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THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

Harris County Mental Health Services for Children, Youth and Families: 2017 System Assessment

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Purpose and Approach

We assessed Harris County's current child and family delivery system by addressing the following questions:

- *How many children and youth need mental health services?*
- *How geographically accessible are mental health providers?*
- *How many children and youth receive mental health services (and are the services they receive evidence-based)?*
- *What is the current capacity / opportunity to further develop each component of an Ideal System of Care in Harris County?*

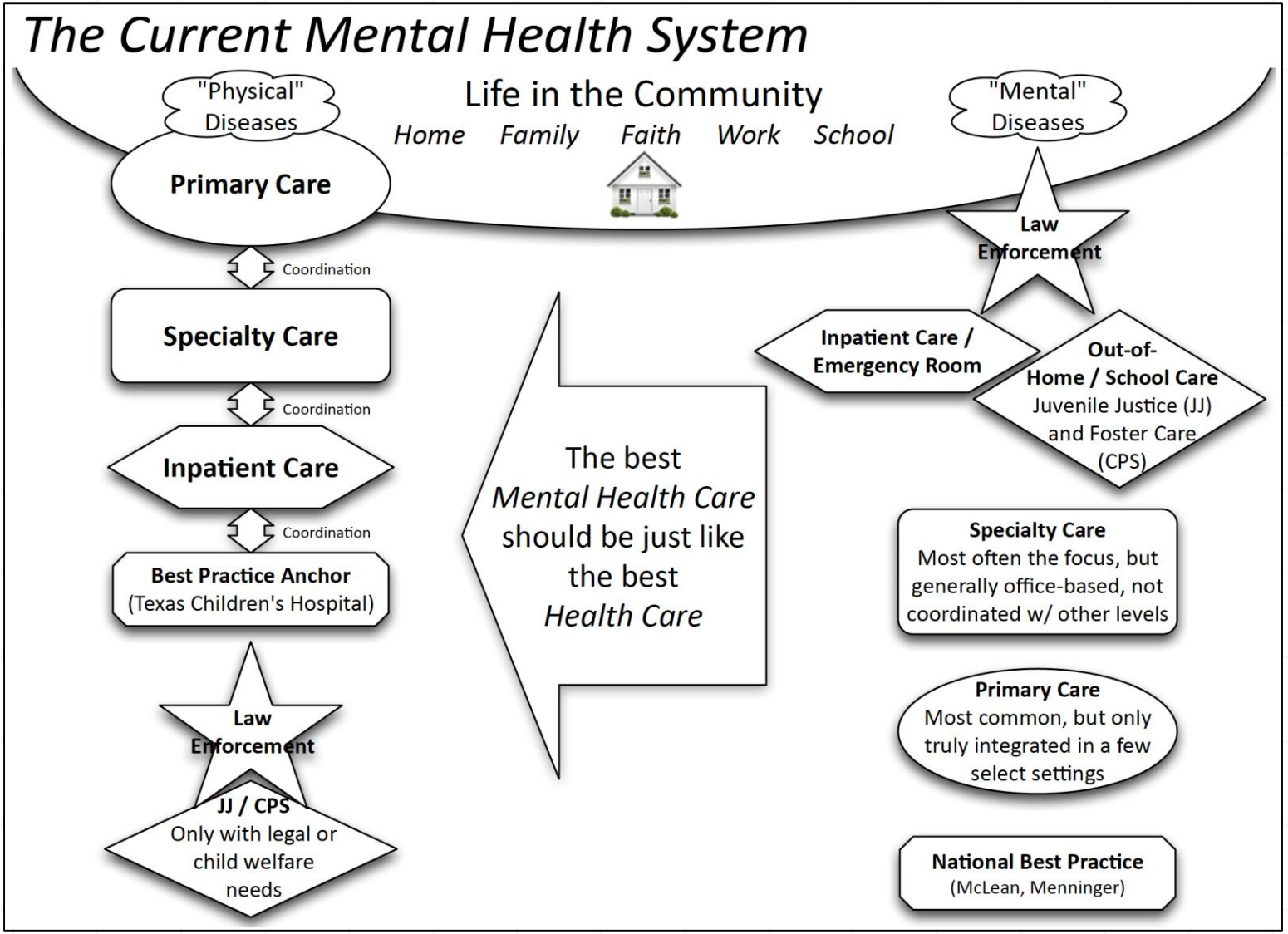
Our multi-disciplinary team met with over 100 leaders in the county across more than 40 agencies and funders.

The community report (and extended version with additional maps and detail on specific providers) can be downloaded at: https://www.houstonendowment.org/resources/reports/

What Did We Find? Big Picture

- No community in Texas or the U.S. has a well-organized system.
- Today, most care in Harris County is delivered – when it is delivered – at the specialty care level.
- Far too little help is available in the primary care or rehabilitation sections of the continuum.
- These systemic barriers to access cause most families not to seek care at all; those that do tend to wait many years until symptoms worsen.
- As a result, too many experience their first behavioral health care in a juvenile justice facility or emergency room.
- *Note: This report was finalized before Hurricane / Tropical Storm Harvey, and need estimates reflect pre-disaster levels.*

We Treat the Brain Differently From the Body



How Many Children / Youth Need Help?

Mental Health Conditions Among Children and Youth in Harris County, 2015

Mental Health Condition	Age Range	Prevalence
Harris County Child / Youth Population		
Total Population – Children and Youth	6–17	810,000
Population in Poverty	6–17	410,000
All Behavioral Health Needs (Mild, Moderate, Severe)		310,000
Mild and Moderate Conditions	6–17	250,000
Severe Conditions: Serious Emotional Disturbance (SED)	6–17	65,000
SED in Poverty	6–17	35,000
At Risk of Out-of-Home / Out-of-School Placement	6–17	4,000

Post-Harvey, we expect rates to begin to increase 60 – 90 days out:

- For children: Peak at 18 months, then slowly reduce after 24.
- Driven by worsening of baseline, not necessarily new cases.
- For adults: Continue to trend higher even after 24 months.

Figures rounded for simplicity; citations provided in the report; numbers do not always sum.

How Many Children / Youth Need Help?

Mental Health Conditions Among Children and Youth in Harris County, 2015

Mental Health Condition	Age Range	Prevalence
Specific Disorders		
Depression	12–17	30,000
Depression/All Mood Disorders – Children	6–11	4,000
Bipolar Disorder	12–17	8,000
First Episode Psychosis (FEP) – New Cases Per Year	12–17	200
Schizophrenia	12–17	900
Posttraumatic Stress Disorder	12–17	15,000
Self-Injury/Harming Behaviors	12–17	35,000
Obsessive-Compulsive Disorder – Children/Youth	6–17	15,000
All Anxiety Disorders – Children	6–11	45,000
Eating Disorders	12–17	3,000
Substance Use Disorders	12–17	20,000

