ABSTRACT

Everything's Better In Texas?
Analyzing Texas' Mental Health Care System

Cristina Mendez

Director Hugh Riley, Ph.D.

As can be seen through numerous studies, Texas' mental health system is in crisis. Mental health services are often ineffective due to obstacles in accessibility, availability, and acceptability. In Texas, the vulnerable populations most affected by these obstacles are the rural, Hispanic, and youth populations. Considering the size of Texas and its growing population, delivery of mental health services must be strategic to ensure all citizens receive quality treatment. This thesis project demonstrates Texas' potential as a leader in mental health by analyzing deficits in care, discussing demographic forecasts, and examining historical policies. From this study, this thesis ultimately contends that by integrating data-driven solutions, educational policies, and furthering professional development in mental health care, the state will optimize its use of resources.

APPROVED BY DIRECTOR OF HONORS THESIS:

_____

Dr. Hugh Riley, Department of Psychology & Neuroscience

APPROVED BY THE HONORS PROGRAM:

_____

Dr. Andrew Wisely, Director

DATE: _____

EVERYTHING'S BETTER IN TEXAS?
ANALYZING TEXAS' MENTAL HEALTH CARE

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By

Cristina Mendez

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INTRODUCTION

At the Kennedy Forum on mental health, former Congressman Patrick Kennedy stated, "The tragedy is not in mental illness. It's in not treating mental illness."[1] The importance of delivering quality mental health services to all citizens cannot be understated; while science has helped the progress of innovation, there still exist obstacles inhibiting the delivery of services through accessibility, acceptability, and availability. Though all citizens are hurt by the poor conditions of a mental health system, vulnerable populations are those whose illness is exacerbated due to their lower social status, social capita, and human capital. This thesis project seeks to do three things: analyze the situation of vulnerable populations in Texas by reflecting on the relative risk posing an obstacle to such specific populations; study past public policies that have impacted these vulnerable populations; and promulgate a view for change. Ultimately, this thesis posits that the public Texas mental health system must be strategically rooted in data-driven solutions as well as in mental health professional development. These strategies are the only ways to ensure that Texas builds up its mental health system in a sound and meaningful way that impacts even the most vulnerable of citizens.

[1] Conaboy, C. "US On The Cusp Of Mental Health Advances, Biden Says." *Boston Globe*. 25 Oct. 2013 <http://www.bostonglobe.com/metro/2013/10/23/biden-and-sebelius-attend-jfk-library-gala-outraging-republicans/qtAKx6Ac9cnaepUhMTv0bP/story.html>.

CHAPTER ONE

Framework

To set up the general framework for this thesis project, Chapter One will provide background information and definitions. First, we will explore the importance of making Texas the focus of this discussion. Second, we will address the question of who makes up the vulnerable populations? Third, we will describe why mental health matters by outlining the most important historical events in mental health policy and by demonstrating the high costs of forgoing further investments in mental health care. Lastly, an explanation will be provided as to why this thesis focuses on data-driven solutions and professional development as the fuel for prudent change in the Texan mental health care system. This outline sets the context for the chapters that follow and creates awareness of the overall state of mental health care in Texas.

Crisis In Texas

In a state-to-state comparison, it is glaringly obvious that the mental healthcare system in Texas is neither extensive nor of high quality. The current status of mental healthcare is unacceptable and, overall, services in the state are subpar. In 2009, the National Alliance on Mental Health (NAMI) produced a report card for each state grading them on four categories. The following chart indicates Texas' scores:

FIGURE 1.1: 2009 TEXAS' CATEGORY GRADES[1]

CATEGORY	GRADE
I. Health Promotion & Measurement	F
II. Financing& Core Treatment/ Recovery Services	D
III. Consumer and Family Empowerment	F
IV. Community Integration & Social Inclusion	D

In 2009, the overall grade for the state was a D whereas in 2006, under the same NAMI parameters, the overall state grade was a C.[2] NAMI's reports indicate the dire need for change in the state of Texas as quality is deteriorating. Furthermore, a recent study conducted by the Henry J. Kaiser Family Foundation in 2010 indicates that the state of Texas ranks 49 out of 50 in regards to its mental health spending per capita, reporting that Texas spent $39 per person in regards to mental health whereas the national average was $121 per person on mental health.[3] Unfortunately, funding for hospital and community based services has not just stagnated; it has steadily declined since 2003.[4] Distressingly,

[1] "Grading the States 2009: A Report On America's Health Care System for Adults with Serious Mental Illness from the National Alliance on Mental Illness." The state of public mental health services across the Nation. (n.d.). 27 Sept. 2013. <http://www.nami.org/gtsTemplate09.cfm?Section=Findings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75255>.

[2] "Grading the States 2009: A Report On America's Health Care System for Adults with Serious Mental Illness from the National Alliance on Mental Illness." The state of public mental health services across the Nation. (n.d.). 27 Sept. 2013. <http://www.nami.org/gtsTemplate09.cfm?Section=Findings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75255>.

[3] "State Health Facts." State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures . (n.d.). 27 Sept. 2013. <http://kff.org/other/state-indicator/smha-expenditures-per-capita/>.

[4] "State Health Facts." State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures . (n.d.). 27 Sept. 2013. <http://kff.org/other/state-indicator/smha-expenditures-per-capita/>.

legislative polls and proposals for the Texas budget indicate no significant movement towards change or redress of these facts; in truth, departments have been warned that funding in mental health may be cut.

As further cause for alarm, in regards to state population, Texas ranks second.[5] It is one of the fastest growing states, having experienced a population increase of over 12.7 percent since 2010, with Texas population experts projecting the state's population to increase by 71.5 percent between 2000 and 2040.[6] Nonetheless, the same pool of resources is expected to service an ever-expanding pool of individuals. As Leslie Secrest, chairman of the department of psychiatry at Texas Health Presbyterian Hospital in Dallas, explains:

> "If you're growing at 1,200 people a day coming into Texas, then in three years, you've added more than 1 million people… You continue to add people who need mental health services, and yet you're not increasing funding, so your resources have to be spread further and thinner."[7]

This lack of funding, and consequently services, is not constrained to just some areas of Texas. In fact, in 2010, 194 of 254, or 76 percent of Texas counties were wholly designated as areas of mental health shortages and dozens of counties were partially

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[5] States ranked by size & population. (n.d.). *ipl2: Stately Knowledge: Facts About the United States*. 21 Oct. 2013. <http://www.ipl.org/div/stateknow/popchart.html>.

[6] "Demographics- Texas In Focus. (n.d.)." Windows on State Government. 22 Oct. 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

[7] Garret, R. "Texas mental health care funding has stagnated, even as calls to boost efforts grow." (2013, February 11). The Dallas Morning News. 15 Sept. 2013. < http://www.dallasnews.com/news/politics/state-politics/20130211-texas-mental-health-care-funding-has-stagnated-even-as-calls-to-boost-efforts-grow.ece>.

[7] "ipl2: Stately knowledge: facts about the United States" States ranked by size & population. (n.d.). ipl.org, 21 Oct. 2013 <http://www.ipl.org/div/stateknow/popchart.html>.

designated.[8] The majority of Texas residents are subject to long waitlists for mental healthcare and even then, certain sectors of the population may not receive quality healthcare that meets their needs.

Vulnerable Populations

While all citizens are at risk of poor mental health, certain populations are most susceptible to the downfalls of the mental health care system. Such sectors of the general population are referred to as vulnerable populations (VPs). Because VPs present a multi-dimensional issue, it is particularly important to pay attention to these cases. The most prudent methodology of examining the mental health crisis in Texas examines the problem at its most severe and defines it holistically. Accordingly focusing on the reasons why certain populations are vulnerable will help us address their mental health care needs and, in turn, improve the distribution of quality mental health care for all.

The mental health sector is somewhat aware of the existence of vulnerable populations. However, many challenges exist in targeting VPs needs, primarily through professional development, and monetary resources, as vulnerable populations often require specialized programs. A more fundamental problem lies in informatics based on difficulties in defining and categorizing VPs. Efforts have been made to categorize them by disease, age, demographic, and even race. Yet these attempts are often not inclusive of multiple risks and disparities in social capital. An increased amount of effort has been

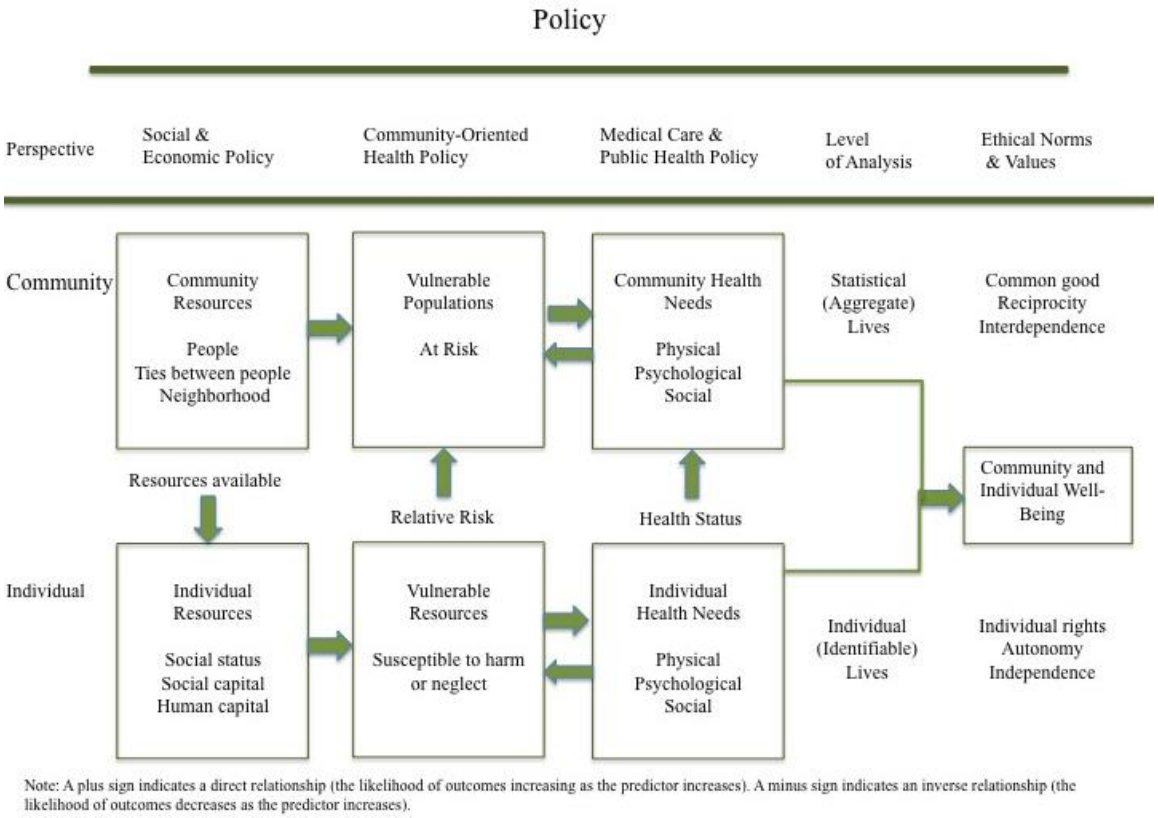
[8] "The Texas Health Care Primer. (n.d.)." CPPP Libary. Center for Public Policy Priorities. 1 Oct. 2013. <http://library.cppp.org/files/3/TxHlthPrimer_2011_Side_by_Side.pdf>.

made as recent as 2010 to address these issues with a focus on the systematization of categorization.

Primarily, this methodological categorization has been centered upon measuring the principle of relative risk. As defined by Lu Ann Aday, author of *At Risk in America; the Health and Health Care Needs of Vulnerable Populations in the United States*, "Underlying this definition of vulnerability is the epidemiological concept of risk, in the sense that there is a nonzero probability that an individual will become ill within a stated period of time." While we are all potentially at risk of poor health, those with high relative risk have an increased probability of occurrence of health related outcome when compared to the rest of the population's ration of risk, due to certain personal (internal) and societal (external) factors.[9] Figure 1.2 outlines the complex interactions between vulnerable populations, the general community, and policy. Note that while policy issues will be examined in the following sections and chapters, this section will concentrate on the general and theoretical factors regarding relative risk.

[9] Aday, L. A. "At risk in America the health and health care needs of vulnerable populations in the United States" (2nd ed.). (2001). San Francisco: Jossey-Bass Publishers.

FIGURE 1.2: FRAMEWORK FOR STUDYING VULNERABLE POPULATIONS[10]



Note: A plus sign indicates a direct relationship (the likelihood of outcomes increasing as the predictor increases). A minus sign indicates an inverse relationship (the likelihood of outcomes decreases as the predictor increases).

Relative risk is the defining factor for vulnerable populations and impacted by many different aspects of society. In order for our discussion to approach the immense topic of risk, the three A's will serve as a framework: accessibility, acceptability and availability. Accessibility deals with conditions and factors influencing an individual's access to quality mental health care. Usually, these deal with tangible infrastructure, with infrastructure including not only the traditional reference to roads, but also the nontraditional elements of the mental health system such as insurance. A population's accessibility is closely intertwined with its social status. Public works and services vary

[10] Aday, L. A. "At risk in America the health and health care needs of vulnerable populations in the United States" (2nd ed.). (2001). San Francisco: Jossey-Bass Publishers.

in quality across the state. Population's that have high political representation and plentiful monetary resources tend to receive better state services in their area. Focusing on accessibility with an emphasis on social status and its implications will illuminate obstacles to mental health care.

Complementary to this focus on accessibility is the inclusion of acceptability. Acceptability speaks to how open a society is to mental health care. Unique and detrimental to mental health care acceptability is the pervasiveness of stigma. Stigma, disapproval or a mark of extreme distaste, radiates from within an individual and those around him. Stigma relates to social capital as an individual's social capital diminishes if he participates in activities, or in our case treatments, stigmatized by his society. While reasons for stigma may vary throughout populations, vulnerable populations face high stigma against mental health care. This lack of acceptability creates a barrier for receiving care. Additionally, availability poses a formidable barrier for care in vulnerable populations. Availability relates to whether or not services are available to an individual. Reasons for lack of availability vary; however they are overwhelming based on a lack of mental health care professional development. When there is a shortage of competent professionals, quality and quantity of services available decreases as well. Figure 1.3 compares the relative risk for populations in regards to social status, as well as social and human capital and serves as a summary for our analysis of correlation between relative risk and vulnerable populations. As we can see, every population may face a sort of relative risk, but when these risks are compounded, vulnerable populations come into existence.

FIGURE 1.3: COMPARISON OF RELATIVE RISK[11]

Community and Individual Resources	Higher Risk	Lower Risk
The people: Social Status		
Age	Infants Children Adolescents Elderly	Working-age adults
Gender	Females	Males
Race and Ethnicity	African Americans Hispanics Native Americans Asian Americans	Whites
The ties between people: Social capital		
Family Structure	Living alone Female head	Extended families Two-parent families
Marital Status	Single Separated Divorced Widowed	Married, mingles
Voluntary Organizations	Nonmember	Member
Social Networks	Weak	Strong
The neighborhood: Human capital		
Schools	Less than high school	High school or beyond
Jobs	Unemployed Blue collar	White collar
Income	Poor Low income	Middle income High income
Housing	Substandard	Adequate or better

Note: "Mingles refers to individuals who are not married but are living with a sexual partner. Voluntary organizations include churches, volunteer interest groups, and civic and neighborhood organizations."

Mental Health Matters

Why is mental health the specific target of this analysis? Mental health care is infamous for obstacles in accessibility, acceptability, and availability. These struggles are present throughout history and even today. Through an overview of federal level policies, in conjunction with Texas policies, the overall complexity of present day Texan mental

[11] Aday, L. A. "At risk in America the health and health care needs of vulnerable populations in the United States" (2nd ed.). (2001). San Francisco: Jossey-Bass Publishers.

health care policies will be illuminated. Additionally, statistics regarding mental health in our society will also help drive the point of prioritizing quality mental health care.

Prior to the 20th century, there were many advocates for mental health. Chief among them was Dorthea Dix, an American activist for the poor and mentally ill. Through vigorous lobbing with state and federal legislatures, her efforts created the first wave of American mental asylums during the 1840s and 1860s.[12] Eventually these reforms would reach the state of Texas. The Sixth Legislature established the first Texan facility exclusively for the mentally ill, a lunatic asylum, in 1856. For the rest of the 19th century and throughout the early 20th century, the nation as well as Texas relied on institutions, private hospitals, prisons, and sanitariums as the primary source of "care" for the mentally ill. In regards to the youth, the first recorded private hospital in the state of Texas for children was founded in 1906. Run by Dr. Margaret Holiday, an assistant superintendent in the state system, the hospital operated twenty-five beds in Austin until 1912. As with most facilities around the country, such hospitals could only be found in areas of dense population.

However, unlike other states, Texas' mental health care system had a considerable advantage. The Texan mental health system extended beyond the capital urban area through the development of psychiatry as a specialty in the Texas' medical schools. Psychiatry became integrated into the core curriculum of the universities and in non-academic settings, so much so that for years the University of Texas branches enrolled

[12] "Dorothea Lynde Dix." (n.d.). History.com. 21 Oct. 2013. <http://www.history.com/topics/dorothea-lynde-dix>.

the largest percentage of medical graduates in psychiatry than any school nationally.[13] Thus began the relationship between the government, research centers, and universities still in existence today. Texas' deinstitutionalization movement benefited from the move to incorporate psychiatry into the medical field.

While Texas experienced progression in mental health, the 1950s provided a startling and concerning reality check. During this time, the United States Public Health Service reported a critical need for mental health clinics. Along with this report came the fact that no other state fell as far below the American Psychiatry Association standards as Texas.[14] As a result, a series of reforms began in the Texas' legislature to change the administrative structure. These efforts extended until the 1960s and were complimented by federal government reforms.

Federal legislation in the 1960s significantly impacted the logistical approach each state government utilized in the administration of its mental health. Under President John F. Kennedy's administration, legislation primarily focusing on mental retardation passed into law. President Kennedy also formalized the inclusion of community health centers into federal programs through legislation. One benefit of this inclusion was that urban patients would no longer be shipped to geographically isolated locations for treatment.[15] Such inclusion signified a federal prioritization of mental illness that would

[13] Creson, D. "MENTAL HEALTH." (n.d.). Handbook of Texas online. 7 Sept. 2013. <http://www.tshaonline.org/handbook/online/articles/smmun>.

[14] Creson, D. "MENTAL HEALTH." (n.d.). Handbook of Texas online. 7 Sept. 2013. <http://www.tshaonline.org/handbook/online/articles/smmun>.

[15] "Kennedy's vision for mental health never realized." The Associated Press (2013, October 20). USA Today. 22 Oct. 2013. <http://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>.

trickle down to the state level. Texas began prioritizing the development of a statewide plan for mental health services. With key emphasis placed on the state's creation of community health centers, many are still in existence today. However, these and other state initiatives lacked a stable stream of funding, therefore failing to reach their full potential for reform in the 1960s.

In the 1970s, disillusionment with mental health system continued and hit an all time high. The legitimacy of the overall mental health systems within the United States faced serious questioning. Throughout the decade, the *Diagnostic and Statistical Manual of Mental Disorders* underwent revision with strict orders to address the uniformity and validity of diagnosing mental health problems. There had been tremendous pressure from activists to focus on such revisions and the movement found encouragement from the scientific community. Foremost among the activists, psychologist David Rosenhan, published "On Being Sane in an Insane Place" in 1974, a study using pseudopatients that concluded that psychiatric facilities could not accurately distinguish the sane from the insane.[16] Together these accelerated the movement to organize and standardize the quality of mental health systems.

As mental health continued to push forward, Georgia's First Lady, Rosalynn Carter spearheaded national reforms and served as a vital catalyst for government action. Previously, Mrs. Carter had become aware of the urgency of the problem as increasing numbers of people approached her inquiring as to what her husband would do to help their rural relatives with mental illness during his 1970 campaign tour for governor of

[16] Rosenhan, David, "The Rosenhan Study: On Being Sane in Insane Places," Science, 179, no. 4070 (1973): 250-258.

