and could have benefited from Forensic ACT (FACT).

As shown in Table 18, about 5,000 people in Fannin County and 19,000 in Grayson County had mild or moderate mental health needs that would have been best served in an integrated primary care setting. Table 19 shows that 2,000 people in Fannin County and 6,000 people in Grayson County had substance use disorders, of whom about 46% (approximately 1,000 and 3,000 people, respectively) would have been best served in integrated primary care settings. These estimates provide a guideline for the needed system capacity.

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[42] Morrissey, J., & Louison, A. (2013). *Forensic Assertive Community Treatment: Updating the evidence*. http://www.prainc.com/wp-content/uploads/2015/10/slides-forensic-assertive-community-treatment-updating-the-evidence.pdf.

[43] Cusack, K.J., et al. (2010). Criminal justice involvement, behavioral health service use, and costs of Forensic Assertive Community Treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356-363.

[44] Washington State Institute for Public Policy. (2016). *Benefit-cost results: Risk, need, and responsivity for moderate-high risk offenders*. http://www.wsipp.wa.gov/BenefitCost/Program/157

[45] Andrews, D. A. (2012). The Risk-Need-Responsivity Model of correctional assessment and treatment. In Dvoskin, J. A., Skeem, J. L., Novaco, R. W., & Douglas K. S. (Eds.), *Using social science to reduce violent offending* (pp. 127-156). New York, NY: Oxford University Press.

Table 18: Prevalence of Mental Health Disorders Among Adults in Fannin and Grayson Counties Compared to Texas Statewide (2018)[46]

Mental Health Conditions – Adults	Prevalence[47]		
	Texas	Fannin	Grayson
Total Adult Population	**20,600,000**	**25,000**	**100,000**
Population in Poverty[48]	6,300,000	8,000	30,000
All Mental Health Needs (Mild, Moderate, and Severe) [49]	**4,800,000**	**6,000**	**25,000**
Mild	2,000,000	3,000	10,000
Moderate	1,850,000	2,000	9,000
Severe – Serious Mental Illness (SMI) [50]	920,000	1,000	5,000
SMI in Poverty[51]	490,000	700	3,000
Complex Needs without Forensic Need (ACT) [52]	10,000	10	40
Complex Needs with Forensic Need (FACT) [53]	8,000	<10	40
Serious Mental Illnesses			
Major Depression[54]	1,450,000	2,000	7,000
Bipolar I Disorder[55]	110,000	200	600

[46] Note that this table continues across multiple pages. This table includes the heading "Mental Health Conditions – Adults" on the top of each page.

[47] All Texas prevalence estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6," and estimated values between 5 and 9 were rounded to "<10."

[48] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.

[49] Behavioral health need according to severity level prevalence rates were estimated from 12-month rates reported in Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*(6), 617–627.

[50] Serious mental illness prevalence was estimated using Holzer, C., Nguyen, H., & Holzer, J. (2018). *Texas county-level estimates of the prevalence of severe mental health need in 2018*. See Appendix A for additional information.

[51] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.

[52] ACT need was estimated using the 12-month prevalence rates in Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many ACT teams do we need? *Psychiatric Services, 57*(12), 1803–1806.

[53] Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic ACT teams do we need? *Psychiatric Services, 59*, 205–208.

[54] Center for Behavioral Health Statistics and Quality. (2020). *2018 National Survey on Drug Use and Health: Detailed tables*. Substance Abuse and Mental Health Services Administration. https://www.samhsa.gov/data/release/2018-national-survey-drug-use-and-health-nsduh-releases.

[55] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information.

Mental Health Conditions – Adults	Prevalence[47]		
	Texas	Fannin	Grayson
Post-Traumatic Stress Disorder[56]	720,000	900	3,000
Schizophrenia[57]	100,000	100	500
First Episode Psychoses (FEP) Incidence – New Cases per Year (Ages 18–34) [58]	2,000	<6	<10
Number of Deaths by Suicide[59] (2013 – 2018)	20,160	54	137
Rate per 100,000	16.5	33.4	23.5

As shown in Table 19, there were about 8,000 adults in Fannin and Grayson counties with substance use disorders (SUD) in 2018, just about half of whom (4,000) were living in poverty. We estimated that about two thirds of all SUD were instances of co-occurring psychiatric and SUD conditions. In 2018, at least 12 adults died from drug overdoses and at least 27 adults had alcohol-induced deaths. Although Table 19 shows that nearly all adults with SUD did not receive the treatment they needed (93%, according to the National Survey on Drug Use and Health), we know that nearly half (46%) of all cases could have been treated in an integrated primary care setting.[60]

Since Fannin and Grayson counties are not expected to have substantial increases in population among young or middle-aged adults, when planning for the future community need, current prevalence estimates may be a good indicator of need for years to come. However, as demographics shift toward an older population, both counties may benefit from additional services that are designed to meet the needs of an older population, including services that address factors that contribute to health inequities among older adults, such as transportation needs, mobility concerns, and isolation. Because older adults often have more medical conditions, they may also benefit from care provided in integrated health care settings, which can treat commonly co-occurring mental health and physical conditions.

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[56] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research, 21*(3): 169–184.

[57] Simeone, J. C., Ward, A. J., Rotella, P., Collins, J., & Windisch, R. (2015). An evaluation of variation in published estimates of schizophrenia prevalence from 1990–2013: A systematic literature review. *BMC Psychiatry, 15*:193.

[58] Simon, G. E., Coleman, K. J., Yarborough, B. J. H., Operskalski, B., Stewart, C., Hunkeler, E. M., Lynch, F., Carrell, D., & Beck, A. (2017). First presentation with psychotic symptoms in a population-based sample. *Psychiatric Services, 68*(5): 456–461.

[59] Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2019, on the CDC WONDER Online Database. Suicide deaths were classified using underlying cause-of-death ICD-10 codes: X60–84 and Y87.

[60] Madras, B. K., et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence, 99*(1), 280–295.

Table 19: Prevalence of Substance Use Disorders (SUD) Among Adults (2018)[61,62]

Population	Adult Substance Use Disorders		
	Texas	Fannin	Grayson
Total Population	**20,600,000**	**25,000**	**100,000**
Total Population in Poverty	6,300,000	8,000	30,000
Any Substance Use Disorder	**1,350,000**	**2,000**	**6,000**
SUD in Poverty[63]	570,000	700	3,000
Comorbid Psychiatric and SUD[64]	790,000	1,000	4,000
Needing But Not Receiving Treatment for Substance Use[65]	1,300,000	2,000	6,000
Alcohol-Related SUD	**1,000,000**	**1,000**	**5,000**
Needing But Not Receiving Treatment for Alcohol Use	990,000	1,000	5,000
Illicit Drug-Related SUD	**460,000**	**600**	**2,000**
Needing But Not Receiving Treatment for Illicit Drug Use	410,000	500	2,000
Number of Drug-Related Deaths in 2018[66]	**2,979**	**<10**	**12**
Number of Alcohol-Induced Deaths in 2018[67]	**4,631**	**<10**	**27**

[61] 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[62] All estimates were rounded to reflect uncertainty in the American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimates between 5 and 9 were rounded to "<10."

[63] The prevalence of any substance use disorder among adults and youth living in poverty was based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2017–2018 restricted access file. The percentage was applied to the estimated number of adults and youth living in poverty in Texas. Poverty estimates were based on the American Community Survey 2018 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates. These figures were rounded because of the uncertainty in the underlying data. As a result of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[64] The local prevalence of co-occurring psychiatric and substance abuse disorders (COPSD) among adults were based on the national prevalence rate of any mental illness (AMI) and substance use disorder (SUD) as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (NSDUH; HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2017–2018 NSDUH rates of AMI for Texas subregions. These figures were rounded because of the uncertainty in the underlying data. As a result of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[65] 2017-2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[66] Death by drug overdose data were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database, accessed at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths were classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

[67] The number of alcohol-induced deaths were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database,

Community Behavioral Health Providers

Table 20 below shows the number of licensed psychiatrists, psychologists, chemical dependency counselors, clinical social workers, professional counselors, and psychiatric nurse practitioners who were providing care in the region in 2020. Fannin County has one licensed psychiatrist while Grayson County has seven licensed psychiatrists.[68] Of these, only two reported a specialization in child and adolescent psychiatry, pediatric psychiatry, or developmental-behavioral pediatrics to the Texas Medical Board. This indicates that one psychiatrist is available per 11,500 residents.

There is a total of 30 licensed psychologists with addresses in Fannin (six providers) or Grayson (24 providers) counties, indicating that one licensed psychologist is available for every 5,200 Fannin County residents and one for every 5,000 Grayson County residents. There are also forty (40) licensed chemical dependency counselors (one provider for every 10,500 residents in Fannin County and one provider for every 3,000 residents in Grayson County), 133 licensed clinical social workers (one for every 900 residents in Fannin County and one for every 1,200 residents of Grayson County), 117 licensed professional counselors (one for every 2,100 residents in Fannin County and one for every 1,200 residents of Grayson County) and three psychiatric nurse practitioners across the two counties. A breakdown of the number of providers and providers per patient is provided in Table 20, below.

Table 20. Number of Behavioral Healthcare Providers in Texoma (2020)[69,70]

Provider Type	Number of Providers	Number of Residents per Provider
Fannin County		
Licensed Psychiatrists	1	31,500
Licensed Psychologists	6	5,200

accessed at http://wonder.cdc.gov/mcd-icd10.html. Alcohol induced deaths were classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes." In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

[68] Registry data on all actively practicing physicians in the state of Texas were abstracted from the Texas Medical Board Open Records Self-Service Portal on March 30, 2020. http://orssp.tmb.state.tx.us/

[69] Data on the number of nurses with mailing addresses in Fannin and Grayson counites were obtained through an open records request to the Texas Board of Nursing. Mailing lists for all registered Texas licensed professional counselors, chemical dependency counselors, and licensed clinical social workers were obtained from the Texas Health and Human Services Commission. Registry data on all actively practicing physicians with practice addresses in either Grayson or Fannin counties were abstracted from the Texas Medical Board Open Records Self-Service Portal. http://orssp.tmb.state.tx.us/ Psychiatrists were classified as practicing in Fannin or Grayson counties if the provider included a practice address located in either Grayson or Fannin counties.

[70] Our list of Texas licensed professional counselors, chemical dependency counselors, and licensed clinical social workers did not include the practice location. Although all providers were licensed to practice in the state of Texas, some providers may reside in Fannin or Grayson counties but practice in other states.

Provider Type	Number of Providers	Number of Residents per Provider
Licensed Chemical Dependency Counselors	3	10,500
Licensed Clinical Social Workers	35	900
Licensed Professional Counselors	15	2,100
Psychiatric Nurse Practitioners	2	16,000
Grayson County		
Licensed Psychiatrists	7	17,000
Licensed Psychologists	24	5,000
Licensed Chemical Dependency Counselors	37	3,000
Licensed Clinical Social Workers	98	1,200
Licensed Professional Counselors	102	1,200
Psychiatric Nurse Practitioners	1	120,000

Veterans Behavioral Health Conditions

Table 21 shows the population of veterans in Texas, Grayson County, and Fannin County in 2018. Overall, there were more than ten thousand veterans living in Fannin and Grayson counties. The majority of these veterans were older males (ages 65 to 85) and three fourths resided in Grayson County. An estimated 500 veterans in the region were living with serious mental illness. Around 1,400 veterans in the region used illicit drugs and nearly 700 misused psychotherapeutic medication such as antidepressants and antipsychotics, or pain relievers.

The National Center for Veterans Analysis and Statistics provides actuarial population projections through the next 30 years. Through the year 2045, the overall veteran population in Texas is expected to decline. In Fannin and Grayson counties, the veteran population is expected to decrease from 12,000 in 2018 to around 8,000 by the year 2045.[71]

We do not have utilization data to compare to these estimates. However, the approximately 1,300 veterans with any mental illness in the region accounts for only 4% of the total adult population with mental health conditions listed in Table 18. This is a significant population with unique needs and should be considered when planning for community-level care.

[71] National Center for Veterans Analysis and Statistics. (2019). *Veteran population by county*. www.va.gov/vetdata/veteran_population.asp
Projected population change was obtained from the Texas Demographic Center (2018).

Table 21: Prevalence of Mental Health and Substance Use Disorders Among Veterans (2018)[72]

Conditions	Texas	Fannin	Grayson
Total Veteran Population	**1,550,000**	**3,000**	**9,000**
Mental Health Condition	**Total Prevalence**		
Any Mental Illness	240,000	300	1,000
Serious Mental Illness	70,000	100	400
Major Depression	85,000	100	500
Alcohol Use Disorder	70,000	100	400
Illicit Drug Use	210,000	400	1,000
Nonmedical Use of Psychotherapeutics	50,000	90	300
Nonmedical Use of Pain Relievers	40,000	70	200
Number of Veteran Suicide Deaths	485	<6	<6

Utilization Data for Adults

Texoma Community Center

More serious behavioral health conditions require specialty care. In Fannin and Grayson counties, people with these conditions are often referred to Texoma Community Center, the local mental health authority. Although Texoma Community Center serves Fannin, Grayson, and Cooke counties, our analysis focused, to the extent possible, only on Fannin and Grayson counties.

Texoma Community Center serves these individuals through core services based on the level of care that they need, which should be aligned with the target population for that level of care. For adults, there are five levels of care (LOC): LOC–1S, skills training and basic services; LOC–2, basic services with counseling; LOC-3, intensive services with team approach; LOC–4, assertive

[72] Pemberton, M. R., Forman-Hoffman, V. L., Lipari, R. N., Ashley, O. S., Heller, D. C., & Williams, M. R. (2016). *Prevalence of past year substance use and mental illness by veteran status in a nationally representative sample*. Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Nonmedical use of prescription psychotherapeutics includes the nonmedical use of pain relievers, tranquilizers, stimulants, or sedatives and does not include over-the-counter drugs. Data were abstracted using data from the Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). National Survey on Drug Use and Health: 2-Year RDAS (2017 to 2018), rdas.samhsa.gov/#/survey/NSDUH-2017-2018-RD02YR/crosstab/?weight=DASWT_1&run_chisq=false&results_received=true

[73] Veteran prevalence and population estimates were rounded to reflect uncertainty in the Department of Veterans Affairs data. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts. Estimates between 5 and 9 were rounded to "<10."

community treatment; and LOC–0, crisis services.[74] For children and youth, there are seven LOCs: LOC-1, medication management; LOC–2, targeted services; LOC–3, complex services; LOC-4, intensive family services; LOC-Y, Youth Empowerment Services (YES) Waiver services; LOC-YC, young children; and LOC-0, crisis services.[75]

The Assertive Community Treatment (ACT) team of the Texoma Community Center serves people with serious and complex mental health needs who are often trapped in cycles of high utilization of expensive hospital and emergency services and involvement in the criminal justice system. This ACT team is considered a rural ACT team and has a very limited capacity, serving a maximum of 20 consumers. The team is made up of two case managers and a nurse. Because the team needs to expand its capacity, the nurse carries a full caseload, which is not the standard practice for an ACT team. With the nurse's caseload, the team can serve 30 consumers. We found that the ACT team has a strong foundation with seasoned caseworkers, supportive leadership, and person-driven care.

Tables 22 and 23 provide an overview of the number of people who received Texoma Community Center outpatient services, including breakouts for the number of people served at each level of care. Comparing these data to the prevalence estimates in Table 18, above, sheds some light on the extent to which most mental health need is adequately treated in Fannin and Grayson counties. In Fannin and Grayson counties, the 6,000 people with serious mental illness (SMI), including 3,700 with SMI who were also living in poverty, most likely needed specialized treatment through Texoma Community Center. These treatments would include case management, medication, counseling, and other supports.

As Table 22 shows, in fiscal year (FY) 2019, 2,372 adults received some type of treatment through Texoma Community Center. Assuming that 74% of Texoma Community Center clients reside in Fannin and Grayson counties,[76] we estimated that 1,755 residents in Fannin and Grayson counties received treatment at Texoma Community Center. When compared to the estimated 3,700 adults who were living with SMI in poverty, of whom many may not have had the resources to obtain commercial insurance, *it is possible that as many as half of the people with SMI in the community were not receiving adequate treatment.*

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[74] Legislative Budget Board. (2019). *Staff report – Overview of community mental health needs and services*. https://www.lbb.state.tx.us/Documents/Publications/Staff_Report/2019/4741_LMHAs_Overview.pdf

[75] Legislative Budget Board. (2019).

[76] This estimate was calculated by assuming that 74% of Texoma Community Center clients were residents of Fannin and Grayson counties per the 2014 report. This information was not updated for the revised assessment.

Table 22: Number of Adults Who Received Outpatient Services by Texoma Community Center (FY 2019)[77]

Adults	Texoma Community Center Region (all counties)	Fannin and Grayson County Residents
SMI in Poverty[78,79]	4,700	3,700
All Levels of Care Served	2,372	1,755
% in Need Served[80]	48%	45%

As previously shown in Tables 3 and 4, we estimated that of the 3,700 adults with SMI who were living in poverty in 2018, about 100 had the highest level of need – those whose conditions cause so much impairment that, if left untreated, they could lead to repeated use of crisis services and psychiatric hospitals, and involvement in the criminal justice system. These people could benefit from an evidence-based practice such as ACT or FACT (Forensic ACT). Table 23 shows that approximately 35 people received ACT in Fannin and Grayson counties in FY 2019.

