HARRIS COUNTY MENTAL HEALTH SERVICES FOR CHILDREN, YOUTH, AND FAMILIES:
2017 SYSTEM ASSESSMENT

HOUSTON ENDOWMENT | OCTOBER 2017

Contents

Acknowledgement

TEXAS STATE *of* MIND
THE MEADOWS MENTAL HEALTH POLICY INSTITUTE

Executive Summary

Thanks to the generous support of Houston Endowment, the Meadows Mental Health Policy Institute (MMHPI) conducted a comprehensive assessment of health care system capacity for providing mental health services for Harris County children, youth, and families. Each year, one in three children and youth ages six to 18, and two in five youth, suffer from mental health and substance use disorders. In Harris County, this equates to just over 310,000 children and youth each year, including just under 250,000 with mild to moderate needs and just under 65,000 with severe needs, often referred to as children and youth with serious emotional disturbances, or SED.[1] Of those children and youth with severe needs, 35,000 live in poverty and 4,000 are at high risk of out-of-home or out-of-school placement.
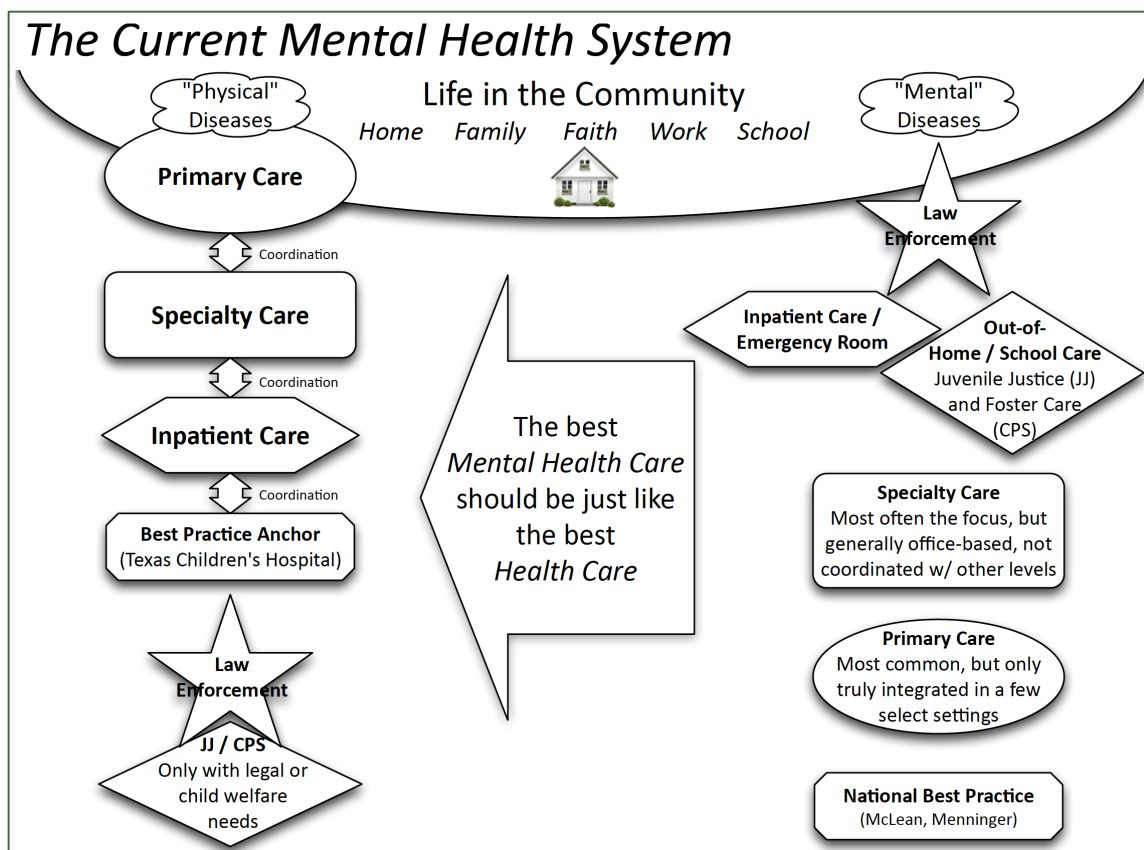
An "Ideal System of Care" for treating these conditions would have four main components:

- Component 1: Integrated Behavioral Health in pediatric primary care settings, serving those with routine needs related to behavior, anxiety, and depression. These conditions represent up to two-thirds of all pediatric mental health needs and affect about 200,000 children and youth in Harris County.
- Component 2: Specialty Behavioral Health Care for those with moderate to severe needs, such as complex depression, bipolar disorder, posttraumatic stress, and other disorders that require specialized intervention beyond the capacity of integrated primary care. About one-quarter of all pediatric mental health needs are classified as moderate to severe, which equals about 75,000 Harris County children and youth.
- Component 3: Rehabilitation Services for the 35,000 children and youth in Harris County with mental health needs so severe that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. The services should include intensive home and community-based services for the approximately 4,000 children and youth with the most severe needs and who face the greatest risk for out-of-home or out-of-school placement.
- Component 4: A Crisis Care Continuum able to respond to the full range of episodic, intense needs that routinely occur over the course of care, including mobile teams able to respond to urgent needs outside of the normal delivery of care, as well as a continuum of placement options ranging from crisis respite to acute inpatient and residential care.

No community in Texas or the nation has a system that works like this. 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 rehabilitative sections of the continuum. These systemic

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[1] These estimates do not sum to the same total due to rounding.

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 children and youth experience their first behavioral health care in a juvenile justice facility or an emergency room.

The Current Mental Health System

Life in the Community
Home   Family   Faith   Work   School

"Physical" Diseases

Primary Care

↕ Coordination

Specialty Care

↕ Coordination

Inpatient Care

↕ Coordination

Best Practice Anchor
(Texas Children's Hospital)

Law Enforcement

JJ / CPS
Only with legal or child welfare needs

The best
Mental Health Care
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Inpatient Care / Emergency Room

Out-of-Home / School Care
Juvenile Justice (JJ) and Foster Care (CPS)

Specialty Care
Most often the focus, but generally office-based, not coordinated w/ other levels

Primary Care
Most common, but only truly integrated in a few select settings

National Best Practice
(McLean, Menninger)

In addition, social determinants of health, including economic stability, education, health, access to health care, and the social and community context in which children and youth live and grow, all have an impact on health, development, and morbidity. Poverty, coupled with adverse childhood experiences (ACEs), can have a lasting, negative effect on physical and emotional well-being. Exclusionary school discipline, such as suspension and expulsion, is among the strongest correlates of future involvement in the juvenile justice system.

For this report, we identified higher-risk areas by mapping poverty rates overall and by school district. We found multiple pockets of need across the county, with higher rates of poverty outside the Inner Loop 610 area than inside it. We also mapped current provider locations, including across school districts. Many areas with the highest need are far from treatment providers and public transportation routes, and many outlying school districts lack providers within their geographic borders. All children, youth, and families in Harris County – whether inside or outside of the child welfare and juvenile justice systems – face stark gaps in care and poor outcomes as a result.

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This report closely examines provider capacity and offerings across all of the components of the system, but the major system-level findings include the following:

Harris County is home to several very effective integrated primary care clinics, including many that are school-based. The most notable are operated by Memorial Hermann Health System, Legacy Health, Vecino Health, the systems within The Harris Center for Mental Health and IDD, and increasingly through Texas Children's Hospital and Harris Health System. These systems provide a strong base to build on, though the need far outstrips available capacity, just as it does in nearly every community across Texas.

Office-based specialty providers are more numerous, but there are gaps in access in outlying areas and in areas with growing poverty. Those gaps are, however, less severe than the gaps for integrated primary care and more intensive services.

Harris County has a well-established platform to address school behavioral health through MHA of Greater Houston's Center for School Behavioral Health, as well as many outstanding programs that provide school-linked and school-based behavioral health initiatives. However, with over 1,000 public schools across Harris County, the school-based and school-linked programs cannot meet current demand.

Nearly all children and youth in poverty are eligible for mental health services paid by Medicaid or CHIP, but less than one in five receive mental health care of any type.

There is a dramatic lack of intensive home and community-based care for the 4,000 children and youth at highest risk of being placed out-of-home or out-of-school. Currently, fewer than 250 children and youth in Harris County receive high-intensity home and community-based services through the mental health system. Essentially none of the treatment provided incorporates evidence-based approaches commensurate with their levels of need. More than twice as many youth (about 670) receive intensive home and community-based care through the juvenile justice system, some receiving evidence-based treatment through the Harris County Juvenile Probation Department (HCJPD).

The primary issues driving youth with severe mental health needs into the juvenile justice system include the limited capacity of community-based mental health providers, particularly at intensive levels; the nearly total absence of any evidence-based models for intensive services; the variable quality of the broader provider capacity; and limited resources for early intervention. Lack of insurance coverage was an important secondary factor.

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The primary barrier to building capacity for intensive home and community-based care is provider capacity, not a lack of insurance coverage. While most children and youth in need have some type of coverage, reimbursement rates are very low for Medicaid, CHIP, and private insurers. There is a general lack of awareness and understanding – even among providers – regarding state-of-the-art, evidence-based, intensive, community-based practices. That means providers are often not aware of the gaps in their own service arrays. And while the Texas Medicaid program includes intensive services among its benefits, such services are not available or covered outside of the public system.

Resources to coordinate care for children, youth, and families with the highest needs and involvement in multiple systems are limited in scope or still in development. Crisis services are particularly stretched, though many well-functioning but limited programs are available.

While there are challenges in accessing inpatient care, most programs have availability on most days. The main barriers to accessing inpatient care are an inability to pay for it, with or without insurance; high demand during the school year; complex needs that some children's psychiatric inpatient settings are unable or unwilling to treat; too few alternatives for crisis diversion; and the relative absence of intensive, evidence-based home and community-based interventions (resulting in lengthened hospital stays because of a lack of discharge options).

Most residential treatment facilities (RTFs) provide limited "treatment" and function primarily as placement options for children and youth who have no other alternative. While most offer safe and sound programs, intensive treatment options are generally limited, particularly in juvenile justice system facilities. Furthermore, research demonstrates that residential treatment is not an effective treatment model for ongoing care.

The report concludes with nine strategic recommendations that could serve as "game-changers" to move Harris County closer to the Ideal System of Care:

1: Expand on-site integrated primary care with an emphasis on school-based integrated primary care. The latest research suggests that up to two-thirds of children and youth with mental health needs, and their families, could be served in integrated primary care settings. School-based clinics are especially convenient and effective, if sufficiently resourced.

2: Specialty behavioral health providers must rethink their roles as more children, youth, and families with mild to moderate mental health conditions are served in integrated care settings, including school-based clinics. Specialty providers will increasingly need to focus on more intensive services for children and youth with moderate to severe mental health conditions or join integrated care practices to serve those with mild to moderate needs.

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3: Strengthen the school liaison function bridging students in need, their families, and providers, and expand liaison capacity more broadly. Efforts should focus on schools and school districts that have adopted and actively promote a developmentally focused social-emotional learning framework. Organizations such as Communities in Schools, ProUnitas, and Community Youth Services are currently filling this type of role in many Harris County schools.

4: Build capacity for the delivery of intensive services by encouraging providers to offer Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitative Services. Work with providers to help them tap into the $2 million in grant funding that will be available through Senate Bill 74 (HHSC Rider 172) to expand capacity to provide TCM and Rehabilitative Services to children and youth in foster care who have intensive needs.

5: Develop a local, multi-year initiative to build capacity for intensive, evidence-based home and community-based services for the 4,000 children and youth who are at highest risk for out-of-home and out-of-school placement. Medicaid currently covers a minimum level of intensive supports, but evidence-based models are typically more intensive. Because they tend to be limited in duration and more effective, these evidence-based models have the potential to be more cost effective than other services. Given the possible expansion of intensive services for children and youth in the foster care system under HHSC Rider 172, local public and private funders may be able to partner with rehabilitation providers to expand capacity and simultaneously add evidence-based practices.

6: First episode psychosis (FEP) treatment programs must be incorporated into child and youth mental health systems, rather than delayed until youth become 18 years old and transition to adult systems. Recent state-level policy changes will allow the Harris Center's small Coordinated Specialty Care program for first episode psychosis to serve youth under age 18 as well as Medicaid-eligible youth. However, the majority of youth and young adults experiencing FEP probably have commercial insurance, so expansion of the model to other providers, perhaps building on the program's current partnership with UTHealth, may help reach a broader range of youth in need.

7: Begin to align child welfare, juvenile justice, and mental health crisis response resources; identify opportunities to expand the available crisis respite service array; and make the array available across systems. Many strong crisis programs exist, but they typically serve children and youth only within their own "silo" and do not coordinate systematically with other efforts. If better aligned, existing resources have the capacity to serve more children and youth and provide better options during a crisis. However, until additional intensive, evidence-based care resources are available, the crisis system will continue to be over-burdened and over-reliant on inpatient and crisis care.

8: Make better use of existing psychiatric inpatient bed capacity. This can be accomplished by exploring ways to purchase capacity in underutilized facilities to supplement the overstretched public resources of the Harris County Psychiatric Center, as well as to expand access into the outlying areas of Harris County. The ultimate goal is to integrate inpatient psychiatric care into broader health systems and increase access for children and youth in poverty.

9: De-emphasize residential placement. When it is used, make sure residential "treatment," provides brief, intensive, family-based services as close to home as possible. Existing forums addressing the needs of high-risk children and youth, such as the Dual Status Youth Initiative, should incorporate this principle into their ongoing planning. In addition, the development of intensive, evidence-based home and community-based care should be incorporated into a multi-year, cross-agency plan to reduce the use of residential placements, starting with children and youth who are able to obtain care safely in their current living arrangements.
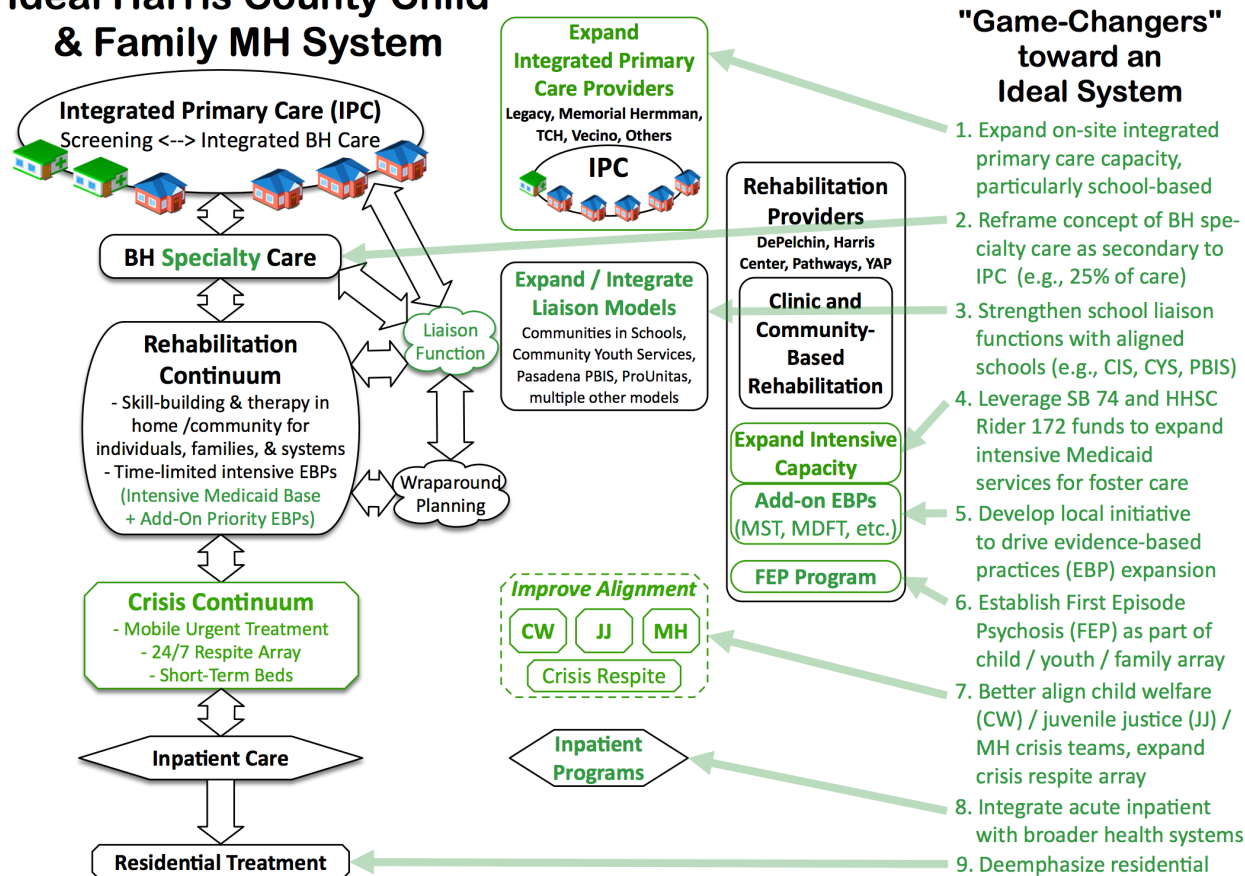
Please note that this report was finalized before Hurricane / Tropical Storm Harvey; need estimates reflect pre-disaster levels and no disaster-specific recommendations are included. However, it is the judgment of MMHPI that all recommendations remain pertinent post-disaster,

though the need to develop systems further is heightened by the increase in needs related to the disaster, including trauma.

Full Report

Thanks to the generous support of Houston Endowment, the Meadows Mental Health Policy Institute (MMHPI) conducted a comprehensive assessment of health care system capacity for providing mental health services for Harris County children, youth and families. MMHPI assessed the scope and quality of services within the framework of an "Ideal System of Care" that has four components:

- Integrated Behavioral Health in pediatric primary care settings;
- Specialty Behavioral Health Care;
- Rehabilitation Services, including intensive home and community-based services; and
- A Crisis Care Continuum, including psychiatric inpatient facilities and residential treatment.

The report also describes a range of contemporary best practices within each component, focusing on evidence-based practices that have demonstrated proven outcomes for children, youth, and their families across a range of demographic groups and populations.

With the ideal system framework and best practices research providing context for our report, we then assess 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 services received evidence-based)?

What is the current capacity and opportunity to further develop each component of an Ideal System of Care in Harris County?

Please note that this report was finalized before Hurricane / Tropical Storm Harvey, and need estimates reflect pre-disaster levels. No disaster-specific recommendations are included. However, MMHPI believes that all recommendations remain pertinent post-disaster, though the urgency of developing systems further is heightened by the increase in needs related to the disaster.

The MMHPI team included experts in diverse fields: behavioral health services; behavioral health integration with primary care; child welfare and foster care; juvenile justice; and mental health delivery systems for children, youth, and their families in communities and schools. We

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initiated this review in the fall of 2016 with meetings with system leaders from across Harris County. Our goal was to engage key stakeholders in the review from the beginning and identify the fullest possible universe of mental health providers. We performed numerous site visits and interviewed mental health providers within primary care, child welfare, juvenile justice, and school systems. We also looked closely at The Harris Center for Mental Health and IDD (Harris Center), which, as the Harris County local mental health authority (LMHA), is the primary provider offering community-based rehabilitation services, including crisis, outpatient clinic, community and school-based services, and intensive mental health services.

We collected archival data from state sources, including the Health and Human Services Commission, the Department of Family and Protective Services (DFPS), and the Texas Juvenile Justice Department. We also compiled data from multiple sources to map resources of several major health systems within the county. We focused on those primarily serving children and youth (Texas Children's Hospital); those focused primarily on the needs of people in poverty (Harris Health); and systems with major school-based efforts (Legacy Community Health, Memorial Hermann Health System, and Vecino Health Centers). We identified their service locations alongside locations of key mental health inpatient and outpatient resources. We supplemented these data with on-the-ground interviews and site visits to yield a population-level view of strengths and needs across the child-serving organizations and geographic communities of the region.

An Ideal System of Care for Pediatric Mental Health
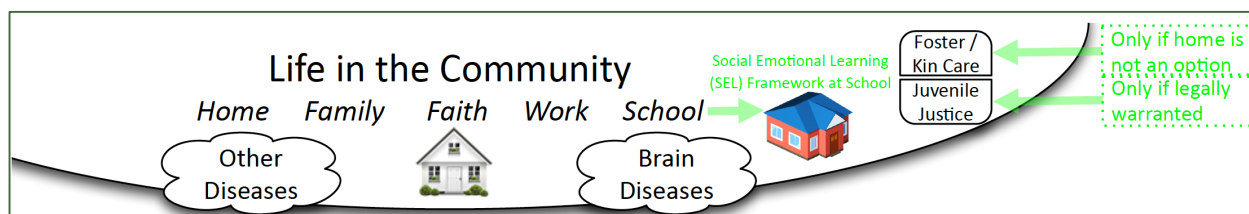
Health care systems are an integral part of every child and family's life, but they are only a part of life. Too many health systems are designed without recognizing this core truth, and they instead focus simply on the care they are attempting to deliver as the overarching concern. But health needs – both diseases affecting the brain, such as mental health disorders, and other conditions – occur in the context of life: home, family, faith, work, and school.

