OPPORTUNITIES WITHIN THE TEXAS CHILD MENTAL HEALTH SYSTEM

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A C K N O W L E D G E M E N T

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Introduction

Overview of the Report. The development of the Texas children's mental health system, inclusive of all state child-serving agencies, has drawn from the System of Care (SOC) framework outlined initially in 1986, and later updated in 2010 and 2021. The SOC framework defines a system of care as:

> *A comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults.* (Stroul, Blau, Larsen, 2021)

This framework will guide the current examination of the Texas children's mental health system, drawing upon the 2021 revision of the SOC approach outlined by Stroul, Blau, and Larsen. This revision builds upon previous descriptions of the SOC core values of family- and youth-driven, community-based, and culturally and linguistically competent systems and services, as well as guiding principles that underlie the design and implementation of the service delivery system. The most recent revision to the SOC framework includes an intentional broadening the SOC approach to incorporate a population-based, public health model, incorporation of the integration of health and mental health systems, the identification of a core service array, and the incorporation of approaches to achieve mental health equity. The resulting definition, values, and guiding principles are provided in Appendix A.

The purpose of this monograph is to conduct an examination of the current mental health system in Texas and identify areas of strength and alignment with best practices, as well as opportunities for further growth and modernization. This review was conducted under a contract between the Texas Health and Human Services Commission (HHSC) and the Texas Institute for Excellence in Mental Health (TIEMH) at the University of Texas at Austin. To achieve this goal, the author conducted a desk review of a variety of written resources available online or provided by key stakeholders, reviewed monographs and other relevant literature from the past ten years, and conducted key informant interviews with stakeholders in a variety of roles.

However, there are several limitations to this methodology that should be noted. The review did not include an examination of access, quality, or outcomes of mental health or related services provided within the state. The author has made no attempt to reflect on whether services are provided with fidelity to the identified service model, are achieving the intended outcomes, or whether they are

provided equitably to appropriate children, youth, young adults, or families. Additionally, key informant interviews were limited due to the availability of some stakeholders, especially those involved in the Texas Legislative session, and the timeframe for report development. The author recommends additional input be gathered from families, youth and young adults, and community providers in varying roles and in different regions of the state to further advance this work. The recommendations provided in the monograph should be considered the opinions of the author, based on the identified methodology, and do not reflect the comprehensive input of all relevant stakeholders or the opinions of state agency representatives.

Outlining the Public Health Approach to Children's Mental Health. The conventional public health approach includes health promotion and prevention activities offered to an entire population (universal prevention), targeted prevention to individuals at risk for developing health conditions, and treatment services intended to intervene, reduce severity and impairment, and support remission and recovery after a health condition has developed. This tiered model has also been applied to children's mental health services, with mental health promotion and universal prevention strategies available to all children, targeted prevention and early intervention services provided to those children identified with specific risks factors or needs, and intensive mental health supports provided to a small proportion of children and youth (Miles, Espiritu, Horen, et al., 2010). One advantage of this model is its emphasis on the critical role that mental health promotion and prevention can play in impacting most or all children and reducing the number of children who need more intensive and costly interventions. By taking a population-based, public health approach to the examination of Texas' child mental health system, one can consider opportunities for balancing resources and creating efficiencies within a multi-systemic approach.

A Modern Array of Children's Mental Health Services. Over the past ten years, several attempts have been made to define what constitutes a comprehensive array of children's mental health services and supports. The primary source for this discussion is SAMHSA's monograph defining a "good and modern" behavioral health system (SAMHSA, 2011). In this document, SAMSHA states their vision that:

> a good and modern mental health and addiction system is grounded in a public health model that addresses the determinants of health, system and service coordination, health promotion, prevention, screening and early intervention, treatment, resilience and recovery support to promote social integration and optimal health and productivity. (SAMSHA, p. 3).

The monograph goes on to provide a description of the core components proposed within a modern continuum of care and describes some of the services provided within each component. These elements form the basis for the array detailed in Table 1. These components were further explored within a joint SAMHSA and Center for Medicare and Medicaid (CMS) bulletin (2013) intended to guide states in designing a benefit package that meets the needs of children, youth, and young

adults with significant mental health conditions. The bulletin draws from the evidence of results from the Children's Mental Health Initiative (CMHI) grants and a large demonstration project to provide alternatives to care in a Psychiatric Residential Treatment Facilities (PRTFs). The revision to the SOC framework utilizes the components outlined in the SAMHSA/CMS bulletin as the core features of a comprehensive system for children with significant mental health concerns. Table 1 provides a brief description of these core components, setting the stage for a review of the ways in which Texas has achieved the goal of a good and modern behavioral health system for children and any current gaps in system design.

Table 1. Components of a Good and Modern Behavioral Health Service Array

Component of Array	Description of Types of Services
Healthcare Home / Physical Health	Pediatric primary and specialty care, including health promotion, general health, developmental, and behavioral health screens, health promotion, referral to community services, care coordination
Mental Health Promotion and Prevention	Screening, brief intervention and referral to treatment, brief motivational interviews, parent training, facilitated referrals, relapse prevention/wellness recovery support, warm line
Engagement Services	assessment, specialized evaluations, consumer and family education, outreach, service planning
Outpatient Services	individual evidence-based therapies; group therapy, family therapy, multi-family therapy, consultation to caregivers*, trauma-focused interventions*
Medication Services	medication management, pharmacotherapy, and laboratory services
Community Support / Rehabilitation	parent/caregiver support, skill building, case management, behavioral management, supported employment*, permanent supported housing, recovery housing, therapeutic mentoring*, traditional healing services
Other Supports / Habilitative	personal care, respite*, supported education*, transportation, recreational services, trained behavioral health interpreters, flex funds (goods and services)*
Intensive Support Services	partial hospital, intensive home-based treatment*, multi-systemic therapy, intensive case management – wraparound approach*
Out-of-Home Residential Services	crisis residential/stabilization, 24-hour observation, children's mental health residential services, therapeutic foster care
Acute Intensive Services	Mobile crisis services*, intensive inpatient, urgent care services, 23-hour crisis stabilization*, crisis hotline services
Recovery Support	Parent and youth peer support*, recovery support coaching, supports for self-directed care

* Service elements emphasized as components of care for children, youth, and young adults with significant mental health needs

Review of the Texas Child Mental Health Service Array

The review of the Texas mental health system of care is presented within the public health framework, recognizing that some interventions are provided universally to all children and families (mental health promotion and prevention), some are intended to prevent mental health problems for those at risk or intervene early when potential concerns are first noticed (targeted prevention and early intervention), and others are intended to provide treatment and support to individuals with mental health diagnoses and their families (mental health intervention services and supports). The following is a description of publicly-funded components of the Texas mental health service array.

Figure 1. *Public Health Framework*
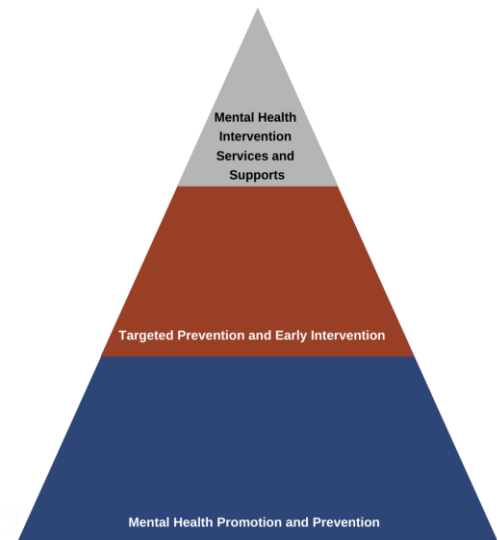
Mental Health Promotion and Prevention

Mental health promotion and prevention strategies aim to strengthen factors that promote positive mental health and prevent the occurrence of mental health concerns. Mental health promotion and prevention efforts should be offered to a broad population, irrespective of any risk factors. There is no state agency in Texas that has as a core component of its mission to promote mental health and well-being and prevent mental health conditions. Rather, several activities undertaken by agencies to achieve other goals contribute in some way to the state's overall public health impact on child and family well-being.