Georgia. Throughout her term as First Lady of Georgia, Mrs. Carter served as a volunteer at an Atlanta hospital with a mental health ward, a position that allowed her to speak to the urgency of reform. Working in tandem with Governor Carter, and the Georgia state legislature, Mrs. Carter helped the state prioritize mental health reform and established high quality services in the state.[17]

This commitment to mental health reform continued into President Carter's 1977-1980 presidential term. By Executive Order, President Carter created the Presidential Commission on Mental Health (PCMH), appointing Rosalynn as Honorary Chairperson. The PCMH took up the task of producing a report on the status of mental health of the nation. As the Commission developed this report, they noted with alarm the lack of proactive leadership in developing mental health legislation. Hence, the PCMH began formulating plans for an act that would address the restructuring of government mental health systems, legitimize their services, and provide quality patient-centered health care.[18]

Chair of the PCMH, John W Gardner, former secretary of the US Department of Health, Education, and Welfare, proved instrumental in pushing for government services reformulation. Gardner, as the founder of Common Cause, a non-partisan, not-for-profit lobbying organization promoting government accountability, advocated for organization and accountability through synthesis of government institutions and financial prudence. A major testament of their work is highlighted by the fact that the Mental Health System

[17] "First Lady Biography: Rosalynn Carter." National First Ladies' Library. 29 Sept. 2013 .< http://www.firstladies.org/biographies/firstladies.aspx?biography=40>.
[18] Grob, Gerald. "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health." Milbank Quarterly . no. 3 (2005): 425–456. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690151/>.

Act (MHSA) continued allotment of categorical grants from previous legislations. In addition, ten new categorical grant programs developed to increase inclusivity and create a deliberate focus on minority populations. The extension of these grants, focusing on addressing the criticism that earlier legislation, did not extend services or make direct financial provisions for all.[19]

Due to the failure of previous legislation to focus on targeting VPs and the need for the MHSA to address this deficiency, the Act ultimately proved to be convoluted. Those involved in the final passing of the legislation defended the Act by pointing out that such complexities were inevitable and that "to make it through the congressional gauntlet, the legislation 'had to give a little something to everyone and as a result became unusually complex'".[20] Regardless of legislative complexities, President Carter stood steadfast in his goal to tailor services. His stance stemmed from the fact that past community-based care "was constantly stripped of its full potential by inflexible program models designed for the 'average' community, rather than for the particular needs of a given local or state".[21] In 1980, President Carter saw his dedication pay off when he signed into law the Mental Health Systems Act. This piece of legislation focused on vulnerable populations, defining their needs, and constructing appropriate programs. As a notable policy shift, community advocates changed the Act's focus from mental illness to

[19] Grob, Gerald. "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health." Milbank Quarterly . no. 3 (2005): 425–456. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690151/>.

[20] Grob, Gerald. "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health." Milbank Quarterly . no. 3 (2005): 425–456. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690151/>.

[21] "Mental Health Systems Legislation Message to the Congress Transmitting the Proposed Legislation ." The American Presidency Project. 1 Oct.2013. < http://www.presidency.ucsb.edu/ws/?pid=32339>.

mental health, a word choice indicative of new attitudes regarding mental health. With this switch in terminology and attitude, the Act took on a greater proactive role than before and generated greater inclusivity of minorities while simultaneously diminishing the roles of stigmatization, poverty, and racial and ethnic discrimination historically rampant in mental health systems.

While progression occurred, problem of the complexities implicated by federal bureaucracy and implementing the MHSA lingered. This would not be directly addressed until the Reagan administration opted to switch from categorical grants to block grants as the primary source of funding for systems and dissolve the in-depth federal involvement at local levels.[22] The Reagan administration did this by repealing the MHSA shortly after President Ronald Reagan began his term. In Texas, this shift in the distribution of grants caused tensions to rise as the ambiguous funding made room for conflicting agendas between the federal, state, and local agendas.

Additionally, conflicts arose between those providing services. In Texas, the certification of social workers and licensed professional counselors occurred in 1981, not only increasing availability of mental health services but also the market competition among them.[23] Interestingly, these problems arose amongst the majority of states. The 1980s witnessed a rise in violent crimes noted by statistical studies in California and New York. Three high-profile cases stood out: the assassination of Congressman Allard Lowenstein and John Lennon, as well as the shooting of President Reagan. Untreated

[22] David, Mechanic. "Mental Health Services Then And Now." Health Affairs. Last modified 2009. 29 Sept. 2013.< http://content.healthaffairs.org/content/26/6/1548.full>.

[23] Creson, D. (n.d.). "MENTAL HEALTH." Handbook of Texas online. 7 Sept. 2013. <http://www.tshaonline.org/handbook/online/articles/smmun>.

schizophrenia proved to be a link that connected the three perpetrators who committed each crime.[24] The deinstitutionalization movement, while well intentioned, did not completely account for the necessity of expanding community sources of care. Homeless shelters, delinquency centers, and prisons became the primary caregivers for thousands of individuals. Nevertheless, resurgence in commitment to the treatment of mental illness failed to emerge.

Fast-forward to present day and similar issues are commonplace. President Barack Obama's administration has focused on increasing accessibility of mental health care services by addressing the issue of health insurance. In 2008, President Obama signed the Mental Health Parity and Addiction Equity Act into law. The Act was primarily formulated to fill in the loopholes of the 1996 Mental Health Parity Act. It requires health insurance to cover physical and mental health equally and extends federal consumer protection laws regarding mental health services to 82 million Americans unprotected by state laws.[25] Additionally, the 2010 Affordable Care Act encourages research into the genetic causes of mental illness and pending articles will increase insurer coverage of mental health services. The Affordable Care Act, though not solely dedicated to mental health care, seeks to increase access to vulnerable populations by integrating them into the health care system through initiatives such as the expansion of subsidies to low-income families. Considering how recent the Act is, it is yet to be seen

[24] Torrey, E.. "Ronald Reagan's shameful legacy: Violence, the homeless, mental illness ." SALON RSS. Salon Media Group, 27 Sept. 2013. <http://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness/>.

[25] "Mental Health Parity and Addiction Equity Act." (n.d.). American Psychological Association (APA). 24 Oct. 2013. <http://www.apa.org/helpcenter/parity-law.aspx?item=2>.

how it will translate into practice, affect access to mental health services and how Texas will respond.[26]

Texas faces the challenge of integrating such federal policies into its state mental health care system. Demographics pose a unique challenge as Texas boasts the nation's largest rural population, contains one of the largest youth populations, and provides a case study of majority-minority populations. With this in mind, the state of Texas must pay special attention to the unique dynamics of the population in order to formulate the best policies and practices for its constituents.

The prevalence of mental illness alone makes a compelling case for prioritizing mental health care. Nationally, in a given year, one in four adults experiences a diagnosable mental illness. Moreover, almost half of all adults in the United States, 46.4 percent, will have a diagnosable mental health condition in their lifetime. Benefits of extending quality mental health services and achieving mental wellness lie beyond the obvious benefits of avoided medical costs.[27] The economic cost of mental illness goes beyond the cost of care. The majority of mental illness related costs are due to the loss of income because of unemployment and expenses for social support. The 2011 World Health Organization's report on non-communicable diseases related mental illnesses as the leading causes of disability adjusted for life years worldwide.[28] Likewise, World

[26] Conaboy, C. (2013, October 23). "US 'on the cusp' of mental health advances, Biden says." Boston Globe. 25 Oct. 2013. < http://www.bostonglobe.com/metro/2013/10/23/biden-and-sebelius-attend-jfk-library-gala-outraging-republicans/qtAKx6Ac9cnaepUhMTv0bP/story.html>.

[27]"CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

[28] "Global status report on non-communicable diseases 2010." World Health Organization. (WHO 2011a). Geneva: WHO.

Economic Forum estimates that enormity of mental illness costs by calculating the global costs of mental illness to be nearly $2.5 trillion in 2010. [29] In Houston alone, as of 2011, $5.6 billion in earnings are lost annually due to severe mental illness.[30] Beyond the social and health benefits, achieving mental wellness matters from an economic perspective.

Policy Proposal

MONEYBALL

To optimally use state resources, mental health care programs must be subject to an intense cost-benefit analysis on a social and economic level. By conducting policies in this way, we ensure that state resources are being spent wisely and servicing as many constituents as possible. Using moneyball formulas allows the state government to achieve this and provide quality services in times of fiscal scarcity. Currently, the government spends funds blindly and without guarantee that funds are going to sectors with the deepest need. According to rough calculations, less than $1 out over every $100 of federal government spending is backed by even the most basic evidence that such

[29] Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, Feigl AB, Gaziano T, Mowafi M, Pandya A, Prettner K, Rosenberg L, Seligman B, Stein A, Weinstein, C. "The Global Economic Burden of Non-communicable Diseases." (2011). Geneva: World Economic Forum.

[30]CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

funds are being spent wisely, with states facing similar obstacles.[31] Applying moneyball strategies would remediate this problem.

Moneyball in government advocates for the prudent stewardship of resources through data-driven policies. The term moneyball has its roots in baseball where scouts' traditional beliefs, hunches, and biases once determined what players would make up a team. It was not until the Oakland Athletics team, faced with a substantial decrease in their budget, $40 million to spend on players in 2002 compared to the Yankee $125 million, that an intense study of what skills actually contributed to winning was undertaken. Oakland's systematic application of data signified a dethronement of established tradition and was considered a gutsy move. It paid off as the Oakland A's set records and experienced a notable winning streak.

Texas can learn from the A's experience. "When compared to other developed countries, America is like the Yankees in terms of payroll — only without the 27 championships."[32] Other developed countries do more with less money because policies are founded on a study of demographics and best practices. The transition into data-driven policy should be something simple to accept. Other types of American enterprises have established intensive studies to yield sophisticated policy-making decisions. Whereas much of public policy is led by partisan politics, hunches, and personal relationships, moneyball allows for less tolerance of these rudimentary tactics.

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[31] Bridgeland, John. "Can Government Play Moneyball?." The Atlantic. Atlantic Media Company, 19 June 2013. Web. 9 Jan. 2014. <http://www.theatlantic.com/magazine/archive/2013/07/can-government-play-moneyball/309389/>.

[32] "Guest Post: Why American Medicine Needs A Moneyball Moment." CommonHealth RSS. N.p., n.d. Web. 15 Dec. 2013. <http://commonhealth.wbur.org/2011/12/medicine-moneyball>.

In regards to Texas' mental health care, applying moneyball strategies may range from fine-tuning methods for collection of data on vulnerable populations to eliminating archaic, expensive treatments. Evidence suggests that vulnerable populations are set to gain the most from this as, expensive treatments can be swapped for cheaper, yet equally as effective, treatments. Not only do treatments become cheaper, but also better outcomes are achieved for the patient. Texas has much to gain beyond the mental health care sphere as the Institute of Health estimates that nationally, more than half of treatments provided to patients lack clear evidence that they are effective.[33] The mental health care sector is the perfect policy arena to begin the application of moneyball.

The evolution of the mental health care system is a continuous learning process, recognizing that, while change is necessary, prudent change is best. Results for America, a non-partisan campaign to encourage moneyball in policies serves, as an example of what Texas should do. The City of San Antonio is a founding member and is beginning to transform many of their policies due to data. The campaign advocates that gathering information is the first step to prudent policy. In the face of increasing information, policy-makers will find it hard to ignore such data and policies will fall subject to strict scrutiny. The Texas legislature is highly influential on the national scale and such a change within a large state would encourage others to do the same. It is clear that Texas has the opportunity for change.

[33] "Can cost-effective health care = better health care?." HSPH News. N.p., n.d. Web. 16 Dec. 2013. <http://www.hsph.harvard.edu/news/magazine/winter10assessment/>.

PROFESSIONAL DEVELOPMENT

The second aspect of policy this analysis focuses on is professional development in the mental health care system. For quality care to be provided, having a complete and competent staff is key. In mental health care services, barriers to recruitment and retention, as well as to cultural and linguistic diversity, are major factors contributing to the crisis in professional development. Policy recommendations will seek to provide alternate solutions to overcoming these barriers within the context of vulnerable populations.

Texas struggles with respect to availability because of the lack of mental health professionals. Not only are there currently enough professionals, but at the present time the aging workforce and the lack of training and recruitment opportunities further exacerbate the issue. An aging workforce (Figure 1.4) means greater numbers of professionals will be retiring in the coming years; consequently, Texas will soon lose many mental health care providers soon.

FIGURE 1.4 AGING MENTAL HEALTH WORKFORCE IN TEXAS[34]

Mental Health Professional	**Median Age Male**	**Median Age Female**
Psychiatrists	57	50
Licensed Chemical Dependency Counselors	53	50
Social Workers	54	47

[34]CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

Simultaneously, Texas struggles to train and recruit new professionals. The number of counselors, psychiatric nurses, family therapists, and psychiatry residents has steadily declined. With one reason being that such individuals are unaware of the opportunities and benefits of pursuing a career in the mental health care system. For example, many have unfounded perceptions of the system, believing it to be lower paying than other health professions or lacking professional support. However, some perceptions, such as the shortage of internship sites for psychology graduate students and reduced funding for psychiatric residencies in state facilities, are factually based.[35]

In areas where there are mental health professionals, cultural and linguistic diversity is low. Considering Texas has a large minority population whose individuals rely on a language other than English as their primary means of communication, this diversity deficit is a barrier to accessibility of care. In mental health services, English terminology can be highly technical from the diagnosis to the treatment stage leading to the marginalization of those who are not proficient in the language. Additionally, some mental illnesses require social and cultural context. Without cultural competency in diagnostics and treatment, individuals will go without the necessary level of care for mental wellness. Creating a culturally and linguistically diverse environment may be promoted by increasing the minority representation among mental health professionals and by increasing the cultural and linguistic literacy of the entire mental health workforce. In turn, professional development that is sensitive to different cultures could help combat stigma among patients and their families as well as increase health literacy

[35]CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

for minorities. Policies endorsing such an approach include programs increasing the minority representation in higher education and establishing cultural competency training of mental health care employees. The need for these policies becomes increasingly urgent as minority populations grow.

CHAPTER TWO

Rural Populations

This chapter focuses on rural populations, one of the unique demographics that sets Texas apart from other states, and seeks to prove that rural populations are a vulnerable population for which specially tailored programs need to be prioritized. To fully understand this component, this topic is broken down into three major segments. First, we will look at the overall picture, which includes the definition of rural populations and this population's mental health status. Second, we will examine elements of the rural population's vulnerability, including a discussion on the risks they face. Third, we will analyze certain policies and programs that have been implemented to provide services to this population. Finally, recommendations for future policy focuses will be outlined based on the information presented.

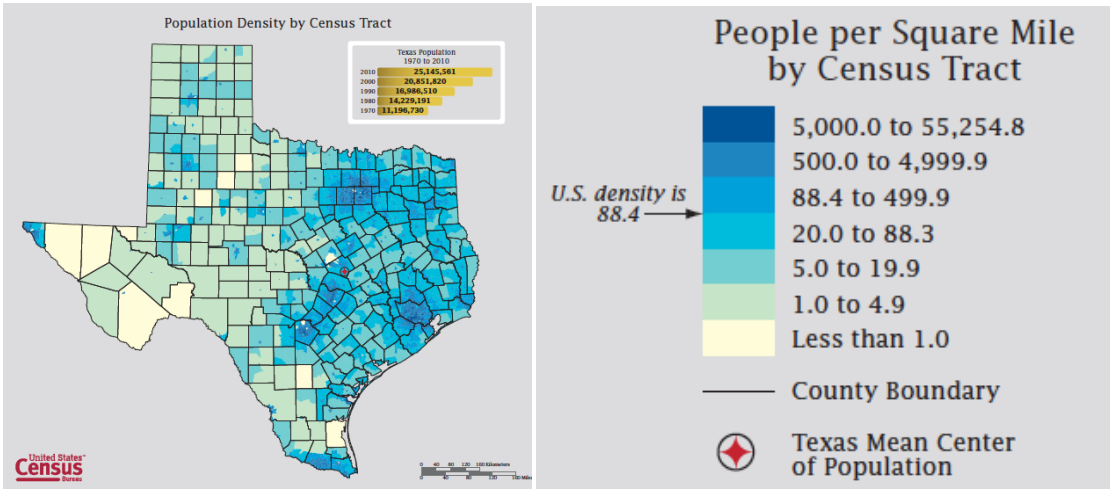
Demographics

DEFINITION OF RURAL POPULATION

Two federal agencies, the United States Census Bureau and the Office of Management and Budget, set the definition of rural populations at least every ten years with a new census. According to the 2010 census, 'rural' is defined as anything outside an urban area and an 'urban area' is defined as an area of census blocks with a population density of 1,000 people or more per square mile combined with surrounding census

blocks with densities of at least 500 people per square mile.[1] Based on these definitions, Texas' 2010 rural population was 3,847,522 or 15.3 percent of its total population. The significance of this statistic is that, in a state-to-state comparison, Texas has the largest overall rural population in the country. To put this into perspective, Texas' rural population is equal to or greater than, the resident population of twenty-four other individual states.[2] Consequently, Texas' mental health care system faces a particularly pressing challenge to create policies tailored to the rural population.

FIGURE 2.1 TEXAS' RURAL POPULATION[3]



[1]Texas Ahead. United States. U.S. Census Bureau. Rural Texas: A Snapshot. Web. <http://www.texasahead.org/map/rural_areas.php>.

[2]United States. U.S. Census Bureau. Urban and Rural Population by States: 2010. Web. <http://www.census.gov/geo/www/ua/2010urbanruralclass.html>.

[3]United . U.S. Census Bureau. 2010 Census: Texas Profile. Web. <http://txsdc.utsa.edu/Data/Decennial/2010/SF1/2010_Profile_Map_Texas.pdf>.

GENERAL HEALTH

While the immense size of Texas' population alone should make rural populations the target of special policies and initiatives, the fact that this population's poor general and mental health attests to a noticeable failure. Compared to their urban counterparts, rural residents are statistically more likely to have chronic health problems and a poorer health status. Rural residents experience higher rates of infant mortality, morbidity, and higher proportions of vulnerable residents (primarily children and elderly). An important feature shared by these rating categories is that each requires more health services.[4] More specifically, in regards to mental health, though studies overall denote comparable prevalence and incidence percentages of behavioral health problems in rural and urban areas, in 2005 the US Department of Health found that substance abuse and suicide rates among adults and children are alarming exceptions. Additionally, in comparison to their urban counterparts, rural rates of depression far exceed the population ratio.[5] To begin exploring the reason for these disparities, challenges particular to the rural situation as well as relative risks associated to their vulnerability must be discussed.

[4]Non-Profit Organization. National Rural Health Association. Workforce Series: Rural Behavioral Health. Web.

[5]Bain, Steve F, Breeze Rueda, Jennifer Mata-Villarreal, and Marie-Anne Mundy. " Assessing mental health needs of rural schools in South Texas: Counselors' perspectives." Research in Higher Education Journal . n. page. Web. 17 Dec. 2013. <http://www.aabri.com/manuscripts/11998.pdf>.

Relative Risk: The 3 A's

ACCESSIBILITY: ROLE OF INFRASTRUCTURE

Historically, compared to urban populations, rural communities have struggled to gain access to quality state services. These struggles have come as a result of the innate qualities of rural populations, and are also due to political and economic struggles. For example, in terms of mental healthcare, most new technologies, medications, and strategies have first been integrated or dispersed in urban centers. Occasionally, these treatments sometimes find their way to rural communities, but such instances are rare. Urban centers have been the focus of policies and initiatives because services are used by a larger number of citizens and are funded by a larger tax base. Whereas rural populations lack political power, the urban tax base and political representation allows for renovation and innovation in the mental health sector. Even today, the quality of amenities and public services in rural areas are, more often than not, inadequate. Partially, this is due to the fact that rural populations, on average, maintain lower per capita incomes, higher poverty rates, and lower education levels than urban counterparts. In correlation to this, rural residents under the age of 65 are also more likely to be underinsured or uninsured in comparison with their urban equivalents.[6] Such factors act as barriers to health care, increasing the vulnerability of rural residents.