Some services look like mental health services, but are not. Schools, foster care, and juvenile justice providers have important roles to play in prevention efforts and the delivery of mental health interventions, but they are not health care providers. For nearly every child, schools can help support healthy development and improve academic performance by implementing social and emotional learning (SEL) models and linking children and youth in need to care. Some
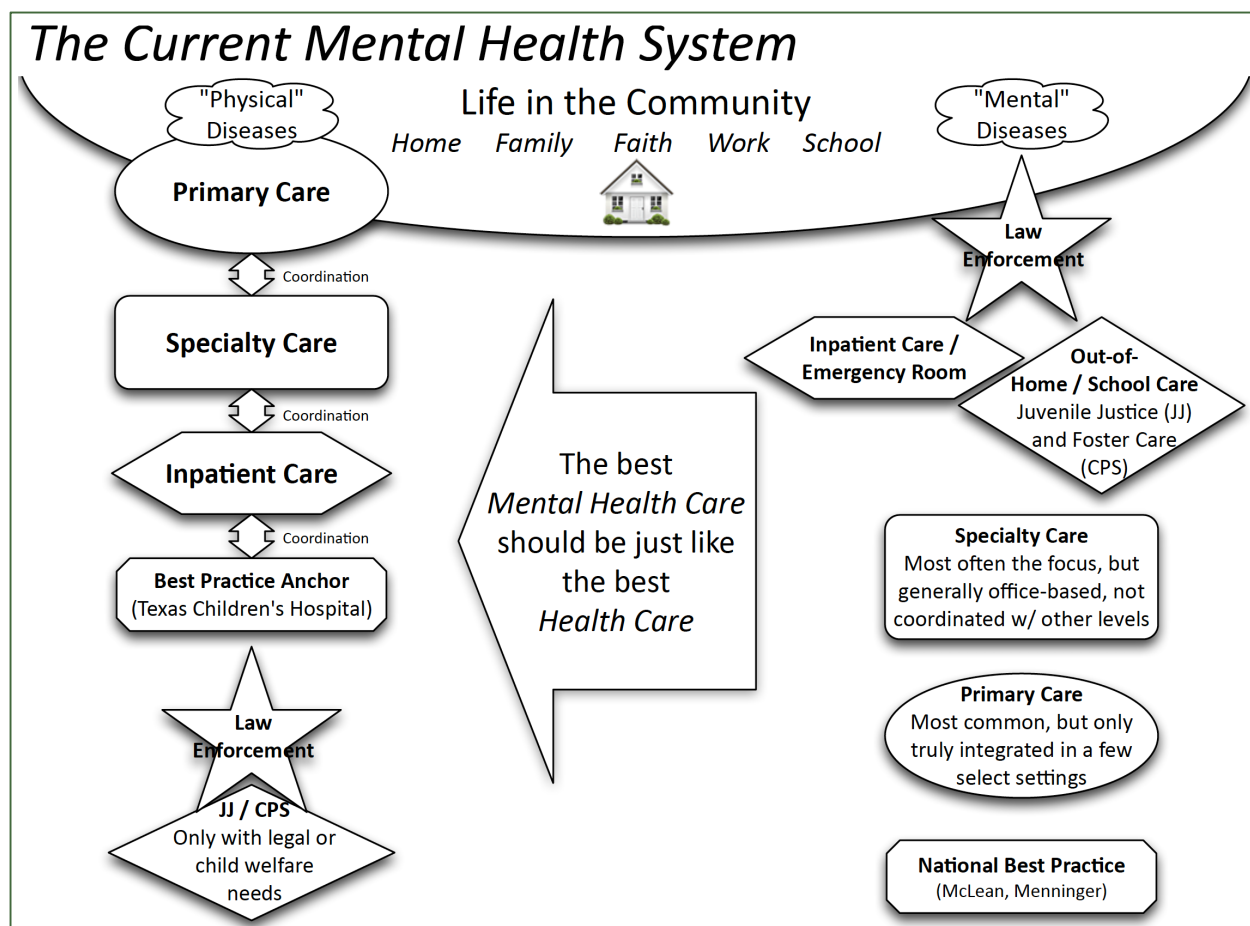
schools are able to house service providers on campus, greatly easing access to care for many children, youth, and families.

While relatively few children and youth are involved at any time in the foster care system, their needs and vulnerabilities are tremendous. Often, access to mental health care is essential to support the success of foster and permanent placements for these children and youth. The same is true for the juvenile justice system. Because the roles of schools, the foster care system, and the juvenile justice system are so integral to the mental health needs of children and youth, we often talk about them as if they are part of the mental health care delivery system, but they are not. In an ideal mental health system, services for children and youth are integrated within the broader health care system and coordinate smoothly with other systems, such as child welfare, schools, and juvenile justice. Furthermore, if appropriate care were provided earlier, children and youth would not end up in the foster care or juvenile justice system solely because of unmet mental health needs.

In addition, children and youth should be served at the right level of care. To demonstrate this concept, consider another type of specialty care: orthopedics. If a child falls at school and sprains her wrist, there is generally no need to go to an orthopedic specialist or hospital; the child can be treated either by the school nurse or a primary care provider. However, if the fall is more severe and the child breaks her arm, she will ideally see a specialist to get a cast or other treatment. But if a child suffers a complex injury, either through sports or trauma (such as an automobile accident), she will need more intensive care. She may need to stay temporarily at the hospital for complex or dangerous procedures requiring such a setting. And she may need weeks or months of intensive rehabilitation to support healing and regain functioning.

Just as an "ideal system of care for orthopedics" requires the organization of interventions in primary care, specialty care, rehabilitation, and hospital settings, so too should an "ideal system of care for mental health." But mental health systems today – in Texas and across the nation – are organized very differently.

The way current mental health systems tend to be organized are highly fragmented, poorly organized, and too often unhelpful (and sometimes harmful), as depicted in the following illustration:

The Current Mental Health System

"Physical" Diseases

Life in the Community
Home   Family   Faith   Work   School

"Mental" Diseases

Primary Care

Law Enforcement

Coordination

Specialty Care

Inpatient Care / Emergency Room

Out-of-Home / School Care
Juvenile Justice (JJ) and Foster Care (CPS)

Coordination

Inpatient Care

Coordination

The best *Mental Health Care* should be just like the best *Health Care*

Best Practice Anchor (Texas Children's Hospital)

Specialty Care
Most often the focus, but generally office-based, not coordinated w/ other levels

Law Enforcement

Primary Care
Most common, but only truly integrated in a few select settings

JJ / CPS
Only with legal or child welfare needs

National Best Practice
(McLean, Menninger)

More specifically:

- The front line of care is frequently an informal mix of law enforcement, hospitals (emergency rooms and inpatient care), and out-of-home care options through the juvenile justice and foster care systems. This happens because too often people do not seek care until symptoms have been present for years and needs have become acute.[2]
- Discussions on mental health care tend to focus too much on the specialty care system, with mental health providers viewed as a generic solution to any type of behavioral health need, with too little discussion of their role in relation to primary care and the broader continuum of care.
- Rehabilitation services for mental health needs are typically only available through public sector providers, rather than being broadly accessible through private and public payers, as they are with physical rehabilitation.

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[2] Wang P.S., Berglund P.A., Olfson M., Kessler R.C. (2004). Delays in initial treatment contact after first onset of a mental disorder. *Health Services Research, 39*(2), 393–415.

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These systemic challenges are not unique to Harris County or Texas: health care providers and families across the nation struggle with them daily. However, health care systems across Texas and the nation are in the early stages of improving how care is organized. We have grouped our discussion of these changes into four distinct components:

1. Integrated Behavioral Health in pediatric primary care settings;
2. Specialty Behavioral Health Care;
3. Rehabilitation Services, including intensive home and community-based services; and
4. A Crisis Care Continuum, including psychiatric inpatient facilities and residential treatment.

Component 1: Integrated Primary Care
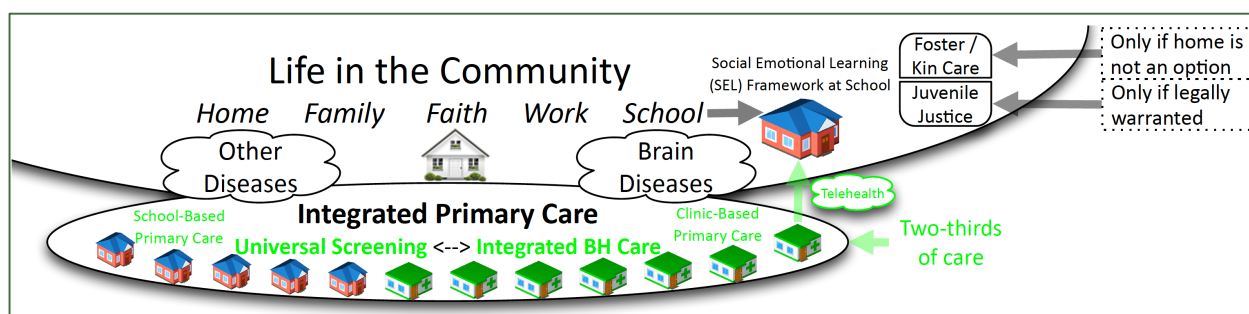
Integrated primary care is the front line for all health care delivery, and research suggests that up to two-thirds of all pediatric behavioral health needs can be met there. Ideally it includes:

- Universal screening for behavioral health needs;
- Integrated behavioral health care in both school and clinic settings; and
- Telehealth as a key strategy for linking schools without on-campus access to care.

Behavioral health integration in pediatric primary care settings should be the core component of an ideal system, and it is an essential strategy for increasing access to mental health services for children and youth, particularly those with mild to moderate conditions. Today, about 75% of children and youth with psychiatric disorders are seen in pediatric and other primary care settings.[3] However, the ability of pediatricians and other primary care providers to deliver mental health services has traditionally been constrained because of limited time for each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and limited access to behavioral health specialists. However, an example of a

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[3] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry into the pediatric health home.* Retrieved on June 1, 2017, at: https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

fully scaled, statewide implementation suggests that two-thirds of behavioral health care could be provided in pediatric settings with the right supports.[4]

Schools are the most natural setting for embedding integrated primary care to identify and assist children and youth with behavioral health concerns.[5] The American Academy of Child and Adolescent Psychiatry (AACAP) identifies key components of the behavioral health integration framework in its publication, "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home."[6] The components include:

- Screening and early detection of behavioral health problems;
- Triage and referral to appropriate behavioral health treatments;
- Timely access to child and adolescent psychiatry consultations that include indirect psychiatric consultation to primary care providers, as well as face-to-face consultation with the patient and family by the child and adolescent psychiatrist, when needed;
- Care coordination that assists in the delivery of mental health services and strengthens collaboration with the health care team, parents, family, and other child-serving agencies;
- Access to child psychiatry specialty treatment services for children and youth who have moderate to severe psychiatric disorders; and
- Monitoring outcomes at both an individual and delivery system level.

There are both national and local models that have established the behavioral health integration framework in pediatric care settings. The Massachusetts Child Psychiatry Access Project (MCPAP), established in 2004, is a national leader and model that has inspired many other states to create similar programs. It currently supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs that consist of a child psychiatrist, a licensed therapist, and a care coordinator. Each hub operates a dedicated hotline that can include the following services: timely clinical consultation over the phone, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers (PCPs). In 2014, following a MCPAP consultation, PCPs reported they

> **Best Practice: MCPAP Regional Hubs**
> - *Timely phone consultation,*
> - *Expedited face-to face psychiatric consultation,*
> - *Care coordination for referrals,*
> - *Education for primary care providers.*

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

[5] Murphy, D., Stratford, B., Gooze, R., Bringewatt, E., Cooper, P.M., Carney, R., & Rojas, A. (2014). *Are the children well? A model and recommendations for promoting the mental wellness of the nation's young people.* Robert Wood Johnson Foundation, pages 6–7.

[6] American Academy of Child and Adolescent Psychiatry (2012).

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were able to manage 67% of the kinds of problems that they typically would have previously referred to a child psychiatrist.

## Component 2: Specialty Behavioral Health Care
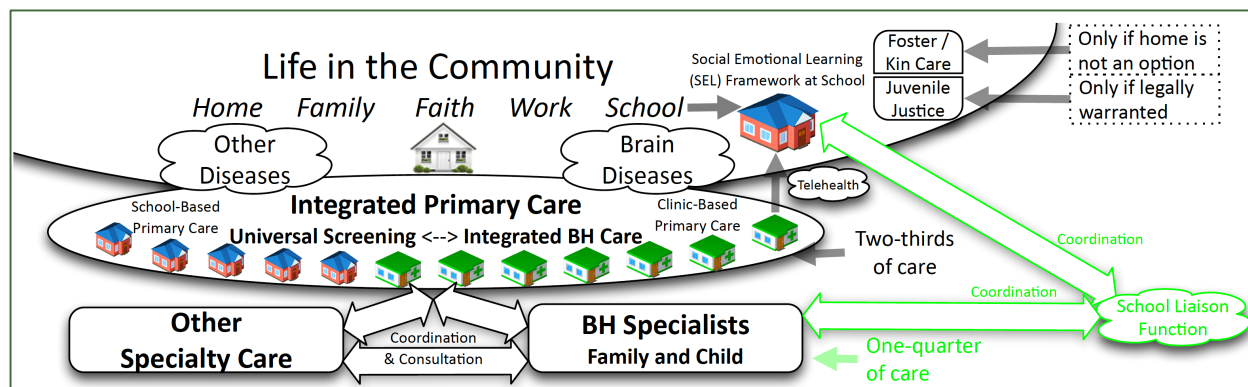
Some conditions, including psychiatric and other illnesses, need treatment by specialists in separate clinical settings. Specialty behavioral health care is the second component of an ideal system. However, rather than being the primary focus of the delivery system – as it often is today – in our ideal system, only about one fourth of all children and youth suffering with mental health conditions would need this level of care. Anxiety and routine depression can be readily treated in integrated primary care settings, but specialists are needed for the treatment of more complex depression, bipolar disorder, posttraumatic stress disorder, and other conditions. The future Ideal System of Care would shift some of the population with mild to moderate mental health conditions from specialty behavioral health care settings to integrated primary care settings. That would allow specialists to focus on children and youth with moderate to more severe conditions, re-allocating scarce resources to those with more intensive needs.

There is also a need for schools to develop a liaison function to help link children and youth in need (and their families) to available care. The liaison function can take on different forms in different schools and school districts, but its focus is the same – linking children and youth in need and their families to available specialty behavioral health resources. As will be seen later in this report, Communities in Schools (CIS) can play that role for the Harris County schools it serves; in districts such as Pasadena Independent School District (ISD), where the district has invested in Positive Behavioral Interventions and Supports (PBIS), school personnel can play the liaison role.

Perhaps most importantly, specialty behavioral health care in the ideal system focuses just as much on parents and caregivers as on children and youth. In addition, because psychiatric

conditions complicate treatment of other illnesses (e.g., diabetes), coordination with primary care providers is essential.

Component 3: Rehabilitation and Intensive Services
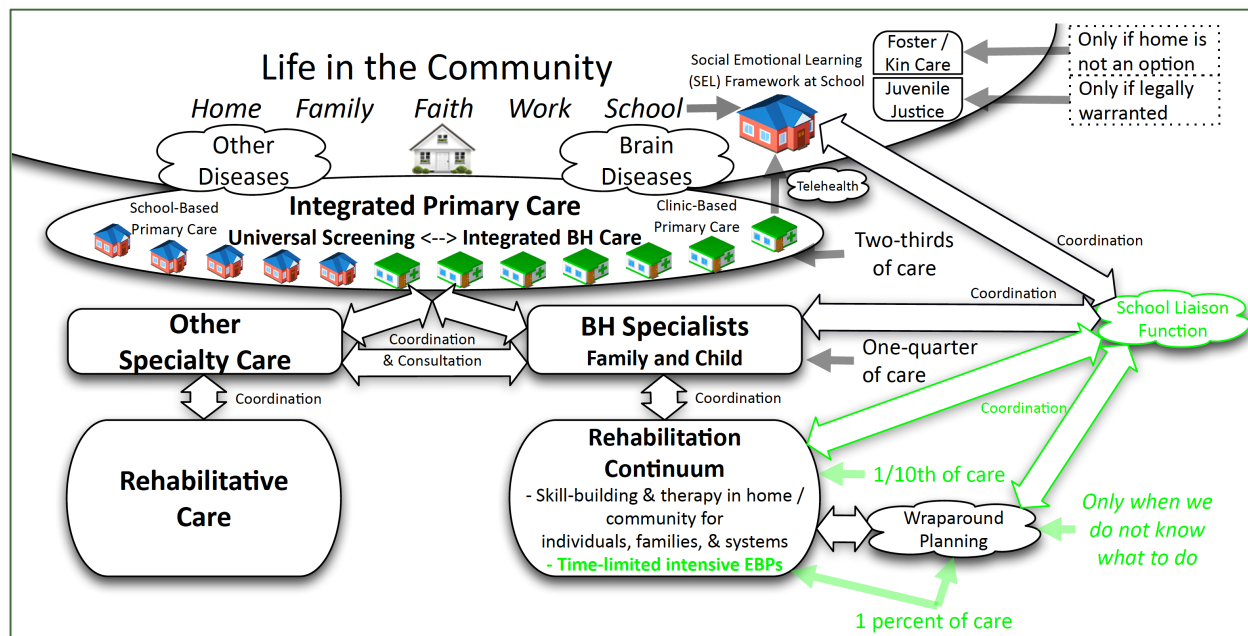
Some conditions are so severe that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. In the same way that a catastrophic orthopedic injury can require a child to have to re-learn how to walk, a severe psychiatric condition such as a psychosis, or a less severe condition that goes untreated for years, requires rehabilitative care to both treat the underlying condition and restore healthy functioning. Just as other rehabilitation, psychiatric rehabilitation involves a combination of medical treatment (generally medication), focused therapies (such as therapies to reduce the effects of trauma), and skill building (including work with the family and important people in the child's life to help them optimally support the child in their recovery).

Based on the best prevalence data available, we estimate that about one in 10 children and youth with mental health needs requires a combination of specialized intervention and functional rehabilitation, and one in 75 needs time-limited, intensive interventions. Below are examples of symptoms and appropriate intensive services:

- For an older adolescent first experiencing a psychosis, the best evidence-based intervention, called Coordinated Specialty Care (CSC), involves about two years of intensive, outpatient treatment that combines effective medication, family education, and skill building to help the youth stay in school and continue on or regain a healthy

developmental track; and supports to help the school or an employer accommodate the youth's symptoms.

- For children and youth caught up in juvenile offending with severe symptoms, such as classroom disruption, angry outbursts, or defiance related to untreated or undertreated depression or severe anxiety, a three- to seven-month regimen of Functional Family Therapy (FFT) or Multisystemic Therapy (MST) may be most effective.

Sometimes the needs are so complex that treatment providers and the multiple child-serving agencies involved in the child or youth's life are unable to identify a clearly optimal treatment option. In these cases, Wraparound Service Coordination is a necessary treatment to help the family and other involved parties sort through needs and determine the best path forward.[7]

Component 4: Crisis Care Continuum

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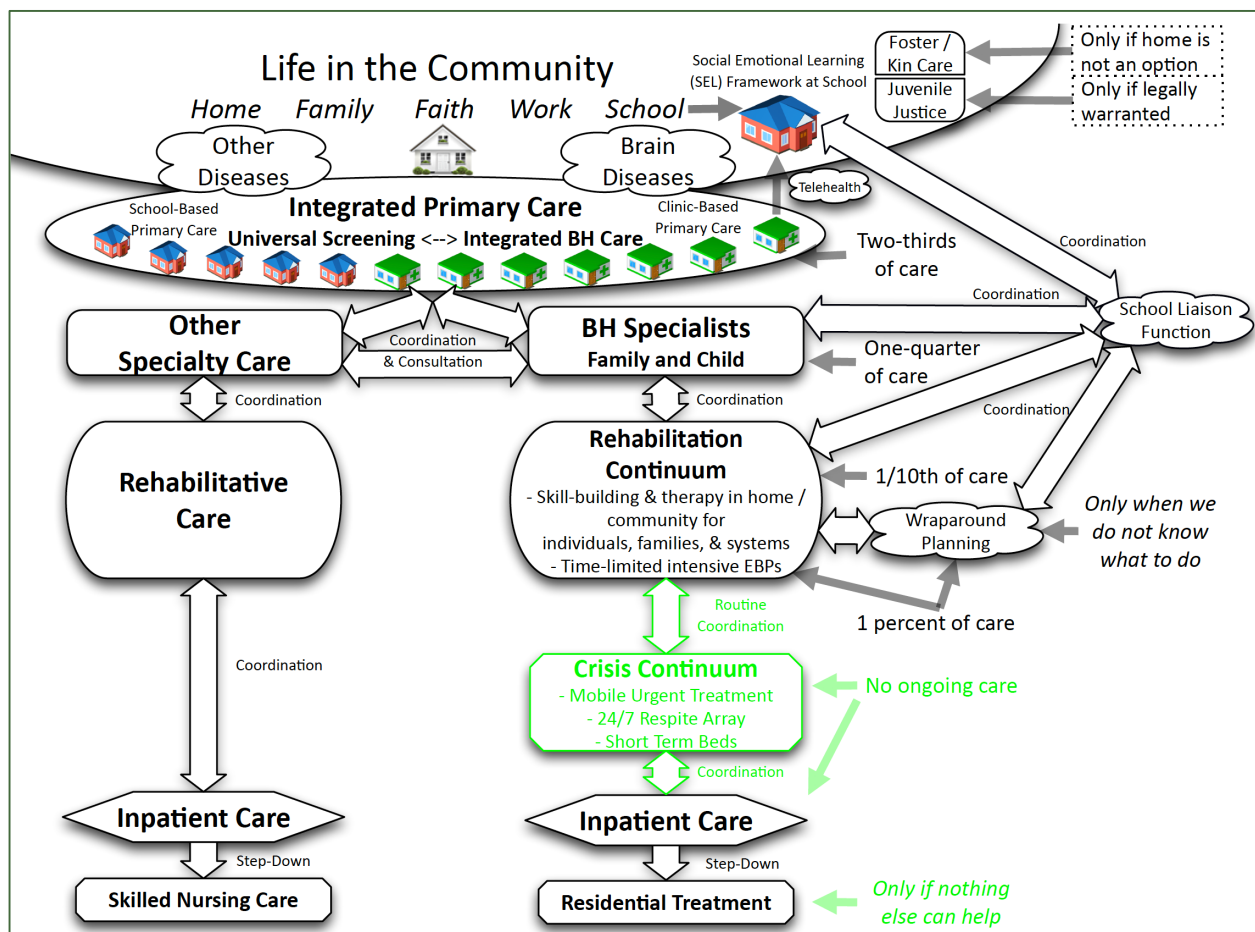
[7] Currently, the Texas Medicaid program requires Wraparound Service Coordination for all children and youth receiving intensive home and community-based services. While the principles of wraparound should inform all intensive treatment, the evidence base suggests that a Wraparound Facilitator and formal wraparound plan is only needed when the needs are so complex that a given type of care (e.g., CSC, FFT, or MST) is not sufficient.