Universal Substance Use Prevention Services. Texas HHSC utilizes SAMHSA Block Grant funding to provide universal substance use prevention services to children in grades 1-12. These prevention services are required to be evidence-based and focus on increasing protective factors, such as feelings of belongingness, self-esteem, and good decision-making. Contractors can choose from the following eight evidence-based curricula:
- All Stars
- Creating Lasting Family Connections
- Life Skills Training
- Positive Action
- Project Toward No Drug Abuse
- Strengthening Families Program: For Parents and Youth 10-14
- Strengthening Families Program: 14-Session curriculum
- Too Good for Drugs

School-based Promotion and Prevention. Independent school districts may choose to provide universal mental health promotion and prevention supports on campuses. This may occur through an evidence-based program, such as one intended to teach social and emotional skills, or through informal activities intended to support student overall well-being, such as emotional check-ins or mindful moments. State statute requires that schools have policies that address specific components of mental health promotion and prevention, including:

- Safe, supportive, and positive school climates
- Building skills related to managing emotions, establishing and maintaining positive relationships, and responsible decision-making
- Early mental health prevention
- Grief- and trauma-informed practices
- Positive behavior interventions and supports
- Positive youth development
- Substance use prevention and
- Suicide prevention.

The TEA and HHSC collaboratively publish a best practice registry to provide a list of programs or resources that schools may opt to implement within each of these component areas. Districts and schools do not receive targeted funding for school-based mental health promotion and prevention, but may choose to use some federal and state funding streams for these purposes. Recent federal COVID-19 relief aid allows districts and schools to use relief funding, in part, to meet the social, emotional, and mental health needs of all students. With the availability of relief funding, the US Department of Education has called for schools to: (a) create a framework for meeting student social, emotional, and academic needs; (b) build strong and trusting relationships among students, families, and educators; (c) establish safe, positive, and stable environments; (d) explicitly teach critical social, emotional, and academic skills; (e) actively engage students in meaningful and culturally and linguistically relevant experiences rooted in high academic expectations for all students; (f) provide supportive and specific feedback to encourage skill growth across add domains; (g) provide access to support from school counselors and mental health professionals; and (h) establish building-level wellness teams to address the social and emotional learning needs of students and staff (US Department of Education, 2021).

PAX Good Behavior Game. The HHSC, in collaboration with TEA, is supporting implementation of PAX Good Behavior Game (GBG) in schools in each region of the state. PAX GBG is a universal prevention program that has been shown by research to reduce problematic behaviors, improve academic performance, and reduce teacher stress levels. Coordination of the initiative is housed in Educational Service Center (ESC) Region 13. Training programs include training for classroom teachers, internal or external coaches who will support implementation, and training to support the use of aligned PAX Tools within the community and human services systems. The current initiative is financed by targeted opioid response funding from SAMHSA, which may not be a sustainable source of implementation support.

DFPS Get Parenting Tips. DFPS Prevention and Early Intervention (PEI) hosts a [website](#) that provides parenting guidance and best practices to all interested families. Articles and videos cover a range of parenting topics, including health and mental health issues. A searchable database is also available to identify DFPS contractors providing targeted prevention and early intervention services.

Targeted Prevention and Early Intervention

Substance Use Prevention. HHSC uses block grant funding to provide targeted substance use prevention services to youth at increased risk (Youth Prevention Selective) and early intervention services (Youth Prevention Indicated) through a variety of contractors throughout the state. These contractors are required to use evidence-based, substance use prevention programming. Contractors can choose from the following seven evidence-based curricula:

- All Stars (Selective)
- Creating Lasting Family Connections (Selective and Indicated)
- Curriculum-Based Support Group Program (Selective and Indicated)
- Positive Action (Selective and Indicated)
- Project Toward No Drug Abuse (Selective and Indicated)
- Reconnecting Youth (Selective and Indicated)
- Strengthening Families Program: 14-Session curriculum (Selective and Indicated)

Prevention and Early Intervention Services. The Department of Family and Protective Services (DFPS) provides an array of targeted prevention and early intervention services across the state, with the goal of prevent child abuse and neglect, juvenile delinquency, runaway youth, and truancy. The following key programs are offered:

- Fatherhood EFFECT – this program collaborates with community coalitions to provide parent information and resources to fathers and increase protective factors, such as family functioning and resiliency, social supports, and nurturing/attachment. The program currently serves nine counties with a total annual budget of $1.24 million, with a target of serving 944 families in fiscal year 2021.

- Community Youth Development (CYD) – this program funds community-based organizations activities to foster positive youth development and build healthy families and resilient communities. CYD funding is targeted to communities in zip codes with high incidences of juvenile crime. The program currently serves 15 counties with a total annual budget of $8.31 million, with a target of serving 16,140 families in fiscal year 2021.

- Family and Youth Services (FAYS) – this program addresses family conflict and everyday struggles while promoting strong families and youth resilience. Providers offer one-on-one coaching or counseling and group-based learning for youth and parents. The program currently serves all 254 counties with a total annual budget of $24.18 million, with a target of serving 21,419 families in fiscal year 2021.

- Statewide Youth Network Services (SYNS) – this program supports two state-level grantees who provide resources and supports to a network of providers supporting positive youth development. Current funding supports Big Brothers Big Sisters of North Texas and the Texas Alliance of Boys and Girls Clubs. The program currently serves all 254 counties with a total annual budget of $1.53 million, with a target of serving 2,526 families in fiscal year 2021.

- Texas Service Members, Veterans, and Families (SMVF) – this program provides parenting, education, counseling, and youth development programs for military and veteran families and builds community coalitions focused on promoting positive outcomes for children, youth, and families. The program currently serves 10 counties with a total annual budget of $1.60 million, with a target of serving 1,954 families in fiscal year 2021.

- Texas Home Visiting (THV) – this program funds early childhood and health professionals to regularly visit the homes of pregnant women and families with children under 6 years of age. The program supports positive child health and development outcomes, increases family self-sufficiency, and creates communities where children and families can thrive. The program currently serves 24 counties with a total annual budget of $19.66 million, with a target of serving 4,392 families in fiscal year 2021.

- Texas Nurse Family Partnership (TNFP) – this program serves low-income, first-time mothers and their families through nurses who provide home visits to improve prenatal care and provide one-on-one child development education and counseling. Families start the partnership with TNFP by their 28th week of pregnancy and can receive support until their child reaches 2 years of age. The program currently serves 26 counties with a total annual budget of $15.86 million, with a target of serving 3,075 families in fiscal year 2021.

- Helping through Intervention and Prevention (HIP) – this program provides in-home parenting education and other support services to pregnant or parenting foster youth, either currently or previously in the foster care system. The program aims to increase protective factors, such as family functioning and resilience and maintain child safety. The program currently serves 66 counties with a total annual budget of $1.18 million, with a target of serving 390 families in fiscal year 2021.

- Healthy Outcomes through Prevention and Early Support (HOPES) – this program provides an array of services and supports for families of children age 0-5 considered at risk for child abuse and neglect. Supports include activities such as home visiting services, developmental screening, parent support groups, early literacy promotion, and parent education. The program currently serves 54 counties with a total annual budget of $23.79 million, with a target of serving 8,768 families in fiscal year 2021.

Texas Juvenile Justice Department (TJJD) Prevention Grants. TJJD provides grants to local probation departments to offer services to youth age 6 to 17 who are at increased risk of later involvement with the juvenile justice system. The way in which local departments use this funding varies. Some departments collaborate with local community youth-serving organizations to provide educational assistance, mentoring, character development, and skills building after school or during summers. Other may focus on providing parents of at-risk youth with the skills, services, and

supports they need to better manage their children's challenging behaviors. In Fiscal Year 2019, the Department provided grants to 35 counties totaling $3.01 million (TJJD, 2020).

