Lubbock Area Comprehensive Mental Health Needs Assessment

Final Report and Recommendations

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MEADOWS
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Acknowledgement

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Executive Summary

In this executive summary, we highlight key findings and recommendations from our comprehensive assessment of the Lubbock area (Lubbock) mental health system. The full report has three major sections. Part I (beginning on page 9) contains system-level findings and recommendations. Part II (beginning on page 29) contains specific findings and recommendations for individuals with mental illnesses who are involved in the criminal justice system and veterans with mental illnesses. Part III (beginning on page 34) contains findings and recommendations for children, youth, and families.

The guiding principle for this report is that our traditional approach of treating the mind and body separately must be replaced by care that is integrated at every turn, from the initial response to a crisis, to community care and inpatient care (pages 2–3). In Lubbock, as in communities throughout Texas, care is more often fragmented.

At the same time, Lubbock has important advantages that open up opportunities to transform its care for people with mental illnesses. Among these opportunities is the active engagement of leaders in all sectors (elected officials and representatives from the major health systems, the major specialty mental health provider, homeless providers, schools, law enforcement, the court system, and the university), who agree that mental health care must be improved (page 9). In addition, as illustrated by our analysis of the prevalence of mental health needs, the number of people in Lubbock most in need (for example, people experiencing first-episode psychosis or those requiring intensive services such as Assertive Community Treatment) is small enough to be manageable (pages 6–9). While the usual problems of funding, lack of integration, and competition between providers creates barriers, Lubbock is a community large enough to contain the necessary infrastructure to address the needs of people with mental health disorders but small enough to enable leadership from political and other sectors to create sustained change over time.

The most important findings from Part I of our report (pages 9–29) focus on the integration of services and the creation of service capacity to help eliminate the use of jails and emergency departments as the first response to mental illness. Integrated care is particularly needed in crisis services, which are provided by law enforcement, StarCare, and the county (through emergency medical transport); however, as a practical matter, law enforcement is typically the primary first responder to mental health crises in Lubbock (page 11–12).

There are strong collaborative relationships between major care providers in the community (for example, between Texas Tech University Health Sciences Center and Covenant Health System, and between StarCare and UMC Health System) that create a foundation for enhancing integrated care and provide the best opportunity for change. However, in many cases the

relationships are bilateral in nature, which in turn contributes to a fragmented service response (pages 10–11).

Stakeholders expressed a strong desire to expand the number of inpatient beds for psychiatric care in the Lubbock area. We found that of all inpatient admissions of Lubbock residents, 53% were admitted to local hospitals and that 47%, including 100% of children and youth, were admitted to non-Lubbock hospitals, often many miles from home (page 12–17). We also found that many individuals admitted with psychiatric diagnoses had complex medical conditions, while many people admitted with physical health diagnoses had secondary diagnoses of psychiatric and/or substance use disorders (pages 17–21). From these data, we concluded that Lubbock could benefit from expanded inpatient capacity for psychiatric illnesses, but that the necessary number of beds, while a local decision, depended on resolving what types of beds were needed (for children or adults, short-term or longer-term length of stay) and where the beds should be located (specialty hospital versus general hospital). We concluded that any new inpatient beds must be located in a setting where complex, comorbid conditions can be assessed and treated (pages 23–24) and that the overall number of new beds needed is likely far fewer than community stakeholders suggested (pages 28–29).

The most important recommendation from Part I of our report (page 26) is that a core group of leaders take on the task of directing change in the Lubbock area mental health system. While there are existing groups that could assume this task, in our view they do not adequately represent the interests of the two major health systems in Lubbock and otherwise are too focused on behavioral health care, which could reinforce the practice of treating health and mental health separately. We do recommend that these existing groups (one focused on criminal justice and the other on veteran's issues) should play a critical role in creating systemic change for those specialty areas.

We also suggest that the primary planning group focus on four core issues initially: (1) the integration of the crisis system, (2) the potential loss of funding represented by the Medicaid 1115 waiver program that will be ending in the near future, (3) targeted expansion of community care capacity to divert people from hospitalization (Assertive Community Treatment) and jail bookings (Forensic Assertive Community Treatment), and (4) expansion of inpatient capacity (pages 27–29).

Our recommendations for individuals with mental illnesses who are involved with the criminal justice system and veterans with mental illnesses (Part II, pages 29–34) are similar, focusing on better integration of care and an improved and integrated use of data. Lubbock area stakeholders identified that the Health Insurance Portability and Accountability Act (HIPAA) was a barrier to data sharing and integration, although neither HIPAA nor state law are barriers to information sharing for the purpose of continuity of care. Feedback from our interviews with

stakeholders revealed a consensus that sharing data across systems could improve care for people with chronic needs who frequently cycle between the criminal justice and crisis systems. There are additional issues to resolve, including the development of treatment capacity that would provide better transitional care for people discharged from jail.

