BEHAVIORAL HEALTH POLITICS IN TEXAS: LESSONS FROM AUSTIN AND THE 86TH LEGISLATURE

Alexander Gajewski

TC 660H

Plan II Honors Program

The University of Texas at Austin

May 13, 2020

David Warner, Ph.D.

Lyndon B. Johnson School of Public Affairs

Supervisor

William Sage, M.D., J.D.

The University of Texas School of Law

Second Reader

ABSTRACT

Author: Alexander Gajewski

Title: Behavioral Health Politics in Texas: Lessons from Austin and the 86th Legislature

Supervising Professor: David Warner, Ph.D., Lyndon B. Johnson School of Public Affairs

How can behavioral health stakeholders engage effectively with Texas' government? To answer this question, my thesis examines three theories of effective advocacy: 1. Effective advocacy attempts to sway public attitudes. 2. Effective advocacy attempts to change who holds office. 3. Effective advocacy introduces policymakers to new ideas. As the thesis brings nuance to each argument, it also provides readers with a basic understanding of the Texas Legislature, Texas politics, and key actors in state government.

Analysis is integrated with narrative vignettes and distilled into seven chapters, each covering one topic in behavioral health policy. These topics include behavioral health lobbying, mental health insurance policy, the Early Childhood Intervention program, the mental health in schools movement, substance use prevention, and the politics of homelessness and comorbid mental illness. Each chapter introduces readers to subfields in public mental health and the political processes relevant to them. Personal experience, secondary research, and a small set of interviews with policy professionals inform the thesis. Ultimately, I hope to empower stakeholders to press the levers of public power and improve Texas' behavioral health care system.

Acknowledgements

I would like to acknowledge my family. Mom, Dad, Teddy, Caia, Little Alex, Heather, and of course Sarah, you have all been an invaluable source of knowledge, inspiration, and support.

I would also like to acknowledge my advisors. Dr. Sage, I appreciate all the times over the last three years you have provided me guidance. Dr. Warner, thank you for all the hard work you put into reviewing my thesis drafts. Your thoughtfulness has not only been invaluable to this project, but crucial for my development as a researcher.

Last, thank you to the Plan II faculty, staff, and students. I cannot put into words how much this program has impacted me. I feel lucky to have gotten to know you. I appreciate the tremendous effort and value you put into my education.

Table of Contents

Introduction

Sixty years ago, behavioral health policy was defined by the psychiatric facilities we see in horror films. Since then it has transformed into an optimistic but opaque and decentralized field, characterized by more effective medications, networks of community supports, and pervasive preventive educational programs. Still today, those concerned about behavioral health are often muzzled by stigma, and the care delivery system continues to fail the American people. Behavioral health refers to prevention and care of mental illness and substance use disorders. As behavioral illness increasingly permeates public discourse and continues to impact us on a personal level, it naturally impacts our politics.

I am not a neutral commentator on this subject. Two of my friends, other full-time students, work jobs just to pay for the treatment of mental health diagnoses that their family members refuse to acknowledge. A third faces a waiting list of one month for an introductory appointment with the only provider that accepts his insurance. Another uses an addictive substance to fend off suicidal ideation. All have faced significant barriers accessing care. This fact should be no surprise since Texas ranks dead last in access to mental health care among the 50 states (MHA). The problem of unmet needs for mental health care, however, is not specific to Texas. Among developed countries, neuropsychiatric disorders are the leading categorical source of disease burden; second worldwide only to parasitic and infectious disease (Eaton et al.).

For behavioral health stakeholders, political engagement is both a necessity and an opportunity. Texas' state government has entangled itself in care, from licensing requirements to state-run health systems. Moving forward, a smart government role in health care promises improved access to care, quality control, public education, and research.

An overreaching government, however, can stifle innovation, cause provider burnout, and spread misinformation. Again, because state involvement in mental health care is non-negotiable and inherently neutral, stakeholders need to work with the state government. To aid in the endeavor, this thesis aims to answer: **How can behavioral health stakeholders effectively engage with Texas' government to improve the behavioral health care system?**

While this thesis will focus on the Texas Legislature, it will touch on advocacy before state agencies, local governments, and the courts. Before diving into advocacy strategies, this introductory chapter will provide a big picture take on the Texas government's power structures, legislative session, politics, judicial system, and elections. By providing this context, the chapter will prime readers to think about structural factors in Texas policymaking.

Arguably, the most powerful man in the state government is the Lieutenant Governor, Dan Patrick. Patrick largely controls the Legislative Budget Board, which drives state budgetary policy. Patrick also controls the flow of bills to Senate committees, who sits on each committee, who chairs each committee, and what bills get to the Senate floor for a final vote. Unlike Congress, the Texas Legislature does not have a discharge petition. In other words, Patrick has near complete control over the functions of the state Senate, including the confirmation of state agency executive nominees.

There are institutional constraints on Patrick's power. For example, the quorum rule requires two thirds of Senators to be present to conduct Senate business. Under the current party division, Patrick needs at least two Democrats in attendance to move legislation. Senate Democrats also have the numbers to block constitutional amendments and gubernatorial appointments. That said,

if you want to create statewide policy, you cannot make an enemy of Patrick. For this reason, among others, the Texas legislature operates in a relatively bipartisan manner.

Patrick is one member of the "Big Three," the most important political players in Texas. The speaker of the house, most recently Dennis Bonnen, and the governor, Greg Abbott, constitute the other two members. The speaker has similar control over the House of Representatives as the lieutenant governor does the Senate. Texas' governor is weak relative to the chief executives of other states, but enjoys significant powers including the bully pulpit and a line-item veto. The governor's veto is typically final, and he has the power to call special legislative sessions to force action on any specific issue. The governor also enjoys the power of appointment to 1500 positions, including seats on several behavioral health advisory councils. The lieutenant governor and governor are directly elected statewide, whereas the speaker of the house is elected by members of the House of Representatives.

The Texas legislature meets for just 140 days every other year. The resulting whirlwind means a lot of good bills die, and some bad bills pass by accident. Speaking generally, *any* controversy or opposition will kill a bill early in the legislative process. If it does not, controversy late in the process can halt the orderly progression of bills on the floor, causing the death of many pieces of legislation. The exception to this rule is, of course, when a controversial bill is a priority of the Big Three. Examples include creating a right to carry weapons on college campuses and banning the direction of federal funds to Planned Parenthood. In these cases, Republican leaders risk the

legislative session grinding to a halt, and Democrat lawmakers decide whether blocking the legislation would be worth the retaliation of the Big Three.[1]

An adversarial, interest-group-dominated model drives health policymaking in the legislature. Most advocacy and trade groups derive their policy positions through a process of coalition building and with input from those on the front lines; however, some groups start with ideological positions and build cases around them (Murphy). While a few groups have the expertise and resources to research and form data-driven policy positions, Texas lacks the health information infrastructure that has enabled other states to rely more heavily on this approach (Khurshid).

Zooming in on the 86th Legislature: The Big Three focused on property tax and school finance reform, whereas in other recent sessions the focus was school voucher programs, "bathroom bills," and "sanctuary city" laws. The shift to "bread and butter" policy issues resulted in a relatively productive, collegial, and drama-light session, although Patrick attributed the change to the departure of moderate former Speaker Joe Straus. All that said, the Legislature still passed a few bills on charged topics, including voting rights (Ramsey) and local partnerships with abortion providers (Sundaram). The Legislature also passed a "religious exemption" bill meant to stop the San Antonio City Council from punishing Chick-fil-A for its anti-LGBT track record (Aviles).

[1] When Senate Democrats blocked the reconfirmation of former Secretary of State David Whitley, Governor Abbott vetoed several of their bills. Since his vetoes came after the end of the legislative session, there was no opportunity to override them (Ura and Platoff).

Texas' judicial branch operates independently from the Big Three and the Legislature. With the exception of the Texas Supreme Court, the Court of Criminal Appeals, and the Third Court of Appeals, Texas' judicial system is funded predominantly at the local level. Furthermore, except for (most) municipal judges, Texas judges are elected in partisan elections by those that they serve. The topic of distinguishing effective advocacy in judicial policy, particularly as it relates to specialty courts, is important, but does not fit within the scope of this project. This thesis will discuss judicial policy, but only as it relates to work done primarily by the legislature and state agencies.

Turning to elections, Democrats do well in the big cities, and Republicans do well everywhere else. The key exceptions are in the suburbs of Austin, Dallas, and Houston. In these political battlegrounds, Democrats have gained significant momentum in the past two years (Gillman). When it comes to statewide elections, everyone acknowledges that the Republican primaries matter more than the general election. Texas is, of course, a conservative state, and both major political parties reflect as much. Election campaigns, meanwhile, are awash in dark money because the state very rarely enforces its campaign finance laws (Goldenstein and Morris).

If Texas' political system seems antiquated and unsalvageable to you, you would not be alone. I believe, however, that there is significant opportunity to work within the current system to effect meaningful, if limited, change in behavioral health policy. I have encountered three theories defining effective advocacy in this field. After presenting them, I will make arguments that bring nuance to each. **1. Effective advocacy attempts to sway public attitudes. 2. Effective advocacy attempts to change who holds office. 3. Effective advocacy brings new ideas to the attention of policymakers.**

On the first point, public opinion ties lawmakers' hands on polarized issues. If lawmakers want to keep their jobs, they need to vote as their constituents want on all bills related to guns, abortion, marijuana, climate change, and health insurance. These issues not only command the public's attention, but also determine access to campaign funds (Gerstle). Additionally, lawmakers may have to play a "scorecard" game. Interest groups score lawmakers based on their votes on specific bills. Lawmakers in tight races may vote to get the scores their constituents and donors want.

But what happens when votes come up on issues that do not rise to the level of public awareness or are unlikely to appear on scorecards? Over 7000 bills were considered during the 140-day 86th legislative session (LRL). The vast majority of bills received little or no press. In these cases, lawmakers can and do vote how they please. The public does not have a clear opinion on the majority of issues before the Texas Legislature; therefore, public opinion cannot influence the likelihood of these bills' passage. Scorecards have a similarly limited influence. Even when a bill ends up on a scorecard, some lawmakers strategize with other members to ensure they only vote against legislation, to score points, when doing so will not impact the success of the bill.

For advocates, some issues (especially those that are already polarized) must be fought in the public light, perhaps through social media or public education campaigns. By swaying the public, you can untie lawmakers' hands and possibly force action. For most issues, however, a keen strategist would keep his bill out of the limelight and pray it does not end up on a scorecard.

Advocates who work to change public attitudes seek ultimately to change the political calculus that determines the fate of legislation. Some advocates believe a better way to change the math is to change who is in power. These individuals might spend their time volunteering for political

campaigns and registering voters. Their philosophy holds true particularly for issues decided by local officials and those elected into key statewide positions. Skilled and open-minded local judges, for example, are pre-requisites for the implementation of mental health courts (Murphy), and as mentioned, the Lieutenant Governor has unparalleled power in the Legislature. Moreover, some local issues require a supportive state representative and senator. For example, a county needs the support of its state lawmakers to raise hotel occupancy taxes to fund promotions for medical tourism. In contrast, for statewide policy, you can bring an initiative to any lawmaker, at which point public opinion and direct advocacy strategies may carry greater weight than who holds individual offices.

The third theory is that direct advocacy (think: speaking to your representatives) can make a difference. This assertion holds true for issues with which legislators or other policymakers are unfamiliar. Ultimately, an advocate can influence policymakers' beliefs, but only if the advocate comes well-informed in both the policy matter *and the relevant political processes*.

Amid a defense of these three theories of effective advocacy, this thesis will seek to provide enough knowledge of political processes and behavioral health policy to start readers on the path to becoming an effective direct advocate.

The thesis is divided into seven chapters. Each one covers the recent history of a topic in Texas' behavioral health policy. The chapters pull, from stories, lessons in effective advocacy. For a deeper knowledge in a specific policy area, readers should explore the "further reading" recommendations provided at the end of each chapter. The conclusion provides a cross-issue analysis of advocacy strategy. It also comments on how applicable the theories of effective advocacy will be moving forward, what issues may be ripe for change, and what future studies

could tell us about behavioral health advocacy. The first appendix provides a bill development timeline that guides advocates through the Texas Legislature's unique biennial calendar. The second appendix provides a statistical breakdown of the bills passed during Texas' 86th Legislative Session and lawmaker success rates.

Research methods include interviews with policy professionals, a review of news articles, and secondary research in subfields of public policy and public health. Unless otherwise cited, the assertions made in this essay are my own observations, informed by a year and half serving as a legislative intern in Senator Zaffirini's capitol office and several years volunteering in an indigent care clinic and state psychiatric hospital. Uncited claims made in the introduction, for example, draw heavily from my experiences and conversations with staffers in the Texas Senate.

My thesis combines stories with facts and analyzes what both tell us about advocacy in Texas. This mixed-method format is popular in health policy commentaries written for the public. For example, T.R. Reid's *The Healing of America* intertwines a comparison of health system models and Reid's personal experiences seeking treatment around the world. Elisabeth Rosenthal's *American Sickness* mashes the stories of patients with an explication of US health care economics.

What is the value of mixing disciplines? Mathematics can demonstrate why medical device monopolies raise deductibles. An anecdote can convey why dependence on your spouse for health insurance creates an ugly power differential. Reid and Rosenthal make use of multiple disciplines to deliver a more robust look at the flaws of the US health care system. My thesis emulates their style and applies it to behavioral health policy and politics.

This focus situates my thesis somewhere between Mark Strand of the Congressional Institute's *Surviving Inside Congress* and the League of Women Voters' *Texas Advocacy Playbook*. The next seven chapters will study everything from legislative rules, to Texas politicians, to addiction treatment barriers. By approaching behavioral health advocacy from all angles, I hope to teach stakeholders how to make the most of their seat at the table.

Chapter Bibliography

Aviles, Gwen. "Texas Gov. Greg Abbott signs 'Save Chick-fil-A bill." *NBCNews.com*. July 19, 2019. Retrieved from https://www.nbcnews.com/feature/nbc-out/texas-gov-greg-abbott-signs-save-chick-fil-bill-n1031786.

Eaton, William, Alexandre, Pierre, Bienvenu, O. Joseph, Clarke, Diana, Martins, Silvia S., Nestadt, Gerald, and Benjamin Zablotsky. "The Burden of Mental Disorders." *Public Mental Health*. Ed. William Eaton and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p. 3-30.

Gerstle, Gary. *Liberty and Coercion*. Princeton: Princeton University. 2015.

Gillman, Todd. "Behind the Texas firewall, suburban shifts leave Trump vulnerable. Can strongholds save him? *DallasNews.com*. Sep. 28, 2019.

Goldenstein, Taylor and Allie Morris. "Texas lobbyists and politicians dodged $800k in fines, thanks to weak campaign finance laws." *Houston Chronicle*. Jan. 23, 2020.

Khurshid, Anjum (Director of Data Integration in the Dell Medical School Department of Population Health). Personal interview. Jan. 24, 2020.

Legislative Reference Library of Texas. "Bill Statistics after Signing/Veto Period, 86th Legislature." *LRL.Texas.gov*. June 17, 2019.

Lobberecht, Marlene. *Texas Advocacy Playbook*. League of Women Voters of Texas. Feb. 2019. Retrieved from https://my.lwv.org/sites/default/files/tx_adv_playbk.pdf.

Mental Health America. "Overall Ranking." *MHANational.org*. Accessed Feb. 2, 2020. Retrieved from https://www.mhanational.org/issues/ranking-states.

Murphy, Kate (Senior Child Welfare Policy Associate at Texans Care for Children). Personal interview. Jan. 24, 2020.

Ramsey, Ross. "Analysis: The Texas Legislature's unexciting, no drama, very humdrum session." *Texas Tribune*. May 13, 2019. Retrieved from https://www.texastribune.org/2019/05/13/texas-legislatures-unexciting-no-drama-very-humdrum-session/.

Reid, T. R. *The Healing of America: A Global Quest for Better, Cheaper, and Fairer Health Care*. New York: Penguin. Aug. 31, 2010.

Rosenthal, Elisabeth. *An American Sickness: How Healthcare Became Big Business and How You Can Take It Back*. New York: Penguin. April 11, 2017.

Strand, Mark, Johnson, Michael, and Jerome Climer. *Surviving Inside Congress*. 5th ed. Ed. Lang, Timothy. Alexandria: Congressional Institute. Dec. 6, 2017.

Sundaram, Arya. "Texas passes bill banning cities from partnering with Planned Parenthood on any services." *Texas Tribune*. May 24, 2019. Retrieved from https://www.texastribune.org/2019/05/24/texas-abortion-bill-called-biggest-threat-planned-parenthood-passes/.

Svitek, Patrick and Naomi Andu. "With GOP supermajority at risk in 2020, Dan Patrick says Texas Senate may lower threshold to bring bills to the floor." *Texas Tribune*. Jan. 23, 2020. Retrieved from https://www.texastribune.org/2020/01/23/dan-patrick-says-he-may-further-lower-threshold-bring-bills-senate-flo/.

Texas Senate. "Senate Agenda – Vote Requirements." Accessed April 21, 2020. Retrieved from https://senate.texas.gov/agenda-votereq.php.

Ura, Alexa and Emma Platoff. “After block David Whitley’s confirmation, Senate Democrats see bills die on Abbott’s desk.” *Texas Tribune*. May 29, 2019. Retrieved from https://www.texastribune.org/2019/05/29/texas-senate-democrats-block-whitley-governor-veto-bills/.

Chapter 1: Entering the Arena, Alissa Sughrue, and NAMI Texas

This chapter describes the work of NAMI Texas and one advocate, Alissa Sughrue, who carries out the organization's work. The chapter aims to familiarize readers with the workers and culture of the Texas Legislature, while also dispelling the myth that effective political engagement requires any one type of expertise. Generalizing from Alissa's story, the chapter makes three observations. 1.) For behavioral health stakeholders, there is value in showing up at the legislature at the right time. 2.) An advocate with a bill idea will find help turning it into policy from staffers and professional advocates. 3.) The power of an individual actor is constrained by legislative gatekeepers and political currents.