Behavioral Threat Assessment Approach. Required by the 86th Texas Legislature in 2019, the Behavioral Threat Assessment model is a proactive approach to identifying students who may pose a threat of violence to themselves or others and providing interventions based on individualized needs before a violence incident occurs. Overseen by the Texas Education Agency, each Texas school district is required to develop one or more multi-disciplinary teams responsible for serving as a point of contact for reports of concerns about student behaviors from staff, students, and families, as well as appropriate assessment of these reports and identification of mental or behavioral health interventions that may address the student's needs.

Communities In Schools. Communities In Schools (CIS) is a network of youth-serving organizations that provide care management and a variety of social services and supports to help students succeed in school. Funded in part by state general revenue funds, there are 27 CIS programs across the state operating within 1,186 campuses (https://www.cisoftexas.org/). Many CIS programs offer mental health services to students with risk factors or identified needs, along with mentoring and other supports. The network serves over 105,000 students each year.

Mental Health Intervention Services and Supports

Texas Child Health Access Through Telehealth (TCHATT). TCHATT is a network of health-related institutions (HRIs) in Texas who provide access to brief mental health assessment, intervention, and referral support for Texas students. Eligible students include pre-kindergarten through 12th grade with identified mental health concerns who are referred by their school for mental health assessment or intervention, following parental consent for the referral. Students and their families can be served by a child and adolescent psychiatrist, nurse practitioner, or mental health professional depending on needs. The service is brief and problem-focused, providing up to five telehealth visits, and can be followed by a referral to a mental health or other provider for further intervention, when needed. HRIs currently have agreements with 191 of the 1,203 school districts in the state.

Child Psychiatric Access Network (CPAN). CPAN supports the provision of mental health supports through primary care practitioners by providing access to psychiatric and other behavioral health consultation services. CPAN is operated by a network of HRIs, providing a single access point through a phone line in which primary care practitioners can receive immediate consultation on mental health care for child and adolescent patients. Primary care practitioners have access to support related to assessment, diagnosis, pharmacotherapy, behavioral management, referral assistance, and general resources. The network also provides training opportunities and written materials to support practitioners.

Medicaid and Child Health Insurance Plan (CHIP). The Texas Medicaid and CHIP programs are operated under a State Plan that outlines available services and supports. Texas primarily uses a managed care approach, which leads to some variability in the service array depending on the health care options available within a region and the services offered by the health plan selected by a family. The Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) service is a comprehensive preventive child health service for eligible children, called Texas Health Steps. In addition to the offered services, any medically necessary health care service are provided to children enrolled in the program, even if not available under the Medicaid State Plan. Texas Health Steps requires regular screening for developmental and mental health conditions from early childhood to young adults within health homes. Additionally, Medicaid covers psychiatric diagnostic evaluations; psychological, neurobehavioral, and neuropsychological testing, telemedicine and telehealth; psychotherapy; pharmacological management, case management, and electroconvulsive therapy (if age 16 or older) (Texas Medicaid & Healthcare Partnership, 2021). In addition, credentialed providers, which includes the Local Mental Health Authorities (LMHAs), can provide targeted case management and rehabilitative services to eligible individuals. Within the child and adolescent service system, this includes the following:

- Medication Training and Support
- Skills training and development
- Crisis intervention
- Routine case management
- Intensive case management (Texas Medicaid & Healthcare Partnership, 2021).

Community-based mental health services. The network of Local Mental Health or Behavioral Health Authorities (LMHA/LBHA) are tasked with providing an array of clinic- or community-based services to meet the needs of children and adolescents with serious emotional disturbance (SED). These services and supports are delivered within a tiered structure, called Texas Recovery and Resiliency (TRR), that operates through utilization guidelines based on the assessed needs and strengths of the individual. The following levels of care (LOC) are offered to children and adolescents between the ages of 3 and 18 (HHSC, UM Guidelines, 2016).

- Crisis Services (LOC 0) – assessment and brief intervention intended to resolve a crisis event and ensure safety of the child and others. This level of care is reserved for children not currently served in a different level of care and no prior authorization is required.
- Transitional Services (LOC 5) – intended to provide services and supports to maintain stabilization after a crisis and support access to appropriate mental health care.
- Young Child Services (LOC YC) – intended to provide interventions to meet the needs of young children age 3 through 5 through an array of all available services. Many services incorporate caregivers within the intervention approach.
- Medication Management (LOC 1) – intended to provide maintenance pharmacological services for children with minimal mental health needs. LMHA/LBHAs are encouraged to transition to other community-based providers (e.g., pediatricians) when available.

- Targeted Services (LOC 2) – intended to provide services targeted to address either internalizing or externalizing disorders, with minimal comorbidity and modest functional impairment.
- Complex Services (LOC 3) – intended to provide services targeted to address both internalizing and externalizing disorders, with moderate levels of risk and functional impairment.
- Intensive Family Services (LOC 4) – intended to meet the needs of children with mental health challenges that place them at risk of out-of-home placement or have resulted in or are likely to result in multiple system involvement.
- YES Waiver (LOC Y) – a specialized Medicaid 1915(c) waiver program intended to provide an array of non-traditional services and supports to prevent out-of-home placement or parental relinquishment due to mental health challenges. Children must meet clinical eligibility for inpatient care to be eligible for enrollment in the YES waiver.
- Residential Treatment Center Services (LOC RTC) – intended to provide adjunctive services for children placed in private, state-funded residential treatment settings for care. Adjunctive services provide support for caregiver engagement, planning, and preparation for family reunification and transition to community-based care.
- Early Onset Psychosis Services (LOC EO) – a team-based specialized service provided to youth and young adults within two years from the initial diagnosis of a psychotic disorder. The program follows the coordinated specialty care model used by OnTrackNY.

Crisis or Emergency Services. HHSC funds an array of services intended to provide prompt face-to-face crisis assessment, crisis intervention, crisis follow-up and transition support, and relapse prevention services. Most of these services are open to individuals of all ages and programs are not specialized to the needs of children, adolescents, or their families.
- Local Crisis Hotlines - each LMHA/LBHA is tasked with operating or contracting for 24-hour telephone crisis support and marketing the hotline to the local community.
- Mobile Crisis Outreach Team – each LMHA/LBHA provides 24-hour access to a mobile crisis team who can provide crisis assessment, intervention, follow-up, and relapse prevention within the community setting.
- Out-of-Home Crisis Continuum – a continuum of crisis care is available within the state, including crisis respite programs, crisis residential, extended observation units, and crisis stabilization units. With a few exceptions, these programs serve only adults and are not available to youth.

Inpatient Psychiatric Hospitalization and Residential Care. Inpatient psychiatric care for children and adolescents consists of an array of four state psychiatric hospitals and an adolescent secure forensic program. Most children with acute psychiatric needs are served through local or regional psychiatric hospitals outside of the state system, allowing for greater opportunity to remain near the child's family. There are currently 62 licensed psychiatric hospitals in the state, although it is unclear from available information what percentage offer services to children and/or adolescents (Texas Department of State Health Services, 2021).

> **Texas State Hospitals Serving Children**
> - Austin State Hospital
> - El Paso Psychiatric Center
> - North Texas State Hospital – Wichita Falls
> - North Texas State Hospital – Vernon, Adolescent Forensic Program
> - Terrell State Hospital

Children and adolescents also have access to residential treatment through an array of facilities. Texas operates the Waco Center for Youth, which provides residential mental health care to children and adolescents between the ages of 13 and 17 with severe emotional or behavioral disorders. HHSC provides residential treatment through contracts with non-profit or private residential treatment facilities through the Residential Treatment Center Project. This initiative provides state-funded residential services to children and adolescents age 5 to 17 who meet eligibility requirements, with a goal of meeting significant mental health needs and preventing child relinquishment. The educational system also provides public-funded residential services in some circumstances. When a student's special education and related needs cannot be met within their designated campus, the district may arrange for a non-public school or off-campus program to meet the student's educational needs at public expense. DFPS also contracts with residential treatment providers for services to children within DFPS conservatorship. Similarly, these services may be a component of care from local juvenile probation departments for youth in both pre-adjudication and post-adjudication, as well as offered through the TJJD. TJJD currently has eight contracted residential providers (TJJD, 2021). Local juvenile justice programs have reduced their use of state-operated facilities over the past decade and increased their use of local residential programs. In the 2020 Annual Report to the Governor, TJJD reported that 31% of youth leaving formal supervision received residential services during their time in services (TJJD, 2020).