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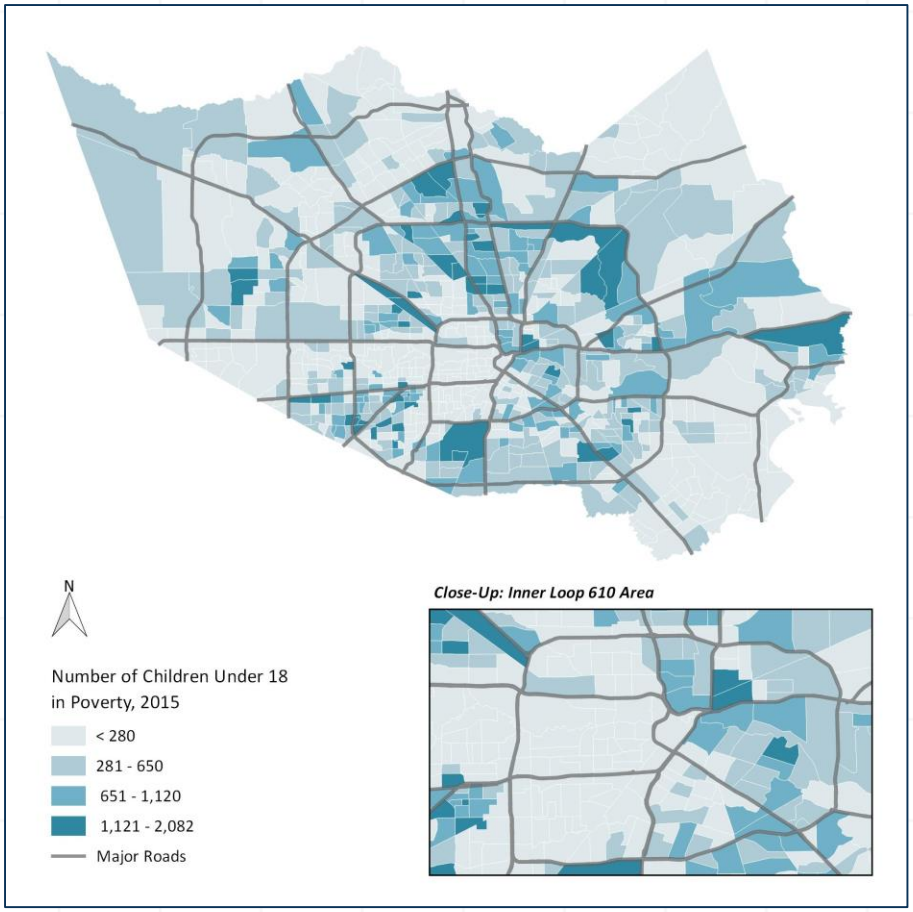
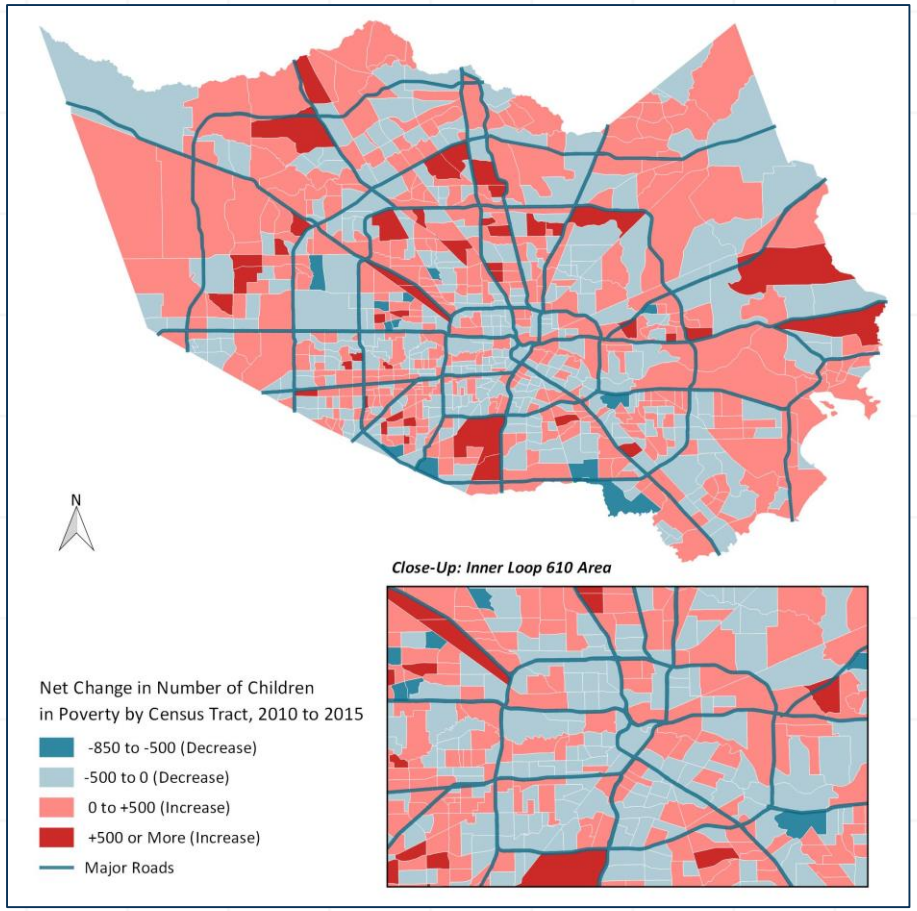
Social Emotional Determinants Matter

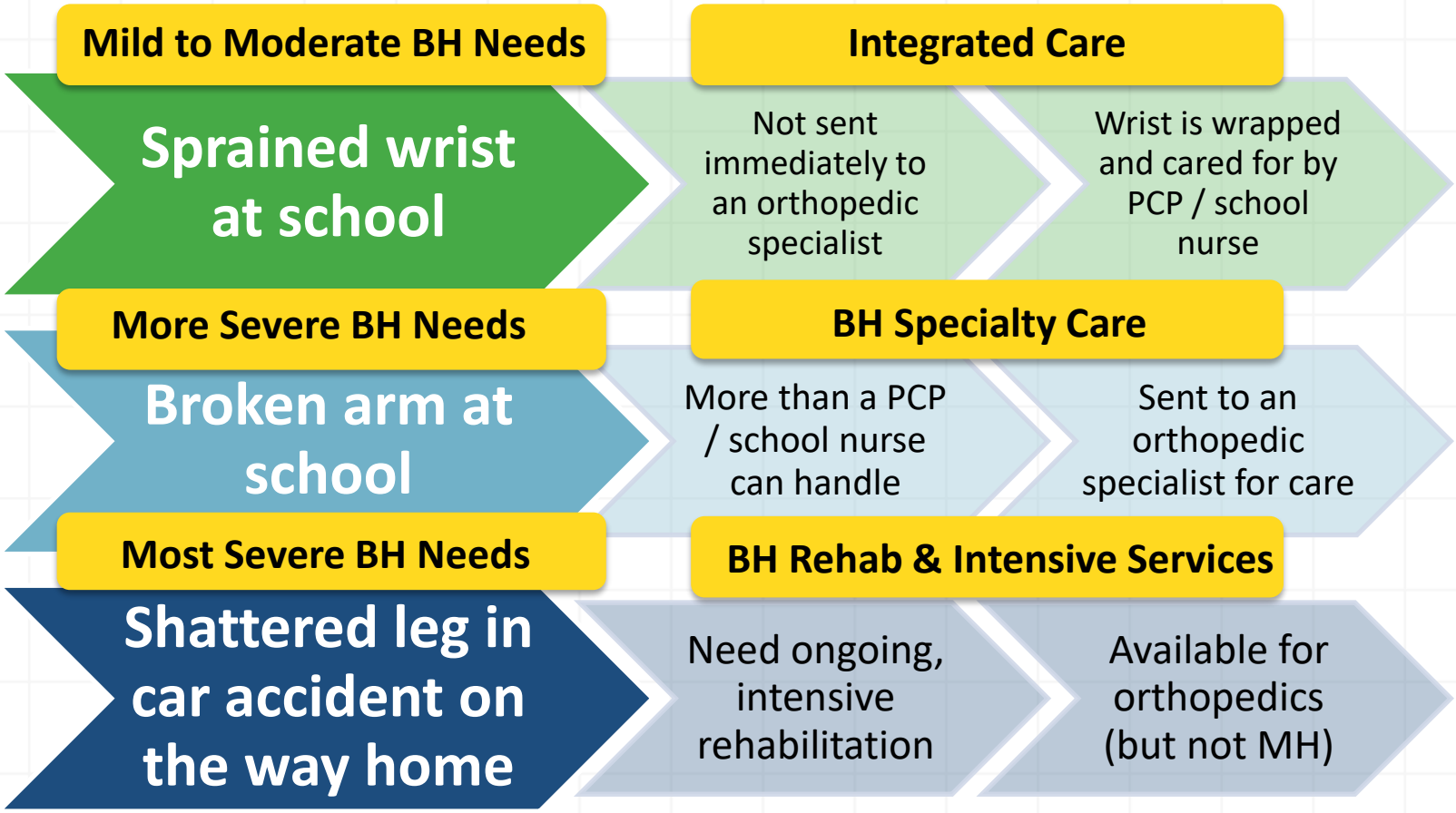
Poverty is increasingly countywide and outside Loop 610.