Alissa Sughrue grew up in Bartlesville, Oklahoma, a small city north of Tulsa. She attended primary and secondary school with the city's rich and poor. She saw peers who lived in foster care speak up about their unmet needs, but not be taken seriously. They felt powerless, and she decided that one-day she would do something about it. Her dream was to become the Secretary of Education.[1] Alissa completed her undergraduate degree in sociology and anthropology at Hendricks College in Arkansas. Her thesis covered gender inequities in science, technology, engineering, and math education.

Alissa assumed the first step to working in public policy was enlisting for the front lines. She took an AmeriCorps position as the education liaison in a LifeWorks emergency shelter. Lifeworks provides housing and social services to youth experiencing homelessness in Austin,

[1] That dream lasted until Alissa realized, in her words, that "the position has to be purchased."

Texas. There Alissa spent a year enrolling at-risk children in school before transitioning to a Youth Care Worker position. She worked essentially as a dormitory supervisor, analogous to a college Residence Assistant, but for 16 to 20-year-olds who would otherwise be living on the streets. She enforced rules, documented the resident's whereabouts, organized activities, managed medications, ensured the kids had food, and cared for residents in crisis.

After two years in that role, Alissa enrolled in a master's program at the Steve Hicks School of Social Work at the University of Texas at Austin. She completed her degree and elected to break into Texas' policy world. She started as a Policy Coordinator for the Texas Chapter of the National Alliance for Mental Illness (NAMI Texas) just before the start of the 86th Legislative Session.

NAMI describes itself as a national organization "dedicated to building better lives for the millions of Americans affected by mental illness." It is a grassroots community. Most of what NAMI does is on the local level, running workshops and support groups. Most of its funds go towards these local activities. The NAMI Texas chapter, a small crew of five, handles statewide administrative tasks and lobbying. They advocate for persons with mental illness and their families, as opposed to mental health care providers.

At the start of the legislative session, NAMI Texas consisted of an Executive Director, Office Manager, Education Director, Policy Director, and a Policy Coordinator. Alissa described having both a Policy Director and Policy Coordinator as "a luxury." Most advocacy groups were lucky to have one full time policy position. With two, NAMI Texas was one of the most active and therefore important mental health interest groups at work in the Texas Legislature.

Texas legislative offices are similarly light on staff. Most House of Representatives offices have just a Chief of Staff, a Legislative Director, and a handful of interns during session. [2] Like Alissa, most lobbyists and staffers are young, full-of-energy, and light on experience in Texas policy. At the end of the day, experience is valuable but not vital. Given the technical complexity of the legislative process, even the older staffers constantly learn on the job.

When a bringing a policy idea forward to the Legislature, most advocates opt to speak with the staff of the representative and senator that represent them, or the legislator whose district is most impacted by the issue. If bringing a policy with a statewide impact, Alissa believes there is no ideal bill author. "I would not write-off a legislator just because they are not on the relevant committee or are a Democrat." Often the legislators who do not hold any committee chairships pass the most bills because they make the fewest enemies. Committee chairs inevitably get the blame for killing hundreds of bills each session. Alissa does recommend finding a staffer who is passionate about your project and close with an experienced mentor.[3]

"My name is Alissa Sughrue. I am the Policy Coordinator for NAMI Texas, and I stand in support of this bill."

---

[2] As an intern in Senator Zaffirini's office, I worked on a bill with the Executive Directors of Public Citizen and Sierra Club's Texas chapters. We sought to update regulations from the 1960s to prevent above-ground hydrocarbon storage tank failures. Five representatives from the Texas Chemical Council, Texas Oil and Gas Association, and Texas Pipeline Association decided to pay my boss and myself a visit. They had a laundry list of issues with the bill. Their organizations also owned a number of above-ground storage tanks. Unknown to me at the time, this army of five constituted an intimidation tactic in the Texas Legislature. SB 1446 died in committee, killed most likely, as my mentor put it, because industry representation went to the committee chair's office and explained behind closed doors why it was bad policy.

[3] Check out Appendix B for a statistical breakdown of bill and author success rates in Texas' 86th Legislature.

Alissa arrived at the House Committee on Public Health hearing armed with facts.

“Over a third of low-income women who experience [postpartum depression] don’t receive any kind of mental health treatment. Over half of women with perinatal depression are not diagnosed.”

When questioned about the source of her facts in front of the Senate Committee on State Affairs, without hesitation Alissa gave the name of the report, the year it was published, and the name of the agency that published it. She and NAMI’s Policy Director were a dream team. They spent their days walking up and down the halls of the Capitol, briefing staffers and strategizing. At the end of each work-day, they started writing one-page briefs and testimony to prepare for the next. The work was tiring and non-stop, but meaningful.

Then halfway through the legislative session, NAMI Texas’ Executive Director resigned. The Public Policy Director became the Interim Executive Director, and Alissa took on the Public Policy Director’s responsibilities, in addition to her 60-hour per week commitments as Policy Coordinator. She worked until midnight at least six days a week. She felt she “never really left work.” For staffers and advocates during a legislative session, this kind of work schedule is pretty typical.

“There’s clearly a lot of thought put into preventing certain unintended consequences; however, without robust protections in place for the individuals being denied important treatment under this law, especially for mental health services, we strongly believe this [bill] will harm the few protections these certain groups have” (Senate Committee on State Affairs).

Alissa testified in support of nine bills and against one. She consulted with staffers on many others, including House Bill (HB) 10 and Senate Bill (SB) 10. These two bills drew much attention and controversy. They sought to create a child mental health "consortium." To do so, the legislature allocated 100 million dollars to network the psychiatry departments of Texas' robust system of medical schools. The appropriation may fund child and adolescent psychiatric telephone consultations and telehealth services, administered by this network. The composition of the consortium's decision-making body heavily emphasizes psychiatry with little representation for the other mental health professional fields. While this fact ruffled some feathers, the bill was widely supported. All the relevant interest groups agreed that Texas desperately needed state-wide coordination of its behavioral health care systems and a child and adolescent psychiatry access program.

This policy also formed a key component of the Governor's school safety plan in the wake of the Santa Fe school shooting. The proposal was so important politically that both the Lieutenant Governor and the Speaker of the House made it a priority item, each assigning it one of the first 30 bill numbers in their respective chambers. Despite having so many factors in their favor, neither HB 10 nor SB 10 survived the legislative process.

Alissa talked with the staffers leading both bills through their journey. Mistrust between the House and the Senate permeated the process. In order for a bill to pass, it has to move through both chambers sequentially, providing the Lieutenant Governor, the Speaker of the House, and a committee chair in each chamber the opportunity to kill the bill. HB 10 and SB 10 were originally very similar. They both flew their respective chambers of origin, but then stalled in the opposite. HB 10 was heavily amended by Senators so that it clashed less with their bill. As the

Senate pondered what exactly to do HB 10, House leadership stalled SB 10 to leverage the Senate to move their bill forward. This practice is called “chubbing” (Wallace 2019).

Especially toward the end of Session, committee chairs stalled numerous bills, as Alissa put it, “for no other reason than the other side not moving that committee chair’s bills.” The chambers played this game so long that the Senate ran out of time to hold a final vote on HB 10. The House brought SB 10 to a vote on the final day allowed, so late in the process that Representative Stickland, a hardline conservative from Bedford, managed to kill the bill with a parliamentary maneuver. Just before the midnight deadline, however, Representative John Zerwas, a Republican from Richmond, amended the entirety of SB 10 onto SB 11, a school safety bill that ultimately passed the House with 137 votes in favor and eight against. Governor Greg Abbott signed the bill into law on April 6, 2019.

Alissa reiterated that everything she shared with me about the suspicion between the House and Senate was heard second or third hand. While hearsay, these types of rumors prompt action in the legislature. Information, right or wrong, flows quickly. This fact puts tremendous pressure on staffers. They are watched, prodded, and fearful of saying too little or too much about their boss’ intentions. They must maintain the trust of others, project competence and passion, and listen carefully for hints that a legislator may quietly suffocate their bill. At the end of the day, one staffer has little control over the legislative process. It feels a lot easier to get a bill killed than passed, and particularly in the field of health and human services, some of the policies at stake easily impact tens of thousands of Texans.

Just a few months before Session, Alissa got engaged. When session began, so did 60-hour work weeks. Meanwhile, Alissa's fiancée worked full time and took night classes to earn her associates in computer science. When Alissa's boss became interim director, Alissa's 60-hour work weeks became 100 hours, and she and her fiancée stopped performing daily chores. The accumulating mess became a significant stressor.

Texas policy circles hold that lobbyists and staffers divorce their partners at abnormally high rates, rates that spike during session. Alissa feels the capitol is like a different planet, and in my experience, your position becomes an important part of your identity. Rumors about legislators occupy your attention. You feel proud to be a piece on the chess board and go home at night just to think about how to protect your favored policy. Your friends and family did not live in the same world. Your interests and obsessions no longer overlap with theirs.

Alissa and her fiancée made it through Session as strong as ever. Since her fiancée was almost equally busy, they put their lives on hold until Session ended. Afterwards, they deep cleaned their apartment and picked up where they left off planning their wedding.

Alissa and SB 10's stories illuminate several limitations of direct advocacy and a few strategies to succeed at it. Regarding limitations, this chapter shows the power of committee chairs and the lieutenant governor to kill legislation. If the relevant committee chair or the lieutenant governor opposes your bill, your best option is to try and **change who holds the office**.

Advocates should also realize that, even before Session began, SB 10 was going to pass. During Session, advocates supported the bill, and individual representatives, like Rep. Stickland, tried their hardest to oppose it. None of that mattered. Senator Nelson (R-Flower Mound) did her homework well before Session. She designed the bill to leverage existing resources in academic

medical centers. Her bill responded to the current school shooting crisis, and she built a coalition that included every Senator and the Lieutenant Governor in support of it. There was a tremendous political current that ensured the bill would pass, and therefore little reason for an advocate to get involved once it had been filed.

Effective advocacy brings *new* ideas to the attention of legislators. As far as lawmakers were concerned once Session began, the case of SB 10 was closed; however, very few bills have as much momentum as SB 10. Advocates can help legislators form opinions on the many issues about which they learn while in office. NAMI Texas proved there is value in doing so. With just two full-time employees, NAMI Texas wrote five bills, helped draft several more, and lobbied for or against 25 bills. While it is difficult to attribute a bill's passage to one actor, Alissa believes at least six policies would not have become law without the work of NAMI.

You do not need to work on policy full-time to see success, but if you want to be influential, first you have to show up and make yourself known to staffers. If you visit in the fall before the craziness of a session, I expect you will meet staffers and other advocates who want to hear your ideas, and if they like them, fight for them.

Further Reading

Frank, Richard and Sherry Glied. *Better But Not Well*. Baltimore: Johns Hopkins University. 2006. p. 1-7; 91-103.

I recommend just the book's introduction and sixth chapter (titled "Policy Making in Mental Health)." These sections make a data-driven assessment of the United States' mental health care system from 1950 to 2006. They introduce how the burden of disease, effectiveness of treatments, and financing & pricing of mental health services have changed over time. In chapter six, Frank and Glied describe the decline of specialty mental health policymakers as their job was cut up and distributed to numerous government agencies. The new mental health policymakers are state Medicaid directors, the Social Security commissioner, the Centers for Medicare and Medicaid administrators, and the Secretary of Housing and Urban Development. The authors highlight the resulting lack of coordination in mental health policy. The work notably does not describe the importance of community behavioral health authorities and two key pieces of legislation passed after its publication. These topics will be explored in other parts of this thesis.

Everett, Anita and Su Yeon Lee. "Community and Public Mental Health Services in the United States: History and Programs." *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p. 396-414.

This chapter of Public Mental Health *complements* Better But Not Well *by focusing on the role of community behavioral health organizations (CBHOs). The piece describes CBHO outpatient services and collaborative programs. It also addresses the challenges these organizations face today. While the chapter does not discuss the impact of the Affordable Care Act on CBHOs, it will nonetheless help readers understand the US mental health system's greatest asset. Additionally, it provides a spark-notes style history of global mental health services development, from the 11th century Islamic Abassid Dynasty's first asylum to 19th century advocate Dorothy Dix, to today's community organizations.*

Chapter Bibliography

National Alliance for Mental Illness. "About NAMI." *NAMI.org*. Accessed August 15, 2019. Retrieved from https://www.nami.org/about-nami.

Texas Legislature. House of Representatives. Committee on Public Health. *Hearing on March 13, 2019*. 86th Legislature.

Texas Legislature. House of Representatives. *House Bill 10*. 86th Legislature. Regular Session. 2019.

Texas Legislature. Senate. Committee on State Affairs. *Hearing on March 25, 2019*. 86th Legislature.

Texas Legislature. Senate. *Senate Bill 10*. 86th Legislature. Regular Session. 2019.

Texas Legislature. Senate. *Senate Bill 11*. 86th Legislature. Regular Session. 2019.

Wallace, Jeremy. "Lt. Gov. Dan Patrick threatens Texas House, accusing members of slow-walking bills." *HoustonChronicle.com*. May 17, 2019. Retrieved from https://www.houstonchronicle.com/politics/texas/article/Lt-Gov-Dan-Patrick-threatens-Texas-House-13854594.php.

Chapter 2: Mental Health Care & Insurance Policy

The purpose of this chapter is to describe the current health insurance paradigm and its relation to barriers to receiving psychiatric care in Texas. With these issues in mind, the chapter examines the state's "non-system" of safety net mental health care. By then focusing on an effort to improve access to care through the enforcement of mental health parity laws, the chapter will demonstrate the role of advocacy in the processes of policy implementation. Effective advocacy in this context extends beyond attending agency hearings and branches into community education and academic work.

Advocates for expanding access to care in Texas have spent hours upon hours fighting uphill battles on insurance mandates, smart taxation, scope-of-practice laws, and funding for studies on X and Y issues. These policies generally have financial losers, either a trade group or the state, and as such are bitterly contested. Controversial bills rarely move in the legislature because the Speaker and Lieutenant Governor have no problem 'filling the docket' with uncontentious items. What makes this process particularly frustrating is that the same leadership refuses to advance a conflict-free, win-win item that would likely do more to expand access to care than any other proposal, all with little investment from Texas.

Since the passage of the Affordable Care Act in 2010, Texas has refused to expand Medicaid, even though the federal government would fund 90 percent of the expansion. As of July 2018, *HealthInsurance.org* reports that if Texas were to expand Medicaid, it would make Medicaid coverage available to an additional 1.6 million people, 600 thousand of whom have "no realistic access to health insurance" (Norris, "Texas and …"). Moreover, the new requirements or 'strings' attached to the federal dollars would have increased enrollment of more than 500,000

children in Texas eligible but not enrolled in Medicaid or the Children's Health Insurance Program (Warner).

In 2018, 17.7 percent of Texas residents had no health coverage – almost twice the national average of 8.9 percent (Fernández). To date, 36 US states and the District of Columbia have expanded Medicaid. In these places, Medicaid is a health insurance program for anyone with a low-income. In Texas and the 14 other states that have not expanded the program, adults can only qualify if you have if they have a low income *and* care for a child, have a disability, are pregnant, or have cervical or breast cancer (among a few other ways to qualify) (TxHHS, "Medicaid and …"). While this may seem reasonable on paper, when you look into the details, the absurdity of the eligibility criteria become clear. For example, an adult caring for a child that qualifies for Medicaid can themselves qualify for Medicaid only if they make less than $196 per month. Meaning, if the adult makes more than $2,353 per year, he does not qualify for Medicaid (TxHHS, "Medicaid for …").[1]

Yet barriers to accessing mental health care go well beyond access to health insurance. Colleen Horton, Policy Program Officer at the Hogg Foundation for Mental Health, reported in 2016 that 79 percent of Texas psychiatrists refuse to bill Medicaid. Additionally, 50 percent refuse to bill private insurance, instead requiring patients to pay out of pocket. While a low rate of

---

[1] One common dismissal of Texas' abysmal insured rate is the argument that anyone can use the emergency room. While true that the federal government requires nearly all emergency rooms to offer emergency medical treatment regardless of a patient's ability to pay, the scope of what emergency rooms must treat is narrow (CMS). Guaranteed treatment does not include, for example, pre and postnatal care, cancer treatment, or mental health care (Carroll). Moreover, patients still get charged for the emergency care they receive. Even Dallas County's flagship public hospital, Parkland Memorial Hospital, drives people into debt after providing emergency procedures (Méndez).

reimbursement contributes to this issue, the simpler truth is that psychiatrists are in short supply. They can fill their schedules with patients who will pay out of pocket. In 2015, 185 out of Texas' 254 counties lacked a single psychiatrist, and 40 counties lacked even a licensed clinical social worker. This shortage is exacerbated for child and adolescent psychiatry (Colleen). In addition to most of rural Texas, El Paso, Fort Worth, Austin, San Antonio, parts of Dallas, and Houston are designated by the federal Health Resources and Services Administration as Mental Health Professional Shortage Areas. Where demand exceeds supply, patients must have cash to pay for mental health care, even if they manage to get off the waitlist and have private insurance.

So what happens if you cannot pay out of pocket? Nearly 80 percent of US workers are living paycheck to paycheck, after all (Friedman). In Texas, responsibility for the mental health safety net is supposed to fall onto Local Mental Health Authorities and ten psychiatric hospitals run by the Texas Health and Human Services Commission (TxHHS, "State Hospitals"). In reality, these services are underfunded, and the largest safety net provider of mental health care is the state's system of jails, although all major cities are broaching progress on this front.[2]

Turning now to the extreme end of the unmet needs spectrum, every city has a population of high-need social service and penal system users. Almost thirty years ago, Pamela Diamond and Steven Schnee with the Hogg Foundation for Mental Health cast a light on this population and the cost of ignoring it for the rest of society. They found that just 21 men living on the streets in downtown San Antonio cost 17 different agencies a total of $1.5 million over 31 months,

[2] Some urban counties have established mental health courts to divert qualifying criminals to treatment. County and federal dollars fund these courts, and they have proven successful at decreasing recidivism. A lack of interested judges, however, currently slows the expansion of these programs (Murphy).

averaging out to $570,000 per year (adjusted for inflation using the Bureau of Labor's online calculator). Most of this cost was borne by the criminal justice system, but the other expenses were significant. A more recent study found that between 2003 and 2009, nine individuals living in the Austin area made 2700 emergency room visits, costing taxpayers three million dollars (AP). This cost is the product of an uncoordinated "non-system" of care (Diamond and Schnee).