Review of the Literature

Select literature was reviewed to capture current thinking on a comprehensive children's mental health system, along with the role of prevention, early intervention, and intensive services and supports. Selected resource materials that were used in the development of this monograph are summarized.

- *The Evolution of a System of Care Approach for Children, Youth, and Young Adults and their Families (2021).* This monograph serves to update the vision of the System of Care approach,

originally documented in 1986, with information gained from additional research and practical lessons and continue to modernize elements of the system of care framework.

- *Making the Case for a Comprehensive Children's Crisis Continuum of Care (August, 2018)* – This monograph defines a comprehensive crisis continuum for children, youth, and families and discusses strategies for implementation and funding.
- *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit (2020)* – This toolkit, published by SAMHSA, outlines best practices for a continuum of crisis care as well as outlining essential principles for a modern crisis care system.
- *Designing the Future of Children's Mental Health Services (April, 2020)* – This article describes challenges in the implementation of evidence-based interventions in children's mental health and describes how human-centered design can be leveraged to increase the accessibility, effectiveness, and equity of children's mental health care.
- *Promotion and Prevention in Mental Health*: *Strengthening Parenting and Enhancing Child Resilience (2007)* – This report to Congress documented the state of the art in mental health prevention and promotion for children.
- *Roadmap to Reopening Safely and Meeting All Student Needs (April, 2021)* – This monograph outlines evidence-based approaches to meeting the social, emotional, and academic needs of student in response to the impact of the COVID-19 pandemic.
- *Agency Coordination for Youth Prevention and Intervention (October, 2020)* – This report, prepared by DFPS, TJJD, TEA, and the Texas Military Department, provides data on juvenile delinquency prevention and dropout prevention and intervention services and seeks to identify opportunities to enhance the coordination, planning, and delivery.
- *Building Systems of Care*: *A Primer 2nd edition* (2010) – This primer provides guidance on system of care functions, core elements of an effective system-building process, and strategies for creating sustainability.
- *Respecting the Needs of Children and Youth in Texas Foster Care*: *Recommendations of the Texas CASA Mental Health Task Force* (December, 2014) – This report reflected the findings and recommendations of a task force charged with identifying approaches to meet the mental health needs of children and youth in the Texas child welfare system.

Stakeholder Interviews

To inform this report, six key stakeholders were interviewed about their perceptions of the strengths of the children's mental health system, critical gaps in care, experiences with collaboration across agencies, key priorities for system enhancements, and opportunities for strengthening the current system. The semi-structured interview protocol is included in Appendix B. Interviews included representatives from mental health, child welfare, juvenile justice, and advocacy organizations. However, it is recognized that this small sample of interviews is not adequate to represent the many views of Texans with different experiences with children's mental health services, including those within primary care, schools, mental health, juvenile justice, and child welfare systems. The sample lacks the critical voice of diverse families and young people, as

well as the voices of service delivery providers and community representatives across different regions of the state. The themes and ideas that arose during the stakeholder interviews are shared in the report, but the reader is cautioned to recognize that the ideas provided are not inclusive of many important voices, and further interviews, focus groups, and feedback opportunities should be undertaken, in a way that engages diverse representation across the state. Results from the interviews are presented collectively, according to themes that arose.

Texas has the opportunity to strengthen mental health promotion and prevention, especially in schools. Individuals stressed the importance of intervening earlier in the lives of children, through coordinated mental health and promotion activities. They frequently engaged with children and youth after significant concerns had arose, but recognized that intervention would be more impactful if provided earlier. Most respondents spoke about the school setting as the ideal place for prevention and promotion to occur. One individual spoke about the importance of focusing on social and emotional learning broadly, from preschool through high school, noting that this focus wanes after elementary school, as well as working to build and reinforce social and emotional skills in school staff and parents or other family members.

A significant focus of quality improvement efforts for children's mental health services should be how to better engage youth and families in care. Individuals reported a variety of barriers that impede engagement in care, including lack of information about services and supports in the community, lengthy waits to access services, poor coordination among different service systems, limited hours of operation, and services and supports that lack the flexibility to meet the needs identified by families. Respondents also noted that some families may be labelled as "non-compliant" and turned away from services when advocating for a system that better aligns with their needs and is culturally sensitive. Individuals expressed concerns that barriers presented by mental health systems can lead to inequities in care and outcomes, especially for families of color.

Much of the system fails to embrace the values of youth-driven and family-driven care. Individuals noted some mental health programs are structured in a way to support youth- and family-driven care and a strengths-based approach, but that the overall system has not embraced these values. Respondents noted that services can be inflexible and fail to meet families' stated needs, as well as complex to navigate. They noted that a restricted provider base also limits family choice in providers. One respondent noted that some systems rely on judges to make decisions, and the youth and family have been given limited voice and choice. Another respondent noted that the use of a strengths-based approach is not widespread in the LMHA system, outside of intensive levels of care.

There remains limited exploration of mental health disparities within child-serving systems. Respondents noted some initial steps to begin to explore issues of cultural responsiveness in the workforce, but indicated a recognition that there are significant gaps in serving children of color, a

need for more culturally sensitive practices; and a need for the workforce to more closely mirror the families that are served. Respondents indicated a need to more fully consider how families of color view mental health care and other child-serving systems, as well as a need to consider how staff within these systems view families. One respondent noted that mental health staff need training, including basic training on terminology and language, on how to create a safe and supportive space for youth identifying as LGBTQ+.

Workforce shortages lead to inadequate services and regional inequities. Individuals noted that mental health workforce shortages have long been a challenge in the mental health system, but have become significantly worse in recent years. While Texas has struggled with shortages of child and adolescent psychiatrists, there is now a significant shortage of licensed mental health providers in the state. Additionally, compensation is low and job stressors are high, leading to high workforce turnover. One respondent noted that the shift to telehealth during the pandemic has made many providers reluctant to return to the long hours and commuting involved in face-to-face, community-based care. An individual commented that rising compensation rates for jobs in other sectors may lead to more staff leaving the mental health sector.

The mental health system needs greater flexibility in service provision, including the opportunity to focus on complex family needs and reducing social determinants of health. Several respondents noted a lack of flexibility in the current system to address the complex needs that some families experience. They indicated that providers are frustrated at being unable to meet the specific needs identified by families within current structures. They indicated that providers saw the importance of addressing social determinants of health, but current funding structures fail to support this. They also expressed the need for flexibility to try innovative approaches, such as the offering of summer camps for youth and two-generational models of care.

There are barriers to building the trusting relationships required for effective state and community collaborations. Respondents expressed valuing the importance of coordination and collaboration at both the state and local level to support an effective mental health system; however, they reflected on several barriers. Respondents indicated that frequent turn-over in positions can be challenging, and large agency systems can make it difficult to identify necessary contacts. Several individuals also noted that people can have one negative experience in the past which disrupts the relationship and it can take a long time for trust to be rebuilt. They described examples of systems not working well together due to historical problems and personal distrust, as well as the cultural differences present across the state. One respondent noted that word-of-mouth (about good experiences and successes) was the most impactful way to have community partners want to work together in meeting family needs.