Table 23: Adult Levels of Care Analysis (FY 2019)[81]

Ideal System Category	Level of Care	Fannin and Grayson counties	
		Number Served	% of Total
Outpatient	Medication Management	0	0%
	Skills Training	1,210	53%
	Medications and Therapy	111	5%
Rehabilitation	Medication and Case Management	327	14%
	Assertive Community Treatment (ACT)	35	2%
	Early Onset Psychosis Services	3	0%
	Transition-Age Youth	0	0%

[77] Data obtained in February 2020 from the Texas Health and Human Services Commission. Level of care data are unduplicated by care identifier and level of care, and they are for state fiscal year 2019.

[78] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information.

[79] All population estimates were rounded to reflect uncertainty in the American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts.

[80] The percent of persons in need of services who were served by the LMHA is calculated by dividing the total number of unique individuals served by the LMHA (All levels of care served) by the estimated population in poverty with SMI (SMI in poverty).

[81] Data obtained in February 2020, from Texas Health and Human Services Commission. Level of care data are unduplicated by care identifier and level of care, and they are for state fiscal year 2019.

Ideal System Category	Level of Care	Fannin and Grayson counties	
		Number Served	% of Total
Crisis	Crisis Services	541	24%
	Crisis Follow-Up	48	2%
Total Served		**2,275**	**100%**
	Total Non-Crisis Served	1,686	74%
	Total Crisis Served	589	26%

Texoma Community Center uses the Adult Needs and Strengths Assessment (ANSA) to assess its adult clients' needed level of care. Once a score is calculated, the Texas Health and Human Services Commission's Utilization Management Guidelines play an integral part in ensuring the delivery of mental health services are "properly tailored to the individual's needs…while utilizing limited available resources in the most efficient and cost-effective manner possible."[82]

Texoma Community Center reported that many more people are assessed at Level of Care 4, the highest level of outpatient care, than actually enroll in it. Many of these people request to be diverted to a lower level of care because they are discouraged by the frequency of visits required at Level of Care 4. Texoma Community Center reported that, once enrolled in a lower level of care (Level of Care 1–3), this particular population continues to need more intensive, high-frequency care (as is the case across local mental health authorities in Texas), which results in the agency providing hours in excess of what the person's preferred level of care package includes. For example, according to the Utilization Management Guidelines, hours included in LOC 1S, LOC 2, and LOC 3 service packages range between 1.3 hours per month (hours/month) and 2.25 hours/month for LOC 1S; 3.25 hours/month and 5.5 hours/month for LOC 2; and 5.87 hours/month and 20.35 hours/month for LOC 3. For LOC 4, the hours per month range between 10 and 26.65. The issue with individuals being deviated to an inappropriate lower level of care is that a local mental health authority such as Texoma Community Center assigns caseloads to programs according to the expected and assigned number of hours in the enrolled service package. Therefore, LOC 1S – LOC 3 caseloads become over-burdened when they are required to serve individuals outside of the anticipated prescribed amount of time provided.

Because engagement is not currently a reimbursable service and capacity is extremely limited, it is difficult for ACT teams to enroll people who need ACT services and take the time needed to build the rapport necessary to engage them into this clinically-intensive treatment. The current

[82] Texas Health and Human Services Commission. (2017). *Texas resilience and recovery – utilization management guidelines: adult mental health services*. https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf

reimbursement structure discourages organizations from providing the most crucial part of building a therapeutic alliance with individuals who are not only the most in need of intensive services, but most difficult to engage in services. Fortunately, state-mandated criteria for services were clarified in 2017 to allow for pre-enrollment outreach to help teams better prioritize care for people most in need of services.[83] Nevertheless, the data indicate that people with the most severe needs such as those with serious mental illnesses may be undertreated in the community.

Adult Crisis/Emergency Department Utilization

Access to high-quality community-based treatments for mental illness reduces the need for crisis services, including emergency department and inpatient psychiatric services. We obtained service utilization data for both of these settings from discharge records we obtained from the Texas Health Care Information Collection (THCIC). THCIC data comprise inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on a client's age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer, and source of admission, among other variables.

We used these THCIC discharge records to analyze psychiatric inpatient and emergency department utilization in Fannin and Grayson counties, as depicted in the following data tables. Data in the tables are limited to a single full year of the latest available data (2018), with the exception of the daily utilization graphs, which report utilization as far back as 2015.

In this section, we provide an analysis of emergency department utilization that is attributed to primary psychiatric and substance use disorder diagnoses. We also provide the primary payers and the estimated payments associated with these visits. This analysis highlights sub-populations of adults who frequently utilize the emergency department, indicating a high need among a specific population, or a lack of capacity to meet the needs of a specific population at lower levels of care. Of particular concern is the group of people who either had Medicaid as their payer, paid for services themselves, relied on charity, or were uninsured. An excessive number of admissions of these people to emergency departments may reflect poor access to outpatient care for populations served by public payers.

Four emergency departments reported adult psychiatric and substance use disorder-related emergency department visits to the THCIC: Carrus Specialty Hospital, Texoma Medical Center –

[83] Miller, J. & Strickland, R. (March 15, 2017). *Broadcast MSG0761*: *Assertive Community Treatment Fidelity Tool: Using the Tool of Measurement of Assertive Community Treatment as an alternative to the Dartmouth Assertive Community Treatment Scale* [Memorandum]. Texas Health and Human Services Commission.

Grayson, Texoma Medical Center – Bonham, and Wilson N. Jones Regional Medical Center. Carrus Specialty Hospital only reported one emergency department visit for primary psychiatric conditions and no substance use disorder (SUD) visits. Because of the small number of total visits, this emergency department was not included in Table 24.[84]

As Table 24 shows, Texoma Medical Center – Grayson was the most frequently utilized emergency department for psychiatric and SUD-related emergency department visits in the region, with nearly half of all visits (776 out of 1,609 total visits). Wilson N. Jones was also frequently utilized, though slightly less so than Texoma Medical Center – Grayson. Texoma Medical Center – Bonham had the fewest number of visits, but still accounted for 15% of all emergency department visits in the region. Across all emergency departments, there were about three times as many emergency department visits for primary psychiatric conditions than there were for substance use conditions. This is consistent with the prevalence data in Tables 18 and 19, which show that mental health conditions were more than three times as prevalent as substance use disorders in the two counties.

Although these emergency departments charged a certain amount for these visits, the actual amounts paid were usually less than what was charged. Self-insured patients living in poverty are often unable to pay for any service. Medicaid frequently pays less than the cost of the service, while Medicare and commercial payers pay a larger portion of each charge. Using per-visit charges that were provided by the hospitals, and adjusting for payer-specific average price-to-charge ratios, we estimated the actual dollar amounts paid for emergency department visits by residents of Fannin and Grayson counties (Table 25). *For all behavioral health-related emergency department visits by adult residents of Fannin and Grayson counties, nearly $1.5 million in costs were attributed to psychiatric emergency department visits and over $500,000 were attributed to SUD-related emergency department visits.*

Since visits to the emergency department may occur when people feel they do not have alternatives to care – whether due to a lack of availability of services or the financial resources to pay for that care – providing comprehensive community-level care may help reduce these costs by providing more effective alternatives to people in need, which may also simultaneously reduce strain on hospital resources.

[84] Data were obtained from the Texas Health Care Information Collection (THCIC) January 2018 – December 2018 discharge records. Hospitals with an average of less than five behavioral health visits per month were not included.

Table 24: Adult Emergency Department (ED) Psychiatric and Substance Use-Related Visits, by Payer (Calendar Year [CY] 2019)[85]

Hospital	Total Number of ED Visits	Payer Percentage				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson						
Psychiatric ED Visits[86]	776	5%	0%	3%	43%	37%
Substance Use ED Visits[87]	296	2%	0%	7%	55%	27%
Texoma Medical Center – Bonham						
Psychiatric ED Visits	237	10%	27%	13%	31%	20%
Substance Use ED Visits	65	8%	18%	22%	37%	15%
Wilson N. Jones Regional Medical Center						
Psychiatric ED Visits	596	4%	20%	0%	0%	76%
Substance Use ED Visits	151	1%	7%	2%	0%	91%
All Emergency Departments						
Psychiatric ED Visits	1,609	4%	11%	4%	25%	49%
Substance Use ED Visits	512	2%	4%	7%	35%	51%

[85] Utilization data were obtained from the Texas Health Care Information Collection (THCIC) January– December 2019 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field.

[86] Ninety-six (96) visits did not have an identified payer. These visits were included in totals but not in payer percentages.

[87] Twenty-four (24) visits did not have an identified payer. These visits were included in totals but not in payer percentages.

Table 25: Adult Emergency Department Psychiatric and Substance-Use Related Visits – Estimated Payments (2018)[88,89]

Hospital	Total Estimated Payments[90]	Payer Percentage				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson						
Psychiatric ED Visits[91]	$655,878	2%	0%	2%	25%	51%
Substance Use ED Visits[92]	$241,636	4%	0%	3%	42%	33%
Texoma Medical Center – Bonham						
Psychiatric ED Visits	$191,044	10%	43%	18%	14%	15%
Substance Use ED Visits	$48,969	3%	5%	65%	19%	9%
Wilson N. Jones Regional Medical Center						
Psychiatric ED Visits	$585,290	1%	12%	0%	0%	87%
Substance Use ED Visits	$217,965	0%	7%	0%	0%	93%
All Emergency Departments						
Psychiatric ED Visits	$1,433,606	2%	11%	4%	13%	61%
Substance Use ED Visits	$508,570	2%	3%	8%	22%	57%

Adult Inpatient Utilization

Two hospitals in Fannin and Grayson counties reported inpatient psychiatric utilization: Wilson N. Jones Regional Medical Center (Wilson N. Jones) and Texoma Medical Center – Grayson. A common concern in many communities across Texas and the nation is that local inpatient facilities do not have sufficient capacity to meet the crisis needs of people with behavioral health conditions. The next section describes three approaches we used to assess this capacity question for Fannin and Grayson counties.

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[88] Texas Health Care Information Collection (THCIC) April 2017– March 2018 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field.

[89] This table could not be updated using 2019 data for multiple reasons, including unavailable patient ratios and methodological questions surrounding the approach.

[90] Emergency department visits reflect visits by residents of Fannin and Grayson counties only. Carrus Specialty Hospital was not included because there were only two psychiatric emergency department visits during 2018.

[91] Eighty-eight (88) visits did not have a clearly identified payer. These visits were included in totals but not in payer percentages.

[92] Twenty-two (22) visits did not have a clearly identified payer. These visits were included in totals but not in payer percentages.

The first approach compared daily inpatient utilization to reported staffed bed capacity for each hospital. This approach can identify hospitals that are operating beyond capacity or under capacity relative to need. Prolonged operation at or above capacity may indicate insufficient capacity to meet need. Additionally, time series graphs (Graphs 1 through 3, below) may be useful for identifying whether periods at full capacity are only seasonal or reflect long-term trends.

The second approach subdivided patients admitted to psychiatric beds by the payer type. Disproportionate use of beds by patients with commercial insurance may indicate a lack of access for patient who pay out of pocket or have (lower-paying) Medicaid. Excessive use of beds by patients use these types of payment may indicate local hospitals' potential financing challenges for psychiatric beds.

Finally, we examined the county of residence of patients admitted to psychiatric beds in the two counties. This analysis can highlight another facet of bed capacity: If many patients residing in distant counties or out of state use psychiatric beds in Fannin and Grayson counties, it is likely because the region has available beds.

Please note that the inpatient utilization data we used were based on the data the hospitals reported to THCIC. In addition, beds that are included in a hospital's capacity are sometimes not available because of staffing, funding, or other issues, even though the physical space is available.

Adult Daily Inpatient Utilization and Capacity

Table 26 on the following page presents an overview of per-day average psychiatric bed utilization for each hospital in Fannin and Grayson counties from October 2015 through November 2019. Averages by age group were calculated only for dates on or after January 1, 2017, when age-specific capacity information for those hospitals were available. The time series charts in Graphs 1 to 3 show day-by-day analysis for each hospital.

Table 26 shows that on most days of the year, psychiatric beds were available at both Wilson N. Jones (88% of days) and Texoma Medical Center – Grayson (98% of days). An average of 39 adult patients at the Texoma Medical Center – Grayson occupied beds each day, compared to 48 beds available to this population. Thus, although many of the beds were being occupied, the hospitals were not usually operating over capacity.[93]

[93] "Over capacity" or "exceeding capacity" indicates that the number of patients occupying beds in a given facility each day is larger than the number of beds listed by the American Hospital Association.

Table 26: Summary of Inpatient Utilization and Capacity (October 2015–December 2019)[94]

Hospital Name	Average Daily Utilization	Reported Capacity	Utilization as % of Capacity	% of Days with Available Beds
Wilson N. Jones Behavioral Health	7	12[95]	70%	88%
Texoma Medical Center – Grayson, Overall	43	60[96]	72%	98%
Adult Utilization	39	48	82%	89%
Children and Youth Utilization	6	12	54%	91%

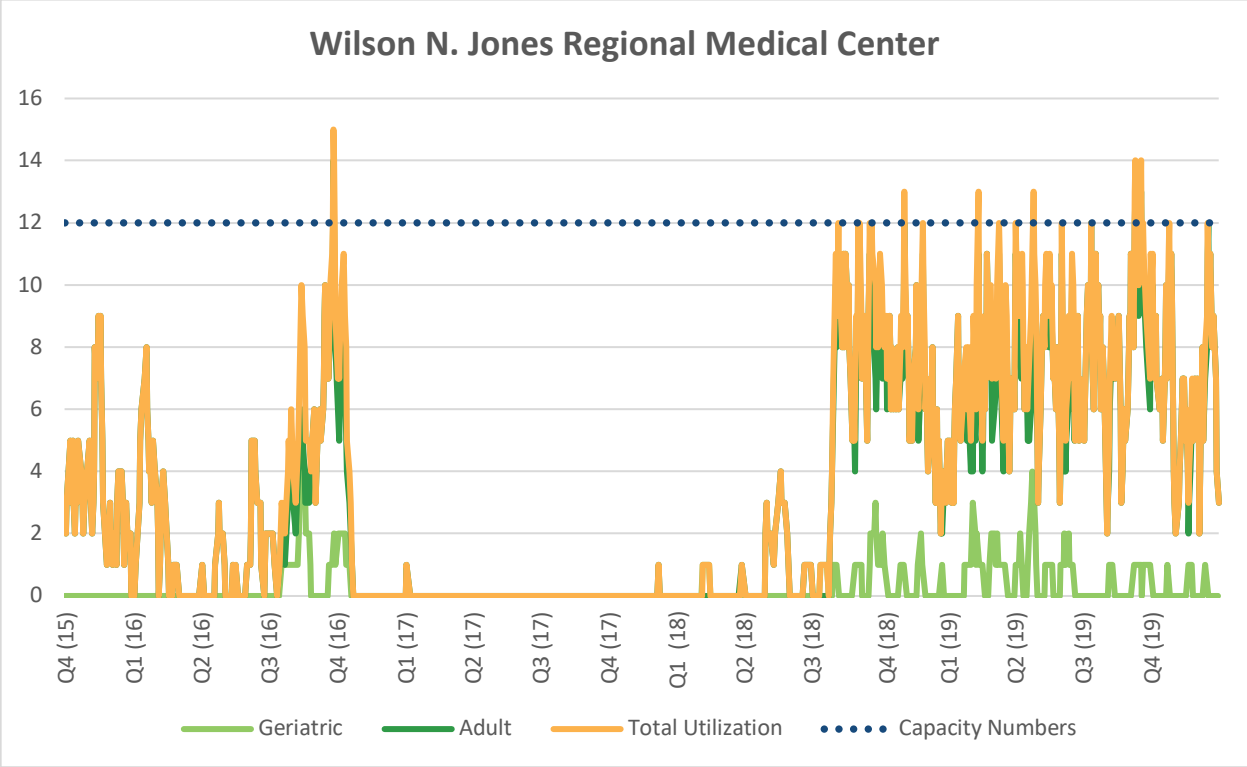
Graphs 1, 2, and 3 show the seasonal trends in adult inpatient utilization from October 2015 to November 2019 for Wilson N. Jones Regional Medical Center (for both the behavioral health unit and the hospital system) and for Texoma Medical Center (Grayson County). Texoma Medical Center – Grayson has a much higher psychiatric bed capacity (60) than Wilson N. Jones (12) and, as expected, reported much higher utilization than Wilson N. Jones (Table 27; Graphs 2 and 3). Although there were multiple periods when the hospital exceeded capacity, as Table 26 shows, this was not the case for 88% of the days shown. There appeared to be a recent upward trend in utilization, with more frequent operation at capacity starting in fall 2018.

[94] Children and youth psychiatric bed capacity was only available from the 2017 American Hospital Association Annual Survey of Hospitals. Because there was no youth utilization before 2017, and we did not have capacity information for youth prior to 2017; data by age group only reflect dates after January 1, 2017. Capacity is assumed to be constant through a given year.

[95] The American Hospital Association (AHA) 2018 data lists the inpatient hospital capacity for Wilson N. Jones as zero. However, the 2015 and 2017 Annual Survey of Hospitals listed Wilson N. Jones as having 20 inpatient hospital beds, while the 2016 survey listed the hospital as having 12 inpatient beds. The hospital's website indicates that it has 12 beds. Because the utilization data appeared to support a capacity of 12 beds, and the AHA survey reported both numbers, we have used the 12-bed capacity number instead of the 20 beds reported though AHA. See Wilson N. Jones Regional Medical Center. (2020). *Behavioral health services: What we provide*. https://www.wnj.org/behavioral-health

[96] The American Hospital Association (AHA) 2018 data lists the inpatient hospital capacity for Texoma Medical Center – Grayson as zero. Therefore, we have retained the prior capacity data reported to the AHA in 2017.