Advocates are trying to fill the gaps in the mental health care system from multiple angles and at multiple levels of government. Several bills have been introduced in both chambers of Congress that would increase the number of Medicare-funded residency positions in psychiatry, addiction medicine, and many other specialties. The passage of one of these bills would mark the first increase in the number of Medicare-funded residency slots since 1997 (AHA). Texas' 2017 Legislative Session saw the creation of an expedited licensing process meant to bring psychiatrists to Texas from other states (TMA). That same legislature strengthened Texas' mental health parity laws, a new development in a 25-year-old movement.

Mental health parity is the legal requirement that health insurance plans that cover mental health treatment offer these benefits 'on par' with medical and surgical benefits. This policy and the movement behind it will be the focus of the rest of this chapter.

The first mental health parity law in the United States was passed by Congress in 1996. It applied only to large-group plans and did not cover substance use disorders. In 2008, Congress passed the Mental Health Parity and Addiction Equity Act (MHPAEA), adding addiction treatment and general mental health care to the benefits that must be offered with no greater restrictions than medical/surgical benefits.

The MHPAEA increased access to substance use disorder treatment in certain circumstances (Goodell), the use of autism spectrum disorder services (Stuart et al.), and individual financial protection; however, it did not significantly decrease out-of-pocket costs (Barry et al.). At the time of its passage, the act fell short in three respects from a patient's perspective. First, the law did not specify how parity would be enforced. Second, it did not apply to individual and small group plans, and third, the law did not require that insurance plans cover mental health treatment, only that there be parity of benefits *if mental illness is covered*. At the time, coverage of mental health treatment was not a requirement. Moreover, in 2008, a mental illness diagnosis could still preclude you from purchasing a private insurance plan (Norris, "How …"). The issue of enforcement persists today. The issues of coverage and pre-existing conditions persisted through 2013.

Louis Norris, the health insurance and health reform authority for HealthInsurance.org, describes the difficulty of finding insurance coverage for mental health illness in 2013:

> A person with a bipolar diagnosis was unable to obtain private individual health insurance in most states. The same was true for people with schizophrenia and other psychotic disorders, anorexia, alcoholism, and a variety of other serious mental or behavioral illnesses.
>
> Even for people with relatively minor mental health diagnoses, health plans were allowed to increase premiums during the initial underwriting process.
>
> The underwriting rules that applied to mental health treatment often trapped people in the health plan they had when they were diagnosed, with no realistic opportunity

> to shop around when annual rate increases were announced. And for people who were uninsured at the time of their diagnosis, securing coverage was challenging and expensive – or impossible, depending on where they lived.
>
> For those who had insurance, it often didn't cover mental health care. According to a 2013 analysis conducted by HealthPocket, only 54 percent of individual health plans in the United State included coverage for substance abuse treatment, and 61 percent covered mental health treatment. (Coverage was better among employer-sponsored plans.)

The Patient Protection and Affordable Care Act (ACA) was signed into law in 2010. In 2014, provisions of the law came into effect that extended mental health parity requirements to include individual and small-group plans. More significantly, the law prohibited insurers from considering pre-existing conditions in underwriting or enrollment decisions. It also required individual and small-group plans to cover ten "essential health benefits" with no dollar limits. These benefits include mental health and addiction treatment, prescription drugs, and behavioral assessments for children. Speaking generally, the ACA made coverage of behavioral health care mandatory and expanded behavioral health benefit parity requirements.

The responsibility for enforcing mental health parity laws is distributed between multiple federal and state agencies (Goodell). The federal Department of Labor (DOL) has jurisdiction over self-insured plans, including the majority of employer-sponsored plans. State insurance agencies enforce private insurance plan regulation (Norris, "What Is …"). In 2018 The DOL closed 115 investigations subject to MHPAEA, citing 21 violations. When a violation is found in a particular insurance plan, the DOL requires the insurer to bring all similar plans into compliance

(a strategy called "voluntary global corrections"), as opposed to, say, levying a fine. The DOL does require plans to reimburse patient payment differences due to a quantitative treatment limitation. For example, the DOL required an insurer to reimburse a modest $26,000 in total to 94 plan participants when it found a plan had higher co-payments for behavioral health outpatient visits than medical (EBSA).

As you might guess, there are many barriers and limitations to enforcement.[3] It is difficult to monitor health management organizations' decision making processes, including those of Medicaid managed care programs. Insurance companies can still refuse to cover specific diagnoses and treatments that arguably fall outside of the ACA's essential benefits; eating disorders are an example of a contested diagnosis. The MPHAEA does not apply to the minority of Texans on Medicaid who receive services solely under a fee-for-service model (as opposed to a managed care or hybrid model). Notably, the majority of this population is disabled and therefore at a higher risk of mental health and substance use disorders (Barry et al.). Furthermore, few organizations are capable of observing a discriminatory *pattern* of claims denials (or other patterns in treatment limitations), and depending on the state, these organizations may not have standing to sue (Goodell). Last and most significantly, in most cases, enforcement requires behavioral health consumers to report potential violations.

> "When consumers are denied coverage for substance use and mental health care, they are generally left to fend for themselves to defend their legal

[3] Before discussing these limitations, it is worth noting that only by the work of numerous researchers and advocates has the issue of parity enforcement come to the attention of policy makers. NAMI, for example conducted a highly cited survey in 2016, illuminating the "unfulfilled promise of parity." Investment in research has kept mental health parity on the national political agenda; Former Vice President Joe Biden brought up a plan to expand mental health parity protections in the January 14, 2020 Democratic Presidential Debate.

> rights. Rather than filing complaints with the state insurance department or attorney general, they generally turn their attention to figuring out how to immediately get their loved ones the help they need, even if it means facing financial ruin." - Harris and Weber, 2018

Effective enforcement requires that consumers know their rights and report violations. Toward this end, the Center for Public Policy Priorities is developing tools to help consumers identify violations, hosting webinars for community leaders, and leading public education efforts through Facebook and Twitter (CPPP, "Parity …"). Since enforcement requires consumers to file complaints, public education is an effective strategy to push for mental health parity.

Advocates have also successfully prompted state legislative action. In 2017, Texas' 85th Legislature recognized that the Texas Department of Insurance (TDI) was unable to enforce parity laws in accordance with the updates made seven years prior by the ACA. The 85th Legislature strengthened state parity laws, empowered TDI to enforce them, created an ombudsman to help citizens file complaints with the appropriate agency, and created a workgroup to strategize for improving enforcement across the state (Villarreal).

The workgroup consists of representatives from three state agencies, commercial health insurance plans, behavioral health providers, hospitals, the new ombudsman's office, and consumer advocacy organizations, in addition to behavioral health consumers and their family members. The workgroup is chaired by NAMI Texas' executive director ("Workgroup Progress Report").

Implementing parity laws requires the lived experience of consumers and knowledge of the bureaucracy of HHSC and TDI. It also relies on expertise in behavioral health treatments, the financing of treatment, and health law. No one person has all the necessary knowledge. People must work and learn together to devise a technical and fair process for identifying and punishing parity violations. This effort is an example of policy implementation. Implementation processes are open to the public. Anyone can join workgroup meetings, and reimbursement for travel may be available, depending on the workgroup.

Yet, while subgroups of the larger parity workgroup iron out concrete policy recommendations, Texas' Attorney General, Ken Paxton, leads an 18-state lawsuit aiming to abolish the entire Affordable Care Act (Norris, "Texas health …"). When it comes to health policy, Texas' government has many brains pulling in opposite directions.

For behavioral health providers looking to get involved in mental health parity, a good start would be to distribute brochures that encourage patients to reach out to the HHSC parity ombudsman if they think their insurance provider may be violating their parity rights. These materials have already been prepared and are available online at DontDenyMe.org. Providers can also record claims denial rates, pre-authorization requirements, and other treatment barriers. They can then compare the barriers with those observed by their colleagues in medicine and surgery and bring any differences to the ombudsman. Meanwhile, any behavioral health stakeholder can join the parity workgroup and petition Texas' Attorney General to take up a parity case.

Returning to the three types of effective advocacy discussed in this thesis, public education to enhance mental health parity enforcement falls into the category of **changing public attitudes**. Regarding changing the mental health insurance paradigm, since the issue is so politicized, large scale reform will require **changing who holds office**. If someone wanted to prevent Attorney General Ken Paxton from contributing to the multi-state case to dismantle the ACA, for example, there is little to do except try to oust him in the 2022 election. On smaller issues like expanding state coverage mandates to eating disorder treatments, **direct advocacy** can play an important role. This chapter has shown policy and clinical expertise, as well as lived experience, are valuable in the process of policy implementation. One way for stakeholders to be effective advocates is to bring these types of knowledge to state agency workgroups.

Further Reading

On mental health policy and economics:

Glied, Sherry and Richard Frank. "The Evolution of Mental Health Policy and Economics." *Oxford Research Encyclopedia of Economics and Finance*. March 2018. Retrieved from https://oxfordre.com/economics/view/10.1093/acrefore/9780190625979.001.0001/acrefore-9780190625979-e-80.

This article goes in depth into the many factors that distinguish mental health insurance policy from medical/surgical. It introduces the study of mental illness' impact on national economics and federal social insurance programs, namely disability insurance and supplemental security income. The article also articulates the field of mental health economics' modern focus on problems in systems coordination, cost-shifting, and early diagnosis. No prior familiarity with the field is necessary; however, if you are new to health insurance policy, you may need to look up some of the jargon used.

Eaton, William, Alexandre, Pierre, Kessler, Ronald, Martins, Silvia, Mortensen, Preben, Rebok, George, Storr, Carla, and Kimberly Roth. "The Population Dynamics of Mental Disorders." *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p.125-150.

This chapter of Public Mental Health *describes the age of onset and likely duration of psychiatric diseases. It provides nuance to the generalization that mental illness begins at an early age and persists through the individual's life and will help guide policymakers to tailor interventions to specific populations.*

On West Texas provider shortage:

Saslow, Eli. "'Out here, it's just me': In the medical desert of rural America, one doctor for 11,000 square miles." *Washington Post*. Sep. 28, 2019. Retrieved from https://www.washingtonpost.com/national/out-here-its-just-me/2019/09/28/fa1df9b6-deef-11e9-be96-6adb81821e90_story.html.

Pultizer-winner Eli Saslow paints a vivid picture of health care in rural Texas. His article follows the only doctor serving four counties east of El Paso as he manages a range of medical cases and administrative challenges.

On mental health courts by city, see full bibliography for complete citation:

Houston: DePrang, "Barred Care," *Texas Observer*, 2014.
Austin: Weidaw, "Travis Co. Jail becomes …" *kxan.com*, 2017.
Dallas: Nye, "Jails …" *CHASP*, 2019.
San Antonio: Moser, "San Antonio …" *ChicagoMag.com*, 2014.
El Paso: Callahan, "El Paso Sheriff …" *CBS4Local.com*, 2019.

Chapter Bibliography

Abelson, Reed, Goodnough, Abby, and Robert Pear. "What Happens if Obamacare Is Struck Down?" *New York Times*. March 26, 2019. Retrieved from https://www.nytimes.com/2019/03/26/health/obamacare-trump-health.html.

American Hospital Association. “Bill to add 15,000 Medicare-funded residency slots introduced in House.” March 14, 2019. Retrieved from: https://www.aha.org/news/headline/2019-03-14-bill-add-15000-medicare-funded-residency-slots-introduced-house.

Associated Press. “9 patients made nearly 2700 ER visits in Texas.” April 1, 2009. Retrieved from http://www.nbcnews.com/id/29998460/ns/health-health_care/t/patients-made-nearly-er-visits-texas/.

Barry, Colleen L., Goldman, Howard H., and Haiden A. Huskamp. “Federal Parity In The Evolving Mental Health and Addiction Care Landscape.” *Health Affairs*. Vol. 35. Iss. 6. June 2016. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2015.1653.

Callahan, Concetta. “El Paso Sheriff says county jail needs more mental health programs to help inmates.” *CBS4Local.com*. May 24, 2019. Retrieved from https://cbs4local.com/news/problem-solvers/el-paso-sheriff-says-county-jail-needs-more-mental-health-programs-to-help-inmates.

Carroll, Aaron. “Why emergency rooms don’t close the health care gap.” *CNN.com*. May 7, 2012. Retrieved from https://www.cnn.com/2012/05/07/opinion/carroll-emergency-rooms/index.html.

City of Houston. “Mental Health & Substance Use Disorder Parity.” *Legislative Report 2017*. Retrieved from https://www.houstontx.gov/txlege/hb-10-behavioral-health-parity.

Center for Public Policy Priorities. “Health Reform 101: Basics for Texas.” Retrieved from http://library.cppp.org/events/event_details.php?eid=256. 2010. Slide 14.

Center for Public Policy Priorities. “Parity for Mental Health & Substance Use Disorder.” *BetterTexasBlog.org*. Accessed Jan. 25, 2019. Retrieved from http://bettertexasblog.org/2019/04/what-is-parity/.

Centers for Medicare & Medicaid Services. “Emergency Medical Treatment & Labor Act.” *CMS.gov*. March 26, 2012. Retrieved from https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA.

DePrang, Emily. “Barred Care.” *TexasObserver.org*. Retrieved from https://www.texasobserver.org/want-treatment-mental-illness-go-to-jail/.

Diamond, Pamela, and Steven Schnee. “Lives in the Shadows: Some of the Costs and Consequences of a ‘Non-System’ of Care.” *Hogg Foundation for Mental Health*. 1991. Retrieved from https://repositories.lib.utexas.edu/handle/2152/38802.

EBIA. “DOL Reports 2018 Mental Health Parity Enforcement Activity.” *ThomsonReuters.com*. Sept. 19, 2019. Retrieved from https://tax.thomsonreuters.com/blog/dol-reports-2018-mental-health-parity-enforcement-activity/.

Employee Benefits Security Administration. “FY 2018 MHPAEA Enforcement Fact Sheet.” Sept. 5, 2019. Retrieved from https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/fact-sheets/mhpaea-enforcement-2018.pdf.

Fernández, Stacy. “Texas has the most people without health insurance in the nation – again.” *Texas Tribune*. Sept. 10, 2019. Retrieved from https://www.texastribune.org/2019/09/10/texas-has-most-people-without-health-insurance-nation-again/.

Friedman, Zack. “78% of Workers Live Paycheck to Paycheck.” *Forbes.com*. Jan. 11, 2019. Retrieved from https://www.forbes.com/sites/zackfriedman/2019/01/11/live-paycheck-to-paycheck-government-shutdown/#757956524f10.

Goodell, Sarah. “Enforcing Mental Health Parity.” *HealthAffairs.org*. Nov. 9, 2015. Retrieved from https://www.healthaffairs.org/do/10.1377/hpb20140403.871424/full/.

Harris, Patrice, A., and Ellen Weber. “Patients need policymakers’ help to enforce mental health parity laws.” *STATNews.com*. Dec. 10, 2018. Retrieved from https://www.statnews.com/2018/12/10/policymakers-must-help-enforce-mental-health-parity-laws/.

Health Resources & Services Administration. “Quick Maps – Mental Health Health Professional Shortage Areas (HPSA).” Accessed on Jan. 10, 2020. Retrieved from https://data.hrsa.gov/hdw/Tools/MapToolQuick.aspx?mapName=HPSAMH.

Horton, Colleen. “Texas Lawmakers Must Address Mental Health Workforce Shortage.” *UT News*. July 2016. https://news.utexas.edu/2016/07/07/there-is-a-mental-health-workforce-shortage-in-texas/.

Khurshid, Anjum. Personal Interview. Jan. 24, 2020.

Méndez, María. “In Dallas County, people of color are more likely to be drowning in debt from medical bills.” *The Dallas Morning News*. Oct. 3, 2019. Retrieved from https://www.dallasnews.com/news/politics/2019/10/02/dallas-county-people-color-likely-drowning-debt-medical-bills/.

Mental Health Condition and Substance Use Disorder Parity Workgroup. “Workgroup Progress Report.” Sept. 2018. Retrieved from https://mentalhealthtx.org/sites/mentalhealthtx/files/docs/mh-condition-substance-use-disorder-parity-workgroup-report.pdf.

Moser, Whet. “San Antonio Reduced Its Jail Population by Treating the Mentally Ill.” *ChicagoMag.com*. Aug. 20, 2014. Retrieved from https://www.chicagomag.com/city-life/August-2014/San-Antonio-Reduced-Its-Jail-Population-By-Treating-the-Mentally-Ill/.

Murphy, Kate. Personal Interview. Jan. 24, 2020.

National Alliance on Mental Illness. “A Long Road Ahead: Achieving True Parity In Mental Health and Substance Use Care.” 2014. Retrieved from https://www.nami.org/about-nami/publications-reports/public-policy-reports/a-long-road-ahead/2015-alongroadahead.pdf.

Norris, Louis. “How Obamacare improved mental health coverage.” *HealthInsurance.org*. July 5, 2018. Retrieved from https://www.healthinsurance.org/obamacare/how-obamacare-improved-mental-health-coverage/.

Norris, Louis. “Texas and the ACA’s Medicaid expansion.” *HealthInsurance.org*. Jan. 10, 2019. Retrieved from https://www.healthinsurance.org/texas-medicaid/.

Norris, Louis. “Texas health insurance marketplace: history and news of the state’s exchange.” *HealthInsurance.org*. Jan. 2, 2020. Retrieved from https://www.healthinsurance.org/texas-state-health-insurance-exchange/.

Norris, Louis. “What is Self-Insured Health Insurance?” *VeryWellHealth.com*. Nov. 4, 2019. Retrieved from https://www.verywellhealth.com/what-is-self-insured-health-insurance-and-how-is-it-regulated-4688567.

Nye, Emma. “Jails: Texas’ Largest Mental Health Institutions.” *Center for Health and Social Policy*. LBJ School of Public Affairs. Jan. 2019. Retrieved from https://chasp.lbj.utexas.edu/jails-texas-largest-mental-health-institutions.

Pogue, Stacy. Parity Webinar Slides. “Parity for Mental Health and Substance Use Disorders: When and how to fight back.” Center for Public Policy Priorities. May 17, 2019. Retrieved from http://bettertexasblog.org/2019/04/what-is-parity/.

