REPORT / MENTAL HEALTH RECOVERY & RESILIENCY

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Texas Early Childhood Mental Health System: State of the State in 2018

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Introduction

Over the past 25 years, Texas has made significant progress in the development of a system of care focused on children and adolescents with serious emotional disturbances (SED) and their families. Texas has strived to align policies and practices to support the values and principles outlined by Beth Stroul, Gary Blau, and Robert Friedman (2010) in the revised monograph on the System of Care framework. Many Texas communities are actively partnering to ensure that all children with SED and their families have access to the services and supports that they need to be successful within their home and community. A state statute identifies the Texas Health and Human Services Commission (HHSC) as the agency responsible for coordinating implementation of the System of Care (SOC) framework and specifies state agencies tasked with partnering in this effort. A Memorandum of Understanding has been enacted that outlines the commitment and responsibility of each agency toward this shared goal.

In contrast, there has been minimal progress in Texas on envisioning or developing an infant and early childhood mental health (IECMH) system of care. Infants and young children have unique needs related to mental health, such as the focus on maintaining strong attachment relationships and supportive home environments and the need to include different service partners. In 2002, in a monograph that parallels Stroul and Friedman (1986), a workgroup of the American Academy of Child and Adolescent Psychiatry outlined the core values and guiding principles that should drive the development of an early childhood mental health system of care. The workgroup emphasized the following core values and guiding principles:

1. The system of care prioritizes the biological, cognitive, and socio-emotional development of the child.
2. The system of care strives to strengthen and preserve the child's primary attachment and family relationships.
3. The system of care emphasizes prevention and early intervention through timely screening, identification and delivery of services, to maximize the child's opportunities for normative development.
4. The system of care supports the stability of the child's family, whether biological, adoptive, or foster.
5. The system of care empowers families by making them full partners in the planning and delivery of services.
6. The system of care provides culturally competent services that respect the family's unique social and cultural values and beliefs.
7. The system of care supports the early identification of infants, young children and families at-risk and provides individualized service plans based on comprehensive biopsychosocial assessment.
8. The system of care provides individualized services that are of appropriate intensity, flexibility, and comprehensiveness to meet the child and family's needs; these services should be integrated and coordinated between different child-caring agencies.
9. The system of care strives for an ethical balance between protecting the rights of children and supporting the rights of parents.

The monograph goes on to describe important characteristics of the system, including primary, secondary and tertiary prevention, screening and early identification of risk, assessment, interventions and services, and care coordination and the wraparound process. Since this time, a number of communities and states have embarked on initiatives to develop IECMH systems of care and strengthen existing services and supports available to families.

The Infant and Early Childhood Mental Health field has grown out of the recognition that early childhood is the opportune time to promote social and emotional health and prevent or intervene early in mental health

challenges. Infant and Early Childhood Mental Health has been defined as "the developing capacity of the child from birth to 5 years of age to form close and secure adult and peer relationships; experience, manage, and express a full range of emotions; and explore the environment and learn - all in the context of family, community, and culture" (Ahlers, Cohen, Duer, et al., 2017). Early childhood is a critical time for brain development, setting the stage for cognitive, social, and emotional development throughout childhood. The development of infants and young children is thoroughly intertwined with the quality of the caregiving relationships in their lives. There are a variety of well-known risk factors that can negatively impact these relationships and ultimately children's social and emotional development, including prematurity and low birth weight, genetic disorders, exposure to substances, exposure to violence, abuse, or chronic stress, and parental mental health.

In addition to the advances in research on the important role that the infant and early childhood period plays in growth and development, several other issues have led states to focus on an IECMH system of care. There has been an increased public awareness and concern about the growing use of psychotropic medications to treat children five and younger with emotional or behavioral problems. A concern about the appropriateness of medication for this age group and a recognition that few psychosocial interventions may be available to families has resulted in increased scrutiny. A review of children in the Medicaid program across seven states found that 2.3% of children between the age two and four were prescribed a psychotropic medication in 2001 (Zito, Safer, Valluri, et al., 2007), doubling the rate found in an earlier study of usage in 1995 (Zito, Safer, dosReis, et al., 2000). While stimulant medication made up two-thirds of the prescriptions, the study raised concerns about the five-fold increase in the use of antipsychotic medications in the preschool population.

Public concern was also raised after a study by Gilliam (2005) highlighted the high rate of preschool expulsion and suspension across 40 states, illustrating an average (weighted) rate of 6.67 children per 100,000 expelled from preschool, which was 3.20 times higher than the national rate of K-12 expulsion (2.09 per 100,000). Black preschoolers were twice as likely to be expelled as White students, both Hispanic and non-Hispanic, and boys were 4.5 times as likely to be expelled as girls (Gilliam, 2005). Research has shown that behavioral problems during the preschool period can be an important indicator of continued behavior problems (Campbell, Shaw, & Gilliom, 2000; Shaw & Gross, 2008), as well as a predictor of poor peer relations (Campbell, Shaw, & Gilliom, 2000; Keane & Calkins, 2004), and future academic problems (Hinshaw, 1992). The issue of preschool suspension and expulsion has been highlighted in Texas, as well. A recent review of data from 2015-2016 school year found 2,147 in-school suspensions and 2,544 out-of-school suspensions for Texas prekindergarten students (Texans Care for Children, 2018). The study found that early childhood suspensions disproportionately impacted children who were Black, male, in the foster care program, and served through special education. Recent research has illustrated the role that gender and racial biases can play in decisions about discipline, illustrating that child care providers view normal child behaviors as more problematic and discipline more when occurring by young boys of color (Gilliam, 2016).

Identifying and addressing social and emotional delays or behavioral problems during the early childhood period is crucial. Infancy and early childhood are critical periods for development, setting the stage for how children interact with their world and supporting the neurodevelopment necessary for social, cognitive, and behavioral health. Intervening early can ensure that a child's developmental trajectory stays on course, minimizing the long-term impacts of adverse childhood experiences and early delays. The early childhood period provides a unique window in which the negative consequences of emotional and behavioral challenges can be prevented or minimized. This report will review the components of an early childhood mental health system that are present in Texas, summarize the history of the Texas system, and examine information on the strengths and needs of the public mental health services available to young children and their families.

Structure of the Texas Early Childhood Mental Health System

State Organizations Serving Young Children

Publicly-funded services and supports aimed at promoting the mental health of infants and young children in Texas are currently dispersed across a number of state agencies and programs, with no clear structure for coordination and alignment. The following organizations are not inclusive of all agencies and organizations, but rather represent some of the primary agencies involved in the system. The role of each agency, scope of services, and population of focus is discussed below.