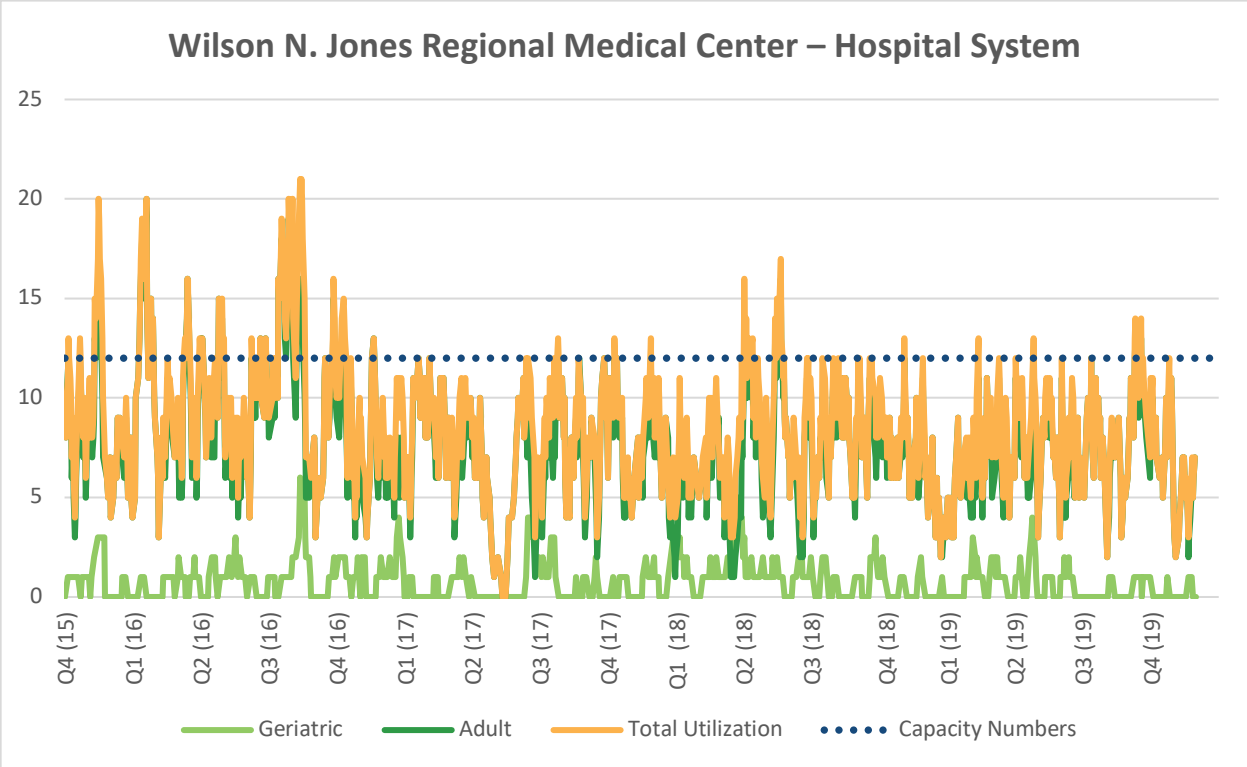
Graph 1: Wilson N. Jones Regional Medical Center–Behavioral Health – Grayson County (October 2015–November 2019)[97,98]



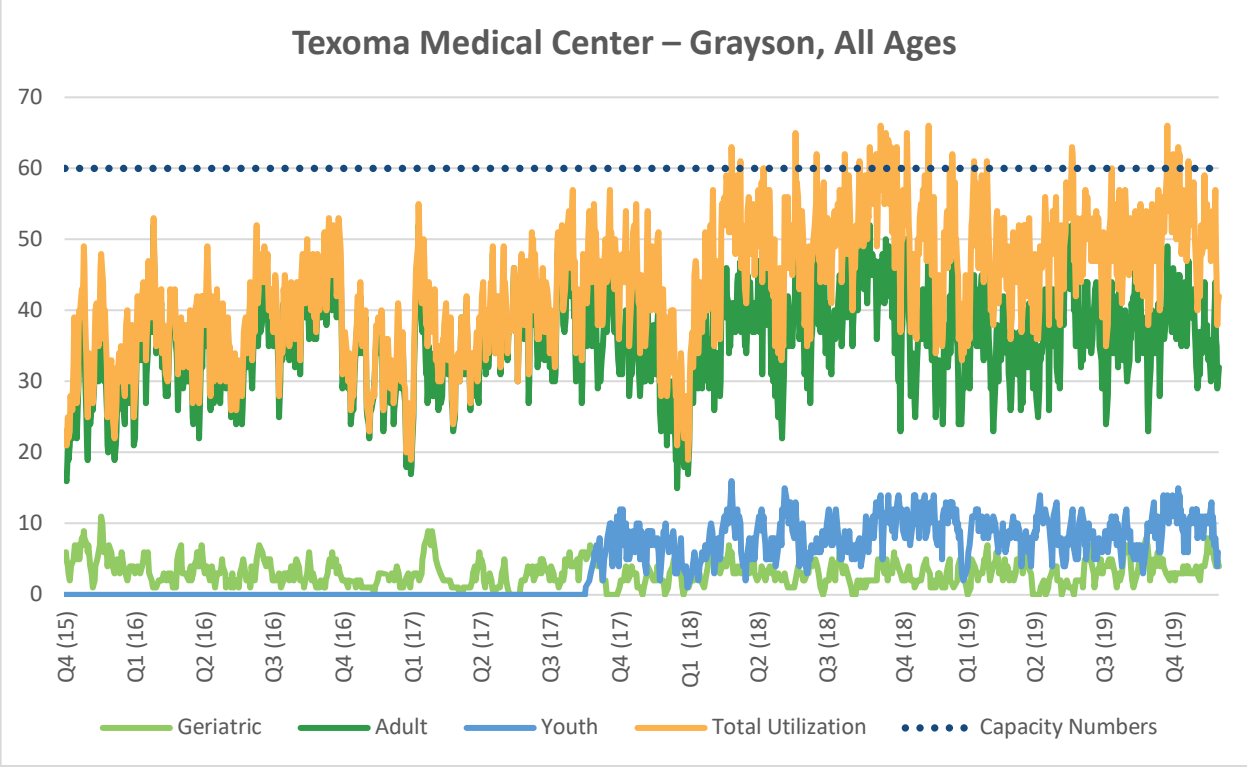
[97] Utilization reflect admissions to Wilson N. Jones Regional Medical Center–Behavioral Health. There was a smaller number of admissions to Wilson N. Jones outside of the behavioral health unit. Among days with utilization, there was an average of four patients occupying a bed; however, more than two thirds of days in the time period that was studied had no occupied beds. This utilization is not reported in the chart above because there was no reported bed capacity that could have been used as a comparison.

[98] Wilson N. Jones Regional Medical Center. (2020). *Behavioral health services: What we provide.* https://www.wnj.org/Behavioral-Health

Graph 2: Wilson N. Jones Regional Medical Center – Grayson County (October 2015–November 2019)



Graph 3: Texoma Medical Center – Grayson County, All Ages (October 2015–November 2019)



The following section shows admissions and estimated payments for inpatient psychiatric beds in the two counties, including admissions and estimated payments by primary payer.

Texoma Medical Center – Grayson has a much higher psychiatric bed capacity (60) than Wilson N. Jones (12) and, as expected, reported much higher utilization than Wilson N. Jones (Table 27). Comparing payment sources, a higher proportion of admissions to Texoma Medical Center – Grayson were self-paid (usually uninsured; 5%) or paid by other governmental programs (5%), whereas no admissions to Wilson N. Jones were self-paid and only 1% were paid for by other governmental programs. Wilson N. Jones had a higher proportion of admissions paid by commercial insurance (74% compared to 60% at Texoma Medical Center – Grayson) and both locations had an equal proportion of Medicare payments (22% at both locations).

Contrasting inpatient admissions in Table 27 with the equivalent emergency department visits in Table 24, patients who self-paid were noticeably absent from inpatient beds. This may be because the hospitals were successful at enrolling patients without insurance into publicly-funded coverage, uninsured patients had restricted access to inpatient beds, or some combination of the two.

Table 27: Adult Admissions to Psychiatric Beds, by Primary Payer (CY 2019) [99,100]

Grayson County Hospitals	All Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson	**1,318**	**7%**	**22%**	**5%**	**5%**	**60%**
Adults Ages 18 to 64	1,228	7%	20%	5%	5%	61%
Adults Ages 65 and Older	90	1%	52%	4%	0%	42%
Wilson N. Jones Regional Medical Center	**290**	**3%**	**22%**	**1%**	**0%**	**74%**
Adults Ages 18 to 64	271	3%	21%	1%	0%	76%
Adults Ages 65 and Older	19	5%	42%	0%	0%	53%

We estimated payments for adult admissions to psychiatric beds (Table 28) for psychiatric inpatient stays in Grayson County hospitals at approximately $11.6 million for 2018. This is significantly higher than the estimated payments for behavioral health emergency department visits (Table 25). These numbers simply demonstrate where the different costs are experienced

[99] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field.
[100] There were no records showing inpatient hospitalizations in Fannin County.

by the hospital systems in their support of the overall behavioral health system in the two counties.

Table 28: Estimated Payments from Adult Admissions to Psychiatric Beds, by Primary Payer (CY 2018)[101]

Grayson County Hospitals[102]	Estimated Payments	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson[103]	**$9,445,974**	**4%**	**18%**	**13%**	**4%**	**60%**
Adults Ages 18 to 64	$8,728,400	4%	16%	14%	5%	60%
Adults Ages 65 and Older	$717,574	0%	42%	1%	1%	53%
Wilson N. Jones Regional Medical Center	**$2,200,908**	**4%**	**21%**	**1%**	**0%**	**74%**
Adults Ages 18 to 64	$1,936,506	4%	19%	1%	0%	75%
Adults Ages 65 and Older	$264,402	0%	34%	0%	0%	66%

Hospital Admissions and Patient Flow for Adults

The next table shows the flow of local residents to psychiatric beds across the state of Texas, with detailed analysis of state hospitals. Of 1,907 total adult admissions to psychiatric beds, the 1,608 (84%) were admitted to local beds. Of all admissions of residents of Fannin and Grayson counties to psychiatric beds, just 34 (2%) received care at state hospitals. Most went to either North Texas State Hospital – Vernon (14) or North Texas State Hospital (11). Because of the small number of admissions to the state hospitals, it does not appear that these institutions are used as the primary treatment centers for uninsured patients from Fannin and Grayson counties.

The remaining 265 admissions of local residents were to non-local beds at hospitals other than state hospitals. These represented approximately 14% of all admissions of local residents. Nine percent (9%) of local resident admissions to these non-local hospitals were self-pay, while 4% of local resident admissions to the two local hospitals were self-pay. Although this indicates that self-pay patients were disproportionately hospitalized out of the immediate region, and not at state hospitals, this disparity was quite small in comparison to the apparent lack of access to inpatient beds for uninsured adults at all locations. As Table 25 showed, 25% of local psychiatric

[101] This table could not be updated using 2019 data for multiple reasons, including unavailable patient ratios and methodological questions surrounding the approach.

[102] There were no records showing inpatient hospitalizations in Fannin County.

[103] Out of all 1,745 admissions, 13 admissions with $360,175 associated charges at Texoma Medical Center – Grayson did not have a clearly identified payer. These accounted for less than 1% of reported admissions and were only included in the "all admissions" column, not in payer breakouts.

emergency department visits were for self-pay patients (35% for SUD emergency department visits), yet self-pay patients only made up 4% of inpatient psychiatric hospitalizations of local residents.

Table 29: Adult Residents of Fannin and Grayson Counties – Admissions to Psychiatric Beds Statewide[104,105]

Resident Admissions	Adult Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Admissions to Local Hospitals	**1,608**	**6%**	**22%**	**4%**	**4%**	**63%**
Texoma Medical Center – Grayson[106]	1,318	7%	22%	5%	5%	60%
Wilson N. Jones Regional Medical Center	290	3%	22%	1%	—	74%
Admissions to Non-Local State Hospitals	**34**	—	—	—	**100%**	—
North Texas State Hospital – Vernon	14	—	—	—	100%	—
North Texas State Hospital	11	—	—	—	100%	—
Admissions to Other Non-Local Hospitals	**265**	**17%**	**30%**	**1%**	**6%**	**46%**
Total Admissions to Psychiatric Beds	**1,907**	**8%**	**23%**	**4%**	**4%**	**59%**

Table 29 shows that 299 admissions[107] were for local residents who were sent out of the region for hospitalization. In some cases, this reflected the need for specialized services, such as competency restoration at state hospitals or specialized treatment that was unavailable at the local hospitals. The next table examines the flow of patients to local beds from outside the region. Of the 1,974 total admissions at Texoma Medical Center – Grayson (Table 30), 1,408 were for residents from Fannin and Grayson counties, with 566 admissions for patients from other counties. Although a larger proportion of Wilson N. Jones capacity was used by local residents of Fannin and Grayson counties, non-local residents still used nearly 29% of its beds.

[104] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records.

[105] One hospital was removed because of low admissions; value was included in totals calculations.

[106] Ten records did not have an identified payer; those admissions were included in total calculations.

[107] State hospitals are included in the "out of region" calculation.

Because this inflow was several times the magnitude of the 299 admission outflow, this suggests that that local psychiatric bed capacity was more than enough to satisfy purely local residential need.

Table 30: Admissions to Texoma Medical Center – Grayson Psychiatric Beds, by County of Residence and Age (CY 2019) [108,109]

County of Residence	Admissions to Texoma Medical Center – Grayson Psychiatric Beds		
	Total Adult Admissions (18 and Older)	Adult Admissions (18 to 64)	Geriatric Admissions (65 and Older)
Total Admissions	**1,974**	**1,850**	**124**
Admissions by County of Residence			
Grayson	1,361	1,276	85
Out of State	203	188	15
Dallas	59-63	58	<6
Gregg	49-53	48	<6
Fannin	42-47	42	<6
Collin	43	43	0
Smith	32	32	0
Lamar	31–35	25	<10
Bowie	21	21	0
Cooke	16–21	15	<6
Harrison	16–21	15	<6
Denton	13	13	0
Hunt	11	11	0
Cass	<10	<10	0
Rusk	<10	<10	0
Tarrant	<10	<10	0

[108] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records.

[109] THCIC. (2019). Counties were omitted if they had less than six total adult admissions. Per our agreement with the Department of State Health Services, cells with less than ten visits (<10) have been masked to prevent deductive disclosure of patient identity.

Table 31: Admissions to Wilson N. Jones Behavioral Health Psychiatric Beds, by County of Residence and Age (CY 2019) [110,111,112]

County of Residence	Admissions to Wilson N. Jones Psychiatric Beds		
	Total Admissions (18 and Older)	Adult Admissions (18 to 64)	Geriatric Admissions (65 and Older)
Total Admissions	**382**	**358**	**24**
Admissions by County of Residence			
Grayson	258	241	17
Non-Texas	45–50	44	<6
Fannin	31–32	30	<6
Cooke	13–18	12	<6
Collin	<10	<10	0
Dallas	<10	<10	0

Based on the analysis presented in this section, there was sufficient local capacity to meet the inpatient psychiatric needs of adult residents of Fannin and Grayson counties within the timeframe we analyzed. Local beds were fully occupied on only a small number of days between 2015 and 2019. Also, many more local patients were admitted to out-of-region hospital beds than out-of-region patients were admitted to local beds.

People who pay for services out of pocket may experience challenges with accessing inpatient care locally. A disproportionate number of these patients have been sent to psychiatric hospitals outside the immediate region. Also, there was a higher proportion of emergency department visits than inpatient admissions for people with behavioral health conditions who paid out of pocket for services, which suggests these people had reduced access to inpatient care.

Crisis and Criminal Justice Systems

Texoma Community Center

Texoma Community Center provides Coordinated Specialty Care for people experiencing their first episodes of psychosis. This program provides mental health services for people ages 15–30

[110] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records.

[111] Per our agreement with the Department of State Health Services, cells with less than six (<6) visits and those with between six and nine visits (<10) are masked to prevent deductive disclosure of patient identity.

[112] Counties were omitted if they had less than six total adult admissions.

who have a psychotic disorder that was diagnosed within the past two years.[113] These team-based services are a level of care that was specifically created for early onset psychosis to provide comprehensive treatment and support services.[114]

Texoma Community Center also operates a crisis division that comprises a 24-hour mobile crisis outreach team (MCOT) and a crisis respite unit. As described by Texoma Community Center leadership, the crisis respite unit allows people a remain on the unit for up to a week and acts as a transition to Texoma Community Center's residential unit. The MCOT team is responsible for crisis response in all three counties (Fannin, Grayson, and Cooke) and provides Level of Care 5 (crisis-transitional) services.

Input from our stakeholder interviews revealed that the local system needs to expand crisis services while enhancing fidelity to best practices. Texoma Community Center developed its crisis residential program in response to inappropriate lengths of stay in emergency departments (often called "boarding"). In this program, Texoma Community Center prioritizes residents who have the most difficulty maintaining stability in the community without assistance as well as those with the highest utilization of hospital and law enforcement resources. The program provides medication management and connection to Texoma Community Center outpatient services. Currently, the program can serve an average of 20 people. Based on identified need, Texoma Community Center is planning to expand this program's operations in the near future.