Part III of the report (beginning on page 34) focuses on children and youth and their families. The framework for this section of the report includes five core components for preventing, identifying, and treating pediatric mental health conditions. These components (pages 38–41) include life in the community (component 0, focused on prevention), integrated behavioral health in pediatric primary care settings (component 1, focused on reliance on pediatric offices to identify and treat children as early as possible), specialty behavioral health care (component 2, for children with more intensive needs who require care from specialists in behavioral health), rehabilitation and intensive services (component 3, focused on the provision of evidence-based, home and community-based services for children and youth with the most severe needs) and crisis care/inpatient services (component 4, when urgent stabilization and inpatient care is required).

We also provide specific findings and recommendations for the populations of children and youth who are involved in the foster care (pages 41–49) and the juvenile justice systems (pages 49–53), and youth and young adults (pages 53–54). Stakeholders from both the foster care and the juvenile justice systems reported that they have seen increasing numbers of children with serious emotional disorders who have also suffered serious trauma, a reliance on the child welfare and juvenile justice systems in lieu of mental health care, and high rates of depression among the children and youth they serve. At the same time, collaboration between the various community agencies and Texas Tech University Health Science Center (TTUHSC) is a strength and can be built upon, particularly given TTUHSC's knowledge of evidence-based practice for children (page 51) and the recent approval for StarCare to develop a first episode psychosis program (page 54).

We found significant strengths in the community's response to children and youth's behavioral health needs more generally. For example, there are many organizations, including the Lubbock Area United Way and its community partners, and the three primary school systems serving the metro Lubbock area and their partners, that have made the provision of preventive services (component 0) a major priority (page 55–59). As with the foster care and juvenile justice systems, there are significant issues – including trauma, the removal of children from families, and related issues – that exacerbate emotional disorders within this population. At the same time, there are conceptual frameworks such as the Multi-tiered System of Supports (MTSS) that include universal mental health promotion strategies for all children (page 61–63) that if adopted could address many of these issues.

We found that although the Lubbock area currently has no integrated pediatric practices (component 1), there are tremendous opportunities to create an integrated approach and expand the practice of supporting pediatricians with specialty mental health resources such as those provided through TTUHSC. These opportunities are particularly worth seizing now, following the enactment of Senate Bill 11, which creates a statutory framework and funding for an integrated approach to children's mental health care (page 71–73).

There is also an excellent foundation for expanding specialty behavioral health care in Lubbock, as appropriate (component 2). The Center for Superheroes (pages 75) is one example of an evidence-driven approach to providing mental health and support services for children with intensive needs. While barriers exist (including stigma, financial sustainability, and transportation issues for families most in need who often live far away from service providers), important resources such as telehealth can be used to address at least some of these issues (pages 82–83).

Lubbock also has important strengths in providing rehabilitative and intensive services (component 3), including the Youth Empowerment Services (YES) waiver program operated by StarCare (page 85). This program provides strength-based services to children, youth, and their families and has been at capacity since its inception in 2015. In addition, plans to create integrated care clinics and expanded inpatient capacity for children and youth will help reduce hospitalizations and emergency department use while allowing children and youth who need inpatient care to receive it closer to home rather than miles away, which is the current practice.

Lubbock's crisis care continuum for children and youth (component 4) includes mobile outreach and other crisis supports provided by StarCare, but this program is threatened by the likely loss of 1115 Medicaid waiver funding (pages 90). This is part of a larger issue of threats to the financing and sustainability of programs funded by the 1115 waiver, as referenced in the general system findings and recommendations, which includes threats to StarCare's extended observation unit and to funding that allows StarCare to provide community-based care for a population that is not covered by other funding sources.

Although Lubbock faces significant challenges, it has core strengths that many communities simply do not have. Our recommendation to create a core group of leaders is not intended to create more bureaucracy, rather we believe this interested and active leadership is the primary strength that Lubbock has to build on across every system to fundamentally transform mental health care in Lubbock. Given this interest and the continued attention from key leaders, and the many other strengths identified in our report, there is little to stand in the way of Lubbock creating a model system of integrated care in Lubbock, over time.

Overview and Background

The Meadows Mental Health Policy Institute (MMHPI) conducted a comprehensive assessment of the Lubbock area's[1] mental health needs – and its local capacity to meet them – from December 2018 through July 2019. We were asked to provide a "comprehensive needs assessment that can serve as the basis for a regional, systemic approach to providing mental health and substance abuse services." In addition to the general review of current capacity, gaps in services, and opportunities for system integration and improvement, we focused, as requested, on the area's "need relative to children and families, veterans, and the criminal justice/mental health intersection."