- Texas Health Steps and Pediatric Health Care. Most opportunities for the support of infants and young children and their caregivers occurs through pediatric health care visits. Texas Health Steps, overseen by the Department of State Health Services (DSHS), is the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) program for children birth to age 20 enrolled in Medicaid. Texas Health Steps recommends developmental screening at 9 and 18 months, and 2 years, and developmental and social-emotional screening at 3 and 4 years old. Texas Medicaid and the Children's Health Insurance Plan (CHIP) within HHSC is responsible for policy related to primary care and specialty mental health care, as well as oversight of Medicaid and CHIP managed care contracts.

- Prevention and Early Intervention (PEI), Department of Family and Protective Services (DFPS). The PEI division within DFPS provides a variety of prevention-based services that target or include infants and young children. PEI supports the *HOPES program*, which funds community organizations in high risk counties to provide home-visiting and other services and foster early childhood community coalitions, with the goal of preventing child abuse and neglect by increasing protective factors of families served. The Texas Home Visiting program aims to enhance maternal and child outcomes and to increase school readiness for children birth to age five through evidence-based home visiting models, including Nurse-Family Partnership, Parents as Teachers, and Home Instruction for Parents of Preschool Youngsters (HIPPY). Several prevention programs under PEI target specialized populations, such as fathers, military families and veterans, and families with previous contact with the child welfare system.

- Early Childhood Education, Texas Education Agency (TEA). The Texas Education Agency is responsible for pre-kindergarten education targeting 3- and 4-year-olds, as well as kindergarten. Pre-kindergarten education is required if districts identify enough 4-year-old children from targeted populations, such as children unable to speak or comprehend English or those from an educationally disadvantaged household. In addition, the Preschool Program for Children with Disabilities (PPCD) provides special education services to children three to five for children meeting disability criteria outlined in the Individuals with Disability Act – Part B (IDEA-B). In addition to the oversight of local educational programs, TEA participates in a state partnership named Start Smart Texas, which aims to ensure grade-level reading by 3rd grade through community coalition activities and the provision of teacher and parent resources.

- Early Childhood Intervention (ECI), Texas Health and Human Services Commission (HHSC). ECI services support families with children birth to age 3 with developmental delays, disabilities, or certain medical diagnoses that may impact child development. Eligibility for ECI includes social and emotional delays. Therapeutic services are intended to support the child's caregivers and occur in the child's natural environment.

- Children's Mental Health, Texas Health and Human Services Commission. Children's Behavioral Health, within the Texas HHSC, contracts with 39 community mental health centers to ensure the provision of an array of mental health services and supports to children ages 3 to 17 and their families. The priority population for Children's Mental Health services is identified as those who have a diagnosis of mental illness and either (a) exhibit serious functional impairment or (b) are at risk of disruption of a preferred living or child care environment or (c) are enrolled in a school system's special education program because of serious emotional disturbance. The agency has established a level of care for young children (ages 3-5) that outlines the goals of service delivery for this population, the available services, and the utilization guidelines for moderate and high levels of intensity.

- Texas Head Start State Collaboration. The Texas Head Start State Collaboration Office is housed in the University of Texas Health Science Center – Houston. The initiative is funded through the Administration for Children and Families to support collaboration among Texas Head Start agencies and organizations that support low income families of children from birth to school age. The Office provides a structure for the national Head Start Office to work with state and local agencies focused on supporting families of young children.

Past and Present Efforts to Enhance the Infant and Early Childhood Mental Health System

Texas has not yet set out to establish an IECMH System of Care. However, Texas has embarked on a number of initiatives that can help inform the development of an effective SOC. This summary of initiatives is likely not inclusive of all such efforts, but rather focused on those that were within the awareness of the author and those stakeholders informally interviewed.

- Infant and Early Childhood program: In the early 2000's, the Texas Department of Mental Health and Mental Retardation (TDMHMR) was funded by the Texas Legislature to provide specialty services to young children and their families. Four community mental health centers were funded, with staff providing consultation to early child care settings and families when children were identified with behavioral or emotional difficulties.

- Raising Texas: In 2004, Texas HHSC was awarded a grant from the Health Resources and Services Administration (HRSA) to develop a comprehensive early childhood system. This initiative involved a collaboration of relevant child-serving agencies and focused on four key areas – health, parent engagement, cognitive development and school readiness, and social and emotional development and behavior. A multi-agency advisory board provided oversight to the early childhood system development, which was outlined in a state strategic plan. The initiative ended in 2013, with some components transferred to an academic partner.

- Implementation of Parent-Child Psychotherapy: Between 2006 and 2009, the DSHS offered specialized training to providers employed by Local Mental Health Authorities (LMHAs) or Early Childhood Intervention programs to develop skill in Dyad Therapy (Parent-Child Psychotherapy). This was the primary model provided to young children at this time. The training was time intensive and resource intensive for LMHAs and the state moved towards a web-based training resource in 2011.

- Implementation of Parent Child Interaction Therapy: In 2013, the Texas DSHS received a grant to enhance services to children who have experienced trauma and their families. Through the Texas Children Recovering from Trauma initiative, the state invested in training and implementation support for Parent Child Interaction Therapy (PCIT), an evidence-based treatment for young children. The training plan

included an effort to develop in-state training capacity, supporting several professionals in becoming certified to train within their own organization or region. A total of 109 providers were trained in PCIT across a variety of organizations. While the training costs were not sustained following the completion of the grant in 2017, some providers continue to offer the intervention within community-based and academic treatment settings.

- Texas LAUNCH: In 2015, the DSHS was awarded a grant to promote social and emotional wellness for children age 0 to 8, expand successful early childhood strategies in three communities, and develop state infrastructure for early childhood menta health. The initiative has focused on increasing developmental and social and emotional screenings (using the Ages and Stages Questionnaires), increasing family strengthening programs (i.e., Incredible Years and Parent Cafes), developing mental health consultation, and strengthening the early childhood workforce. Texas LAUNCH has also led to the development of a state-level coordinating committee, which reports to the Child and Youth Behavioral Health Subcommittee of the Behavioral Health Advisory Committee.

Best Practices in Early Childhood Mental Health

While the field is still developing, a variety of best practices have been identified as communities, regions, and states have worked to develop early childhood mental health systems of care. The following practices have been identified as key elements to consider in system development.

Coordinated Workforce Development Strategy. Accomplishing a full continuum of care inclusive of mental health promotion, prevention, and intervention requires a well-trained, competent workforce. Addressing only the needs of the behavioral health workforce is inadequate, as key competencies are needed for others working closely with young children and their families, such as health care providers, child care providers, educators, and specialty providers (e.g., child welfare caseworkers, early intervention providers, home visitors). The infant mental health endorsement system (see First3Years Texas), focused on birth to age three, provides a structure to identify key competencies across different types of providers.