There are unexplored opportunities to improve early interventions with young children and their families. Several respondents reflected on the mental health system not meeting the needs of

young children evidencing early mental health concerns. One respondent noted that the Early Childhood Intervention (ECI) program could be an important component of the system, but it is not generally thought of as providing early mental health intervention. Several respondents reflected that many young children are served by LMHAs within a level of care designated for young children, but it isn't well-defined. However, they noted it has the potential to provide more early intervention services and prevent more serious concerns. Several respondents shared their perception that the system has not really had the opportunity to fully design the early childhood mental health program to meet family needs.

The current system does not meet the needs of transition-age youth. Several respondents noted that the current system inadequately serves this population, with one individual noting that we have created a "cliff" for young people. Individuals noted that some children in this group have complex needs, such as co-occurring substance use, and need a robust array of programming that meets their developmental needs. It was noted that youth in the public mental health system usually qualify for minimal services as they transition from child to adult systems, and there is a need to begin planning transitions much earlier. One service that was specifically noted was crisis respite care, providing a safe place for youth and young adults to regulate their emotions and for families to re-engage productively.

Some children needing residential services do not have access to appropriate care. Several respondents noted that some children who have a need for residential care are challenging, if not impossible, to place in an appropriate setting. Individuals noted that the following children have limited access to residential services: pre-adolescent children, females, children with co-occurring intellectual delays, children with autism, children with aggressive behaviors, and medically-complex children. Respondents also noted that many residential settings do not provide appropriate care for children who have experienced significant trauma (e.g. those experiencing trafficking) or for those who identify as transgender. More than one respondent noted that the quality of residential services varies greatly, with access to high-quality care limited for all children, and noted that many residential programs focus primarily on maintaining safety and provide minimal focus on mental health treatment.

Exciting opportunities exist to strengthen the mental health system in Texas. Respondents shared a few ideas that they saw for strengthening the current system of care, drawing up existing initiatives. These included the roll-out of the new Teen Mental Health First Aid (tMHFA) training approach in schools, strengthening collaboration between LMHAs and DFPS single source regional contractors; the culture change and greater flexibility within the Certified Community Behavioral Health Center (CCBHC) model; the opportunity posed by crisis respite funding; DFPS's investment in treatment foster care, inclusion of family partner and youth peer support in Medicaid, and opportunities for prevention that could be leveraged through the Family First Act.

Community Resource Coordination Groups Survey. One stakeholder representing the state Community Resource Coordination Group (CRCG) Office recommended utilizing results from a state CRCG survey that was conducted in January 2020 with 74 responses, representing 72 CRCGs. CRCGs are multi-agency regional groups who meet to identify regional resources to meet the needs of children, families, and adults whose needs may exceed the resources of any one agency. The survey found that youth peer support, recovery supports for youth, respite services, transition-age youth services, and family advocacy and mentoring were either not available or limited in their availability. The respondents indicated that the primary barriers to providing an effective system of care included lack of services and service providers, as well as funding barriers.

Key Findings

Key findings from the review will be framed using the core service array identified in Table 1, and followed by a series of recommendations that could be considered for enhancing the current children's system of care.

Healthcare Home / Physical Health. Texas has a robust EPSDT program that includes developmental screening and mental health screening in accordance with American Academy of Pediatrics recommendations. Most primary care clinics lack access to integrated behavioral health services, but models of integrated care exist throughout the state. The CPAN initiative, implemented over the past two years, provides immediate access to psychiatric consultation for primary care providers, with the number of enrolled providers continuing to grow as the program matures.

Mental Health Promotion and Prevention. Texas offers limited universal mental health promotion and prevention activities, and there is no state agency responsible for strategic planning and coordination. DFPS provides universal parent education programming. Public schools offer an opportunity to provide universal mental health promotion and prevention to most children in the state, and new federal funding to reduce the negative impacts of the pandemic on learning loss provides an opportunity for significant advancement of school-based universal supports.

Engagement Services. The current service array provides opportunities for assessment, specialized evaluation, service planning and outreach to enhance engagement in services. However, challenges to engagement were also noted, including difficult to navigate systems, a lack of a strengths-based approach in service planning, inflexible service arrays that do not meet family needs, and regional variations on access to services.

Outpatient Services. The Texas children's mental health system offers individual evidence-based therapies within multiple systems. Financing structures also allow for group therapy and family therapy. The state has invested in the dissemination of evidence-based trauma-focused interventions across the mental health, child welfare, and juvenile justice systems. The system

provides parent training to support family caregivers, but there is not a current mechanism for providing consultation to other caregivers, such as classroom teachers or childcare staff.

Medication Services. Medication services are a component of the Texas children's mental health system. While shortages of child and adolescent psychiatrists has been a significant issue, Texas has increased its reliance on Advanced Practice Nurses, as well as developed the CPAN initiative to support consultation to primary care practitioners on psychiatric medication management. Texas is also striving to increase the child and adolescent psychiatry workforce through an initiative to place psychiatry faculty, residents, and fellows within community-based mental health settings through the Texas Child Mental Healthcare Consortium. Texas has also developed the Psychotropic Medication Utilization Parameters to support best practice in medication services for children and youth.

Community Support / Rehabilitation. The Texas children's mental health system provides access to case management, behavioral management, skill building supports for children and youth, and parent behavioral management training to children qualifying for these services. Communities In Schools provides case management and skill building to students in partnering schools, and parent/caregiver services are offered to families of children with child welfare of juvenile justice involvement. Parent/caregiver support and skill building are also components of some prevention programs offered in the state. Texas does not currently offer supported employment or supported housing to youth under 18, and services are limited to young adults. Texas does not offer therapeutic mentoring in the array of services or access to traditional/culturally-based healing services.

Other Supports / Habilitative. Access to other supports varies across the region, but is generally limited to specialized programs. Respite services, recreational services, and supported education services are limited to programs such as the YES Waiver and the First Episode Psychosis programs, serving only a small proportion of children. Flexible funds are identified as a component of the array for individuals enrolled in the public mental health system, but its use remains limited and access varies across the state. Transportation services are offered through Medicaid, but transportation needs continue to be a significant barrier to care in many regions.

Intensive Support Services. Texas offers intensive case management, specifically wraparound planning, through the public mental health system and the YES Waiver. Other intensive support services are not available in the public mental health system, including intensive home-based treatment approaches. A recent report indicates that four multi-systemic therapy teams operate in three regions of the state, primarily funded by juvenile justice, and meet an estimated three percent of state need (Meadows Mental Health Policy Institute, 2020). There are currently five programs in the state offering Functional Family Therapy, with three housed in juvenile probation departments and two housed in organizations with juvenile justice funding. Access to partial hospitalization or

intensive outpatient programs varies across the state, as well as coverage through health care insurance.

Out-of-Home Residential Services. Children's residential services are offered through the Waco Center for Youth and state-contracted residential programs, operating under contracts with DFPS, HHSC through the Residential Treatment Center project, or through state or local juvenile justice programs. Current licensing records for "Residential Treatment Centers" identified 100 programs with a current capacity for 3,376 beds (Department of Family and Protective Services, 2021). DFPS offers therapeutic foster care to youth in state custody with significant mental health or behavioral needs, although, as noted in a recent report (US Department of Health and Human Services, 2018), most state programs do not adhere to the research-based models, which can be costly to implement. Hill Country Mental Health and IDD and Heart of Texas Region MHMR operate crisis respite units for youth. Other components of the crisis continuum, as noted on the HHSC website, are available only to adults.

Acute Intensive Services. The state has crisis hotlines and mobile crisis services available 24/7 across the state. All mobile crisis teams are required to receive training on the specific needs of children and adolescents, but few teams are dedicated specifically to serving children and adolescents. The Center for Health Care Services (CHCS) was identified as having a dedicated Children's Mobile Crisis Outreach Team, as well as a Children's Crisis Unit. The state operates four psychiatric inpatient hospitals serving children and adolescents and one secure adolescent forensic unit. Most psychiatric hospital stays occur within local psychiatric hospitals.