This is the final report of our findings and recommendations. With the agreement of the Lubbock "Community Parties,"[2] we created an iterative process to provide the community with multiple opportunities to offer feedback on our findings and recommendations. As part of this process, we submitted an interim report on March 8, 2019 that addressed hospital capacity and bed use for people with psychiatric diagnoses, and presented an in person overview of that interim report to key stakeholders on April 10, 2019. We submitted a written summary of draft findings and recommendations on July 22, 2019 and met with representatives of the Community Parties on July 24, 2019, to present and discuss that summary, inviting and receiving feedback on our findings and recommendations. We incorporated that feedback into a draft report titled **Detailed Findings and Recommendations**, which we submitted on August 26, 2019, inviting multiple stakeholders to comment. After we received comments, we presented our findings and recommendations to a larger group of community stakeholders in Lubbock on October 2, 2019, and invited them to provide additional feedback. This final report incorporates feedback and suggestions we received throughout this process. In addition, all organizations referenced in individual findings were given the opportunity to review and provide edits to their write-ups in order to ensure accuracy.

In the course of our assessment, we interviewed nearly 200 leaders and other community members in key positions who had important perspectives to share about the functioning of the current mental health system, including stakeholders from law enforcement, health systems, mental health providers, the three Lubbock independent school districts, philanthropic organizations, multiple divisions within Texas Tech University (including the medical school), people with lived experience of mental illness, the court system, the juvenile justice system, the child welfare system, and county and city elected officials. We incorporated

[1] Lubbock refers to Lubbock County and, as noted for purposes of the quantitative analyses that specifically reference "Lubbock area," Cochran, Crosby, Hockley, Lubbock and Lynn counties.

[2] The "Community Parties" include Lubbock County, the City of Lubbock, StarCare Specialty Health System, University Medical Center, Covenant Health System, Texas Tech University Health Sciences Center, and the Community Foundation of West Texas.

information from prior assessments, including the September 2018 Report on the Sequential Intercept Mapping exercise conducted in 2018, the 2018 Community Needs Assessment, the 2018 Senate Health and Human Services Interim Report Summary, the Texas Tech University Health Sciences Center Proposal for an Integrated State Psychiatric Hospital Plan for North West Texas, the Covenant Health System Mental Health Gap Analysis, and multiple other documents. We visited many treatment and service sites, including but not limited to the jail; StarCare Specialty Health System (StarCare) – the local mental health authority – and Sunrise Canyon Hospital, its inpatient psychiatric facility; UMC Health System's emergency department; Covenant Health System; Open Door; and each school district. We also analyzed quantitative data relevant to prevalence of mental health conditions and service capacity, use, and need. We worked with the community to distill key findings and develop recommendations at the major system level as well as findings and recommendations specific to criminal justice, veterans, and children and youth, as specified in our scope of work. As noted above, all findings about individual agencies and organizations were shared with the respective organizations and revised based on their feedback prior to including them in any public draft reporting our work.