Screening for Social and Emotional Concerns. Recognizing early signs of social, emotional, or behavioral challenges can be difficult for caregivers. Many people may not recognize that even pre-verbal children have "mental health." Regular screenings in settings in which young children abide, such as pediatrician offices and child care, can help identify potential concerns and begin a discussion with parents and other caregivers on strategies to promote positive social and emotional growth. Access to a universal "front door," such as a parent warm line, can allow families to access information and obtain appropriate referrals for a variety of concerns.

Developmentally Appropriate Assessment and Diagnosis. Many professionals in infant and early childhood mental health have outlined the limited resources available for assessing and diagnosing mental health concerns. Existing diagnostic systems were felt to not fully capture the clinical definitions of disorders of infancy and early childhood. *The Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood* (DC:0-5) was developed out of a need for a developmentally-based classification system of mental health and developmental disorders occurring in the first six years of life. Some states allow the use of the DC:0-5 within Medicaid or CHIP health care programs.

Infant and Early Childhood Mental Health Consultation. Mental health consultation, provided by a clinician with early childhood expertise, aims to build the capacity of individuals who care for young children (e.g., parents, teachers, child care providers) to "prevent, identify, and reduce the impact of mental health problems among children from birth to age six and their families" (Cohen & Kaufman, 2005). Mental health consultation is currently required within federally-funded Head Start programs, as well as being provided in other settings, such as child care, home visiting, and health care. A randomized, controlled trial of a state mental health consultation system (Gilliam, Maupin, & Reyes, 2016) found that identified children whose teachers received mental health consultation had greater reductions in externalizing behaviors and total problem behaviors than children whose teachers were placed on a wait list. Differences were not found, however, between the teachers with mental health consultation and control teachers on measures of classroom quality or children's risk of expulsion. This is inconsistent with a national study of prekindergarten teachers, where Gilliam (2005) found that teachers who reported having a mental health consultant working with them were half as likely to report expelling a student than those teachers without this support.

Integrated Behavioral Health in Pediatric Care. Integrated health care has been identified as a best practice for mental health; however most integrated practices do not include clinicians with specialized expertise in early childhood. In the Healthy Steps model, a professional with child development expertise, embedded in a pediatric clinic, meets with families during well child visits to conduct screenings and provide guidance to parents on developmental issues, such as feeding, sleep, and parenting practices. A national evaluation of the Healthy Steps model showed that participation was associated with greater security of attachment and fewer child behavior problems over time (Caughy, Huang, Miller, & Genevro, 2004).

Evidence-Based Specialty Mental Health. An effective mental health system of care will provide access to a variety of evidence-based treatments, shown to be effective with young children. Best practices for the treatment of mental health disorders in young children focus on the parent (or other caregiver) and child dyad. Examples of evidence-based or promising practices are Parent-Child Interaction Therapy, Trauma-Focused CBT, Incredible Years, Child-Parent Psychotherapy, Attachment Biobehavioral Catch-up, Child Parent Relationship Therapy, and Preschool PTSD Treatment.

A resource tool has been developed by the National Technical Assistance Network for the System of Care initiatives to summarize the key lessons learned from communities and states who engaged in building early childhood systems of care (Horen, 2016). Key lessons covered the importance of early childhood partnerships, services and supports that are developmentally appropriate, financing appropriate to the early childhood system, comprehensive workforce development strategies, and strategic communications.

Review of Current Status in Texas

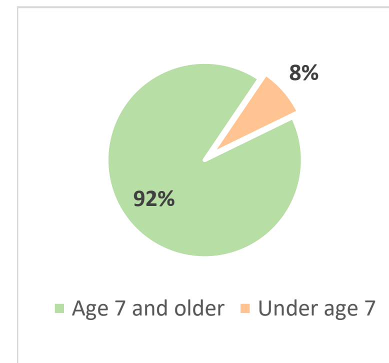
Public Mental Health System Service Data

Overview of Data Analysis. The public mental health system gathers data on young children receiving mental health services through a Local Mental Health Authority. An examination of the data showed that some children younger than three were represented in the data and some children served in Level of Care "Young Child" (LOC YC) had ages both below and above the recommended age of three to five years, with the allowance to continue through age six to complete a course of treatment. A decision was made to limit the sample by age, rather than Level of Care, to represent the appropriate sample. This analysis included all children served in a Level of Care (non-crisis) who were between the ages of three and six by the end of the fiscal year. The analysis included data from Fiscal Year (FY) 2017 and three quarters of FY 2018 data. The analysis used the existing data to address the following questions:

- How many children between three and six years of age are served in the public mental health system and what are their characteristics?
- What presenting problems are identified for young children served in the public mental health system?
- What services are provided to young children and their families?
- How many young children demonstrate improvements in presenting problems over time?

Characteristics of Young Children in Public Mental Health. A total of 5,760 children between the ages of three and six were served in FY 2017 and 4,916 children were served to date in FY 2018. This represents 9.04% and 7.61% of all children served in a non-crisis level of care, respectively. The children are predominantly male (70.3%). The proportion of young children out of all children served varies across LMHAs, with a low of 2.2% and a high of 10.9%. The largest number of children entered services when they were five years of age (44.0%), with 11.3% entering at age three, 29.0% at age four, and 15.7% at age six. The average age at admission was 4.6 years (*SD*=0.88). The sample of young children is distributed between White, Hispanic (35.7%), White, non-Hispanic (28.0%), and Black (27.7%), with 8.5% reporting more than one race or other. This is similar to the racial and ethnic breakdown of the older child population (age 7 to 18), where 38.9% identify as White, Hispanic, 31.4% as White, non-Hispanic, 22.6% as Black, and 6.1% as more than one race or other. The majority (88.4%) of the young child population was eligible for Medicaid.

Figure 1. *Proportion of Child Population Under Age 7*



Community mental health providers complete an assessment using the Child and Adolescent Needs and Strengths Scale (ages 3-5; CANS). The definition of each scale can be found in the CANS manual on the state mental health website. The earliest assessment for each child in the sample was identified to summarize the key problem areas identified at program entry. The CANS is scored on a 4-point scale, with a "0" reflecting no evidence of need, a "1" reflecting watchful waiting or preventative need, "2" reflecting a need requiring action, and "3" reflecting an immediate or intensive need. The most commonly identified problem areas are summarized in Table 1. Based on this analysis, the vast majority of young children are being served for externalizing problem types, with impulsivity and hyperactivity (88.5% of sample), oppositional behavior (52.5% of sample), aggressive behavior (51.6% of sample), and problematic social behaviors (40.5% of sample) the most frequently identified need areas.