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As noted at the start of this section, today, children and youth across Texas and the nation typically end up in inpatient care and residential treatment too often. It is important to understand that these levels of care are not places for ongoing treatment – they are specialized settings designed to address either acute needs or an inability to reside at home. We also discussed in the last subsection how intensive, evidence-based treatment can reduce the need for residential care, so in our ideal system, we would only have to use residential treatment in cases where safety concerns, combined with a lack of effective alternatives, requires it. This is similar to the role that skilled nursing care plays for children and youth with other complex medical conditions.

But evidence-based, intensive treatment is not enough. The most effective systems of care for children and youth, such as the renowned system in Milwaukee, WI, recognize that crises still happen even when optimal care is provided – arguments escalate, over-taxed caregivers require respite, and threats to self or others require an immediate response. An ideal system therefore requires a crisis care continuum that includes mobile teams that are able to respond not just to a range of urgent needs that occur outside of normal business hours and treatment environments, but also when there is a risk of an inpatient hospital admission. This continuum also requires a range of placement options ranging from crisis respite to acute inpatient.

In 2016, MMHPI and St. David's Foundation collaborated to publish a report that defined the ideal continuum of crisis services[8] and outlined the essential values for crisis services as promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines.[9] These

> *The crisis care continuum should be an adjunct to a robust array of outpatient and intensive community based services, not a substitute for these services.*

values and guidelines emphasize: 1) rapid response, 2) safety, 3) crisis triage, 4) active engagement of the individual in crisis, and 5) reliance on natural supports. A crisis care continuum for children and youth within an Ideal System of Care goes beyond that to include the following service components:

- A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team);[10]

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[8] Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services. A component of the continuum of care*. Commissioned by St. David's Foundation.

[9] Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Rockville, MD: Office of Consumer Affairs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved on August 31, 2016 at https://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf

[10] For more information, see http://wraparoundmke.com/programs/mutt/.

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- Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate level of services;
- Coordination with emergency medical services;
- Crisis telehealth and phone supports; and
- An array of crisis placements tailored to the needs and resources of the local system of care, including options such as:
  - In-home respite options,
  - Crisis foster care (placements ranging from a few days up to 30 days),
  - Crisis respite (one to 14 days),
  - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision,
  - Acute inpatient care, and
  - Linkages to a full continuum of empirically supported practices.

While this full array does not currently exist in any county in Texas, Harris County already has some components within its mental health, child welfare, and juvenile justice systems. These components are not well coordinated or even conceptualized as a coordinated crisis system. In an Ideal System of Care for Harris County, the crisis care continuum would be more integrated, with a broader array of crisis intervention services aimed at supporting families and caregivers, schools, children, and youth across the child-serving agencies. While there is evidence of collaboration among different agencies within the current system, most crisis programs are designed to help individual target populations within each specific sub-system.

Even with a full continuum of crisis options, children and youth will still need inpatient care for acute and complex needs. While inpatient psychiatric care is not a substitute for ongoing, well-coordinated outpatient mental health care, inpatient psychiatric hospitalizations can be helpful to stabilize children and youth when there are safety concerns or medication adjustments that require close monitoring. Hospitalization should be available when needed, but generally it should be brief and supported by the broader crisis array. For example, short-term placement in crisis foster or residential care can divert children and youth with sub-acute needs from inpatient settings, as well as provide support as they transition home. The availability of intensive community-based services and supports for families and foster care providers can also assist children, youth, and their caregivers with the transition back to their homes post hospitalization. In an Ideal System of Care for Harris County, inpatient care access would be targeted to children and youth who need this level of care rather than to children and youth with serious mental health conditions who are in crisis and simply have no place to go.

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Residential treatment is a component of the continuum of care for children and youth whose behavior cannot be managed safely in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth. As such, it should be reserved for situations where less restrictive placements are ruled out, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who may not respond to intensive, nonresidential service approaches.[11] Across Texas and nationally, children and youth are too often placed in residential treatment because more appropriate community-based services are not available. When utilized, residential services should be brief, intensive, family-based, and as close to home as possible. In the Ideal System of Care, intensive in-home community-based services and other rehabilitation skills-building services in Harris County would be available earlier to prevent most out-of-home placements.

How Many Harris County Children and Youth Have Mental Health Needs?

This section provides an overview of the number of children and youth in Harris County with different types of mental health conditions. We also briefly summarize some of the factors, including trauma and poverty, that have an impact on the mental health of children and youth. Based on the latest epidemiological research, one in three children and youth, and two in five adolescents, suffer each year from mental health and substance use disorders.[12] However, individual needs vary in intensity

Harris County – Prevalence and Severity of MH Conditions among Children and Youth:
- *250,000 mild to moderate needs*
- *65,000 with severe needs (SED)*
- *35,000 with SED in poverty*
- *4,000 at high risk of out-of-home or out-of-school placement*

from very mild to extremely acute and severe. To revisit the analogy to orthopedic care used earlier, while many children and youth sprain their ankles or break their arms each year, a much smaller number suffer catastrophic injuries that require rehabilitation to regain functioning.

However, we believe that summing up the entire range of mental health needs in a statistic, such as "one in three" or "two in five," can actually create barriers to better treatment of mental illness. Such simplistic groupings are not done for other severe medical conditions. For example, the most recent Texas Cancer Plan does not even note the total number of people in Texas with cancer, which is just under 740,000, nor does it break out the number of severe

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[11] Stroul, B. (2007). *Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes*. Washington, DC: Georgetown University Center for Child and Human Development, National TA Center for Children's Mental Health.

[12] Kessler, R C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 617–709. Kessler, R.C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*, 372–380.

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cases (e.g., "Stage Four" cases). Instead, the plan focuses on specific cancers, such as breast cancer or prostate cancer, and the number of new cases diagnosed each year.[13, 14]

In addition, it can often be challenging to determine a discrete diagnosis for children and youth because their emotions, self-control, and perceptions vary as they mature through the stages of development. Nevertheless, it remains important to assess whether a child has a routine anxiety disorder or depression, which can be treated in an integrated primary care setting, or a more severe condition that requires specialized or intensive treatment. In the following table, we present the best available epidemiological research to provide rounded estimates[15] of the number of children and youth up to age 18 with mental health needs in Harris County.

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[16]	6–17	410,000
All Behavioral Health Needs (Mild, Moderate, and Severe)		310,000
Mild and Moderate Conditions	6–17	250,000
Severe Conditions: Serious Emotional Disturbance (SED)[17]	6–17	65,000
SED in Poverty	6–17	35,000
At Risk of Out-of-Home / Out-of-School Placement[17]	6–17	4,000

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[13] Cancer Prevention and Research Institute of Texas. (2012, April). *Texas cancer plan.* (2012). Retrieved from http://www.cprit.state.tx.us/images/uploads/tcp2012_web_v2a.pdf

[14] Texas Department of State Health Services (DSHS). (2017). *Texas prevalence counts, invasive cancers only, January 1, 2014 using different tumor inclusion criteria*. Retrieved from http://www.dshs.texas.gov/tcr/data/prevalence.aspx

[15] Numbers do not always add up due to rounding. All prevalence estimates are based on either Texas-specific algorithms (Holzer et al., 2016) or estimates from the literature then applied to population estimates from the American Community Survey, 2015. Unless otherwise noted, age of onset estimates come from Kessler, R.C., et al. (2005). Lifetime prevalence and age of onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 593–768. Overall prevalence estimates of all conditions combined are from the Federal Register and from Kessler, R.C., et al. (2012). Severity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 6*9(4), 381–389.

[16] "In poverty" refers to the number of individuals below 200% of the federal poverty level for the specified region.

[17] Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2015*. Dallas, TX: Meadows Mental Health Policy Institute. The overall prevalence (including mild, moderate, and severe conditions) are drawn from the national sources identified in the note above. The Kessler et al. (2012) breakouts yield slightly different numbers of youth with serious conditions than are estimated in the more Texas-specific SED estimates produced through the Holzer/MMHPI algorithms. For this reason, we use our SED estimates and subtract them from the nationally-based overall prevalence figures to produce the mild-moderate total.

Mental Health Condition	Age Range	Prevalence
Specific Disorders – Youth (unless otherwise noted) [19]		
Depression	12–17	30,000
Bipolar Disorder	12–17	8,000
First Episode Psychosis (FEP) Incidence – New Cases Per Year[20]	12–17	200
Schizophrenia[21]	12–17	900
Posttraumatic Stress Disorder	12–17	15,000
Self-Injury/Harming Behaviors[22]	12–17	35,000
Obsessive-Compulsive Disorder – Children/Youth[23]	6–17	15,000

[18] Meadows Mental Health Policy Institute (2015). *Estimating the percentage of lower-income youth with serious emotional disturbances who need time-limited, intensive home/family/community-based services*. Unpublished documents and data. Based on work in multiple states that have developed community-based service arrays in response to system assessments and Early and Periodic Screening, Diagnostic and Treatment (EPSDT) legal settlements (WA, MA, CT, NE, and PA), and based on the input of leading national experts on the need for wraparound services.

[19] Kessler, R.C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication – Adolescent Supplement. *Archives of General Psychiatry, 69*, 372-380. Estimates for depression, post-traumatic stress disorder, and bipolar disorder were calculated by multiplying the estimate of the 12-17 population by the prevalence estimate for each respective disorder. Kessler and colleagues did not include some specific diagnoses, such as schizophrenia and obsessive-compulsive disorder; we used other sources for estimating prevalence of those and other conditions not reported in Kessler et al., 2012.

[20] Kirkbride, J. B., Jackson, D., Perez, J., Fowler, D., Winton, F., Coid, J. W., Murray, R. M., & Jones, P. B. (2013, February). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*(2), 1–12. Note that, while approximately 200 youth each year will manifest a first episode of psychosis, not all develop schizophrenia. However, the total number of youth with schizophrenia is much larger at any one time because many, if not most, youth with psychosis fail to receive timely and effective treatment and thus suffer from the disorder for long periods of time.

[21] Androutsos, C. (2012). Schizophrenia in children and youth: Relevance and differentiation from adult schizophrenia. *Psychiatriki, 23*(Supl), 82-93. (Original article in Greek). The estimate is that among youth ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia. Another study from Sweden reported that 0.54% of youth were treated for psychotic disorders at least once during the ages of 13–19: Gillberg, C, et al. (2006). Teenage psychoses-epidemiology, classification, and reduced optimality in the pre-, per-, and neonatal periods. *Journal of Child Psychology and Psychiatry, 27*(1), 87–98.

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

[23] There is no definitive study of obsessive-compulsive disorder (OCD) prevalence among children and adolescents. On the weight of the epidemiological evidence, we have chosen a 12-month estimate of 2% among children and youth ages 6-17. See: Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401-411; Peterson, B. et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological study. *Journal of the American Academy of Child & Adolescent Psychiatry, 40*(6), 685-695; and Douglas, H.M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child & Adolescent Psychiatry, 34*(11), 1424-1431.

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Mental Health Condition	Age Range	Prevalence
Eating Disorders[24]	12–17	3,000
Substance Use Disorders[25]	12–17	20,000
Specific Disorders – Children Only[26]		
All Anxiety Disorders – Children	6–11	45,000
Depression/All Mood Disorders – Children	6–11	4,000
Schizophrenia – Childhood Onset (before age 13)[27]	6–11	Approximately 10

However, data on the prevalence of specific disorders do not paint the entire picture of need:

- **We also know that poverty has a negative impact on the social determinants of health.** Economic stability, education, health, access to health care, and the social and community context in which children and youth live and grow all affect health, development, and morbidity.[28] Poverty, coupled with adverse childhood experiences (ACEs), can have a lasting, negative effect on a child or youth's physical and emotional well-being. Those who have experienced multiple ACEs are at highest risk for negative outcomes, including health and behavioral problems.[29] National prevalence estimates and state-level data suggest that approximately 10% of Texas children and youth have experienced three or more ACEs in their lifetime.[30] In addition, children and youth

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[24] Swanson, et al. (2011). Prevalence and correlates of eating disorders in adolescents. Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. The prevalence estimate for eating disorders encompasses only Anorexia Nervosa and Bulimia Nervosa.

[25] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

[26] Data on disorders in children are not as robust as they are for youth. These estimates for children are based on adult data from Kessler et al. (2005) regarding the ages at which mood and anxiety disorders have their first onset. On average, anxiety disorders have a much earlier onset than mood disorders, with half of all anxiety disorders, but only 5% of all mood disorders, appearing in childhood (by age 11). The figures here show the number of children estimated to have ever had a mood disorder or an anxiety disorder; they are not 12-month prevalence estimates.

[27] Childhood onset schizophrenia is estimated to have a prevalence of one in 40,000 children under age 13. See Gochman, P., et al. (2011). Childhood-onset schizophrenia: The challenge of diagnosis. *Current Psychiatry Reports*, *13*(5), 321–322.

[28] Office of Disease Prevention and Health Promotion. (n.d.). Healthy People 2020. Retrieved from https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources

[29] Felitti, V. J., Anda, R. F., Nordenberg, D., Williamson, D. F., Spitz, A. M., Edwards, V., & Koss, M. P. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults: Adverse Childhood Experiences (ACE) Study. *American Journal of Preventive Medicine, 14*(4), 245–258.

[30] Sacks, V., Murphy, D., Moore., K. (2014). *Adverse childhood experiences: National and state-level prevalence. Publication #2014-28*. Bethesda, MD: Child Trends.

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involved in the child welfare and juvenile justice systems are much more likely to have experienced ACEs.

- **While race and ethnicity are not correlated with substantial differences in the prevalence of mental health conditions, children and youth of color in Harris County are at a much higher risk of poverty and its negative effects on mental health.** Two-thirds of Harris County residents identify with a race/ethnicity other than white. Among those living in extreme poverty, 87% are people of color. Latinos and Hispanics represent a majority of the county population living in poverty.[31]

- **Most children and youth in foster care have experienced ACEs or trauma as a result of disruptions in their family life such as abuse and neglect, separation from home and siblings, school changes, and multiple foster placements**. Children and youth in foster care experience an elevated incidence of developmental delays – up to 25% in some age groups – and high rates of posttraumatic stress disorder. Over 80% of youth aging out of foster care have received a psychiatric diagnosis.[32]

- **School suspension and expulsion, also referred to as exclusionary discipline, are among the strongest correlates of future involvement in the juvenile justice system.** This "school-to-prison pipeline" first manifests in the classroom. When combined with zero-tolerance policies, a decision to refer students for discipline rather than treatment can push students out of the classroom and place them at higher risk for entry into the justice system. Research clearly shows that a student suspended from 9th grade is at three times the risk of future incarceration and two times the risk of dropping out, compared to other students.[33] This is not because suspensions increase the risk, but because the underlying factors which lead to the suspension, including untreated or

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[31] Data were provided by the Harris Center in 2015 and verified by MMHPI. The Harris Center obtained from the county-level race/ethnicity data from the 2012 American Community Survey. In identifying the population in poverty, the Harris Center used 100% of the federal poverty level (FPL) as the reference point.

[32] American Academy of Pediatrics. (2015). Helping foster and adoptive families cope with trauma. Retrieved June 22, 2017 from https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf. As cited in Salisbury A. L., Ponder, K. L., Padbury, J. F., Lester, B. M. (2009). Fetal effects of psychoactive drugs. *Clinics in Perinatology*, 36(3), 595–619.
Greeson, J. K., et al. (2011). Complex trauma and mental health in children and youth placed in foster care: findings from the National Child Traumatic Stress Network. *Child Welfare*, 90(6), 91–108.
Salazar A. M., Keller, T. E., Gowen, L. K., & Courtney, M.E. (2012). Trauma exposure and PTSD among older youth in foster care [published online ahead of print August 17, 2012]. *Social Psychiatry and Psychiatric Epidemiology*. doi:10.1007/s00127-012-0563-0

[33] Balfanz, R., Byrnes, V., & Fox, J. (2013). Sent home and put off-track: The antecedents, disproportionalities, and consequences of being suspended in the ninth grade. Paper presented at the Closing the School Discipline Gap: Research to Practice, Washington, DC. As cited in Losen, D.J. & Martinez. T. (2013). Out of school and off track: The overuse of suspensions in American middle and high schools. Center for Civil Rights Remedies at UCLA's Civil Rights Project. Retrieved from http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutofSchool-OffTrack_UCLA_4-8.pdf

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inadequately treated mental illness, increase the odds of future incarceration or dropping out if left unaddressed. Students are also far more likely to be arrested at school than they were 10 years ago. While the increase has been driven in part by safety concerns, the vast majority of these arrests are for nonviolent offenses such as classroom disruption.[34] The Council on State Government's landmark 2011 study[35] in Texas that focused on the school-to-prison pipeline definitively showed the following:
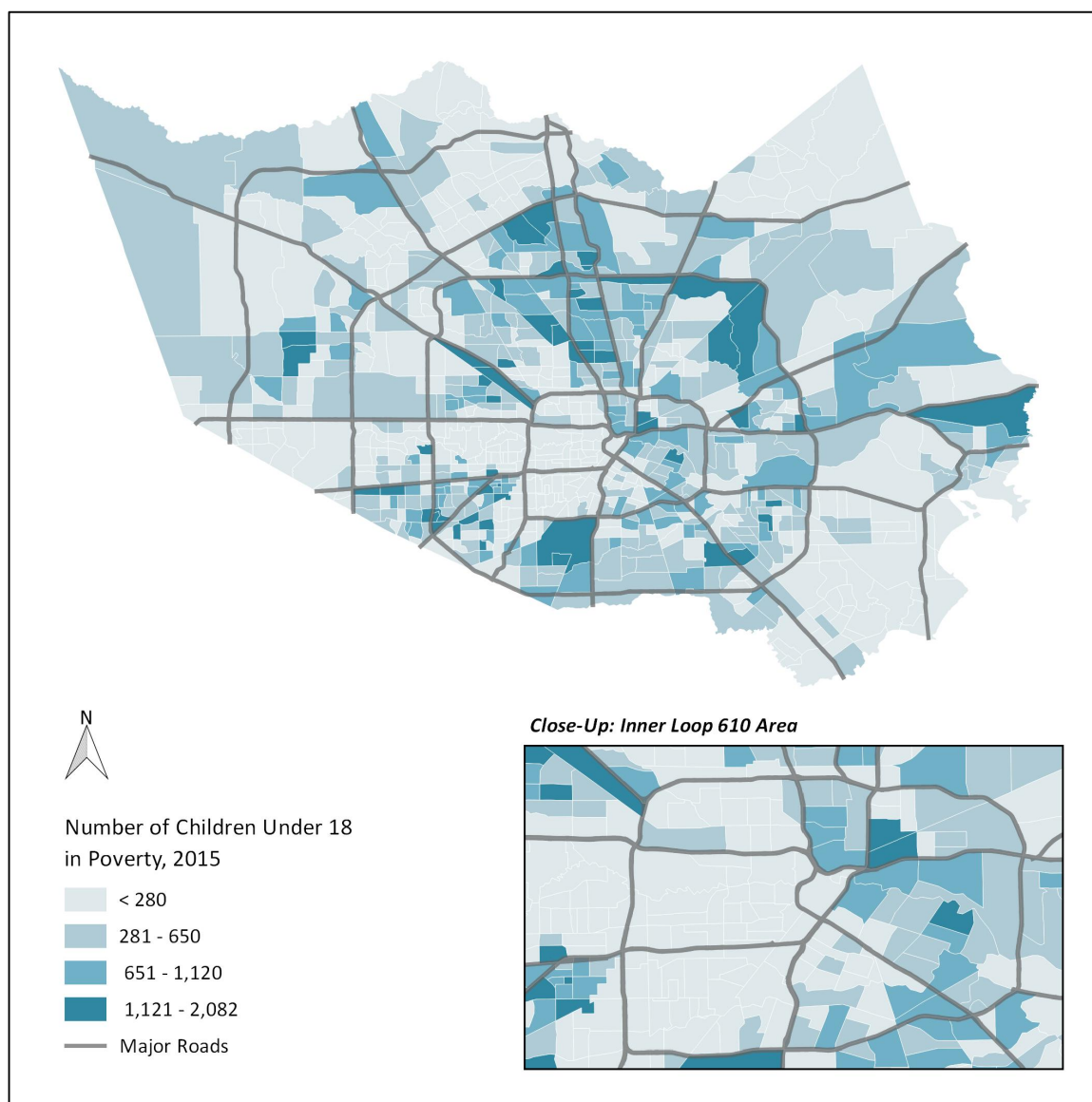
– Ten percent (10%) of Texas students who receive disciplinary action drop out of school, and 31% of those who receive disciplinary action are held back at least once.

– Ninth-grade African-American students in Texas have a 31% higher likelihood of a discretionary school disciplinary action compared to the rate for white students.

– Hispanic students in Texas have a 16% higher likelihood of receiving a mandatory action compared to otherwise identical white students.

– In response to state level policy changes, Harris County has dramatically reduced the number of students arrested at school, but there has not been a corresponding level of increase in access to the services needed to address the behaviors that put these children and youth at risk.

Mapping Poverty. Across these various risk factors, poverty is the one most comprehensively tracked, so we mapped poverty levels geographically, by school district, and in reference to provider locations. The first map shows the number of children and youth in poverty per census tract in Harris County in 2015.