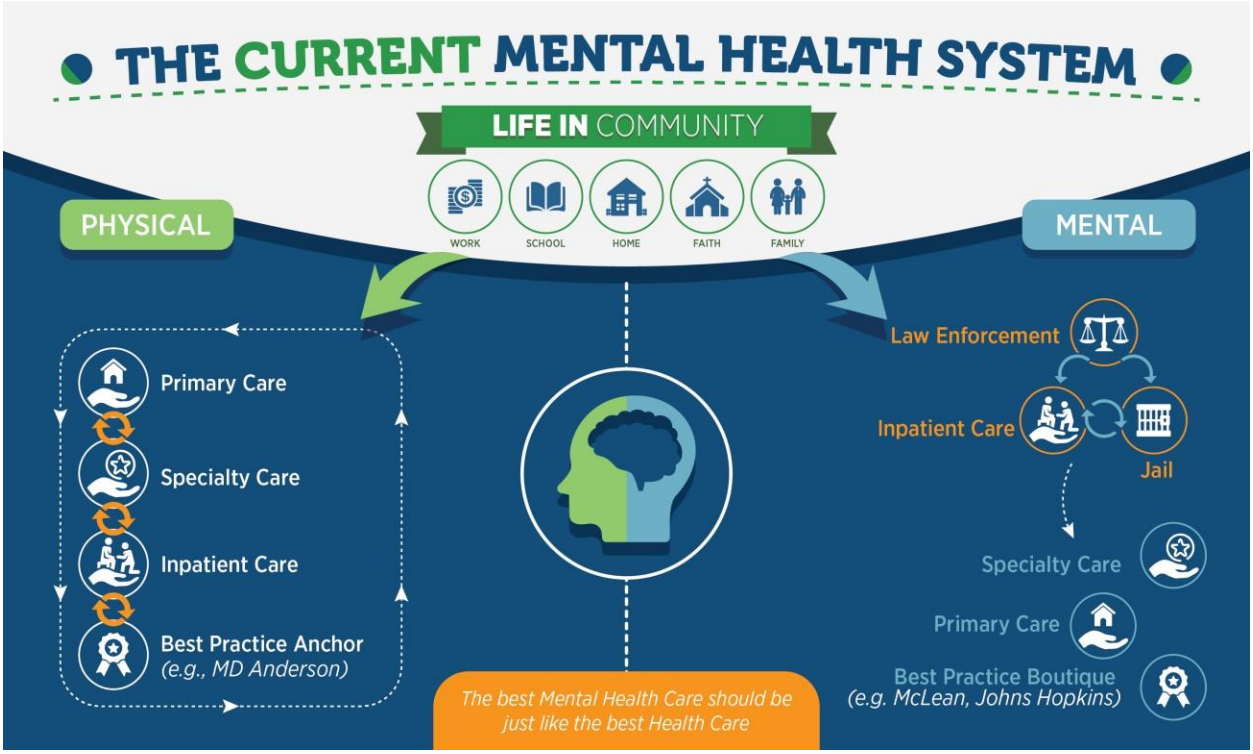
Framing Our Findings and Recommendations

Several principles guided our assessment:

- Identification and treatment of mental illness should occur at the earliest possible moment and should be provided, whenever possible, in the general health care system, from the initial response to a crisis through the use of specialty outpatient and inpatient care.
- Many people with diagnoses of mental illnesses have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses such as depression that can compromise care. Given this, emergency assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and treat both physical and mental health conditions.
- It is particularly important to identify and provide treatment for children, youth, and families at the earliest possible point because untreated mental illnesses and emotional disturbances can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.
- Although all communities believe they need more psychiatric inpatient beds, there is no formula for determining how many beds or what types of beds a community may need; ultimately, bed need is a function of how well the emergency response system coordinates and integrates its responses to crises, having the right mix of community services that sustain community tenure and buffer against hospitalization, and coordinating and sustaining care after hospitalization. In addition, as data presented in

the report illustrates, there is a considerable flow of patients from Lubbock to inpatient beds outside of Lubbock as well as a flow of patients into Lubbock beds from other communities. Determining whether to add new beds must address these patterns and the regional nature of facilities such as Covenant Health Systems and Sunrise Canyon.