Table 1. *Identified Needs at Initial Assessment for Child and Family*

CANS Item	Non-significant (Score of 0 or 1)	Moderate Concern (Score of 2)	Acute Concern (Score of 3)
Child Needs and Risks			
Attachment Problems	90.7%	8.6%	0.7%
Regulatory Problems	85.3%	13.9%	0.8%
Failure to Thrive	98.2%	1.7%	0.1%
Depression	95.7%	4.2%	0.1%
Anxiety	84.7%	14.8%	0.5%
Atypical Behaviors	89.1%	10.4%	0.5%
Impulsivity-Hyperactivity	21.5%	69.9%	8.9%
Oppositional	47.5%	47.6%	4.9%
Adjustment to Trauma	91.9%	7.6%	0.5%
Aggressive Behavior	48.4%	48.1%	3.4%
Self-Harm	89.4%	10.4%	0.3%
Social Behavior	59.5%	37.9%	2.6%
Caregiver Strengths & Needs			
Supervision	89.1%	10.6%	0.3%
Involvement	98.1%	1.7%	0.2%
Knowledge	87.5%	12.0%	0.5%
Empathy for Child	98.5%	1.4%	0.1%
Family Stress	88.6%	11.0%	0.4%
Intimate Partner Violence	98.4%	1.3%	0.3%
Mental Health Needs	95.1%	4.8%	0.1%
Substance Use Needs	99.4%	0.4%	0.2%

Several need areas are notably low, including attachment problems (9.3%), depression (4.3%), and adjustment to trauma (7.6%). This may reflect a lack of identification and referral for these problem areas, as these internalizing problem areas may impact caregivers less and fail to be recognized in young children. This may also reflect a difficulty in assessing for and identifying these problems, since providers must rely on observation and the reports of informants.

Few caregiver needs were identified in the sample, with caregiver/parent knowledge (12.5%), family stress (11.4%), and supervision (10.9%) representing the most frequent areas of need. Concerns related to parental substance use (0.6%), intimate partner violence (1.6%), and parental mental health issues (4.9%) were infrequently documented, which may suggest inadequate procedures to screen for these concerns.

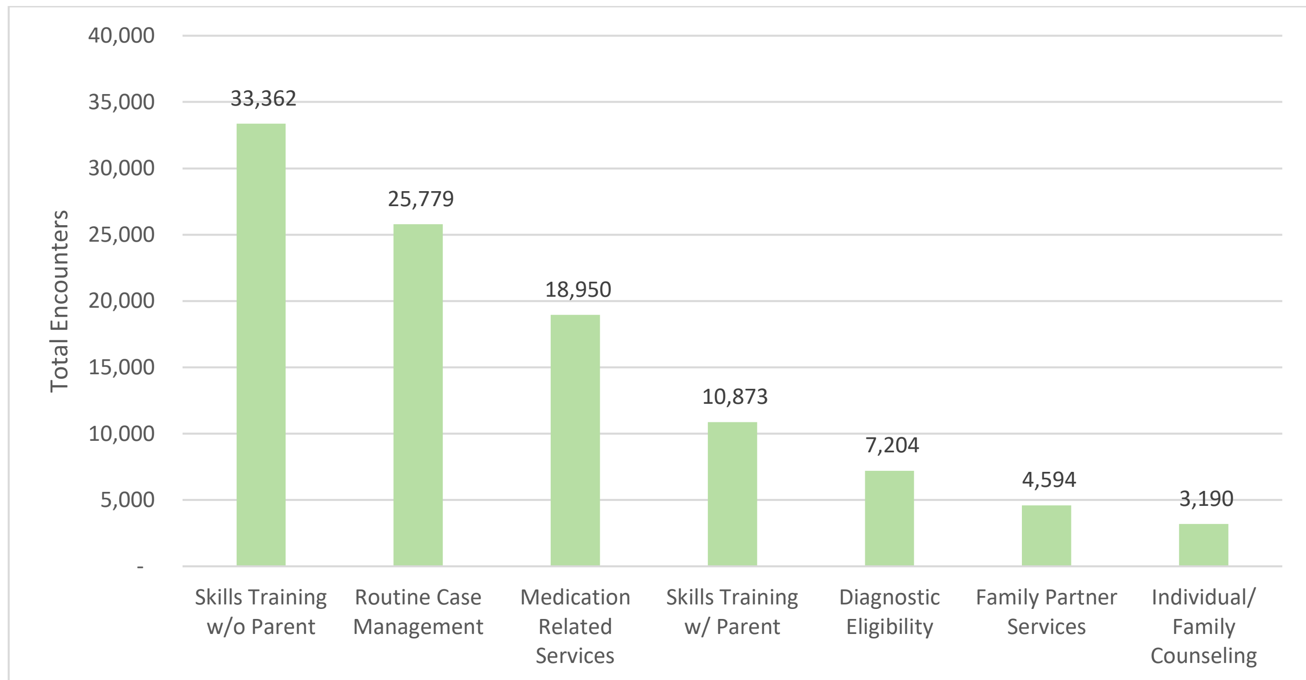
Services Provided. The young child population was served in all available levels of care; however, the majority were served within the specific level of care targeting early childhood. The breakdown of the levels of care is provided in Table 2.

Table 2. *Level of Care Authorized for the Young Child Sample*

Level of Care	FY17 (n=5,760)		FY18 (n=4,916)	
	N	%	N	%
C1: Medication Management	216	3.8%	153	3.1%
C2: Targeted Services	1,093	19.0%	814	16.6%
C3: Complex Services	303	5.3%	228	4.6%
C4/CY: Intensive Family Services and YES Waiver	60	1.0%	52	1.1%
CYC: Young Child Services	4,088	71.0%	3,669	74.6%

Services can be examined by identifying the proportion of the sample who received a service category (e.g., therapy), as well as by the most frequent services that were provided to the sample. Figure 2 depicts the most frequently provided services to the young child population. As illustrated in the figure, skills training provided to the child alone, routine case management, and medication-related services are the most common services provided to young children and their families. Family partner services and individual or family counseling were provided less frequently.

Figure 2. *Total Encounters Provided to Young Children – Fiscal Years 2017 and 2018*