To some extent these factors are due to the decentralized nature of rural communities. By definition, rural communities are small and remote making it difficult

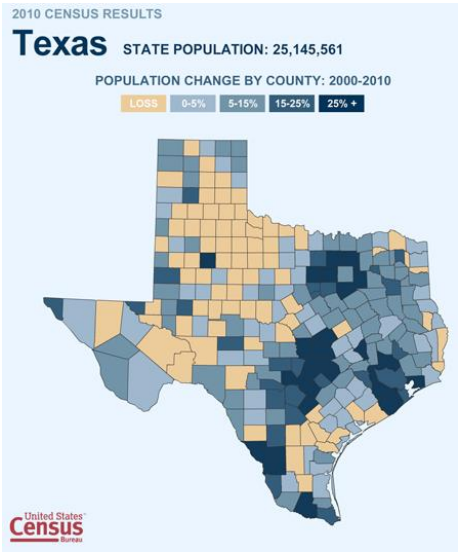
[6]Theodori, Gene L, and Cheryl L Hudec . "The 2012 Texas Rural Survey: Perceptions of Rural and Urban Living ." Center for Rural Studies: Research and Outreach. (2012): n. page. Web. 17 Dec. 2013. <http://www.shsu.edu/~org_crs/TRS/TRS 2012 Perceptions of Rural and Urban Living.pdf>.

for advocacy groups, medical services, and insurance companies to reach all residents. These obstacles inhibiting accessibility, as well as most being faced by rural populations, are rooted in infrastructure. While urban centers are synonymous with highways and paved streets in Texas, rural populations are notorious for having less public transportation, challenging roads, and being situated in extreme environments. Rural communities are geographically alienated; consequently, the infrastructure is used less than in urban areas. For example, roads in rural areas may be expansive and traveled less. Among the many reasons for this reduced usage is that rural institutions, like farms and ranches, function more as independent, self-sustainable units and do not require the transportation systems necessary to support an urban center. These facts explain the decreased population density that defines rural populations. Current challenges are threatening to further aggravate the obstacles already faced by the rural populations.

The social and economic fabric of rural areas suffers due to urbanization more so now than in any time in the past century. Increasingly, urbanization continues to change demographics, spatial organizations, and extracts an economic toll. As more people move to urban areas, the dwindling population leaves a shrinking tax base that may make infrastructure upkeep and improvements difficult, while creating political hindrances for rural regions as voters transfer districts.[7] Additionally, as the population becomes less dense, health care centers may shut their doors and patients will have to travel greater distances to seek care.

[7]Texas. Window on State Government: Texas Comptroller of Public Accounts. Texas in Focus: A Statewide View of Opportunities; Demographics. Web. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

FIGURE 2.2 POPULATION CHANGES[8]



ACCEPTABILITY: REGIONAL STIGMA

For remote communities with distinct features, rural populations can only be expected to develop a unique set of cultural values. More often than not, these translate into stigma, barriers to accessible mental health care, increasing the vulnerability of the rural population. While such distinct mindsets and feelings of community may be characteristic of some urban neighborhoods, these are traits of entire communities in rural settings. Studies have found that such distinctions based upon an individual's religion, community, and personal values affect their health care decisions much more significantly in rural settings.[9]

[8]Texas Ahead. United States. U.S. Census Bureau. Rural Texas: A Snapshot. Web. <http://www.texasahead.org/map/rural_areas.php>.

[9]Non-Profit Organization. National Rural Health Association. Workforce Series: Rural Behavioral Health. Web.

Rural communities, because of their remote setting and traditional culture, value self-reliance, self-care, and strong work ethic. As a result, these communities often display distinctive perceptions of health, care, and illness. These values impact health care decisions, as many are more likely to seek care through neighbors, families, churches, and community groups. However, many residents hesitate to seek care because of stigmas that label those who do as weak, dependent, and even crazy. Moreover, residents live in small communities where everyone knows everyone, which heightens stigmas. Patients become overly self-aware and afraid that someone will recognize their vehicle parked outside the mental health care provider's office. This stems from a fear of being labeled or even marginalized from their community. Pervasive stigmas continue as patients hesitate to disclose information, a habit rooted in a distrust of providers or in the general mental health care system. This is related to the fact that rural patients are often transferred to urban facilities to receive care unavailable in their region. Such distaste for the mental health sector is based on the idea that patients will have to move away from their family and support group, acclimate to a different city lifestyle and setting, as well as pay for the move. Such factors heighten stigmas and hinder those seeking treatment.

AVAILABILITY: LACK OF MENTAL HELATH PROFESSIONALS

Barriers to rural mental health go beyond the consumer and are evident in providers of mental health services. Rural mental health centers struggle to keep up with consumer demand due to a lack of professionals and funding. Appallingly, Texas ranks far below the national average of mental health professionals per 100,00 residents and in 2009, 173, or 68 percent of Texas counties, were designated as mental health profession

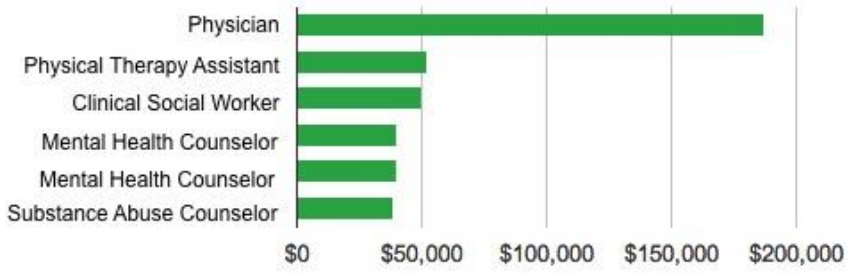
shortage areas.[10] Compounding this issue, in 2009 there were forty Texas counties that failed to report a single social worker. Rural counties are most affected by this challenge, primarily because such shortages are commonplace.

This then leads to an obvious question: why is there a shortage of mental health professionals? The answer to this is complicated, but is primarily rooted in the struggles inherent in attracting professionals to the field. First, an average mental health professional receives less pay and a smaller financial base, especially in Texas. The evidence for this is displayed in Figure 2.3, which shows that mental health professionals, in comparison to other health care jobs, earn wages on the lower end of the pay scale. With non-competitive wages, the mental health care sector struggles to retain laborers and attract new recruits. This is further aggravated by the fact that in a simple comparison of average wages, urban health care workers earn more. In addition to monetary compensation, research has shown that professional isolation, less control over hours as well as access to amenities, and fewer spousal job opportunities are concerns as professionals consider rural job placement.[11] Said factors further sway practitioners and professionals away from employment openings in the rural mental health care system.

[10]"Hogg Foundation Awards Scholarships to Graduate Social Work Students in Texas." Hogg Foundation of Mental Health. N.p., 12 Jul 2011. Web. 5 Dec 2013. <http://www.hogg.utexas.edu/detail/214/ima_hogg_scholars_ 2011.html>.

[11] National Rural Health Association, Issue Paper 13, "Physician Recruitment and Retention," November 1998, Kansas City, Mo., available a t*www.nrharural.org/dc/issuepapers/ipaper13.html*.

FIGURE 2.3 COMPARISON OF PAY[12]



Second, the amount of work health care professionals do in rural communities is greater. Rural primary care physicians typically work about ten percent more hours a week than urban counterparts and are estimated to carry a significantly larger on-call burden.[13] Although these statistics are for physicians, inferences drawing similar conclusions are applicable to mental health care professionals. The work of a mental health care professional is arduous in hours and commitment; this lends itself to disproportional financial compensation.

A third factor decreasing incentives for rural mental health professionals is the higher proportion of patients covered by Medicaid or Medicare in rural areas, fifty-six percent in rural practices compared to forty-five percent in urban practices.[14] These patients, because a public program covers their health care, in general pay less than those privately insured. Many considering a rural practice may not consider it economically feasible.

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[12]"Mental Health Counselor: Salary." US News: Money. US News. Web. 17 Dec. 2013. <http://money.usnews.com/careers/best-jobs/mental-health-counselor/salary>.

[13]Reschovsky, James D., and Andrea Staiti. "Physician Incomes in Rural and Urban America." Center for Studying Health System Change. 92 (January 2005): n. page. Web. 21 Feb. 2014. <http://www.hschange.com/CONTENT/725/>.

[14] Reschovsky, James D., and Andrea Staiti. "Physician Incomes in Rural and Urban America." Center for Studying Health System Change. 92 (January 2005): n. page. Web. 21 Feb. 2014. <http://www.hschange.com/CONTENT/725/

Finally, as mental health care professionals weigh the benefits of rural job placement, most struggle to make an educated decision. For the most part, professionals attend universities and graduate programs in urban centers, intern in cities, and do residencies in urban areas. They are educated in the culture, strategies, and needs for urban communities and are unfamiliar with these concepts in regards to rural populations. With fear of the unknown, they instead seek stable jobs in urban centers. These four reasons indicate that a lack of resources, especially in regards to finances, present significant challenges to both the policy maker and health care professional seeking to increase the quality and quantity of rural mental health services.

Policy Evaluation

SIGNIFICANT POLICIES

Issues such as securing funding and adapting to the needs of communities prove to be constant struggles. States' complicated relationship with the federal government and their reliance on federal grants for health care services consistently pose challenges. Federal legislation significantly impacted the logistical approach each state government used in the administration of mental health services during the 1960s. Under President John F. Kennedy's administration, two crucial pieces of legislation regarding mental health passed into law. President Kennedy put the first, the Maternal Children Health and Mental Retardation Planning Amendment to the Social Security Act, into force on October 24, 1963.[15] This was the first major piece of legislation to combat mental illness

[15] JFK and people with intellectual disabilities. (n.d.). *John F. Kennedy Presidential Library & Museum*. 16 Oct. 2013. < http://www.jfklibrary.org/JFK/JFK-in-History/JFK-and-People-with-Intellectual-Disabilities.aspx>.

and retardation, granting $265 million in federal aid to support programs for the mentally retarded.[16] The second bill, the Community Mental Health Act signed on October 31st, stood as the last piece of legislation President Kennedy signed prior to his assassination. The Act promoted the construction of community mental health centers with a two-pronged goal: increasing accessibility and reducing stigmas by treating the mentally ill as any other illness would be treated, through community clinics rather than remote institutions.[17] The legislation increased the prominence of mental health issues on the federal agenda and provided momentum for a national movement of deinstitutionalization. This would come to trigger reform in state policies and programs.

In response to this movement by the federal government, Texas prioritized the development of a statewide plan concerning mental health services. The development of a statewide plan was one of the requirements to receive the federal funds. Uncharacteristically, the state greatly supported this endeavor and provided a considerable amount of resources. Researchers, legislators, agencies, advocates, doctors, and private vendors made up the corps of 116 citizens that came together to organize Texas' plan.[18] At the heart of the plan was the reformulation of administration. The Texas Mental Health/Mental Retardation Act of 1965 and bills creating the Texas Department of Mental Health and Mental Retardation prioritized the formation of comprehensive

[16] A national plan to combat mental retardation. (n.d.). *JFK Maternal Child Health & Retardation Act*. 15 Oct. 2013. <https://www.arcmass.org/JFKMaternalChildHealthRetardationAct.aspx>.

[17] The Associated Press (2013, October 20). Kennedy's vision for mental health never realized. *USA Today*. 22 Oct. 2013. < http://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>.

[18] Allee, S., & Jones, D. (n.d.). TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. *Handbook of Texas online*. 7 Sept. 2013, <http://www.tshaonline.org/handbook/online/articles/mctvf>.

community centers promoting mental health. This newly created department oversaw the distribution of grants, created annual performance contracts and fostered a collaborative relationship with the centers in order to generate a single state system fostering mental health. Since then, thirty-five community mental health and mental retardation centers have been constructed in Texas.[19] Nonetheless, even with this newfound funding and resurgence of dedication to mental health care, the state and nation struggled to yield services catering to all sectors of the population. The lack of funding necessary to meet the goal of mental health proved to be another area of concern. The acts of the 1960s fell short when translated into actual practice.

TEXAS PROGRAMS

Case in point of the community mental health centers initiative is the Burke Center located in Lufkin, Texas. Pertinent to our discussion is the fact that the Mental Health and Substance Abuse Division contracts the Center as a Local Mental Health Authority. While it offers the basic features most community centers offer, the Burke Center has also integrated programs to overcome obstacles particular to its rural community. Using this example, we can see how the concept of community centers is an effective framework but also the barriers and challenges posed by implanting them into practice.

The Burke Center came about as a result of Texas legislation passed in 1965. The Center opened its doors in 1974 with support from the state and funds provided by the TLL Temple Foundation, a nonprofit organization operated exclusively to support

[19] Allee, S., & Jones, D. (n.d.). TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. *Handbook of Texas online*. 7 Sept. 2013. <http://www.tshaonline.org/handbook/online/articles/mctvf>.

community health, education, and human services for the Texas pine timber belt.[20] The region covered by the Center is composed of twelve counties considered 'Health Professional Shortage Areas' for mental health: Angelina, Nacogdoches, Houston, Jasper, Newton, Polk, San Augustine, San Jacinto, Shelby, Sabine, Tyler, and Trinity county. The Burke Center provides services ranging from early childhood intervention to behavioral healthcare services for individuals with mental illness as well as for those with intellectual and developmental disabilities. Services also include the standard provision of information, referring citizens to specialists, and adult and child mental health care clinics. In an effort to accommodate the rural culture of deep East Texas, the Burke Center created the Consumer Benefits Program, which offers rental assistance and help in navigating Social Security Income, Department of State Health Services, and community resources. This program is dedicated to:

> "upholding the dignity, pride and independence of the individuals who are eligible for assistance. The program assists the consumers, who require specialized financial supports to live in natural living situations as much as possible, like those individuals who do not require specialized support."[21]

Such a program supports the central tenants of rural life while simultaneously increasing the individual's resilience and mental health.

Likewise, in an effort to address the dynamic needs of the community, the Center consults the Rural East Texas Health Network (RETHN). While all community mental health centers of Texas are required to consider public input, the region of deep East

[20] "Welcome to the Burke Center." The Burke Center. Web. 18 February 2014. <http://www.burke-center.org/home.asp>.

[21] "Consumer Benefits." The Burke Center, n.d. Web. 18 Feb 2014. <http://www.burke-center.org/mh_consumerbenefits.asp>.

Texas is unique in that in 2006 it established an active, organized network for this sole purpose. Funded by federal grants from the Office of Rural Health Policy of the Health Resources and Services Administration, the Network is composed of one local advisory board per county whose members are an assortment of law enforcement representatives, hospital staff, city and county government employees, magistrates, mental health providers and consumers, and interested community members. The chairman from each local board serves on the RETHN regional board of directors.[22] Together these boards coordinate the effort to promote awareness, education, and communication between all levels of providers and consumers of mental health.

Attesting to the fact that RETHN is not naïve to the increased vulnerability of rural populations is that it was founded "in response to tremendous need within our rural communities for a strategic plan/infrastructure to improve the mental health delivery system for our region".[23] The Network recognizes that the largest hurdles are the lack of inpatient psychiatric treatment facilities and the lack of funding for mental health care. With this in mind, they play a large part in the Burke Center's Mental Health Emergency Center Program (MHEC), another East Texas innovation.

The MHEC is comprised of two programs: extended observation units and crisis residential services. Extended observation units seek to provide an environment for short-term emergency stabilization by supplying immediate access to medical evaluation and providing direction to treatment according to the needed level of care. Crisis residential

[22]"Directory." rethn.org. Rural East Texas Health Network. Web. 22 Jan 2014. <http://www.rethn.org/resize.asp?h=730>.

[23]"Rural East Texas Health Network." rethn.org. Rural East Texas Health Network. Web. 22 Jan 2014. <http://www.rethn.org/resize.asp?h=730>.

services are also short term, community based treatments for persons believed to pose a risk to themselves or others, psychiatric crisis, or have severe functional impairment. These services require a potential patient to possess a minimal level of engagement and to make commitments with their respective MHEC to stay for prescribed twenty-four hour periods. These periods may range from one to fourteen days depending on the condition of the patient. The MHEC witnesses high demand from their community and have recently received the National Council Award of Excellence for Service Innovation by the National Council for Community Behavioral HealthCare.[24] Such success indicates the potential of rural mental health authorities.

The Rural East Texas Health Network, the Burke Center, and the Mental Health Emergency Center Program are examples of innovative programs established throughout the state of Texas. Primarily, they have found their success by establishing partnerships with the federal, state, and local spheres. However, the centers' capabilities are dwarfed by the quantity of consumers demanding services. These rural mental health facilities still face overwhelming challenges rooted in budgetary uncertainty, lack of infrastructure, and shortage of mental health professionals. For example, the RETHN consistently cites the lack of inpatient psychiatric treatment facilities, lack of funding for mental healthcare, and the deficiency of physiatrists and specialty health care providers as primary concerns.[25] The Deep East Texas Region is not alone in this struggle, with one example being the Helen Farabee Centers, a local mental health authority established in 1969 that serves nineteen counties in North Texas. The Centers operate twenty programs within

[24]"RETHN.". The Lufkin News, 19 May 2013. Web. 15 Feb 2014. <http://lufkindailynews.com/business/image_bdddfa9e-bfef-11e2-b123-0019bb2963f4.html>.

[25] "Rural East Texas Health Network." Rural East Texas Health Network. Rural East Texas Health Network, n.d. Web. . <http://www.rethn.org/divisions.asp>.

their 16,655 square mile catchment area serving over 7,000 individuals and their families every month.[26] To put this into perspective, Dallas County contains a land area of only 992 square miles.[27] Managing the expansive catchment area is a challenge and the Centers cites barriers mentioned in *Availability* and *Accessibility.* The volatility of budget cuts, particularly in the 2011 Texas Legislative Session, has further set back the organization in regards to making concrete plans for the Centers.[28] These, and other Local Mental Health Authorities, would benefit from reevaluation of policy.

POLICY PROPOSAL

The following policy suggestions consider the aforementioned factors of vulnerability and the forecasted demographic changes concerning rural populations. Urban areas are expected to grow faster than rural areas and, though the percentage of share of the rural population will continue to fall, the actual number will continue to grow. Texas will still have the nation's largest rural population in years to come. Additionally, the rural Hispanic population is projected to double to 1.6 million between 2020 and 2040.[29] Such demographic changes will undoubtedly only aggravate the current challenges the population faces. Investment in infrastructure and professional

[26] "Helen Farabee Centers." HFC Home. N.p., n.d. Web. 10 Feb. 2014. <http://www.helenfarabee.org/>.

[27] "Congressional Edition." Google Books. US Congress, n.d. Web. 14 Feb. 2014. <http://books.google.com/books?id=APVGAQAAIAAJ&pg=PA1031&lpg=PA1031&d, q=dallas+340+square+miles&source=bl&ots=kY2ut5_hxZ&sig=o8wRdfc3n9wDBy_o5b2ntTq1niU>.

[28] "Helen Farabee Regional MHMR Centers PROVIDER NETWORK DEVELOPMENT PLAN." *HelenFarabee.org*. Helen Farabee Regional MHMR Centers, n.d. Web. 8 Feb. 2014. <http://www.helenfarabee.org/Download/LPND.pdf>.

[29] "Rural Texas In Transition." *Rural Texas In Transition*. Window on State Government, n.d. Web. 14 Feb. 2014. <http://www.window.state.tx.us/specialrpt/rural/7wherenow.html>.

development will be crucial in making sure these populations receive adequate mental health care.

Investing in rural infrastructure will be crucial for the state of Texas. As the rural population dwindles in percentage, they will continue to struggle with underrepresentation in state budgetary matters. Prioritizing rural infrastructure will ensure that upkeep will continue to stop roads and the social and economic fabric from further deterioration. If the state prioritized these matters, mental health providers and professionals would be incentivized to move to developed areas. Furthermore, such development would also encourage businesses to invest in rural areas. Rural areas are already considered growth areas and at a comparative advantage for industries like retirement havens, birding, tourism, industrial parks, prisons, and outdoor recreation. Communities need the tools to ensure their harnessed potential comes to fruition. Most fundamental to the idea of prioritizing rural infrastructure is the suggestion that a thorough study be conducted as a collaborative effort, spearhead by the Texas State Office of Rural Development (USDA).