Texoma Community Center leadership noted that its forensic services are one of the agency's strengths. In 2007, recognizing the intersection between criminal justice and mental health, Texoma Community Center participated in establishing one of the first diversion mental health courts in Texas. Since then, Texoma Community Center has developed additional diversion mental health courts and reported having strong collaborative relationships with the sheriffs' offices and court systems throughout these communities.

The Texoma Community Center diversion team has developed an ongoing collaboration with county sheriffs' offices and local judges to reduce the burden on law enforcement officers in addressing behavioral health crises. This team has developed a mutual respect with the criminal justice community and believes it is able to coordinate efficient hand-offs of people experiencing a behavioral health crisis when they encounter police and are in need of care at Texoma Community Center. Texoma Community Center leadership reported that: (1)

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[113] Texas Health and Human Services Commission. (n.d.). *Coordinated specialty care for first episode of psychosis*. https://hhs.texas.gov/doing-business-hhs/provider-portals/behavioral-health-services-providers/coordinated-specialty-care-first-episode-psychosis

[114] Texas Health and Human Services Commission. (n.d.).

agreements are in place between local emergency departments and law enforcement to enable these systems to coordinate with Texoma Community Center when they encounter a person who is experiencing a behavioral health crisis; and (2) the next phase of system coordination efforts will create true pre-arrest jail diversion by allowing law enforcement officers to have access to Texoma Community Center client information, including diagnosis and last date of care, prior to booking these people into the jail.

Although Texoma Community Center operates an Assertive Community Treatment (ACT) team, it currently does not have a Forensic ACT (FACT) team. FACT is an intensive, evidence-based, multi-disciplinary team-based intervention for people with serious mental illnesses who are at high risk for criminal recidivism. These people often cycle through the criminal justice system and have a pattern of high utilization of behavioral health care services, especially the local emergency system and hospital services. FACT is based on ACT principles, but staff are specially trained to focus on factors that increase a person's risk for recidivism (called "criminogenic" risk).

Although it is not a specialized FACT team, it should be noted that Texoma Community Center does provide extensive forensic services and supports through a Level of Care 3 program (as defined by the Texas Correctional Office on Offenders with Medical or Mental Impairments), which provides forensic services to individuals involved with the criminal justice system. This program was funded through Senate Bill 292 (85th Legislature) and had just started at the time of our interviews. The program supports mental health deputies and provides up to eight beds of forensic transitional housing, medication management, and other supports, and assists people who are transitioning from jail to the community.

House Bill 13

Another example of mental health and justice collaboration is the project funded by the Community Mental Health Grant through House Bill 13 (85th Legislature). This program allows participating law enforcement agencies in Grayson County to request an off-duty law enforcement officer with advanced mental health training, mostly through the Grayson County Sheriff's Office, to respond to behavioral health incidents and relieve the on-duty officer when it is apparent additional resources are needed and the incident will take a significant amount of time to resolve. The off-duty officer then continues to provide scene stabilization and security until a mobile community outreach team arrives to complete an assessment and connect the individual to appropriate treatment. The goal of the program is to relieve on-duty law enforcement officers from protracted time on behavioral health calls and return them to service more quickly.

Related to this work is a partnership between the Texoma Behavioral Health Leadership Team, Grayson College, and Texoma Community Center to provide training in fall 2020 to law enforcement officers on responding effectively to calls involving mental health incidents.[115]

Law Enforcement Officer Focus Groups

We conducted focus groups with law enforcement officers from the Sherman Police Department, Denison Police Department, and Bonham Police Department.[116] We then completed an analysis to determine prevailing themes in these focus groups. Assured of anonymity, officers identified both strengths and gaps in the current system, which were often in contrast to the strengths identified by Texoma Community Center and other stakeholders. One prevailing theme was a lack of engagement at the time of crisis and a lack of a clear understanding of alternatives to hospitalization or arrest for people in less immediate need of care.

Table 32: Prevailing Themes from Police Department Focus Groups

Theme	Description
Access to Crisis Resources	Officers conveyed that when they are at a behavioral health incident, there are very few appropriate resources such as a behavioral health consult at their disposal to guide them in their decision making. Additionally, there is a lack of alternative services for people who have committed low-level offenses. The majority of the officers we interviewed said that if a person met the minimum threshold for an emergency detention, a custodial arrest was made because of a lack of more suitable options. Officers were unaware of the roles that Texoma Community Center and the mobile crisis outreach team (MCOT) play in the community.
Community Education	There is a need to educate community members and inform them of mental health resources prior to and during law enforcement interactions. Often, officers encounter situations in which an emergency detention or voluntary admission is not the most appropriate response; however, officers lack vital behavioral health information and knowledge of resources to pass on to those individuals or family members.

[115] Staff writer. (2020, September). GC to provide mental health response training for law enforcement. *Herald Democrat*. https://www.heralddemocrat.com/story/news/2020/09/17/gc-to-provide-mental-health-response-training-for-law-enforcement/42641867/

[116] For a description of each police department, please see Appendix E.

Theme	Description
Behavioral Health Workgroup	Law enforcement agencies' leadership see a need to create a workgroup comprising a wide range of stakeholders (emergency departments, hospitals, police, fire, Texoma Community Center, sheriff's office, etc.) to coordinate a community treatment/behavior health plan for frequent users of emergency services. This group would debrief specific incidents and address law enforcement agencies' questions about services provided by the local mental health authority, hospitals, etc.
Continuity of Care	Officers identified that when people who had experienced a behavioral health crisis are prematurely released from hospitals/facilities, they tend to cycle back through contact with law enforcement, emergency detention, hospitalization, or incarceration. Officers expressed concern that this is due to providers' lack of – or inefficient – follow-up and continuity of care procedures.
Housing	Officers reported a lack of resources for both transitional and supportive housing. They noted that, without stable housing, people are unable to maintain mental health stability, which would lead them back into a cycle of high utilization of emergency services.
Transportation	Officers noted that there is a lack of public transportation or a lack of awareness of regional transportation resources that allow people to access behavioral health resources.
Information Access	A lack of access to information about a person's mental health history or current connection to services prevents officers from diverting people to proper care or coordinating with current treatment providers for individualized responses.
Law Enforcement Crisis Intervention Training	There are ongoing training needs for law enforcement to appropriately address behavioral health calls, specifically with veterans and people with intellectual and developmental disabilities (IDD). Training needs include identifying available community resources and connecting people with these resources.
Dispatcher Training	Although all agencies with a computer-aided dispatch system and primary dispatch model said they met tele-communicator and dispatcher training requirements, there was a desire for enhanced behavior health training to improve triage of behavioral health calls.

Locally Developed Initiatives

There are two locally developed initiatives that proved to be strengths in the overall system: a streamlined emergency detention process and an innovative use of public safety software. The emergency detention process has been streamlined for law enforcement officers at both of the main hospitals in Grayson County: Wilson N. Jones Regional Medical Center and Texoma Medical Center – Grayson. In order to return law enforcement officers back to their respective jurisdictions to perform law enforcement duties, both hospitals have put policies and practices in place to expedite the intake process and use hospital staff to provide security or monitoring for people brought to those facilities by law enforcement officers. Both hospitals immediately assign the appropriate hospital staff when officers present a person under an emergency detention order. Officers conveyed that for most incidents, they were able to clear from the hospitals in under thirty minutes.

Conversely, those policies had not been adopted by Texoma Medical Center – Bonham in Fannin County at the time of our interviews. This hospital insists that law enforcement officers remain at the medical facility until a complete assessment is completed. Leadership at Texoma Medical Center – Bonham stated that they do not have security or hospital staff that can monitor people brought in on emergency detentions, making it necessary for officers to remain at the hospital for an extended period of time. Officers indicated that because of excessive wait times at Texoma Medical Center – Bonham, they often divert people experiencing behavioral health crises to other providers, when possible. This mandate is an in-house policy and is not supported by any law or regulation that requires law enforcement officers to remain at a facility until an assessment is completed. Leadership at Texoma Medical Center – Bonham indicated that they continually evaluate the intake process; however, there were no immediate plans to change their policy.

The Sherman Police Department used existing public safety software to initiate an innovative initiative called *Project H.E.L.P. – The Help Emergency Life Plan.* This program has expanded to include the Grayson County Sheriff's Office and has been featured in national police publications. The program allows caretakers to voluntarily submit information about family members with mental illnesses through an online form. The information is uploaded and stored in the department's communications database and will provide alerts based on name and address. The system also allows for photographs to be uploaded, which will give officers vital information to ensure the safety of interactions between the police and the people in crisis.

System-Level Recommendations: Adults and the Crisis and Criminal Justice Systems

Adult Services

With an estimated 3,700 adults with serious mental illness (SMI) living in poverty in the region, of whom many may not have the resources to obtain commercial insurance, there are adults in the region who are not receiving adequate treatment. Overall, across Fannin and Grayson counties, about 30% of adults live in poverty. However, among those with serious mental illnesses, nearly 52% live in poverty. Living with a serious mental illness (SMI) can cause financial strain such as lost productivity and wages that can lead to or exacerbate poverty. At the same time, living in poverty may also make it harder to obtain adequate care – it may be difficult or impossible for someone living with SMI to take the time to access care. They may face difficulties with transportation if care is located far away, or they may not be able to pay for treatment. Living with SMI while in poverty can also lead to other strains such as food and housing insecurity that can exacerbate both mental illness and poverty.

There is a need to increase high-quality intensive outpatient services such as Assertive Community Treatment, with fidelity to the cutting-edge Tool for Measurement of Assertive Community Treatment, for adults with complex needs in Fannin and Grayson counties. When we assess a community's utilization of services, we pay close attention to people who are served through the local mental health authority and compare that to the estimated prevalence of community members with SMI who are living in poverty. A comparison of these data shows that among an estimated 3,700 adults with SMI who were living in poverty in Fannin and Grayson counties, just over 1,700 received care at Texoma Community Center in fiscal year 2019. Furthermore, of the approximately 100 people with the most severe needs – those with SMI who were living in poverty and were also at risk for repeated jail and hospital use – only 35 received Assertive Community Treatment (ACT) or Forensic ACT.

Supporting the previous finding, adding intensive outpatient capacity such as ACT for people with severe needs may further reduce the need for additional inpatient psychiatric beds. When a person does not receive the care they need, they may enter into a state of crisis, turning to the local emergency department to obtain needed care. In 2019, there were 2,121 adult visits to emergency departments from Fannin and Grayson counties for a psychiatric or substance use-related crisis. These visits put a strain on hospital resources and staff, yet many of the visits could have been prevented by providing high-quality care in the community, including integrated primary care and specialized behavioral health clinics.

Based on the availability of inpatient psychiatric beds on most days in the year, and the use of many of the current beds by residents of counties outside the region, it does not appear that there is a shortage of inpatient capacity in the two counties. Very few Fannin and

Grayson County residents are sent to state hospitals. Inpatient hospitals in Fannin and Grayson counties are generally operating within their capacity to provide care; however, there have been instances within the past year and a half when total utilization exceeded capacity at Texoma Medical Center – Grayson. Yet, our analysis of overall inpatient utilization revealed that hospitals with psychiatric beds in the two counties have beds available at least 88% of the time. It may be that demand for treatment is increasing. However, our analysis of population growth trends revealed that, in general, the adult population in the two counties is not expected to dramatically rise over the next 30 years. It is possible that Texoma Medical Center – Grayson is facing increased demands for care of residents from other regions, or that shifts in treatment availability or other demographics (such as an increase in poverty) may be causing an increased need for inpatient care.

Despite the general availability of inpatient beds, patients without insurance may not be able to access them. Our analysis of the types of payment used for inpatient services shows that people with behavioral health conditions who were uninsured of paid out of pocket for services frequently used the two Texoma Medical Center emergency departments. These payer categories had a disproportionately lower rate of reimbursement for inpatient psychiatric beds. This may reflect that there are well-developed programs for linking uninsured patients to coverage at time of admission for inpatient services, or a relative lack of access to inpatient beds for people who are uninsured.

Crisis, Law Enforcement, and Justice System

One significant limitation for people with mental illnesses who are involved with the criminal justice system is that those who are placed in forensic beds might be better treated in the community with enhanced services such as Forensic Assertive Community Treatment (FACT). Developing FACT services for the community would provide an opportunity for cross-system collaboration between the criminal justice system and behavioral health care providers, and it would also enhance the region's continuum of care. Collaboration between behavioral health care agencies and the criminal justice system is essential to managing care for people with serious mental illnesses and criminal justice involvement when they are in community settings.[117]

Although a full FACT team may not be feasible for, or of interest to, Texoma Community Center at this time, additional steps should be taken to help the team integrate a FACT model component within the ACT team. Texoma Community Center staff reported that participants in the ACT program who are currently involved in the criminal justice system receive the same treatment as those who are not involved in the criminal justice system, which is not best

[117] Lamberti, S. (2016). Preventing criminal recidivism through mental health and criminal justice collaboration. *Psychiatric Services, 67,* 1206–1212.

practice for forensic services. Although there is forensic capacity within Texoma Community Center, unless it has fidelity to FACT, the program's participants are more likely to experience reincarceration since ACT has not been shown to be effective in reducing arrests and jail time.[118]

Adding dedicated forensic expertise to the ACT team and establishing, at a minimum, a specialized track within the program, with its own caseload, will create a more targeted approach to treating ACT program participants who are involved in the criminal justice system. At the time of the initial assessment, Texoma Community Center had a staff member who identified people with mental health needs and assisted them while they are incarcerated. This position requires experience in working with people with serious mental illnesses, co-occurring substance use disorders, and criminal justice system involvement. If adequately qualified, this person could be formally integrated into the ACT team to provide the needed forensic specialist expertise. Stand-alone jail-based assessment is important, but the forensic component of an ACT team needs formal linkages to the jail program to facilitate diversion services. This position could still provide outreach and engagement more broadly (as not everyone leaving the jail will need FACT services), though the degree to which this position's duties are broadened would diminish the dedicated forensic capacity of the team. Overall, alignment of this position with the ACT team would increase the team's capacity to engage people leaving the jail and support best practices.

With further specificity and agreement between Grayson County and Texoma Community Center, realigning the dedicated jail staff and the ACT team would provide more optimal pre- and post-booking case management services. Pre-booking diversion services could be developed by creating a collaborative relationship between the forensic component of the ACT team and the Inmate Processing Unit (IPU). Designing an alert within the system to identify people with current or past involvement with Texoma Community Center services would provide the booking officer with a prompt to contact the ACT team and engage the forensic specialist to help the unit coordinate with the appropriate program. Therefore, we recommend that the jail assessment position be rolled into the ACT team, with the team taking responsibility for specific tasks for assertive engagement through in-reach to the jail, local hospitals, and emergency departments. This position should be tasked with prioritizing people who are most in need of services while providing ongoing engagement with potential program participants until they accept services.

[118] Beach, C., Dykema, L., Appelbaum, P., Deng, L., Leckman-Westin, E., Manuel, J., McReynolds, L., & Finnerty, M. (2013). Forensic and non-forensic clients in assertive community treatment: A longitudinal study. *Psychiatric Services, 64*(5), pp.437–444.

FACT teams need to closely coordinate services with community supervision and implement Risk-Need-Responsivity (RNR) principles,[119] which would entail assessing and reducing various aspects of criminogenic risk – criminal thinking, substance use, and associating with criminal companions, for example – by matching interventions to each person's specific constellation of risk factors. The primary driver of criminogenic risk is a history of involvement with the criminal justice system (e.g., recidivism), but there are multiple factors involved in this risk and the forensic component of the ACT team, and its system partners, will require training in using the RNR model and incorporating its principles into case identification and management. The investment in RNR is important, as research on FACT has shown that incorporating RNR into case assignment and care planning reduces both psychiatric hospitalizations and jail use among people who previously were caught in patterns of frequently cycling through the criminal justice system and local emergency and hospital services.[120] Just as matching ACT services to people who repeatedly cycle through restrictive and expensive services can maximize outcomes such as reduced hospital and emergency department use, matching FACT services to people who have a moderate to high criminal risk score can reduce jail use and criminal justice system involvement. FACT also requires tailoring intensive wraparound services and interventions to target criminogenic thinking and actions. The fidelity model created by the Meadows Institute and the University of California, Berkeley,[121] combines best practices in RNR and ACT to support a model that is practical to implement in real world settings.

The community collaborative initially funded through House Bill 13 should continue to find ways to reduce the use of on-duty law enforcement to support mental health calls. In particular, Fannin and Grayson counties should consider more medically-facing models to respond to mental health crises. The work the community has undertaken through House Bill 13 funding is important. Yet, it also continues to employ a law enforcement response (off-duty deputies) for mental health crises rather than a medical response.

The Texoma Community Center's MCOT is primarily utilized for conducting assessments in hospitals. Texoma Community Center could expand its MCOT's role so that it could conduct field assessments through telehealth technology. Placing mobile telehealth equipment in patrol vehicles and ambulances throughout the region would allow law enforcement to return to patrol duties more rapidly while also providing a clinical approach, rather than emphasizing a law enforcement approach to field triage and service connections.

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[119] Skeem, J., et al. (2014). Offenders with mental illnesses have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*(3), 212–224.

[120] Cusack, K.J., et al. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363.

[121] Meadows Mental Health Policy Institute. (2017). *Smart justice FACT fidelity scoring guide*.