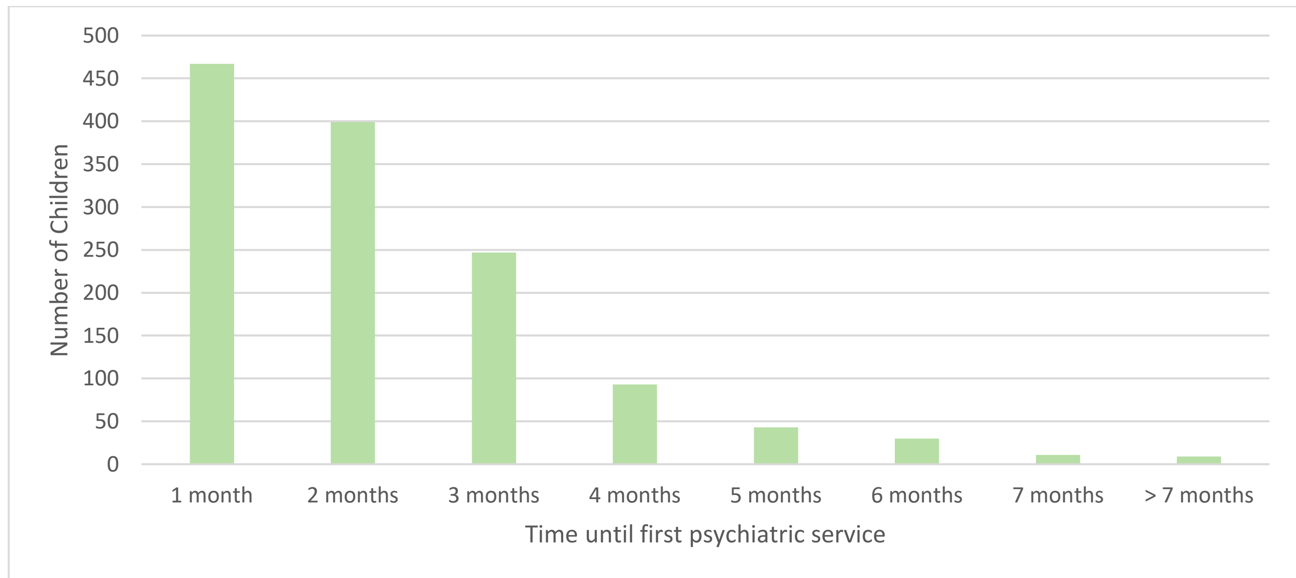
The proportion of youth who received these services (at least one encounter) are illustrated in Table 3. The sample size differs from the full sample, as a small number of children had no encounters within the data system. The majority of families received a diagnostic assessment, skills training, routine case management, and medication services. Counseling and family partner supports were less common.

Table 3. *Youth Receiving Specific Mental Health Services*

Service Category	Fiscal Year 2017 (n=4,856)		Fiscal Year 2018 (n=4,243)	
	n	%	n	%
Skills Training	3,034	62.5%	2,667	62.9%
Routine Case Management	3,081	63.4%	2,607	61.4%
Medication-Related Services	2,521	51.9%	2,218	52.3%
Diagnostic Eligibility	2,707	55.7%	2,531	59.7%
Family Partner Services	947	19.5%	697	16.4%
Individual or Family Counseling	307	6.3%	231	5.4%

One of the concerns raised by serving infants and young children in the mental health system is the use of psychotropic medications. Psychiatric consensus for the treatment of preschoolers recommends that developmental and psychosocial interventions be prioritized above treatment with medication (American Academy of Child and Adolescent Psychiatry, 2012). An analysis was conducted to examine the length of time between admission to the mental health system and the initiation of medication-related services. This analysis was conducted with a subsample of the population, those children receiving psychiatric services whose initial admission occurred on or after September 1, 2016. Focusing on a subset of the sample allowed for their entire course of treatment to fall within the current dataset. The results are presented in Figure 3. As can be noted in the figure, most children who receive psychiatric services begin these soon after admission to care, usually within the first two months. This suggests that providers may not be initiating psychosocial interventions for a period of time, prior to a decision to consider medication.

Figure 3. *Time from Admission to Care to First Psychiatric Service*



Outcomes of Young Children in Services. Child outcomes were examined by comparing the initial CANS assessment with the last available assessment, ensuring that a separate follow-up assessment had been completed. Children were considered to have "worsened" if their score changed from "no concern" to "moderate/acute concern" over time and "improved" if the initial elevation lowered to the "no concern" level. Children were considered to have "maintained" if the score remained within the "no concern" or "moderate/acute concern" across both time periods. Caregiver outcomes were not examined in this analysis because of the relatively infrequent needs that were identified. Findings are summarized in Table 4. The greatest impacts were seen on aggressive behavior and social behavior, with about 50% of those children demonstrating

needs on these domains improving over time. Similarly, while few children were identified with needs related to adjustment to trauma, more than half of those who were identified showed improvement.

Table 4. *Outcomes of Young Children on the Child and Adolescent Needs and Strengths Scale (3-5)*

CANS Item	**No Concern at Initial Assessment CANS Score of 0 or 1**		**Moderate/Acute at Initial Assessment CANS Score of 2 or 3**	
	Worsened	**Maintained**	**Maintained**	**Improved**
Attachment Problems	3.9%	86.2%	4.1%	5.6%
Regulatory Problems	3.9%	81.0%	6.7%	8.4%
Failure to Thrive	0.9%	97.5%	0.6%	1.0%
Depression	2.3%	94.0%	1.2%	2.5%
Anxiety	7.6%	77.4%	7.1%	7.9%
Atypical Behaviors	4.2%	85.2%	4.0%	6.6%
Impulsivity-Hyperactivity	9.7%	10.2%	67.7%	12.4%
Oppositional	14.6%	31.5%	34.9%	19.0%
Adjustment to Trauma	2.4%	89.9%	3.7%	4.1%
Aggressive Behavior	9.7%	56.6%	29.4%	24.0%
Self-Harm	0%	89.0%	11.0%	0%
Social Behavior	10.4%	47.6%	22.0%	20.0%