The USDA's report would not only allow Texas to be a wise steward of limited state funds, but also make Texas a national leader in rural development. This report would gather data on the status of current infrastructure, economic development, and the effects these are currently having on social sectors such as medical services and schools. Additionally, case studies of rural communities that have successfully initiated development, such as Snyder, Archer City, and Yoakum would be featured. The USDA report should also include features on the most vulnerable industries in rural communities, such as the medical sector, and list incentives communities may use to

build these up. Upon completion, it is suggested that this report be disseminated to Councils of Governments (COGs), local government officials, district representatives, and be made available to the public via the state's websites. The report would be generated to serve as a guide for rural communities so they may focus on best practices and develop in collaboration with the state government.

The urgency of the report cannot be stressed enough. Rural communities are in desperate need of guidance and the shortage of funds means that every initiative must be strategic. Attesting to the need for data-driven policy, the Comptroller of Texas conducted a special report on new paths for rural communities. Of the surveyed states with significant rural populations, most could not provide definitive answers on the amount of funding earmarked for rural development in a given year. Zoom in and it becomes clear that as it stands, Texas faces this problem: funding is dispersed at the local level and comes from local tax incentives, preventing rural development funds from being tracked at the state level. The Comptroller's survey also found that in most states, including Texas, rural development did not receive more attention than development in other areas.[30] Texas has many advantages because is a considered pro-business, right-to – work state. Without state imposed zoning or a corporate or personal income tax, rural communities are able to tailor development to their strengths. According to the Texas Comptroller's Office:

> "Rural Texas is poised at a new crossroads and faced with enormous technological opportunities to operate in arenas previously denied them due to their physical isolation.

[30] "Rural Texas In Transition." *Rural Texas In Transition*. Window on State Government, n.d. Web. 14 Feb. 2014. <http://www.window.state.tx.us/specialrpt/rural/6newpaths.html>.

> Businesses can operate worldwide over the Internet while residents can participate in activities that were just a few years ago only available in Texas' urban areas."[31]

There is much hope for the development of rural communities, and a USDA report would garner the community's strengths and empower it as whole.

The second central tenant for policy suggestions in rural areas is the development of mental health professionals. An increased emphasis on rural communities during professional training would help overcome barriers and increase the number of people practicing in rural areas.[32] Currently, professionals are dissuaded by the lack of knowledge of rural communities and decide to practice in familiar urban areas. The state of Texas should partner with universities and professional schools to increase the emphasis on rural populations within the curriculum. If a future mental health provider learns early on about rural needs, he will be more inclined to service the community later on. Moreover, the state of Texas should produce a report educating professionals about rural communities and the benefits of working in such areas. This report could be made available to many through the Texas State website and the website of the Department of State Health Services.

Education serves as the key to attracting health professionals in the area. Education will help to quell the misperceptions many have of professionals in rural communities. Case in point, though it seems rural health professionals are paid less, when "real" compensation is examined a new picture emerges. When incomes are

[31] "Rural Texas In Transition." *Rural Texas In Transition*. Window on State Government, n.d. Web. 11 Feb. 2014. <http://www.window.state.tx.us/specialrpt/rural/7wherenow.html>.

[32] "Workforce Series: Rural Behavioral Health." *National Rural Health Association Policy Position*. National Rural Health Association Policy Position, n.d. Web. 8 Feb. 2014. <file:///C:/Users/Priscilla/Downloads/WorkforceRuralBehavHealth%20(2).pdf>.

adjusted for local cost-of-living index, rural health professionals have significantly more purchasing power than their urban counterparts.[33] Furthermore, state and federal government already have financial incentives in place to entice young professionals to rural medicine. There are a number of loan-repayment programs, loan forgiveness programs, and scholarships for practitioners who commit to serving in rural areas for a period of time. Rural communities have also reduced or eliminated business taxes for medical practitioner businesses and offered housing at considerably reduced prices and interest rates for them.[34] While these resources concerning rural areas exist, the information is not collected nor presented in a user-friendly way. Presenting it in a better format and to future professionals would greatly increase the mental health professional presence in rural communities.

These policy proposals target the weaker areas of rural communities and build them up through education as well as data-driven solutions. The suggestions are cost-effective and Texas is in desperate need of them. Rural communities are at a turning point, but they must take initiatives to strategize about future development and the state government must prioritize their communities. Through such a partnership, not only will rural communities be able to provide quality mental health services, but they will also improve the overall quality of rural life.

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[33] Reschovsky, James D., and Andrea Staiti. "Center for Studying Health System Change." *Issue Brief No. 92*. Center for Studying Health System Change, Jan. 2005. Web. 14 Feb. 2014. <http://www.hschange.com/CONTENT/725>.

[34] "Doctors Need Apply: Incentives for Rural Physicians." *Doctors Need Apply: Incentives for Rural Physicians*. Texas Medical Association Insurance Trust, n.d. Web. 7 Feb. 2014. <http://www.tmait.org/articles-and-insights/case-in-point/doctors-need-apply-incentives-for-rural-physicians/>.

CHAPTER THREE

Hispanic Majority-Minority

This chapter focuses on the Hispanic population in Texas as a majority-minority state. Texas is currently experiencing first-hand the majority-minority shift that will soon be a common occurrence throughout many states in the decades to come. With this in mind, this chapter seeks to shed light on the opportunities to increase the accessibility, availability, and acceptability of mental health services for Hispanics, a population that contributes largely to the aforementioned predicted demographic shifts. First, it is vital to define the Hispanic minority-majority population and its general health status. Second, we will examine risk factors hindering the Hispanic community in terms of mental health. Third, we will analyze historical policies specifically promoting mental health within the Hispanic population. Finally, we will discuss potential avenues for future policies and make recommendations based on this chapter's analysis.

Demographics

DEFINITION OF HISPANIC MAJORITY MINORITY

Hispanics are an integral part of Texas' position as a majority-minority state. To better understand the population, we will first examine overall demographics and continue to define pertinent terms. The state of Texas is one of the fastest growing states in the nation. Census population estimates from 2000 to 2008 indicate that the Texan population grew by 16.7 percent whereas the average growth of other states was less than

half of this percentage.[1] Demographically, Texas' population growth is largely due to ethnic minorities, so much so that in 2004 Texas became a majority-minority state.

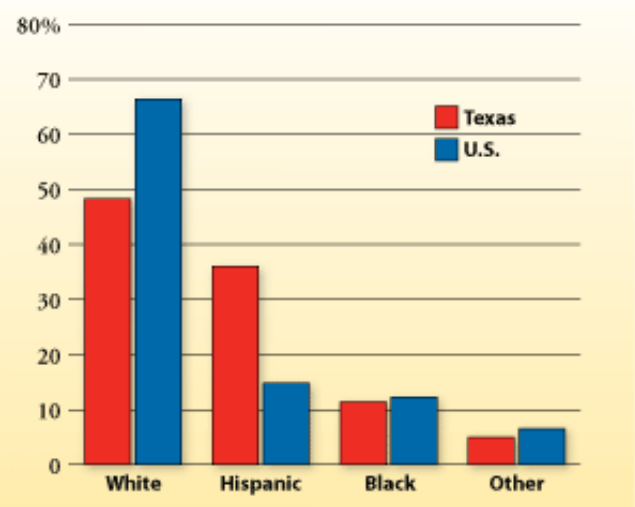
Majority-minority states are those whose jurisdiction population is less than 50 percent non-Hispanic Whites. In the United States, the data for this is derived from self-identification questions on the US Census and based on Census Bureau estimates.[2] In 2004, Texas joined the company of Hawaii, New Mexico, and California in being the only states with majority-minority populations. Joining such group is largely due to rising rates of the Hispanic population within the Lone Star State. Texas has the nation's second largest percentage of Hispanics, with the 2006 Pew Hispanic Trends Research Project of reveling that 48.3 percent of Texans are White and 35.7 percent Hispanic.[3] Hispanics in Texas are of particular interest because the percentage of Hispanics in Texas is much higher than the average in the US (Figure 3.1).

[1] Sherman, Lauren. "America's 10 Fastest-Growing States." Forbes. (2008): n. page. Web. 14 Nov. 2013. <http://www.forbes.com/2008/12/22/fastest-growing-states-forbeslife-cx_ls_1222realestate_slide_9.html>.

[2]"Texas in Focus: A Statewide View of Opportunities; Demographics." Window on State Government. Window on State Government. Web. 2 Nov. 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

[3]"Demographic Profile of Hispanics in Texas, 2011." Pew Research: Hispanic Trends Project. Pew Research, n.d. Web. 20 Nov. 2013. <http://www.pewhispanic.org/states/state/tx/>.

FIGURE 3.1 "U.S. AND TEXAS POPULATION BY ETHNICITY, 2006" [4]



To further illustrate this point, in 2011 in Maverick County (Eagle Pass) recorded the highest percentage of minority populations nationally with 96.9 percent while Webb County (Laredo) with 96.4 percent took on the title of the second highest, the majority being Hispanics. Furthermore, Starr County (Rio Grande City-Roma) had the highest percent of Hispanics in any county of the US at 95.7 percent.[5] US Census predictions indicate that in the future, a similar shift towards higher percentages of Hispanics will occur throughout the country.

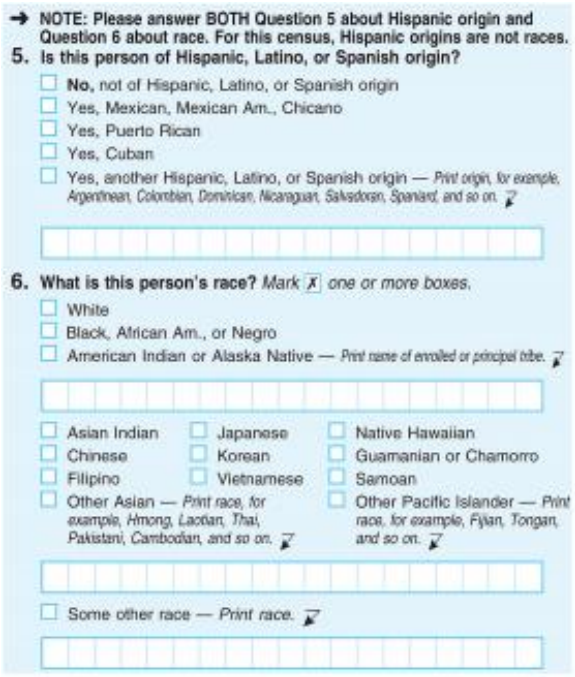
It is important to note the different labels currently used to define Hispanics, Latinos and Hispanics, before proceeding in this discussion. The US federal government, as well as many organizations and think tanks, use the terms interchangeably in

[4] "Texas in Focus: A Statewide View of Opportunities; Demographics." Window on State Government. Window on State Government. Web. 5 Nov. 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

[5] "Texas in Focus: A Statewide View of Opportunities; Demographics." Window on State Government. Window on State Government. Web. 2 Nov 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

publications.[6] While citizens, including both Hispanics and Latinos, use the terms in a similar fashion. It is important to note that data referred to in this chapter is based on the United States Census Bureau's figures and we will be using their terminology. Since 1970, the Bureau has classified Hispanics as an ethnic group (Figure 3.2).

Figure 3.2: "REPRODUCTIONS OF THE QUESTIONS ON HISPANIC ORIGIN AND FACE FROM THE 2010 CENSUS"[7]



→ **NOTE: Please answer BOTH Question 5 about Hispanic origin and Question 6 about race. For this census, Hispanic origins are not races.**

5. Is this person of Hispanic, Latino, or Spanish origin?

- ☐ **No,** not of Hispanic, Latino, or Spanish origin
- ☐ Yes, Mexican, Mexican Am., Chicano
- ☐ Yes, Puerto Rican
- ☐ Yes, Cuban
- ☐ Yes, another Hispanic, Latino, or Spanish origin — *Print origin, for example, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.*

6. What is this person's race? *Mark* ☒ *one or more boxes.*

- ☐ White
- ☐ Black, African Am., or Negro
- ☐ American Indian or Alaska Native — *Print name of enrolled or principal tribe.*
- ☐ Asian Indian
- ☐ Chinese
- ☐ Filipino
- ☐ Japanese
- ☐ Korean
- ☐ Vietnamese
- ☐ Other Asian — *Print race, for example, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.*
- ☐ Native Hawaiian
- ☐ Guamanian or Chamorro
- ☐ Samoan
- ☐ Other Pacific Islander — *Print race, for example, Fijian, Tongan, and so on.*
- ☐ Some other race — *Print race.*

[6] Lopez, Marc Hugo. "Hispanic or Latino? Many don't care, except in Texas." Pew Research Center. Pew Research, 28 Oct 2013. Web. 8 Nov. 2013. <http://www.pewresearch.org/fact-tank/2013/10/28/in-texas-its-hispanic-por-favor/>.

[7] "Overview of Race and Hispanic Origin: 2010." US Census Bureau . US Census Bureau , n.d. Web. 15 Nov. 2013. <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>.

Technically speaking, not all Hispanics are Latinos and vice versa.[8] For our purposes in regards to the state of Texas, these terms will be interchangeable because 88 percent of Hispanics are of Mexican origin in Texas, meaning that most are Latinos.[9] Additionally, a large majority of Hispanics in Texas shares a common cultural, linguistic, and geographical background. Thus *General Health* will take this into account and portray an accurate picture of the Texan Hispanic aspect of the majority-minority population.

GENERAL HEALTH

The rate of mental illness within the Hispanic ethnicity is roughly equivalent to that of other ethnicities. In 2011, 15.9 percent of Hispanic adults reported suffering a mental illness to the National Survey on Drug use and Health.[10] Two large problems negatively affect the overall health of the Hispanic population. First, the socioeconomic status of Latinos on average is very low. Given its reduced educational and economic resources, the Latino population's health is poorer than that of other communities.[11] Second, Latinos struggle to contact mental health professionals for treatment. Though they are identified as a high-risk group for depression, anxiety, and substance abuse, only a small percentage of the community seek help.[12] In 2001 the Surgeon General's report

[8] "Hispanic Origin." United States Census Bureau. U.S. Department of Commerce. Web. 20 Nov 2013. <http://quickfacts.census.gov/qfd/meta/long_RHI825212.htm>.

[9] "Demographic Profile of Hispanics in Texas, 2011." Pew Research: Hispanic Trends Project. Pew Research, n.d. Web. 20 Nov 2013. <http://www.pewhispanic.org/states/state/tx/>.

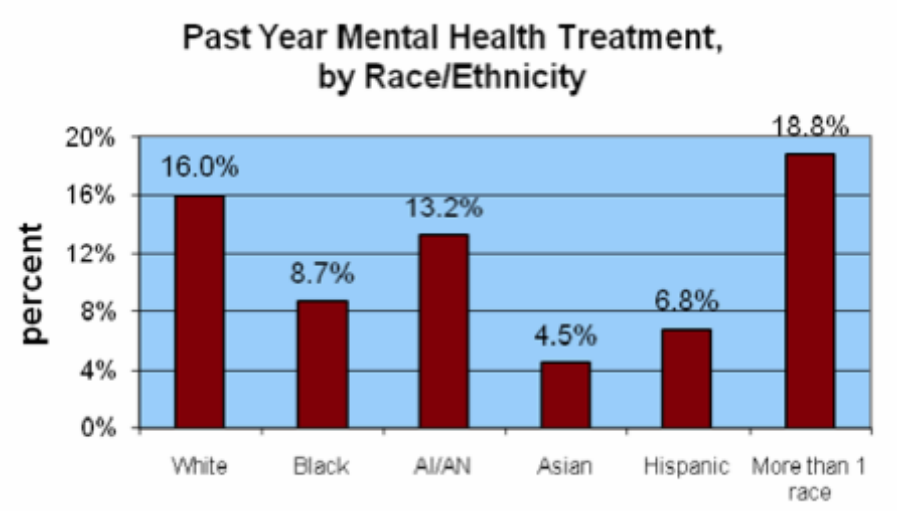
[10] "Mental Health Disparities: Hispanics/Latinos ." apa.org. American Psychological Association, n.d. Web. 8 Nov. 2013. <file:///C:/Users/Priscilla/Downloads/fact-sheet---latinos%20(1).pdf>.

[11] National Center for Biotechnology Information . National Center for Biotechnology Information , n.d. Web. 2 Nov. 2013. <http://www.ncbi.nlm.nih.gov/books/NBK44247/#A2285>.

[12] Latino Community Mental Health Fact Sheet ." nami.org. Nami Multicultural Action Center, n.d. Web. 17 Nov. 2013.

described that only twenty percent of Latinos with psychological disorders actually consult a general health care provider and an even smaller percentage, ten percent, contact mental health specialists.[13]

FIGURE 3.3 2008 NATIONAL SURVEY OF DRUGE USE AND HEALTH[14]



While few contact the health care system to receive treatment, an even smaller percentage receives adequate mental health services. For example, one scientific study found that while thirty-six percent of Latinos sought treatment, only twenty-two percent received adequate treatment for depression (see Figure 3.4).

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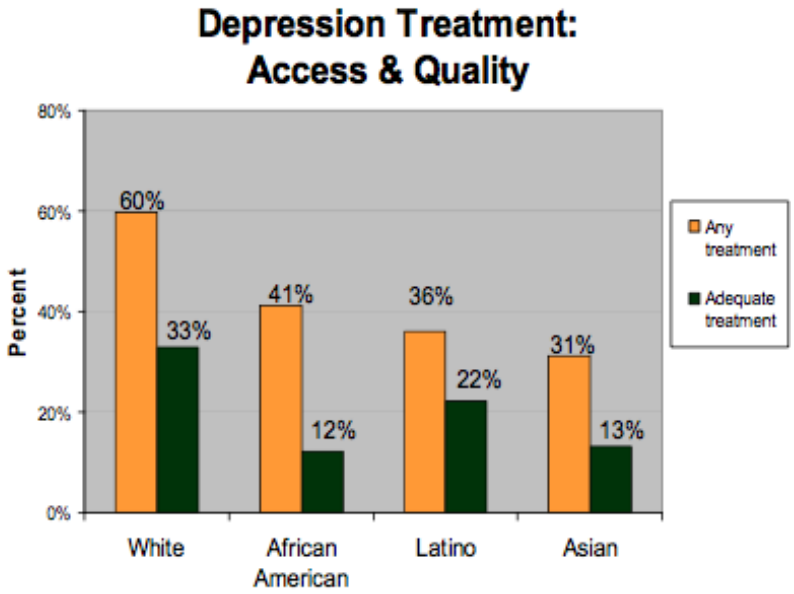
[13] Surgeon General, HHS. (2001) Mental Health: Culture, Race and Ethnicity 2001. <www.surgeongeneral.gov/library/mentalhealth/cre/>.

[14] SAMHSA, National Survey APA Fact Sheet. Web. 20 Nov. 2013. <http://www.psychiatry.org/File%20Library/Practice/Diversity%20OMNA/Diversity%20Resources/Fact-Sheet---Latinos.pdf>.

FIGURE 3.4 PERCENTAGES OF ADEQUATE TREATMENT[15]



The general health of Latinos is complex, as health rates vary among Latino sub-groups by country of origin. Even the difference of ones status as a US-born or an immigrant contributes to the equation. The reasons for varying degrees of health and the range of struggles facing those seeking adequate mental health care are a vital part of this discussion.