Stuart, Elizabeth A., McGinty, Emma E., Kalb, Luther, Huskamp, Haiden A., Busch, Susan H., Gibson, Teresa B., Goldman, Howard, and Colleen L. Barry. “Increased Service Use Among Children With Autism Spectrum Disorder Associated With Mental Health Parity Law.” *Health Affairs*. Vol. 36, Iss. 2. Feb. 2017. Retrieved from https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2016.0824.

Texas Health and Human Services. “Medicaid and CHIP.” *HHS.Texas.gov*. Accessed on Jan. 11, 2020.

Texas Health and Human Services. “Medicaid for an adult caring for a child.” *YourTexasBenefits.HHSC.Texas.gov*. Accessed on Jan. 11, 2020.

Texas Health and Human Services. “State Hospitals.” *HHS.Texas.gov*. Accessed on Jan. 10, 2020. Retrieved from https://hhs.texas.gov/services/health/medicaid-chip.

Texas Medical Association. “Medicine’s Big Winners as Legislature Wraps Up Regular Session.” *TexMed.org*. Nov. 7, 2017. Retrieved from https://www.texmed.org/wins/.

Villarreal, Monica. “Mental Health and Substance Use Disorder Parity in the 2017 Texas Legislative Session.” *Center for Public Policy Priorities*. Aug. 28, 2017. Retrieved from: https://forabettertexas.org/images/HW_2017_MentalHealthParityin2017txlege.pdf.

Warner, David. “Texas.” *Health Politics and Policy*. 5th ed. Ed. Morone, James and Daniel Ehlke. Stamford: Cengage. 2014. p. 190-195.

Weidaw, Kate. “Travis Co. Jail becomes largest provider of mental health help after hospital overcrowding.” *KXAN.com*. Feb. 7, 2017. Retrieved from https://www.kxan.com/news/travis-co-jail-becomes-largest-provider-of-mental-health-help-after-hospital-overcrowding/.

Chapter 3: Mental Health in Schools & Budgetary Policy

This chapter draws lessons in effective advocacy from the history of the mental health in schools movement, including the impact of school shootings. The chapter looks to the state's response to these crises to launch a discussion of the structural and political factors in Texas' budgetary processes. Last, the chapter advises advocates on framing and targeting political messaging when trying to secure state funding.

This chapter will start by tracing the history of the mental health in schools movement, before analyzing how a debate about the over-prescription of psychotropic medications fits into the broader historical narrative. The chapter will illustrate how this narrative influenced mental health in schools' legislation during Texas' 86th Legislative Session. Then, after a few comments on legislative attempts to fund school-based mental health care, the chapter will transition to a general discussion of budgetary politics in Texas.

The placement of health and social services in school facilities first began around the turn of the 20th century as a way to connect immigrants and other members of the urban poor with community resources (Emihovich and Herrington). Taken in the context of the Progressive Era, this effort was a natural outgrowth of the Settlement House and Labor movements as well as the urban political machines that used welfare to win votes. The school-based health center (SBHC) movement, if it could be called a movement at the time, was small and fragmented, led by a few localities in isolation.

In the 1970s, the Robert Wood Johnson Foundation catapulted the idea of an SBHC into public awareness, leading hundreds of school districts to partner with local health departments or hospitals to fund school-based health centers. Around this time, the United States dramatically reduced the incidence of many traditional childhood ailments, including tuberculosis, smallpox, and polio. School based health programs started to shift their focus to the "new morbidities," those "induced by behavior." Think violence by or against children, accidents, obesity, suicide, and sexual health, all of which correlate with poor academic achievement, thereby justifying SBHC involvement. While SBHCs continued to provide primary care and immunizations, many added health education and behavioral health care to their repertoire (Emihovich and Herrington).

Momentum behind the SBHC has built from the 1980s to today. Federal funds began to flow to SBHCs in 1988 and expanded in 1997 via Medicaid payments. These payments have proven crucial in funding positions for school counselor and education for school staff in drug intervention strategies (Schubel). In 1995 the federal government began its direct involvement in the mental health in schools movement, starting pilot projects and a since-steady, though modest, flow of funds for research. In 2010 the Affordable Care Act created a federal grant program to fund the physical construction of an SBHCs in any district that would like one (Kilbreth and Ziller). Today, approximately 2000 SBHCs operate across the United States (HRSA), including around 100 in the state of Texas (TASBHC).

The creation of an SBHC, however, is no walk in the park. A proposed SBHC requires the approval of multiple siloed bureaucracies, typically including the school district and local hospital district. Clinic funding comes from a mix of local, state, federal, and private insurance dollars, all of which require separate administrative procedures (Kilbreth and Ziller). Clinic

longevity depends on the continued support of school officials and is not a given. Longevity correlates positively with being in large, black, or progressive districts. Clinic longevity correlates negatively with being in southern or conservative districts, perhaps due to greater distrust of reproductive health initiatives (Rienzo et al.).

SBHCs constitute just one of four delivery mechanisms for mental health in schools that predominate today. The other three are district mental health units, formal connections with community mental health services (and ideally "wrap-around" services for those with high need), and a social and emotional learning curriculum.[1] The result of this decentralized approach is an unequal distribution of services and large gaps in care (Howard and Taylor).

In Texas, the current system of school-based behavioral health care is fragmented, and the political movement is uncoordinated and in pursuit of piecemeal advances. State government involvement is limited to two programs. Regional "education service centers" train school staff in behavioral health, among other topics, and "coordinated school health models" promote access to counseling, psychological, and social services in school strategic planning. There are three important federal programs: In 2018 the Communities in Schools program foot the bill for case management and some mental health services for around 100,000 children in Texas to combat dropout rates (Hogg Foundation).[2] The other two programs are Children's Medicaid and the Children's Health Insurance Program. These programs entitle any adolescent, legal US resident,

[1] These measures are distinct from special education services, which fall outside the purview of this chapter.

[2] For context: Texas had 5.4 million students enrolled in public schools that year (TEA). Around 25 percent of Texas children live in households making below the federal poverty line, which is around $25,000 per year for a family of four (NCPP). Around 60 percent of public school students lived in households below 180 percent of the federal poverty line - $48,000 per year for a family of four (TEA).

whose family earns less than 200 percent of the federal poverty line, to public health insurance (TxHHSC). For the reasons discussed in chapter two, this entitlement does not equate with access to behavioral health services.

The only students who are entitled to access to school-based behavioral health care are those who qualify for special education and have behavioral health needs listed in their Individualized Education Program plan. Advocates agree that much has yet to be done to address the unmet behavioral health needs of children and Texas would benefit greatly from statewide coordination of services (Hogg Foundation).[3]

Political opposition to the mental health in schools movement has been significant and based partly on fair points. Chief among them are fears of over-pathologizing behaviors and over-prescribing psychoactive medications. When I worked in the Texas Senate, my boss signed on to a bill that would advance research of and access to child and adolescent psychiatric care. A few weeks later, a concerned constituent, a mother, came in to talk about the bill. She declared her opposition to mental health in schools. I asked if she could be more specific, and she listed two concerns: (1) giving money to mental health care providers would be wasteful compared to spending it on playgrounds and green spaces and (2) bringing mental health into schools would exacerbate pill pushing. Two reasonable people could disagree on the first point. As to the second, whether psychotropic medications are over-prescribed to children is hotly debated.

On the surface, the psychiatrists seem to have a strong defense. Many would blame high prescription rates on the reality that general practice doctors have to cover for an inadequate

[3] In recent years, successful advocacy efforts have pushed to lessen the use of seclusion, restraint, corporal punishment, Tasers, pepper spray, and other forms of force in school (Hogg Foundation).

psychiatric workforce (RWJF), an issue that the bill would counteract. Moreover, recent research suggests prescribing patterns match psychiatric illness incidence rates (Sultan et al.). Yet critics respond to these arguments asserting that the diagnostic tools used by clinicians and researchers lead to false positives. They might say, for example, that the criteria for Attention-Deficit / Hyperactivity Disorder are too easy to satisfy and do not warrant treatment with medication.

A closer assessment of the issue of over-pathologizing reveals a larger political conundrum than worries about pill pushing. The public and behavioral health providers see psychiatric diagnoses in very different lights. First, behavioral health providers cannot agree on what constitutes a psychiatric illness. Overgeneralizing for a moment, there is a fundamental ambiguity in psychiatric diagnoses that does not exist for diagnoses in other medical fields. Psychiatric diagnoses describe undesirable mental statuses, whereas other medical diagnoses describe a malfunctioning physiological process.[4]

Behavioral health providers are comfortable with diagnostic ambiguity. The public does not understand it. Skilled behavioral health providers realize diagnostic codes rarely provide clinically relevant information. Psychiatric diagnoses are simply a common language for communicating about disruptions of the mental world. Good providers understand their limited applicability, but may offer them to comfort patients, please public health researchers, or satisfy billing requirements (McHugh).

[4] A quick comparison to demonstrate this point: We understand Parkinson's disease to be, generally, the buildup of misfolded proteins in the brain. The disease can have several symptoms, and the diagnosis implies a certain treatment plan and prognosis. In contrast, a diagnosis of depression is just a description of impairment caused by or correlating with certain thought patterns. The diagnosis does not imply an internal pathology (think malfunction of the body), and the prognosis is much less certain than in the case of Parkinson's disease.

In some cases, school-based diagnoses are inappropriately used to draw greater reimbursement, particularly in underfunded special education and mental health systems; however, the last thing providers want is for a diagnosis to shape a person's future. They understand the potential harm of labels (typically). The political problem is that the public assumes providers do not, and the public fails to see the utility of diagnoses. The gulf between providers and the public can be difficult to bridge. Advocates should not expect the public to trust behavioral health providers, and effective advocacy in school-based behavioral health should seek, at least in part, to counter inappropriate labeling and build trust (Adelman and Taylor).

The history of school-based health centers, fears of over-pathologizing, and lack of public understanding of behavioral health care practices all influenced mental health legislation in Texas' 86th Legislature. In the wake of the Santa Fe high school shooting, Governor Greg Abbott released a three-pronged plan, calling, among many other things, for greater access to school-based counseling services. House Bill 18 and Senate Bill 11 constituted the legislature's response. These bills sought to increase awareness of adolescent mental illness and make existing resources go further. Despite political momentum, available funds, and existing school-based health infrastructure, these legislative efforts came short of meaningfully investing in school-based mental health.

House Bill 18 requires the Texas Education Agency (TEA) and Health and Human Services commission to disseminate best practices for a variety of behavioral health intervention strategies to school stakeholders. It encourages schools to incorporate this information into school strategic planning and partner with their local mental health authority to identify community supports. The bill also requires schools to report their mental health education practices to the TEA (Texas House), which will, in theory, allow researcher to study statewide practices for the first time

(Hogg Foundation). When the Legislative Budget Board placed a price on the piece of legislation, it noted but did not accept the Texas Council of Community Centers' belief that the bill would require local mental health authorities to hire additional staff (LBB, "HB …"). We will return to this example of budgetary politics after a brief discussion of the other main mental health in schools bill passed by the 86th Legislature.

Senate Bill 11 generally sought to educate parents, teachers, and students in preventive mental health practices, collect and use data to inform a future statewide planning process for enhancing student access to mental health resources, and provide immediate monetary assistance to schools to prevent school shootings. As filed, the bill proposed a grant program for school counselor loan repayment. This provision did not survive the legislative process; however, separate measures did fund psychiatric residency and child and adolescent psychiatry fellowship positions.[5] SB 11 may help the existing behavioral health workforce reach more children through its proposed child and adolescent psychiatry telemedicine program, to be funded and administered by the new Mental Health Consortium.

As mentioned, SB 11 provides $50 million dollars annually to schools at a rate of $9.72 per student in average daily attendance to prevent school shootings. The schools must use these funds, per the LBB report, only for securing school facilities ("school hardening"), employing security staff, planning safety measures, or training staff in safety measures. Hidden in the bill, however, is a provision that gives schools discretion to use these funds on suicide prevention, intervention, and postvention – a decisive victory for behavioral health advocates. None of the documents most likely to be read by other legislative offices (the two committee reports and the

[5] This trade is one example of a strong tendency in the Legislature to defer to physicians and their wealthy trade organization, the Texas Medical Association, over other health professions.

LBB's fiscal note) mention this point. The only references to mental health educational support talk specifically about suicidality and trauma-informed practices. This messaging turned out to be an effective strategy to increase funding of mental health school-based services.

Before we further generalize and examine effective strategies in budgetary policymaking, this chapter will provide a brief background on Texas' budget process. Texas' budget totals around $110 billion per year (LBB, "Fiscal …"). The budget process begins in the fall before each legislative session, when the state agencies submit their budget requests to the Legislative Budget Board. The LBB is a nonpartisan government institution that consists of around 100 analysts tasked with the job of managing the state government's budget. These analysts also provide part-time legislators all the information necessary to craft the state budget. As we saw with the LBB's decisions to exclude costs to local mental health authorities when pricing HB 18 and exclude mention of SB 11's funding for suicide-related programs in schools, budget estimations can be political. The Lieutenant Governor and Speaker of the House chair the LBB's managing board. The board selects the executive officers of the 100-person office of analysts. Just recently, Lt. Gov. Patrick has sought to further politicize budget estimates by waging war against the LBB (and the "liberal bureaucrats" within it) with the end goal of completely replacing it (Patrick).

After compiling state agency budget requests into a full, draft budget, the LBB submits the draft budget to the House Committee on Appropriations and the Senate Finance Committee. Both chambers hold hearings on the budget and ultimately pass their own versions of a budget bill. A conference committee writes the final bill, and both chambers must approve it. Any lawmaker can submit a "budget rider," a line-item appropriation. Riders can be added, amended, and deleted on the floor or by the conference committee.

Regarding control of this process: the Lieutenant Governor and Speaker of the House set all committee appointments and chairships in their respective chambers and each pick half of the members of every conference committee. Therefore, they have tremendous influence over the budget. The next most powerful members are the chairs of the House Appropriations and Senate Finance committees, as they have a lot of power to stall or push forward the budget and budget riders. Legislative staffers believe that the chairs tend to fund their own initiatives before those of other lawmakers.

There are a few other structural components to budgetary power. Texas' constitution prohibits a state income tax and requires that the state maintain a balanced budget. Without an income tax or deficit spending, Texas is severely limited in its ability to fund new initiatives. Bills with price tags must include a novel funding source or support for dipping into a different program's pot. For proposals that have a cost but should also yield state revenue or cost savings down the line,[6] the LBB fiscal note may determine their fate. Even a cost neutral fiscal note, however, does not guarantee success. The Office of the Comptroller can veto any appropriation that it deems in violation of the balanced budget rule.

The governor also has the power to veto any line-item in the budget, and he enjoys, in coordination with the LBB, the power to move money between programs, and even between agencies, in between legislative sessions if a need arises (Texas Politics Project).

[6] For example: economic development policies could stimulate more income from sales tax and early childhood intervention services could prevent children from needing special education services.

So, where does this leave you if you want to get an initiative funded by the state government? Many people will tell you the Texas Legislature is where bills go to die. If this is true for all bills, it is certainly true for bills that have a price tag. Unless you are a state agency asking for the funds needed to continue providing approved services, your bill has a much better shot at passing if it is revenue neutral. That means you need to find a specific funding source; maybe a federal grant or a forgotten state fund. You could also rely on downstream economic development or cost saving effects, but know that both rely on a generous adjudication by the LBB and Comptroller, two processes over which you have no control. If you cannot make a bill revenue neutral, you will have to meet a much higher bar for political support. The following table oversimplifies a complex political calculation, and as such should be taken with a grain of salt. Nevertheless, it provides a framework to begin thinking about how to target political messaging for initiatives that require significant sums of state money.

Cost of the proposed program	**Active political support needed**
$1 - $5 million	At least the relevant business, trade, and other interest groups
$5 - $50 million	At least the chair of the House Appropriations or Senate Finance Committee
$50 - $100 million	At least one member of the Big Three (the speaker of the house, lieutenant governor, or governor)

$100 - $500 million	At least all members of the Big Three
$500 + million	The public and the Big Three

Any bill, but especially bills with a price, should be framed as *necessary*, rather than simply a good idea. You should bring the bill to legislators in the summer or fall before the legislative session. If you find there is a lot of interest in an initiative, but the enthusiasm comes just shy of the support needed to fund it, consider the time-honored tradition of advocating for a pilot program, and if it is implemented, work to expand it after the program has proven itself valuable. As we saw with mental health in schools bills in the 86th Legislature, you should stake your funding proposals to concrete goals that are easy for lawmakers to understand. Think suicide prevention, residency slots, and physical infrastructure. Make friends of the Texas Medical Association, chairs of the House Appropriations and Senate Finance committees, and, of course, Dan Patrick. Finally and of particular challenge in behavioral health, make sure your program can be easily and objectively evaluated based on results and, ideally, cost savings to the state.

These strategies all relate to the larger theme that effective advocacy **brings new ideas to the attention of policymakers**. Framing an issue in a new light makes a difference. Unfortunately, budgetary policy is one area where the impact of direct advocacy is unlikely to be large. Budgetary policymakers have only a small pot of funds to distribute at their discretion, and the Lieutenant Governor and other key state officials have and exert tight control over budget

processes. Consequently, effective advocacy on budgetary issues may be limited to **changing who holds these offices**.

That said, public opinion played a major role in forcing action after the Santa Fe shooting. Behavioral health advocates used this momentum to their advantage. The power of public opinion is clear, and it follow then that **changing public opinion is effective advocacy**. One specific strategy in this vein would be to build trust between the public and behavioral health providers, especially those that care for children.

Further Reading

On Mental Health in Schools:

Adelman, Howard and Linda Taylor. *Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools*. Thousand Oaks: Corwin. 2010.

Adelman and Taylor provide the historical and political background you should know before working on mental health project in a school. When providing advice to advocates, they tend to focus less on "how" and more on "why." This style proves particularly effective when they discuss how to recognize and manage competing motivations in school stakeholders. Last they stress the importance of moving the Mental Health in Schools movement forward, creatively, and how stakeholders can contribute.

Forman, Susan. *Implementation of Mental Health Programs in Schools*. Washington: American Psychological Association. 2015.