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[34] Petteruti, A. (2011, November). *Education under arrest: The case against police in schools.* Retrieved from https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=264688

[35] Fabelo, T., Thompson, M.D., Plotkin, M., Carmichael, D., Marchbanks, M.P., & Booth, E.A. (2011, July). *Breaking schools' rules: A statewide study of how school discipline relates to students' success and juvenile justice involvement*. Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University. Grant from the Atlantic Philanthropies and Open Society Foundations. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf

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Number of Individual Children and Youth Under Age 18 in Poverty, Harris County, 2015[36]

Close-Up: Inner Loop 610 Area

Number of Children Under 18
in Poverty, 2015
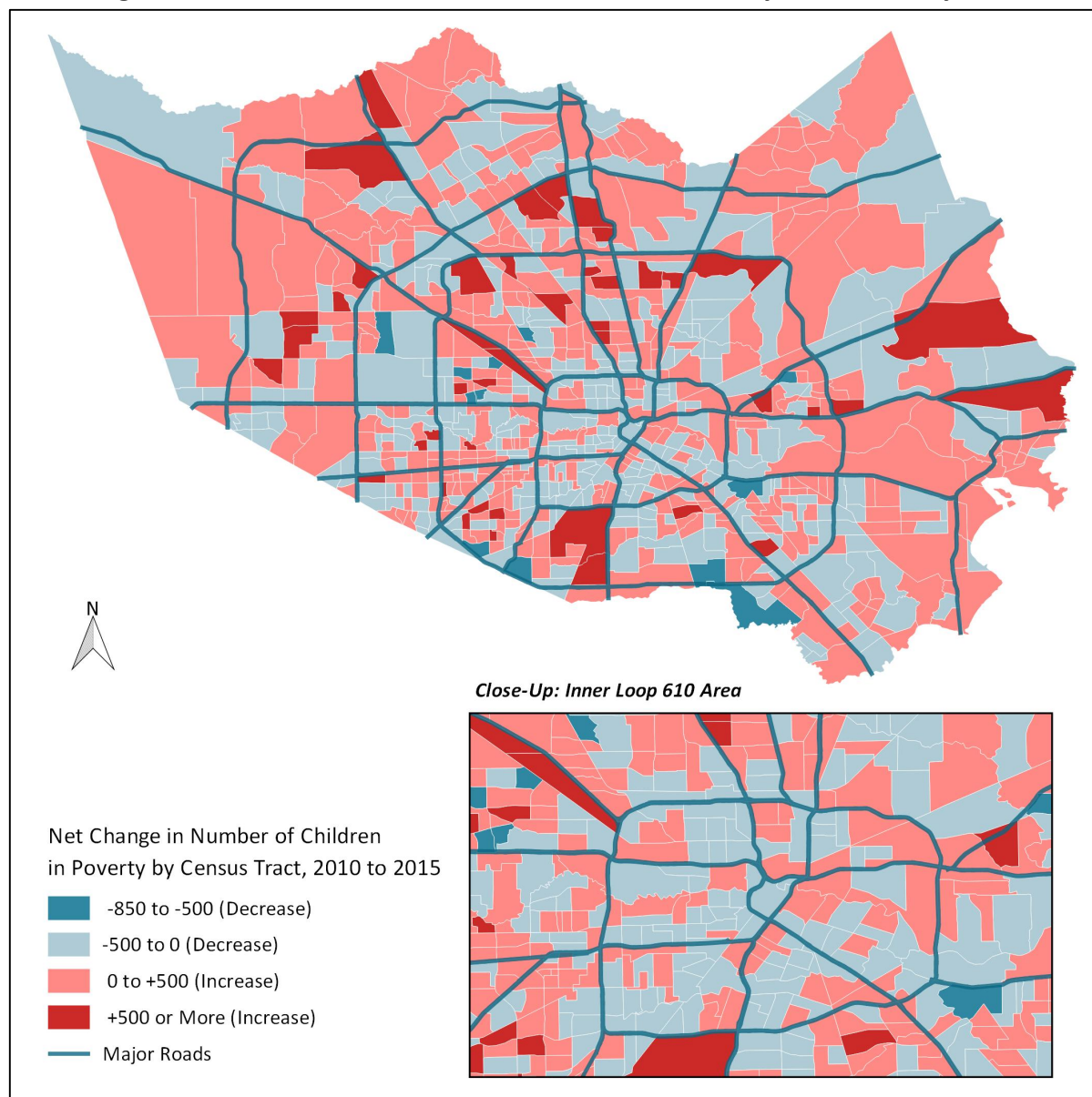
< 280
281 - 650
651 - 1,120
1,121 - 2,082
Major Roads

The map reveals that the areas with the highest number of children and youth in poverty are just outside the Inner Loop 610 area. There are also areas of high poverty in north and east Harris County.

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[36] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org

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The next map shows the net change (increase or decrease) in the number of children and youth in poverty by census tract from 2010 to 2015. Note that the areas with the most significant growth in poverty were outside of the Inner Loop 610 area.

Net Change in Number of Individual Children / Youth in Poverty, Harris County, 2010–2015[37]

Net Change in Number of Children
in Poverty by Census Tract, 2010 to 2015

- -850 to -500 (Decrease)
- -500 to 0 (Decrease)
- 0 to +500 (Increase)
- +500 or More (Increase)
- Major Roads

Close-Up: Inner Loop 610 Area

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[37] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at
http://data.ohouston.org

Poverty and School Districts. There are 21 independent school districts (ISDs) in Harris County, with 1,070 public schools serving 877,593 students.[38] Schools are natural settings to provide access to primary and mental health services, but each campus and school system has a set of local rules and policies that must be navigated to successfully implement school-based or school-linked services. The map below includes the base layer of poverty by census tract in 2015, but adds an overlay of the independent school districts (ISDs) in Harris County. Additionally, each ISD includes the percentage of economically disadvantaged students.

**Harris County ISDs and Economic Disadvantage**[39]

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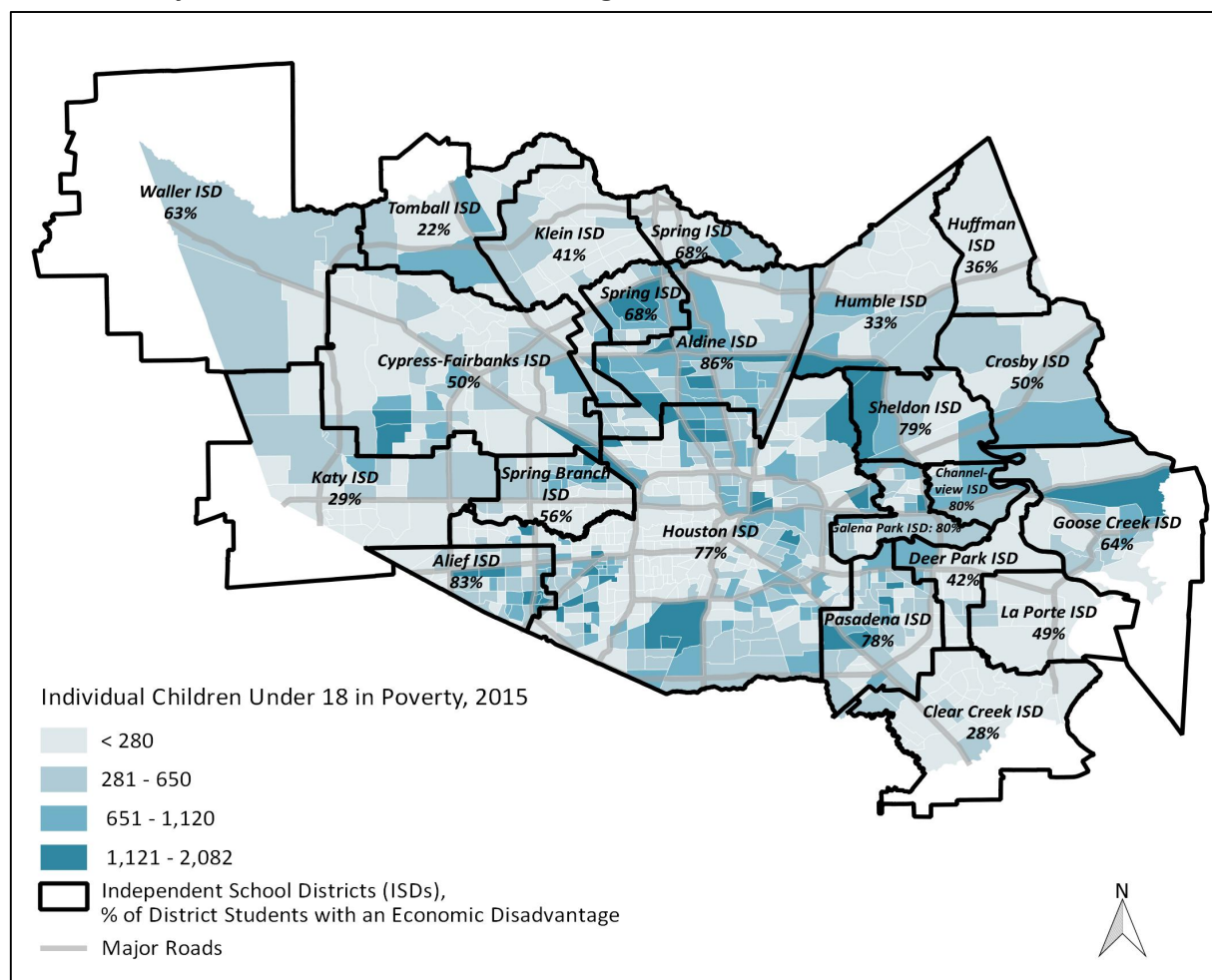
[38] Public School Review. (n.d.) *Harris County public schools*. Retrieved on June 24, 2017, from https://www.publicschoolreview.com/texas/harris-county

[39] Independent school district boundaries obtained from The Texas Education Agency. (n.d.) *Texas Education Agency public open data site, current 2014-2015 statewide school districts for Texas*. Retrieved from http://schoolsdata2-tea-texas.opendata.arcgis.com/datasets/e115fed14c0f4ca5b942dc3323626b1c_0
The number of students with an economic disadvantage was obtained from The Texas Education Agency. (n.d.). *2016-2017 economically disadvantaged students, statewide totals*. Retrieved from https://rptsvr1.tea.texas.gov/cgi/sas/broker

We also looked at a daily snapshot of the number of children and youth in foster care per ISD. The next map shows a base layer of this population per school district. These data were obtained from the Texas Department of Family and Protective Services for a single day in early 2017; daily rates are approximately half of the annual number of children and youth in foster care. The map also includes the locations of mental health rehabilitation providers and foster care-specific clinics, which will be discussed later.
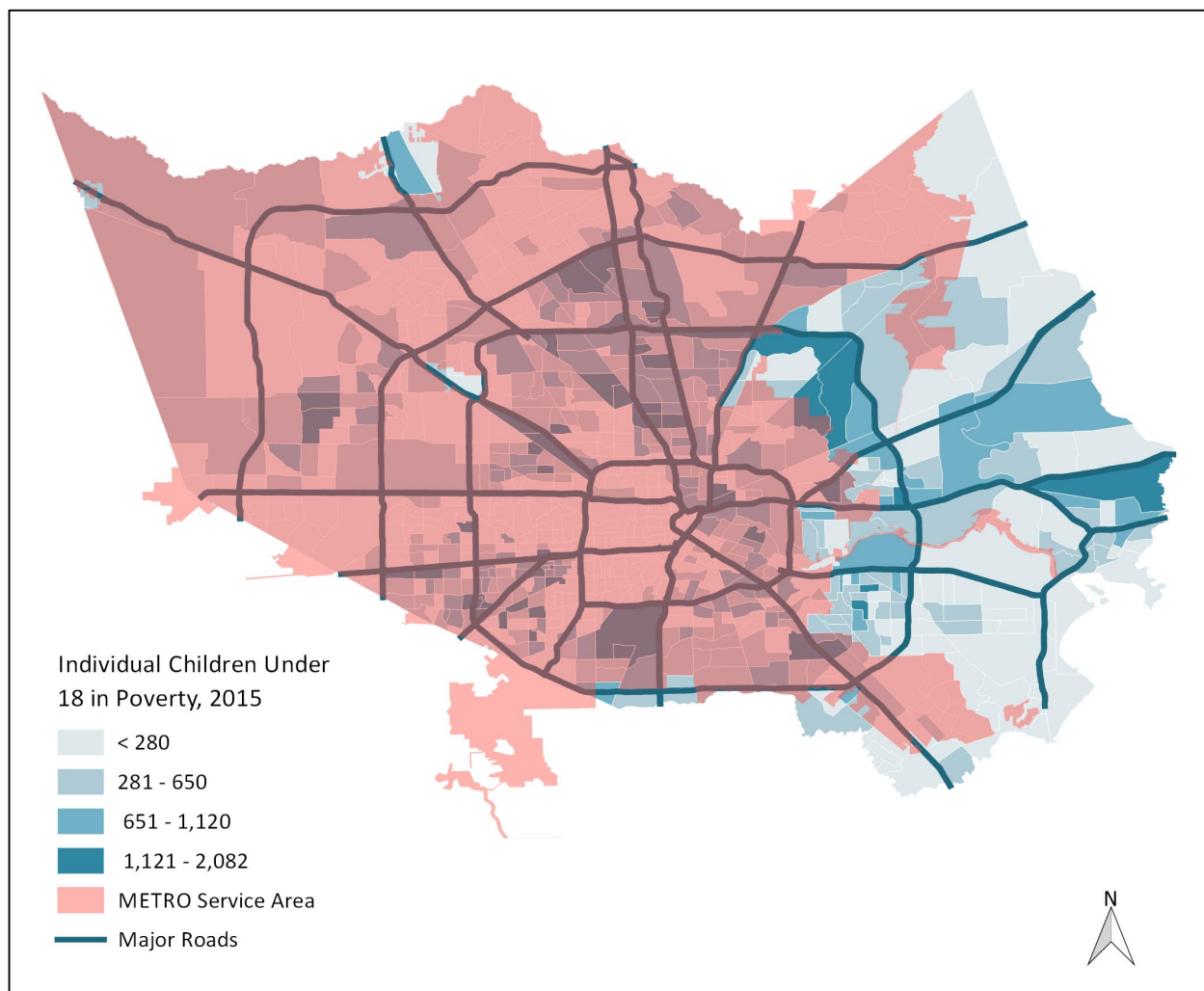
Children and Youth in Foster Care Per School District and Mental Health Rehabilitation Clinics[40]

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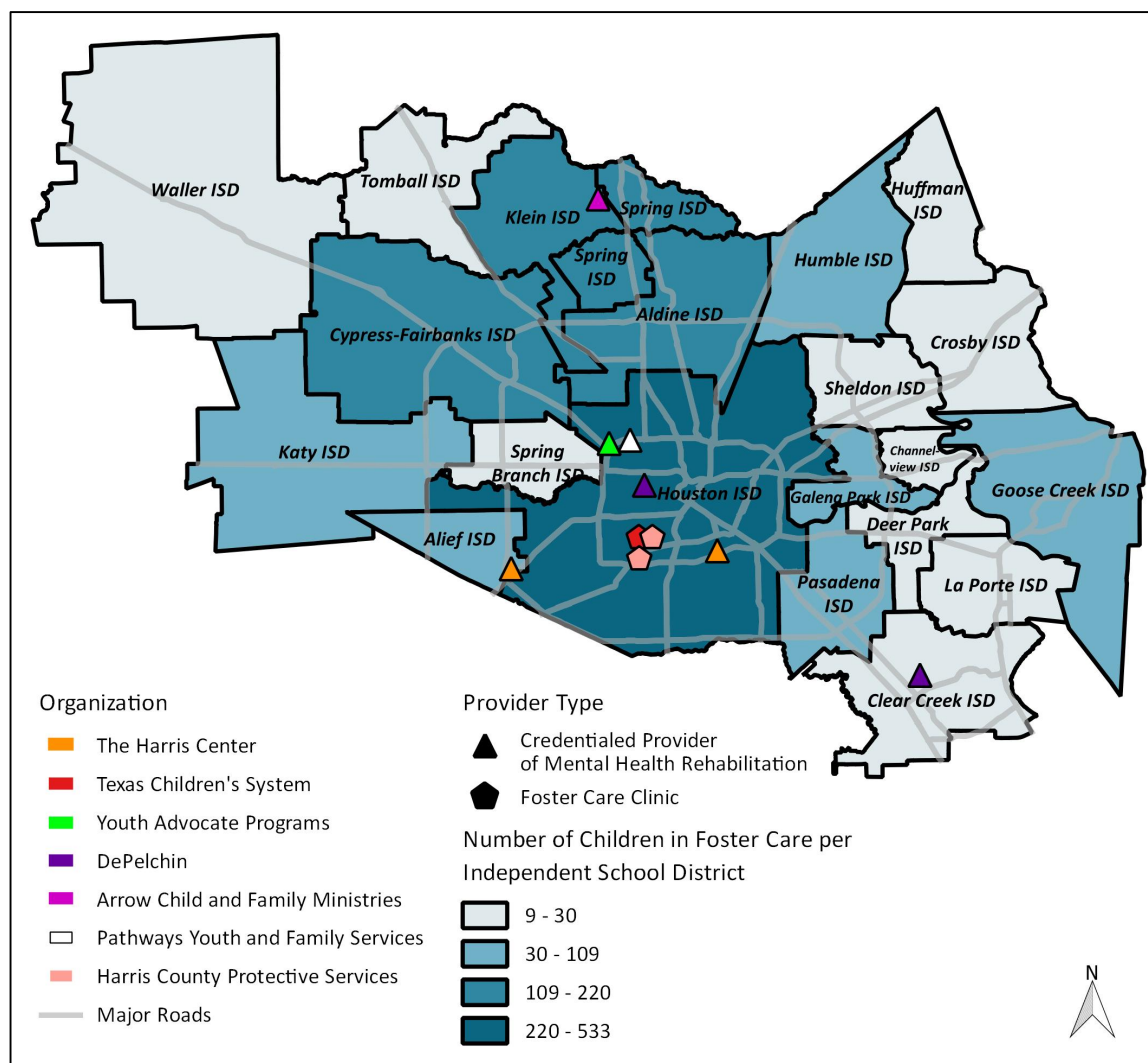
[40] Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. Independent school district boundaries obtained from The Texas Education Agency. (n.d.) *Texas Education Agency public open data site, current 2014-2015 statewide school districts for Texas*. Retrieved from http://schoolsdata2-tea-texas.opendata.arcgis.com/datasets/e115fed14c0f4ca5b942dc3323626b1c_0.
The number of children in foster care per district was obtained from the TDFPS IMPACT system and is current, 2017 data. Foster Care Clinics obtained via personal communication with Joel Levine.

Public Transportation. The map that follows shows the service area for the Metropolitan Transit Authority of Harris County (METRO). There is no public transportation for people living in eastern Harris County. The lack of providers and public transportation in eastern Harris County almost certainly make it more difficult for some residents to access needed services.

METRO Service Area[41]

Individual Children Under 18 in Poverty, 2015

	< 280
	281 - 650
	651 - 1,120
	1,121 - 2,082
	METRO Service Area
	Major Roads

With poverty as a proxy for highest need, and knowing that rates of mental illness and barriers to care are highest for children and youth in poverty, we then looked at the geographic

[41] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. METRO service area obtained from the Metropolitan Transit Authority of Harris County ("METRO"), GIS Data Layers at http://www.ridemetro.org/pages/newsdownloads.aspx.

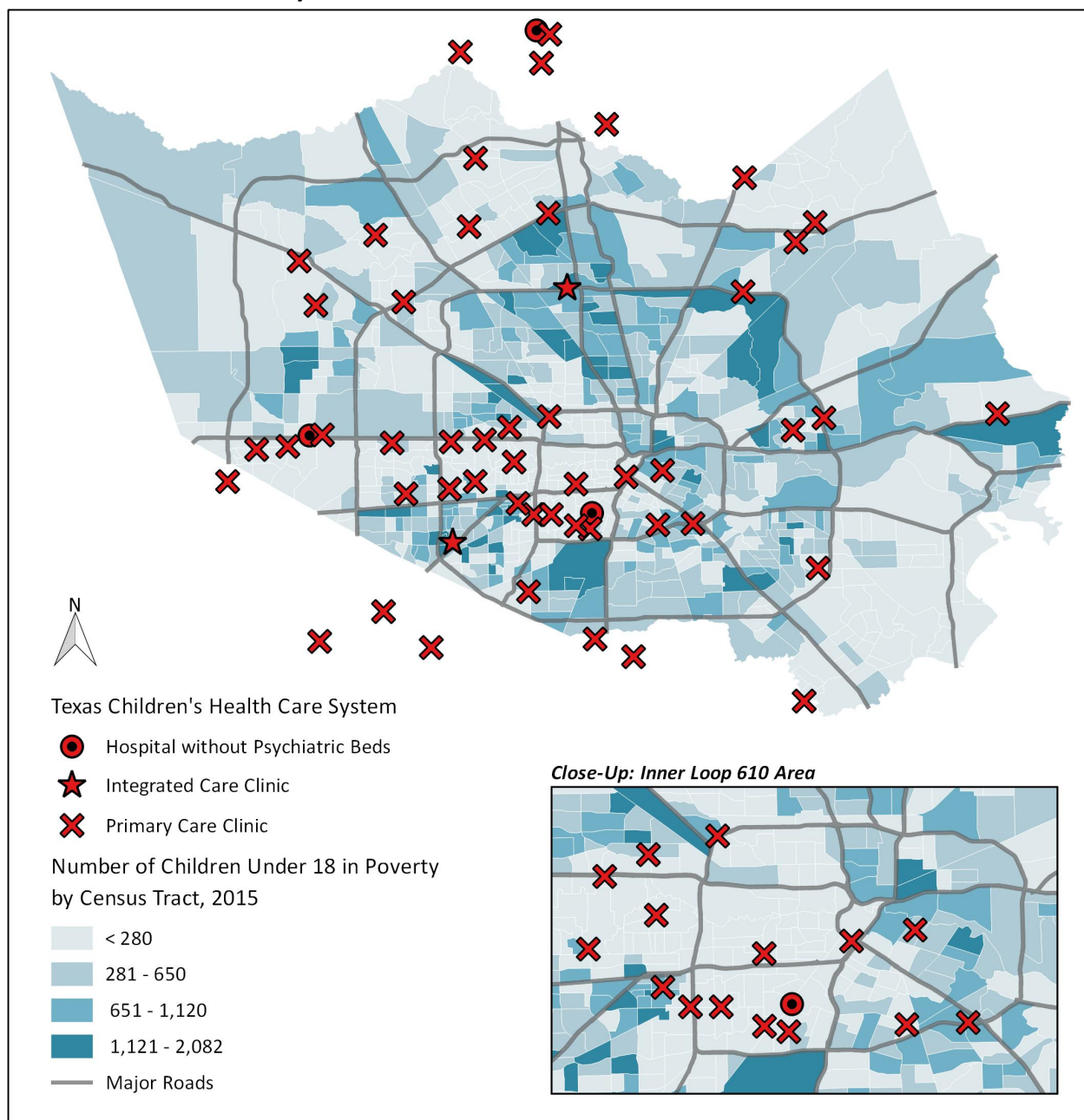TEXAS STATE *of* MIND
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accessibility of major providers with the current and potential capacity to address mental health needs. The maps in this section show the geographical accessibility to various health and mental health systems throughout Harris County. This analysis found limited geographical access for almost every service type in the areas with the highest growth in poverty: north, northwest, and northeast of the city center within the Inner Loop 610 area. Additionally, a sizeable area just south of the city center shows high growth in poverty and limited access to providers.