The community could also consider piloting medically-staffed response teams that are composed of a paramedic (to provide medical screening), a mental health professional (to respond to immediate mental health issues), and law enforcement (to secure the scene, as appropriate) rather than relying on law enforcement alone, or mental health providers alone, to respond to a crisis. Many Texas communities, including Dallas, Austin, Abilene, Houston, and others, have either implemented or are considering these multi-disciplinary response teams.

Early returns on this integrated approach are promising, with reductions in arrests and emergency department stays and resolutions of many situations in the community (instead of in emergency rooms or jails). For example, as outlined in our final report regarding our work on the Dallas County Smart Justice Project, a three-year project funded by the W.W. Caruth Jr. Foundation at the Communities Foundation of Texas, the City of Dallas deployed a multidisciplinary response team called Rapid Integrated Group Healthcare Team (RIGHT) Care. This unit is a collaborative partnership between the Dallas Police Department, Dallas-Fire Rescue, and Parkland Health and Hospital System – whose service area was identified as the geographic areas of greatest need – to respond to mental health-related 911 calls for service. RIGHT Care provides on-site clinical assessment and linkage to appropriate care at the point of intervention for people who have mental health needs and are experiencing a mental health crisis in the community.

RIGHT Care has reduced the burden on law enforcement in responding to 911 mental health calls in the Dallas community and has fundamentally altered intervention practices in the South Central Patrol Division, where it has been implemented since 2018. From implementation through December 15, 2019, RIGHT Care has had 5,514 total interactions with individuals. Of these interactions, 1,972 resulted in diverting people from arrest or involuntary hospitalization and connecting them instead to treatment or services.

We recommend this approach highly, particularly with its integration of a paramedic, mental health professional, and law enforcement. We are happy to provide additional information on these approaches. In the interim, we provide specific findings and recommendations from the current interactions in Fannin and Grayson counties between law enforcement and those experiencing a behavioral health incident.

There is an opportunity (and need) for local law enforcement agencies to substantially improve their use of data. All law enforcement agencies we interviewed reported that obtaining data was a challenge. Basic data queries for date and time, location, call type, final disposition, and length of time on call required a manual process. Each agency reported there was no functionality in the software used to extract or sort specific queries. We recommend that an analysis be conducted to evaluate respective agencies' Computer Aided Dispatch (CAD)

systems to ensure each system is operating with maximum capabilities. In addition, we recommend enhanced policies to ensure officers reclassify initial "call types" to conform more with a final disposition classification, if necessary, prior to clearing the call for service. Having such information would provide insight into call types that officers respond to, emerging crime trends, and the ability to perform predictive analytics. Denison Police Department switched to a new CAD system (Athena, September 2018) that will make data mining more efficient. Staff conveyed they are still learning the system and its capabilities.

Law enforcement officers should continue to receive advanced mental health training. Although all law enforcement agencies in the region have met the basic mental health training requirements mandated by the Texas Commission on Law Enforcement, they all identified that having more advanced mental health training for their officers was a priority. Law enforcement leadership stressed that advanced mental health training such as the Texas Commission on Law Enforcement (TECOLE) Mental Health Peace Officer course (4001) would not only enhance officer safety it would also improve customer service to the community. Providing advanced behavioral health training to officers is challenging for most agencies because of staffing limitations. We recommend continuing the partnership between the Texoma Behavioral Health Leadership Team, Grayson College, and Texoma Community Center to provide training to law enforcement on responding effectively calls involving mental health incidents. We also encourage law enforcement agencies to use existing interagency/mutual aid crisis response agreements that would allow all agencies to participate in training opportunities. The agreement would be structured so that it would allow officers from different agencies to backfill patrol shifts in other agencies to cover those who attend the training.

County and city dispatch centers should provide mental health training for call takers. Counties and cities with dispatch centers could collaborate with an accredited training agency to create a training on evidence-based and research-informed mental health crisis call identification and management for all call takers. The training should be of high quality, with academic or external professional review. Topics should cover, but not be limited to, active listening, mental health symptom recognition, communication techniques for people experiencing a mental health crisis, and verbal de-escalation techniques. Each call taker should receive this training and demonstrate competency as a core part of their duties. Several curriculum examples exist and have been deployed with success in areas across the state and country.

A community stakeholder group should identify and provide appropriate resource materials for law enforcement officers and the community. There appears to be a lack of clarity and consensus in the community regarding the potential disposition of situations in which a person appears to have a mental illness as well as available behavioral health resources and criteria for accessing care. A dedicated work group consisting of law enforcement officers (rank and file),

mental health crisis clinicians, jail personnel, and hospital emergency room staff should be convened to produce resource materials that can be distributed to law enforcement officers as a reference guide for behavioral health issues. These resources could increase officers' confidence in making effective decisions and increasing diversion opportunities. In addition, this work group could produce separate educational materials that can be easily disseminated by officers or posted on agency websites and social media platforms to educate the public on behavioral health issues and available resources.

Communities should capitalize and expand on innovative programs. Although we have not evaluated the innovative *Project H.E.L.P – The Help Emergency Life Plan* that was created in September 2019 by the Sherman Police Department and the Grayson County Sheriff's Office, we believe the program has merits and could provide officers with valuable information while responding to behavior health calls, which could increase officer and citizen safety as well as enhance customer service. We encourage the Sherman Police Department to fully evaluate the program and make those findings available to area law enforcement agencies to allow them to assess the program individually and determine if it is appropriate for regional expansion.

System-Level Findings: Children and Youth

Children and Youth Behavioral Health Conditions

Table 33 compares the distribution of mental health conditions across Fannin County, Grayson County, and the state of Texas. Overall, there were approximately 2,000 children and youth in Fannin County and 8,000 children and youth in Grayson County with any mental health needs. The total number of children and youth with mental health needs in the region (approximately 10,000) was between one third and one half of the total child and youth population in the two counties.

Of these children and youth with mental health needs, we estimated that more than half (6,000) had mild conditions, whereas about 20% (one in five) had moderate conditions and more than 2,000,[122] or one out of every five children with mental health needs, had conditions that caused enough impairment to be considered serious emotional disturbances (SED). Approximately half (800) of the children and youth with SED were living in poverty in 2018. We estimated that the most severe conditions (those that caused so much impairment that the child was at risk for out-of-home or out-of-school placement or involvement in the child welfare system) affected about 80 children and youth in the region. These children and youth could have benefited from intensive, wraparound care such as programming provided by Texoma Community Center through Youth Empowerment Services (YES) Waiver services (see Table 33).

[122] This value was calculated using unrounded estimated prevalence of SED in Grayson and Fannin counties.

Table 33 also shows that the most common condition affecting children and youth in Fannin and Grayson counties is depression (400 children and youth), although anxiety and self-injury / self-harming behaviors closely follow. According to the most recent data available from the Centers for Disease Control and Prevention, the suicide rate in Fannin County is more than twice the statewide rate for 2013–2018. The suicide rate for Grayson County is also substantially higher than the statewide rate.

Table 33: Twelve-Month Prevalence – Mental Health Disorders in Children and Youth in Fannin and Grayson Counties Compared to Texas Statewide (2018)

Mental Health Condition – Children and Youth[123]	Age Range	Texas Prevalence	Fannin County Prevalence	Grayson County Prevalence
Total Population	**6–17**	**4,900,000**	**5,000**	**20,000**
All Mental Health Needs (Mild, Moderate, and Severe)[124]	**6–17**	**1,900,000**	**2,000**	**8,000**
Mild	6–17	1,100,000	1,000	5,000
Moderate	6–17	430,000	500	2,000
Serious Emotional Disturbance (SED)[125]	6–17	370,000	400	2,000
SED in Poverty[126]	6–17	200,000	200	800
At Risk for Out-of-Home/Out-of-School Placement[127]	6–17	20,000	20	80
Specific Disorders – Children and Youth[128]				
Depression[129]	12–17	320,000	400	1,000

[123] All prevalence estimates were rounded to reflect uncertainty in the American Community Survey estimates.

[124] Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *69*(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[125] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information.

[126] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information. Poverty data were obtained from the U.S. Census Bureau, American Community Survey 2018 Five-Year Public Use Microdata Sample (PUMA): https://www.census.gov/programs-surveys/acs/data/pums.html

[127] Based on our work in multiple states that have developed community-based service arrays in response to system assessments (WA, MA, CT, NE, and PA), the Meadows Institute estimated that one in 10 children with SED would require time-limited, intensive home and community-based services to reduce risk of out-of-home or out-of-school placement.

[128] Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380.

[129] Center for Behavioral Health Statistics and Quality. (2020).

Mental Health Condition – Children and Youth[123]	Age Range	Texas Prevalence	Fannin County Prevalence	Grayson County Prevalence
Bipolar Disorder[130]	12–17	50,000	60	200
Post-Traumatic Stress Disorder	12–17	95,000	100	400
Schizophrenia Incidence – New Cases Per Year[131]	12–17	3,000	<6	10
First Episode Psychosis (FEP) Incidence – New Cases per Year[132]	12–17	900	<6	<6
Obsessive-Compulsive Disorder – Children/Youth[133]	6–17	100,000	100	400
Eating Disorders[134]	12–17	20,000	20	80
Self-Injury/Harming Behaviors[135]	12–17	230,000	300	1,000
Conduct Disorder	12–17	130,000	200	600
Number of Deaths by Suicide[136] (2013–2018)	1–17	20,910	60	144
Suicide Rate per 100,000 Population	1-17	12.8	29.6	19.1
Specific Disorders – Children Only				
All Anxiety Disorders – Children[137]	6–11	270,000	300	1,000
Depression/All Mood Disorders – Children	6–11	25,000	30	100

[130] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3): 169–184.

[131] Frejstrup Maibing, C., Pedersen, C., Benros, M., & Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin,* 41*(4),* 963–970.

[132] J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.

[133] Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.

[134] Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, *68*(7), 714–723. The prevalence estimate for eating disorders encompassed only anorexia nervosa and bulimia nervosa.

[135] Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(11). doi.org/10.1186/1753-2000-6-10

[136] Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2018, on the CDC WONDER Online Database. Date range adjusted for 2013-2018.

[137] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012).

Mental Health Condition – Children and Youth[123]	Age Range	Texas Prevalence	Fannin County Prevalence	Grayson County Prevalence
Children and Youth with Adverse Childhood Experiences (ACEs)[138]				
Population with 1 or 2 ACEs	0–17	2,600,000	3,000	10,000
Population with 3 or More ACEs	0–17	720,000	700	3,000

Table 34 provides an overview of the estimated number of youth with substance use disorders in Fannin and Grayson counties. Using the latest available data from the National Survey on Drug Use and Health, we estimated there were approximately 400 youth in the two counties with substance use disorders. An estimated one in three were living in poverty and less than half had co-occurring psychiatric and substance use disorders.

Table 34: Prevalence of Substance Use Disorders (SUD) Among Children and Youth in the State of Texas Compared to Fannin and Grayson Counties (2018)[139]

Population	Youth Substance Use Disorders		
	Texas	Fannin	Grayson
Total Population (Ages 12–17)	**2,450,000**	**3,000**	**10,000**
Total Population in Poverty	1,050,000	1,000	4,000
Any Substance Use Disorder	**80,000**	**80**	**300**
SUD in Poverty[140]	<1,000	30	100
Comorbid Psychiatric and Substance Use Disorder[141]	35,000	30	100

[138] Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Child Trends. https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[139] All population estimates were rounded to reflect uncertainty in the Texas Demographic Center estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[140] The prevalence of any substance use disorder among adults and youth living in poverty is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty cross-tabulation, National Survey on Drug Use and Health, 2017-2018 restricted access file. The percentage was applied to the estimated number of youth living in poverty in Texas. Poverty estimates were based on the American Community Survey 2018 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates. These figures were rounded due to the uncertainty in the underlying data. As a result of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[141] Co-occurring psychiatric and substance use disorders (SUD) estimates among youth ages 12–17 were based on the national prevalence rate of major depressive episodes and SUD, as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2017–2018 NSDUH sub-state rates of major depressive episodes for Texas. These figures were rounded due to the uncertainty in the underlying data. As a result of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Population	Youth Substance Use Disorders		
	Texas	Fannin	Grayson
Needing but not Receiving SUD Treatment[142]	75,000	70	300
Alcohol-Related SUD	**30,000**	**30**	**100**
Needing but not Receiving Alcohol Use Disorder Treatment[Error! Bookmark not defined.]	30,000	30	100
Illicit Drug-Related SUD	**55,000**	**50**	**200**
Needing but not Receiving Treatment for Illicit Drug Use Disorder[Error! Bookmark not defined.]	55,000	50	200
Number of Drug-Related Deaths in 2018[143]	**22**	**<10**	**<10**
Number of Alcohol-Induced Deaths in 2018[144]	**<10**	**<10**	**<10**

As previously depicted in Tables 13–15, the population of children and youth in Fannin and Grayson counties is expected to remain relatively stable, or slightly increase over time, through 2050. The child and youth population in Grayson County is expected to grow by only about 10% (around 2,000 children and youth), whereas this population in Fannin County is expected to decline by about 7% (about 500 children and youth). Thus, absent any major events that would cause an increase in adverse childhood experiences or any major shifts in the two counties that could protect against mental illness (like a major decrease in poverty rates), we do not expect these prevalence estimates of mental illness or substance use disorders to substantially change over time.

Utilization Data for Children and Youth

The utilization data included in this report counts the number of children and youth served by Texoma Community Center, which, when compared to the estimated prevalence of mental health and substance use disorders, can help identify underserved populations and unmet need. Because high utilization of emergency departments and inpatient psychiatric beds can indicate inadequate community care, we have provided an analysis of emergency department and inpatient bed use among children and youth in Fannin and Grayson counties that is attributable to primary psychiatric and substance use conditions.

[142] 2017–2018 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[143] Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

[144] Centers for Disease Control and Prevention, National Center for Health Statistics, Multiple Cause of Death 1999–2018 on the CDC WONDER Online Database. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

Among all children and youth with mental health conditions or serious emotional disturbances (SEDs), we expect that approximately two thirds of the 10,000 children and youth affected by mental health conditions could be treated in integrated community settings and the remaining 2,500 children and youth would need more intensive care, such as care provided in a specialty behavioral health clinic. We did not obtain any data on the availability of integrated pediatric primary care, but in most communities only a small portion of pediatric practices currently provide integrated behavioral health care. The vast majority of children and youth with substance use disorders (92%) do not receive the care they need, even though almost half of all cases of substance use disorders can be treated in integrated primary care settings.[145]

Children and Youth Specialty Care Outpatient Data

Tables 35 and 36 provide an overview of the number of children and youth served at Texoma Community Center, including breakouts for the number served at each level of care. Comparing the number of children and youth served to the 3,000 children and youth needing specialty care allowed us to determine the extent to which child and youth mental health need is adequately treated in Fannin and Grayson counties.

Table 35: Children and Youth with SED in Poverty Who Were Served by Texoma Community Center (FY 2019)[146]

Region	Total Child and Youth Population in Poverty[147]	Children and Youth with SED in Poverty[148]	Children and Youth Served in Ongoing Treatment[149]	Exact Percentage	Percentage Medicaid[150]
Fannin and Grayson County Residents[151]	**15,000**	**1,000**	**452**	**45%**	**70%**

[145] The number of people with SUD who can be served in integrated care was estimated using Madras, B. K. et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple healthcare sites: Comparison at intake and 6 months later. Drug & Alcohol Dependence, 99(1), 280–295.

[146] All estimates were rounded to reflect uncertainty in the American Community Survey estimates. As a result of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[147] "In poverty" is the estimated number of people living below 200% of the federal poverty level for the region.

[148] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information.

[149] Data in the "Children and Youth Served in Ongoing Treatment" column are the unduplicated number served by the local mental health authority (LMHA) across LOCs C1, C2, C3, and C4, as well as CY (YES Waiver) and CYC (Young Child Services).

[150] This percentage represents the proportion of children and youth served by the LMHA who were receiving Medicaid during FY 2018. Data provided by DSHS (personal communication, February 2019).

[151] The proportion of Fannin and Grayson County residents served by Texoma Community Center was estimated by subtracting the total number of Cooke County residents served in the region. The proportion of Fannin and Grayson County residents of the total number served by Texoma Community Center was applied to each subset of data.

As Table 35 shows, about 452 Fannin and Grayson County children and youth received care at Texoma Community Center in fiscal year (FY) 2019. If we limit the number of children and youth with severe needs to just those living in poverty (estimated as 1,000), many of whom may have lacked access to commercial insurance, *it appears that there may have been more than 500 children in the region who were not receiving treatment for their conditions*.

Furthermore, Table 36 shows that four children and youth received intensive family services in FY 2019, compared to approximately 100 children and youth in the region who could have benefited from such care and who, without it, may have been at risk for hospitalization, alternative education, or involvement in child welfare and the juvenile justice systems.

Table 36: Children and Youth Levels of Care Analysis (FY 2019)[152]

Treatment Category	Level of Care	Texoma Community Center	
		Number Served	% of Total Served[153]
Outpatient	Medication Management	76	12%
	Targeted Services	261	43%
Rehabilitation	Complex Services	142	23%
	Intensive Family Services	4	1%
	Early Onset Psychosis Services	1	<1%
	Young Child Services	16	3%
	YES Waiver	0	0%
	Transition-Age Youth	24	4%
Crisis	Residential Treatment Centers	0	0%
	Crisis Services	84	14%
	Crisis Follow Up	4	1%
Total Served			**612**
	Total Non-Crisis Served	524	86%
	Total Crisis Served	88	14%

According to Texoma Community Center data obtained by TriWest Group, 74% of Texoma Community Center patients were residents of Fannin or Grayson counties.