Recovery Support. Texas requires the provision of parent peer support in contracts with LMHAs, but mental health peer support services (parent or youth) are not currently a funded component of the mental health service array. Family support, which may be provided by family peer providers, is available within the YES Waiver. The state has provided funding for youth peer recovery support (from substance use) in several regions of the state through Youth Recovery Communities.

Recommendations

Support state agency collaboration and coordination through the hiring and funding of cross-agency leadership positions. State agencies should explore using blended funding to hire leaders who serve as employees across several state agencies, for the purpose of enhancing coordination around key mental health issues. A recent example of this model is the hiring of the Interagency Deputy Director for Early Childhood Education, a position shared by DFPS, HHSC, TEA, and the Texas Workforce Commission. Shared positions could strengthen collaboration and reduce siloes among state agencies.

Provide mental health consultation to caregivers of young children showing early signs of mental health concerns. Child behavioral or emotional concerns sometimes begin in early childhood, resulting in disruptions in childcare and parental distress. While CPAN can provide consultation to primary care physicians encountering mental health concerns in young children, consultation to parents, child care providers, and teachers can help prevent the development of significant mental health disorders through early intervention and support. HHSC should consider a program that embeds early childhood mental health consultants within children's mental health or early childhood intervention (ECI) programs to provide both programmatic and individual, family-focused consultation to child care and early childhood education programs in their catchment area. Consultation would focus on promoting social and emotional health, supporting screening for social and emotional concerns, and providing early intervention through coaching of the child's caregivers.

Modernize the available evidence-based mental health services within the public mental health system. Texas has successfully implemented a variety of evidence-based practices to address common mental health concerns, but providers lack options when current practices are not effective or are a poor fit for the unique needs of a child or family. Texas should re-examine allowable practices for children and youth, with a priority towards expanding options for individuals or conditions where evidence was previously lacking during the design of the current system or where new innovations have arisen that meet unique needs. For example, research has shown the benefit of a modular approach to therapy, which can provide greater flexibility for addressing co-occurring conditions and reduce the burden of training for multiple models (Ng & Weisz, 2016). Additionally, the Level of Care designed for young children provides minimal guidance on best practices for two generational, dyadic interventions for young children. Practices intended to teach critical skills to youth and young adults are outdated and are not informed by young people. Consider providing opportunities for LMHAs, in collaboration with family stakeholders, to propose evidence-based or evidence-informed practices that could further expand the current array of services and/or meet a specific need within the community.

Standardize the provision of medication training and support with a focus on shared decision-making. Approximately two decades ago, Texas partnered with family advocacy organizations and individuals with lived experience to develop a comprehensive psychoeducation program to be used in the public children's mental health system (Lopez, 2005). The program emphasized empowerment of families and children to understand mental health symptoms, make informed decisions about available evidence-supported interventions, and monitor and communicate about symptoms and side effects. Components of the program were provided by family peer support providers. Since this time, the concept of shared decision-making has been further defined and researched, with studies showing that parents who report greater shared decision-making in mental health care were more likely to report that their child received all needed care (Butler, Weller, & Titus, 2015) and had higher levels of child- and parent-rated improvement (Edbrooke-Childs et al., 2015). Texas HHSC should consider designing a shared decision-making program in collaboration

with family members and youth with lived experience, intended to ensure individuals in care receive developmentally-appropriate information about mental health conditions; are active, informed partners in decision-making; and are taught skills for self-management of personal wellness goals. Educational materials and shared decision-making tools should utilize modern technologies.

Texas Health-Related Institutions (HRIs) should collaborate with primary care providers enrolled in the Child Psychiatry Access Network (CPAN) to implement routine screening for mental health conditions within primary care practices. One of the common concerns raised by pediatricians about regular mental health screening is the identification of mental health issues when referral options are not available to families. The CPAN initiative aims to enhance pediatricians' capacity to manage behavioral health concerns and support referral to specialist care when needed. This initiative provides an ideal opportunity to continue to expand upon screening and early identification of mental health concerns in children and adolescents in Texas. CPAN psychiatric specialists can provide training and academic detailing to enrolled pediatricians in evidence-based screening procedures and support increased adherence to Medicaid and CHIP screening requirements.

LMHAs should explore partnerships with HRIs and primary care providers within CPAN to support medication maintenance care for children and youth who have achieved remission of symptoms. The Texas Resiliency and Recovery model aimed to address the acute treatment needs of children, adolescents and young adults through levels of care tailored to an individual's needs. The model aimed to support individuals who have achieved symptom remission, but require a level of on-going medication management and care coordination, to transition from specialty care to a primary care provider, thereby increasing the capacity of specialty providers. However, many providers have noted that primary care providers are reluctant to take responsibility for the management of mental health concerns, beyond medication for attentional problems. The CPAN initiative now offers PCPs immediate telephone consultation with a child psychiatrist, as well as support from other behavioral health specialists. The LMHAs should intentionally establish partnerships with PCPs and CPAN teams within their region to plan and support efforts to strengthen transitions in care and increase capacity for serving children with complex needs. This may include agreements about care coordination during the transition phase and consultation or other options if symptom relapse occurs.

Utilize regional telehealth cooperatives to increase access to care in rural and workforce shortage areas. Workforce shortages have led to significant variability in access to some services for children and families. Explore a regional telehealth pilot that provides access to specialized services in areas with workforce shortages. Many regions have begun to create cooperatives to use limited resources efficiently. This infrastructure could be an efficient way to support access to providers able to offer services such as Parent Child Interaction Therapy (PCIT) or Dialectical Behavior Therapy (DBT), but outside of the catchment area. Providing a tablet to allow families to use telehealth platforms for

crisis intervention and stabilization may also reduce the need for out-of-home care by providing rapid responses in stressful circumstances.

Include efforts to address social determinants of health and build family resiliency as a key components of comprehensive mental health care for children and families. Studies have shown the long-term negative effects that adverse childhood experiences, poverty, racism, and other inequities can have on the mental health of children and youth. Taking a whole child approach, mental health care providers can intentionally screen for social risks and protective factors, adjust service provision to best meet families' needs (e.g., provide transportation passes), assist families in building social capital and connect families with assistance, and leverage community resources to meet family needs. This aligns with the approach recommended by the National Academy of Sciences (2019).

Provide services to prevent and mitigate the impact of emerging serious mental illness in adolescents and young adults. Based on numerous studies demonstrating the importance of intervening early (e.g., within the first two years of symptoms) in psychosis-related disorders, Texas has invested in First Episode Psychosis programs in most regions of the state. Given the enhanced vulnerability to mental health conditions during the adolescent and young adult period, as well as the opportunity inherent in continuing brain development and neuroplasticity of this developmental period, this window provides a key period for secondary and tertiary prevention of serious mental illness. Interventions for transition-age youth aim to alter the trajectory of these emerging mental illnesses by reducing the duration of untreated illness, preventing comorbid substance use, reducing disruption in family and social support, and preventing relapse or incomplete recovery (Fusar-Poli, McGorry, and Kane, 2017).

Texas should consider redesigning public mental health services to adolescents and young adults at risk of serious mental illness to provide multidisciplinary, integrated services and supports aimed at supporting young people's behavioral health, physical health, vocational, educational, and social needs. Initiated in Australia in 2006, the "Headspace" model incorporates a "one-stop" location for individualized and holistic mental health support to 12- to 25-year-olds (Rickwood, Telford, Mazzer, Parker, Tani, & McGorry, 2015). Early evaluation studies of this model have shown reductions in mental health symptoms, decreased substance use, and improvements in well-being and functioning (Hetrick, Bailey, Smith, Malla, Mathias, Singh, et al, 2017). Core elements of this model indicating best practice include (a) being highly accessible (affordable, convenient, inclusive, non-stigmatizing); (b) acceptable to youth (e.g., youth friendly, respectful, engaging, collaborative); (c) appropriate (developmentally appropriate, comprehensive, suitable to complexity and comorbidity, evidence-based); and sustainable (e.g., community-embedded, integrated across provider types, effectively managed) (Colizzi, Lasalvia, & Ruggeri, 2020). Several states have implemented programs utilizing this best practice approach.