To be more specific, we first looked at three of the largest health networks serving Harris County children and youth – Harris Health, Memorial Hermann Health System (Memorial Hermann), and Texas Children's Health System (Texas Children's). All of these networks have the potential to serve as a base of integrated behavioral health capacity in the county. As will be discussed later, Texas Children's is just beginning to roll out integrated behavioral health, whereas Memorial Hermann has been delivering integrated behavioral health in its school-based clinics for many years. Neither system offers psychiatric inpatient capacity in its hospitals.
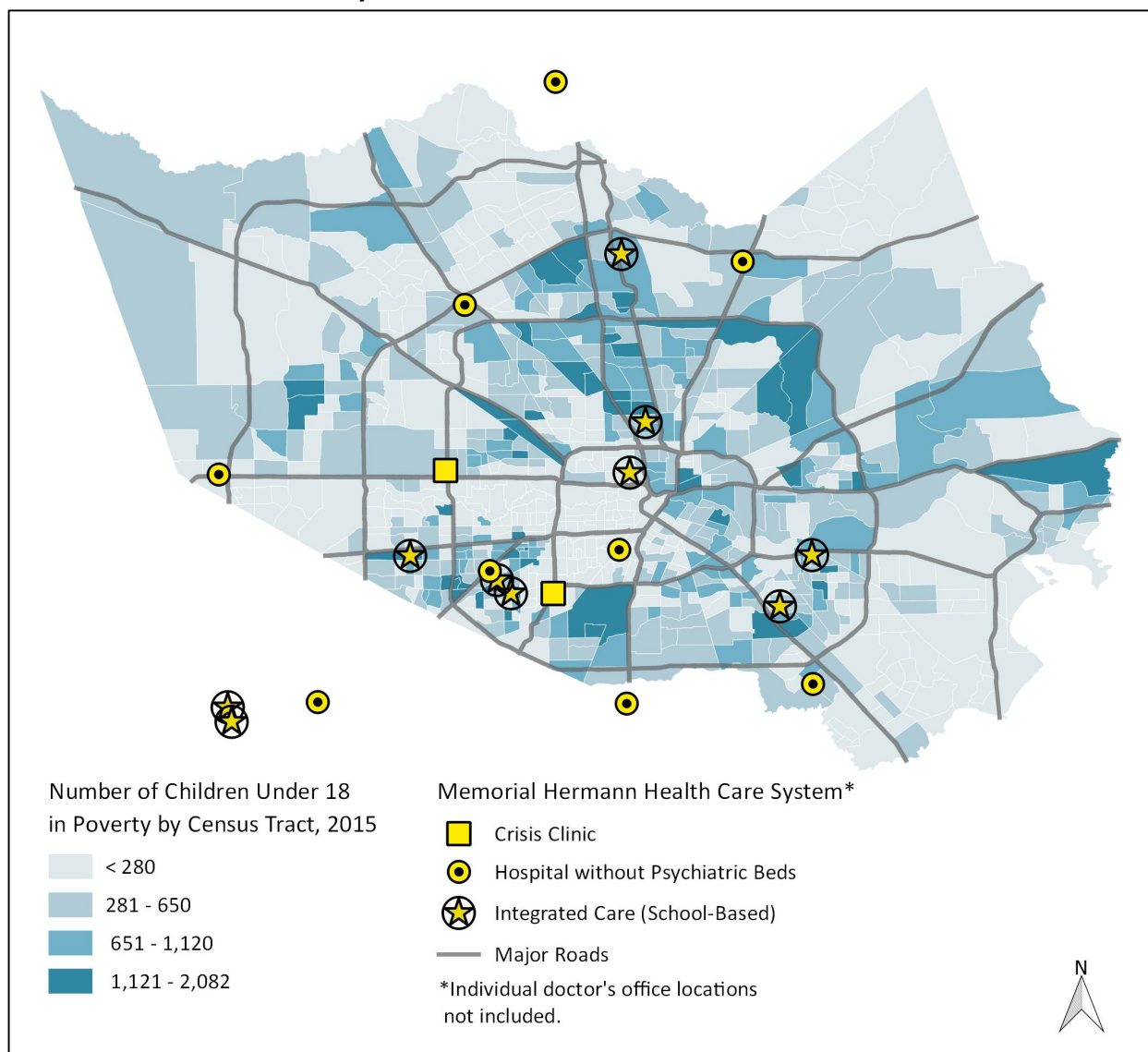
Harris Health System (Harris Health) operates 24 general primary care clinics, three of which are dedicated pediatric and adolescent primary care clinics. It also operates five additional school-based clinics. Behavioral health services for children and youth are provided at one of the pediatric and adolescent clinics, one of the school-based clinics, and three of the general clinics. Harris Health also operates one of the anchor psychiatric hospitals in the region, Ben Taub Hospital. Its psychiatric units typically accept only adult patients, but in times of high need it will serve some adolescents. While some of its behavioral health care is integrated into some sites, most behavioral health care is provided as specialty care.
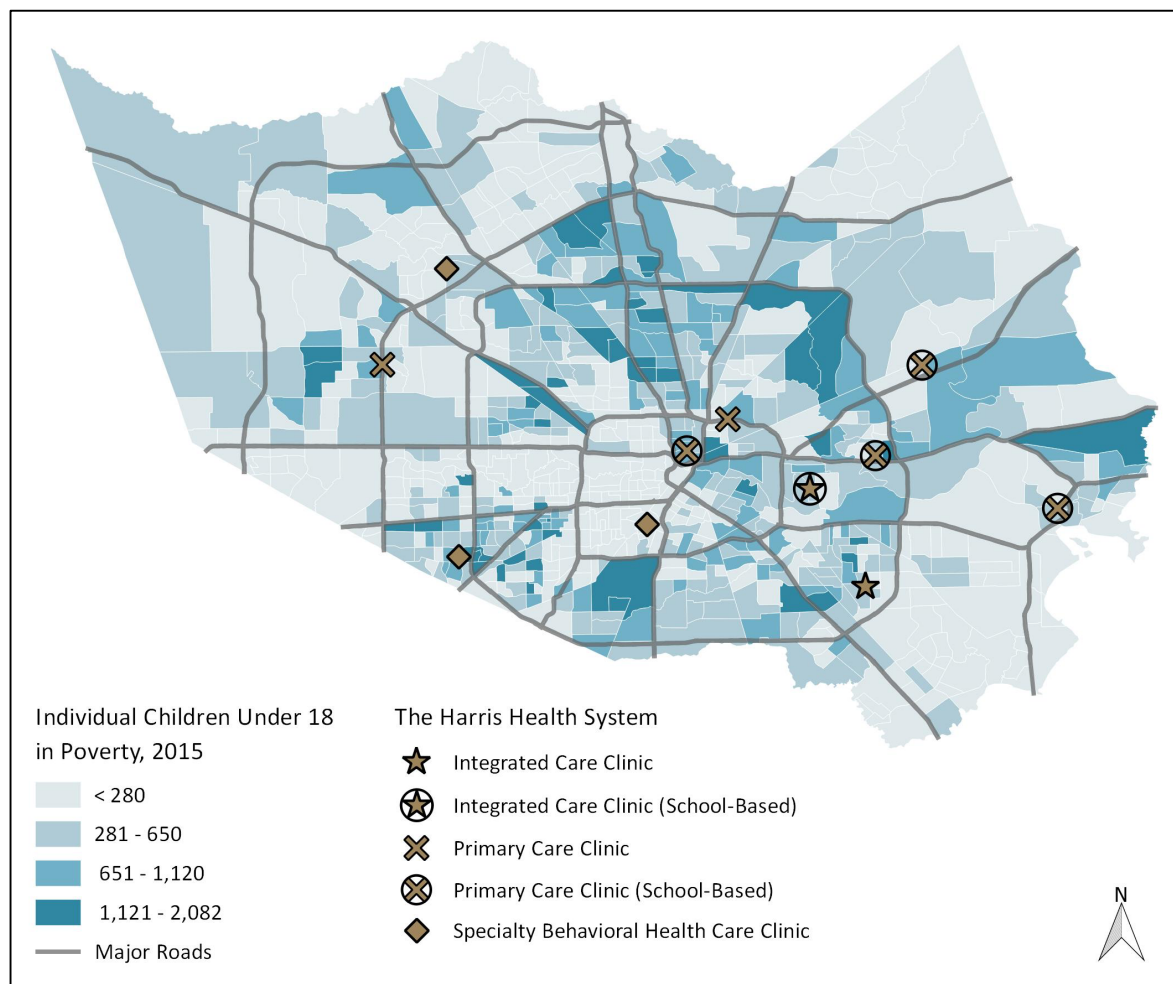
Regarding the maps:
- The first map shows the Texas Children's Health System with the locations of the Texas Children's hospitals, its children's clinics, and Health Plan Integrated Care clinics.
- The second map shows the Memorial Hermann Health System (Memorial Hermann) with the locations of the Memorial Hermann hospitals and the Memorial Hermann school-based clinics. The school-based clinics are generally located in south Harris County.
- The third map depicts the Harris Health System, showing locations for all of its child and youth-serving clinics, highlighting the three pediatric and adolescent primary care clinics, the five school-based primary care clinics, and the three general clinics that offer specialty behavioral health care.

Texas Children's Health System[42]

Texas Children's Health Care System

⊙ Hospital without Psychiatric Beds

★ Integrated Care Clinic

✖ Primary Care Clinic

Number of Children Under 18 in Poverty
by Census Tract, 2015

☐ < 280
☐ 281 - 650
☐ 651 - 1,120
☐ 1,121 - 2,082
— Major Roads

Close-Up: Inner Loop 610 Area

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[42] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. Texas Children's locations obtained from the Texas Children's Hospital website, available at http://www.texaschildrens.org.

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Memorial Hermann Health System[43]

Number of Children Under 18
in Poverty by Census Tract, 2015

- < 280
- 281 - 650
- 651 - 1,120
- 1,121 - 2,082

Memorial Hermann Health Care System*

- Crisis Clinic
- Hospital without Psychiatric Beds
- Integrated Care (School-Based)
- Major Roads

*Individual doctor's office locations
 not included.

N

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[43] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. Memorial Hermann hospital locations obtained from the American Survey of Hospitals 2013 Annual Survey. School-based clinics obtained from the Memorial Hermann website, http://www.memorialhermann.org.

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Harris Health System[44]

Individual Children Under 18 in Poverty, 2015

	< 280
	281 - 650
	651 - 1,120
	1,121 - 2,082
———	Major Roads

The Harris Health System

★ Integrated Care Clinic

⊛ Integrated Care Clinic (School-Based)

✖ Primary Care Clinic

⊗ Primary Care Clinic (School-Based)

◆ Specialty Behavioral Health Care Clinic

N

We also mapped clinic and school-based sites for The Harris Center for Mental Health and IDD (Harris Center), which is also the local mental health authority (LMHA) for Harris County. The Harris Center is the primary public mental health provider for Harris County, and until 2013, it was the only provider eligible to offer a continuum of rehabilitation services for children, youth, and families with higher needs. The following map of the Harris Center System combines the Harris Center child-serving clinics (excluding clinics that only serve adults) with Harris Center

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[44] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. Harris Health outpatient clinics obtained from the Harris Health website, www.harrishealth.org, and via personal communication with Dr. Shah at Harris Health.

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school-based clinics. There are no clinics of either type in the northern, western, or eastern parts of Harris County. South central Harris County also lacks a clinic.

The Harris Center System[45]
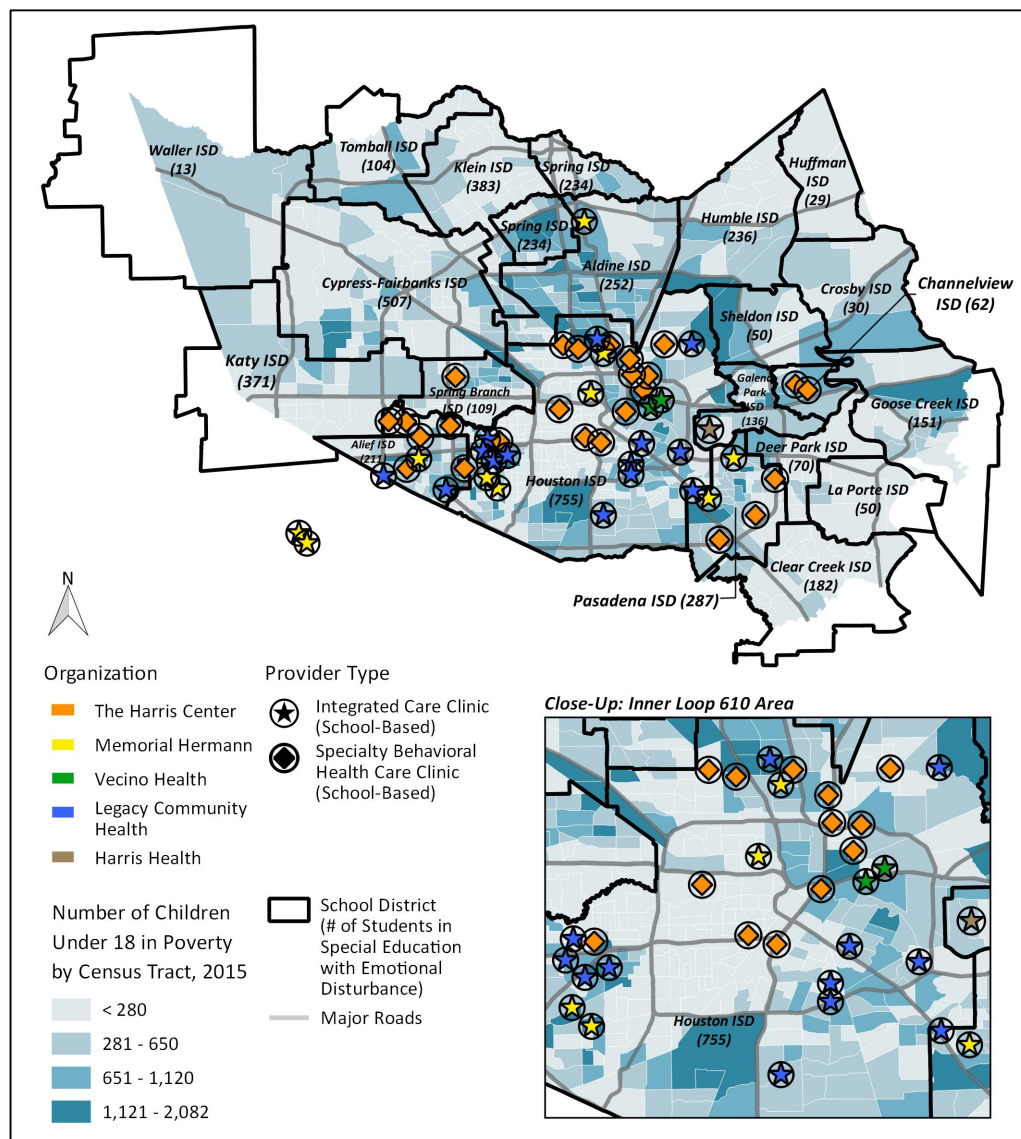

Close-Up: Inner Loop 610 Area
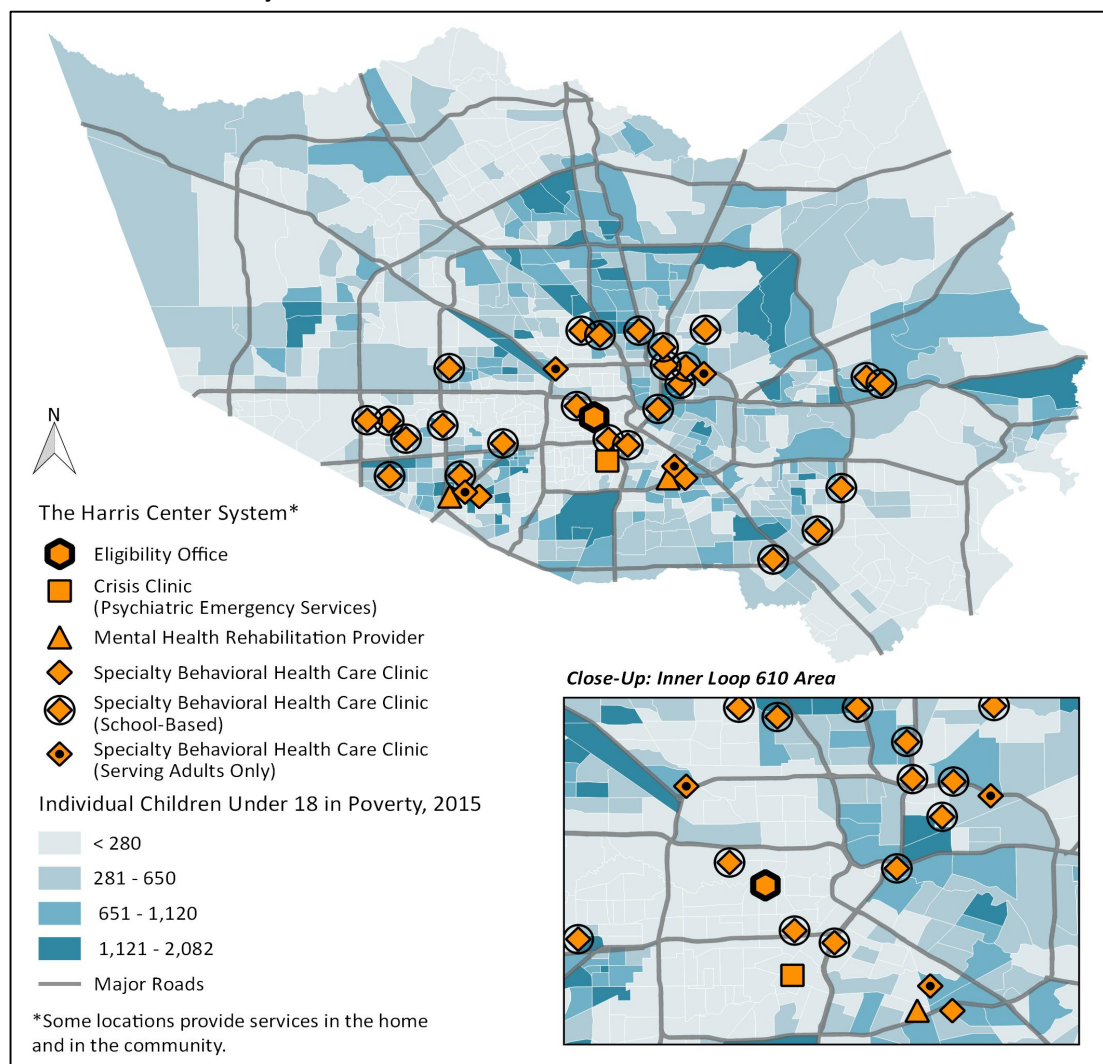
The next map combines the school-based resources from the Memorial Hermann and Harris Center systems, plus additional resources from two leading federally-qualified health center systems with school-based integrated behavioral health capacity: Legacy Health System and

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[45] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org. The Harris Center Child-Serving Clinic locations obtained from the Harris Center for Mental Health and IDD website, available at http://www.mhmraharris.org. School-based clinic locations obtained via personal communication from the Harris Center.

Vecino Health. The map overlays school-based clinic locations onto a map of poverty rates by census tract and numbers of students with special education for emotional needs per ISD.

School-Based Clinics Compared to Indicators of Need by ISD[46]

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[46] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org.
The number of students receiving special education because of emotional disturbance was obtained from the Texas Education Agency. (2017). *PEIMS standard reports, special education reports, 2016-2017*. Retrieved from https://rptsvr1.tea.texas.gov/adhocrpt/adser.html

Comparing Harris County to the Ideal System of Care
Component 1: Harris County's Integrated Primary Care Capacity

Few communities in the nation – and no community in Texas – has a substantial base of integrated primary care services. While there are multiple systems in Harris County that include some integrated care capacity, access remains very limited, especially in high poverty areas. We identified six integrated care programs in Harris County, including school-based clinics, shown in the map below.