Relative Risk: The 3 A's

ACCESSIBILITY: INSURANCE

Historically, the Latino population has quietly suffered from mental illness due to the outstanding number of uninsured individuals. In 2007, Hispanics had the highest uninsured rate of any ethnic group, with nearly one-third of individuals lacking

[15] SAMHSA, National Survey APA Fact Sheet. Web. 20 Nov. 2013. <http://www.psychiatry.org/File%20Library/Practice/Diversity%20OMNA/Diversity%20Resources/Fact-Sheet---Latinos.pdf>.

insurance.[16] These numbers have slightly decreased but are still significant impediments to mental health services. Currently, so disproportionally uninsured is the Latino population that as many as one in four uninsured individuals, or 10.2 million, will be eligible for coverage through the national Health Insurance Marketplace. Texas is at the hub of this gap, as the majority of uninsured Latinos, 62 percent, live in California, Texas, and Florida.[17] Though extensions of mental health care have recently become available, Hispanics struggle to integrate themselves into the health insurance system.

The Latino population is highly unfamiliar with US mental health care system insurance. The following are the four main reasons Texan citizens struggle in this area. First, having little access and exposure to mental health benefits, the population has minimal working knowledge of these resources in relation to other populations. A 2006 American Psychological Associate survey found that only forty-one percent of insured Hispanics had access to mental health benefits compared to 65 percent of Whites and 63 percent of African Americans.[18] Second, asymmetry of information has impeded access for many Latino citizens. In mental health, the effect of asymmetric information is compounded, as not only are mental illnesses and disorders complex, but the forums of treatments and services are as well. Furthermore, the legality and fine print of paperwork associated with gaining mental health benefits has deterred many from using health resources, especially those whose second language is English.

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[16] "Hispanic-Latino." psychiatry.org. American Psychiatric Association, n.d. Web. 4 Nov. 2013. <http://www.psychiatry.org/latinos>.

[17] "The Affordable Care Act and Latinos." United States Department of Health and Human Services. US Department of Health and Human Services, 10 Apr. 2012. Web. 5 Nov. 2013. <http://www.hhs.gov/healthcare/facts/factsheets/2012/04/aca-and-latinos04102012a.html>.

[18] Dichoso, Sheila, and Copyright 2011. "Stigma haunts mentally ill Latinos." CNN. Cable News Network, 15 Nov. 2010. Web. 28 Nov. 2013. <http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/>.

A third reason the Latino population of Texas lacks a familiarity with the US mental health care system is that, along border towns in Texas, there is a high prevalence of Hispanic Texas residents who use health care services in Mexico. In a 2008 survey of residents along the entire Texan border, forty-nine percent of the sample reported having purchased medications in Mexico and 37.3 percent reported doctor visits. In the case of these residents, the most significant predictors of health care utilization in Mexico were the lack of US health insurance coverage and dissatisfaction with the quality of the US health care system.[19] Finally, the economic status of many Latinos hinders their investment in health insurance. In Texas, the median annual personal earnings of Hispanics match the poverty level, $20,000. This is significantly lower than the wages of non-Hispanic whites and blacks earning $36,000 and $25,000 respectively.[20] Having little to no income to spare, Hispanics struggle to justify insurance investments because their economic situation makes it difficult to consider anything outside of short-term solutions.[21] Furthermore, many are employed in manual labor and service jobs that require long and irregular hours making it difficult to schedule care or insurance meetings. Add to this that many individuals work only part-time at multiple jobs that fail

[19] Su, Dejen, Chad Richardson, Ming Wen, and Jose A. Pagan. "Cross-Border Utilization of Health Care: Evidence from a Population-Based Study in South Texas." Wiley Online Library. Health Research and Educational Trust, 1 Jan. 2010. Web. 11 Dec. 2013. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01220.x/abstract>.

[20] "Demographic Profile of Hispanics in Texas, 2011." Pew Research Centers Hispanic Trends Project RSS. Pew Research Center, 1 Jan. 2011. Web. 14 Dec. 2013. <http://www.pewhispanic.org/states/state/tx/>.

[21] Shah, Anuj K. , Sendhil Mullainathan, and Eldar Shafir. "Some Consequences of Having Too Little." sciencemag.org. Science Magazine, n.d. Web. 13 Dec. 2013. <http://www.sciencemag.org/content/338/6107/682>.

to provide a full range of benefits, and the problem is presented in greater clarity.[22] These four reasons attribute to Hispanic's minimal working knowledge of the American overall mental health care system.

ACCEPTABILITY: CULTURAL STIGMA

Stigma towards mental health in Texan Hispanics is deeply rooted in their culture and traditions. So entrenched are these elements of the Hispanic population that dislodging stigmas is extremely difficult and acceptability of mental health care within the community is consistently hindered. It is alarming to note that, while rates of mental illness are roughly equal between Whites and Hispanics, minority patients are less likely to seek treatment, more likely to delay treatment, and more likely to receive poor quality health care upon treatment.[23] Analyzing cultural issues barring access for Hispanics such as collectivism, *machismo*, and immigration status will help us better understand these trends and obstacles to acceptability.

Collectivistic values or a group orientation are central to Hispanic culture. Such celebrations of family and community directly impact health habits, with one example being that a significant portion of Hispanics often fail to look beyond their immediate community for mental health treatment. Partially, this is due to the fact that Hispanics more often rely on the advice of fellow Hispanics for referrals to treatments and specialists. A cultural reluctance to look outside the Hispanic community causes

[22] Dichoso, Sheila, and Copyright 2011. "Stigma haunts mentally ill Latinos." CNN. Cable News Network, 15 Nov. 2010. Web. 28 Feb. 2014. <http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/>.

[23] U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999

individuals to rely solely on churches, folk healers, *espiritualistas*, and family members for diagnosis and care.

Startlingly, statistics indicate that Latinos are twice as likely to seek treatment through general health care providers or the church as they are to pursue treatment from mental health specialists.[24] This reliance on traditional healing systems is not only common due to cultural approval, but also because it is significantly cheaper than systemized care and is readily available. Furthermore, traditional outlooks on health impact the community's view on mental health. Though views vary among Hispanics, a notable amount still maintain false opinions that health stems from good behavior or luck while illness is a result of supernatural or natural causes.[25] For instance, symptoms of mental illness that would typically be recognized in other populations are mistaken for nervousness, tiredness, physical ailment or varying temperaments.[26] In a traditional Hispanic perspective, such symptoms are attributed to *susto,* a feeling known as fright sickness caused by a traumatic experience believed to cause soul loss.[27] Accordingly, Hispanics will look to traditional remedies and the church for healing. These views lead to a failure to achieve proper diagnosis and treatment, thus increasing the population's

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[24]"Latino Community Mental Health Fact Sheet ." nami.org. Nami Multicultural Action Center, n.d. Web. 11 Feb. 2014. <http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf>.

[25] Spector, R. (1996). Health and illness in Hispanic American communities. In R. Spector (Ed.), *Cultural diversity in health and illness* (4th Ed., pp. 279-297). Stanford, CT: Appleton and Lange.

[26] Rodriguez, Cindy. "Latinos struggle to find help for mental health issues." CNN. Cable News Network, 1 Jan. 1970. Web. 17 Jan. 2014. <http://www.cnn.com/2013/10/09/health/latino-mental-health-disparities/>.

[27] Kemp, C. & Rashbridge L.A. (2004). Mexico In *Refuge and Immigrant: A Handbook for Health Professionals* (pp. 260-270). Cambridge: Cambridge University Press.

vulnerability. As a result, thousands of Hispanics suffer from mental illness without ever receiving professional care.

The cultural values of *machismo* also increase the Hispanic population's vulnerability. *Machismo* "vaguely refers to a standard of behavior exhibited by men".[28] This standard behavior, more so than in mainstream American culture, values self-reliance while discouraging conversations about problems or seeking help.[29] Add in societal stigma, and it becomes evident why many men are at odds with the idea of mental health treatment. Moreover, adherence to *machismo* impacts more than just Hispanic males, as a man's reluctance to accept consultation on mental health may mean his wife and extended family may also be forced to face prolonged diagnosis and treatment.[30] Such delays can have disastrous effects and significantly impact the length of recovery as well as the effectiveness of treatments.

Acculturation and immigration are two elements that further set the Hispanic population apart as a vulnerable population. Especially along Texan border towns, there exists a high percentage of Hispanics that have recently immigrated to the United States. Immigrants tend to reside in underserved communities, and are at a higher relative risk because of a decrease in social status and capital. Their move to a new country often

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[28] Paper: Arciniega, G. Miguel, Thomas C. Anderson, Zoila G Tovar-Blank, and Terence J. G. Tracey. "Toward a fuller conception of Machismo: Development of a traditional Machismo and Caballerismo ScaleR." Research Gate. Journal of Counseling Psychology, 1 Jan. 2008. Web. 13 Jan. 2014. <http://www.researchgate.net/publication/232558454_Toward_a_fuller_conception_of_Machismo_Development_of_a_traditional_Machismo_and_Caballerismo_Scale/file/9fcfd50be76ffcb9af.pdf.>.

[29] Dichoso, Sheila, and Copyright 2011. "Stigma haunts mentally ill Latinos." CNN. Cable News Network, 15 Nov. 2010. Web. 3 Mar. 2014. <http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/index.html>.

[30] Parangimalil, G. J. (2001). Latino health in the new millennium: The need for a culture-centered approach. *Sociological Spectrum, 21,* 423-429.

implies a lack of family support, additional stressors of immigration and acculturation, and a disparity in their beliefs and those of the mainstream US culture.[31] Various studies, most dealing with Mexican Americans, have found that lifetime rates of mental disorders among Mexican American immigrants are significantly lower than rates of mental disorders among Mexican Americans born in the US. However, for immigrants, time spent in the US is an important factor as evidenced by a study that found that immigrants having spent at least thirteen years in the US had higher prevalence rates of mental illness than those who had lived in the US for a shorter time span.[32] Such findings have led researchers to hypothesize that the stress of acculturation accumulates and isolates individuals, a process that leads to mental illness. Still, no longitudinal studies or tests ruling out other factors have been conducted to bolster this conclusion.

Nonetheless, studies prove that second and later generation Hispanic youth have higher levels of risk for emotional distress. This distress is due to the pressures to rapidly embrace a new culture while simultaneously dealing with poverty, marginalization, discrimination, and inequality. Though these problems are similar to those faced by their parents, youth do not have as secure an identity or hold as fast to traditional values as do their elders. Hispanic immigrant parents also add to the pressures faced by youth via their high expectations and hopes that their children will live the American dream.[33]

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[31] "Hispanic-Latino." apa.org. American Psychiatric Association, n.d. Web. 9 Feb. 2014. <http://www.psychiatry.org/latinos>.

[32]"Help seeking for mental health care among poor Puerto Ricans: problem recognition, service use, and type of provider.." National Center for Biotechnology Information. U.S. National Library of Medicine, n.d. Web. 2 Feb. 2014. <http://www.ncbi.nlm.nih.gov/pubmed/9674622>.

[33]"Mental Health in the Hispanic/Latino Community." psychiatry.org. American Psychiatric Association, n.d. Web. 6 Feb. 2014.

These influences all have an impact on the Hispanic formation of health habits. Understanding the cultural and linguistic diversity of the Hispanic population and its relationship to mental health decisions is key to Texan policy making.

AVAILABILITY: LANGUAGE BARRIERS

According to the findings of the US Census, a seemingly obvious feature of the county's Hispanic population is revealed: the prevalence of Spanish speakers is widespread within this population. In 2000, throughout the United States 70 percent of Hispanic children lived in households where foreign languages were spoken, the highest of any other ethnic group.[34] Many Hispanics have little to no clinically functional English and rely on Spanish as their main conduit for communication and interaction. A shortage of Spanish-speaking health professionals and a plethora of linguistically isolated households serve as barriers to the availability of quality mental health services. In Texas, linguistic diversity is a common. For Spanish in particular, it is not abnormal to hear the language used outside of the home in contexts beyond familial settings . In 2011, a study discovered that the number of US residents five years or older that spoke Spanish at home was 37.6 million. This study also revealed a 117 percent increase in Spanish speakers since 1990.[35] Although increasing numbers of people speak Spanish as their primary language, the growth of health professionals who can accurately translate has, thus far, failed to keep pace in meeting the burgeoning demand.

<http://www.psychiatry.org/File%20Library/Mental%20Illness/Lets%20Talk%20Facts/APA_Ment-Hisp_ENGL_B3_4-10-08_2.pdf>.

[34] Rong, Xue Lan, and Judith Preissle. Educating immigrant students in the 21st century: what educators need to know. 2nd ed. Thousand Oaks, Calif.: Corwin Press, 2009. Print.

[35]"Hispanic Americans By the Numbers." Infoplease. US Census Bureau, n.d. Web. 20 Feb. 2014. <http://www.infoplease.com/spot/hhmcensus1.html>.

More specifically, the amount of Latinos in the mental health care system is appallingly minimal. In fact, in a national survey of licensed psychologist members with active clinical practices, the American Psychological Association found that one percent of those sampled identified as Latino.[36] Additionally, for every 100,000 mental health professionals there were roughly twenty-nine Hispanic mental health professionals compared to 173 professionals for every 100,000 non-Hispanic Whites.[37] The shortage of Spanish-speaking and Latino health professionals is distressing for a variety of reasons, one of which is that such professionals more readily understand the culture, terms, and concerns of Hispanic patients. The fact that Hispanics usually use physiological symptoms to describe mental illness, a process called, term disconnect, intermixed with the unique outlook Hispanics have on mental health, further highlights the necessity for professionals who are linguistically and culturally aware.[38]

A growing trend that specifically highlights the linguistic vulnerability of Hispanics is the documented growth of linguistically isolated households. Linguistically isolated households, as defined by the US Census Bureau, are households in which no one over the age of fourteen speaks fluent English well. Not only does Texas report one of the highest numbers of linguistically isolated households, but most of these

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[36]"Latino Community Mental Health Fact Sheet ." *nami.org*. Nami Multicultural Action Center, n.d. Web. 7 Feb. 2014. <http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf>

[37] "On Co-Occurring Mental Health and Substance Abuse Disorders " mwcog.org. Metropolitan Washington Council of Governments Co-Occurring Disorders Committee, n.d. Web. 26 Jan. 2014. <https://www.mwcog.org/uploads/pub-documents/8FpZWw20060313155447.pdf>.

[38] Dichoso, Sheila, and Copyright 2011. "Stigma haunts mentally ill Latinos." CNN. Cable News Network, 15 Nov. 2010. Web. 29 Jan. 2014. <http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/index.html>.

communities, ranging from Brownsville, El Paso, Laredo, to McAllen, are located along the Border.[39] Linguistic isolation causes concern as it is not limited to immigrants and the use of a non-English language is prevalent (Figure 3.5).[40]

Figure 3.5 "IMMIGRATION-RELATED CHARACHIRERISTICS US HOUSEHOLDS FOR CHILDREN 5-18 OLD BY RACE-ETHINICY AND IMMIGRATION STATUS"[41]

	All Children (2,694,073)	Immigrant Children (125,792)
% of Children Who Spoke a Language Other Than English at Home		
All Children	17.3%	84.9%
Non-Hispanic White	5.3%	76.0%
Hispanic	69.3%	95.0%
Black	5.8%	48.4%
Asian	58.3%	80.5%
% of Children Who Lived in Linguistically Isolated Households		
All Children	4.5%	34.4%
Non-Hispanic White	0.7%	24.9%
Hispanic	20.7%	42.8%
Black	0.8%	13.1%
Asian	18.6%	29.3%

[39] " The educational implications of linguistic isolation and segregation of Latino English Language Learners (ELLs)." The Civil Rights Project. The Civil Rights Project, n.d. Web. 27 Jan. 2014. http://civilrightsproject.ucla.edu/legal-.>.

[40] "*Isolation and Segregation of Latino English Language Learners*." N.p., n.d. Web. 25 Feb. 2014. <http://www.census.gov/hhes/socdemo/language/data/census/li-final.pdfdevelopments/court-decisions/the-educational-implications-of-linguistic-isolation-and-segregation-of-latino-english-language-learners-ells>.

[41] "On Co-Occurring Mental Health and Substance Abuse Disorders." mwcog.org. Metropolitan Washington Council of Governments Co-Occurring Disorders Committee, n.d. Web. 26 Jan. 2014. <https://www.mwcog.org/uploads/pub-documents/8FpZWw20060313155447.pdf>.

The presence of multiple non-English language communities as well as the continuation of the traditional Spanish language in Hispanic homes seems to indicate that such a trend will continue.

Policy Evaluation

SIGNIFICANT POLICIES

It was not until the 1970s that Latino concerns began to be recognized on the US policy stage, yet garnering data on Latinos remains a constant struggle. The 1970 Census served as the first widespread attempt to estimate the size of the Hispanic population. Census forms included one question inquiring as to the person's origin or descent, with response categories including Mexican, Puerto Rican, and Cuban. The question did not yield accurate results as it appeared only on the long form, was sent to only a five percent sample of households, and obscurely phrased. This led to two contrary issues: underreporting by some Hispanics who did not self-identify as such and over reporting due to confusion, as some people who lived in the central or southern United States filled in the circle for "Central and South American".[42] Fast-forward to the most recent Census in 2010 and the US Census Bureau is still tweaking the wording to ensure accurate data is derived about the demographics of the population. In the 2010 Census, the Hispanic question was located before the question on race, demonstrating the Census' commitment

[42] "Changing the Way U.S. Hispanics Are Counted." prb.prg. Public Reference Bureau, n.d. Web. 25 Jan. 2014. <http://www.prb.org/Publications/Articles/2012/us-census-and-hispanics.aspx>.

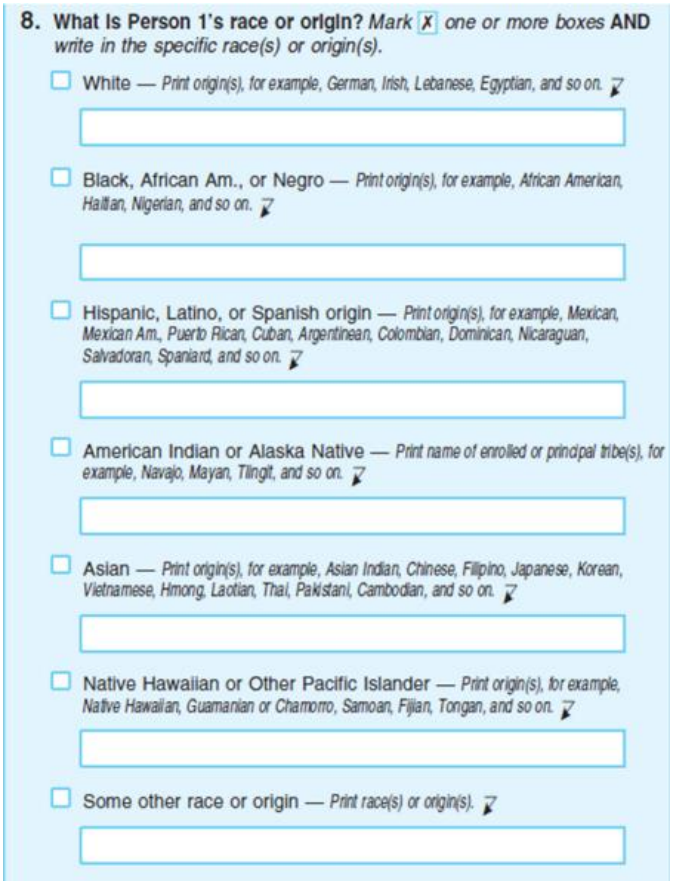
to receive more Hispanic responses, while maintaining its insistence on keeping the two questions separate. [43]

Although the US Census Bureau has historically separated the Hispanic question from that of race, the Bureau is currently testing a considerably different approach. In 2010, the Bureau began preparing for the 2020 census through a research project entitled the 2010 Census Race and Hispanic Origin Alternative Questionnaire Experiment (AQE). With the priority being to improve the accuracy of the Census' race and Hispanic question, the AQE is the largest quantitative effort ever undertaken for race and Hispanic origin research.[44] Figure 3.6 illustrates a possible combination format for the 2020 Census.

[43] "Census History: Counting Hispanics." Pew Research Centers Social Demographic Trends Project RSS. Pew Research Center, n.d. Web. 28 Jan. 2014. <http://www.pewsocialtrends.org/2010/03/03/census-history-counting-hispanics-2/>.