Provide training and incentivize certification to gain competencies in the care of children and youth with co-occurring mental health and intellectual or developmental disabilities. Many stakeholders identified significant gaps in services for individuals with co-occurring mental health and intellectual or developmental disabilities, including children, youth, and young adults with autism spectrum disorder. While these gaps occur at all levels of the system, there is an underlying recognition that the mental health workforce is unprepared to provide adequate services to individuals with co-occurring disorders. HHSC should create a time-limited workgroup tasked with developing and overseeing a multi-faceted approach to enhancing the dual diagnosis competencies of the workforce. The following potential strategies should be considered within the workgroup. Training to providers should consider workshops and practical guidance in the use of the *Diagnostic Manual – Intellectual Disability: A Clinical Guide for Diagnosis of Mental Disorders in Persons with Intellectual Disability (DM-ID 2).* This is an adaptation of the *DSM V* that provides variations in the criteria for psychiatric diagnoses for persons with varying degrees of intellectual and/or developmental disabilities. Training could also include approaches to adapting evidence-based psychotherapy approaches to individuals based on the individual's expressive and receptive language skills. Additionally, training could include enhanced awareness about both the mental health and IDD service systems and strategies for enhancing collaborative care for individuals with dual diagnoses, including approaches to person-centered planning. The workgroup may also want to consider financial or other incentives to IDD/MI Dual Diagnosis Certification for direct support professionals, clinicians, and specialists, or accreditation of dual diagnosis programs, as outlined by the National Association for the Dually Diagnosed (NADD).

Continue to expand the availability of family and youth peer support services and examine opportunities for funding services. Workforce shortages continue to be a critical issue in the state, especially in rural communities, and several research studies have shown that task-shifting mental health tasks to peer providers to be an effective strategy for extending care. There is limited access to parent peer support within the state and minimal access to youth peer support. Texas should continue to grow this workforce and offer additional opportunities for interested provider organizations to utilize this workforce to provide needed services. Texas should consider the use of youth and family peer support providers within care navigation roles, supporting families in navigating different child-serving systems, and maintaining consistent support as families enter and exit specific programs. Additionally, Texas should consider the role of family and youth peers to support family resiliency following acute or intensive treatments and continue to grow access to natural support systems. Texas should also consider the role that family and youth peers can plan in innovative, engaging programming for families, such as social activities and opportunities for informal support. While many options exist to enhance funding for peer services, further clarifying the role of peers in the provision of medication training and support could be one avenue.

Texas should examine opportunities to provide intensive in-home interventions to children and youth. While the Texas continuum of services provides an array of evidence-based skills training and

individual psychotherapies, the continuum does not include intensive in-home interventions for children with significant behavioral or emotional disorders, other than a small number of programs available through juvenile services. Research has shown several intensive in-home interventions to be either as effective or more effective than residential care, with considerable cost-savings (Liddle et al., 2018; Dopp, Cohen, Smith, et al., 2018). While these programs can be expensive to implement with fidelity, Texas could consider a small pilot intended to divert children from the RTC project to intensive in-home intervention program, and examine the effectiveness and cost of both service modalities. Additionally, the availability of intensive in-home services would provide options for children at high risk of repeat hospitalization or involvement in the juvenile justice system.

HHSC could partner with provider organizations to explore different evidence-based or promising intensive in-home models and examine factors such as fit, desired outcomes, provider qualifications, cost, and feasibility. Possible programs to consider include multi-systemic therapy, Treatment Foster Care Oregon, functional family therapy, or intensive home-based behavioral health treatments. Quality standards for intensive in-home services have recently been proposed (Bruns, Benjamen, Shepler, et al., 2021).

Texas should consider funding specialized crisis services for children and youth that reduce the need for juvenile detention, psychiatric hospitalization and residential care. While detention, psychiatric hospitalization, and residential treatment have a role in the continuum of care, they generally have not been shown to have long-term, sustainable positive outcomes, while at times resulting in iatrogenic effects, such as experiences of trauma and familial abandonment. Rather than mapping adult crisis service designs onto the children's mental health system, HHSC should explore options that uniquely meet the needs of children and families. One model that HHSC should consider is in-home crisis stabilization, which provides short-term, whole-family crisis intervention and counseling services during a period of crisis. Examples of this model include Care and Connection for Families and The Priority Center. Additionally, HHSC should consider out-of-home crisis respite services, scaled to the size of the community or catchment area. For example, this could be a small, homelike program housing several young people and staff, or it could be brief placement with a home-based respite provider, such as an appropriate-trained foster parent placement. While some of these options are currently available within the YES Waiver program, they are not available to youth and families outside of eligibility for this program. Another possible service in the continuum that could reduce the use of costly out-of-home care is 1:1 crisis stabilizers who provide 1:1 care in the home, school, or community to monitor, stabilize, and support the youth's well-being and appropriate behavior consistent with their crisis plan. This is a model that is used within Wraparound Milwaukee to support youth within the community.

HHSC should conduct a redesign of the Waco Center for Youth to meet the most significant, specialized residential treatment needs within the state. The Waco Center for Youth is the only state-operated residential treatment facility for children with mental health needs and has been in

operation for over forty years. The Residential Treatment Center Project, funded by Texas general revenue, now provides state funding to support children and youth needing residential mental health treatment through a network of contracted treatment providers. This provides an additional residential treatment option for families needing this level of care. However, there are noted gaps within the network of non-profit or for-profit residential providers, and HHSC has limited capacity to incentivize these providers to meet identified child needs. The current landscape of state-funded residential mental health care suggests that Waco Center for Youth, as the only state-operated facility, could be repurposed in way that does not duplicate residential offerings within the RTC Project, but rather serves youth and families for which appropriate residential care is not accessible within the state. Examples of some potential specialized needs include pre-adolescents, youth with aggressive behaviors, youth with co-occurring IDD, and youth who identify as transgender.

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Appendix A

Definition

System of Care
A system of care is a comprehensive spectrum of effective services and supports for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a coordinated network of care, builds meaningful partnerships with families and youth, and is culturally and linguistically responsive in order to help them to thrive at home, in school, in the community, and throughout life. A system of care incorporates mental health promotion, prevention, early identification, and early intervention in addition to treatment to address the needs of all children, youth, and young adults.

Philosophy

Philosophy: Values and Principles	
Core Values	**Systems of Care are:**
1. Family and Youth Driven	Family and youth driven, with families and young people supported in determining the types of treatment and supports provided (with increasing youth/young adult self-determination based on age and development), and their involvement in decision-making roles in system-level policies, procedures, and priorities.
2. Community Based	Community based, with services and supports provided in home, school, primary care, and community settings to the greatest possible extent, and with responsibility for system management and accountability resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community or regional level.
3. Culturally and Linguistically Competent	Culturally and linguistically responsive, with agencies, services, and supports adapted to the cultural, racial, ethnic, and linguistic diversity of the young people and families they serve to provide care that meets individual needs, including those shaped by culture and language, and to ensure equity in access, quality, and effectiveness of services.
Guiding Principles	**Systems of Care are Designed to:**
1. Comprehensive Array of Services and Supports	Ensure availability and access to a broad, flexible array of effective, high-quality treatment, services, and supports for young people and their families that address their emotional, social, educational, physical health, and mental health needs, including natural and informal supports.
2. Individualized, Strengths-Based Services and Supports	Provide individualized services and supports tailored to the unique strengths, preferences, and needs of each young person and family that are guided by a strengths-based planning process and an individualized service plan developed in partnership with young people and their families.
3. Evidence-Based Practices and Practice-Based Evidence	Ensure that services and supports include evidence-informed, emerging evidence-supported, and promising practices to ensure the effectiveness of services and improve outcomes for young people and their families, as well as interventions supported by practice-based evidence provided by diverse communities, professionals, families, and young people.
4. Trauma-Informed	Provide services that are trauma-informed, including evidence-supported trauma-specific treatments, and implement system-wide policies and practices that address trauma.