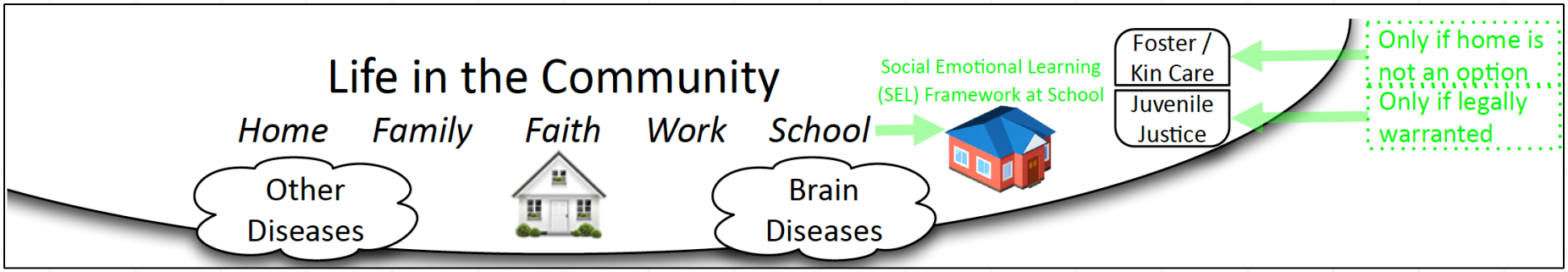


WHAT DOES AN "IDEAL" SYSTEM LOOK LIKE?

Comparison: The Right Level of Care for Bones Versus Brains



Component 0: The Community

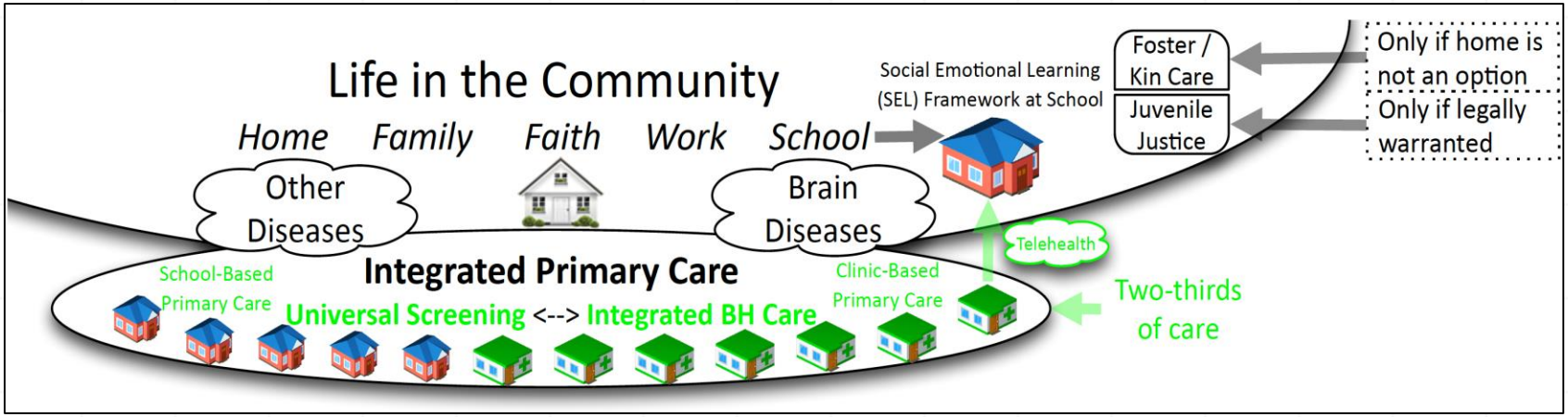


Schools can also promote mental wellness, healthy development (Social Emotional Learning models in schools).

Schools are not medical providers; THEY ARE IDEAL SERVICE SITES.

Foster care and juvenile justice placements are not medical placements; but care is often needed there.

Component 1: Integrated Pediatric Primary Care



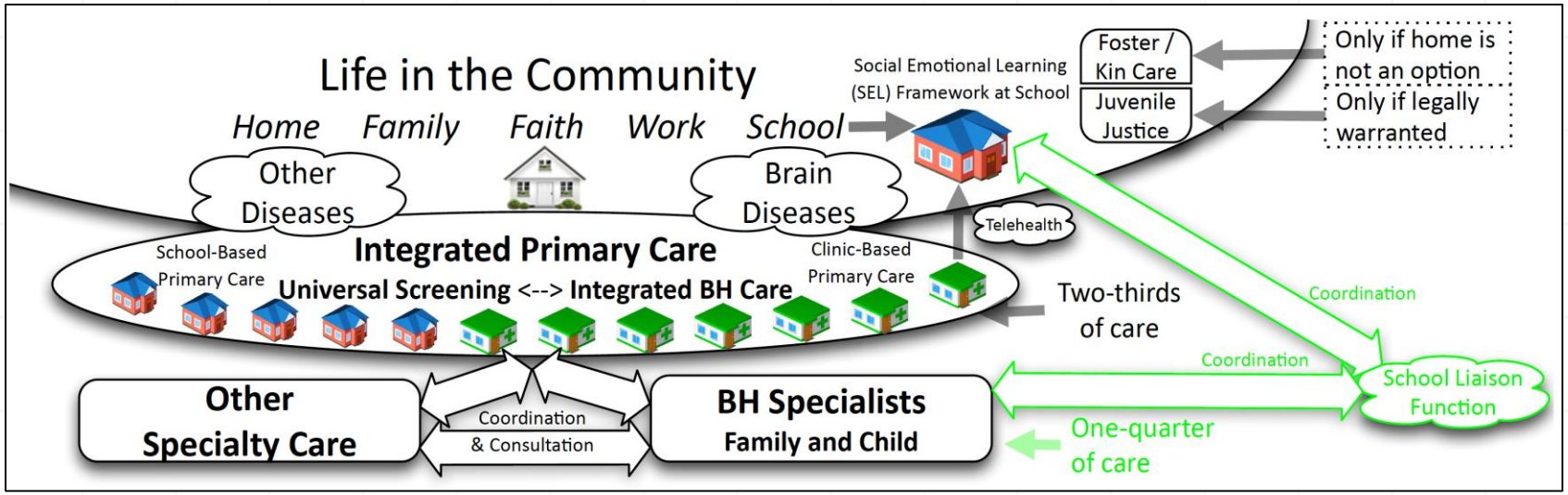
Most behavioral health care (2/3 or more) can be effectively delivered in integrated primary care settings.

Standardized, easy to use screening tailored to the needs of children & youth is essential.

Primary care should be available in both school and clinic settings.

Telehealth is a key strategy for linking schools without school-based clinics to primary care resources off campus.