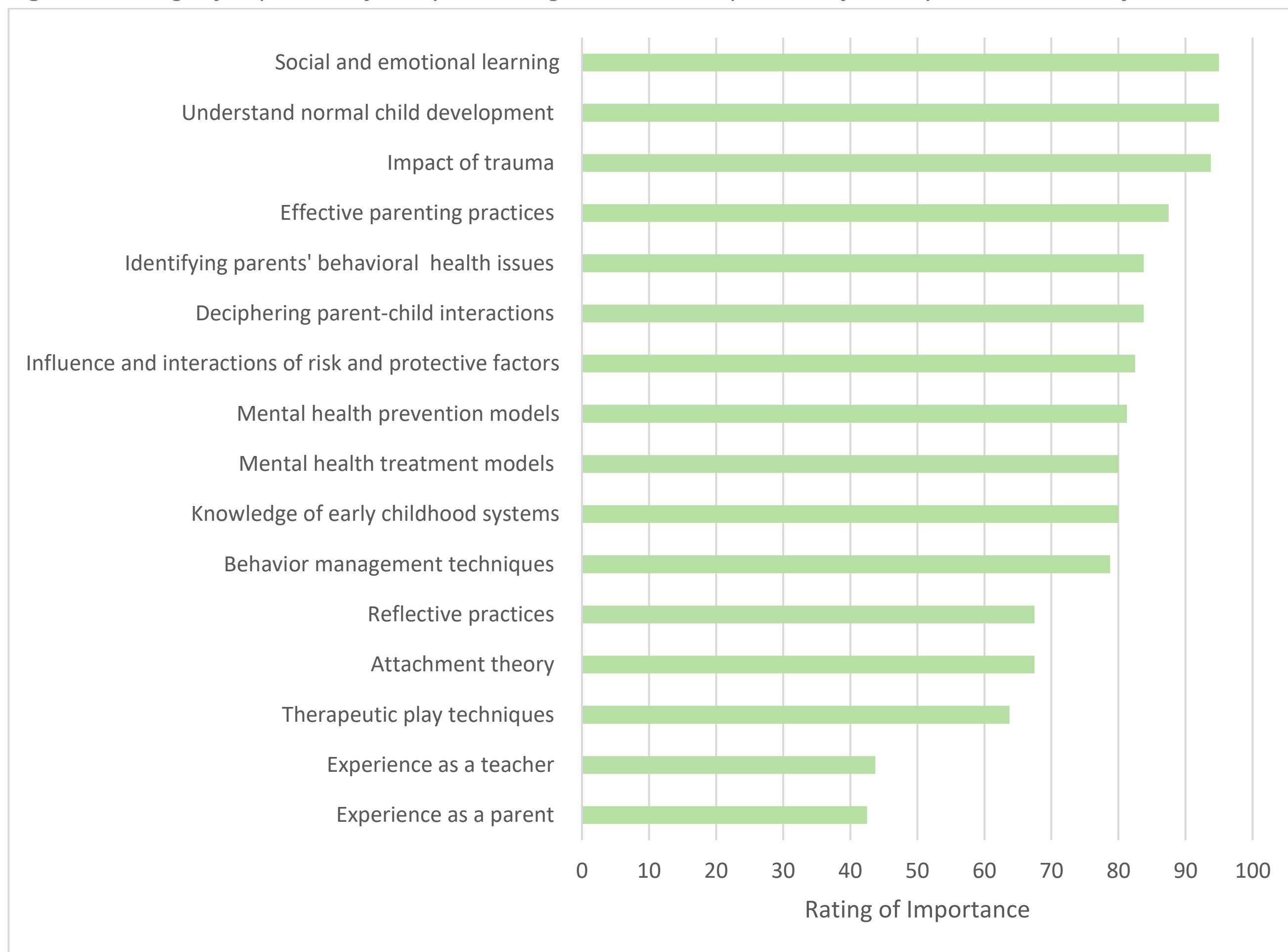
Outcome data from the CANS suggests that LMHAs may be most effective at reducing significant aggression and problematic social behavior in young children, with less impact on impulsivity and hyperactive behaviors or oppositionality. This is demonstrated by an almost equal number of children worsening and improving over time in these areas. Internalizing problems, such as depression and anxiety were not identified as problem areas for most children, and outcomes were more limited. It should be noted that the CANS instrument measures child and family needs on a large-scale level (range of 0 to 4); therefore, a moderate level of improvement may not be detected without a more discrete scale of measurement. For example, a 15% improvement in impulsive behaviors may be clinically significant and impactful for a family, but the CANS impulsivity-hyperactivity item may still remain at the level of a need (score of 2 or 3).

Survey of Local Mental Health Authorities

Methodology. To further explore the public mental health system's approach to children three to five years old, the author met with the Texas Council of Community Centers' Children's Special Interest Group (C-SIG), consisting of Children's Directors and other organization leaders across several LMHAs. The workgroup suggested a survey and interviews with select organizations would be the most successful strategy for obtaining information on system practices, system needs, and innovative approaches to serving young children and their families. A draft survey was developed, shared with the C-SIG, and modified based on the resulting feedback. The survey link was distributed to all LMHAs through the Texas Council, with directions that it be completed by one or more leaders knowledgeable about services to young children. Twenty-eight individuals responded to the survey, representing 22 of the 39 local authorities, for a response rate of 56.4%. While the response rate is modest, the respondents include authorities within urban and rural areas, of varying sizes, and within each region of the state. When multiple responses were provided for one LMHA, responses were averaged across respondents so that each LMHA is represented only once within the survey results. More than half of the respondents (59.1%) indicated that they provide Early Childhood Intervention services, in addition to children's mental health.

Workforce and Training. One-quarter of respondents (22.2%) reported that *all* providers who worked with the 3 to 5-year-old population had or received specialty training for working with young children and their families. The majority (50%) reported that *some* providers had specialty training for the early childhood population, but not all, while another 22% were unsure. Children's mental health leaders were asked to identify how important specific knowledge, skills, or experiences were for staff working with the population and the results are summarized in Figure 4. Respondents rated social and emotional learning and normal childhood development, as well as the impact of trauma, effective parenting practices, and identifying parent mental health issues as some of the most critical workforce competencies. Specific experiences as a teacher or parent were rated as the least important.

Figure 4. *Ratings of Importance for Key Knowledge, Skills, and Experiences for Early Childhood Workforce*



The majority of respondents (76.2%) indicated that they were "sometimes" able to hire new staff with the knowledge and skills needed to serve young children and their families. No respondents indicated they were able to hire such staff members "often" and 23.8% responded "rarely". To help staff members gain competency in working with young children, 63.6% reported offering internal training, 54.5% reported offering access to online trainings, and 22.7% reported other training opportunities. No respondent reflected having no training opportunities related to working with young children. Almost all agencies (86.4%) also reported staff attend conferences or workshops to gain additional training on working with young children.

Respondents were asked open-ended questions about training needs and responses are reflected in Table 5. Respondents indicated that live workshops (86.4%) and web-based trainings (77.3%) were the preferred training methods, followed by live webinars (50%) and training videos (50%). Readings/manuals, Texas Health Steps, and university classes were not preferred.

Table 5. *Identified Training Needs for Early Childhood Workforce*

Training Topics (indication of multiple responses)	
Trauma informed care/trauma-based practices (6)	Trauma-focused CBT
Parent-Child psychotherapies (2)	Parent Child Interaction Therapy
Working Model of the Child	Social and emotional learning (2)
Risk and protective factors (2)	Prevention models
Play therapy/play therapy techniques (2)	Parent Child dyad
Assessing parent-child interactions (2)	Identifying parent behavioral health issues
Parenting skills	Engaging parents in treatment (2)
Medication and young children	Working with grandparents as primary caregiver
Self-regulation	Brain development
Attachment/attachment theory	

In addition to identifying training topics that could support staff competency, one respondent emphasized the importance of offering training at least every two years to address the frequent staff turn-over. Another respondent identified the desire to have training offered that supported providers in obtaining the Texas Infant Mental Health Endorsement® provided by First3Years, possibly a guided training to support providers in completing all requirements.

Services and Supports. Respondents provided information on the specialized services that are available to children three to five and their families. All respondents indicated providing services in the home and almost all (95.2%) indicated providing clinic-based services. In addition, a large proportion indicated that they provided services to young children in schools/school-based clinics (71.4%), Head Start and/or Early Head Start (57.1%), and child care programs (52.4%). Other settings, such as primary care, Federally Qualified Health Centers, hospitals, residential substance use treatment parenting programs, teen parenting programs, and shelters were identified by a small number of organizations. The types of services and/or treatment models provided by each agency is reported in Table 6.