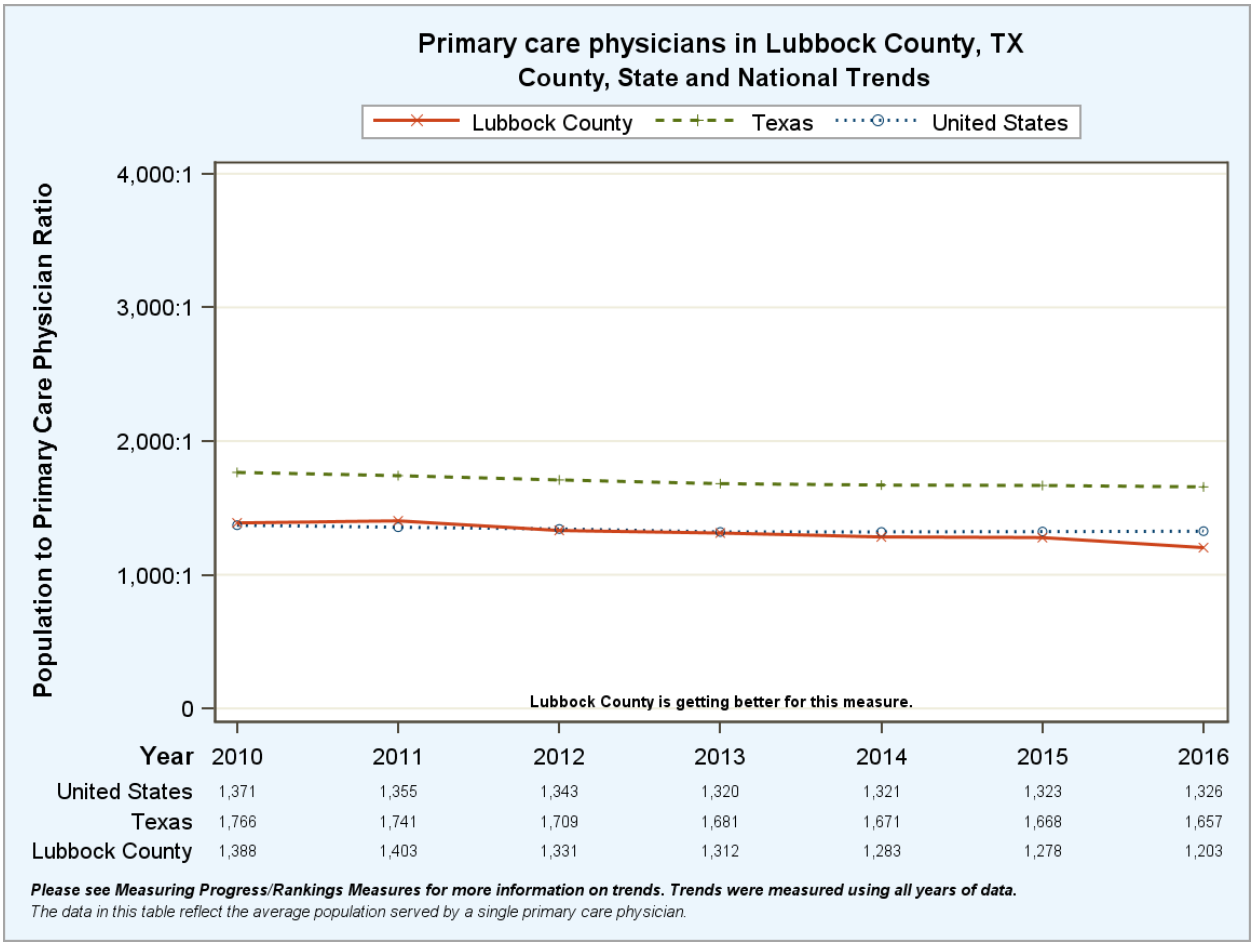
No community in Texas or the nation has a system that seamlessly incorporates all of these principles. Like most communities, mental health care in Lubbock is often delivered primarily by specialists at the point of crisis. In addition, and unlike the case with other diseases, law enforcement often provides the first response to a mental health crisis. Service capacity at the point of crisis is often limited, as is follow-up care for intensive needs, as we note in the report. Too often, the mental health system in Lubbock, as in much of Texas, looks like the system depicted on the right in the following figure, when it should look as much as possible like the system depicted on the left.



Contextual Issues Affecting Mental Health Care in Lubbock

Social determinants of health, including economic stability, education, health, access to health care, and the social and community context in which people live, have an impact on health, development, and morbidity. Poverty, coupled with adverse childhood experiences (ACEs), can have a lasting, negative effect on physical and emotional well-being. Fortunately, Lubbock has several core attributes that are related to positive social determinants of health. For example, according to the City of Lubbock Department of Community Development 2018 Community

Needs Assessment,[3] Lubbock has 8% more primary care physicians than the average in the 500 cities to which it was compared.[4] In fact, as the following table illustrates, Lubbock has approximately one primary care physician for every 1,200 residents, compared to a Texas average of one for every 1,660 residents.[5] As mental health care evolves toward more reliance on primary care settings for initial assessment and treatment, this represents a positive foundation for integrating general and mental health care.



Year	2010	2011	2012	2013	2014	2015	2016
United States	1,371	1,355	1,343	1,320	1,321	1,323	1,326
Texas	1,766	1,741	1,709	1,681	1,671	1,668	1,657
Lubbock County	1,388	1,403	1,331	1,312	1,283	1,278	1,203

Please see Measuring Progress/Rankings Measures for more information on trends. Trends were measured using all years of data.
The data in this table reflect the average population served by a single primary care physician.

The percentage of mothers who did not receive prenatal care is lower than the average for women in Texas who received no care (2% in Lubbock County did not receive care versus nearly

[3] City of Lubbock Department of Community Development. (2018, October). *2018 community needs assessment*. Retrieved from https://ci.lubbock.tx.us/storage/images/wQfnAGYtWk1KKYlliwxGlqEckpzXsjDKQPPZFFFY.pdf

[4] City of Lubbock Department of Community Development. (2018, October).