Component 2: Behavioral Health Specialty Care

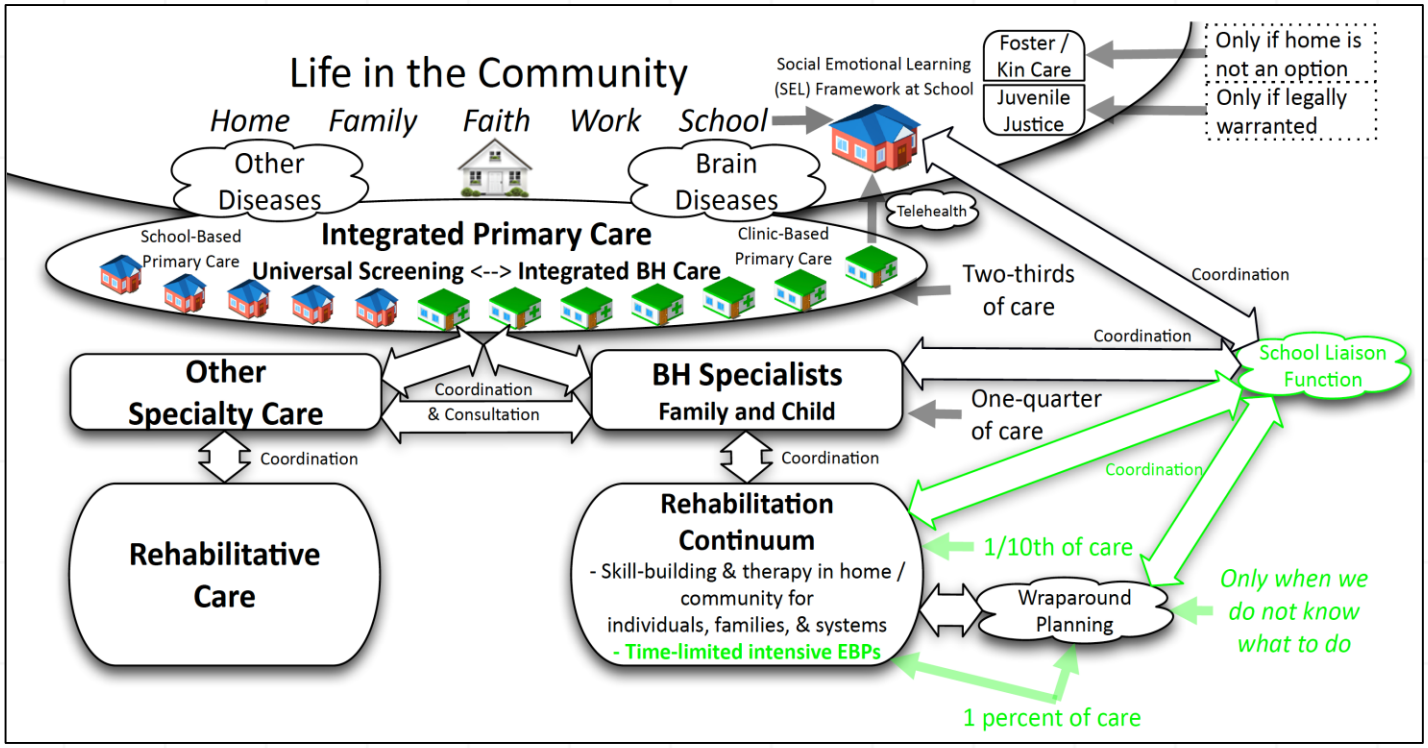


About 1/4 of psychiatric conditions need treatment by specialists in clinic and office settings.

Children with higher needs can often only access care if schools have liaison functions to link them and their families to care proactively.

BH specialty care should focus just as much on parents and caregivers as on children.

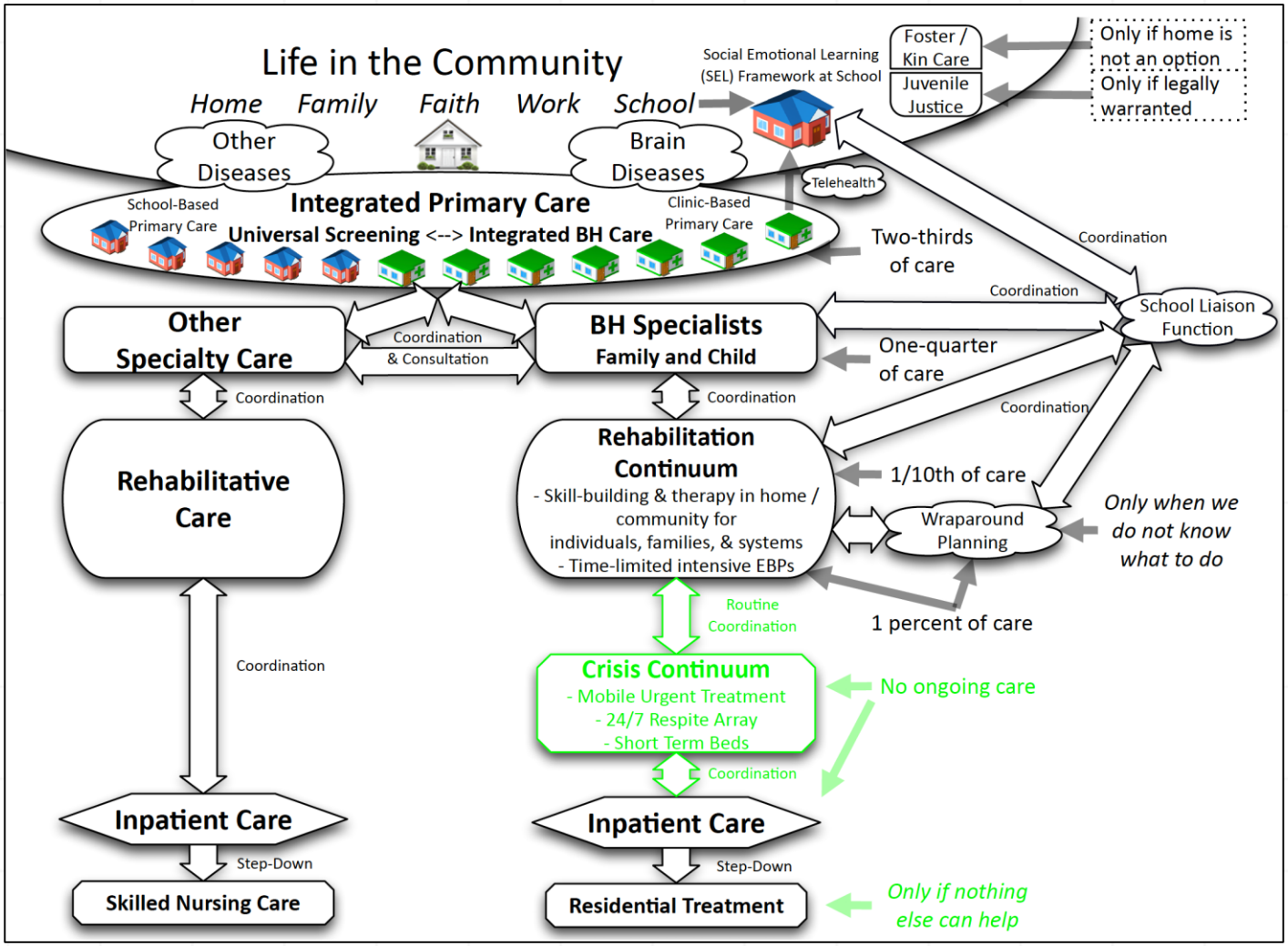
Component 3: Rehabilitation & Intensive Home/Community-Based Services



There needs to be a continuum of rehabilitative care with both skill-building and psychiatric interventions.