[44] "2010 CENSUS PLANNING MEMORANDA SERIES ." census.gov. United Stated Department of Commerce: Economics and Statistics Administration, n.d. Web. 11 Feb. 2014. <http://www.census.gov/2010census/pdf/2010_Census_Race_HO_AQE.pdf>.

FIGURE 3.6 EXPERIMENTAL QUESTION COMBINING RACE AND ETHINCITY[45]


8. What is Person 1's race or origin? *Mark ✗ one or more boxes* **AND** *write in the specific race(s) or origin(s).*

- ☐ White — *Print origin(s), for example, German, Irish, Lebanese, Egyptian, and so on.*
- ☐ Black, African Am., or Negro — *Print origin(s), for example, African American, Haitian, Nigerian, and so on.*
- ☐ Hispanic, Latino, or Spanish origin — *Print origin(s), for example, Mexican, Mexican Am., Puerto Rican, Cuban, Argentinean, Colombian, Dominican, Nicaraguan, Salvadoran, Spaniard, and so on.*
- ☐ American Indian or Alaska Native — *Print name of enrolled or principal tribe(s), for example, Navajo, Mayan, Tlingit, and so on.*
- ☐ Asian — *Print origin(s), for example, Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, Hmong, Laotian, Thai, Pakistani, Cambodian, and so on.*
- ☐ Native Hawaiian or Other Pacific Islander — *Print origin(s), for example, Native Hawaiian, Guamanian or Chamorro, Samoan, Fijian, Tongan, and so on.*
- ☐ Some other race or origin — *Print race(s) or origin(s).*

On a positive note, the AQE found that the combination question led to more people responding to the race and ethnicity questions. However, the project still recommends further testing of experimental combined questions to refine design strategies.[46] Regardless of the past hurdles, the Census continues to be a tool for research and policy.

Another landmark contributor to policy and the general discussion of mental health was the 2001 supplement report *Mental Health, Culture, Race and Ethnicity.*

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[45] "U.S. Census looking at big changes in how it asks about race and ethnicity." Pew Research Center RSS. Pew Research Center, n.d. Web. 14 Feb. 2014. <http://www.pewresearch.org/fact-tank/2014/03/14/u-s-census-looking-at-big-changes-in-how-it-asks-about-race-and-ethnicity/>.

[46] United States Department of Commerce: Economics and Statistics Administration. US Census Bureau, n.d. Web. 3 Mar. 2014. <http://www.census.gov/2010census/pdf/2010_Census_Race_HO_AQE.pdf>.

Authored by the Surgeon General, it was an addition to the Surgeon General's first ever report exclusively on mental health. The document's value lies its extensive use of polls, demographics, and studies to highlight that the scientific base for race and ethnic minority mental health is inadequate, access to care is poor, and that these minorities tend to receive poorer quality mental health services. The Supplement proved monumental, in that it encouraged state and local authorities to invest in initiatives specific to ethnic minorities. While such prominence of tailored research and services did not occur until later, the Supplement catalyzed the movement as:

> A hallmark of this Supplement is its emphasis on the role that cultural factors play in mental health. The cultures from which people hail affect all aspects of mental health and illness, including the types of stresses they confront, whether they seek help, what types of help they seek, what symptoms and concerns they bring to clinical attention, and what types of coping styles and social supports they possess. Likewise, the cultures of clinicians and service systems influence the nature of mental health services.[47]

By highlighting the role of culture in mental health, the Supplement demonstrated the need for states to allocate resources for ethnic minorities so that unmet health needs could be properly addressed without further burdening the individual.

TEXAS PROGRAMS

The Surgeon General's report and the collected data served to spur Texan investment in mental health care. In 2011, Texas Senate Bill 501 created the Center for Elimination of Disproportionality and Disparities, placing the Center under the Texas Health and Human Services Commission (HHSC). The Center addresses challenges that

[47] "Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General." The Minority Health and Healthy Equity Archive. Minority Health and Healthy Equity, n.d. Web. 8 Feb. 2014. <http://health-equity.pitt.edu/866/>.

burden minorities with poor quality health care, while also serving as a way to organize resources between federal agencies, universities, foundations, communities and offices of minority health. Aside from this specific task, the Center has teamed up with the HHSC to pilot a "help center". The help center is a Cisco technology hub equipped with tools such as bilingual software and a scanner. The hub allows a person visiting the Houston HHSC benefits office to do everything from submit missing documents to reserve translators. The document submissions and requests are automatically referred to the HHSC main offices for processing. A second hub will soon be established in the Valley to further test the software.[48] The goal of this hub concept is increasing the user-friendliness of the overall health care process by facilitating benefits enrollment. In the Valley, users will be able to access advisors in far-away metropolitan areas. Such connectivity will help those with questions get quick health care answers about benefits free of charge.

Further investment in Hispanic Texan mental health care services can be tied to the Affordable Health Care Act. Making general health coverage guaranteed and required, the Act also mandates that insurance plans include coverage for essential health benefits. Among these benefits, as defined by law, is the coverage of mental health and substance abuse treatment.[49] While the Affordable Health Care is changing the dynamics of traditional insurance, it has not been without obstacles in Texas. Two main obstacles

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[48] In Touch: Technology station might help expand benefit services." hhs,gov. US Department of Health and Human Services, n.d. Web. 3 Feb. 2014. <http://www.hhsc.state.tx.us/stakeholder/2014/march-april/7.shtml>.

[49] Law: "In the Senate of the United States, December 24, 2009." hs.gov. US Department of Health and Human Services, n.d. Web. 7 Mar. 2014. <http://www.hhs.gov/healthcare/rights/law/patient-protection.pdf>.

remain regarding the Act's implementation in Texas from the Hispanic perspective. First, a main tenant designed for Hispanic benefit was Medicaid expansion. Medicaid expansion is estimated to extend coverage to 1.5 million uninsured Texans. Though the extension is optional for the state of Texas, the state has received funds from the federal government in an attempt to coax the state into implementation of this supplemental policy.[50] The debate on this issue continues to be contentious and the complete effect on Hispanics has yet to be analyzed. Nonetheless, an expansion would extend coverage to low-income citizens of which Hispanics comprise a large percentage in Texas. A second issue standing as an obstacle to coverage is a lack of knowledge about the Act throughout the Hispanic population. Concerns about immigration status and language barriers are central to this challenge. However, Enroll America's national Get Covered America campaign has placed immense priority on reaching the Hispanic population. Simply by diversifying its enrollment methods in regards to the Latino community, Enroll America has demonstrated its increased focus on this vital segment of the population. Enroll America's toolkit to insure Latinos ranges from coordinating community events to hiring Latinos to go door to door within their communities distributing Spanish materials regarding insurance.[51] Additionally, Texan grocery stores, gas stations, doctor's offices, and shopping malls have designed brochures promoting enrollment in both Spanish and English. The effect of these initiatives has yet to be seen. However, such attempts to reach out to the Latino community are notable.

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[50] "Texas and the Affordable Care Act." www.covertexasnow.org. Cover Texas Now, n.d. Web. 10 Feb. 2014. <http://www.covertexasnow.org/content/texas-and-affordable-care-act>.

[51] "Get Covered America' Campaign Launches in Texas - Get Covered America." Get Covered America RSS. Get Covered America, n.d. Web. 17 Mar. 2014. <https://www.getcoveredamerica.org/press/get-covered-america-campaign-launches-in-texas/>.

POLICY PROPOSALS

In future policymaking, it is imperative to consider the Hispanic perspective within the context of polices already in place. Forecasted for the Hispanic population is tremendous growth and changes resultant from this will be monumental. By 2020, the Texas Hispanic population is expected to outnumber the White population, and between 2020 to 2040, the population is expected to triple in urban areas. High immigration rates coupled with high birth rates make the Comptroller's projections of a 530 percent increase from 1980 to 2040 foreseeable.[52] Clearly, from these colossal numbers, barriers regarding the Latino community must be addressed. Before any policymaking concentrating on Latinos can be made, an accurate, in-depth account of Latinos and their mental health barriers must be outlined.

An outline of Latinos and their mental health barriers would have to be multi-dimensional. At the foundation of this endeavor would be the counting of the Hispanic population by the Texas Comptroller's Office and the US Census Bureau. Though the US Census has improved throughout the years, an accurate numeric portrayal of Hispanics is still in the works. The general public remains uneducated on the technical differences between races and ethnicities. Additionally, Hispanics struggle to identify between origin and ethnicity, a struggle which is only exasperated by the interchanging use of Latino and Hispanic throughout governmental literature. In order to attain an accurate portrait of the population, terms must be standardized and the public educated about their definitions. This may be done through the existing US Census structure. Distributed census forms can

[52] "Demographics." Window on State Government. Window on State Government, n.d. Web. 12 Feb. 2014. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

include a simple informational bulletin on these terms and differences. Furthermore, door-to-door census promoters can be instructed to share this information as well. This innovative action to attain data on the population also serves as a cost-effective way to educate the majority of the US population about the diversity of ethnicities and races.

This push to educate is necessary at a national level because much of the information Texas uses comes from the US Census. The Comptroller's estimates, which are the primary source of demographic information for other state departments, are based mainly on Census estimates. However, Texas must also strategize on the state level. Texas faces the problem of an immense shortage of health professionals, as over 68 percent of counties are considered to have health shortages.[53] Likewise, the shortage of mental health professionals is immense and minorities are greatly underrepresented amongst professionals. Texas must lead in implementing a campaign to increase the awareness and interest of individuals in mental health professions. A model can be found in the White House *Educate To Innovate*, a series of initiatives meant to stimulate participation in the STEM fields. The campaign strategically targets STEM teachers, the private and public sectors as well as the youth to ensure the programs success. Schools and companies partner to provide students with mentors whose careers are in the STEM fields. With a particular focus on women and minorities, the STEM campaign has also formulated a Women in STEM Speakers Bureau to excite girls about careers in STEM areas. Similarly, a campaign can be launched in Texas to showcase careers in mental health professions.

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[53] CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

Such a campaign would target the Hispanic minority by organizing current Hispanic health professionals to speak and serve as role models to their greater community. Organizing a Speakers Bureau would also help in the dissemination of information on mental health and improve health literacy. These presentations could serve as the keynote event for entire health fairs. Hispanic tailored health fairs centered upon heart health and diabetes are becoming increasingly common. These pre-existing forums would be an efficient way to integrate information regarding mental health and professions in it. As more Hispanics work in mental health care, more would become educated about preventative care, diagnostics, and treatment. This is one way to combat stigma that would help the general population and Hispanics.

Once more, this presents an opportunity for Texas to show leadership on a national policy-making stage and beyond as only Mexico has a larger Hispanic population than the US.[54] The entire US will experience an increase in the Hispanic population and campaigns to increase the number of Hispanic mental health professionals will be commonplace. Texas has the opportunity to create a program that works while sharing its structure with others states. By building this on reported demographics, Texas will demonstrate the importance of data-driven solutions.

[54] "Hispanic Americans By the Numbers." Infoplease. Infoplease, n.d. Web. 8 Feb. 2014. <http://www.infoplease.com/spot/hhmcensus1.html>.

CHAPTER FOUR

Youth Populations

This chapter is dedicated to examining the intersections of the rural and Hispanic populations within arguably the most vulnerable population - the youth. In light of multiple societal and economic factors, the youth's risk is compounded more so than other age groups. With little independence, high surrounding stigma, and few specialists available, Hispanic youth suffers tremendously in rural areas. Keeping previous chapters in mind, this chapter will formulate the argument that the youth population's risk is high and in most urgent need of quality mental health care. We will also study barriers constantly faced by mentally ill youth in Texas. To conclude this discussion, policy proposals will be discussed that will benefit Hispanic, rural, and youth populations in the decades to come.

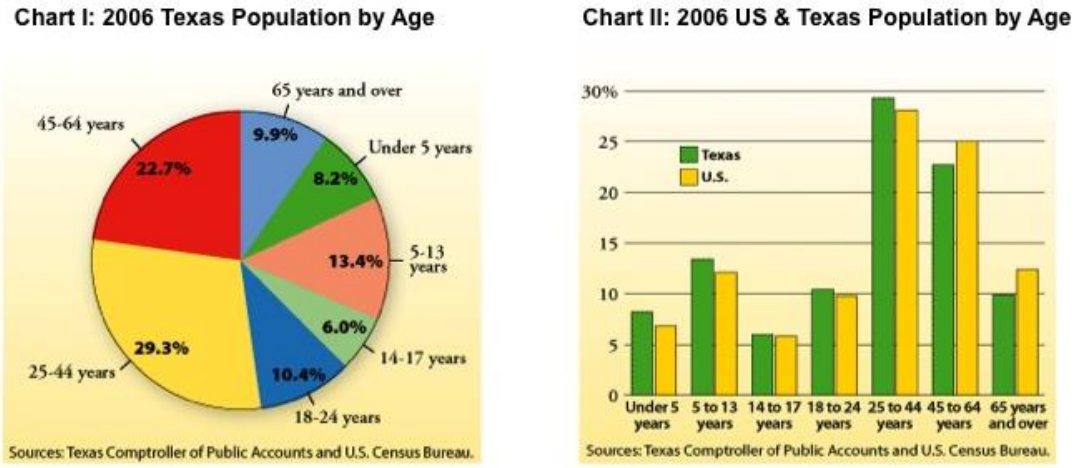
Demographics

DEFINITION OF YOUTH

The definition of the youth varies according to context and defined in terms of adulthood. In the mental health care system, whether or not an individual is a youth will depend on his development and the decision as to what level of treatment he falls under, either youth or adult, is commonly left to the specialist. However, for general purposes one who is under the age of eighteen will be considered a youth in this thesis project. Within the state of Texas, the youth population comprises a large percentage of the total

population (Figure 4.1 Chart I). Similarly, the youth rates in Texas are higher than the national average (Figure 4.1 Chart II).

FIGURE 4.1: POPULATION CHARTS[1]



In Texas, the youth population provides the ideal case study of a multitude of issues facing the vulnerable populations of Texas. One significant, overarching obstacle is the lack of funding. The Texas Department of State Health Services has suffered cuts in funding within departments designed for the youth despite the growing number of youth. By using this provided definition of health and the increasing youth population, this chapter highlights the contradictory nature of further budget cuts.

[1] "Demographics- Texas In Focus." (n.d.). *Windows on State Government*. Retrieved 22 Oct. 2013 <http://www.window.state.tx.us/specialrpt/tif/population.html>.

GENERAL HEALTH

The importance of addressing this population's needs must not be downplayed; the general health of the youth is poor and its negative effects spill over beyond the health care sector. Providing youth services is a challenge that must be addressed immediately. If this is not done, greater pressure will be placed on society's material and nonmaterial rescourses, such as those pertaining to education and individual safety.

Beginning with education, it is alarming to note that approximately 50 percent of students nationally and 40 percent of students in Texas age fourteen and older with a metal disorder drop out of high school. This is the highest drop out rate for any disability group.[2] Children with disorders or emotional disturbance have a harder time adapting to standard classroom settings and are more likely to have trouble focusing. Additionally, their disruptions may affect their relationship with their peers and their peers' learning experience. Statistically, dropouts also increase the strain on welfare and social services such as prisons because they are affiliated with higher rates of crime. This inhibits individuals from becoming well-adjusted adults and productive citizens (economically and socially). Furthermore, it is an economically wise decision to provide adequate mental healthcare to the youth, as indicated by a report by Children At Risk that states that high school dropouts cost Texans an estimated loss of up to $9.6 billion per cohort.[3] Clearly, there is much to be gained from achieving mental wellness.

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[2] "State advocacy" 2010. (n.d.). *State statistics: Texas*.18 Oct. 2013. <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93522>.

[3] Schnee, S., & Martinez, O. (2011, January 23). "Mental health system can't take budget cuts." *Houston Chronicle*. 1 Oct. 2013. < http://www.chron.com/opinion/outlook/article/Mental-health-system-can-t-take-budget-cuts-1690116.php>.

Perhaps the most compelling case advocating the urgency of increased care is the matter of individual safety. Nationally, suicide is the third leading cause of death in youth ages fifteen to twenty-four. In over 90 percent of these cases, a mental disorder is involved. In addition to the emotional toll, such cases are economically burdensome. States spend almost one billion dollars collectively on medical costs of completed suicides and attempts by youth up to age twenty.[4] Once again, these statistics are simply unacceptable and the loss of life unnecessary. The lack of mental health care and its urgency cannot be ignored. Granted, it is a challenge to increase funds and find solutions that are tailored to the youth, but the population is in dire need and therefore this commitment to mental health is non-negotiable.

Relative Risk: The 3 A's

ACCESSIBILITY: SOCIAL STATUS

The youth has an increased relative risk mainly because of social factors affecting its access to mental healthcare. The youth's social status plays a key role in its access to quality care. Social status is defined by the social roles characterizing a population in a specific life stage. Case in point, the social status of infants is limited because of their dependency on adults while the social status of adolescents is monitored because of their notoriously risky behavior. Social status impacts access to societal

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[4] NAMI: Facts on children's mental health in America." Child and adolescent action center. (n.d.). 21 Oct. 2013. <http://www.nami.org/Template.cfm?Section=federal_and_state_policy_legislation&template=%2FContentManagement%2FContentDisplay.cfm&ContentID=43804>.

opportunities, awards, and services. For example due to their age, the youth lack material resources, have restricted political and civil rights, and are excluded from income generation and employment thus furthering obstacles. Lack of material resources may be seen through the fact that youth poverty rates are inordinately high; in Texas, child poverty is rampant at twenty six percent and growing.[5] In correlation, the youth are greatly dependent on adults and not full-fledged participants in society. This lack of autonomy increases obstacles to the accessibility of care.

Intertwined with social status is social capital. The lack of social capital supplies another factor of risk and vulnerability to the youth population. Social capital is the quality and quantity of interpersonal ties, basically the support system created by our society. Investments in an individual's skills and abilities, such as education, are major sources of social capital that increase individual human capital and are associated with better overall health. Increasing human capital is important because such growth helps an individual form his identity while instilling a stable sense of value. Because the youth do not have a stable sense of identity, they are subject to increased relative risk. Furthermore, social capital and human capital also play a role in the organization of the youth as constituents. Unlike the elderly, the youth have limited capital and are less of a political force. As a result, concerns regarding access to mental health care may not come to light.

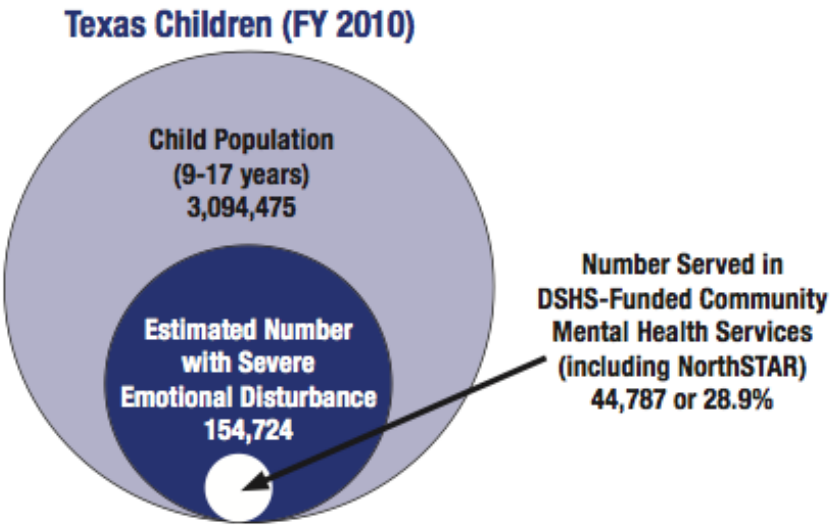
[5] Children in Poverty." datacnter.kidscount.org. Kids Count Data Center, 1 Jan. 2012. Web. 20 Nov. 2013. <http://datacenter.kidscount.org/data/tables/43-children-in-poverty?loc=1&loct=2#ranking/2/any/true/868/any/322http://datacenter.kidsco>.