Forman provides an excellent analysis of the current literature on school-based interventions' efficacy and the political science of their implementation. She addresses the difficulty of translating evidence-based best practices into real workplaces and schools. She covers how to select interventions for your organization and community and also offers a step-by-step framework for overcoming institutional inertia. She includes guidance regarding program evaluation, adapting to and influencing larger systems, and ensuring program sustainability.

On classifying psychiatric illnesses:

McHugh, Paul. "The Perspectives of Psychiatry: The Public Health Approach." *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p. 31-40.

This chapter of Public Mental Health *will help those who do not provide mental health services understand how providers think about illness and problem solve. It also introduces the difficulty and complexity of studying psychiatric intervention effectiveness, especially in the high-functioning subset of the mentally ill population.*

On the role of the Legislative Budget Board:

Walters, Edgar. "Capitol insiders: Texas Lt. Gov. Dan Patrick is letting the state's budget agency fall apart." *The Texas Tribune*. Oct. 29, 2019. Retrieved from https://www.texastribune.org/2019/10/29/texas-lt-gov-dan-patrick-wages-war-texas-legislative-budget-board/.

This article covers the Legislative Budget Board's functions during and in between legislative sessions. It also articulates the extent of the feud between the Board and Dan Patrick and comments on the possible implications of Patrick's victory.

Chapter Bibliography

Adelman, Howard and Linda Taylor. *Mental Health in Schools: Engaging Learners, Preventing Problems, and Improving Schools*. Thousand Oaks: Corwin. 2010.

Emihovich, Catherine, and Carolyn Herrington. *Sex, Kids, and Politics: Health services in schools*. New York: Teachers College Press. 1997.

Health Resources and Services Administration. "School-Based Health Centers." HRSA.gov. May 2017. Retrieved from https://www.hrsa.gov/our-stories/school-health-centers/index.html.

Hogg Foundation for Mental Health. *A Guide to Understanding Mental Health Systems and Services in Texas*. 4th ed. 2018. p. 249 - 270. Retrieved from https://hogg.utexas.edu/what-we-do/policy-engagement/mental-health-guide.

Kaiser Family Foundation. "Children's Health Insurance Timeline." *KFF.org*. May 9, 2013. Retrieved from https://www.kff.org/wp-content/uploads/2007/02/5-09-13-childrens-health-insurance-timeline.pdf.

Kilbreth, Elizabeth and Erika Ziller. "Children." *Health Politics and Policy*. 5th ed. Ed. Morone, James and Daniel Ehlke. Stamford: Cengage. 2014. p. 306 – 327.

Legislative Budget Board. "Fiscal Size-Up Interactive Graphic." Oct. 11, 2018. Retrieved from https://www.lbb.state.tx.us/FSU.aspx.

Legislative Budget Board. "HB 18 Fiscal Note." May 6, 2019.

McHugh, Paul. "The Perspectives of Psychiatry: The Public Health Approach." *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2002. p. 31-40.

National Center for Children in Poverty. "Texas Demographics of Poor Children." *NCCP.org*. Nov. 19, 2018. Retrieved from http://www.nccp.org/profiles/TX_profile_7.html.

Office of the Texas Governor. "Governor Abbott Unveils Plan to Address School Safety in Texas." May 30, 2018. Retrieved from: https://gov.texas.gov/news/post/governor-abbott-unveils-plan-to-address-school-safety-in-texas.

Rienzo, Barbara, Button, James, and Kenneth Wald. "Politics and the Success of School-Based Health Centers." *Journal of School Health*. Vol. 70. Iss. 8. Oct., 2000. p. 331-337.

Robert Wood Johnson Foundation. "Senate Hearing: Why are Psychotropic Drugs Overprescribed in the U.S.?" *RWJF Culture of Health Blog*. Originally published on the RWJF *New Public Health* blog. Feb. 26, 2014. Retrieved from https://www.rwjf.org/en/blog/2014/02/senate_hearing_why.html.

Patrick, Dan. “Dan Patrick: Yes, I intend to downsize the Legislative Budget Board.” *The Dallas Morning News*. Nov. 8, 2019. Retrieved from https://www.dallasnews.com/opinion/commentary/2019/11/08/dan-patrick-yes-i-intend-to-downsize-the-legislative-budget-board/.

Schubel, Jessica. “Medicaid Helps Schools Help Children.” *Center on Budget and Policy Priorities*. April 19, 2017. Retrieved from https://www.cbpp.org/sites/default/files/atoms/files/4-19-19health.pdf.

Sultan, Ryan S., Correll, Christoph, Schoenbaum, Michael, King, Marissa, Walkup, John, and Mark Olfson. “National Patterns of Commonly Prescribed Psychotropic Medications to Young People.” *Journal of Child and Adolescent Psychopharmacology*. Vol. 28. Iss. 3. April 1, 2018. Retrieved from https://www.ncbi.nlm.nih.gov/pubmed/29376743.

Texas Association of School-based Health Centers. “List-of-SBHCs-July-2010.” Retrieved from: https://www.tasbhc.org/texas-school-based-health-centers/.

Texas Education Agency. *Enrollment in Texas Public Schools 2017-2018*. Retrieved from https://tea.texas.gov/sites/default/files/enroll_2017-18.pdf.

Texas Health and Human Services Commission. “CHIP and Children’s Medicaid.” *YourTexasBenefits.HHSC.Texas.gov*. Accessed April 21, 2020. Retrieved from https://yourtexasbenefits.hhsc.texas.gov/programs/health/child/childrens-medicaid.

Texas House Committee on Public Health. “C.S.H.B. 18 Committee Report.” April 3, 2019.

Texas Politics Project. “The budget process in Texas.” Sep. 25, 2005. Retrieved from https://texaspolitics.utexas.edu/archive/html/pec/features/0403_01/slide1.html.

Chapter 4: Early Childhood Intervention and Lobbying

This chapter explicates the Early Childhood Intervention Program's financial crisis in a manner parallel to how Texas legislators learned of it. The chapter then describes the development of two policies meant to address the crisis. As the story unfolds, I hope to show how the legislature works with incomplete information. Last, using the politics surrounding these bills as a backdrop, this chapter offers lessons in lobbying.

On March 10, 2017, Texas State Representative Rick Miller (R-Sugar Land) filed a bill on behalf of behavioral health therapists working out of the same office building as his district staff. The bill would have required private insurance plans to provide greater coverage for early childhood therapy. Two months later, Rep. Miller and his building-mates testified in support of this progressive legislation in front of the Texas House Committee on Insurance. These events were a satisfying example of representative democracy working as intended: constituent needs triumphed over political ideology. The bill never got out of committee, but that same legislative session, House Speaker Joe Straus (R-San Antonio) charged the Texas House Appropriations Subcommittee on Health and Human Services with studying the Early Childhood Intervention program and its financial difficulties. The interim study revealed the following wealth of information.

The 1975 federal Individuals with Disabilities Education Act (IDEA) requires all states to provide free and appropriate special education to individuals with disabilities. It also provides grants to assist in the voluntary implementation of early intervention services for children three years of age or younger (Committee on Appropriations).

Since 1993 Texas has provided Early Childhood Intervention Services (ECI) to all eligible children. ECI offers case management, assistance with referrals, and the creation of an Individualized Family Service Plan. ECI therapists visit family homes, evaluate the child, and teach the family how best to work on improving their child's condition during daily activities. Examples of the range of illnesses treated include the effects of trauma, being born without a hand or foot, a fear of playing with other children on the playground, and intellectual or developmental disability. The goal of these visits is to teach parents to provide daily therapy so their children can develop alongside their peers (Committee on Appropriations).

Pediatricians across the state rely on ECI. They are, in fact, required to refer children with intellectual or developmental disability, visual deficiency, or auditory deficiency to ECI. Texas' foster care system also relies on ECI. In addition to all its other services, ECI is the frontline for kids younger than three who have suffered trauma or been exposed to addictive substances; ECI is the mental health authority for kids age zero through three (TxHHS, "Early …"). "Studies have shown that early childhood education programs have long-term beneficial effects on cognition, language, academics (reading and math), and youth behavior" (Purugganan).

Texas' ECI program serves around 50,000 kids per year. 67 percent of service users have Medicaid and are thus exempt from out-of-pocket costs. The rest of the families pay for services on a sliding scale that considers insurance reimbursement and family financial status. No family can be denied the services outlined in their Individualized Family Service Plan due to an inability to pay. Consequently, the state ECI program (using state and federal dollars) frequently picks up the tab (LBB, "Financing Options").

Federal funding for Texas' ECI program comes from the U.S. Department of Education. Despite the requests of the Texas Health and Human Services Commission, the U.S. Department of Education would not consider an increase in funding for the state's ECI program. Unlike typical entitlement programs, federal funding for ECI is not distributed on a per-capita basis, but rather like a fixed block grant. For this reason, as Texas' population has increased, ECI providers have received fewer dollars per child and struggled to make ends meet. ECI providers are organizations that contract with the Texas Health and Human Services Commission to provide services to all eligible children within a region of Texas. They are contractually required to see all kids who qualify for services within their region; yet the state can only reimburse these services until funds run out (Committee on Appropriations).

HHSC reports that of ECI providers in fiscal year 2017: 66 percent delayed hiring staff, 55 percent delayed system upgrades or equipment purchases, 45 percent reduced efforts to find children in need, 45 percent downsized staff, and 23 percent reduced staff benefits in order to continue to meet their obligation to serve all eligible children. Not all providers have succeeded in making ends meet. Texas has lost a net of 16 provider organizations since 2010 (6 since 2016), bringing the total number down to 42 (Committee on Appropriations).

As providers drop their contracts with the state, the remaining providers are required to take over their clients, which increases costs for the remaining providers. Two regions will shortly lose their ECI providers without a contracted replacement. HHSC representatives testified that the

state may be sued as a result, since HHSC must maintain access to ECI services for all eligible children, without a waitlist, to comply with federal regulations (Committee on Appropriations).[1]

In 2012 HHSC, faced with a similar predicament as today, decided to toughen the eligibility requirements for ECI services. HHSC testified in front of the House Appropriations Committee that this decision decreased access to care and increased downstream costs to the special education system as well as in the areas of criminal justice, health care, and other social services. Black children disproportionately lost access to ECI after this rule change (TxHHS, "Presentation …").

Today the ECI program is still in jeopardy, and Texans are suffering as a result. Providers are overwhelmed and their situation is worsening. Texas could again heighten eligibility criteria, decreasing enrollment in the program to make ends meet. If they do not, the collapse of the program is a possibility and would be expensive for both the state and its citizens (Committee on Appropriations).

The interim study that brought to light this wealth of information on the ECI program was led by Representative Sarah Davis (R-Houston) and resulted in her filing House Bill 1295. The bill received a preliminary $370 million dollar price tag (a "fiscal note" that was never made public), even though HHSC had evidence that the program was revenue neutral (or arguably beneficial) when factoring in how the ECI program reduces need for special education services.[2] Yet the

[1] There is a rich history of federal courts forcing the state of Texas to improve public health services, including cases that forced the state to spend more money on Medicaid services for children (Warner, "Texas."); however, a lawsuit may not have this effect. In response to a previous program budget shortfall in 2012, for example, HHSC simply toughened the eligibility requirements for ECI services.

[2] Texas Health and Human Services based this judgement on data obtained from one provider of both ECI and special education services, the Katy Independent School District (Committee on

Legislative Budget Board had made its calculation, and since Texas' government must have a balanced budget, per its constitution, Davis would have to come up with a way to pay for the bill. Instead, however, she decided to cut a provision that would have mandated automatic Medicaid enrollment for certain children (in addition to a few other high-dollar items) and re-file the bill.

While Rep. Davis had to gut part of her bill, she and her staff (primarily a public affairs graduate student named Leila Al-Hamoodah) did not give up on it. Rep. Davis successfully lobbied the Speaker of the House, Dennis Bonnen (R-Lake Jackson), to make the new bill a priority item. Accordingly, it received one of the first 30 bill numbers: House Bill 12.

At this point, I had gotten involved in various efforts to stabilize the ECI program's finances. I ended up working on a legislative proposal that Senator Zaffirini file the Senate companion bill to HB 12. As filed, the bill had eleven parts. The most significant sections were an insurance coverage mandate and expansion of Medicaid eligibility for children, meant to draw additional private and public funds into the ECI program. In the process of vetting the bill, I reached out to ECI providers, impacted state agencies, and the foreseeable opposition, the Texas Association of Health Plans (TAHP).[3] TAHP represents both private and public insurance plans and its feedback was distressingly technical. Apparently, the bill "could" cause conflict with everything from Texas' telemedicine scope-of-practice law to the federal Health Insurance Portability and Accountability Act (HIPAA).[4] TAHP officially fought back against the insurance mandate provisions, saying they would raise costs for consumers. TAHP also argued about our

---

Appropriations); however, academia has not reached a consensus on these cost savings effects (Warner, Personal …).

[3] Other stakeholders include independent school districts and the Texas Pediatric Society.

[4] I learned in a later conversation with the Hogg Foundation for Mental Health's Executive Director that pressing potential conflict with HIPAA is a common strategy for defeating health policy initiatives, regardless of a bill's actual relation to the federal act.

assessment of what was and was not currently covered, even under state run plans. Some of their critiques I could verify myself, such as the potential cost to state run health plans and the potential for conflict with other laws, but others (like claims about what "may" currently be covered) I could not. TAHP seemed careful to couch almost all of its written talking points in uncertain terms like "could" and "may."

TAHP's lobbyist, however, was genuinely helpful. He seemed eager to help us fix potential problems with the bill. He told me that we should not worry too much about industry opposition. TAHP's blanket policy is opposition to insurance mandates. The real issues lay in how the bill would impact public plans.

> "The best lobbyists 'provide really good information, ideally very quickly, and capitalize on what you already want to do – not something that's bad for you or your [legislator]. If they try to spin you, as opposed to giving good, straightforward information, that's not good … and their reputation will decline, *fast*."
> – a senior US Senate staffer, as cited by Kersh

Leila took the lead on addressing TAHP and others' concerns, or at least those that seemed to hold water. The Senate companion bill was not given a hearing because HB 12 seemed to be progressing smoothly. HB 12 ultimately passed the House with 132 votes in favor and 10 against. Per legislative procedure, the bill then moved into the Senate. The Lieutenant Governor should have then referred the bill to the appropriate Senate committee, but he never referred the bill to *any* committee. The rumors maintained the Lieutenant Governor was punishing Davis for

opposing his school voucher legislation during the previous legislative session.[5] At this point, it was too late to hold a hearing on the Senate companion bill. The next time I talked with Leila, she was crestfallen.

The ECI program's funding crisis did not have the public's attention. Perhaps for this reason, the Lieutenant Governor was able to suffocate HB 12. Yet the lack of attention may have also permitted Rep. Davis and the Speaker of the House, Dennis Bonnen, to pass a bill through the conservative Texas House with new mandates on private insurance. Depending on your perspective, the bill ultimately died because Dan Patrick killed it or because Rep. Davis, rightly or wrongly, chose to pick a fight with him. Either way, the bill's death demonstrates **the importance of who we elect to key positions**. It also shows the importance of staying on the good side of the Lieutenant Governor, as someone who **brings ideas to legislators**. The next story focuses on a bill with a more typical course through the legislative process and the advocate who fought for it.

Lauren Rangel, mother of three, has a deep, personal commitment to disability advocacy. Two of her young children have an Autism Spectrum Disorder diagnosis. During the 86th Legislature, she worked for Easterseals Central Texas as a Public Policy Fellow. The Texas Council for Developmental Disability funded her position. As ECI providers, Easterseals included, struggled to stay afloat, they reduced "child find" activities. Consequently, places like Travis and Harris Counties saw a 20-35 percent decline in ECI enrollment. Lauren brought her idea for a policy solution to Senator Zaffirini's office. She wanted to direct the Texas Health and Human Services Commission to apply for federal funding to pilot a 211-screening service that would combat the

[5] The passage rate of Rep. Davis' bills was 13.8 percent, compared to 48.5 percent for other Republican committee and subcommittee chairs (see Appendix B for methods).

enrollment decrease. Senator Zaffirini's staff, with the help of Texas Legislative Council staff, drafted and filed the corresponding bill, SB 1955.

During Session, Lauren fell seriously ill. Nonetheless, she would regularly call into the Senator's office to discuss bill language. Managing illness, she also cared for her three young children and pushed a host of other bills related to disability care and rights. Despite her hard work, a clear need for SB 1955, and the bill's $0 price tag, the bill never received a hearing.

While the stories of HB 12 and SB 1955 might seem like failures, they represent progress. Every member of the Texas House learned of the issues facing the ECI program. Moreover, Rep. Davis' policy now has a record of bipartisan support, which will expedite its future movement through the legislative process. Lauren's bill caught the attention of the Health and Human Services governmental relations department and may resurface as part of a future legislative or agency-led initiative.

The timescale for setting public policy is years to decades. Persistence is key, but it can be difficult. Leila left Texas for another job. I will leave Austin for medical school, and the grant that funds Lauren's position will run dry in a few months. Lauren hopes Easterseals will find funding for her position by another means, but even if not, she knows she will continue with disability advocacy in one way or another. For now, Lauren is pushing to fund her 2-1-1 pilot program through a Pritzker Foundation grant.

While private lobbyists have the advantage of expertise and job stability, public interest advocates have their own advantages. For starters, there are many people willing to donate their time to a good cause. When an advocate must move away from the legislature or legislative work, advocacy networks can ensure someone will pick up where they left off. Finally, when

trying to effect change, as we saw with the two policies responding to the ECI crisis, there are numerous ways to go about it. Effect advocates hoping to **bring their ideas to policymakers** seek help, listen to feedback, approach problems from every angle, and persist through failure.

Further Reading

Mendelson, Tamar, Pas, Elise, Leis, Julie, Bradshaw, Catherine, Rebok, George, and Wallace Mandell. "The Logic and Practice of the Prevention of Mental Disorders." *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p. 459-509.

This chapter of Public Mental Health *covers evidence that prevention methods work and yield benefits over an individual's lifetime. It breaks down prevention strategies by disease and population. The chapter has large sections on family-level preventive interventions, written from the perspective of a health authority. It also covers interventions at the school level, including for pre-school. Last, the authors identify key challenges and opportunities in mental illness prevention moving forward.*

Chapter Bibliography

Kersh, Rogan. "Ten Myths about Health Lobbyists." *Health Politics and Policy*. 5th ed. Ed. Morone, James and Daniel Ehlke. Stamford: Cengage. 2014. p. 236-253.