1 in 10 children with severe needs require time-limited, evidence-based intensive mental health services.

Component 4: Crisis Continuum



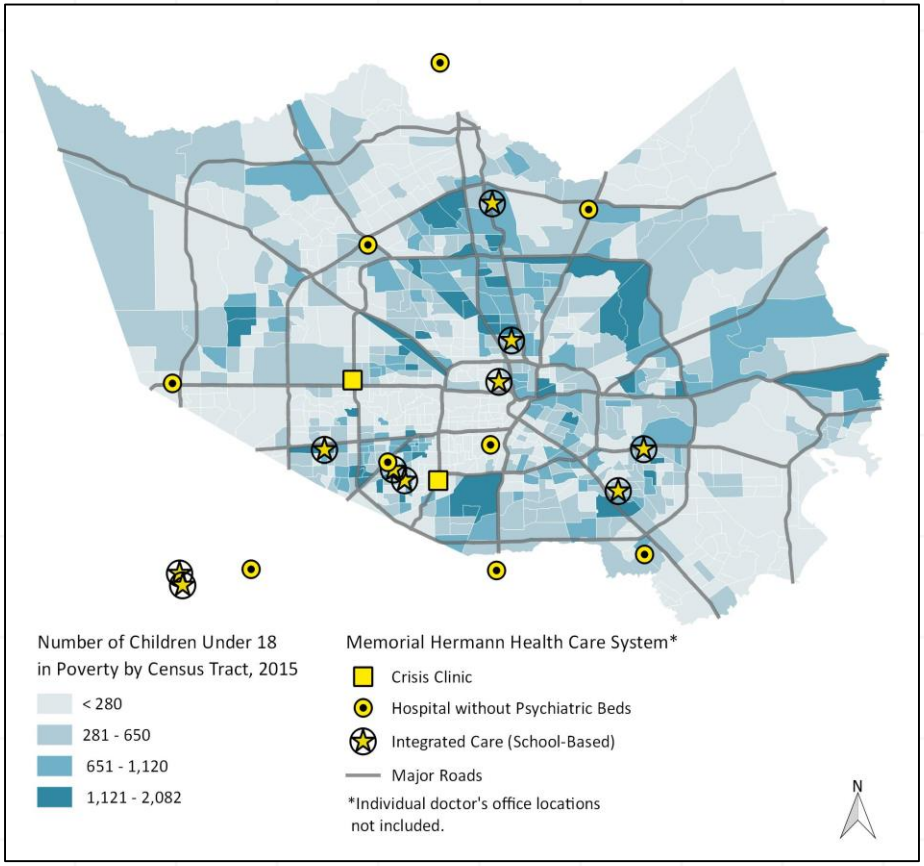
Mobile teams are needed to respond to a range of urgent needs outside of normal care delivery.

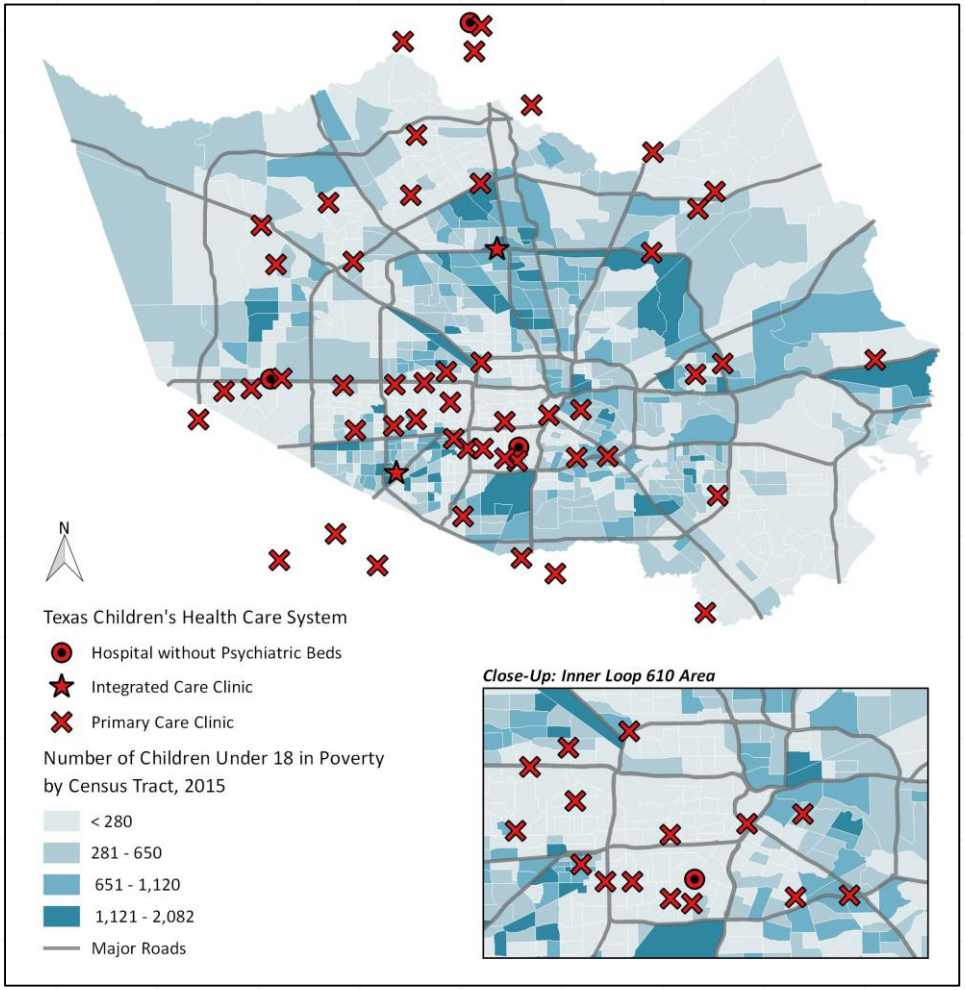
Requires an array of crisis placements tailored to the needs and resources of the local system.

Residential treatment should be the last option, only when nothing else can help.

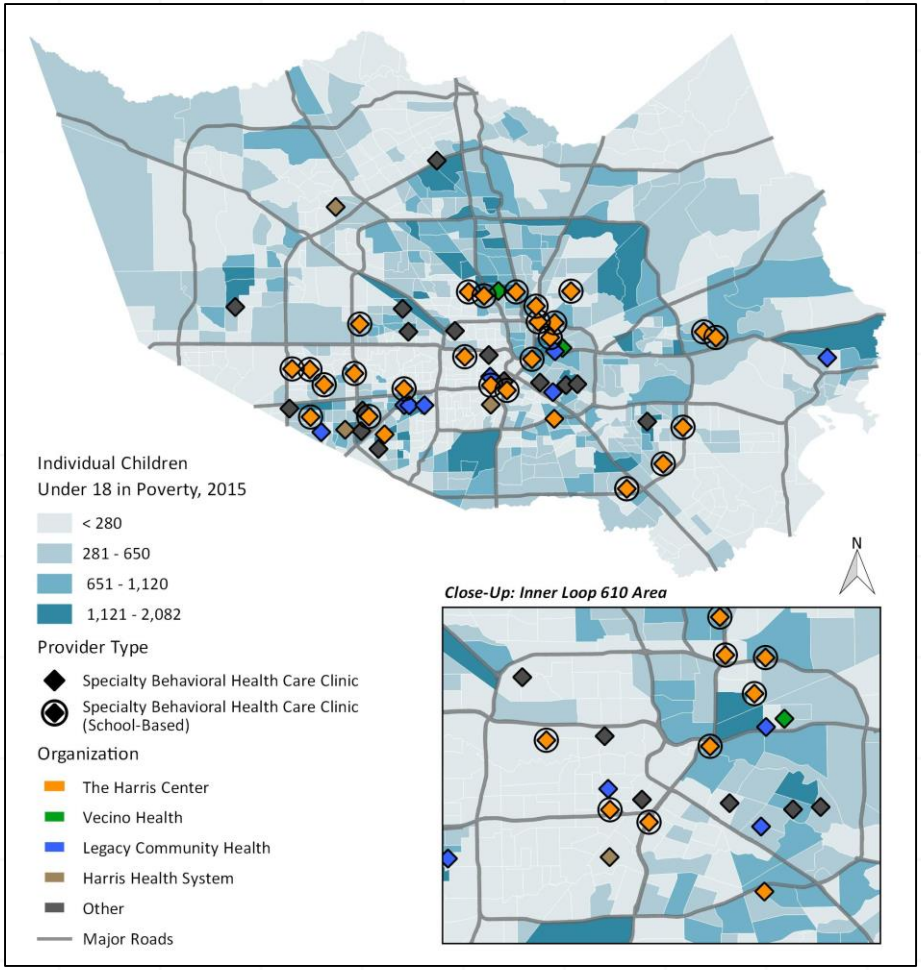
HOW CLOSE DO WE COME IN HARRIS COUNTY?