[5] County Health Rankings & Roadmaps. (2019). *Texas, Lubbock County, clinical care, primary care physicians*. Robert Wood Johnson Foundation and the University of Wisconsin Population Health Institute. Retrieved from https://www.countyhealthrankings.org/app/texas/2019/rankings/lubbock/county/outcomes/overall/snapshot

5% in Texas); receiving prenatal care is an important determinant of maternal and child health.[6] At the same time, the Lubbock community ranks lower than the state of Texas on several variables associated with mental illnesses and serious emotional disorders and their treatment:

- Lubbock County had 28.6 deaths per 100,000 people from diabetes compared to 20.3 for the state of Texas;[7] diabetes care can be compromised by untreated mental illness and there is a significant link between diabetes and depression as well, with depression occurring in 25% of people with diabetes.[8]
- Lubbock County ranked in the top 10 of Texas counties for cases of sexually transmitted diseases and in the top 20 for prevalence of HIV and AIDS cases.[9] People (often youth) suffering from these diseases have high rates of depression.[10]
- Lubbock County had a higher rate of alcohol-impaired driving deaths (35% of driving deaths) than Texas (28%) or the United States (11%).[11]
- Lubbock County has had difficulty attracting and retaining some types of caregivers. For example, Lubbock County has 21 psychiatrists, or 6.9 per 100,000 residents, approximately one half the national average. There is a shortage of psychiatrists in Texas in general,[12] though the Texas Tech University Health Sciences Center (TTUHSC) provides an important opportunity to attract psychiatrists and to extend the reach of available psychiatrists through its telehealth network. According to the Robert Wood Johnson Foundation, Lubbock has one mental health professional per 700 residents, compared to a Texas average of one per 960 (the national average is one per 310)[13] and, according to the Texas Department of State Health Services, Lubbock has 65

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[6] City of Lubbock Department of Community Development. (2018, October).

[7] City of Lubbock Department of Community Development. (2018, October).

[8] Williams, M. M., Clouse, R. E., & Lustman, P. (2006). Treating depression to prevent diabetes and its complications: Understanding depression as a medical risk factor. *Clinical Diabetes, 24*(2), 79–86.

[9] City of Lubbock Department of Community Development. (2018, October).

[10] Shrier, L. A., Harris, S. K., Sternberg, M., & Beardslee, W. (2001). Associations of depression, self-esteem, and substance use with sexual risk among adolescents. *Preventive Medicine, 33*(3), 179–189.

[11] City of Lubbock Department of Community Development. (2018, October).

[12] One analysis of Health Professional Shortage Areas suggests that Texas has enough psychiatrists to meet only 35% of need. See Henry J. Kaiser Family Foundation. (2018). *Mental health care professional shortage areas*. Available at https://www.kff.org/other/state-indicator/mental-health-care-health-professional-shortage-areas-hpsas/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. MMHPI's own analyses have described shortfalls in the number of mental health professionals available to Texans. See https://www.tribtalk.org/2015/05/13/behavioral-health-emergency/.

[13] County Health Rankings & Roadmaps. (2019). Mental health providers are defined as psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and mental health providers who treat alcohol and other drug abuse, as well as advanced practice nurses specializing in mental health care. The Robert Wood Johnson Foundation notes that these data come from the National Provider Identification data file, which has some limitations. For examples, while providers have the option of deactivating their identification number, some mental health professionals included in this list may no longer be practicing or accepting new patients. This may result in an overestimate of active mental health professionals in some communities. It is also true that mental health providers may be registered with an address in one county while practicing in another county.

psychologists, or 21 per 100,000 residents, compared to a statewide average of 15.8 per 100,000, ranking Lubbock 10th statewide.[14] Lubbock also ranks third among Texas counties in the per capita supply of registered nurses, with 1,429 registered nurses per 100,000 people compared to a Texas average of 828 per 100,000.[15] Texas Tech also provides an important resource for attracting nursing students and professionals to the Lubbock area.

Although there are several social determinants of health that may be associated with higher rates of mental illness and serious emotional disorders, Lubbock is very well positioned to significantly improve care and shift mental health care over time to an integrated model in which mental health care is provided as often as possible within a general health framework.

For example, Lubbock has several unique strengths in geography alone. Although the Lubbock Metropolitan Statistical Area (MSA) contains three counties (Lubbock, Crosby, and Lynn), Lubbock institutions such as its health care system and academic centers (e.g., Texas Tech University/Texas Tech University Health Sciences Center) reach a vastly wider area (e.g., TTUHSC's telehealth program reaches 102 counties). In addition, the two major health systems (UMC Health System and Covenant Health System) provide health care for people far beyond the immediate Lubbock area. Because of its geography, Lubbock has attracted many organizations that are self-sufficient and willing to provide services that would not be available otherwise; many people we interviewed talked about a shared history and tradition of self-reliance and helping one's neighbor that have distinguished Lubbock from its beginning. The multiple academic centers, two large health systems, and a local mental health authority provide the necessary infrastructure to create integrated care for people with mental illnesses and complex medical needs. In addition, multiple stakeholders are interested in mental health, including leadership from all key sectors and, importantly, political leaders. These factors create a tremendous opportunity for positive change.