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5. Least Restrictive Natural Environment	Deliver services and supports within the least restrictive, most natural environments that are appropriate to the needs of young people and their families, including homes, schools, primary care, outpatient, and other community settings.
6. Partnerships with Families and Youth	Ensure that family and youth leaders and family- and youth-run organizations are full partners at the system level in policy, governance, system design and implementation, evaluation, and quality assurance in their communities, states, tribes, territories, and nation.
7. Interagency Collaboration	Ensure that services are coordinated at the system level, with linkages among youth-serving systems and agencies across administrative and funding boundaries (e.g., education, child welfare, juvenile justice, substance use, primary care) and with mechanisms for collaboration, system-level management, and addressing cross-system barriers to coordinated care.
8. Care Coordination	Provide care coordination at the service delivery level that is tailored to the intensity of need of young people and their families to ensure that multiple services and supports are delivered in a coordinated and therapeutic manner and that they can move throughout the system of services and supports in accordance with their changing needs and preferences.
9. Health-Mental Health Integration	Incorporate mechanisms to integrate services provided by primary health care and mental health service providers to increase the ability of primary care practitioners and behavioral health providers to better respond to both mental health and physical health problems.
10. Developmentally Appropriate Services and Supports	Provide developmentally appropriate services and supports, including services that promote optimal social-emotional outcomes for young children and their families and services and supports for youth and young adults to facilitate their transition to adulthood and to adult service systems as needed.
11. Public Health Approach	Incorporate a public health approach including mental health promotion, prevention, early identification, and early intervention in addition to treatment in order to improve long-term outcomes, including mechanisms in schools and other settings to identify problems as early as possible and implement mental health promotion and prevention activities directed at all children, youth, and young adults and their families.
12. Mental Health Equity	Provide equitable services and supports that are accessible to young people and families irrespective of race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socioeconomic status, geography, language, immigration status, or other characteristics; eliminate disparities in access and quality of services; and ensure that services are sensitive and responsive to all individuals.

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13. Data Driven and Accountability	Incorporate mechanisms to ensure that systems and services are data-driven, with continuous accountability and quality improvement mechanisms to track, monitor, and manage the achievement of goals; fidelity to SOC values and principles; the utilization and quality of clinical services and supports; equity and disparities in service delivery; and outcomes and costs at the child and family and system levels.
14. Rights Protection and Advocacy	Protect the rights of young people and families through policies and procedures and promote effective advocacy efforts in concert with advocacy and peer-led organizations.

Infrastructure

Infrastructure Elements	
Point of accountability structures for SOC policy and for system management and oversight	Structure and/or process for outreach, information, and referral
Financing for SOC infrastructure, services, and supports	Extensive provider network for comprehensive service array
Structure and/or process to manage care and costs for high-need populations (e.g., care management entity, health home)	Structure and/or process for training, technical assistance, coaching, and workforce development
Structure and/or process for interagency partnerships/agreements	Structure and/or process for implementing and monitoring evidence-informed and promising interventions
Structure and/or process for integrating primary health and mental health care	Structure and/or process for achieving mental health equity and eliminating disparities in access, quality of services, and outcomes for diverse populations
Structure and/or process for partnerships with family organizations and/or family leaders	Structure and/or process for accountability and quality improvement, including measuring and monitoring service utilization, quality, outcomes, equity, and cost, including utilization of psychotropic medications
Structure and/or process for partnerships with youth organizations and/or youth leaders	Structure and/or process for strategic communications
Defined access/entry points to care	Structure and/or process for strategic planning and identifying and resolving barriers

Array of Services and Supports

Array of Services and Supports	
Home- and Community-Based Treatment and Support Services	**Residential Interventions**
Screening	Treatment Family Homes
Assessment and Diagnosis	Therapeutic Group Homes
Outpatient Therapy – Individual, Family, and Group	Residential Treatment Services
Medication Therapies	Inpatient Hospital Services
Tiered Care Coordination	Residential Crisis and Stabilization Services
Intensive Care Coordination (e.g., Using Wraparound)	Inpatient Medical Detoxification
Intensive In-Home Mental Health Treatment	Residential Substance Use Interventions (Including Residential Services for Parents with Children)
Crisis Response Services – Non-Mobile (24 Hours, 7 Days)	**Promotion, Prevention, and Early Intervention**
Mobile Crisis Response and Stabilization	Mental Health Promotion Interventions
Parent Peer Support	Prevention Interventions
Youth Peer Support	Screening for Mental Health and Substance Use Conditions
Trauma-Specific Treatments	Early Intervention
Intensive Outpatient and Day Treatment	School-Based Promotion, Prevention, and Early Intervention
School-Based Mental Health Services	**Specialized Services for Youth and Young Adults of Transition Age**
Respite Services (Including Crisis Respite)	Supported Education and Employment
Outpatient Substance Use Disorder Services	Supported Housing
Medication Assisted Substance Use Treatment	Youth and Young Adult Peer Support
Integrated Mental Health and Substance Use Treatment	Specialized Care Coordination (Including Focus on Life and Self-Determination Skills)
Therapeutic Behavioral Aide Services	Wellness Services (e.g., Exercise, Meditation, Social Interaction)
Behavior Management Skills Training	**Specialized Services for Young Children and Their Families**
Youth and Family Education	Early Childhood Screening, Assessment, and Diagnosis
Mental Health Consultation (e.g., to Primary Care, Education)	Family Navigation
Therapeutic Mentoring	Home Visiting
Telehealth (Video and Audio)	Parent-Child Therapies
Adjunctive and Wellness Therapies (e.g., Creative Arts Therapies, Meditation)	Parenting Groups
Social and Recreational Services (e.g., After School Programs, Camps, Drop-In Centers)	Infant and Early Childhood Mental Health Consultation
Flex Funds	Therapeutic Nursery
Transportation	Therapeutic Day Care

Child Mental Health Stakeholder Interview

1. Tell me a little about your role and how it relates to Texas' children's mental health system.
2. A complete public health system should strive to support positive mental health for all children and build protective factors, identify and intervene early when social or emotional concerns arise, and provide an array of services and supports to meet the needs of children with mental health conditions.
   a. How would you describe the adequacy of Texas' approach to mental health promotion and prevention?
   b. How would you describe the adequacy of Texas' approach to early intervention?
   c. How would you describe the adequacy of Texas' approach to mental health services and supports?
3. How do you understand children's access to services? Are there approaches that are currently working to improve access to services? Are there other things that Texas could do to improve access to services and supports?
4. Are there certain types of children who have inequitable access to mental health services and supports? What are the barriers that you think create these inequities?
5. How do you feel about the quality of the mental health services and supports that are available to children and youth in Texas?
   a. Are there particular services or supports that you feel are critical and should be protected or expanded upon?
   b. Are there particular services or supports that are lacking in Texas that should be considered for inclusion?
   c. Are there other approaches to improving the quality of services that should be considered?
6. Texas strives to serve children in the least restrictive setting, but some children with mental health needs are served in detention centers, psychiatric hospitals, and residential treatment programs. Are there ways that Texas could strengthen the mental health system to reduce the number of children cared for outside the home?
7. Are there some children for whom existing out-of-home care is inadequate or children for whom no appropriate services/supports are available in the state?
   a. What might Texas do to improve on this situation?
8. Texas has a high rate of uninsured children and relies on a variety of state and federal funding sources for creating the mental health system. Are there opportunities to improve the efficiency or adequacy of funding for mental health services?
9. Texas is a diverse state with a majority of young people identifying as persons of color, significant language diversity, and children whose families came to Texas through many different pathways. Are there opportunities to improve the service system to meet the diverse needs of families in Texas?