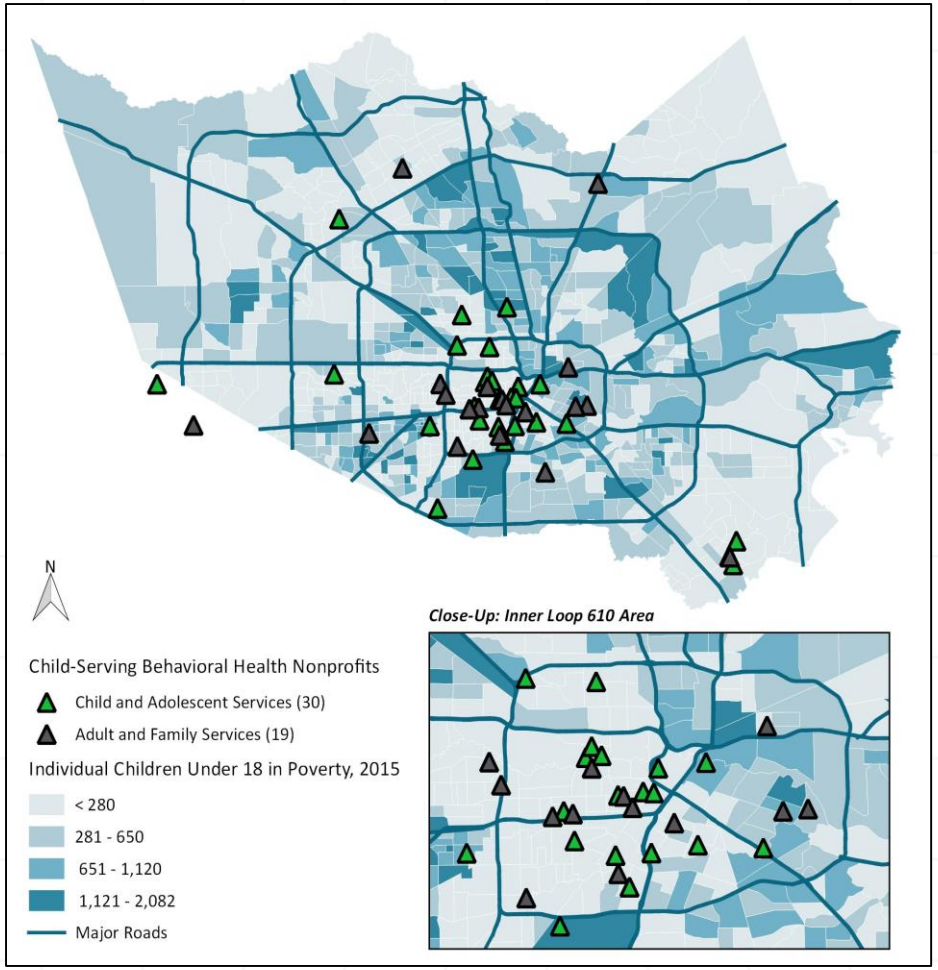
Component 1: Integrated Pediatric Primary Care





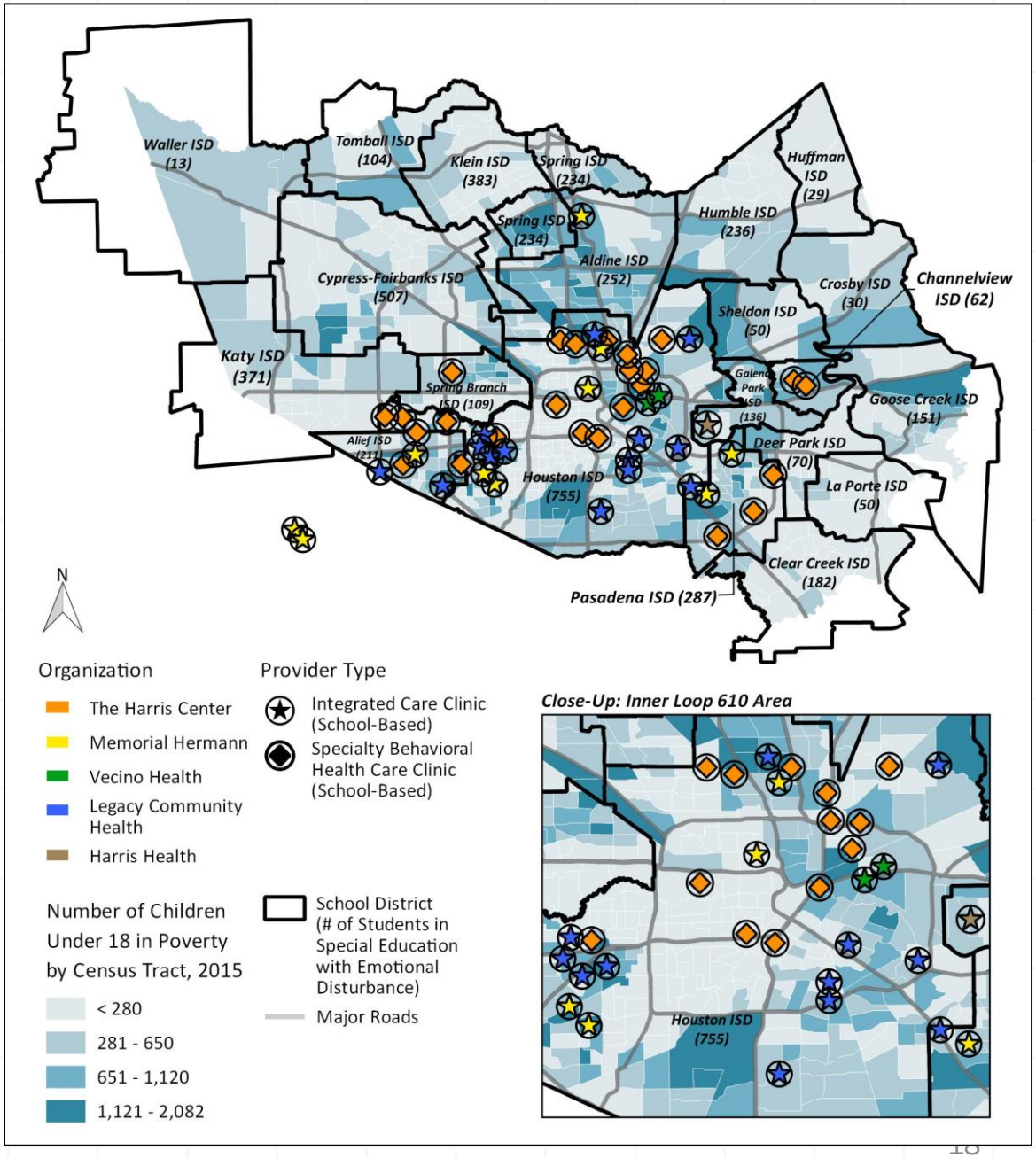
Component 2: Behavioral Health Specialty Care