[152] Data obtained in February 2020, from Texas Health and Human Services Commission. Level of care data are unduplicated by care identifier and level of care, and they are for state fiscal year 2019.

[153] The percentage represents the proportion of the total unduplicated patients served in each level of care.

Children and Youth Crisis Utilization

Crisis system capacity is a crucial component of the ideal system of care. However, when communities have insufficient integrated primary care and specialty behavioral health care capacity, emergency departments or inpatient psychiatric services can become the default treatment option. This section provides an analysis of child and youth emergency department utilization by people with primary psychiatric and substance use diagnoses. We also provide the primary payers and the estimated payments associated with those visits. This analysis highlights sub-populations that frequently utilize the emergency department, which can indicate a high need among a specific population or a lack of capacity to meet the needs of a specific population at lower levels of care.

Three emergency departments reported child and youth psychiatric and SUD-related emergency department visits to the Texas Health Care Information Collection (THCIC): Texoma Medical Center – Grayson, Texoma Medical Center – Bonham, and Wilson N. Jones Regional Medical Center. As indicated in the prevalence Tables 33 and 34 above, there were about 2,500 children and youth with SED in Fannin and Grayson counties in 2018, about 1,000 of whom lived in poverty and about 100 had the most severe conditions. Additionally, we estimated that about 400 youth had substance use disorders and 130 had co-occurring psychiatric and substance use disorders.

As shown in Table 37, across all hospitals, emergency department visits for both psychiatric and SUD-related reasons were most frequently paid for using commercial insurances (72% and 74%, respectively). This distribution is largely driven by the payer mix of Texoma Medical Center – Grayson, which was the most frequently utilized emergency department for psychiatric- and SUD-related emergency department visits among children and youth (Table 37).

Across all emergency departments, there were more than nine times as many emergency department visits for primary psychiatric conditions then there were for substance use conditions. The prevalence data similarly show that mental health conditions (10,000 with any mental illness, 2,500 with serious emotional disturbance; see Table 33) were much more prevalent than substance use disorders in Fannin and Grayson counties (400 children and youth; see Table 34).

Table 37: Child and Youth Emergency Department (ED), Inpatient, and Outpatient Psychiatric Visits – Visits by Payer (CY 2019)[154]

Hospital	Total Number of ED Visits	Payer Percentage				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson						
Psychiatric ED Visits	124	12%	0%	2%	11%	74%
Substance Use ED Visits	19	5%	0%	0%	26%	68%
Texoma Medical Center – Bonham						
Psychiatric ED Visits	27	67%	0%	0%	0%	30%
Substance Use ED Visits	0	0%	0%	0%	0%	0%
Wilson N. Jones Regional Medical Center						
Psychiatric ED Visits	47	9%	0%	0%	0%	91%
Substance Use ED Visits	<6	0%	0%	0%	0%	100%
All Emergency Departments						
Psychiatric ED Visits	198	19%	0%	2%	8%	72%
Substance Use ED Visits	23	4%	0%	0%	22%	74%

Table 38 shows the estimated payments associated with visits to emergency departments by children and youth between April 2017 and March 2018. Across all emergency department visits for psychiatric and substance use-related crises, about $200,000 was paid for patients' care. Since visits to emergency departments may occur when people feel they have no alternatives to care (whether because services are not available or they lack the financial resources to pay for that care), providing comprehensive community-level care may help reduce these costs by providing more effective alternatives to people in need, and it may simultaneously reduce the strain on hospital resources.

[154] Texas Health Care Information Collection (THCIC) January – December 2019 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field. Per our agreement with the Department of State Health Services, cells with less than six (<6) visits and those with between six and nine visits (<10) are masked to prevent deductive disclosure of patient identity.

Table 38: Estimated Payments for Child and Youth Emergency Department Psychiatric Visits (April 2017–March 2018)[155,156]

Hospital	Total Estimated Payments[157]	Payer Percentage				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Texoma Medical Center – Grayson						
Psychiatric ED Visits	$102,435	0%	0%	2%	11%	86%
Substance Use ED Visits	$9,148	0%	0%	0%	33%	67%
Texoma Medical Center – Bonham						
Psychiatric ED Visits	$7,871	72%	0%	0%	0%	28%
Substance Use ED Visits	$3,882	4%	0%	0%	0%	96%
Wilson N. Jones Regional Medical Center						
Psychiatric ED Visits	$71,873	2%	0%	0%	0%	98%
Substance Use ED Visits	$9,768	0%	0%	0%	0%	100%
All Emergency Departments						
Psychiatric ED Visits	$182,179	4%	0%	1%	6%	88%
Substance Use ED Visits	$22,798	1%	0%	0%	13%	86%

Children and Youth Inpatient Utilization

One hospital in Grayson County, Texoma Medical Center – Grayson, provided data on inpatient psychiatric utilization by children and youth for our analysis. In this section, we use the same three approaches as we did in the section on adults to assess if there was sufficient local inpatient capacity for children and youth. The first approach compared daily inpatient utilization to capacity, which can reveal how frequently Texoma Medical Center – Grayson had available beds. Then, we provide an analysis of the primary payers associated with admissions to psychiatric beds at Texoma Medical Center – Grayson. This analysis can highlight populations that may not have adequate access to care in the community. Finally, we examined the counties of residence of Texoma Medical Center – Grayson child and youth patients; a significant portion of patients from outside the two counties would be evidence of sufficient local capacity to meet the inpatient psychiatric service needs of local patients.

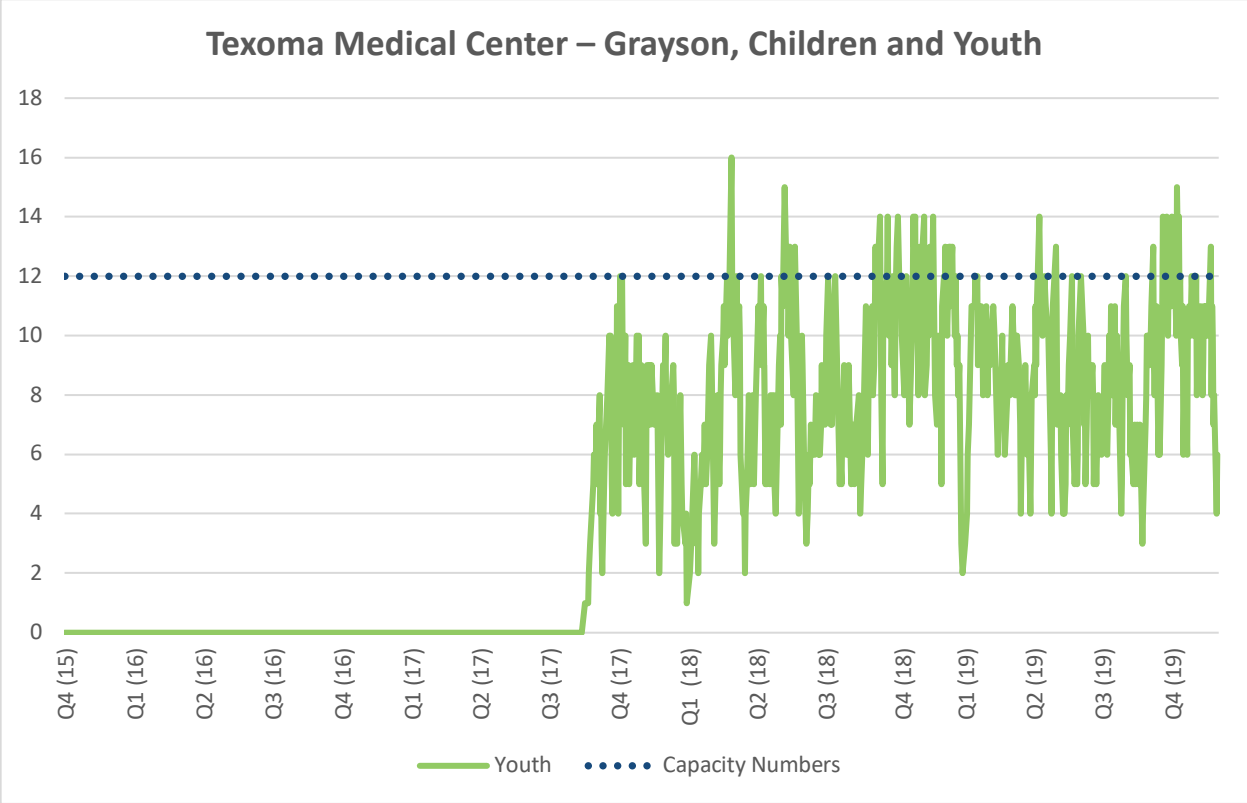
[155] Texas Health Care Information Collection (THCIC) April 2017– March 2018 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field.

[156] This table could not be updated using 2019 data for multiple reasons, including unavailable patient ratios and methodological questions surrounding the approach.

[157] Emergency department visits reflect visits by residents of the Texoma region (Fannin and Grayson counties).

As was shown earlier in Table 26, from October 2015 through November 2019, Texoma Medical Center – Grayson had a capacity of 12 pediatric beds for psychiatric inpatient care. On average, about six beds were occupied on any given day within this timeframe, meaning that only 54% of capacity was utilized on the majority of days. Graph 4 shows the daily utilization by children and youth from September 2017 through November 2019 compared to reported capacity. Beginning around September 2017, children and youth began using Texoma Medical Center – Grayson psychiatric beds. There were multiple instances when utilization exceeded capacity in March, May, and the majority of the fourth quarter of 2018, again in second and fourth quarters of 2019, indicating an upward trend in demand for inpatient child and youth psychiatric beds.

Graph 4: Texoma Medical Center – Grayson, Children and Youth Daily Inpatient Utilization (2017–2019)[158]



Our analysis of admissions and estimated payments to inpatient psychiatric beds in Fannin and Grayson counties, including admissions and payments by primary payer (Table 39), shows that the majority of the 418 children and youth who were admitted to Texoma Medical Center –

[158] Children and youth psychiatric bed capacity was only available from the 2017 American Hospital Association Annual Survey of Hospitals. Because there was no youth utilization prior to 2017, and we do not have capacity information for youth prior to 2017, daily utilization graphs by age group reflect dates on or after January 1, 2017.

Grayson (231 of which were residents of Fannin and Grayson counties) were paid for through commercial insurance (80%). The remainder were paid through Medicaid (14%) and other government sources (5%), with only 1% of admissions for uninsured children and youth. As with adults, a larger percentage of emergency department visits were for children and youth without insurance. This raises the question of whether uninsured children and youth gained access to coverage as part of their admission to an inpatient psychiatric bed, were sent to hospitals outside the region, or had no access to expensive inpatient facilities.

Table 39: Children and Youth Admissions to Psychiatric Beds by Primary Payer (CY 2019)[159]

Texoma Medical Center	All Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Admissions by Payer	418	14%	0%	5%	1%	80%

Table 40 addresses the question of where uninsured Fannin and Grayson County youth receive inpatient psychiatric services.[160] This table shows, by payer type, the location of psychiatric hospitals where youth from Fannin and Grayson counties were admitted. Almost one third (96 patients) of the total 327 statewide psychiatric admissions for youth residents of Fannin and Grayson counties were to non-local hospitals. Four of these 96 admissions were to state hospitals, which are categorized as "self-pay" in our dataset, even though they are entirely state-funded.

Across all admissions, 77% were paid for by commercial insurance. This disparity was particularly evident when comparing local and non-local admissions. Among youth who were admitted to local psychiatric beds at Texoma Medical Center – Grayson, 88% had their treatment covered by commercial insurance. In contract, slightly more than half of admissions to non-local hospitals were funded through commercial insurance plans. Youth who were admitted to non-local hospitals were slightly more likely to have their treatment covered by commercial insurance (51%) than by Medicaid (45%); however, only 8% of those admitted to local psychiatric beds had their treatment funded through Medicaid.

Data presented in Table 38 shows that in 2019, 72% of psychiatric emergency department visits were funded by commercial insurance, 19% were funded through Medicaid, and 8% were uninsured patients. It appears that youth who had commercial insurance were most likely to be

[159] Texas Health Care Information Collection (THCIC) January – December 2019 discharge records. Psychiatric and substance use disorder visits were identified using the primary diagnosis field.

[160] There were no psychiatric admissions for children (ages 6 to 11) residing in the Texoma region (Fannin and Grayson counties).

placed in a local inpatient bed, while those without insurance or with Medicaid were disproportionately sent out of the region for inpatient services.

Table 40: Fannin and Grayson County Youth Admissions to Psychiatric Beds Statewide, by Payer Type (CY 2019)[161,162]

Grayson and Fannin County Resident Admissions	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Admissions to Local Hospitals Texoma Medical Center – Grayson	231	8%	—	3%	1%	88%
Admissions to Non-Local State Hospitals North Texas State Hospital	<6	—	—	—	100%	—
Admissions to Other Non-Local Hospitals	92	45%	—	—	4%	51%
Total Admissions to Psychiatric Beds	**327**	**18%**	—	**2%**	**3%**	**77%**

Finally, Table 41 shows that, among the 418 youth admitted to Texoma Medical Center – Grayson, 231 were from Grayson (206) or Fannin (25) counties, with the remainder coming from other Texas counties (128 patients) or out of state (59 patients). These 187 non-resident youth who use Grayson and Fannin County hospitals outweigh the 98 Fannin and Grayson County youth who were admitted to psychiatric beds outside of Fannin and Grayson counties (see Table 40).

[161] There were no psychiatric admissions for children (ages 6 to 11) residing in the Texoma region.

[162] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records. Per our agreement with the Department of State Health Services, cells with less than six (<6) visits are masked to prevent deductive disclosure of patient identity.

Table 41: Admissions to Texoma Medical Center – Grayson Psychiatric Beds, by County of Residence (CY 2019)[163]

County of Residence	Youth Admissions (Ages 12–17)
Total Admissions	418
Admissions by County of Residence	
Grayson	206
Collin	30
Fannin	25
Lamar	22
Hunt	13
Dallas	11
Gregg	11
Smith	<10
Bowie	<10
Cooke	<10
Denton	<6
Wood	<6
Cherokee	<6
Harrison	<6
Camp	<6
Cass	<6
El Paso	<6
Henderson	<6
Hopkins	<6
Kaufman	<6
Rockwall	<6
Titus	<6
Van Zandt	<6
Out of State	59

Although it appears that there is sufficient local capacity to meet the inpatient psychiatric needs of adults in Fannin and Grayson counties, it was less clear at the time of this analysis that

[163] Texas Health Care Information Collection (THCIC) January– December 2019 discharge records. Per our agreement with the Department of State Health Services, cells with less than six (<6) visits and those with between six and nine visits (<10) are masked to prevent deductive disclosure of patient identity.

there were sufficient local psychiatric beds in aggregate to serve children and youth. On most days, utilization was below the reported staffed bed capacity; however, Graph 4 clearly shows that inpatient facilities serving children and youth operate over capacity at least one time per quarter. Less than half of the inpatient utilization was attributed to youth from areas outside of Fannin and Grayson counties, and fewer local youth were admitted to psychiatric beds outside of the local region (96 youth) than were admitted locally from other regions (187 youth).

Similar to adults in Fannin and Grayson counties, there was a much smaller number of uninsured youth who used Texoma Medical Center – Grayson inpatient psychiatric services than uninsured youth who used the emergency department. Children and youth who visited Grayson and Fannin County emergency departments were most likely to have psychiatric care covered through commercial insurance or Medicaid; conversely, substance use treatment was primarily funded through commercial insurance and self-pay options. However, commercially-insured children and youth were more often placed in a local psychiatric bed, and children and youth who relied on Medicaid or self-pay for treatment were much more likely to be placed in a non-local bed for psychiatric care. In fact, only 8% of local psychiatric placements were funded by Medicaid, but 45% of non-local psychiatric placements were paid for using Medicare funds.