Integrated Primary Care Service Sites[47]
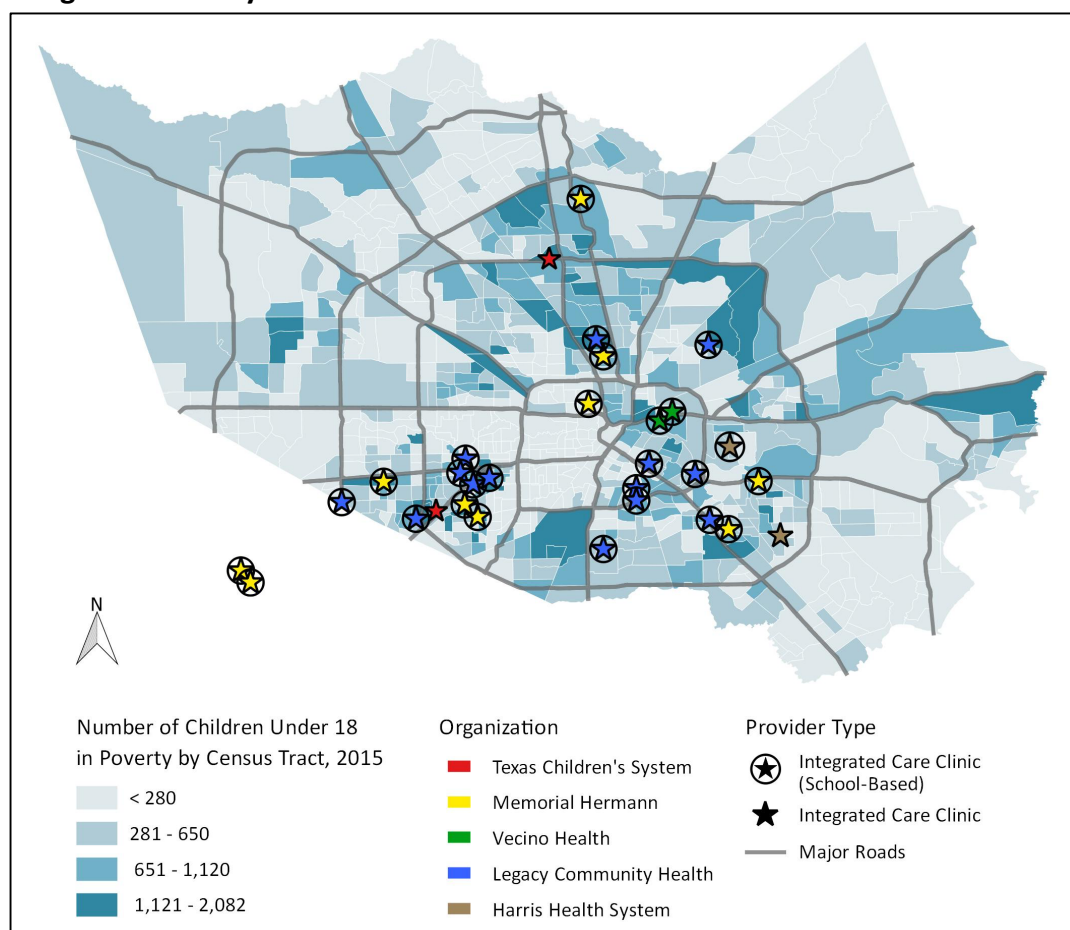
School clinic data obtained via personal communication with the Harris Center and Legacy Community Health, and through the Memorial Hermann website, http://www.memorialhermann.org, and the Vecino Health website, http://www.vecinohealthcenters.org.

[47] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org.

Integrated Primary Care Findings. We focused this review on three of the largest health systems serving children and youth in Harris County – Memorial Hermann, Texas Children's Health, and Harris Health, as well as two leading federally-qualified health center (FQHC) providers – Legacy Community Health and Vecino Health. These systems and centers can serve as a base for expanding access to integrated primary care in Harris County.

Integrated Care Finding (ICF)-1: While there are some very effective integrated care clinics, the need far outstrips supply. Each of the integrated care providers described above has models that can be replicated. Any added integrated care capacity should include the seven core components identified by MMHPI in a report for the St. David's Foundation in 2016, *Best Practices for Integrated Behavioral Health: Identifying and Implementing Core Components*.[48] These include 1) Integrated Organizational Culture, 2) Population Health Management, 3) Structured Use of a Team Approach, 4) Integrated Behavioral Health Staff Competencies, 5) Universal Screening for the Most Prevalent Physical Health and Behavioral Health Conditions, 6) Integrated, Person-Centered Treatment Planning, and 7) Systematic Use of Evidence-Based Clinical Models.

ICF-2: Payment models contribute to barriers in communications and consultations between and among physicians and other practitioners. These barriers include reimbursement limits or policies that deny payment for consultative services or coordination of care that involves multiple systems. For example, a major strength of collaborative models includes consultations between primary care providers and child and adolescent psychiatrists. However, Medicaid does not traditionally allow reimbursement for this consultative service, so negotiations with MCOs are necessary to obtain alternative payment methods, resulting in long delays for payment or no payment at all.

ICF-3: Pediatric primary health care providers require ongoing support of and consultation with behavioral health clinicians and prescribers if they are going to address screening, identification, and care of their pediatric patients and families. Implementing integrated care without the incorporation of best-practice integrated care models will place more administrative and treatment burden on pediatricians and their staff, and limit their effectiveness.

School-based integrated care clinic data obtained via personal communication with Legacy Community Health and the Memorial Hermann website, http://www.memorialhermann.org, and the Vecino Health website, http://www.vecinohealthcenters.org.
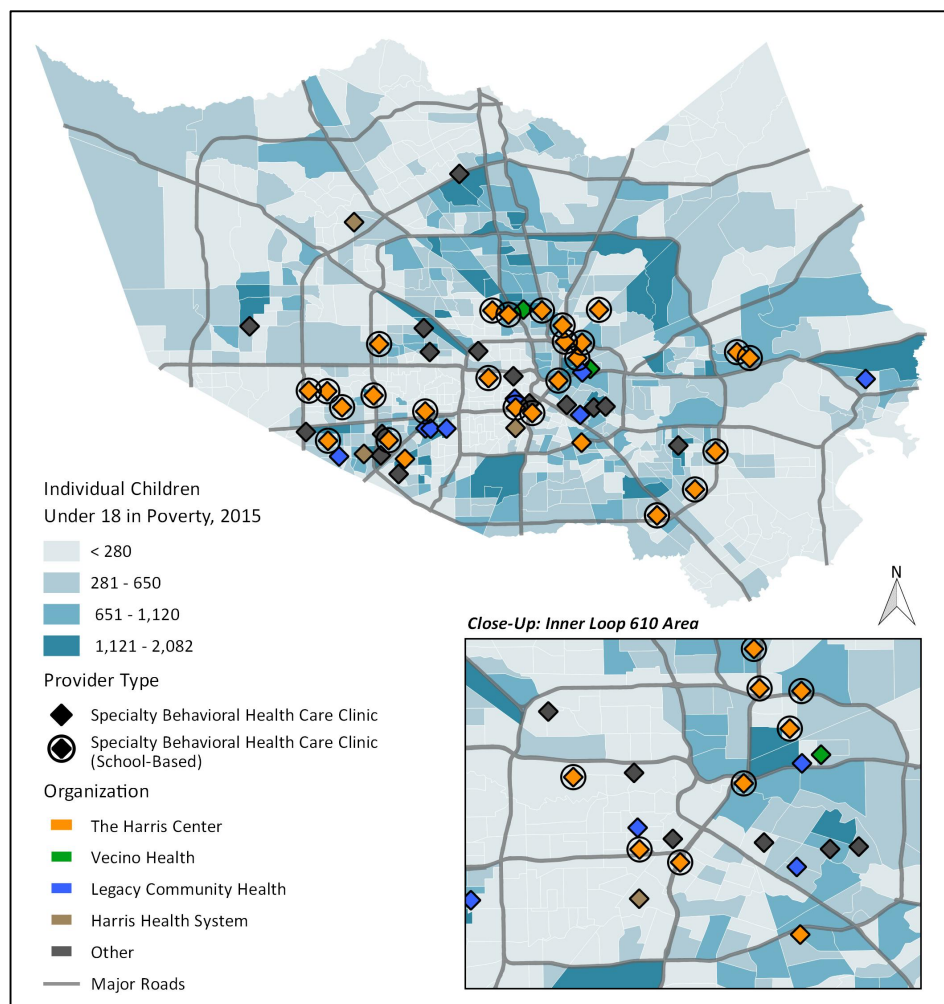
Texas Children's integrated care clinic locations obtained from the Texas Children's Hospital website, available at http://www.texaschildrens.org.

[48] Meadows Mental Health Policy Institute. (2016) *Best practices for integrated behavioral health: Identifying and implementing core components.* Retrieved from http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf

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Component 2: Harris County's Specialty Behavioral Health Care Capacity

The following map shows all specialty behavioral health care clinics identified through this assessment: FQHCs and community health centers (CHCs) with specialty capacity; The Harris Center for Mental Health and IDD clinic locations; Harris Health outpatient locations with specialty mental health resources; and other providers identified through our contacts with key informants. The map also indicates school-based centers.

Specialty Care Clinics and Mental Health School Clinics[49]

Close-Up: Inner Loop 610 Area

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EMBARGOED UNTIL 11 A.M. CENTRAL, MONDAY OCTOBER 30.

The following map shows additional child- and family-serving non-profit organizations that provide specialty mental health services in Harris County. Most of these clinics are located within the city center inside Inner Loop 610, with only a few organizations identified in northwest, north, northeast, and southeast Harris County.

Child-Serving Behavioral Health Nonprofit Organizations[50]
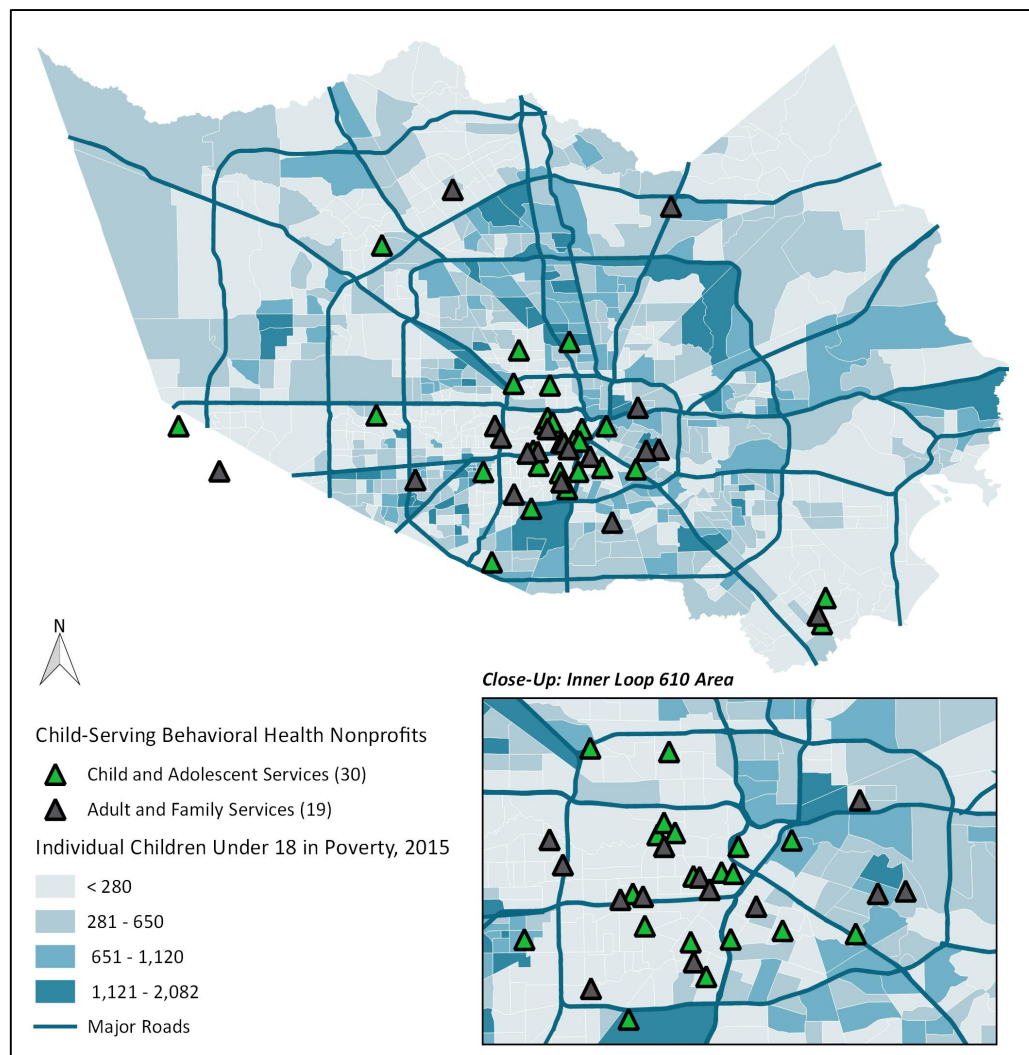
FQHC/CHC locations obtained from the Texas Association of Community Health Centers, and from the individual websites of Central Care, El Centro de Corazon, Eastwood Health Center, Good Neighbor Clinic, Hope Clinic, Pasadena Health Center, and Vecino Health Centers.

Harris Health outpatient locations obtained via personal communication with Dr. Shah at Harris Health.

[50] Nonprofit providers of behavioral health services obtained from Mental Health America of Greater Houston. (n.d.). *The guide: A listing of nonprofit mental health services in Harris County.* Retrieved from http://www.mhahouston.org/media/files/files/ce74590c/The_Guide__2015-17_FINAL_PDF_Rotated.pdf MMHPI removed the providers that did not serve children/adolescents.

Many Harris County school districts offer school-based or school-linked programs to support student behavioral health, as shown in the map that follows. These programs range from school-based initiatives that address social and emotional learning to campus-based mental health clinics that provide therapy, family support, and skills training.

School Clinics with a Behavioral Health Program[51]
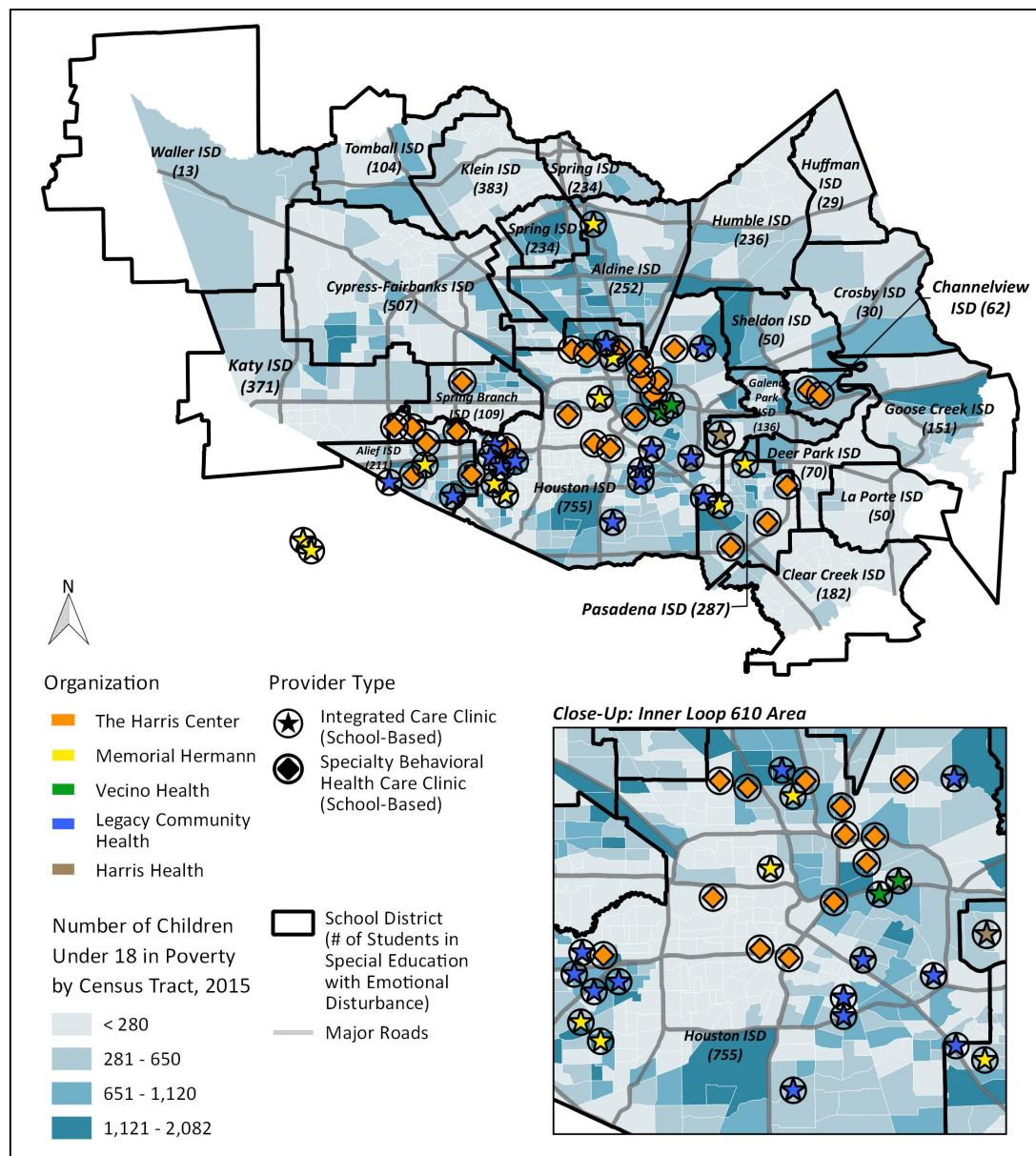
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The Center for School Behavioral Health at Mental Health America (MHA) of Greater Houston. MHA of Greater Houston has partnered with administrators from local schools and school districts, behavioral health providers, and other child-serving agencies and organizations to create a platform to increase support, collaboration, and coordination for behavioral health care. The Center for School Behavioral Health (Center) offers a variety of education and advocacy opportunities to the 25 school districts and 80 organizations affiliated with the initiative at the time of this report. The Center works collectively with its affiliates to advance systemic change by providing training in children's mental health, youth suicide prevention, trauma-informed classroom practice, advocacy consortiums, and stigma reduction initiatives. It also provides best practices demonstration grants and a regional conference.

Specialty Behavioral Health Care Finding (SBHF)-1: Office-based specialty providers are numerous, but there are gaps in access to care in the outlying geographic areas and in areas with growing rates of poverty. Filling these gaps has less potential to increase access to effective care than would filling gaps in Integrated Behavioral Health in primary care settings (Component 1) and intensive services (Components 3 and 4).

SBHF-2: As in the rest of the nation, there is a significant gap in the availability of child psychiatrists and other prescribers for children and youth with moderate to severe behavioral health conditions who cannot be served in integrated primary care settings. By integrating psychiatrists and other licensed professionals into pediatric primary care settings, the Ideal System of Care would allow many children and youth with mild to moderate mental health conditions to shift from specialty behavioral health settings to the integrated care system. This shift would allow behavioral health specialists to extend their reach in focusing on children and youth with moderate to severe conditions, re-allocating resources to serve children and youth with higher intensity needs.

SBHF-3: Harris County has a well-established platform for mobilizing efforts to address school behavioral health through MHA of Greater Houston's Center for School Behavioral Health.

SBHF-4: Harris County has some outstanding programs that provide school-linked and school-based behavioral health initiatives; however, their reach is limited given the size of Harris County. With over 1,000 public schools across Harris County, school-based and school-linked

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Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways, available at http://data.ohouston.org

The number of students receiving special education because of emotional disturbance was obtained from the Texas Education Agency. (2017). *PEIMS standard reports, special education reports, 2016-2017*. Retrieved from https://rptsvr1.tea.texas.gov/adhocrpt/adser.html

School-based integrated care clinic data obtained via personal communication with the Harris Center and Legacy Community Health, and through the Memorial Hermann website, http://www.memorialhermann.org, and the Vecino Health website, http://www.vecinohealthcenters.org

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behavioral health programs cannot meet current demand. However, there are multiple, well-functioning efforts to build on.

SBHF-5: Addressing the full continuum of students' needs requires support from partners outside the school or clinic to address basic needs (food, clothing, shelter) and provide support for parent and caregiver mental health needs. When basic needs are not met, students are more likely to experience crisis. Time spent in crisis can inhibit learning and positive mental health outcomes for children and youth, and managing crises is time-consuming and resource intensive for health systems. School- and clinic-based mental health services are most successful when paired or coordinated with other community resources that address the child's and family's broader needs. A robust school mental health plan or program will include information and resources to help parents and caregivers who require their own mental health support. The Family Partner Program through the Harris Center helps parents and caregivers navigate the school system and provides emotional support from people who have had similar experiences. Also, continuity of care outside of school hours is critical. Community-based organizations can enhance school-based efforts by providing support and resources to students after school hours and during school breaks. Even if a school does not have a school-based or school-linked behavioral health program, simply providing positive activities outside of the school day can keep students out of trouble and support them in times of need.

Component 3: Harris County's Rehabilitation and Intensive Services Capacity

In an Ideal System of Care, the rehabilitation continuum provides care for children and youth suffering from conditions that are so severe that they impair functioning across multiple life domains. These conditions require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. The rehabilitation continuum includes intensive evidence-based, home and community-based practices that focus on providing family and caregiver services, as well as interventions that help children and youth learn skills that enhance their well-being and allow them to achieve success at home, in school, and in their communities. With a few exceptions, the recommended practices are largely absent in Harris County. The exceptions include the Multisystemic Therapy program offered by the Harris County Juvenile Probation Department (HCJPD); wraparound facilitation through the YES Waiver; and some treatment foster care (discussed below in the child welfare section). But for the most part, Harris County is overly reliant on crisis services, inpatient psychiatric hospitals, and the more restrictive and costly residential treatment programs. Overall, those in poverty face glaring gaps in access to rehabilitation and intensive community services and those with insurance have essentially no options if they do not access care through the public system.

The map that follows shows current and potential credentialed providers of rehabilitation services: The Harris Center, DePelchin, and Pathways, which are current providers; and Arrow

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Child and Family Ministries and Youth Advocate Program, which have the potential to become rehabilitation providers.