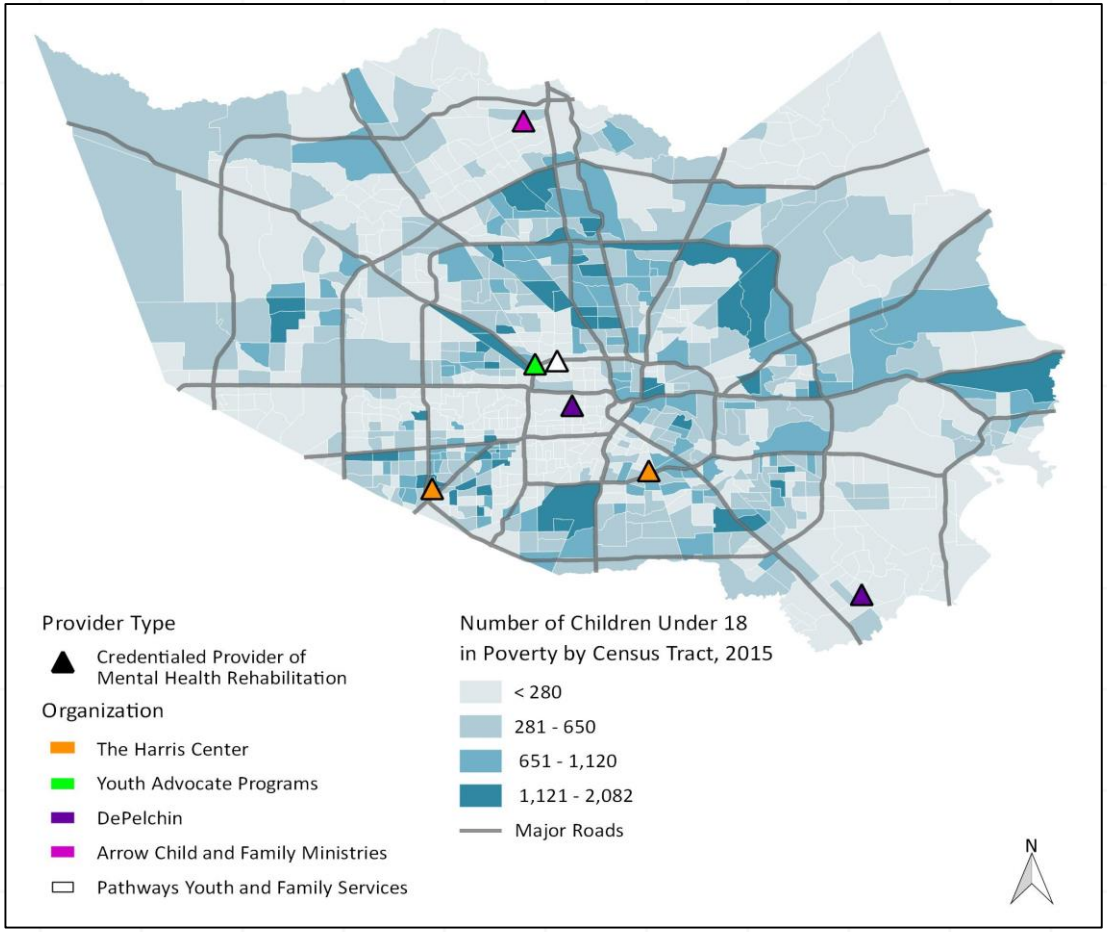
Services in Schools

- Includes both integrated and specialty clinics.
- There are many models and providers to build on.
- Very little to the west, north, and east.



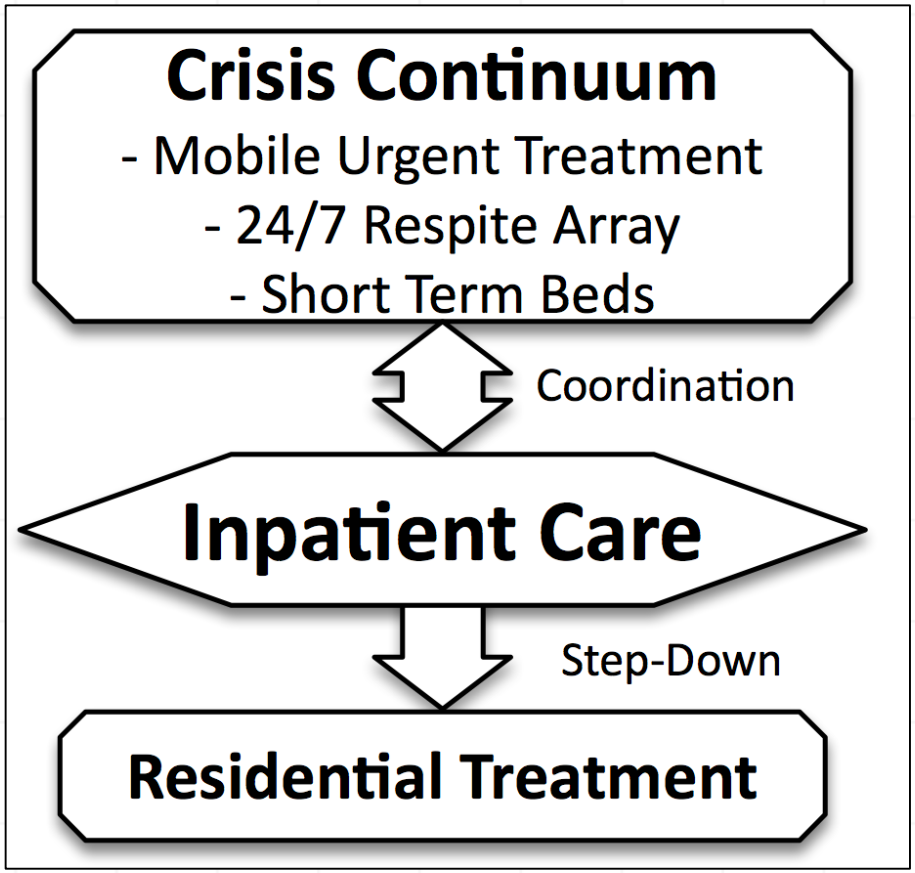
Component 3: Rehabilitation & Intensive Home/Community-Based Services

- No access outside of public system.
- Only 3 providers currently; potentially 2 more over time.
- Only about 1 in 6 overall and 1 in 15 with intensive needs access needed LOC.
- Essentially no evidence-based treatment (because wraparound is not a treatment).