System-Level Recommendations: Children and Youth

Children's Services Recommendations

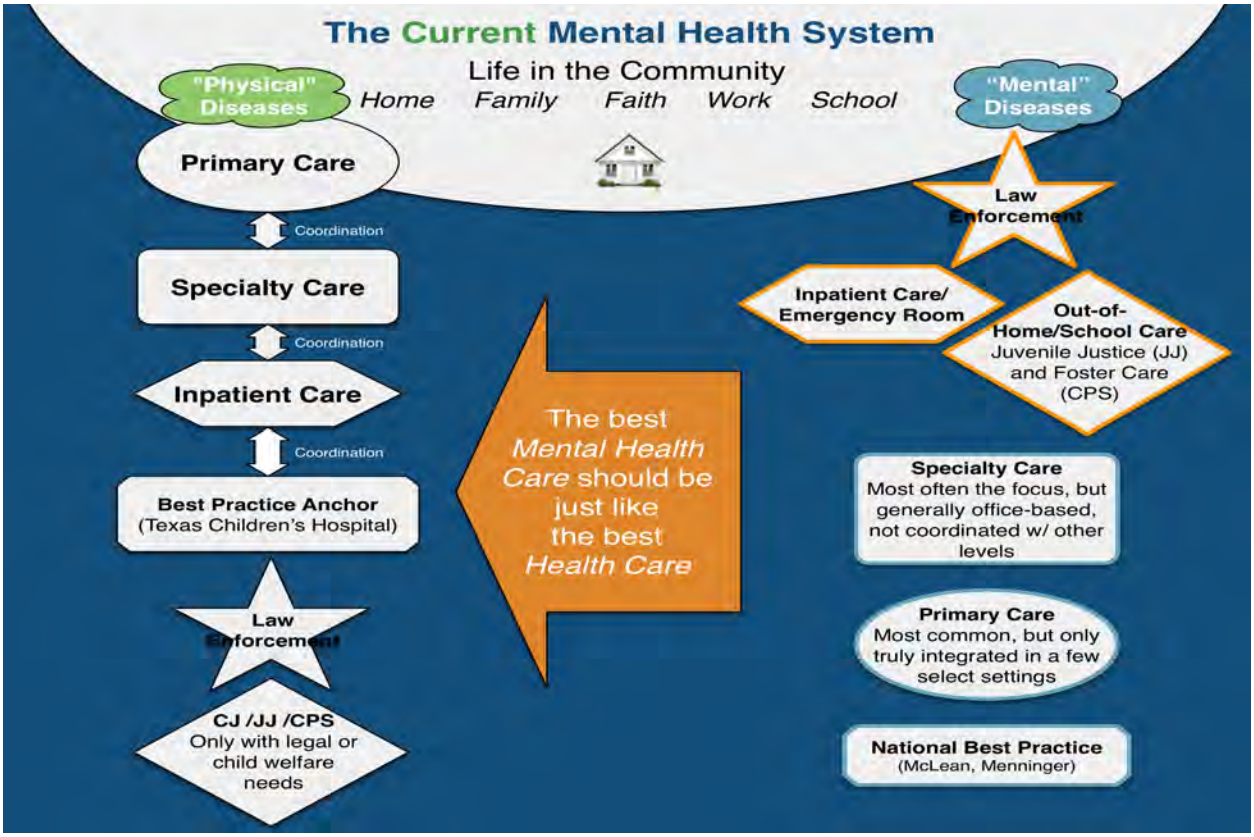
Our assessment of mental health services for children, youth, and their families focused on the current array of mental health services in the community. Core issues emerged in Fannin and Grayson counties and although these issues may have a different impact on each community, they were similar across the two counties. Common themes included:

- A need to strengthen the focus on retaining quality clinicians;
- A need to increase organizational collaboration, including collaborating with the faith community;
- A need to increase parent and family educational opportunities;
- A lack of access to transportation, which limits families' abilities to attend appointments;
- A chronic lack of providers, although this appears more significant in Fannin County, where there is a lack of individual clinicians, mental health provider organizations, and pediatricians; and
- A need to continue to focus on anti-stigma efforts to improve service engagement for children, youth, and their families.

We have organized our findings and recommendations primarily according to a comprehensive framework for addressing the mental health needs of children and youth, which can be broken down into five components:

- Life in the community (Component 0),
- Integrated behavioral health care (Component 1),
- Specialty behavioral health care (Component 2),
- Rehabilitation and intensive services (Component 3), and
- Crisis care continuum (Component 4).

Figure 3: Mental Health System Framework for Children and Youth



Although key systematic challenges and opportunities are consistent across populations, children and youth are served through different systems and have unique needs, many that differ from adult needs. The findings outlined in this section describe strengths and challenges identified through our assessment as well as opportunities that could improve key outcomes. The highlights provided below represent some of the findings described in each component of the children's framework as well as several of the key recommendations.

Summary of Child and Youth Services Findings

Based on our stakeholder interviews, it appears that there is a shortage of mental health service providers for children, youth, and their families in Fannin and Grayson counties. This shortage includes providers that accept Medicaid/Children's Health Insurance Program and commercial insurance, and those that offer free or sliding-fee-scale services. Systemic issues,

such as delays in processing managed care organization credentialing for licensed staff and low Medicaid reimbursement rates, contribute to the shortage of providers. Independent providers and non-profit organizations that offer services in the region simply do not have the resources to deal with these challenges and, therefore, need to rely heavily upon grants and other community funds to keep their doors open. Furthermore, providers we interviewed reported having challenges retaining clinicians because they are competing with Metroplex providers who often offer a higher pay scale for their clinicians. Providers we interviewed noted that these challenges have resulted in the need for services far exceeding the region's capacity to provide needed care, and that there is often a waiting list to access services. Another major provider in the region, Child and Family Guidance Center of Texoma, reported having a waiting list of up to 60 children or youth at one point in time.

In addition to a shortage of mental health providers, there is also a lack of other needed providers. In Fannin County, in particular, the Texas Department of State Health Services reported that in 2018, there were zero pediatricians in the county.[164] Stakeholders reported that this has led to families having to drive to Sherman or other neighboring communities to receive pediatric care. In both Fannin and Grayson counties, access to pediatric primary care is also limited by the availability of transportation. Stakeholders noted that many families have unreliable transportation and that the public transportation options, where present, are not sufficient to meet families' needs. This results in a lack of access to pediatric health care services, which is where many families turn when a mental health concern initially presents itself. The passage and eventual implementation of Senate Bill 11 (Taylor, 86th Regular Session) will improve access to mental health screenings and services through pediatric primary care. However, if families cannot access pediatricians, this opportunity for early intervention will not be realized.

There is a gap between the number of children who need intensive services and the number who receive them. Prevalence estimates for 2018 indicated that about 2,000 Fannin and Grayson County children and youth ages 6 to 17 years had a serious emotional disturbance, 1,000 of whom were living in poverty.[165] However, the number of children and youth who had received intensive services with major providers did not come close to that number. In fiscal year (FY) 2019, Texoma Community Center reported serving 21 children and youth in their most intensive levels of care (i.e. Intensive Family Services, Young Child, Youth Empowerment Services, and Early Onset). Notably, there were zero children and youth enrolled in the Youth Empowerment Services (YES) Waiver program, which is a program most often used by communities to serve children and youth with the most complex service needs. It is important

[164] Texas Department of State Health Services. (2018, December 7). *Primary care specialties, 2018.* Texas Health and Human Services Commission. https://www.dshs.texas.gov/chs/hprc/tables/2018/PCSpec18.aspx
[165] Holzer, C., Nguyen, H., & Holzer, J. (2018). See Appendix A for additional information.

to acknowledge that we did not obtain data on the number of children and youth with intensive needs served by other major providers serving Grayson and Fannin counties. However, even with this data, it is unlikely current providers are able to meet the intensive service needs of children and youth who have serious emotional disturbances (SED). Similar to many communities throughout Texas, the estimated need far exceeds current capacity. A lack of availability of intensive services can, over time, can lead to an increase in unnecessary hospitalizations for needs that could have been addressed in a community setting.

Universally, stakeholders we interviewed identified stigma as a barrier to accessing mental health treatment or support. Both the Sherman Independent School District and Bonham Independent School District provide mental health education and resources to students and their families. Accessing mental health resources in a familiar, non-stigmatizing environment such as a school building helps reduce stigma, but schools' ability to provide these services are necessarily limited. In many instances, families must be referred to community-based providers to get the types of services they need.

Recommendations for Child and Youth Services

Overall, it appears that the capacity of inpatient services in Fannin and Grayson counties is adequate to meet the needs of its child and youth residents. However, just under half of children and youth with SED who were living in poverty received care through Texoma Community Center in FY 2019. Out of an estimated 100 children and youth with severe needs that put them at high risk for out-of-home or out-of-school placement, not all of them would have received the services they needed[166] and no youth received YES Waiver services in FY 2019. Efforts to increase the availability of services and reduce barriers to lower levels of care (including integrated care, specialty care, and targeted services) may help more children and youth engage in the services they need and prevent unnecessary hospitalizations and visits to emergency departments for conditions that could be treated in the community. The recommendations presented below are based on current system realities combined with tangible opportunities to strengthen the reach and quality of services.

Component 0: Fannin and Grayson counties have undertaken initiatives to address the stigma of mental illness, including the Okay to Say campaign. Although this campaign has increased awareness of mental health needs and resources, the region should build upon these efforts to increase their reach. Through collaborative efforts such as the Texoma Behavioral Health Leadership Team, providers and community leaders can come together to continue to work to reduce stigma. School districts and mental health non-profit organizations should partner to

[166] Based on the data, these children might have received the following services: intensive family services (4), early onset psychosis services (1), young child services (16), and transition-age youth services (24).

offer parent/caregiver education nights and host events such as back-to-school information fairs that include information on mental health and mental health resources.

Component 0: Ensure that school districts obtain the knowledge to effectively recognize the signs and symptoms of mental health needs and crises, which will help students access appropriate services and supports more quickly. Schools are often challenged with not knowing how to structure their mental/behavioral health programs, particularly if there is little to no available funding for these programs. Stakeholders noted that although schools have counselors, many do not have a background in mental health counseling. More training should be available for school counselors to develop the knowledge and skills they need to address the concerns they encounter. Trainings such as Youth Mental Health First Aid can be accessed through Texoma Community Center (through funding from the Health and Human Services Commission). Additionally, passage of Senate Bill 11 requires mental health training for school districts and the Texas Education Agency is expected to provide guidance about these new requirements. We recommend that schools in Fannin and Grayson counties take advantage of these trainings to increase staff knowledge and improve their responsiveness to students' behavioral health needs.

Component 1: Fannin and Grayson counties should take full advantage of the opportunity to establish integrated care efforts by expanding the use of psychiatric consultation through new opportunities established by Senate Bill (SB) 11. SB 11 established the Texas Child Mental Health Care Consortium (Consortium) to foster collaboration among state medical schools, promote and coordinate mental health research, and help address workforce issues. SB 11 also established the Child Psychiatry Access Network (CPAN), which, through the Consortium's oversight, will establish a network of comprehensive child psychiatry access hubs to provide consultation services and training opportunities for pediatricians and primary care providers operating within a hub's geographic region. The hub for the region that includes Fannin and Grayson counties is the University of Texas Southwestern Medical Center. This hub will offer pediatric and family medicine providers with support in meeting their patients' mental health needs, including clinical consultation, care coordination assistance with referrals to specialty outpatient providers, and continuing education. The development of CPAN will expand the use of integrated pediatric primary care, simplify service navigation for families, and improve access to mental health care overall. It is critical that Grayson and Fannin county providers support the CPAN hubs in establishing relationships with pediatric and family practices in the counties, and that providers be included in the database that is being developed for the referral network.

Component 1: Improve early detection and support for emerging and low-to-moderate pediatric mental health needs by establishing pediatric integrated care programs. Most children and youth in Fannin and Grayson counties receive primary care services through Greater Texoma Health Clinic, Breeze Pediatrics, Hilltop Pediatrics, and TexomaCare. In these

settings, children and youth ages six to 17 years in both counties should be screened regularly for behavioral health needs. Recent research of a fully-scaled statewide integrated care program indicated that about two thirds of children and youth with behavioral health needs were served in a pediatric care setting with integrated behavioral health supports[167] and proper training and support for pediatricians and family doctors.

Component 2: Continue the intentional efforts to improve the referral process to better match children, youth, and their families to needed services through efforts such as Here for Texas. These efforts can help families in need of immediate care locate appropriate service providers. There should be a coordinated effort to encourage providers to ensure their information is included and up-to-date on the Here for Texas website. It will also be important to recognize that a warm referral—those in which the individual in need is directly connected from one provider to another—is the most effective way to ensure individuals access a service provider.

Component 2: Improve access to providers by forming strategic partnerships between child serving systems. Stakeholders in Fannin and Grayson counties, through the Behavioral Health Leadership Team, should explore the feasibility of developing school-based health care resources that could bring both behavioral health and pediatric primary care services to students, perhaps through telemedicine and telehealth services. Senate Bill 670 (Senator Buckingham, 86th Legislature) repealed the requirement that a "health professional" be present at a school when a telemedicine service is delivered in a school setting, thereby making it more feasible for schools to provide these services. The bill also requires the Texas Health and Human Services Commission to ensure that Medicaid managed care organizations do not deny reimbursement for a covered health care service or procedure delivered by a health care provider through telemedicine or telehealth solely because the covered service or procedure is not provided through an in-person consultation. Both actions remove barriers to implementing telemedicine services in schools, which increases the potential to improve access to mental health services for students, particularly through school-based solutions.

Additionally, Fannin County should strengthen its relationship with the Texoma Community Center to make mental and behavioral health services more available in Bonham and the surrounding areas. Explore the potential for Texoma Community Center to offer school-based services in addition to education and outreach opportunities it may be able to provide. In general, Fannin County stakeholders were aware of Texoma Community Center, but there is potential for Texoma Community Center to have more of a presence in the county through strategic partnerships with the school district, for example, or other community organizations

[167] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs, 33*(12), 2153–2161.

that can offer Texoma Community Center a space to provide services. If Texoma Community Center had a regular presence in the county, or a staff person dedicated to outreach in Bonham and surrounding communities, it could strengthen its relationship with the county and improve access to services.

Component 3: Expand the availability of intensive, evidence-based services and supports to prevent inpatient hospitalizations and crisis events. Although inpatient services are a critical component of the behavioral health service array, intensive community-based services can help prevent hospitalizations for children and youth whose needs can be met in a community setting. For the estimated 2,000 school-age children and youth in Fannin and Grayson counties with SED, and particularly for about 10% of these children with the most acute needs and risk for out-of-home placement,[168] the absence of multi-faceted, evidence-based crisis and ongoing interventions in their homes and communities increases the risk for negative outcomes, including psychiatric hospitalization and decompensation. Intensive evidence-based practices, such as Multisystemic Therapy (MST), have proven to improve family functioning and reduce the need for placement in more restrictive settings.[169] The leadership and collaborative efforts of the Texoma Behavioral Health Leadership Team can help improve the referral process to better match children, youth, and their families to needed services through efforts such as Here for Texas. This, in turn, would help providers better understand the services offered across the region and increase their capacity to serve children and youth, making it easier to connect children, youth, and their families with the services they need.

Component 4: After approval from the Sherman City Council in February 2019, Carrus Behavioral Hospital opened a new 28-bed child and adolescent behavioral health care facility that provides 24-hour inpatient behavioral health care for children and youth ages five through 17. As the region integrates Carrus Behavioral Hospital into the service delivery system, it will be important to develop relationships between this provider and other providers to facilitate needed step-down services as children and youth transition from inpatient care back to their homes and communities.

[168] The Meadows Institute estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

[169] Henggeler S. W., Weiss, J., Rowland M. D., & Halliday-Boykins, C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry, 42*(5), 543–551.

Appendix A: Prevalence Estimation Methodology

Introduction

To provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding overall prevalence of serious emotional disturbance (SED) and serious mental illness (SMI), we utilize the work of Dr. Charles Holzer.[170] In 2014, the Meadows Institute commissioned Dr. Holzer to estimate the prevalence of SMI in Texas counties using 2012 and earlier data.[171] We believe that Dr. Holzer's original SED and SMI estimates and our adaptation of his data, findings, and methodologies to current Texas populations provide the most practically relevant estimates available. The method, described in detail below, uses statistical formulas that apply national prevalence rates to Texas population and demographic data.

Estimating the prevalence of specific mental illnesses such as bipolar disorder, depression, or schizophrenia in different age groups (e.g., children, youth, adults) is a more complicated endeavor – one requiring us to incorporate the best available national studies of the prevalence of those specific disorders. In cases where these alternative epidemiological sources are used, they are always cited and represent what we judge to be the best available contemporary source.

Holzer and "Horizontal Synthetic Estimation"

Beginning with his work at the University of Florida in the 1970s, Holzer drew connections between established data (drawn largely from census data), demographics, and the careful study of how these factors correlated with various needs among populations. Holzer derived principles about these connections as presented in the Mental Health Demographic Profile System (MHDPS). This system matched demographic data from the Florida Health Survey with community demographics and known needs for mental health services, creating a model for estimating need in places and situations in which survey data were not available.

The method, which those in the MHDPS team termed "Horizontal Synthetic Estimation," evolved as Holzer refined his work. A crucial step came in the 1980s following the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) program, the largest psychiatric epidemiological study in the United States at the time. Holzer used ECA findings to develop a series of prevalence estimates for the Texas Department of Mental Health and

[170] Charles E. Holzer III, PhD, was an esteemed psychiatric epidemiologist who has worked and published in behavioral science for forty years.

[171] In 2014, the Meadows Institute hired Dr. Holzer to perform a revised county-level prevalence estimate throughout Texas. Dr. Holzer licensed the study and methodology to the Meadows Institute on an ongoing basis.

Retardation, a project which led to several similar projects in Colorado, Ohio, and Washington State. Following the 1990 Census and the 1993 National Comorbidity Survey (NCS), Holzer developed estimates in other states, including Colorado, Wyoming, and Nebraska, among others, and included county-level prevalence estimates.

Holzer's method represented a departure from previous, less-precise methods. He argued that prior approaches mistakenly assumed that local mental health systems served all people with mental health needs. He also criticized indirect methods of estimation, such as those using social indicators (crime levels, poverty, divorce, etc.) with no data on mental illnesses.

Holzer argued that if prevalence estimates and their correlates with demographic characteristics from national epidemiological studies were applied to state and county populations, he could provide more precise estimates of mental health need. He used statistical methods that analyzed survey data from the 2001–2003 Collaborative Psychiatric Epidemiology Surveys (CPES) to estimate the relationships between seven socio-demographic characteristics (i.e., age, sex, race/ethnicity, marital, education, poverty, housing status) and SED and SMI prevalence rates. He then applied these rates to the most up-to-date, available county- or state-level American Community Survey (ACS)[172] population and demographic data, which include estimates of the number of people who can be categorized by the same seven socio-demographic characteristics.