ACCEPTABILITY: MISBEHAVIOUR STIGMA

In terms of acceptability, stigma poses the greatest barrier for the youth in accepting mental health care systems. Interestingly, unlike other vulnerable populations who hold a stigma against all things mental health related, it is not the youth who hold such positions; rather, it is the adults around them. The two main stigmas are the following: first, the vitality of youth makes the youth unable to experience mental illness and second, that mental health is simply misbehavior or a bad attitude. Such stigmas create significant barriers to youth in need of services for mental wellness.

Many parents struggle to come to terms with the fact that someone so young could be emotionally disturbed. We often associate youth with an immunity to disease. However, emotional disturbance in children is strikingly common. Note that in Texan children, emotional disturbances are comparable to full-fledged mental illness in adults (Figure 4.2).

FIGURE 4.2 UNMET NEED FOR COMMUNITY MENTAL HEALTH SERVICES[6]



In too many cases, parents are uneducated as to how emotional disturbances presents in children and thus thousands of cases advance without professional care. Parents and society in general do not realize that misbehavior can also be symptom of an emotional disturbance. If left untreated, the misbehavior will crescendo into a situation where law enforcement becomes involved.

Interactions between mental illness and law enforcement often occur throughout the juvenile correctional system. What is the relation between mental wellness and incarceration? Particularly in the youth where cases may be hard to diagnose, emotional disturbance may manifest itself in the form of crime. According to a National Institutes of Mental Health (NIMH) funded study, a distressing 65 percent of boys and 75 percent of girls in juvenile detention have at least one mental disorder. The NIMH report is the

[6]" CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 12 Dec. 2013. <http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf>.

largest study analyzing the juvenile delinquent population. It proves significant as it highlights the disparities of youth (some as young as eight years old) who tragically end up within the correctional system due to undiagnosed and untreated mental disorders.[7] As for Texas' involvement, the state is infamous for having a large population of inmates and detained juveniles. Certainly, these are unacceptable issues that can be resolved with an extension of quality, accessible mental health services.

AVAILABILITY: FEW SPECIALISTS

Underlying obstacles in accessibility and acceptability contribute to barriers of availability. The fundamental problem in availability is the dwindling number of professionals specializing in mental health for the youth. The Hogg Foundation for Mental Health reports that, while studies estimate that 14.38 child and adolescent psychiatrists (CAPs) per 100,000 youth are needed, Texas has less than half the recommended number with 6.7 CAPS per 100,000.[8] Coupled with the fact that most CAPs are concentrated in urban areas, barriers are heightened. As discussed in Chapter 2, professionals choose to not set up their practice in rural areas for numerous reasons. Nonetheless, there is a high need, especially within the Hispanic population as discussed in Chapter 3. The Hispanic rural youth takes the hardest hit as not only are professionals hard to find in rural areas but most of these are neither culturally nor linguistically diverse.

[7] Schnee, S., & Martinez, O. (2011, January 23). Mental health system can't take budget cuts. *Houston Chronicles*. 1 Oct. 2013. < http://www.chron.com/opinion/outlook/article/Mental-health-system-can-t-take-budget-cuts-1690116.php>.

[8]"CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 12 Dec. 2013.

Policy Evaluation

SIGNIFICANT POLICIES

In discussing policies of the past and present, it is important to become informed of the current status of the youth population within a national context and more specifically, Texas. Nationally, statistics indicate that one in four children or youth will have a mental illness or serious emotional disturbance.[9] There are around four million children and adolescents suffering from said conditions and significant impairments in their interactions with their society. Yet from this number, only 20 percent of cases are detected and administered mental health services.[10] Rather than being overwhelmed by these numbers and the lack of care, we should see view these facts as motivation to improve the system and opportunities for reform.

There is much room for optimism when addressing the youth population. Half of all lifetime cases of mental disorders begin by the age of fourteen and 75 percent by age twenty-four. Early detection and preventative methods can minimize co-occurring mental illness down the road and reduce overall health expenditures.[11] The youth also has great resiliency, a great tool in achieving mental health. Additionally, the youth population is still at its development stage. That is, neuronal pathways are still being arranged, hormone levels are fluctuating immensely and certain behavioral patterns are barely

[9] Family guide: children's mental health services . (n.d.). *Texas resiliency and recovery*. 21 Oct. 2013. <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979979>.

[10] Texas resiliency and recovery." Family guide: children's mental health services . (n.d.). 21 Oct. 2013. <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979979>.

[11] Schnee, S., & Martinez, O. (2011, January 23). Mental health system can't take budget cuts. *Houston Chronicles*. 1 Oct. 2013 <http://www.chron.com/opinion/outlook/article/Mental-health-system-can-t-take-budget-cuts-1690116.php>.

beginning to form. Because of these facts, administrators of mental health services should find hope in that the population is very malleable and flexible as to methods of care.

The publicly funded Texas mental health care system has begun to shift into a more positive, modern outlook aligned with national trends. In recent efforts, most significant in combating the issues of accessibility and acceptability is the redesign of Texas' mental health system under the Department of State Health Services. This change in mission has greatly impacted departments servicing the youth. In 2012, the name of the system was changed from Resiliency and Disease Management (RDM) to Texas Resilience and Recovery (TRR). The shift from RDM to TRR signifies an alignment with federal policy that is moving towards a patient centered view rather than a disease centered focus. Change in the Texan system is significant far beyond the name change. The Texan system has sought to incorporate resilience and recovery-oriented support and practices within the entirety of its publicly funded mental health care system.[12] Youth programs are a fundamental part of this initiative.

Central to this redesign is that mental health is a continuum. As a result of this perspective, early development and intervention become increasingly important For example, in order to align all Texan mental health policies, the Texas Recommended Assessment Guidelines (TRAG) used to diagnoses and evaluate the treatment of mental health in the youth was replaced in 2013 with Child and Adolescent Needs and Strengths

[12] "Texas resiliency and recovery." Family guide: children's mental health services . (n.d.). Retrieved 22 Oct. 2013. <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979979>.

(CANS).[13] As seen through these name changes, the state is dedicated to applying positive, inclusive wording.

Most of these changes by the state of Texas are based on feedback and input from the mental health community. While subcommittees have been charged with integrating best practices, there has not been a tremendous effort to consolidate data. However, there are resources already beginning data collection on the youth. Though privately funded, the Annie E. Casey Foundation's campaign, Kids Count, has proven to be a great resource for Texan policy. The regional branch of Kids Count is housed under the Center for Public Policy Priorities, a research organization housed in Texas dedicated to research for public policies. Kids Count Texas has reported on poverty, race and opportunity, and tracks a series of indicators on its website. The website is specifically policy-maker friendly, allowing for the generation of customized data profiles, maps, and trend lines on select indicators. This information is linked to the Kids Count database allowing it to be automatically updated when new data is uploaded. Additionally, the campaign issues an annual data book, State of Texas Children, which relates the standard of living of Texan children through data and policy analysis.[14] Though the resources are not comprehensive, they still represent an underutilized tool by the state legislature.

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[13] Texas Resilience and Recovery (formerly RDM): The Mental Health System Redesigned." Texas Resilience and Recovery (TRR). N.p., n.d. Web. 6 Dec. 2013. <http://www.dshs.state.tx.us/mhsa/trr/>.

[14] "The State of Texas Children 2012 :: Overview." The State of Texas Children 2012 :: Overview. N.p., n.d. Web. 15 Dec. 2013. <http://www.cppp.org/sotc/>.

TEXAS PROGRAMS

The state legislature has invested in innovative solutions that are considered alternatives to the traditional mental health care delivery system. Working in tandem with the 2009 Texas Mental Health Transformation Project, the State began investing in the Via Hope Texas Mental Health Resources organization. As part of The University of Texas at Austin Center for Social Work Research, the Texas Department of State Health Services provides funding in conjunction with the private Hogg Foundation for Mental Health. Together these two fund an innovative organization that supports youth engagement, integration of peer specialists, and training for families.

Via Hope is unique in that it seeks to transform the Texas mental health system through a recovery focused process that is centered on resilience, the individual, youth, and family. The organization provides practical technical training, assistance, and consultation to individuals involved in the recovery process. The first strategy used is the organization's integration of youth engagement. Not only does the organization work with individual youth to promote advocacy and education programs within Via Hope, it also seeks to formalize their involvement in other venues. The organization has devoted resources to the initiative, expanding the capacity of systematic youth engagement in councils and coalitions dedicated to mental health. The second fundamental initiative Via Hope launched in 2010 has also been significantly effective.

The Peer Specialist program seeks to ease the burden of local mental health centers while simultaneously combating the shortage of mental health professionals. Peer specialists are trained by Via Hope to deliver consultative support in provider settings.

Specialists are trained through a rigorous process to service the mental health needs of their community. In conjunction with a competitive application process, the program has garnered much interest from providers seeking to hire Peer Specialists. This program has the potential to create a completely new stream of support for mental health professionals. Complementary to this is Via Hope's third initiative is the program's provision of a family partner training and certification. Certified Family Partners (CFPs) are parents or guardians who have personally raised a child with emotional disturbances and mental challenges.[15] CFPs train to help other parents experiencing these issues for this first time. In these ways Via Hope empowers citizens with educational tools to promote mental wellness. Additionally, the organization creates a new stream of support for mental health professionals.

POLICY PROPOSALS

The youth population is most vulnerable when its members fall into both the Hispanic and rural population classifications. Policies in rural areas are not as developed, especially in the case of minority children. The following policy proposal takes this into consideration and discusses the implantation of a new policy within the context of an already existing framework. In alignment with the main argument of this thesis, this policy would ensure that funds are used strategically in order to optimize the use of state resources.

[15] "Our Programs." *mhatexas.org*. Mental Health America: of Texas, n.d. Web. 15 Dec. 2013. <http://www.mhatexas.org/#!/programs/via-hope/>.

While Chapters Two and Three make the case for the necessity of increasing mental health staff and professionals, training of current staff is equally important. In a study of the rural South Texas Coast Bend, nineteen percent of schools surveyed had no mental health services whatsoever.[16] Integrating mental health activity into schools is a way to ensure an audience, as well as maximize resource use and efficiency. This can be done through the following two ways. First, furthering the training of teachers, counselors, and administrators in schools is necessary. As seen through Texas' new approach, mental health is an ongoing challenge that is present in every daily activity. For the youth, school is part of their weekly routine. Their interactions with authorities that are well versed in mental health literacy, symptoms, and resources would decrease the number of undiagnosed children as well as increase the number that seek treatment. In the Coast Bend study, school councilors perceived that thirty percent of families had no understanding of mental health. Moreover, of the counselors surveyed, all respondents affirmed that it would be beneficial to extend staff development, include a mental health day, or create workshops to educate teachers and staff.[17] Teachers and counselors in particular develop relationships with both the youth and their parents. Using the existing relationship of trust and respect might decrease the stigma possessed by parents hesitant to seek treatment. The school staff, having knowledge of what resources are available for youth in the area, would at the very least be able to direct families to appropriate authorities.

[16] Bain, Steve F., Breeze Rueda, Jennifer Mata-Villareal, and Marie-Anne Mundy. "Assessing mental health needs of rural schools in South Texas: Counselors' perspectives." aabri.com. Research in Higher Education Journal, n.d. Web. 18 Dec. 2013. <http://www.aabri.com/manuscripts/11998.pdf>.

[17] Bain, Steve F., Breeze Rueda, Jennifer Mata-Villareal, and Marie-Anne Mundy. "Assessing mental health needs of rural schools in South Texas: Counselors' perspectives." aabri.com. Research in Higher Education Journal, n.d. Web. 18 Dec. 2013. <http://www.aabri.com/manuscripts/11998.pdf>.

The costs of time and money associated with the training necessary for teachers to partake in such policies would be fairly minimal. Participation could occur within the school year or even during summer staff training. Other states that require such training have found that it does not take a large amount of time to present the necessary information. Additionally, a new policy could mandate schools to require that counselors or directors enroll in the Peer Specialist program as part of professional development. The Via Hope program is available at little to no cost and the organization is dedicated to such staff development. Another efficient way of increasing mental health resources for the youth could be achieved through the acquisition of a Graduate Counseling Intern. Designating a single staff member as a Peer Specialist or having an expert in the field integrate into a school system could make a significant impact on mental wellness in the educational structure. All would reap benefits, but considering that most schools already have a requirement of cultural competency and linguistic diversity in place, minority youth stand to gain even more.

The impact of such positive effects such a policy would pose for minority youth is substantial. Texas youth of color are one-third to one-half as likely as White youth to receive the mental health care they need.[18] With the Latino population standing at approximately 868,000 in non-metro areas, this fact takes on significant importance.[19] Moreover, representatives of education, probation, or child welfare most often refer youth

[18] "Juvenile Justice, Mental Health, and Youth of Color: A Framework for Action in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, 1 Jan. 2010. Web. 21 Dec. 2013. <http://www.hogg.utexas.edu/uploads/documents/JuvenileJustice.pdf>.

[19] Saenz, Rogelio. "A Profile of Latinos in Rural America." carseyinstitute.unh.edu. Carsey Institute, 1 Jan. 2010. Web. 9 Dec. 2013. <http://www.carseyinstitute.unh.edu/publications/FS_RuralLatinos_08.pdf>.

of color to mental health services.[20] Considering these facts, the capacity of the educational system to identify and address mental health issues in minority children is greatly strengthened by initiatives in schools. The common factor of educational infrastructure in rural and urban areas means that both populations could benefit. Urban areas have more mental health programs in place with one example being Dallas ISD's comprehensive school-based mental health centers (one of the first in the nation).[21] While such programs would be ideal they are not yet achievable due to high implementation costs. However, this proposed policy serves to lay the foundational infrastructure needed for a program such as Dallas' to come to fruition within rural school systems.

We end on this specific policy because of its centrality in regards to other initiatives. In fact, each of the policies previously recommended works in conjunction with it. With the data gathered from the rural mental health report, as well as the Hispanic demographics, training for the educational system could be tailored to specific community needs. While this youth policy would serve to guide students to acceptable services, polices proposed in the rural and Hispanic chapters would ensure that services are available and accessible to the youth. The interconnectedness of these policies must be highlighted to fully appreciate their potential benefits for Texans.

Investing in Texas youth through the mental health system must be a priority. Not only is it economically wise, but is also representative of the state's valuation of its citizens. A commitment to youth mental wellness empowers an entire demographic to

[20] "Juvenile Justice, Mental Health, and Youth of Color: A Framework for Action in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, 1 Jan. 2010. Web. 21 Dec. 2013. <http://www.hogg.utexas.edu/uploads/documents/JuvenileJustice.pdf>.

[21] "History of the Youth and Family Centers." dallasisd.org. Dallas Independent School District, n.d. Web. 9 Dec. 2013. <http://www.dallasisd.org/Page/27209>.

build up its human capital while expanding its opportunities. While less than half of the youth in Texas receive the treatment they need, there is still hope for the Texan system.[22] However, the Texas public mental health system must remedy this quickly to avoid exacerbating existing challenges.

[22] "Juvenile Justice, Mental Health, and Youth of Color: A Framework for Action in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, 1 Jan. 2010. Web. 21 Dec. 2013. <http://www.hogg.utexas.edu/uploads/documents/JuvenileJustice.pdf>.

CONCLUSION

While it is clear Texas' mental health care system is in crisis, the state stands at a crossroads that offers the opportunity for significant systematic improvements that could transform the state into a leader of mental health care policy. Texas has already begun the arduous task of dedicating itself to change, with reforms within the Mental Health and Substance Abuse Division of the Texas Department of State Health Services serving as one of the strongest examples. Arguably the most significant indicator of the Lone Star state's commitment is the increased mental health spending passed into law this past legislative session. While notably the largest increase in budget in state history, with an increase of $259 million over the next two years, this funding is simply not enough to institute the quality mental health services Texans deserve.[1] The immense size of Texas and its unique demographics imply the prevalence of vulnerable populations who require special attention. It is necessary to recognize that, through the use of existing infrastructure, data-driven solutions, and professional development, Texas can overcome barriers in acceptability, accessibility, and availability. The Texan educational system proves to be one of the most efficient and effective delivery systems for mental health services. If policymakers unite to institute these strategic policies, Texas will have an opportunity to improve the standard of living for all. The world knows everything is better in Texas; it is high time for mental health to be included in that boast.

[1] "What Has Your State Done to Improve Mental Health Care?." nami.org. Nami: National Alliance on Mental Illness , n.d. Web. 3 Dec. 2013. <http://www.nami.org/Content/NavigationMenu/Top_Story/What_Has_Your_State_Done_to_Improve_Mental_Health_Care_.htm>.

BIBLIOGRAPHY

"2010 CENSUS PLANNING MEMORANDA SERIES ." census.gov. United Stated Department of Commerce: Economics and Statistics Administration, n.d. Web. 11 Feb. 2014. <http://www.census.gov/2010census/pdf/2010_Census_Race_HO_AQE.pdf>.

A national plan to combat mental retardation. (n.d.). *JFK Maternal Child Health & Retardation Act*. 15 Oct. 2013. <https://www.arcmass.org/JFKMaternalChildHealthRetardationAct.aspx>.

Aday, L. A. "At risk in America the health and health care needs of vulnerable populations in the United States" (2nd ed.). (2001). San Francisco: Jossey-Bass Publishers.

Allee, S., & Jones, D. (n.d.). TEXAS DEPARTMENT OF MENTAL HEALTH AND MENTAL RETARDATION. *Handbook of Texas online*. 7 Sept. 2013, <http://www.tshaonline.org/handbook/online/articles/mctvf>.

Bain, Steve F, Breeze Rueda, Jennifer Mata-Villarreal, and Marie-Anne Mundy. " Assessing mental health needs of rural schools in South Texas: Counselors' perspectives." Research in Higher Education Journal . n. page. Web. 17 Dec. 2013. <http://www.aabri.com/manuscripts/11998.pdf>.

Bloom DE, Cafiero ET, Jané-Llopis E, Abrahams-Gessel S, Bloom LR, Fathima S, Feigl AB, Gaziano T, Mowafi M, Pandya A, Prettner K, Rosenberg L, Seligman B, Stein A, Weinstein, C. "The Global Economic Burden of Non-communicable Diseases." (2011). Geneva: World Economic Forum.

Bridgeland, John. "Can Government Play Moneyball?." The Atlantic. Atlantic Media Company, 19 June 2013. Web. 9 Jan. 2014. <http://www.theatlantic.com/magazine/archive/2013/07/can-government-play-moneyball/309389/>.

"Can cost-effective health care = better health care?." HSPH News. N.p., n.d. Web. 16 Dec. 2013. <http://www.hsph.harvard.edu/news/magazine/winter10assessment/>

Census History: Counting Hispanics." Pew Research Centers Social Demographic Trends Project RSS. Pew Research Center, n.d. Web. 28 Jan. 2014. <http://www.pewsocialtrends.org/2010/03/03/census-history-counting-hispanics-2/>.

"Changing the Way U.S. Hispanics Are Counted." prb.prg. Public Reference Bureau, n.d. Web. 25 Jan. 2014. <http://www.prb.org/Publications/Articles/2012/us-census-and-hispanics.aspx>.

Children in Poverty." datacnter.kidscount.org. Kids Count Data Center, 1 Jan. 2012. Web. 20 Nov. 2013. <http://datacenter.kidscount.org/data/tables/43-children-in-poverty?loc=1&loct=2#ranking/2/any/true/868/any/322http://datacenter.kidsco>.

Conaboy, C. "US On The Cusp Of Mental Health Advances, Biden Says." *Boston Globe*. 25 Oct. 2013 <http://www.bostonglobe.com/metro/2013/10/23/biden-and-sebelius-attend-jfk-library-gala-outraging-republicans/qtAKx6Ac9cnaepUhMTv0bP/story.html>.

"Congressional Edition." Google Books. US Congress, n.d. Web. 14 Feb. 2014. <http://books.google.com/books?id=APVGAQAAIAAJ&pg=PA1031&lpg=PA1031&d, q=dallas+340+square+miles&source=bl&ots=kY2ut5_hxZ&sig=o8wRdfc3n9wDBy_o5b2ntTq1niU>.