Prevalence

Although the Lubbock mental health system has critical gaps, its problems are not overwhelming in scope. For example, the number of people requiring care is manageable, given Lubbock resources. The following tables present 12-month prevalence data of mental health disorders and related information for children, youth, and adults in Lubbock County. Several items in these tables are worth noting (and are highlighted in yellow). Note that Appendix D

[14] Texas Department of State Health Services (2019). *Licensed psychologists by county, 2018*. Retrieved from https://www.dshs.texas.gov/chs/hprc/tables/2018/LP18.aspx

[15] Texas Department of State Health Services (2019). *Registered nurses by county*. Retrieved from https://www.dshs.texas.gov/chs/hprc/tables/2018/RN18.aspx

contains a description of the methodology that underlies these prevalence estimates, as well as endnotes providing information about specific items in these tables.

First, we estimated that, in 2016, 4,000 children and youth suffered from serious emotional disturbances and that there were fewer than 10 cases of first episode psychosis among children and youth and 40 cases of first episode psychosis among adults. For reasons detailed below, we strongly recommend the establishment of a first episode psychosis program. Lubbock has sufficient resources to respond to the number of people developing a first episode psychosis, assuming accurate assessment and identification practices.

Second, all of these disorders – except in rare situations involving threats to public safety or self, or acute symptomatology that substantially impairs behavior – can be managed in community settings, *if adequate community services exist.* As the body of this report makes clear, there are gaps in community services in Lubbock, but those gaps can be filled.

Third, relatively few adults require the most intensive community services. We estimate 100 adults in the Lubbock area require Assertive Community Treatment (ACT) and 90 require Forensic Assertive Community Treatment (FACT). These are needs that can be met.

Finally, poverty is an important social determinant of health and, as noted in the report's section on children's services, service locations do not match particularly well with where children in poverty live.

Table 1. Twelve-Month Prevalence of Mental Health Disorders in Children and Youth in Lubbock County (2016)

Mental Health Condition – Children and Youth	Age Range	Prevalence[16]
Total Population	6–17	50,000
Population in Poverty[i]	6–17	25,000
All Behavioral Health Needs (Mild, Moderate, and Severe) [ii]	6–17	20,000
Mild	6–17	10,000
Moderate	6–17	4,000
Severe – Serious Emotional Disturbance (SED)[iii]	6–17	4,000
SED in Poverty	6–17	2,000
At Risk for Out-of-Home/Out-of-School Placement[iv]	6–17	200

[16] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Mental Health Condition – Children and Youth	Age Range	Prevalence[16]
Specific Disorders – Youth (Unless Otherwise Noted)[v]		
Depression	12–17	2,000
Bipolar Disorder	12–17	500
Post-Traumatic Stress Disorder	12–17	1,000
Substance Use Disorders[vi]	12–17	1,000
Schizophrenia[vii]	12–17	60
First Episode Psychosis (FEP) Incidence – New Cases per Year[viii]	12–17	9
Obsessive-Compulsive Disorder – Children/Youth[ix]	6–17	1,000
Eating Disorders[x]	12–17	200
Self-Injury/Harming Behaviors[xi]	12–17	2,000
Conduct Disorder	12–17	1,000
Number of Deaths by Suicide (2016)[xii]	0–17	<10
Specific Disorders – Children Only		
All Anxiety Disorders – Children	6–11	3,000
Depression/All Mood Disorders – Children	6–11	200

Table 2. Twelve-Month Prevalence: Mental Health Disorders for Adults in Lubbock County (2016)

Mental Health Condition – Adults	Prevalence[17]
Total Adult Population	230,000
Population in Poverty[xiii]	85,000
All Behavioral Health Needs (Mild, Moderate, and Severe)[xiv]	55,000
Mild	25,000
Moderate	20,000
Severe – Serious Mental Illness (SMI)[xv]	10,000
SMI in Poverty[xvi]	7,000
Complex Needs Without Forensic Need (ACT)[xvii]	100
Complex Needs With Forensic Need (FACT)	90
Specific Diagnoses[xviii]	

[17] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Mental Health Condition – Adults	Prevalence[17]
Major Depression[xix]	20,000
Bipolar I Disorder[xx]	1,000
Post-Traumatic Stress Disorder	8,000
Any Substance Use Disorder (SUD)[xxi]	20,000
Alcohol-Related SUD	15,000
Drug-Related SUD	5,000
Schizophrenia[xxii]	1,000
First Episode Psychoses (FEP) Incidence – New Cases per Year Ages 18–34[xxiii]	40
Number of Deaths by Suicide[xxiv]	48