Rehabilitation Services Providers[52]
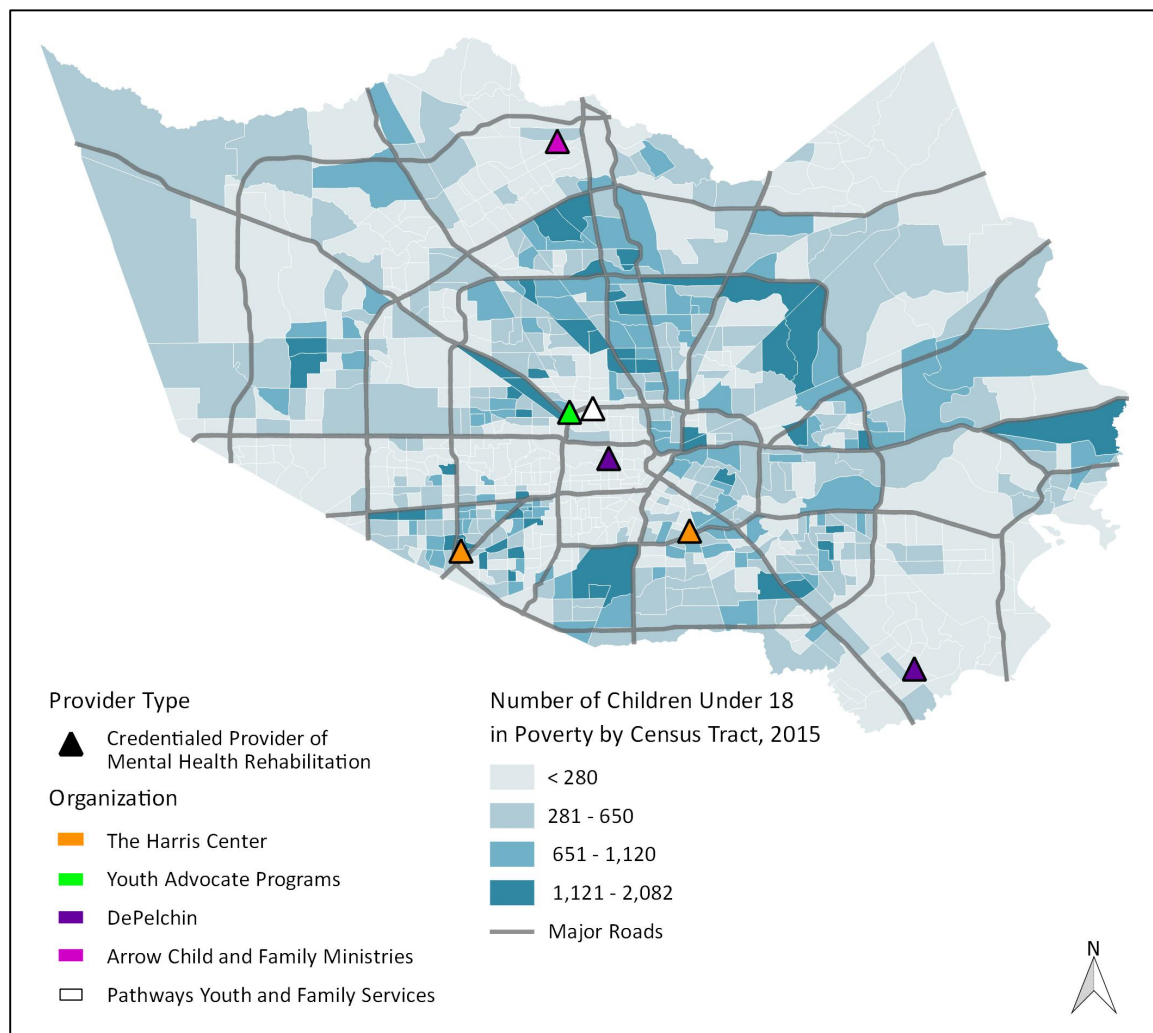
Currently, thousands of children and youth do receive rehabilitation services every year. However, that care is only available in the public mental health system and most of those served receive far less intensive or evidence-based care than what they and their families need. Just as critically, there are essentially no evidence-based, intensive home and community-based

[52] Poverty data obtained from The United States Census Bureau, American Community Survey 2015 Five-Year Estimates and 2010 Five-Year Estimates. The United States Census Bureau. (n.d.). *Table B17001: Poverty status in the past 12 months by sex by age*. Retrieved from
https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk
Major Roads shapefile obtained from the Houston Data Portal: Shapefile of Harris County Highways. Retrieved from http://data.ohouston.org
Providers of mental health rehabilitation services obtained via personal communication with the providers.

services in the current mental health system, other than a small program for first episode psychosis that primarily serves young adults and a larger set of programs centered on wraparound facilitation. The wraparound facilitation program is not actually a treatment, but instead a coordination intervention, and fewer than 250 children and youth of the approximately 4,000 in need of intensive services each year receive it. While expanded access to high-fidelity Wraparound Service Coordination is a positive development with potential to improve care, current Medicaid requirements do not adequately differentiate which cases are truly in need of such support versus other intensive, evidence-based care. Instead, the Texas Medicaid program currently requires every child and family in need of intensive services (Level of Care 4) to receive that level of support. While the principles of wraparound should inform all intensive treatment, the evidence base suggests that a wraparound facilitator and formal wraparound plan is only needed when the needs are so complex that a given type of intensive evidence-based care (e.g., Coordinated Specialty Care, Functional Family Therapy, or Multisystemic Therapy) is not sufficient. Since few of these modalities are currently available in Harris County or Texas more broadly, this strategy makes sense for now, but it should be revisited as intensive, evidence-based capacity is expanded.

The sole example of an evidence-based, intensive home and community-based service is only available in the juvenile justice system (Multisystemic Therapy, described below in the juvenile justice section of the report). This finding is consistent with our prior work in Harris County and in other areas of Texas. It reflects a substantial, statewide gap in the availability of intensive, home and community-based services for children and youth with complex needs who are involved in the foster care and juvenile justice systems, as well as those at risk more broadly for out-of-home or out-of-school placement. As a result, Texas communities, including Harris County, have little to offer children, youth, and families who need mental health services that are more intensive than routine outpatient visits but that do not require the restrictiveness of residential or inpatient care.

During the 85th Legislature, Regular Session, lawmakers worked to increase the state's capacity to expand access to Medicaid Managed Care Mental Health Rehabilitative Services and Targeted Case Management (TCM) for children and youth with severe mental health needs who are involved in foster care. Senate Bill (SB) 74, which streamlined the Medicaid managed care credentialing process, overwhelmingly passed both legislative houses and was signed by Governor Abbott on June 9, 2017. SB 74 is associated with a budget rider (HHSC Rider 172) that makes $2 million available statewide to encourage providers to increase access to intensive Mental Health Rehabilitative Services and TCM for underserved children and youth in the child welfare system. This one-time grant program must be established by November 1, 2017. The grant program will provide funds to providers making investments to either become providers of TCM and Mental Health Rehabilitative Services or to expand their existing capacity to provide these services for children and youth in foster care.

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Rehabilitation and Intensive Services Finding (RISF)-1: There are almost no evidence-based, intensive home and community-based services available through the two currently operating rehabilitation providers (Harris Center and Pathways). The exceptions are a small first episode psychosis (FEP) program, which is not currently allowed to serve youth, and wraparound facilitation, which is a best-practice service coordination function, not a treatment service. Although the Harris Center's Coordinated Specialty Care program for FEP is currently only allowed to serve adults, it could provide a base for beginning to serve the 200 Harris County youth who first experience a psychosis each year. And while the wraparound-focused programs knit together an array of less intensive rehabilitation supports and treatment, none of the approximately 4,000 children and youth in need of intensive services each year receive care that is sufficiently intense or evidence-based. That is not to say that children and youth receiving care are not receiving effective or high-quality services; many at lower levels of need are, and these systems work diligently every day to help those with the highest needs recover functioning. Nevertheless, our overall finding is that the best services are not funded by the public mental health system, and are not available at all in the private system, at the level of intensity or with the evidence that should be the standard of care based on the current state of industry research and practice nationally.

RISF-2: There are limited rehabilitation skill-building and TCM services available through three providers; two additional providers are in the process of becoming credentialed to offer TCM and rehabilitative services under Medicaid. This is promising and will position Harris County to have more of these providers than any other region of the state, and offers a base of committed, high quality providers to build on.

RISF-3: Services on the rehabilitation continuum, especially evidence-based, intensive home and community-based services, require more training and supervision on an initial and ongoing basis to achieve the best outcomes for children, youth, and their families. The start-up costs, and funds to phase-in these services, are not covered through current Medicaid programs. While HHSC Rider 172 (associated with SB 74) may provide start-up funds to expand offerings for children and youth in the foster care system, Medicaid funding for ongoing care is not sufficient to pay for much-needed, evidence-based, intensive treatment.

RISF-4: There are significant opportunities provided through SB 74 and its associated $2 million budget rider (HHSC Rider 172) to assist providers with the cost of training and credentialing needed to provide Mental Health Rehabilitative Services and TCM to underserved children and youth in the child welfare system. Organizations bidding on these grants will need to access local matching funds, which will also be needed to supplement Medicaid funding if evidence-based, intensive services are to be made available. Such care – a single Multisystemic Therapy program – is currently only available in the juvenile justice system. Because of its expanding provider base, Harris County does offer the opportunity to braid local

funds with core state funding to demonstrate the potential benefit of these services. If successful and well documented, a focused, well-evaluated expansion could serve as a basis to inform state-level policy changes that could make these services more widely available.

RISF-5: The Texas Health and Human Services Commission's (HHSC) Texas Resilience and Recovery Utilization Management Guidelines (RRUMG), originally designed for LMHAs operating outside of a managed care system, are too rigid for the delivery of many intensive, evidence-based, home and community-based practices for children and youth. Most of these practices have their own internal guidelines and time frames for achieving the best outcomes and should not be constrained by rigid utilization management requirements such as the RRUMG. Furthermore, the RRUMG was developed for LMHAs before Medicaid managed care was established and needs to be updated to support optimal care in a Medicaid managed care environment that has a utilization management function.

RISF-6: Rehabilitation services are not currently available to children and youth outside of the public system, and evidence-based care is widely lacking in both the private and public sectors. This is a statewide and, in many ways, a national problem. Many services have been developed in the public sector without attention to the requirements of evidence-based models with demonstrated efficacy. As their quality and evidence base improves, it will be important to widen access to these services beyond children and youth in poverty. Thousands of families with incomes too high to quality for public benefits also experience mental health conditions so debilitating – either a severe psychiatric condition such as a psychosis or a less severe condition that goes untreated for years – that they impair functioning across multiple life domains. These families also need access to evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder.

Component 4: Harris County's Crisis Care Continuum

The mental health crisis care continuum in the Ideal System of Care described in the initial section of this report includes three distinct levels: 1) a range of **crisis intervention options**, including mobile crisis teams capable of immediate and ongoing crisis intervention and supported by a range of crisis respite and short-term, out-of-home supports, most of which do not exist in Harris County or anywhere in the nation; 2) **acute psychiatric inpatient facilities** for needs that are too dangerous or complex to address in less intensive treatment settings;

> ***Ideal Crisis Intervention Options***
> - ***Mobile crisis teams***
> - ***Screening, assessment, triage, ongoing consultation, and time-limited follow-up***
> - ***Crisis telehealth and phone supports***
> - ***Coordination with emergency medical services***
> - ***An array of crisis placements:***
>   - ***In-home respite***
>   - ***Crisis foster care***
>   - ***Crisis respite***
>   - ***Crisis stabilization***
> - ***Linkages to a full continuum of empirically supported practices***
> - ***Linkages to transportation***

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and 3) **residential treatment facilities** for children and youth with subacute needs that cannot be safely treated in any other setting. This section of the report addresses the capacity and utilization of each of these levels of crisis care in Harris County and compares them to the Ideal System of Care.

Crisis intervention options. There are several agencies that provide some of the ideal crisis intervention options. Mobile crisis teams are available through the Harris Center and serve the county at large. Memorial Hermann Health System and other private health systems have focused on diverting patients from the emergency department and general hospital beds to more appropriate resources. Turning Point provides crisis supports for children and youth living in foster care, as does the TRIAD Prevention Program for children and youth with or at risk of justice system involvement, jointly run by Harris County Juvenile Probation Department, Harris County Protective Services for Children and Adults, and the Harris Center. There is capacity for screening, assessment, and triage through multiple providers. Crisis telehealth is also offered by at least one provider. In addition, an emergency shelter is available for children and youth, including those in foster care. A variety of providers offer crisis consultation.

Each of these services targets a specific subpopulation of children and youth. But in part because there is no overarching system framework aligning these programs, significant gaps remain. Crisis intervention options within an Ideal System of Care emphasize rapid response, safety, crisis triage, active engagement of the individual and family in crisis, and reliance on natural supports. Crisis systems must have effective communication across multiple resources located in different parts of the county as well as access to transportation and the range of services needed to stabilize crises. All these components need protocols to link communication across individuals and systems, regardless of the specific child/youth's funding source or agency affiliation.

Acute psychiatric inpatient facilities. Inpatient psychiatric hospitalizations can be helpful for acute stabilization of children and youth with complex needs, such as those who may be suicidal or a danger to others, as well as those who need their medications monitored closely. These hospitalizations should be available when needed, but generally should be brief and supported by the broader crisis and ongoing evidence-based services array. Admission is generally based on safety and whether the child or youth presents harm to self or others as a result of psychiatric illness. We surveyed hospitals during the summer of 2016 and determined that there were 380 inpatient psychiatric beds available for children and youth. Two hospitals did not report their bed capacity. The following map shows the locations of hospitals with units that serve children and youth.

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Inpatient Psychiatric Hospital Beds[53]
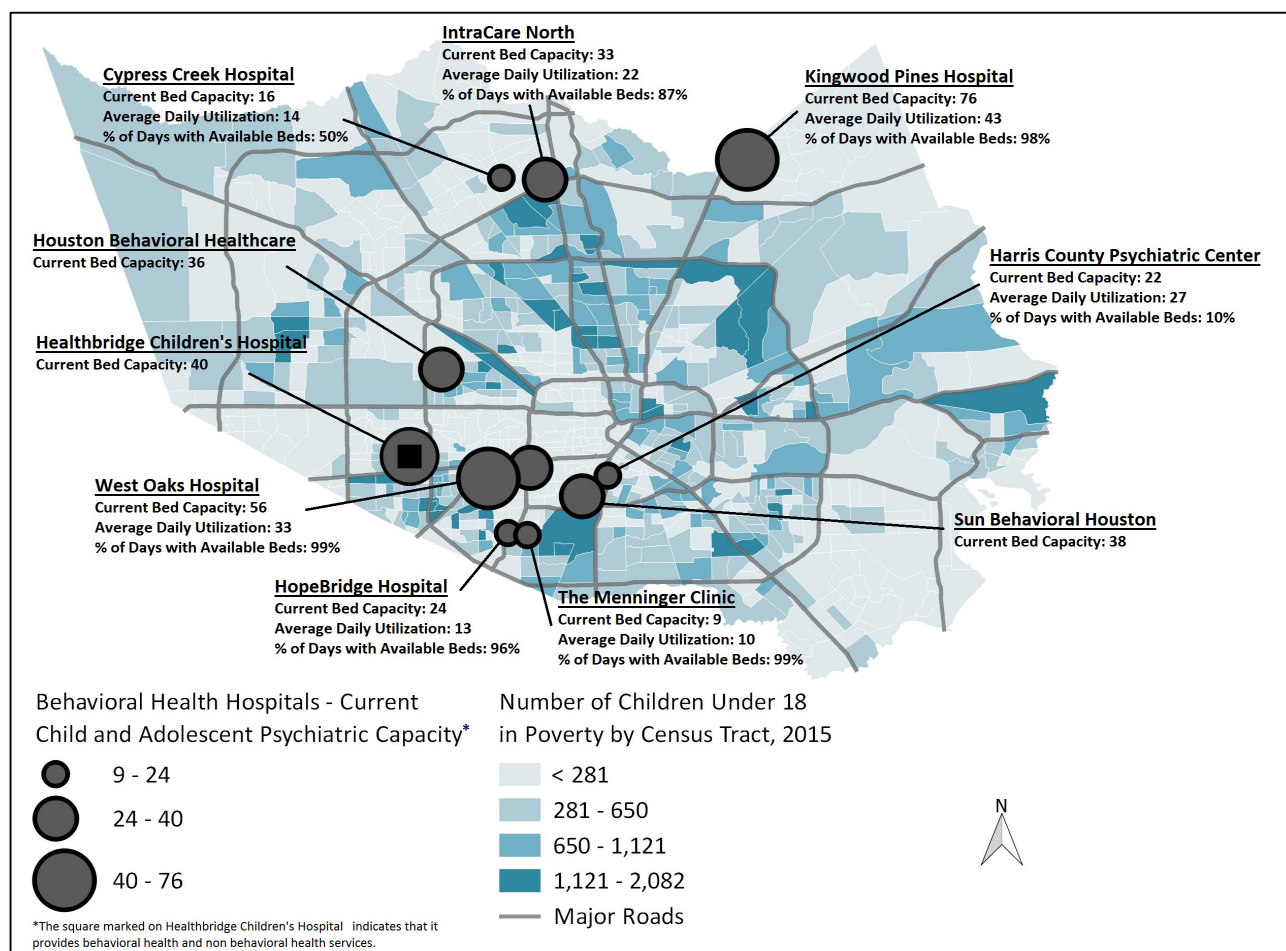
The lack of definitive standards regarding the needed number of inpatient psychiatric beds for children and youth, and the decline of bed availability in Texas more broadly, have prompted recent in-depth studies of the reduced levels of access to inpatient beds in Texas. In January 2015, two important reports attempted to define the need for inpatient beds in the state of Texas.[54] Findings from the two Department of State Health Services reports suggest that Harris County needs between 260 and 310 publicly and privately funded beds for children and youth. Current public and private inpatient capacity includes 380 public and private inpatient beds for children and youth in the community. For state-operated facilities, there are 22 public inpatient beds for children and youth at The University of Texas Health Science Center at Houston Health

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[53] Hospital addresses obtained from individual hospital websites and from the American Hospital Association 2015 Annual Survey of Hospitals, http://data.ohouston.org.

[54] CannonDesign. (2014, November). *Analysis for the ten-year plan for the provision of services to persons served by state psychiatric hospitals.* Retrieved from: https://www.dshs.texas.gov/mhsa/reports/SPH-Report-2014.pdf
    DSHS. (2015, January). *Allocation of outpatient mental health services and beds in state hospitals.* Retrieved from: http://www.dshs.texas.gov/legislative/2015/HB3793-LegislativeReport-011315.pdf

(UTHealth) Harris County Psychiatric Center. Rusk State Hospital, which serves Harris County, does not have any children's beds.

While nearly all stakeholders who discussed the issue reported that Harris County lacks sufficient inpatient capacity to serve the demand of its population base, analysis of the 2015 utilization of facilities suggests a more complex situation. Among the nine facilities for which data were available, only two did not have available beds the majority of days in 2015. However, this does not mean that beds were actually accessible to children and youth in need. Multiple stakeholders emphasized the lack of access to inpatient beds for children and youth in poverty and those with complex needs (e.g., comorbid substance use disorders, conduct disorder). This suggests that the number of beds is not the issue, but rather that existing psychiatric inpatient beds serve limited populations.

Beyond these findings, the child welfare and juvenile justice systems reported substantial challenges in finding intensive post-acute services, which often results in longer lengths of stay than necessary when the children and youth they serve require inpatient care. In addition, all child-serving systems in Harris County have limited alternative options for addressing crises and many turn to inpatient facilities, just as they do in most communities across Texas and the nation. Hospital staff indicated that their facilities receive numerous admission requests as a result of the lack of crisis respite services in the community. As caregivers increasingly face challenges in identifying placement options for children and youth with complex needs, others worry that inpatient psychiatric facilities, along with residential treatment facilities, are being utilized because of the lack of an alternative placement option, even when there is no clinical need for hospitalization.

Residential treatment facilities. In an Ideal System of Care, residential treatment represents a component of the continuum of care for children and youth whose behaviors are not acute enough to require inpatient care, but cannot be managed safely in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. Based on our review of provider information, there are more than 40 private residential treatment facilities available through contracts with the juvenile justice system in the southeast region, which includes Harris County. There are also residential treatment facilities that serve children and youth in the foster care system who require an out-of-home placement. An unduplicated count of children and youth in residential treatment is not available, but we know that 1,258 children and youth received residential placements

through the juvenile justice system in Harris County.[55] Not all of these facilities provide mental health "treatment." Based on stakeholder and provider input, many residential facilities provide more of a "placement" for children and youth who have no other home rather than actual treatment. As a result, we are characterizing them as residential placements.

Crisis Care Continuum / Inpatient / Residential Findings (CCIRF)-1: The need to develop a coordinated crisis response system across all payers, including Medicaid managed care, mental health, child welfare, and juvenile justice systems, is essential to improve care delivery during crises and make best use of limited inpatient and other high-cost resources. While Harris County has made a concerted effort over the past decade to develop its behavioral health crisis services and create alternatives to incarceration and psychiatric hospitalization, crisis diversion programs tend to be specific to particular delivery systems or facilities. That is, they focus on the diversion needs of a single provider, subset of providers, or population of children and youth (e.g., child welfare, juvenile justice), rather than the needs of the community as a whole. In addition, all crisis programs outside the child welfare and juvenile justice systems primarily serve adults, rather than children and youth.

As a result, the array of crisis services does not function as a system, which leads to redundancies that prevent children and youth from getting the right services, including psychiatric hospitalization, at the right time. This observation is not a criticism of any provider or delivery system. Rather, it highlights the need to build a coordinated crisis response system across all payers. Many of the necessary pieces are in place, but there would need to be a will to develop a more comprehensive system and more supportive payment protocols. Experience in other systems nationally suggests that improvement is incremental and very few systems have achieved high degrees of sustained coordination over time.

The long-term goal should be to build an organized county-wide "crisis system" capable of responding across the various delivery systems and geographies, and with protocols that identify coordination and communication strategies – including electronic communications. The crisis array should ideally be jointly funded across all payers (e.g., state, Medicaid, child welfare, juvenile justice, local, private) to better coordinate access, avoid duplication, and identify gaps, rather than have each funding stream supporting a separate crisis care continuum. It would also be important to establish performance metrics to ensure responsiveness to payer priorities.

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[55] Harris County Juvenile Probation Department. (2016). *Collaboration: Commitment to juvenile success: 2016 annual report*. Retrieved from https://hcjpd.harriscountytx.gov/Published%20Reports/Annual%20Report%202016.pdf

The 2015 Sunset Advisory Commission report on HHSC reforms prioritized such cross-payer crisis coordination.[56]

CCIRF-2: While there are challenges in accessing inpatient care for many children and youth, the issues appear to be factors other than overall insufficient inpatient capacity. The relevant issues include:

- A lack of resources for inpatient care for children and youth without insurance or with limited insurance;
- The need for more coordination among inpatient, crisis, and emergency room providers at a system level;
- Utilization peaks during the school years and lower levels during vacation times;
- Zero-tolerance and school exclusion policies that result in increased pressure on inpatient systems when schools are in session;
- Too few appropriate alternatives for crisis diversion and intensive, evidence-based home and community-based interventions for children and youth, especially for those in the child welfare and juvenile justice system;
- Lack of specialized inpatient services for children and youth with complex needs, including co-occurring mental health and intellectual disabilities; and
- Lack of transition services to return to community-based settings.