Meadows Institute Adaptation of Holzer's Methodology and Data

In 2014, the Meadows Institute hired Dr. Holzer to perform a revised county-level estimate throughout Texas using 2012 Three-Year ACS data (the most recently available data at the time). Dr. Holzer then licensed the methodology to the Meadows Institute for use in estimating prevalence in Texas. From this work, and by using Dr. Holzer's findings, especially his 2012 Texas estimates which were commissioned by the Meadows Institute, we have developed a new series of 2018 estimates utilizing the 2018 ACS Five-Year dataset and the 2018 Population Estimates. These data were the most current at the time of our analysis.

Estimating the Prevalence of Specific Disorders

In estimating the prevalence of specific disorders, we draw on the most recent national prevalence studies conducted by psychiatric epidemiologist Ron Kessler and colleagues, as well as on reviews of prevalence studies that target specific disorders. The two primary national

[172] The ACS is an extension of the U.S. Census Bureau. It is an ongoing statistical survey that gathers significant data that, among other things, track shifting demographic data. The use of ACS data helps to align the Holzer estimates with the most up-to-date, local demographic data.

studies are the National Comorbidity Survey Replication (NCSR)[173] and the National Comorbidity Survey Replication-Adolescent Supplement (NCSR-A).[174] These studies provide national estimates of specific disorders. We then apply these estimates to the Texas populations of the same age groups (all adults ages 18+ and adolescents ages 12–17, respectively).

The national studies did not include all disorders of interest. For example, because of its very low prevalence rate, schizophrenia was not included in the NCSR. In cases of missing diagnoses in the NCSR or SCSR-A, we rely on what we determine to be the best available reviews of epidemiological studies specific to each diagnosis.[175]

[173] Kessler, R.C., et al. (2005).

[174] Kessler, R.C., et al. (2012b).

[175] See for example McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76.

Appendix B: Methods

Qualitative Methods

The Meadows Institute worked with the Texoma Behavioral Health Leadership Team to identify stakeholders throughout Fannin and Grayson counties. Through ongoing collaboration and dialogue, we identified and invited key stakeholders to participate in focus groups and key informant interviews to identify issues relevant to the behavioral health needs in Fannin and Grayson counties.

We were able to engage stakeholders from nonprofit organizations, law enforcement agencies, legal firms, hospitals and mental health providers, the Texoma Community Center, higher education, government, and school districts.

Each key informant interview (individual or small group) or larger focus group session was moderated or co-led by project leads from the Meadows Institute.

- **Guide Questions:** Meadows Institute staff created an interview framework (see Appendix C) as a guide for one-on-one sessions. Often our Meadows Institute content experts went beyond this guide to ask more focused questions, gaining further information as deemed most appropriate by the interviewer. These questions became more focused as the interview permitted. Open-ended questions covered local, systemic, and institutional issues and experiences in various areas – from local innovative programming developed to divert people from hospitalization and incarceration to changes in the collaborative efforts of mental health-engaged agencies over time. We also added questions to further identify needed system changes, gaps in services, and resources that might be expanded or used strategically in an improved service delivery system.
- **Key Informant Interviews:** We conducted key informant interviews from April 2019 through September 2019, in addition to other types of engagement, described below. All interviews were conducted by phone or in person. The information we gathered from these interviews is included throughout this report and detailed in the qualitative sections below. As we conducted interviews, we asked for recommendations for other stakeholders we could interview, enabling us to achieve a diverse pool of participants that were representative of Fannin and Grayson counties and their community members.
- **Focus Group Interviews:** We held multiple focus groups with stakeholders who we felt could share information best in a group format: four groups with three police departments, including officers across all shifts assigned to patrol, departmental leadership, and communications staff; and a consumer group with the Texoma Community Center.

- **Planning Meeting:** The BHLT and key stakeholders met in April 2019 to initiate the engagement and will meet again for the draft report presentation.

Appendix C: Stakeholder Engagement Participants

We interviewed a total of 80 stakeholders during the engagement process. A full list of the people who were interviewed is provided in the table below. The key informant interview question guide is provided in Appendix C. In addition to the key informants listed below, we held five focus groups with stakeholders who we felt could share information best in a group format: four groups with Sherman, Denison, and Bonham Police Departments across all shifts assigned to patrol, and one consumer group with the Texoma Community Center.

Texoma Community Center

Name	Title	Organization
Diana Cantu	Chief Executive Officer	Texoma Community Center
Whitney Redden	Director of Forensic Services	Texoma Community Center
Kristi Gourd	Deputy Chief Operating Officer	Texoma Community Center
Brent Phillips-Broadrick	Chief Operating Officer	Texoma Community Center
Dale Jackson	Chief Financial and Strategy Officer	Texoma Community Center
Michael Weed	Director of Data Analytics	Texoma Community Center
Margie Morris	Board of Trustees & Treasurer	Texoma Community Center
Yvonne Posada	Family Partner	Texoma Community Center
Whytney Mask	Director of Crisis, Outreach, and Mental Health Services	Texoma Community Center
Amanda Thiele	Assistant Crisis Director	Texoma Community Center
Amanda Hudgens	Adult Mental Health Program Manager	Texoma Community Center
Amberlee Conley	Adult Mental Health Assistant Director	Texoma Community Center
Penny Poolaw	Military Veteran Peer Network Coordinator	Texoma Community Center

Law Enforcement/Legal

Name	Title	Organization
Tom Watt	Sheriff	Grayson County Sheriff's Office
Zachary Flores	Chief of Police	City of Sherman Police Department
Debra Roberts	Director	Fannin County Adult Community Supervision Corrections Department
Mike Eppler	Lieutenant	City of Denison Police Department
Mark Johnson	Sheriff	Fannin County Sheriff's Office
Wendell Bockman	Captain	City of Bonham Police Department
Jeff Ashabranner	Chief of Police	City of Collinsville Police Department
Brian Meserole	Chief of Police	City of Leonard Police Department
Curtis Macomb	Chief of Police	City of Tioga Police Department
Sherry Robinson	Jail Nurse	Grayson County Sheriff's Office
Tony Bennie	Chief Deputy	Grayson County Sheriff's Office
Marty Hall	Lieutenant	Grayson County Sheriff's Office
Carl Harrell	Chief of Police	City of Savoy Police Department
Tracy Stenger	Communications Supervisor	City of Sherman Police Department
Jami Brown	Communications Supervisor	Grayson County Sheriff's Office
Bart Bowman	EMS Director	City of Sherman
Gregg Loyd	Fire Chief	City of Denison
Destiny Tweedy	Communications Supervisor	Fannin County Sheriff's Office
Alan Brown	Director	Grayson County Adult Community Supervision Corrections Department
Brett Smith	District Attorney	Grayson County
William Magers	County Judge	Grayson County
Larry Phillips	Judge	Grayson County 59th District Court
Laurie Blake	Judge	Fannin County 336th District Court
John Skotnik	Municipal Court Judge	City of Bonham
Richard Glaser	Criminal District Attorney	Fannin County
Kenny Karl	Judge	Fannin County Justice of the Peace Precinct 3
Bob Clemons	Judge	Fannin County Justice of the Peace Precinct 2

Hospitals/Mental Health Providers

Name	Title	Organization
Ryan Tatu	Former Chief Executive Officer	Texoma Medical Center – Behavioral Health Center
Tonya Price	Former Chief Nursing Officer	Wilson N. Jones Medical Center
Geri Larson	Emergency Department Director	Texoma Medical Center – Grayson
Jimmie Dick	Security Director	Wilson N. Jones Medical Center
Jon Sisk	Emergency Department Director	Texoma Medical Center – Bonham
Erin Holt	Licensed Professional Counselor	Private Practice
Brenda Hayward	Executive Director	Child and Family Guidance Center of Texoma
Tiffany Dancer	Clinical Director	Child and Family Guidance Center of Texoma
Sandy Barber	Executive Director	Fannin County Children's Center

Government

Name	Title	Organization
Jimmy Petty	Veterans Service Officer	Grayson County
Paul Changler	Veterans Service Officer	Fannin County
Shawn Teamann	City Councilman, Deputy Mayor District 1	City of Sherman
William "Bill" Magers	County Judge	Grayson County
Sean Norton	Public Information Officer, Media Manager	Texoma Council of Governments

School District

Name	Title	Organization
David Hicks	Superintendent	Sherman ISD
Kelly Trompler	Interim Superintendent	Bonham ISD
Julie Hill	Coordinator of Counseling and Student Services	Sherman ISD
Tamy Smalskas	Assistant Superintendent of Student Support and Family Engagement	Sherman ISD

Higher Education

Name	Title	Organization
Jeremy McMillen	President	Grayson College
Kevin Nugent	Director of Public Safety & Emergency Management	Grayson College
Regina Organ	Vice President of Student Affairs	Grayson College
Barbara Malone	Director of Counseling & Advising	Grayson College
Carla Fanning	Social Sciences Chair/Professor/Ombudsman	Grayson College

Other

Name	Title	Organization
Michelle Lemming	President and CEO	Texoma Health Foundation
Gail Utter	President	Utter Wealth Management Group
Cindy Bankston	Director	Glaser Charitable Family Foundation
Stephanie Chandler	President and CEO	United Way of Grayson County
Dana Coker	Senior Pastor	First United Methodist Church – Bonham
Jayna Hearn	Consumer	

Appendix D: Interview Guide Questions

Key Informant Interview Questions

1. **What are your goals for this assessment?**

2. **What are the primary strengths the community has in meeting the mental health needs of the community?**
   a. Why are these components of the system working well?
   b. How do these components affect service delivery?
   c. Are there any changes that could be made to improve these components?

3. **What are the primary mental health weaknesses and gaps you see in your community?**
   a. Why are these components of the system of care not working?
   b. How do these inadequacies affect service delivery?
   c. What problems do these inadequacies create for you in your role in the service delivery system?
   d. From your perspective, what strategies or solutions could be used to overcome these inadequacies?
   e. How would these solutions improve service provision to all populations treated within the Texoma region?

4. **What are one or two things that would most significantly improve the community's ability to meet the mental health needs of the community?**
   a. Which services/capacity could be added and what would it take to add them?

5. **What other general comments would you like to offer?**

6. **Considering your community leaders and elected officials, who do you believe is someone that should provide feedback on this assessment?**

Appendix E: Law Enforcement Agencies in Fannin and Grayson Counties

Data regarding law enforcement agencies in Fannin and Grayson counties was collected during our initial interviews in 2019 and updated based on feedback from the Texoma Behavioral Health Leadership Team.

Although the Grayson County Sheriff's Office employs more officers and civilians than the Fannin County Sheriff's Office, each county jail has similar capacity. Fannin County has less staffing because its jail operation is contracted out to La Salle Corrections. Both Fannin and Grayson County Sheriff's Offices provide law enforcement services to the unincorporated areas of their respective areas and support all law enforcement agencies, as needed. In addition to patrol duties, the Grayson County Sheriff's Office operates its own jail facility and provides a central intake for people who are arrested on all Texas penal code offenses, Class B and higher. The jail will also accept Class C charges for agencies that do not have a municipal jail. The Fannin County Sheriff's Office also provides patrol duty. As noted above, it contracts out all jail operations to La Salle Corrections. However, the county maintains the jail license and it is the custodian of record and maintains personnel training records.

Grayson County Staffing and Jail Beds	
Jail Staffing	
Deputies	13
Civilians	88
Patrol Staffing	
Deputies	49
Civilians	23
Total Staffing	**183**
Jail Beds	**478**

Fannin County Staffing and Jail Beds	
Deputies	21
Civilians	9
Total Staffing	**30**
Jail Beds	**530**
*Fannin County jail operations are contracted out to La Salle Corrections	

Grayson County Cities		
Cities with Police Agencies	**Number of Officers**	**Cities Without a Police Agency**
Sherman	75	Knollwood
Denison	51	Sadler
Whitesboro	8	Dorchester
Van Alstyne	8	
Whitewright	8	
Howe	6	
Pottsboro	6	
Tioga	4	
Tom Bean	4	
Bells	4	
Southmayd	3	
Collinsville	3	
Gunter	2	

Fannin County Cities		
Cities with Police Agencies	**Number of Officers**	**Cities Without a Police Agency**
Bonham	21	Ladonia
Leonard	5	Bailey
Honey Grove	4	Pecan Gap
Savoy	1	Ravenna
Ector	1	Dodd City
Trenton	1	Windom

Sherman Police Department

The Sherman Police Department employs 75 officers and 13 civilians and serves over 42,000 residents. The Sherman Police Department maintains its own Public Safety Access Point (PSAP). The PSAP is a call center responsible for answering emergency calls for service for police, fire, and ambulance services and it employs 11 civilian dispatchers. According to the data we received for July 2, 2017, through July 30, 2019, police communications dispatched approximately 780 calls that were either initially coded as a mental health call or were classified with a final disposition as a mental health-related call.

Denison Police Department

The Denison Police Department employs 51 officers and 17 civilians and serves over 24,400 residents. The Denison Police Department maintains its own Public Safety Access Point PSAP and it employs 10 civilian dispatchers. According to the data we received for January 1, 2017, through September 11, 2019, police communications dispatched approximately 5,638 calls that were either initially coded as a mental health call or were classified with a final disposition as a mental health-related call. During that same time period, Denison Police Department reported that 393 of those call resulted in an emergency detention.

Bonham Police Department

The Bonham Police Department employs 19 officers, two animal control officers, and one civilian and serves over 11,000 residents. The Bonham Police Department maintains its own PSAP and it employs six civilian dispatchers. We requested call data from the Bonham Police Department, but we did not receive this information.

Appendix F: Ancillary Tables and Data

Table A: Demographic Characteristics of Adults in Fannin and Grayson Counties (2018)[176]

Adult Population	Texas	Fannin	Grayson
Total Adult Population	22,350,000	25,000	100,000
Age			
18–20	6%	3%	5%
21–24	7%	7%	6%
25–34	19%	13%	15%
35–44	17%	13%	15%
45–54	16%	13%	15%
55–64	15%	17%	20%
65 and older	16%	23%	25%
Sex			
Male	47%	50%	50%
Female	49%	50%	55%
Race / Ethnicity			
Non-Hispanic White	43%	83%	80%
Black/African American	11%	7%	6%
Asian American	5%	0%	1%
Multiple Races	2%	2%	3%
Hispanic / Latino	34%	10%	10%

[176] Population estimates from Texas Demographic Center. (2018). All Texas population estimates were rounded to reflect uncertainty in the underlying population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Table B: Demographic Characteristics of Children and Youth in Fannin and Grayson Counties (2018)[177]

Children and Youth Population	Texas	Fannin County	Grayson County
Total Children and Youth Ages 6–17	4,900,000	5,000	20,000
Age			
Ages 6–11	50%	40%	50%
Ages 12–17	50%	40%	50%
Sex			
Male	51%	40%	50%
Female	49%	40%	50%
Race/Ethnicity			
Non-Hispanic White	32%	60%	75%
Black/African American	12%	6%	5%
Asian American	4%	0%	1%
Multiple Races	3%	4%	5%
Hispanic/Latino	49%	18%	25%

[177] Population estimates from the American Community Survey (2018) and the Texas Demographic Center. (2018). All Texas population estimates were rounded to reflect uncertainty in the underlying population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Appendix G: All Access Texas

In 2019, the Texas Legislature, through Senate Bill 633, created the initiative to increase mental health services capacity in rural areas.[178] Through this initiative, the Health and Human Services Commission (HHSC) identified local mental health authorities (LMHAs) that are located in counties with a population of 250,000 or less, or that provide services predominantly in a county with a population of 250,000 or less, as determined by HHSC. These LMHAs, including Texoma Community Center, were assigned to regional groups based on state hospital catchment areas. Texoma Community Center was included in the Terrell State Hospital (TSH) Regional Group, even though two of counties it serves fall into the North Texas State Hospital catchment area.

In December 2020, HHSC released its *All Access Texas Report*,[179] which includes the TSH Regional Plan. Of particular note, the regional plan indicated that Texoma Community Center is using $2,472,986 in Delivery System Reform and Incentive Payment (DSRIP) funding for its services.[180] As DSRIP funding terminates in September 2021, the Texoma Behavioral Health Leadership Team should work with Texoma Community Center on a contingency planning process to determine which DSRIP activities will continue when funding is no longer available, and identify potential funding sources, strategies to create cross-county quality health outcomes, and collaboration opportunities among the DSRIP providers. Planning now will allow elected officials to fully understand the impact on the health care system if Texas does not come to an agreement with the federal government for a DSRIP replacement program.

The *All Access Texas Report* also details opportunities to expand capacity for existing services, including increasing access to housing and outpatient competency restoration, and build capacity for needed services, including increasing alternative competency restoration options, creating a funding pool for LMHAs to provide electronic equipment to people receiving services in rural areas, increasing private psychiatric bed funding, creating outreach materials for LMHAs, emulating the Texas Faith-Based Model operated within the Department of Family and Protective Services, establishing step-down services through assisted living facilities, and establishing peer-run clubhouses.

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[178] Section 531.0221, Texas Government Code (2019).

[179] Health and Human Services Commission. (2020). *All access Texas report*. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2020/all-texas-access-report-dec-2020.pdf

[180] The report notes: "The LMHA/LBHAs in this regional group report that the majority of DSRIP-funded activities are at risk of ending if this funding is not sustained. LMHA/LBHAs report that they will be forced to reduce or eliminate telehealth opportunities for extremely rural clients, reduce current LMHA/LBHA staffing levels, and create wait lists for routine services once DSRIP ends. Additionally, one LMHA/LBHA noted that losing DSRIP funding may potentially increase community costs for increased ER visits for mental health crisis care."