"Consumer Benefits." The Burke Center, n.d. Web. 18 Feb 2014.

Creson, D. "MENTAL HEALTH." (n.d.). Handbook of Texas online. 7 Sept. 2013. <http://www.tshaonline.org/handbook/online/articles/smmun>.

"CRISIS POINT: Mental Health Workforce Shortages in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, n.d. Web. 7 Jan. 2014. http://www.hogg.utexas.edu/uploads/documents/Mental_Health_Crisis_final_032111.pdf.

David, Mechanic. "Mental Health Services Then And Now." Health Affairs. Last modified 2009. 29 Sept. 2013.< http://content.healthaffairs.org/content/26/6/1548.full>.

"Demographic Profile of Hispanics in Texas, 2011." Pew Research: Hispanic Trends Project. Pew Research, n.d. Web. 20 Nov. 2013. <http://www.pewhispanic.org/states/state/tx/>.

Demographics- Texas In Focus. (n.d.)." Windows on State Government. 22 Oct. 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

Dichoso, Sheila, and Copyright 2011. "Stigma haunts mentally ill Latinos." CNN. Cable News Network, 15 Nov. 2010. Web. 28 Nov. 2013. <http://www.cnn.com/2010/HEALTH/11/15/latinos.health.stigma/>.

"Directory." rethn.org. Rural East Texas Health Network. Web. 22 Jan 2014. <http://www.rethn.org/resize.asp?h=730>.

"Doctors Need Apply: Incentives for Rural Physicians." *Doctors Need Apply: Incentives for Rural Physicians*. Texas Medical Association Insurance Trust, n.d. Web. 7 Feb. 2014. <http://www.tmait.org/articles-and-insights/case-in-point/doctors-need-apply-incentives-for-rural-physicians/>.

"Dorothea Lynde Dix." (n.d.). History.com.Web. 21 Oct. 2013.

Family guide: children's mental health services . (n.d.). *Texas resiliency and recovery*. 21 Oct. 2013. <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979979>.

"First Lady Biography: Rosalynn Carter." National First Ladies' Library. 29 Sept. 2013. <http://www.firstladies.org/biographies/firstladies.aspx?biography=40>.

Garret, R. "Texas mental health care funding has stagnated, even as calls to boost efforts grow." (2013, February 11). The Dallas Morning News. 15 Sept. 2013. <http://www.dallasnews.com/news/politics/state-politics/20130211-texas-mental-health-care-funding-has-stagnated-even-as-calls-to-boost-efforts-grow.ece>.

"Get Covered America' Campaign Launches in Texas - Get Covered America." Get Covered America RSS. Get Covered America, n.d. Web. 17 Mar. 2014. <https://www.getcoveredamerica.org/press/get-covered-america-campaign-launches-in-texas/>.

"Global status report on non-communicable diseases 2010." World Health Organization. (WHO 2011a). Geneva: WHO.

"Grading the States 2009: A Report On America's Health Care System for Adults with Serious Mental Illness from the National Alliance on Mental Illness." The state of public mental health services across the Nation. (n.d.). 27 Sept. 2013. <http://www.nami.org/gtsTemplate09.cfm?Section=Findings&Template=/ContentManagement/ContentDisplay.cfm&ContentID=75255>.

Grob, Gerald. "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health." Milbank Quarterly . no. 3 (2005): 425–456. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2690151/>.

"Guest Post: Why American Medicine Needs A Moneyball Moment." CommonHealth RSS. N.p., n.d. Web. 15 Dec. 2013. <http://commonhealth.wbur.org/2011/12/medicine-moneyball>.

"History of the Youth and Family Centers." dallasisd.org. Dallas Independent School District, n.d. Web. 9 Dec. 2013. <http://www.dallasisd.org/Page/27209>.

"Helen Farabee Centers." HFC Home. N.p., n.d. Web. 10 Feb. 2014. <http://www.helenfarabee.org/>.

"Helen Farabee Regional MHMR Centers PROVIDER NETWORK DEVELOPMENT PLAN." *HelenFarabee.org*. Helen Farabee Regional MHMR Centers, n.d. Web. 8 Feb. 2014. <http://www.helenfarabee.org/Download/LPND.pdf>.

Help seeking for mental health care among poor Puerto Ricans: problem recognition, service use, and type of provider.." National Center for Biotechnology Information. U.S. National Library of Medicine, n.d. Web. 2 Feb. 2014. <http://www.ncbi.nlm.nih.gov/pubmed/9674622>.

"Hispanic Americans By the Numbers." Infoplease. US Census Bureau, n.d. Web. 20 Feb. 2014. <http://www.infoplease.com/spot/hhmcensus1.html>.

"Hispanic Origin." United States Census Bureau. U.S. Department of Commerce. Web. 20 Nov 2013. <http://quickfacts.census.gov/qfd/meta/long_RHI825212.htm>.

"Hispanic-Latino." psychiatry.org. American Psychiatric Association, n.d. Web. 4 Nov. 2013. <http://www.psychiatry.org/latinos>.

"Hogg Foundation Awards Scholarships to Graduate Social Work Students in Texas." Hogg Foundation of Mental Health. N.p., 12 Jul 2011. Web. 5 Dec 2013. <http://www.hogg.utexas.edu/detail/214/ima_hogg_scholars_ 2011.html>.

In Touch: Technology station might help expand benefit services." hhs,gov. US Department of Health and Human Services, n.d. Web. 3 Feb. 2014. <http://www.hhsc.state.tx.us/stakeholder/2014/march-april/7.shtml>.

ipl2: Stately knowledge: facts about the United States" States ranked by size & population. (n.d.). ipl.org, 21 Oct. 2013 <http://www.ipl.org/div/stateknow/popchart.html>.

"*Isolation and Segregation of Latino English Language Learners*." N.p., n.d. Web. 25 Feb. 2014. <http://www.census.gov/hhes/socdemo/language/data/census/li-final.pdfdevelopments/court-decisions/the-educational-implications-of-linguistic-isolation-and-segregation-of-latino-english-language-learners-ells>.

JFK and people with intellectual disabilities. (n.d.). *John F. Kennedy Presidential Library & Museum*. 16 Oct. 2013. < http://www.jfklibrary.org/JFK/JFK-in-History/JFK-and-People-with-Intellectual-Disabilities.aspx>.

"Juvenile Justice, Mental Health, and Youth of Color: A Framework for Action in Texas." hogg.utexas.edu. Hogg Foundation for Mental Health, 1 Jan. 2010. Web. 21 Dec. 2013. <http://www.hogg.utexas.edu/uploads/documents/JuvenileJustice.pdf>.

"Kennedy's vision for mental health never realized." The Associated Press (2013, October 20). USA Today. 22 Oct. 2013. <http://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>.

Kemp, C. & Rashbridge L.A. (2004). Mexico In *Refuge and Immigrant: A Handbook for Health Professionals* (pp. 260-270). Cambridge: Cambridge University Press.

Law: "In the Senate of the United States, December 24, 2009." hs.gov. US Department of Health and Human Services, n.d. Web. 7 Mar. 2014. <http://www.hhs.gov/healthcare/rights/law/patient-protection.pdf>.

Lopez, Marc Hugo "Hispanic or Latino? Many don't care, except in Texas." Pew Research Center. Pew Research, 28 Oct 2013. Web. 8 Nov. 2013. <http://www.pewresearch.org/fact-tank/2013/10/28/in-texas-its-hispanic-por-favor/>.

"Latino Community Mental Health Fact Sheet ." nami.org. Nami Multicultural Action Center, n.d. Web. 11 Feb. 2014. <http://www.nami.org/Content/NavigationMenu/Find_Support/Multicultural_Support/Annual_Minority_Mental_Healthcare_Symposia/Latino_MH06.pdf>.

"Mental Health Counselor: Salary." US News: Money. US News. Web. 17 Dec. 2013. <http://money.usnews.com/careers/best-jobs/mental-health-counselor/salary>.

"Mental Health: Culture, Race, and Ethnicity-A Supplement to Mental Health: A Report of the Surgeon General." The Minority Health and Healthy Equity Archive. Minority Health and Healthy Equity, n.d. Web. 8 Feb. 2014. <http://health-equity.pitt.edu/866/>.

"Mental Health Disparities: Hispanics/Latinos ." apa.org. American Psychological Association, n.d. Web. 8 Nov. 2013. <.http:file:///C:/Users/Priscilla/Downloads/fact-sheet---latinos%20(1).pdf.>.

"Mental Health in the Hispanic/Latino Community." psychiatry.org. American Psychiatric Association, n.d. Web. 6 Feb. 2014. <http://www.psychiatry.org/File%20Library/Mental%20IIlness/Lets%20Talk%20Facts/APA_Ment-Hisp_ENGL_B3_4-10-08_2.pdf>.

"Mental Health Parity and Addiction Equity Act." (n.d.). American Psychological Association (APA). 24 Oct. 2013. <http://www.apa.org/helpcenter/parity-law.aspx?item=2>.

"Mental Health Systems Legislation Message to the Congress Transmitting the Proposed Legislation ." The American Presidency Project. 1 Oct.2013. < http://www.presidency.ucsb.edu/ws/?pid=32339>.

NAMI: Facts on children's mental health in America." Child and adolescent action center. (n.d.). 21 Oct. 2013. <http://www.nami.org/Template.cfm?Section=federal_and_state_policy_legislati

on&template=%2FContentManagement%2FContentDisplay.cfm&ContentID=43804>.

National Center for Biotechnology Information . National Center for Biotechnology Information , n.d. Web. 2 Nov. 2013. <http://www.ncbi.nlm.nih.gov/books/NBK44247/#A2285>.

National Rural Health Association, Issue Paper 13, "Physician Recruitment and Retention," November 1998, Kansas City, Mo., available a t*www.nrharural.org/dc/issuepapers/ipaper13.html*.

Non-Profit Organization. National Rural Health Association. Workforce Series: Rural Behavioral Health. Web.

"On Co-Occurring Mental Health and Substance Abuse Disorders " mwcog.org. Metropolitan Washington Council of Governments Co-Occurring Disorders Committee, n.d. Web. 26 Jan. 2014. <https://www.mwcog.org/uploads/pub-documents/8FpZWw20060313155447.pdf>.

"Our Programs." *mhatexas.org*. Mental Health America: of Texas, n.d. Web. 15 Dec. 2013. <http://www.mhatexas.org/#!/programs/via-hope/>.

"Overview of Race and Hispanic Origin: 2010." US Census Bureau . US Census Bureau , n.d. Web. 15 Nov. 2013. <http://www.census.gov/prod/cen2010/briefs/c2010br-02.pdf>.

Paper: Arciniega, G. Miguel, Thomas C. Anderson, Zoila G Tovar-Blank, and Terence J. G. Tracey. "Toward a fuller conception of Machismo: Development of a traditional Machismo and Caballerismo ScaleR." Research Gate. Journal of Counseling Psychology, 1 Jan. 2008. Web. 13 Jan. 2014. <http://www.researchgate.net/publication/232558454_Toward_a_fuller_conception_of_Machismo_Development_of_a_traditional_Machismo_and_Caballerismo_Scale/file/9fcfd50be76ffcb9af.pdf.>.

Parangimalil, G. J. (2001). Latino health in the new millennium: The need for a culture-centered approach. *Sociological Spectrum*, *21*, 423-429.

Reschovsky, James D., and Andrea Staiti. "Physician Incomes in Rural and Urban America." Center for Studying Health System Change. 92 (January 2005): n. page. Web. 21 Feb. 2014. <http://www.hschange.com/CONTENT/725/>.

"RETHN.". The Lufkin News, 19 May 2013. Web. 15 Feb 2014. <http://lufkindailynews.com/business/image_bdddfa9e-bfef-11e2-b123-0019bb2963f4.html>.

Rodriguez, Cindy. "Latinos struggle to find help for mental health issues." CNN. Cable News Network, 1 Jan. 1970. Web. 17 Jan. 2014. <http://www.cnn.com/2013/10/09/health/latino-mental-health-disparities/>.

Rosenhan, David, "The Rosenhan Study: On Being Sane in Insane Places," Science, 179, no. 4070 (1973): 250-258.

Rong, Xue Lan, and Judith Preissle. Educating immigrant students in the 21st century: what educators need to know. 2nd ed. Thousand Oaks, Calif.: Corwin Press, 2009. Print.

"Rural East Texas Health Network." rethn.org. Rural East Texas Health Network. Web. 22 Jan 2014. <http://www.rethn.org/resize.asp?h=730>.

"Rural Texas In Transition." *Rural Texas In Transition*. Window on State Government, n.d. Web. 14 Feb. 2014. <http://www.window.state.tx.us/specialrpt/rural/7wherenow.html>.

Sherman, Lauren. "America's 10 Fastest-Growing States." Forbes. (2008): n. page. Web. 14 Nov. 2013. <http://www.forbes.com/2008/12/22/fastest-growing-states-forbeslife-cx_ls_1222realestate_slide_9.html>.

Saenz, Rogelio. "A Profile of Latinos in Rural America." carseyinstitute.unh.edu. Carsey Institute, 1 Jan. 2010. Web. 9 Dec. 2013. <http://www.carseyinstitute.unh.edu/publications/FS_RuralLatinos_08.pdf>.

SAMHSA, National Survey APA Fact Sheet. Web. 20 Nov. 2013. <http://www.psychiatry.org/File%20Library/Practice/Diversity%20OMNA/Diversity%20Resources/Fact-Sheet---Latinos.pdf>.

Schnee, S., & Martinez, O. (2011, January 23). "Mental health system can't take budget cuts." *Houston Chronicle*. 1 Oct. 2013. < http://www.chron.com/opinion/outlook/article/Mental-health-system-can-t-take-budget-cuts-1690116.php>.

Shah, Anuj K. , Sendhil Mullainathan, and Eldar Shafir. "Some Consequences of Having Too Little." sciencemag.org. Science Magazine, n.d. Web. 13 Dec. 2013. <http://www.sciencemag.org/content/338/6107/682>.

Spector, R. (1996). Health and illness in Hispanic American communities. In R. Spector (Ed.), *Cultural diversity in health and illness* (4th Ed., pp. 279-297). Stanford, CT: Appleton and Lange.

"State advocacy" 2010. (n.d.). *State statistics: Texas*.18 Oct. 2013. <http://www.nami.org/ContentManagement/ContentDisplay.cfm?ContentFileID=93522>.

"State Health Facts." State Mental Health Agency (SMHA), Per Capita Mental Health Services Expenditures . (n.d.). 27 Sept. 2013. <http://kff.org/other/state-indicator/smha-expenditures-per-capita/>.

States ranked by size & population. (n.d.). *ipl2: Stately Knowledge: Facts About the United States*. 21 Oct. 2013. <http://www.ipl.org/div/stateknow/popchart.html>.

Su, Dejen, Chad Richardson, Ming Wen, and Jose A. Pagan. "Cross-Border Utilization of Health Care: Evidence from a Population-Based Study in South Texas." Wiley Online Library. Health Research and Educational Trust, 1 Jan. 2010. Web. 11 Dec. 2013. <http://onlinelibrary.wiley.com/doi/10.1111/j.1475-6773.2010.01220.x/abstract>.

Surgeon General, HHS. (2001) Mental Health: Culture, Race and Ethnicity 2001. <www.surgeongeneral.gov/library/mentalhealth/cre/>.

Texas Ahead. United States. U.S. Census Bureau. Rural Texas: A Snapshot. Web. <http://www.texasahead.org/map/rural_areas.php>.

"Texas and the Affordable Care Act." www.covertexasnow.org. Cover Texas Now, n.d. Web. 10 Feb. 2014. <http://www.covertexasnow.org/content/texas-and-affordable-care-act>.

"Texas in Focus: A Statewide View of Opportunities; Demographics." Window on State Government. Window on State Government. Web. 2 Nov. 2013. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

Texas Resilience and Recovery (formerly RDM): The Mental Health System Redesigned." Texas Resilience and Recovery (TRR). N.p., n.d. Web. 6 Dec. 2013. <http://www.dshs.state.tx.us/mhsa/trr/>.

Texas resiliency and recovery." Family guide: children's mental health services . (n.d.). 21 Oct. 2013. <http://www.dshs.state.tx.us/WorkArea/linkit.aspx?LinkIdentifier=id&ItemID=8589979979>.

Texas. Window on State Government: Texas Comptroller of Public Accounts. Texas in Focus: A Statewide View of Opportunities; Demographics. Web. <http://www.window.state.tx.us/specialrpt/tif/population.html>.

"The Affordable Care Act and Latinos." United States Department of Health and Human Services. US Department of Health and Human Services, 10 Apr. 2012. Web. 5 Nov. 2013. <http://www.hhs.gov/healthcare/facts/factsheets/2012/04/aca-and-latinos04102012a.html>.

The Associated Press (2013, October 20). Kennedy's vision for mental health never realized. *USA Today*. 22 Oct. 2013. <

http://www.usatoday.com/story/news/nation/2013/10/20/kennedys-vision-mental-health/3100001/>.

“ The educational implications of linguistic isolation and segregation of Latino English Language Learners (ELLs)." The Civil Rights Project. The Civil Rights Project, n.d. Web. 27 Jan. 2014. http://civilrightsproject.ucla.edu/legal-.>.

"The State of Texas Children 2012 :: Overview." The State of Texas Children 2012 :: Overview. N.p., n.d. Web. 15 Dec. 2013. <http://www.cppp.org/sotc/>.

“The Texas Health Care Primer. (n.d.).” CPPP Libary. Center for Public Policy Priorities. 1 Oct. 2013. <http://library.cppp.org/files/3/TxHlthPrimer_2011_Side_by_Side.pdf>.

Theodori, Gene L, and Cheryl L Hudec . "The 2012 Texas Rural Survey: Perceptions of Rural and Urban Living ." Center for Rural Studies: Research and Outreach. (2012): n. page. Web. 17 Dec. 2013. <http://www.shsu.edu/~org_crs/TRS/TRS 2012 Perceptions of Rural and Urban Living.pdf>.

Torrey, E.. "Ronald Reagan’s shameful legacy: Violence, the homeless, mental illness ." SALON RSS. Salon Media Group, 27 Sept. 2013. <http://www.salon.com/2013/09/29/ronald_reagans_shameful_legacy_violence_the_homeless_mental_illness/>.

United States. U.S. Census Bureau. Urban and Rural Population by States: 2010. Web. <http://www.census.gov/geo/www/ua/2010urbanruralclass.html>.

United . U.S. Census Bureau. 2010 Census: Texas Profile. Web. <http://txsdc.utsa.edu/Data/Decennial/2010/SF1/2010_Profile_Map_Texas.pdf>.

"U.S. Census looking at big changes in how it asks about race and ethnicity." Pew Research Center RSS. Pew Research Center, n.d. Web. 14 Feb. 2014. <http://www.pewresearch.org/fact-tank/2014/03/14/u-s-census-looking-at-big-changes-in-how-it-asks-about-race-and-ethnicity/>.

United States Department of Commerce: Economics and Statistics Administration. US Census Bureau, n.d. Web. 3 Mar. 2014. <http://www.census.gov/2010census/pdf/2010_Census_Race_HO_AQE.pdf>.

U.S. Department of Health and Human Services. Mental Health: A Report of the Surgeon General. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health; 1999

"Welcome to the Burke Center." The Burke Center. Web. 18 February 2014. <http://www.burke-center.org/home.asp>.

"What Has Your State Done to Improve Mental Health Care?." nami.org. Nami: National Alliance on Mental Illness , n.d. Web. 3 Dec. 2013. <http://www.nami.org/Content/NavigationMenu/Top_Story/What_Has_Your_State_Done_to_Improve_Mental_Health_Care_.htm>.

"Workforce Series: Rural Behavioral Health." *National Rural Health Association Policy Position*. National Rural Health Association Policy Position, n.d. Web. 8 Feb. 2014.<http:www.file:///C:/Users/Priscilla/Downloads/WorkforceRuralBehavHealth%20(2).pdf>.