Table 6. *Mental Health Services and Treatment Model Availability within LMHAs*

Service Type or Treatment Model	Number Reporting Service is Offered		Number Reporting Not Offered or Uncertain	
	n	%	n	%
Developmental Screenings	12	57.1%	9	42.9%
Social and Emotional Development Screenings	15	71.4%	6	28.6%
Age-appropriate Trauma Screening	9	42.9%	12	57.1%
Assessment and Diagnosis	21	100%	0	0%
Nurturing Parenting Treatment Model	20	95.2%	1	4.8%
Incredible Years Parenting Treatment Model	2	9.5%	19	90.5%
Parent Child Interaction Therapy	6	28.6%	15	71.4%
Other Parenting Program	5	23.8%	16	76.2%
Trauma-Focused CBT	16	76.2%	5	23.8%
Attachment Biobehavioral Catch-up	1	4.8%	20	95.2%
Parent Child Psychotherapy	6	28.6%	15	71.4%

Parent Child Relationship Therapy	7	33.3%	14	66.6%
Preschool PTSD Treatment	1	4.8%	20	95.2%
Other Psychotherapy	4	19.0%	17	81.0%
Early Childhood Mental Health Consultation	11	52.4%	10	47.6%
Family Partner Supports	20	95.2%	1	4.8%
Respite	11	52.4%	10	47.6%
Behavioral Analysis and Consultation	3	14.3%	18	85.7%
Other	2	9.5%	19	90.5%

All organizations offered assessment and diagnostic services, with more than half also screening for developmental and social-emotional delays. Fewer than half utilized age-appropriate trauma screenings. All organizations provided parenting interventions, with almost all offering Nurturing Parenting (95.2%) and a few offering Parent Child Interaction Therapy (28.6%), Barkley's Parent Training (4.8%), 1-2-3 Magic (4.8%), and Incredible Years (9.5%). About half of the respondents indicated that they provide Early Childhood Mental Health Consultation (52.4%) and about one-third indicated that they provided either Parent Child Relationship Therapy (33.3%) or Parent Child Psychotherapy (28.6%). Almost all respondents indicated that family partner supports were available to parents of young children in care.

Respondents were asked an open-ended question about the services and supports that they would like to offer to young children and their families, but currently do not. Responses included Parent Child Interaction Therapy, Family Connections (a comprehensive child abuse prevention program), play therapy, family therapy, a teen parent curriculum, respite services, adaptive aids/flexible supports, housing, transportation, and services integrated into a primary care physician's office. Respondents identified some of the barriers that have prevented them from providing these services, with the most common barriers being training requirements/cost of training and the requirement of licensed or credentialed providers.

Community Collaborations. A large majority (81.0%) of the respondents reported that their organization participates in a local early childhood collaboration. Respondents reported collaborating with a wide variety of organizations in this work, with schools, Head Start and Early Head Start, child care providers, pediatricians/primary care, Community Resource Coordination Groups (CRCGs), child welfare, early childhood intervention (ECI), hospitals, and non-profits reported by over half of the respondents. Respondents were also asked a question about referrals and coordination from the ECI system to the children's mental health system. Responses to the question varied significantly. Some respondents indicated that the transition was smooth; others indicated that there is a lack of providers within the mental health system to see young children. Two respondents indicated that ECI typically refers children to schools at age three and then the schools refer for mental health services at four or five-years-old. One respondent noted that families who are referred from schools indicate that they have been referred for a diagnosis and medication, leaving providers to advocate that they try psychosocial interventions first. Another respondent noted that providers lacked the time to know what resources were available in the community; another noted that they have struggled to get timely documentation to support referrals. One respondent indicated that their organization has done cross-training between ECI and children's mental health to enhance coordination, but also recommended that ECI be mandated to include children's mental health in the transition planning, as they currently do with schools.

Opportunities to Strengthen the Early Childhood System of Care. Respondents identified a variety of "needs" or "gaps" within the system, as well as opportunities to strengthen the system of care. Workforce issues were identified by many respondents, including the struggles hiring and retaining qualified and experienced staff and maintaining the necessary consistency in staffing with families. Several respondents highlighted the need for staff

who could effectively engage around parents' mental health and/or trauma experiences, as well as an understanding of family systems. Many respondents expressed a desire for more regional or web-based training for working with this population. Additionally, several respondents expressed a desire for more options for both therapy/counseling and skills training approaches. One respondent reflected that some evidence-based programs for school-age children are not effective for this population, and one respondent reflected a need for "curricula change." In addition, many respondents indicated a need for increased funding to recruit and retain competent staff and to increase access to wraparound, family partners, and quality respite services.

Many respondents also shared their recommendation for ways to strengthen collaborations and build better systems of care. These ideas included incorporating screening tools into primary care and child care systems to better identify young children with social and emotional challenges and refer to care, strengthening the connection between ECI and LMHAs through local agreements, enhancing cross-system collaborations within local communities, embedding mental health providers in primary care offices and child care settings, and creating a comprehensive system that addresses the child and family's needs across systems with a "no wrong door" approach. Respondents also cautioned that additional funding would be necessary, as ECI and children's mental health systems do not have capacity to provide the needed care as new families are identified and referred into the system.

Other Sources of Data

The purpose of this review was not to identify all available sources of data on infant and early childhood services in Texas, but rather to focus on the public mental health system. However, some publicly available data can provide additional context for a review of the existing system. In FY2017, the *Early Childhood Intervention* system served 55,412 children birth to three. The majority (81.5%) were identified with a developmental delay; however, social and emotional delays are not delineated within the broader category of developmental delays and so the number of children identified with these delays is not available. Some inferences can be drawn from a description of the planned service type, with 2.4% (an estimated 1,330) served through psychological or social work providers and 0.5% (estimated 277) served through behavioral intervention (Texas HHSC, 2018). This suggests that ECI, while including social and emotional delays within its priority population, may provide limited access focused on these issues. *Prevention and Early Intervention* (PEI) served 4,702 families through the HOPES program in FY17 and documented that 99.0% of the participants remained safe (no child welfare referrals; Texas DFPS, n.d.). The *Texas Education Agency* reports serving 232,177 children in prekindergarten in school year 2017-2018 (Texas Education Agency, 2018). Data was not publicly available on the number of children in the thee to five-year-old age category served in special education. In 2017, the federally-funded *Head Start program* served 65,446 children (26% of those three to five eligible) and 10,374 in *Early Head Start* (4% of eligible children under three) (National Head Start Association, 2018).

Stakeholder Interviews

Several unique practices and system structures to support infant and early childhood mental health were identified during the data gathering activities. Key leaders of these programs were interviewed to gather additional descriptive information about these programs. These programs do not necessarily reflect all of the unique practices or community systems of care supporting early childhood mental health in the state. However, there stories can provide a glimpse at local practices that could be supported and replicated.