CCIRF-3: Based on information from stakeholders and providers, many of the residential facilities are not residential "treatment" programs but rather placement options for children and youth who have no other alternative. While most residential treatment options offer safe and sound programs, intensive treatment options are generally limited, particularly in juvenile justice system facilities. What is more, research demonstrates that residential treatment is not an effective treatment model for ongoing care, so, when utilized, residential treatment should have a brief length of stay; an intensive, family-centered focus; and a location close to the child's or youth's family.

Mental Health Capacity in the Harris County Child Welfare System

Child Welfare Findings (CWF)-1: The lack of intensive home and community-based services that support both foster families (e.g., Treatment Foster Care Oregon) and families of origin, (e.g., Multidimensional Family Therapy) means Harris County has limited capacity to meet the needs of children and youth with SED who have the highest needs. These gaps result in more placements in residential treatment centers and psychiatric inpatient facilities, and limited community supports or alternative services when children and youth leave these restrictive

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[56] Sunset Advisory Commission (2015, February). *Report to the 84th Legislature* (see page 15 and 42). Retrieved from https://www.sunset.texas.gov/reviews-and-reports/agencies/health-and-human-services-commission-hhsc

settings. These findings are echoed in the Stephen Group report that identified that the supply of "step-down settings" for children and youth in foster care is dramatically lacking.[57]

CWF-2: Opportunities for providers to obtain additional funding to become credentialed in the delivery of Medicaid Mental Health Rehabilitative Services and Targeted Case Management (TCM) will be available in late 2017 / early 2018. By updating requirements, the recently passed Senate Bill 74 aims to expand the provider base and the capacity to deliver TCM and Mental Health Rehabilitation Services. There will also be funding through associated grants (under HHSC Rider 172) to assist providers serving children and youth in foster care with expanding capacity for rehabilitative skills-building and wraparound for children and youth with intensive mental health needs.

CWF-3 Providers already recognize the need for alternative ways of serving children and youth. To address the severe lack of intensive home and community-based services and its negative impact on placement stability, non-profit foster care providers such as DePelchin, Pathways, and Arrow are investing significant resources to provide, or become credentialed to provide, wraparound facilitation through Targeted Case Management (TCM) and skill building services through Mental Health Rehabilitative Services under Medicaid.

CWF-4: Foster families need ongoing support and training to improve child and youth outcomes. Implementing the Keeping Foster and Kin Parents Supported and Trained (KEEP) program could help foster families, children, and youth learn coping skills and ways to negotiate strategies that address challenging behaviors. The availability of Integrated Treatment Foster Care would also help alleviate the shortage of intensive services, which results in children and youth being placed in more restrictive settings such as shelters, residential treatment facilities, and psychiatric inpatient hospitals.

CWF-5: The need for services along the crisis care continuum is critical. Services such as mobile crisis response, emergency shelters and crisis respite can divert foster children and youth from unnecessary restrictive care settings as well as support families, schools, and other caregivers. One hospital reported that the average length of stay for the general pediatric population was five to six days. However, for foster children and youth, the average length of stay was 10 days due to a lack of available placements. One foster child was hospitalized for six months because of limited services for transitioning from hospital care. When such situations occur, children and youth do not have access to school or other community-based activities that support positive development. Furthermore, the disconnection from families and

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[57] The Stephen Group. (2015). *Meeting the needs of high needs children in the Texas child welfare system*. Manchester, NH: The Stephen Group. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf

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caregivers over that period of time prevents the child, youth, and family from working on and mastering the skills that are necessary to effectively resolve conflicts and communicate needs.

CWF-6: Adding services along the crisis care continuum, such as foster care respite, could reduce some of the stress that families and caregivers, including foster families, experience. The Stephen Group identified that in 2015, while the general foster care population experienced an average of 2.7 placements, those with the "emotional indicator" averaged 5.7 placements.[58] Placement disruptions are more likely to occur when foster parents are not equipped to anticipate and address the trauma, behavioral challenges, and mental health needs of the children for children and youth in their care. Foster parents receive a limited amount of training related to mental health needs and few services to support placements. The little training that foster parents receive generally happens toward the beginning of a new placement, before real-life challenges have occurred. Although it is still a relatively new program, Turning Point has found that foster parents need access to services along the crisis care continuum. About half of Turning Point crisis calls are effectively managed over the phone by providing foster parents with guidance on how to de-escalate a challenging situation. Turning Point estimates the other half of calls are referred to mental health and case management services that were previously lacking.

CWF-7: Managed care organizations (MCOs) also need to begin expanding their service arrays to include more intensive treatment. MCOs can assist providers by offering incentives to deliver evidence-based practices and by using alternative payments such as case rates. These rates cover the costs of all parts of an evidence-based practice linked to achieving positive outcomes, such as reducing the utilization of more expensive inpatient hospital care and residential treatment. More importantly, such services can help children, youth, and their families get back on a healthy developmental track.

Mental Health Capacity in the Harris County Juvenile Justice System

Juvenile Justice Findings (JJF)-1: There is an over-reliance on residential services and inpatient psychiatric facilities to address safety concerns. Community members, judges, family members, schools, and others who struggle to manage challenging behaviors in the absence of adequate home and community-based resources place continuous pressure on the Harris County Juvenile Probation Department (HCJPD) to "find" an out-of-home placement. Despite HCJPD efforts to provide evidenced-based practices directly, without adequate system-wide

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[58] The Stephen Group. (2015). *Meeting the needs of high needs children in the Texas child welfare system*. Manchester, NH: The Stephen Group. Retrieved from https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf

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capacity to provide such care, too many children and youth continue to be served in residential placements.

JJF-2: The actual treatment capacity at juvenile justice residential facilities is limited. The facilities provide primarily housing and behavior management. While most residential treatment options offer safe and sound programs, intensive treatment options are generally absent. Research also demonstrates that residential treatment is generally not effective for ongoing care. When used, residential services should be brief, intensive, family-centered, and close to home.

JJF-3: Children and youth involved with HCJPD who have a flagged mental health need experience worse outcomes than other children and youth in the juvenile justice system. The Council on State Government Justice Center's findings indicate that children and youth in the juvenile justice system who were identified with mental health needs were less likely to successfully complete probation, more likely to end up in a secure placement, and more likely to reoffend at higher rates than children and youth without a previously identified mental health need.

JJF-4: HCJPD, independently and in collaboration with the Harris Center and the Youth Advocate Program (YAP), provides a limited amount of intensive, home and community-based services to a small number of children, youth, and their families. Approximately 670 children and youth have access to this care each year through Harris County juvenile authorities. These services include Multisystemic Therapy (MST), a Family Preservation Program, Texas Correctional Office on Offenders with Medical or Mental Impairment (TCOOMMI) services, and wraparound services. **But even this limited capacity is more than twice the level that is provided to children, youth, and families *before* the young people come in contact with in the juvenile justice system.** Children and youth served through the juvenile probation department's Multisystemic Therapy program are the only children or youth in Harris County currently receiving an intensive evidence-based treatment.

System-Level Recommendations

No community in Texas or across the nation currently has an Ideal System of Care for children and youth with mental health needs. Even worse, we have been unable to identify any community in the state or nation that has moved beyond general aspirations to developing a concrete strategy to build such a system. The good news is that Harris County has a chance to be the first community to do so. This report can serve as a basis for community and health system leaders to work together to create such a strategy, and we recommend nine strategic shifts that could serve as "game-changers" to help move Harris County steadily closer to the Ideal System of Care.

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Ideal Harris County Child & Family MH System
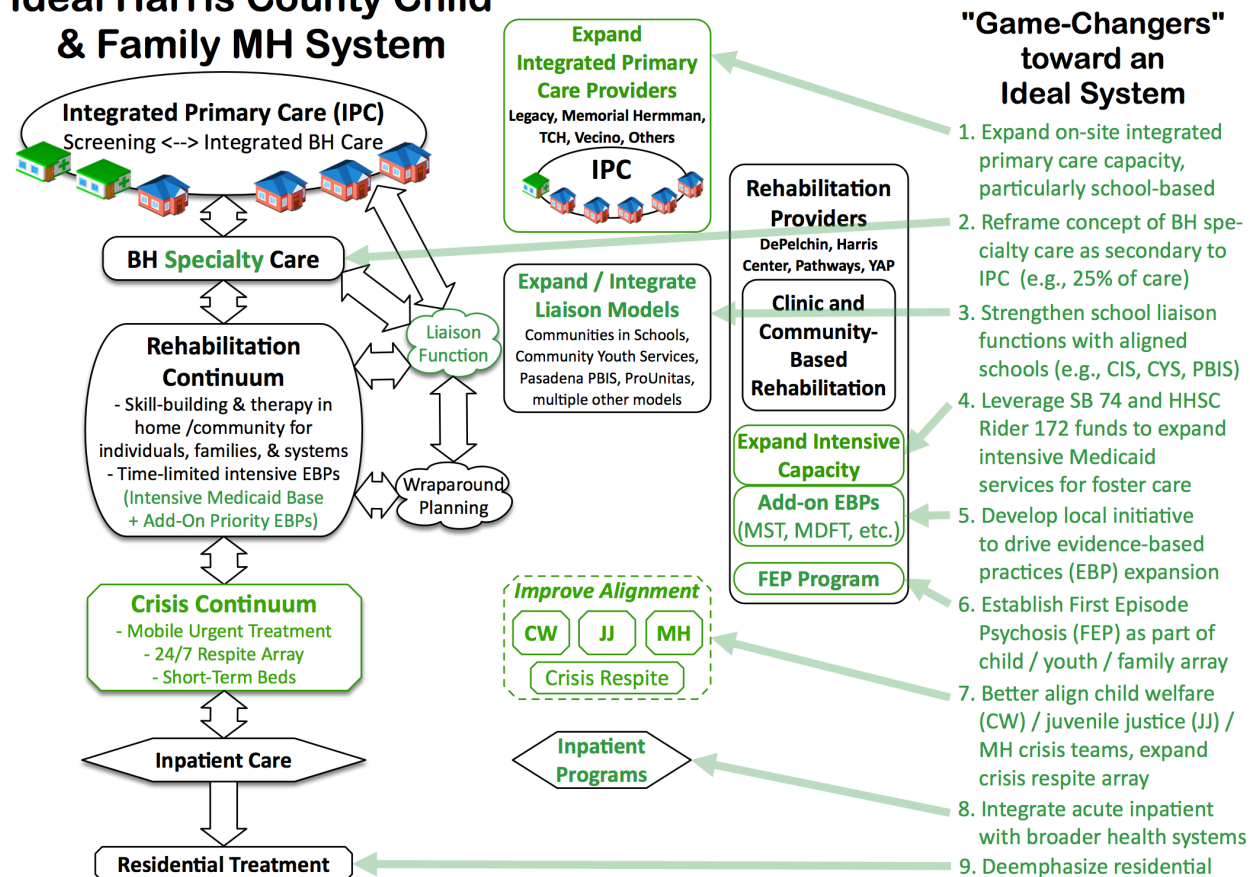
Component 1: Integrated Primary Care

System-Level Recommendation (SLR)-1: Expand on-site integrated primary care, with an emphasis on school-based integrated primary care. The latest research suggests that up to two-thirds of children and youth with mental health needs, and their families, could be served in integrated primary care settings, especially school-based clinics, if those settings have sufficient supports and resources. Schools are located where children, youth and their families live. Specialty provider offices are generally not in high poverty areas where adverse childhood experiences are most challenging. While students and their families can still choose to seek care off-site, school-based resources can improve access for many children, youth, and families.

- Integrated care clinics in schools normalize the process of obtaining mental health services as part of whole health care. However, it is critical that the school and school district adopt and actively promote a developmentally focused social-emotional learning framework, otherwise challenging behavior is likely to be viewed through a "zero tolerance" lens. These social-emotional learning models would complement successful implementation of school-based integrated clinics. Many schools across Harris County have adopted such models, and MHA of Greater Houston's Center for School Behavioral Health is a key support to broadening adoption of these models.

- Engaging teachers and school staff can also improve efforts to identify and address critical issues that influence mental health, such as unstable housing, hunger, domestic and neighborhood violence, and lack of access to health providers.[59]
- To effectively expand integrated care settings, pediatric primary care providers will need the support of child psychiatrists, nurse prescribers, and other licensed mental health clinicians. School-based clinics can also use of the consultation models described in the Ideal Service Array, as well as telemedicine supports, to help extend access to mental health treatment. Linking Family Partners to these services also assists families of children and youth with more complex mental health issues to help them navigate "the system."
- To ensure the maximal funding for health care delivery, school-based clinics need greater assistance to understand how to enroll as a provider, bill, and get reimbursed for Medicaid and other insurance.

Component 2: Specialty Behavioral Health Care

SLR-2: As more children, youth, and families with mild to moderate mental health conditions are served in integrated care settings, including school-based clinics, the roles of specialty behavioral health providers must be reframed to offer more intensive services and to serve the population of children and youth with moderate to severe mental health conditions.
- Office-based, evidenced-based practices can be very effective for children and youth with moderate to severe issues.
- For children and youth with the most severe needs, providers will need to be part of multi-disciplinary teams to provide rehabilitation and intensive, evidence-based practices in home and community-based settings.
- Providers who desire to serve children and youth with mild to moderate needs would be optimally deployed as part of integrated practice settings.

SLR-3: Strengthen the school liaison function within schools that have them and work to expand liaison capacity more broadly. Efforts should focus on schools and school districts that have adopted and actively promote a developmentally focused social-emotional learning framework. MHA of Greater Houston's Center for School Behavioral Health may also be able to actively promote the liaison model.
- Organizations such as Communities in Schools (CIS), ProUnitas, and Community Youth Services (CYS) are currently serving this type of role in many Harris County schools. Many of these organizations also help children, youth, and families address a broader range of basic and social needs, connecting them to an array of community resources.

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[59] Mathematica Policy Research. (2017, June 27). *Bridging the gap: Identifying and addressing social determinants of health*. Retrieved from https://mathematica-mpr.com/news/bridging-the-gap-identifying-and-addressing-social-determinants-of-health

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- If a child or youth has a behavioral health problem that goes beyond available on-site resources, the school liaison function can help determine needs and link the student and family to off-site providers. The school liaison can work on identifying strategies to connect the student and family to Medicaid, when eligible.

Component 3: Rehabilitation and Intensive Services

SLR-4: Build capacity for the delivery of intensive services by encouraging providers to offer Medicaid TCM and Mental Health Rehabilitation Services. Some funding for this goal is available through the $2 million in grant funds associated with SB 74 (HHSC Rider 172) to expand capacity to provide TCM and rehabilitative services to children and youth in foster care who have intensive needs. The Health and Human Services Commission (HHSC), in collaboration with the Department of Family and Protective Services (DFPS), must establish the initiative no later than November 1, 2017.

- This legislation could assist additional specialty behavioral health providers in Harris County with becoming credentialed to provide rehabilitative and TCM services.
- The focus of the grant program under HHSC Rider 172 is to expand the capacity of intensive home and community-based services for children and youth in foster care who have high needs. Existing TCM and rehabilitation providers will likely be best positioned to develop these supports, as the intensive levels of care are the most resource-intensive and difficult to establish.
- Funds may only be used to pay for costs directly related to developing, implementing, and expanding capacity, so it will be important for providers to work closely with STAR Health to ensure that their models will qualify for ongoing funding.
- There is also a broader need to train specialty behavioral health providers on Medicaid billing requirements. Many community-based specialty mental health providers are not accessing Medicaid to fund their services for children and youth in poverty, and some may be willing to consider becoming rehabilitation and TCM providers if they became Medicaid providers. Resources are available to help providers that want to access Medicaid funding. For example, MMHPI helped develop a technical assistance resource in collaboration with LifeWorks, Impact Austin, and the St. David's Foundation: *Community Report: Strategies to Obtain Medicaid and Other Third-Party Mental Health Services Reimbursement.*[60]

SLR-5: Develop a local, multi-year initiative to build capacity for intensive, evidence-based home and community-based services for the 4,000 Harris County children and youth with the most severe needs who are at highest risk for out-of-home and out-of-school placement.

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[60] Meadows Mental Health Policy Institute. (June 2017). *Community report: Strategies to obtain Medicaid and other third party mental health services reimbursement*. Dallas, TX: MMHPI.

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- Medicaid currently covers a minimum level of intensive supports, but evidence-based models are typically more intensive. Because they tend also to be of limited duration and more effective, they have the added potential to be cost effective.
- Given the possible expansion of intensive services for children and youth in the foster care system, local public and private funders may be able to partner with rehabilitation providers to expand capacity and simultaneously add on evidence-based practices. It will likely take several years to demonstrate the cost effectiveness of these approaches, so the provider and local funders will need to commit to a multi-year initiative with a strong independent evaluation component.
- Because Medicaid is a critical partner, Medicaid MCOs will need to participate in planning to ensure that these programs target the highest priority needs and to potentially develop value-based purchasing arrangements to support service delivery. It may also be possible to access additional Medicaid support for any cost-effective alternative services that can be approved on a case-specific basis.

SLR-6: First episode psychosis (FEP) treatment programs must be incorporated into the child and youth delivery system, not delayed until youth become 18 years old and transition to the adult system. Currently, the Harris Center's small Coordinated Specialty Care program for first episode psychosis has only served adults, but state-level policy changes now allow the program to serve youth under age 18 as well as Medicaid-eligible youth. However, the incidence of FEP is not correlated strongly with poverty, so the majority of youth and young adults experiencing FEP likely have commercial insurance and need to be able to access services through private insurance networks.

- Early identification and treatment of psychosis can help youth and families build skills to mitigate the impact of psychosis and learn to manage the illness, stay on a healthy developmental path, and avoid the deterioration in functioning that comes with untreated or inadequately treated psychosis.
- Expanding access to the Harris Center program for children and youth with Medicaid would be a good next step.
- Expansion of the model to other providers, perhaps building on the program's current partnership with UTHealth, may help reach a broader range of youth in need.

Component 4: Crisis Care Continuum

SLR-7: Begin to align child welfare, juvenile justice, and mental health crisis response resources; identify opportunities to expand the available crisis respite service array; and make this array of services available across systems. As noted in the report findings, many strong crisis programs exist, but they typically serve children and youth only within their own "silo" and do not coordinate systematically with other efforts. If better aligned, existing resources have the capacity to serve more children and youth and provide better options

during a crisis. However, until additional intensive, evidence-based care resources are available, the crisis system will continue to be over-burdened and overly reliant on inpatient and crisis care.

- In an Ideal System of Care, there would be an organized county-wide "crisis system" that can respond across the various delivery systems, geographies, and system requirements to improve coordination of care, access to resources, and communication strategies. Development of joint initiatives such as the Dual Status Youth Initiative should also be pursued.

- The crisis array should ideally be funded jointly by all payers (e.g., state, Medicaid, local, private, and MCOs) to better coordinate access, avoid duplication, and identify gaps rather than having each funding stream supporting a separate crisis care continuum. The 2015 Sunset Advisory Commission report on HHSC reforms prioritized such cross-payer crisis coordination.[61]

- This alignment is especially important for children and youth involved in TRIAD's Community Resource Coordination Groups and the Dual Status Youth Initiative designed to coordinate care across the juvenile justice and child welfare systems. With TRIAD, there is already an effort underway to provide crisis assessment, triage, and crisis respite. The lessons learned from this effort should form the basis of future planning.

- It may be possible to build on the existing TRIAD and the Dual Status Youth initiative to establish more cross-system efforts to coordinate care. These initiatives have had some early successes. The Dual Status Youth Initiative recently hired an executive director, and has begun to develop a back-bone agency to facilitate system alignment. The goal is to develop robust and effective supports for youth involved in both systems.

SLR-8: Make better use of existing psychiatric inpatient bed capacity by exploring options for purchasing capacity in underutilized facilities to supplement the overstretched public resources of the **Harris County Psychiatric Center, as well as to expand access in outlying areas of Harris County. The ultimate goal would be to integrate inpatient psychiatric care into broader health systems and increase access for children and youth in poverty.** The primary barrier to inpatient care is access to current bed capacity by children and youth in poverty and by those with complex needs, especially co-morbid intellectual or developmental disability. It may be necessary to convene inpatient psychiatric providers for children and youth and Medicaid MCOs to identify strategies for taking advantage of this underused capacity.

SLR-9: De-emphasize residential placement. When used, make sure residential "treatment" provides brief, intensive, family-based services as close to home as possible.

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[61] Sunset Advisory Commission (2015, February). *Report to the 84th Legislature* (see page 15 and 42). Retrieved from https://www.sunset.texas.gov/reviews-and-reports/agencies/health-and-human-services-commission-hhsc

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- Existing forums addressing the needs of high-risk children and youth, such as the Dual Status Youth Initiative, should incorporate this principle into their ongoing planning.
- The development of intensive, evidence-based home and community-based care should be incorporated into a multi-year, cross-agency plan to reduce the use of residential placements, starting with children and youth who are able to obtain care safely in their current living arrangements. This effort can only succeed if intensive, evidence-based home and community-based care options are available, including treatment foster care.
- Harris County Protective Services (HCPS) and Harris County Juvenile Probation Department (HCJPD) should consider the development of a cross-agency work group to review current financing of residential treatment and how Medicaid and other resources might be used to develop evidence-based, intensive home and community-based treatment alternatives. If a financing strategy is developed, HCPS and HCJPD could issue a request for services to provider organizations to develop targeted capacity for transitioning youth from out-of-home placements to evidence-based, intensive home and community-based services. Youth at high risk of out-of-home placements could also benefit from these alternative services.
- The cross-agency work group should involve current residential treatment providers to assess their interest and capacity to expand their treatment array to include more intensive home and community-based services, as well as treatment foster care and small, family-based residential programs closer to where children and youth live.
- The work group should also prioritize the use of evidence-based training and support for foster parents and enhanced treatment foster care options to address the needs of foster children and youth placed in inpatient services. A promising example, Keeping Foster and Kin Parents Supported and Trained (KEEP), was designed by the developers of the Treatment Foster Care Oregon (TFCO) model. KEEP is a skills development program for foster parents and kinship parents of children from birth to age five and teenagers (KEEP SAFE).