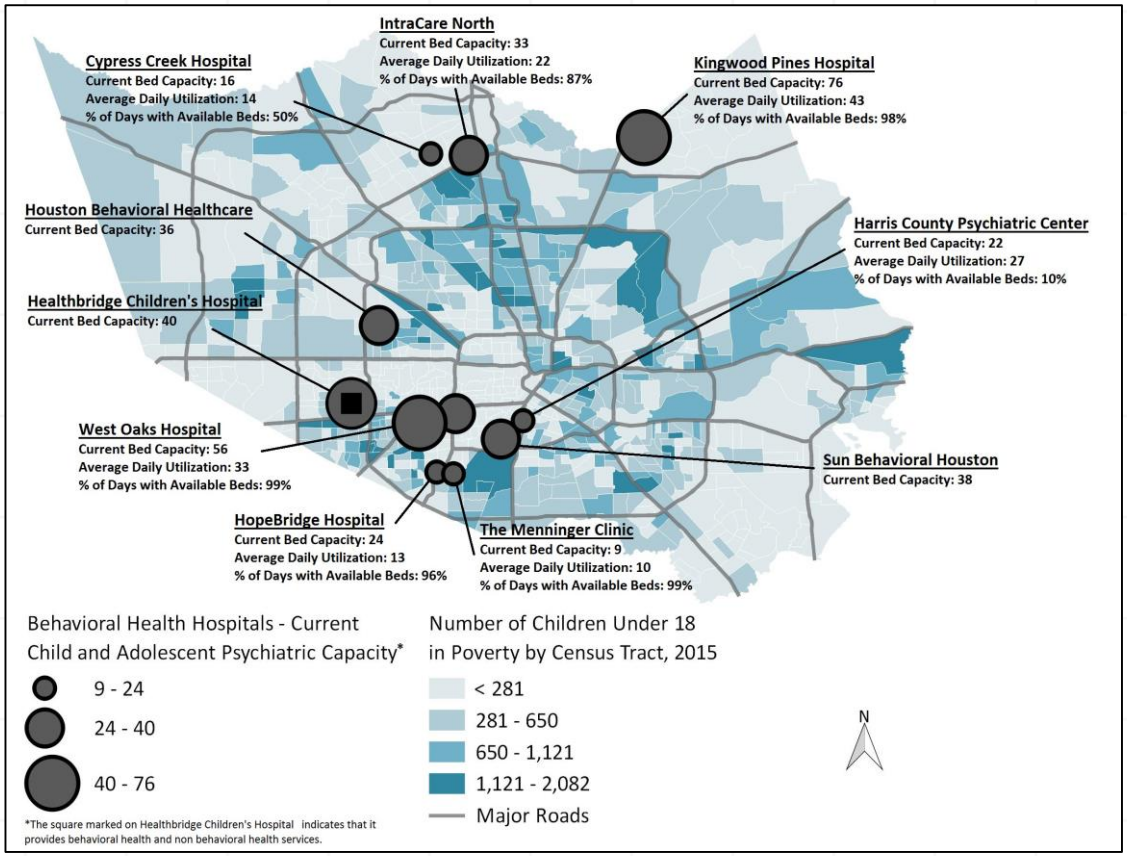
Component 4: Crisis Continuum

- Many components of potential cross-system mobile crisis response in each sub-system (MH, JJ, CW).
- Focused on sub-system goals, not cross-system goals.
- No crisis respite capacity outside of child welfare system.
- Too much reliance on inpatient and residential facilities (and very little residential treatment occurs).



Inpatient Care

- Access to inpatient is a major concern.
- The number of beds is less the issue than access to beds for those in poverty and those with severe needs.
- Most facilities have vacant beds on the majority of days (but need varies seasonally).



Child Welfare & Juvenile Justice Findings

In both systems:

- There is an over-reliance on residential and inpatient care due to a lack of evidence-based intensive services / crisis options.

The Harris County Child Welfare System:

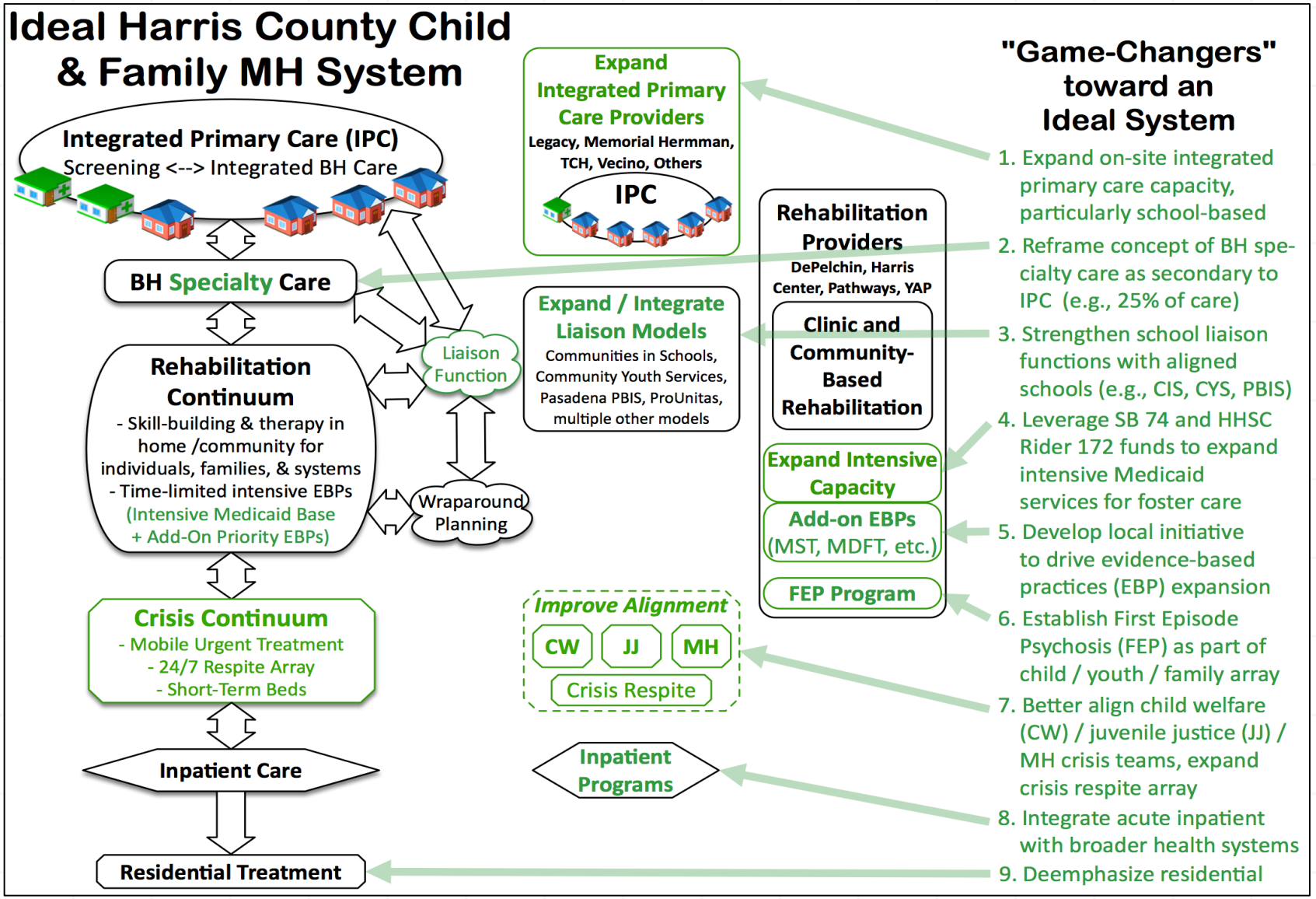
- Opportunities for providers to expand capacity for Medicaid Mental Health Rehabilitative Services and Targeted Case Management will be available in late 2017 / early 2018 for children and youth in foster care who have severe mental health needs.

The Harris County Juvenile Justice System:

- Currently offers the only evidence-based intensive service in the county (Multisystemic Therapy) for just over 60 youth.

WHAT STEPS CAN WE TAKE TO IMPROVE?

Nine Potential "Game-Changers"



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MMHPI believes all recommendations remain pertinent post-disaster, though the need to expand capacity will be heightened by increasing needs.