Legislative Budget Board. "Early Childhood Intervention (ECI) Program Funding Sources (Infograhpic)." May 2016. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Info_Graphic/3038_Funding_Sources_for_ECI_Program.pdf.

Legislative Budget Board. "Financing Options for the Early Childhood Intervention Program." *Legislative Budget Board Staff Reports*. Jan. 2017. Retrieved from http://www.lbb.state.tx.us/Documents/Publications/Staff_Report/3729_LBB_Staff_Reports.pdf#early_childhood.

Legislative Reference Library of Texas. "Bill Statistics after Signing/Veto Period, 86th Legislature." *LRL.Texas.gov*. June 17, 2019. Retrieved from https://lrl.texas.gov/whatsNew/client/index.cfm/2019/6/17/Bill-Statistics-after-SigningVeto-Period-86th-Legislature.

Purugganan, Oscar. "Intellectual Disabilities." *Pediatrics in Review*. Vol. 39, Iss. 6. June 2018. Retrieved from https://pedsinreview.aappublications.org/content/39/6/299.

Rangel, Lauren. Personal Interview. Nov. 11, 2019.

Texas Health and Human Services. "Early Childhood Intervention Services." *HHS.Texas.gov.* https://hhs.texas.gov/services/disability/early-childhood-intervention-services.

Texas Health and Human Services. "Presentation to the House Appropriations Committee: Early Childhood Intervention program." March 28, 2018. Retrieved from https://hhs.texas.gov/reports/2018/03/presentation-house-appropriations-committee-early-childhood-intervention.

Texas Legislature. House of Representatives. Committee on Appropriations – Subcommittee on Article II (Health and Human Services). *Hearing on March 28, 2018*. 85th Legislature.

Walters, Edgar. "Capitol insiders: Texas Lt. Gov. Dan Patrick is letting the state's budget agency fall apart." *The Texas Tribune*. Oct. 29, 2019. Retrieved from https://www.texastribune.org/2019/10/29/texas-lt-gov-dan-patrick-wages-war-texas-legislative-budget-board/.

Warner, David. Personal Interview. March 5, 2020.

Warner, David. "Texas." *Health Politics and Policy*. 5th ed. Ed. Morone, James and Daniel Ehlke. Stamford: Cengage. 2014. p. 190-195.

Chapter 5: Homelessness and Severe Mental Illness

The purpose of this chapter is to describe two complicating elements that distinguish mental health policy for individuals experiencing homelessness from general physical and mental health policy. The first element is the complexity of both the illnesses and their successful treatment. The second is the scare factor associated with the patient population. By understanding the unique needs of these individuals and the ways that the public and lawmakers view them, advocates can develop more effective strategies for improving Texas' mental health care system for everyone.

The purpose of this chapter is *not* to conflate homelessness with mental illness. The homeless community is diverse. Some individuals experiencing homelessness have been on the street for decades. Some just started living out of their vehicles after, for example, being hit with a major medical bill. Many homeless individuals are mentally healthy. Many suffer from depression and anxiety but are naturally less concerned with their mental hygiene than finding food and shelter. And some have a serious psychiatric condition that must be managed for them to get back on their feet. This chapter focuses on the challenges of providing care to the last group.

The Austin State Hospital (ASH) serves patient who have been ostracized by society and struggle with a high level of impairment. As a public psychiatric hospital, ASH provides necessary psychiatric services to any Texan. ASH officially serves adults from 38 counties and youth from 75. In reality, ASH takes patients from all over Texas. ASH maintains 252 beds, all of which are full year-round. Many of the patients are there for "competency restoration" so that they can stand trial. Those who cannot get to the front of the 100-person queue for one of ASH's beds must wait, often in a hospital bed or jail cell (UTADMS).

Meanwhile, “approximately 70 patients essentially live at ASH” in the extended-stay unit, where I volunteer occasionally (UTADMS). The patients in this unit could not function on their own, and they have no family or social support outside the hospital, otherwise they would not be given one of ASH’s limited beds.

A 20-year-old patient in the extended-stay unit told me that she would soon have to leave the hospital and go to a group home. She was not excited but thought the alternatives, “returning to her family or returning to prison,” were worse.

The extended-stay unit houses individuals from approximately 18 years of age to 70 with conditions that range from suicidal ideation to intellectual or developmental disability. Often the patients have multiple mental health conditions and comorbid physical ailments, in addition to a criminal record.

On another visit to ASH, I spent about an hour coloring with a woman in her 50s. She would repeat the same question four or five times, and I would answer respectfully, trying to provide the same answer in different words each time.

“Where do you go to school?”

“Just down the street, at the University of Texas.”

After about 45 minutes, she managed to answer one of my questions about her hopes. She wanted to be a college student at the University of Texas at Austin. She began to talk also about her past. It was not an uplifting story, but a highlight for her was that she had had five children. I worried she might one day realize she could not be a student, that she could not have the life she

envisioned living at the University, and I worried more so for her children. Yet frankly, that day might not come, and the children might not really exist.

For some patients with severe psychiatric conditions and nowhere else to go, ASH provides, in its own, unofficial way, palliative care, rather than rehabilitative therapy. Unfortunately, the patients receiving this care are still encouraged to leave the hospital to free up a bed for another individual in need. ASH sends the patients typically to group homes that, according to one member of ASH's staff, rarely provide an appropriate level of care. At these homes, many patients feel taken advantage of, and some stop taking their medications or lose access to them. Some patients then end up homeless. The bravest may travel downtown to be near homeless resource centers, including CD Doyle, but many (especially the women) avoid the area, fearing for their safety.

Mental illness in the homeless population can seem like an unsolvable crisis, certainly in part because these illnesses may stem from a lifetime of unmet social needs and trauma. When mental health conditions manifest as dramatic changes in behavior, they are like "end-stage" illnesses. They would have been easier to treat years in the past, and at this point, treatment options are limited. What treatments do exist (e.g. antipsychotic drugs) often carry strong side-effects (weight gain and a feeling of mental haziness) that discourage their use. Not to mention, these drugs must be taken indefinitely to manage the symptoms of the illness (NIMH).

The bottom line is that severe psychiatric illness in the homeless population is difficult and expensive to treat. Effective treatment would address social ails, the root causes of the illness. The city of Austin and its health ecosystem are hard at work toward this end. In September 2019, Integral Care finished building an apartment complex for the homeless that includes both a

health care clinic and employment and social services. It will house 50 individuals, putting the total number in Integral Care's housing programs at 500. Despite this progress, as of 2019, there are at least 2,200 individuals still experiencing homelessness in Austin. The complex is the product of a larger movement in public health to provide "housing first" to care ultimately for debilitating substance use and mental health disorders (Winkle).

The City of Austin has recently attacked the issue of homelessness from another angle: "decriminalizing poverty." Noting that many homeless individuals cannot land a job because they have criminal records for panhandling or camping in public locations, the City Council decriminalized these activities. To many in the public health field, these measures were common sense; however, downtown stakeholders campaigned against them fiercely. After the Council approved the measures, the University of Texas Police Department Chief came out against it, citing concern for the safety of students (Torre).

At work in this resistance is a pervasive scare factor. An Austin State Hospital staff member once commended my volunteer group because we were not afraid of the patients, unlike all the other groups. But it is reasonable to be afraid. ASH employees routinely have to restrain violent patients who have, for example, destroyed frontal lobes and zero impulse control. Moreover, in 2016, a University of Texas student was killed walking home from class. Two years later, a jury found a then-homeless, 20-year-old man guilty of murdering her (McCausland). At CD Doyle, I interviewed a homeless patient worried about a skin condition. He went through our process calmly, walked outside the clinic after receiving treatment, and knocked a man standing on the street to the ground before kicking his head against the curb, for no apparent reason.

The vast majority of homeless individuals with whom I have worked have been sweet and not in the least bit violent; however, individuals considering work with the homeless ought to be prepared for the worst. They also need to be ready to direct patients to regional free medical services, housing services, and other social services. Moreover, anyone looking to get involved in mental health policy needs to understand mental illness in the homeless population. Individuals experiencing both homelessness and severe psychiatric conditions are often the most visible members of the mentally ill community. They color the public's perceptions of a variety of issues. For this reason, mental health advocates ought to educate themselves on the realities of mental illness in this population and include these individuals in conversations to improve our mental health care policy.

In simpler terms, these strategies will make advocates better prepared when **bringing new ideas to legislators**. Another way to approach advocacy in homeless policy is to combat the influence of the scare factor. By **changing the public perception** of individuals experiencing homelessness, advocates can decrease resistance to innovative housing and health policy.

Returning to the story of Austin's decriminalization policy, the University of Texas police department turned out *not* to be the most vocal opponent. On Twitter, Governor Abbott began a multi-month tirade against the Austin City Council. Abbott also directed the Texas Department of Transportation to clear homeless encampments under state highways that run through Central Austin. While homeless advocates were frustrated by Abbott's response, they were more-or-less happy with his results, as were the affected homeless individuals (Tatum).

Abbott offered a state-owned empty lot, far away from downtown (and social services), for homeless individuals to set up tents (Tatum). At no cost to those living there, the public camp

now offers three meals a day, and a state trooper provides 24/7 security. The camp was just the first of Abbott's helpful actions. Several months and many angry tweets after the whole debacle began, Abbott instructed the Department of Public Safety to add patrols in downtown Austin and around the University of Texas (Garnham). Currently, a nonprofit funded by the Austin business community is partnering with Abbott to create a new, permanent shelter in place of the public camp. The organization aims to provide 300 beds, although only about 140 individuals currently sleep at the camp (Tatum and Andu).

Abbott interjected himself into an ongoing conversation between homeless advocates, local business leaders, and city police. One take-away from this story is that homeless policy balances the priorities of these three groups. Advocates in Texas should also see that top state officials consider haranguing Austin's city leaders a favorite pastime. These state officials, however, are not all talk. While Abbott's criticism has so far led to constructive policy, the Legislature has a long history of simply overturning Austin's city ordinances (Jankowski).

Further Reading

Hooks, Christopher. "Street Fight: Inside Austin's Bitter Brawl Over Homelessness." *Texas Monthly*. Nov. 2019. Retrieved from https://www.texasmonthly.com/news/austin-brawl-homeless-population/.

This article covers the reasons for the Austin City Council's decriminalization ordinances and the public resistance that followed their passage. The article also highlights the impact of the changes on homeless individuals, the role of misinformation in opposition campaigns, and tension between the city council and police department.

Agus, Deborah. “Mental Health and the Law.” *Public Mental Health*. Ed. Eaton, William and the faculty, students, and fellows of the Department of Mental Health, Johns Hopkins Bloomberg School of Public Health. New York: Oxford University. 2012. p. 351-380.

Agus offers first a broad discussion of the US legal system before zooming in on salient topics. These topics include: 1. mental health law and the rights of children; 2. how courts handle minor criminal charges in relation to treatment; and 3. the problems with mental health and drug specialty courts.

Stuckey, Skyler, Levin, Marc, and Kate Murphy. “Enhancing Public Safety and Saving Taxpayer Dollars: The Role of Mental Health Courts in Texas.” *Texas Public Policy Foundation*. April 2015. Retrieved from https://files.texaspolicy.com/uploads/2018/08/16100821/PP-The-Role-of-Mental-Health-Courts-in-Texas.pdf.

Written by an Austin-based conservative think tank, this piece does not try to provide a balanced take on mental health courts, but rather advocate for their expansion. The article is worth reading because it discusses evidence for the success of these courts in reducing recidivism. It also provides information on the history of these courts and data on the current extent of their use in Texas.

Chapter Bibliography

Garnham, Juan Pablo. “Greg Abbott blames another stabbing on Austin’s homeless policies and ramps up DPS patrols.” *Texas Tribune*. Jan. 9, 2020. Retrieved from https://www.texastribune.org/2020/01/09/texas-gov-greg-abbott-ramps-dps-patrols-austin-after-stabbing/.

Jankowski, Philip. “Reversals at Legislature have spelled an unhappy tale for Austin.” *Austin American Statesman*. Sep. 25, 2018. Retrieved from https://www.statesman.com/NEWS/20170530/Reversals-at-Legislature-have-spelled-an-unhappy-tale-for-Austin.

National Institute of Mental Health. “Mental Health Medications: Antipsychotics.” *nimh.nih.gov*. Oct. 2016. Retrieved from https://www.nimh.nih.gov/health/topics/mental-health-medications/index.shtml#part_149866.

Tatum, Carrington. “Austin’s homeless residents consider Abbott’s camp helpful but say his tweets still stigmatize them.” *Texas Tribune*. Feb. 4, 2020. Retrieved from https://www.texastribune.org/2020/02/04/texas-gov-greg-abbotts-homeless-camp-helpful-his-tweets-stigmatizing/.

Tatum, Carrington and Naomi Andu. “Abbott’s state-run camp for the homeless in Austin to be taken over by nonprofit with new shelter plans.” *Texas Tribune*. Feb. 27, 2020. Retrieved from https://www.texastribune.org/2020/02/27/greg-abbotts-camp-austins-homeless-will-be-run-nonprofit/.

Torre, Melanie. “Police push back against panhandling, public camping changes in Austin.” *CBSAustin.com*. June 7, 2019. Retrieved from https://cbsaustin.com/news/local/utpd-chief-pens-letter-to-city-council-asking-for-homeless-ordinances-to-not-be-repealed.

The University of Texas at Austin Dell Medical School. *ASH Brain Health System Redesign*. Dec. 2018. Retrieved from https://www.ashredesign.org/.

Winkle, Kate. “50-unit apartment complex to house the homeless opens in east Austin.” *Kxan.com*. Sep. 23, 2019. Retrieved from https://www.kxan.com/news/local/austin/50-unit-apartment-complex-to-house-the-homeless-opens-in-east-austin/.

Chapter 6: Addiction & Central Health

The purpose of this chapter is to describe the difficulties of managing opioid addiction from the perspectives of a health care provider and public health official. The chapter gives concrete examples of steps that can be taken to address social determinants of behavioral health and underlines the importance of advocacy efforts within a health system. Last, the chapter argues that, as demonstrated by the work of Central Health, effective advocacy starts with a problem and pursues every policy lever to combat it.

> I know persons who have been opium-eaters for some years who now daily consume enough of this poison in the form of morphine to kill a half dozen robust men not used to the poison. I have heard them, with tears in their eyes, say that they wished it had never been prescribed for them … -W.G. Rogers, 1884

The National Institute on Drug Abuse (NIDA) estimates that "abuse of tobacco, alcohol, and illicit drugs [exacts] more than $740 billion annually in costs related to crime, lost work productivity and health care" in the United States. Addiction has gained salience in recent years due to the opioid epidemic: a crisis, as journalist Beth Macy describes, created by pharmaceutical advances, maleficent or misguided physicians, and the criminal company Purdue Pharma. Yet despite recent devastation and public attention, not to mention centuries of awareness of addiction, no silver bullet has surfaced.

Opioid use disorder is a particularly devastating addiction, and treatment options leave much to be desired. According to NIDA, opioid use disorder is "chronic and relapsing." In common terms, dependency and craving for the effects of opioid drugs plague the affected mind for not months or weeks, but decades. Medication can reduce cravings, but it must be taken daily and for the rest of the patient's life. NIDA reports that when patients stop taking medication "relapse rates are high … even when the medication is tapered and patients are highly motivated to stop

opioid use." Though the risk of relapse does decrease with time, the goal is managing the symptoms as opposed to curing them, or in certain cases even replacing the illegal addiction with daily, supervised use of a legal drug, such as methadone (NIDA, "Office-based …").[1]

Overcoming addiction, on an individual level, poses an immense challenge. It should be no surprise that so does addressing addiction from a policy perspective. Some cities particularly hard hit by the opioid crisis have considered dramatic measures, such as opening supervised injection sites. These facilities seek to mitigate the public health risks of intravenous drug use. Critics argue that they attract drug users to the community in which the site resides (Laslo 2019). These sites aim to provide a point-of-contact between drug users and social services; however, as discussed in chapter five, even robust social service networks struggle to offer the comprehensive care that many users need.

Advocacy in the field of substance use disorders has been hampered by significant cultural bias against medication assisted therapies, an ideology that favors criminality over treatment, and division within the "treatment camp," namely a rivalry between "12 step program" and "harm reduction" advocates (Macy). Furthermore, arguments over who deserve blame for the opioid crisis may have contributed to a slow response on the part of the federal Drug Enforcement Agency (AP), the American Medical Association, and Purdue Pharma (Macy).[2]

---

[1] "[40] to 60 percent of addicted opioid users can achieve remission with medication-assisted treatment, according to 2017 statistics, but sustained remission can take as long as ten or more years." It take an average of roughly eight years, once treatment starts, to achieve one year of sobriety. "Meanwhile, about [four] percent of the opioid-addicted die annually of overdose" (Macy, p. 45).

[2] Fun fact: Back in 2001, when Purdue Pharma first came under fire for its role in spreading opioid addiction, the company hired none other than New York City Mayor Rudy Giuliani to bolster its reputation with Republican lawmakers (Macy).

Given the difficulty of treatment, the stigma associated with substance use disorders, and national hesitation on policy intervention, it is easy to see why the Texas government might chose to avoid the issue. And yet, it has not done so. In 2019, the Texas Legislature created continuing education requirements to keep prescribers of pain medication up-to-date on best practices, limited the quantity of opioids they can give with one prescription, expanded reimbursement for addiction treatments, and provided limited supplies of the overdose-reversing drug Naloxone to first responders (*HB 3285*, *HB 2454*, and *HB 2174*).

So, we have seen Texas expand care for those currently living with addiction, but to what extent is Texas trying to prevent addiction?

In the spring of 2019, Austin Mayor Steve Adler and Austin Councilwoman Kathie Tovo visited an undergraduate seminar at the University of Texas at Austin and asked several of my classmates for help with this goal. The pair knew the opioid crisis had not hit Austin in full force, but that it was coming. They wanted the students to research how to get ahead of the crisis and share with them what they learned. While this assignment was an exercise in writing white papers, it was also a real issue for Austin's city leaders. Adler and Tovo recognized they had an opportunity to get ahead of the incoming disaster, but felt unprepared to seize it.

The Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Drug Abuse (NIDA), and Campaign for Tobacco Free Kids recommend three methods to prevent substance-use disorders (SUDs). The root cause of much addiction is unmet social needs. Since social issues vary region by region, community members will know best how to address the common social ails in their community. Correspondingly, SAMHSA recommends that policymakers seek to empower communities to address the social determinants of behavioral

health. Public education constitutes one key tool for community empowerment. NIDA argues a second way to prevent SUDs is to identify at risk children and provide rapid intervention at the first signs of drug use. The corresponding policy is to bring mental health care into schools. The Campaign for Tobacco Free Kids advocates for a third method to decrease the incidence of SUDs: restrict access to addictive drugs.

Goal	**Policy Framework**	**Example Policies**
Address social ails	Community empowerment	Representation in local government; public education on SUDs
Early diagnosis and rapid intervention	Mental health in schools	Fund school counselors; train teachers to identify SUDs
Restrict access to addictive drugs	Drug-control laws and enforcement	Restrict the age of sale of tobacco; restrict prescription authority for opioids

Texas nonprofits, police departments, school districts, city councils, and other organizations continue to push on all three fronts. In the coming months, Central Health will enter the ongoing fight to get addictive substances out of the reach of children. Central Health is Travis County's hospital district, but it runs no hospitals. The voters of Travis County created the organization in 2004 to eliminate the County's health disparities, thereby achieving "health equity."

Toward this end, Central Health administers two publicly subsidized insurance plans, one of which is for the county's indigent population (Central Health). The organization also provides oversight of and some funding for CommUnityCare, a private, non-profit primary care health

system for underserved populations (CommUnityCare). Additionally, Central Health brings together local community and public health professionals for networking events and its Equity Policy Council bi-annual meetings. Around 50 community members, including employees of Austin Public Health, the University of Texas at Austin, State Senator Kirk Watson's office, Integral Care (the Local Mental Health Authority), and Travis County Health and Human Services, attended the July 2019 Policy Council meeting. A local judge and representatives of Austin's numerous nonprofits also attended.

At this meeting, the opioid crisis came up, and a polite but heated debate broke out. One council member attacked the group's focus on opioids, a drug associated with white men, while the drugs that have been plaguing the black community continue to be ignored.

"This is the *equity* policy council, after all."

A public health researcher who devoted the past five years of her life to the study of opioid use shot back that, despite the association of the drug, it is also a women's issue, and it is predicted to be an issue for every community in the future. Ultimately, the Equity Policy Council will decide Central Health's policy priorities by vote. Before then, the Policy Council's research committee will decide on which items the council will vote. The research committee sets the agenda.

The Central Health Equity Policy Council research committee is a group of volunteers. Its monthly attendees include a county health official, an Austin Public Health employee, an American Heart Association government relations specialist, myself, researchers, a consultant hired by Central Health, and Central Health's full-time policy and advocacy director. Those of us who are not paid to be there attend because we enjoy learning from one other.

In late July of 2019, eight of us began discussing flavored nicotine products. We agreed that flavored products target children, often causing nicotine addiction. The US Center for Disease Control and Prevention reported that in 2018 more than *one in four* high school students used a tobacco product; "This increase—driven by a surge in e-cigarette use—erased past progress in reducing youth tobacco product use." Past progress is the result of a 60-plus-year political and legal war against big tobacco that climaxed in $264 billion dollar settlement around the turn of the century ("Tobacco Master Settlement" 2019). We all agreed we ought to do something about youth e-cigarette use, and two solutions were put forward: ban flavored tobacco products or restrict them to 21-and-up stores. We quickly decided that banning tobacco flavoring would be too steep an uphill battle. "Austin isn't San Francisco."

So, we focused on the more feasible option.

"If this restriction were to pass city council, would the tobacco companies sue Austin Public Health?"[3]

"Well, didn't Bloomberg agree to pay for the legal defense of any tobacco-control ordinance?"

People nodded.

"So are we all okay with moving forward with this policy? We should keep in mind Juul is moving into Austin."

[3] Tobacco companies have a history of suing local governments to increase the financial burden of passing a tobacco-control ordinance. In this way, the industry has sought to deter other cities from passing similar ordinances (Nixon, Mahmoud, and Glantz 2004).

“They’ve been pretty egregious in their marketing. I’ve seen posters that advertises Juul as a way to quit smoking, which sends the message that it’s not addictive.”

“It’s also been proven an ineffective method for quitting.”

The research council navigated the world of big tobacco and billionaires. In a few months, the policy will likely go before the full Policy Council. If selected, Central Health will find champions for the policy and support them as they talk to Austin’s City Council. The political process will take months to years. Some members of the research committee will likely move to a new city or otherwise stop being able to attend. Central Health’s paid policy team, however, will continue advocating for the chosen policy position.

When **bringing ideas to the attention of policymakers**, persistence is key. If the ordinance passes, the State Legislature may try to overturn it in the following session and Austin Public Health may face a lawsuit. The timescale for setting public policy is at best years and at worst decades. Publicly financing a policy coordinator, as does Central Health, ensures that important issues do not get dropped. The other genius in Central Health’s strategy is that it brings together members of health organizations across Travis County. By networking and distributing information to these individuals, Central Health facilitates the decentralized, institution-by-institution evolution of policy. In summary, Central Health pursues positive change through every avenue.

Further Reading

Macy, Beth. *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America*. New York: Little, Brown, and Company. 2018.

Beth Macy makes use of her unique connections as an ex-local reporter in Virginia to trace the opioid epidemic from its beginnings in Appalachia to its spread across the nation. This well-researched page turner provides a comprehensive look not just at the extent of the crisis, but also the responses. She describes some responses that are effective and some ineffective, including measures taken at the family, school, state, and federal levels.

Case, Anne and Angus Deaton. *Deaths of Despair: And the Future of Capitalism*. Princeton: Princeton University. 2020.

Two leading economists (one a Nobel-winner) take an analytic look at the factors driving income inequality, suicidality, drug overdoses, and chemical dependence in the United States. Case and Deaton provide an academic, birds' eye view of the opioid crisis that complements Macy's local perspective. While the whole book is worth reading, I recommend chapters eight and nine, in particular, because they describe how a burgeoning meritocracy and national shakedown are exacting a steep toll on the mental wellbeing of the American working class.

Bibliography

Associated Press. "Watchdog finds DEA was 'slow to respond' to opioid epidemic." *SeattleTimes.com*. Oct. 1, 2019. Retrieved from https://www.seattletimes.com/seattle-news/health/watchdog-finds-dea-was-slow-to-respond-to-opioid-epidemic/.

Campaign for Tobacco Free Kids. "Prevention and Cessation Programs." *TobaccoFreeKids.org*. Jan. 9, 2019. Retrieved from https://www.tobaccofreekids.org/what-we-do/us/prevention-cessation.

Center for Disease Control and Prevention. "Progress Erased: Youth Tobacco Use Increased During 2017-2018." *CDC.gov*. Feb. 11, 2019. Retrieved from https://www.cdc.gov/media/releases/2019/p0211-youth-tobacco-use-increased.html.

Central Health. "Our Services." *CentralHealth.net*. Accessed April 22, 2020. Retrieved from https://www.centralhealth.net/our-services/.

CommUnityCare. "Our History." *CommunityCareTX.org*. Accessed April 22, 2020. Retrieved from https://communitycaretx.org/about/history.html.

Laslo, Matt. “Weighing options to fight opioid crisis, few U.S. lawmakers tout supervised injection site.” *WHYY.org*. March 21, 2019. Retrieved from https://whyy.org/articles/weighing-options-to-fight-opioid-abuse-few-u-s-lawmakers-tout-supervised-injection-site/.

Macy, Beth. *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America*. Little, Brown, and Company: New York. 2018.

National Institute on Drug Abuse. “Office-based Buprenorphine Treatment for OUD.” *Youtube.com*. September 27, 2018. Retrieved from https://www.youtube.com/watch?v=H0vWVLuXTW0&t=18s.

National Institute on Drug Abuse. “Prevention.” *DrugAbuse.gov*. Last modified March 2014. Retrieved from https://www.drugabuse.gov/related-topics/prevention.

Rogers, W. G. “Letter to the *Daily Dispatch* editors in favor of imposing restrictions on over-the-counter opioid products.” *Daily Dispatch*. 1884. (As cited in Macy, *Dopesick*, p. 23).

Substance Abuse and Mental Health Services Administration. “Substance Abuse Prevention and Treatment Block Grant.” *Samhsa.gov*. Last modified September 15, 2017. Retrieved from https://www.samhsa.gov/grants/block-grants/sabg.

Texas Legislature. House of Representatives. *House Bill 2174*. 86th Legislature. Regular Session. 2019.

Texas Legislature. House of Representatives. *House Bill 2454*. 86th Legislature. Regular Session. 2019.

Texas Legislature. House of Representatives. *House Bill 3285*. 86th Legislature. Regular Session. 2019.

Chapter 7: Tobacco 21 & the Influence of National Politics

This chapter assesses why the national political scene has shifted strongly in favor of restricting the age of sale for tobacco products. The chapter begins by discussing the tobacco industry's surprising response to the epidemic of youth e-cigarette use. It then addresses how worried Republican leaders partnered with the tobacco industry to woo suburban women back to the GOP. Last, the chapter examines how these national politics have influenced efforts in the Texas Legislature to restrict tobacco's age of sale. This chapter argues ultimately that a savvy advocate can take advantage of the larger political moment.

Tobacco's addictive component is the chemical nicotine. Nicotine is likely less addictive than concentrated opioids, similarly addictive to benzodiazepines and alcohol, and more addictive than sugar, videogames, and exercise (Nutt, et al.). The regulation of nicotine products is contentious. Public health experts recognize the damage caused by use of nicotine to personal finances, mental health, and physical health. They also recognize that the complete removal of nicotine from the market would be disastrous for those already dependent on it. Their goal, therefore, is to prevent the substance from finding new users. "Tobacco 21 bills" are one tool to do so. They raise the minimum legal age of sale for nicotine-containing products to 21. These bills saw a lot of action in the 2019 US and Texas legislative sessions.

In May of 2019, the Texas Tribune reported: "Texas' moves on the tobacco age are in line with a national trend. Last month, representatives in both the US House and Senate introduced legislation to raise the national purchase age for tobacco from 18 to 21. Senate Majority Leader

Mitch McConnell and the tobacco industry have also expressed support for such legislation, though Politico reported last month that anti-tobacco advocates fear the efforts are a 'Trojan horse' to block other, more proven measures to reduce youth smoking such as flavor bans and higher taxes on tobacco products" (Byrne).

The fact that Juul and other tobacco industry members support raising the legal age of sale marks a sharp change in strategy from previous years. Philip Morris, Inc. was one of the four tobacco companies forced to settle in the landmark 1998 Tobacco Master Settlement Agreement ("Tobacco Master Settlement Agreement"). Part of the settlement prohibited Philip Morris from continuing to market tobacco to children. The company was found violating this provision, among other laws, in a 2006 racketeering case ("United States v. Philip Morris"). Philip Morris, Inc. changed its name to Altria in 2003, a public relations strategy to distance the company from its criminal wrongdoing. Altria now owns a controlling share of Juul, the most popular e-cigarette maker ("Juul"). On April 24, 2018, the federal Food and Drug Administration announced it "has been conducting a large-scale, undercover nationwide blitz to crack down on the sale of e-cigarettes – specifically JUUL products – to minors … The blitz … has already revealed numerous violations of the law." The FDA is also investigating Juul for marketing nicotine-containing products to children (USFDA).

Sharon Eubanks led the Justice Department's racketeering case against Philip Morris, Inc. She described tobacco industry support for tobacco 21 legislation as "a Jedi mind trick," meant to obscure industry's contribution to the youth vaping epidemic (Dreisbach). Whatever the motives

of its proponents, in early 2019, McConnell and Kaine's bill stalled in the US Senate.[1] Texas, meanwhile, passed its tobacco 21 legislation.

State Sen. Joan Huffman, a Republican from Houston, led the effort to pass Senate Bill 21. The bill had fifteen other authors and coauthors in the Senate, and twenty-one sponsors and co-sponsors in the House in addition to the clear support of the Lieutenant Governor. Andrew Hendrickson, the experienced staffer in State Sen. Zaffirini's office who worked on SB 21, did not feel there was "any reason to think" that the tobacco industry brought the bill to Sen. Huffman. Huffman filed a similar bill during the previous legislative session. "Morever, most of the experts [Hendrickson consulted] agreed the bill is good policy." While it may have taken the steam out of other efforts to reduce youth e-cigarette use, SB 21 "has positive impacts that shouldn't be ignored."

Tobacco control advocates worry that tobacco 21 legislation may contain pre-emption clauses or inadequate enforcement (Myers); however, neither of these concerns appear to apply in Texas' case. SB 21 has a pre-emption clause, but it is narrow. The bill prevents local governments from raising the legal age of sale above 21. Additional methods of tobacco-control, such as those discussed by the Central Health Policy Council, are generally permissible. SB 21 leaves enforcement to local governments and may even provide block grants to fund related enforcement activity.

[1] A bipartisan coalition of senators ultimately succeeded in raising the national age of sale by attaching the policy to a defense budget bill (Howard).

So, did this bill pass because it was a good idea? In 2017, the policy had the official support of no Republican senators besides Huffman. The 2017 bill did not receive a committee hearing (TLO, “SB 910”). In 2019, the Lieutenant Governor put his full weight behind the policy, assigning the bill, poetically, the number 21. The bill overcame challenges in both chambers of the Legislature. Ultimately it passed in the House, with 110 votes in favor, 36 against, and 2 abstaining, and in the Senate with 27 yeas and 4 nays (TLO, “SB 21”).

So why did the Lieutenant Governor decide to support tobacco 21 legislation the second time around? We have to consider that the Lieutenant Governor’s job is not to move good policy. It is to maintain party strength. That goal means keeping the Democrats in check and the Republicans voting as a unit. In the current political moment, his job also entails defending Republicans in general elections.

In 2014, Sen. Huffman won re-election by 52,900 votes. In 2018, against the same opponent, Sen. Huffman won re-election by just 14,300 votes. Huffman’s district includes a large swathe of Houston suburbs, a politically moderate population moving notably further away from the Republican party in the wake of President Trump (Mason 2019). The region selected a pro-choice Republican, Rep. Sarah Davis, to represent them in the Texas House of Representatives, a sign of suburban women’s voting power and moderate political orientation (Houston Chronicle Editorial Board). Senate Bill 21 is a progressive piece of legislation. Patrick may have boosted the bill to give Huffman a win in her district. If he did, it would be consistent with the way many staffers in the Legislature believe he operates.

Assuming my assessment is correct, **public attitudes**, namely suburban women's concern for school-age children, drove SB 21's passage. Naturally then, effective advocacy can target public opinion in swing districts as a means to effect policy change. We can also see room to make use of this causal relationship in direct advocacy. If behavioral health advocates understand the political moment, they can frame their initiatives as responding to current crises and delivering a political win for key constituencies *and therefore party leaders*. In this way, advocates can more effectively **sell policies to policymakers**. So long as politicians continue to fight for the allegiance of suburban women, behavioral health advocates should align their proposals with the priorities of this constituency.

Further Reading

Dreisbach, Tom. "Tobacco's 'Special Friend': What Internal Documents Say About Mitch McConnell." *Embedded*. National Public Radio. June 17, 2019. Retrieved from https://www.npr.org/2019/06/17/730496066/tobaccos-special-friend-what-internal-documents-say-about-mitch-mcconnell.

The article and podcast cover US Senate Majority Leader Mitch McConnel's longstanding relationship with the tobacco industry and the importance of this relationship in McConnel's championing of Tobacco 21 legislation. In an engaging format, the piece depicts the national context for Texas' debate on Tobacco 21 legislation.

Mason, Melanie. “In suburban Texas, ‘it feels like there’s no place for lifelong Republicans like me.’” *LATimes.com*. Aug. 13, 2019. Retrieved from https://www.latimes.com/politics/story/2019-08-13/texas-congress-suburban-women-republicans.

The Los Angeles Times reports on Texas suburban women’s faltering political allegiance to the Republican party. The potential fallout of this change has caught the attention of Texas’ Republican leadership, and the article documents several legislative actions meant to woo these women back to the Republican party.

Chapter Bibliography

Byrne, Elizabeth. “Texas House votes to raise legal smoking age to 21.” *TexasTribune.org*. May 14, 2019. Retrieved from https://www.texastribune.org/2019/05/14/texas-legal-age-tobacco-21-senate-bill-21/.

Dreisbach, Tom. “Tobacco’s ‘Special Friend’: What Internal Documents Say About Mitch McConnell.” *Embedded*. National Public Radio. June 17, 2019. Retrieved from https://www.npr.org/2019/06/17/730496066/tobaccos-special-friend-what-internal-documents-say-about-mitch-mcconnell.

Houston Chronicle Editorial Board. “For State Representative, District 124: Sarah Davis.” *HoustonChronicle.com*. Oct. 5, 2018. Retrieved from https://www.houstonchronicle.com/opinion/recommendations/article/Texas-House-District-134-Sarah-Davis-endorsement-13285440.php.

Howard, Jacqueline. “The US officially raises the tobacco buying age to 21.” *CNN.com*. Dec. 27, 2019. Retrieved from https://www.cnn.com/2019/12/27/health/us-tobacco-age-21-trnd/index.html.

“Juul.” *Wikipedia.org.* Last modified July 26, 2019. Retrieved from https://en.wikipedia.org/wiki/Juul.

Mason, Melanie. “In suburban Texas, ‘it feels like there’s no place for lifelong Republicans like me.’” *latimes.com*. Aug. 13, 2019. Retrieved from https://www.latimes.com/politics/story/2019-08-13/texas-congress-suburban-women-republicans.

Myers, Matthew L. “Tobacco-Free Kids Statement on McConnell-Kaine Bill to Raise the Tobacco Age to 21 Nationwide.” *TobaccoFreeKids.org*. May 23, 2019. Retrieved from https://www.tobaccofreekids.org/press-releases/2019_05_23_tobacco21.