Burke Mental Health Consultation. Burke, serving twelve counties in East Texas, has established contracts with 21 Head START programs in the region to provide mental health consultation. The agency provides mental health consultation to GETCAP Head Start, which covers five counties and provides Head Start and Early Head Start to about 700 families, and Tri-County Community Action, which covers seven counties and supports 625 families. As a part of this contract, Burke has licensed, trained therapists who conduct observations of each classroom and provide recommendations and guidance to program directors and teachers. Based on the need, the consultant may provide resources and tools, teach and practice key skills, or provide training within the program. Burke clinicians also provide consultation when an individual child or family is identified with a possible need through a referral, which may involve working directly with the teacher and/or parent to support the child's development and/or address emotional or behavioral concerns. When asked about lessons that had been learned in developing the program, the leader indicated that they learned how important it was to take the time to develop relationships with the director, teachers, and staff within the Head Start programs, and that until a trusting relationship was developed, most of the recommendations were not being implemented. She also stressed the importance of having a strong training program available for the consultants. Over time, Burke has developed an in-house training that they then follow with an opportunity to shadow an experienced consultant. These mentors in turn shadow the new consultant and provide feedback and coaching support. In addition, the team of consultants meet regularly to discuss recommendations and challenging situations, allowing for supervision specific to the consultation task. When families require referral for mental health treatment at Burke, the program leader noted that they have overcome some of the challenges to engaging families by providing all but the initial contact at the Head Start location. This collaboration has reduced the burden on families to travel to several locations to access services.

North Texas Early Childhood System. MHMR of Tarrant County (MHMRTC) has developed an early childhood system that targets Tarrant and 11 surrounding counties. MHMRTC recognized the need for specialty care for children birth to six across each of its divisions – Early Childhood Intervention (ECI), Mental Health, and Intellectual and Developmental Disabilities (IDD). The agency developed an Early Childhood Division and began a partnership with other community organizations serving young children and their families. MHMRTC leadership envisioned holistic, team-based care that aimed to coordinate community-based services and supports to meet the family's needs, address the impact of family trauma, and prevent exposure of children to adverse childhood experiences (ACES). The system has been developed through braided funding from a LAUNCH grant, a HOPES prevention grant, and existing federal, state, and local funding. The team is exploring opportunities for state and local foundation grants, as well. The system is anchored through a "one-stop" phone intake system where initial screening occurs. A cross-discipline team meets to identify a family support coach who will be a good fit for the family. The family support coach serves as the primary care coordinator, maintaining a consistent relationship with the family for approximately one year, frequently beyond the end of formal services. The family support coach completes an initial assessment with the family and identifies the primary needs, focusing on the entire family. The cross-discipline team utilizes the assessment to identify the best organization(s) to meet the family's primary needs. The family could be served through the ECI system, a home visiting program, specialty pediatric services., prevention programs, and non-profit partner organizations. The community has invested in the Ages and Stages Enterprise System, a web-based portal with access to screening tools, and supports multiple organizations in regular screening for developmental and social and emotional delays. The platform provides immediate scoring and reporting functions and supports aggregation of data to examine regional trends.

The system has utilized two primary models across all of the collaborators – Trust-based Relationship Interventions (TBRI) and Parent Cafes. These two approaches are offered throughout the system by a variety of partners. The program leaders highlighted the importance of the "shared language" that has resulted from cross-training opportunities in these models. In addition, providers offer a wide variety of services and supports, depending on the needs of the parent(s) and children. Providers have been trained and implemented Incredible

Years parenting program, Mental Health Consultation, and are preparing to implement Healthy Steps, an evidence-based integrated care model within pediatric clinics. When asked about lessons learned through implementation, leaders indicated the following:

- Providers have to be able to cross all systems and engage with all of the service systems necessary to meet families' needs (e.g., child care, health care, school).
- The system has to focus on the family. For young children, the child's needs cannot be separated from the parent's needs.
- Staff need training in the impact of trauma as it relates to young children, even if they are familiar with its impact generally.
- Staff have differing competencies depending on the systems in which they have worked. Early childhood staff have strong backgrounds in child development, but may be less experienced with social and emotional development, family needs, and available community resources. Prevention staff have strong background in working within the family context and available community resources, but may need more training related to child development. The team continues to identify the specific roles for licensed clinicians, and currently has identified their role as a consultant to the team.
- Families need to have a stable relationship with one person, even if they may access a variety of services from different providers. The family support coach plays this role in the North Texas system.
- There needs to be strong, visionary leadership in place with flexibility to continually adjust and grow over time.

Recommendations

Based on the research review and data collected for this report, the following recommendations are made to strengthen the early childhood mental health system of care in Texas:

1. Key agencies, families, and other stakeholders should collaborate to create a Texas Infant and Early Childhood Mental Health Strategic Plan. The development and oversight of a strategic plan could increase coordination, effectiveness and efficiency across the state agencies. Examples of statewide early childhood mental health strategic plans include:
    a. Oklahoma IECMH Strategic Plan
    b. Michigan Great Starts Systems
2. Texas should consider re-integrating the specialty treatment for young children with mental health challenges within one state agency. Currently, this task is split between Early Childhood Intervention (ECI) and Children's Mental Health (CMH), based on the age of the child. Both agencies report challenges in hiring staff with expertise in IECMH and both are challenged by this population being a small focus of their services. There are benefits and challenges to having each of the current agencies responsible for mental health services to the 0-5 population, so no specific recommendation is provided.
3. Texas should develop a state-supported workforce development plan to support infant and early childhood mental health. The plan should include strategies to build a diverse workforce, with core competencies aligned with the specific role of early childhood professionals. The First 3 Years Endorsement system could serve as the model for the plan, but should be tied with state agency expectations for professionals tasked with roles within the Texas IECMH system of care.
4. Texas HHSC should develop a pilot program to fund mental health consultants within seven to ten LMHAs or ECI regions. The pilot program would allow child care providers to access expert consultation and refer children and families in need of additional assessment and/or support.
5. Texas HHSC should examine the existing approved treatment models within the public mental health system and consider the addition of specific practices targeting the early childhood population. Particular gaps include evidence-based therapies and parent-child skills training approaches.
6. Texas should explore opportunities to blend funding to support mental health consultation, which has been a successful strategy in several states. Potential sources of funding include general revenue (including a legislative appropriation request), mental health block grant (including the required early intervention set-aside), Home Visiting grants, the Child Care and Development Fund, and Medicaid/private insurance.
7. Communication strategies aimed at a parent audience should strive to increase awareness of the importance of social and emotional development, ways to promote social and emotional wellness, ways to identify possible developmental delays, and the array of supports available in Texas to support families. The development and implementation of the communications plan should be a collaborative effort among relevant state agencies and families of young children.

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