Nutt, David, King, Leslie, Saulsbury, William, and Blakemore, Colin. “Development of a rational scale to assess the harm of drugs of potential misuse.” *The Lancet*, Vol. 369. Iss. 9566, 24-30. March 2007. p. 1047-1053. Retrieved from https://www.sciencedirect.com/science/article/pii/S0140673607604644.

Office of the Texas Secretary of State. “Election Results.” *Sos.State.tx.us*. Accessed August 14, 2019. Retrieved from https://elections.sos.state.tx.us/index.htm.

Texas Legislature. Senate. *Senate Bill 21*. 86th Legislature. Regular Session. 2019.

Texas Legislature Online. “SB 910.” 2017. Retrieved from https://capitol.texas.gov/BillLookup/History.aspx?LegSess=85R&Bill=SB910.

“Tobacco Master Settlement Agreement.” *Wikipedia.org*. Last modified July 25, 2019. Retrieved from https://en.wikipedia.org/wiki/Tobacco_Master_Settlement_Agreement.

“United States v. Philip Morris.” *Wikipedia.org*. Last modified August 13, 2018. Retrieved from https://en.wikipedia.org/wiki/United_States_v._Philip_Morris.

US Food and Drug Administration. “Statement from FDA Commissioner Scott Gottleib, M.D., on new enforcement actions and a Youth Tobacco Prevention Plan to stop youth use of, and access to, JUUL and other e-cigarettes.” *FDA.gov*. April 24, 2018. Retrieved from https://www.fda.gov/news-events/press-announcements/statement-fda-commissioner-scott-gottlieb-md-new-enforcement-actions-and-youth-tobacco-prevention.

Conclusion

Pulling from the content of the past seven chapters, the conclusion analyzes the three strands of effective advocacy first presented in the introduction. Afterwards, it assesses the generalizability of these theories. The penultimate section comment on behavioral health policy options that may soon be politically feasible to implement. The final paragraphs identify a few remaining questions worth answering in behavioral health policy.

Effective advocacy influences public attitudes.

In the introduction, I discussed how public opinion can tie lawmakers' hands. The public's fear of individuals experiencing homeless, for example, pushed the Austin City Council to partially reverse its camping decriminalization policy (CBS Austin). Undoubtably, public attitudes can also force action. The Santa Fe shooting prompted state investment in mental health in schools. Furthermore, moderate suburban women's alienation from the national Republican Party may have fueled passage of tobacco 21 legislation.

These are high profile battles. They deal with the life and death of Austinites, children, and the Republican Party respectively. So, what happens with all the issues dealt with by the Texas Legislature that do not catch the public's attention? The Early Childhood Intervention program's funding crisis is a good example. Action may have been forced if the issue had more press, but more press may also have prevented prominent Republicans from entertaining a new insurance coverage mandate. Advocates should realize the political rules are different when the spotlight is pointed somewhere else.

Last, to influence public attitudes, you do not need a major media campaign. The job can be simple, like providing educational materials that empower consumers to fight back when an

insurance provider violates mental health parity law. The job can also include building trust between communities; for example, between adolescent behavioral health experts and parents or between individuals experiencing homelessness and the public.

Effective advocacy changes who holds office.

I began this thesis by discussing the singular power of the lieutenant governor. This directly elected official has much greater influence over legislation that any individual representative. Generally, the lieutenant governor passes what policies he wants and blocks all that he does not. The holder of this office matters a lot when it comes to state appropriations. Other key officials, like gubernatorial appointees to state agencies and the directly elected Attorney General, have profound power and discretion over insurance policy. If you have made an enemy of one of these individuals, or they oppose your favored policy, you may have no hope but to try and change who holds office. Barring these scenarios, however, there is value in bringing your thoughts to legislators if you are smart about how you do it.

Effective advocacy brings new ideas to the attention of policymakers.

I made the claim in the introduction that direct advocacy can effect change if the advocate is well-informed in policy and politics. The last seven chapters described how advocates apply these two types of knowledge to influence those in positions of power. Alissa Suhgrue knew the issues important to NAMI inside and out. She was available to talk to staffers, and she was ready to testify anytime during Session. From Alissa’s story, I hope potential advocates learn that there are a number of people not just interesting in helping you push innovation in behavioral health policy, but paid to do it.

Faced with a funding crisis, Early Childhood Intervention program managers and care providers used the same strategies as Alissa, although they did it in their spare time. Effective advocacy in this context involved assisting legislative staffers by providing evidence-based and thoughtful feedback promptly when asked for it. If you are trustworthy, you will build trust. Trust will encourage staffers to fight for your bill. The stories of disability advocate Lauren Rangel's work on Early Childhood Intervention enrollment and Central Health 's work on youth vaping illustrate two additional points: Effective advocates are in it for the long hall, and there are many ways to address a particular issue. Advocates should not get hung up on one policy solution, but rather take every path to address a problem.

The chapter on mental health parity implementation highlights how advocates can leverage expertise and lived experience in the processes of ironing out policy specifics. Stakeholders who do not have the patience for this admittedly long and dry process might find legislative advocacy more their speed. As we saw with the mental health in schools movement, there are strategies to boost your odds of passing a bill. You should try to make the bill revenue neutral and frame it as a response to a current crisis. Furthermore, Texas' tobacco 21 legislation taught us that a savvy advocate can design a bill to deliver party leaders a political victory, while also addressing a particular issue.

Generalizability

I made arguments for three theories of effective advocacy based on historical evidence. A lot of this evidence is anecdotal or gathered from just one legislative session. Naturally, this fact draws into question the applicability of the theories outside of Texas' 86th Legislature and, more generally, 2019. Moreover, policy and politics change constantly. The "political moment" has

shifted dramatically over just the last three months due the Covid-19 pandemic. The continued relevance of my theories depends on two relative certainties and two key uncertainties.

First, Texas will remain a conservative state. Elected officials will continue to respect their constituents' preferences. Despite the strong performance of Democrats in the 2018 election, Texans are not going to abandon their suspicion of government and ideologic resistance to welfare and regulatory expansion (Yglesias). Second, many key players will not change. While true that Texas' demographic trends are making many general elections more competitive, statewide elections are not likely to be competitive for some time (Yglesias). Even during the 2018 "blue wave" that swept many Democrats into local offices, Governor Abbott still won by a margin of 13 points, and the Lieutenant Governor won by 5. The Republican candidates for Comptroller, Commissioner of the General Land Office, and Railroad Commissioner all won by 10 points. The controversial Sid Miller won Commissioner of Agriculture by 5 points. Even the incumbent Attorney General, Ken Paxton, who was indicted on felony securities fraud and awaiting trial, won re-election by three and a half points (OSOS). We can expect many of the institutional and political determinants of a bill's fate to remain constant.

While few of the directly elected top positions are likely to change hands, the Speaker of the House will change by 2021 (Pollock). The most recent speaker, Dennis Bonnen, chose to be a unifying figure in the House, notably appointing Democrats and moderate Republicans to be committee chairs (Pollock, Samuels, and Platoff). Since Bonnen has announced his retirement, the House must pick a new Speaker in the coming months. Who they will elect is a key uncertainty. House members could select someone further to the right than Bonnen, or they could pick again a leader who honors Joe Straus' legacy of bipartisanship. There is also a potential for Democrats to gain control of the Texas House in the 2020 election, securing them a Democratic

Speaker (Pollock and Svitek). If that occurs, the political dynamics of the Texas Legislature will change significantly, and additional advocacy strategies may become relevant.

The second key uncertainty is the effect of the Covid-19 pandemic on Texas politics. The pandemic has already decimated the budgets of local and state governments across the nation. Texas will be especially hard hit due to the collapse of oil prices (Garnham). Houston Mayor Sylvester Turner gave a glum forecast: "We work on the budget year-round, and we anticipate even the worst scenarios. This one is even worse than anyone had imagined" (As cited by Garnham). No one knows what the full toll of the pandemic will be, whether Congress will bail out state and local governments, or how the pandemic will change Texas politics. History argues that times of crisis often lead to precedent-setting expansions of the federal government. While the pandemic might unleash a new era in federal spending, Texas is unlikely to follow suit because of its constitutional balanced-budget requirement and, of course, its inability to print money. As far as behavioral health policy is concerned, I expect Texas' state and local governments will cut back on physical and mental health services to address budget shortfalls.

Some of the knowledge needed to be an effective advocate will change. Undoubtably, this thesis focuses on the facts that were important during the 86th Legislative Session. This work will remain relevant, however, because it introduces readers to the larger factors that influence behavioral health politics in Texas, including institutional structures, the political moment, and the limited influence of constituent preferences. When behavioral health stakeholders look to influence policy in the future, I hope my thesis will have clarified both the importance of these factors and the feasibility of thinking analytically about them.

Issue Areas Ripe for Change

I have outlined many obstacles to changing Texas' behavioral health status quo. Assuming a quick recovery from the Covid-19 pandemic, I have a hunch the timing may soon be right to address a couple longstanding grievances with our system. First, we could complete the development of Texas' psychiatric workforce. Other states have done it (HRSA); Texas can too. Texas politicians recognize that our health care market is not healthy (Texas Legislature). When it comes to behavioral health care, high demand and low supply clearly contributes to the market's failure to serve the population. We can increase supply not just by expanding training programs for psychiatrists, psychiatric nurse practitioners, and clinical psychologists, but also by requiring insurance plans to reimburse the work of peer counselors, community health workers, and case managers. These proposals are not new, but at last individuals on both sides of the aisle can agree on the problem.

In addition to market reform, policymakers have a new appetite for mental illness prevention. "Mental hygiene" is also not a new concept, but political leaders, moved by mass shootings and afraid of voters in suburban Texas, have at last been willing to take up the cause. Credit for this change should also go to lawmakers, like State Representative Garnet Coleman, who have spent decades destigmatizing mental illness.[1] Promising prevention policies include expanding school-based counseling services, creating behavioral health education programs for parents, and laying high-speed internet cables that would enable tele-health in rural areas. While these proposals

[1] In 2003, Rep. Coleman publicly acknowledged he had bipolar disorder. The 86th Legislative Session marked Coleman's 28th year in office, and as Chair of the House County Affairs Committee, he continued to show other lawmakers that individuals with chronic mental illness can be hard-working, productive citizens (Coleman and Vallas).

carry significant price tags, they could provide cost savings to the state several years after implementation. Unfortunately, net savings is not a given, and the hypothetical impacts of the policies are not easy to study.

Future Studies

This thesis examines strategies to improve behavioral health policy as a private advocate. A future study should assess strategies to promote public mental health from the perspective of the public sector. In other words, if the State decides it has money to put towards public mental health, how should it spend it? Two questions follow: Which behavioral health policy interventions are the most cost effective? And, which are sustainable?

Chapter Bibliography

CBS Austin. "City Council approves new restrictions on homeless camping ordinance." *CBSAustin.com*. Oct. 17, 2019. Retrieved from https://cbsaustin.com/news/local/city-county-continues-debate-over-homeless-camping-ordinance-changes.

Coleman, Garnet and Rebecca Vallas. "Mental Illness and Elected Office." *RealClearHealth.com*. Feb. 8, 2018. Retrieved from https://www.realclearhealth.com/articles/2018/02/08/mental_illness_and_elected_office_110767.html.

Garnham, Juan Pablo. "Local governments, already hard hit by the coronavirus, are facing a fresh budget threat: economic recession." *Texas Tribune*. April 2, 2020. Retrieved from https://www.texastribune.org/2020/04/02/texas-coronavirus-threatens-city-budgets-services-recession-looms/.

Health Resources and Services Administration. "Mental Health Professional Shortage Areas." Accessed April 24, 2020. Retrieved from https://data.hrsa.gov/maps/map-tool/.

Office of the Secretary of State. “2018 General Election: Race Summary Report.” Nov. 6, 2018. Retrieved from https://elections.sos.state.tx.us/elchist331_state.htm.

Pollock, Cassandra. “Texas House Speaker Dennis Bonnen won’t seek reelection after recording scandal.” *Texas Tribune*. Oct. 22, 2019. Retrieved from https://www.texastribune.org/2019/10/22/Dennis-Bonnen-to-not-seek-reelection-to-Texas-House/.

Pollock, Cassandra and Patrick Svitek. “Democrats could gain control of the Texas House for the first time since 2001. Here are the seats in play in 2020.” *Texas Tribune*. Dec. 13, 2019. Retrieved from https://www.texastribune.org/2019/12/13/will-texas-house-turn-blue-after-2020-elections/.

Texas Legislature. Senate. Committee on Business and Commerce. *Hearing on December 10, 2018*. 86th Legislature.

Yglesias, Matthew. “Texas isn’t a swing state - but it matters.” *Vox.com*. Oct. 9, 2019. Retrieved from https://www.vox.com/policy-and-politics/2019/10/9/20900662/texas-democrats-swing-state-blue-2020.

Appendix A: Texas Legislative Advocacy Timeline

The Texas Legislature convenes for 140 days at the start of every odd numbered year. Advocates need to plan *when* to communicate their ideas to legislators. Even though legislating is a part-time job in Texas, policy development goes year-round. The following guide provides a timeline for legislative advocacy in accordance with the Texas Legislature's unique biannual calendar. In addition to pairing step-by-step recommendations with this calendar, I offer a few suggestions to improves chances of bill passage during each phase. This guide is meant for policy proposals that are inexpensive. For proposals with a price tag, you should move the steps listed in the timeline up by a few months and engage members of the House Appropriations or Senate Finance committees from an early point.

No later than January through July of an even numbered year:

1. Prepare your policy proposal.
    A. Recommendations: Establish why the bill is necessary.
    B. Make the policy change revenue neutral.
    C. Include a way to measure and evaluate the policy's impact, if it were to become law.
2. Start coalition building.

During August through November of an even numbered year:

1. Bring your proposal to at least one legislator in the House and Senate.
    A. Pick the legislator whose district is most impacted by the issue.
    B. If there is not a district most impacted, pick the relevant committee chairs.
    C. If the committee chairs are not interested in authoring the bill, pick a legislator with a history of working on similar issues.
        a. Keep in mind, you can ask multiple legislators in each chamber to author or sponsor the bill.
        b. Note that if you file identical bills in each chamber at the start of session, the bills are technically separate pieces of legislation. One will need to move through both chambers for the policy to become law. The state budget is the only bill that can be processed in both chambers simultaneously.

2. Work with capitol staffers and attorneys to draft bill language.
3. Reach out to any likely opponents of your bill. Explain your position and ask for feedback.
4. Be prepared to assist capitol staffers as they vet your bill with the relevant stakeholders.
5. Try to accommodate any concerns about the bill and work with legislative staff to edit bill language accordingly.
6. Bills can be pre-filed in early November. Encourage legislators to file once the bill language is finalized.

During December through January:

1. Help capitol staff develop a one-page brief on your bill.
    A. The "one-pager" should outline why the bill is necessary, what it costs, who supports it, and who opposes it.
    B. Assume your audience is unfamiliar with behavioral health and even less familiar with behavioral health policy.
2. Talk with the relevant committee chair offices in the House and Senate; advocate for your bill to get a hearing.
3. While the legislative session begins in early January, the state budget is typically the only item considered during this month.
4. Pester your chosen legislator's staff to file your bill no later than the end of January, even though the official deadline is not until March.

During February through the first week of May (of an odd numbered year):

1. Your bill will be referred to a committee. Lobby the appropriate committee chair for a hearing, if you have not done so already.
2. Try to be available to testify from roughly the second week of February through the first week of May, in case your bill is scheduled for a hearing. Do not expect more than one week's notice.

3. If a committee chair schedules your bill for a hearing, you or your partner legislative office should distribute the one pager to every member of the committee. Ideally, you would meet with staff in each office as well.
    A. Remember your bill is never safe from opposition.
    B. Do not expect opposition to announce themselves to you.
    C. Check in frequently with legislative staffers working on your bill to make sure they are doing their part.
4. If your bill is voted out of committee, distribute your one pager to all members of the appropriate chamber of the Legislature.
5. If your bill passes in one chamber, repeat steps one through four once it has been sent to the other chamber.

Appendix B: Summary of 86th Legislature Statistics

Sample size

Legislators: 181

- Representatives: 147
  - Democrats: 64
  - Republicans: 83
- Senators: 31
  - Democrats: 12
  - Republicans: 19

Bill count: 10878

- Bills-that-became-law count: 4484

Methods

I downloaded three LegiScan.com datasets with information about Texas' 86th Legislature. I merged all three to create one dataset that tied each bill to its primary author, the author's political party, and the bill's "final status," including information on whether or not it became law. I added a column coding how many chairships each legislator held and merged that data with the composite set. I used Pearson's Chi-Squared test to compare groups of legislators' success rates (bills that became law divided by bills filed). I used a p-value cut-off of 0.05 to conclude whether two groups of lawmakers had significantly different success rates.

Key Findings

Committee chairs' bills became law at a significantly higher rate than those of non-chairs. This finding was consistent when looking just at legislators from one political party.

Table 1: Chairs and Non-chairs

	Chairs	Non-chairs	P-Value
Success Rate	0.46	0.38	2.2e-16

Table 2: Democrat Chairs and Non-chairs

	D Chairs	D Non-chairs	P-Value
Success Rate	0.40	0.34	0.00019

Table 3: Republican Chairs and Non-chairs

	R Chairs	R Non-chairs	P-Value
Success Rate	0.49	0.44	0.00026

Other Findings

Republicans' bills became law at a significantly higher rate than Democrats' bills. This finding was consistent when looking just at bills with the same chamber of origin.

Table 4: Democrats and Republicans

	Democrats	Republicans	P-Value
Success Rate	0.35	0.46	2.2e-16

Table 5: House of Representatives Democrats and Republicans

	D Representatives	R Representatives	P-Value
Success Rate	0.36	0.49	2.2e-16

Table 6: Senate Democrats and Republicans

	D Senators	R Senators	P-Value
Success Rate	0.33	0.40	1.3e-6

Limitations

Bills that became law because they were amended onto a separate bill could not be distinguished in the data and therefore were not counted as a successful bill.

Bill passage rates correlate with the political party and status as a chair or non-chair. This correlation could easily be caused by a confounding variable, namely bill content. This analysis is therefore of very limited applicability for advocates wondering if they should pick a republican, democrat, or committee chair to file their bill. Moreover, the 87th Legislature will have a new Speaker of the House and may see a different party in control the House. What makes a bill likely to succeed may be very different in the next legislative session.