Part I: System-Level Findings and Recommendations:

System-Level Findings

Identifying prevalence is only the first step in thinking about systemic transformation. The functioning of the current system is also important. And if there is one phrase that captures both the opportunities and challenges ahead for Lubbock, it is this response from a stakeholder to a question about what works and what does not work in the current Lubbock system: "We have cooperation, but we need coordination." This specific conversation addressed crisis care, in which (as described below) many organizations play individual roles that are not integrated. However, as our findings and recommendations illustrate, this response captures the current state and future opportunities for the broader mental health care system in Lubbock.

Findings regarding the general system are presented immediately below.

Lubbock leaders from every sector are committed to fundamentally improving mental health care and, for at least two years, have engaged in ongoing discussions about strategies to make these improvements. Elected officials, public health officials, philanthropic organizations, the heads of major health and mental health systems, law enforcement leadership, academic leaders, social service providers, school officials, and countless others expressed a deep-seated desire to improve care for people with mental illnesses. In addition, many leaders are either newly elected or have been in their positions a comparatively short time. This has had the effect of energizing the community at large to focus on improving the response to mental illness in Lubbock. These leaders have made the issue a priority in their own discussions and actions, as evidenced by the decision to fund this assessment. This cooperation among leaders is the most critical asset Lubbock has going forward. The test will be to find ways to maintain this cooperation. This challenge informs our recommendation (discussed in detail below) to

create a formal governance structure to guide future planning for transforming mental health care in Lubbock.

Lubbock has significant health, social service, academic, and political infrastructures that can be strategically coordinated to improve mental health care within a general health care framework. Admittedly, there are gaps in resources and concerns regarding sustained financing of care for people with serious mental illnesses. StarCare is bound by state eligibility and funding rules, and there is uncertainty regarding the future of 1115 Medicaid waiver funding. In addition, particularly in the children's area, more attention could be paid to pursuing reimbursement for certain services that are reimbursable and which are now being provided gratis. In addition, commercial insurance plans often provide limited coverage for mental health care. However, the presence of two major health systems (UMC Health System and Covenant Health System), a leading specialty mental health care provider (StarCare, the local mental health authority), and the Texas Tech University and its resources (as well as other academic institutions); the commitment and data-driven strategies of leading homeless services providers (such as Open Door) to end homelessness; and high-level elected officials' interest in providing needed investments to make significant change all provide ample opportunity for the systematic improvement of care. In addition, representatives from the criminal justice system – including judges, the Lubbock Private Defenders Office, and the Lubbock County District Attorney – have a deep commitment to improving care for people in the criminal justice system, as do law enforcement officials in the Lubbock Police Department and the Lubbock County Sheriff's Office. Many smaller counties lack these resources; in larger counties it can be difficult to use such resources to affect systemic change because of the challenges in retaining the long-term focus of system leaders. In this respect, Lubbock is almost uniquely situated to provide integrated leadership in transforming its mental health system over time.

There are strong collaborative relationships between major care providers that create a foundation for further integration and implementation of systemic initiatives. For example, StarCare and the sheriff's office have developed an excellent working relationship in which StarCare provides assessment and treatment services in the jail. And StarCare, through Sunrise Canyon, is the preferred provider of inpatient psychiatric care for patients admitted to the UMC Health System (UMC) emergency room. The Texas Tech University Health Science Center (TTUHSC) Department of Psychiatry staffs and trains its residents at Covenant Health System (Covenant Health), and TTUHSC provides excellent consultative and treatment services for school-age children. The agreement between TTUHSC and the health systems to expand both inpatient and clinic care for children is an exciting development, and among other benefits should reduce the number of children transferred from Lubbock to inpatient care in other areas of the state (discussed in more detail below). These are just examples of the collaboration that already exists in Lubbock.

However, while there are strong existing partnerships, they are often bilateral rather than multi-party; relatedly, there are multiple initiatives that could benefit from integration but are at least somewhat isolated because they are single-entity initiatives. For example, although UMC and StarCare coordinate emergency care provision, and the TTUHSC Department of Psychiatry and Covenant Health partner well, there is a lack of integration among multiple initiatives and, as a result, no system-wide coordinated effort to address gaps in the crisis care system. As another example, the Lubbock Police Department operates a highly regarded Homeless Outreach Team and Crisis Intervention Team, and StarCare operates a Mobile Outreach Team, but our assessment did not find any formal coordination between those efforts. Open Door operates an onsite clinic to address health needs of people receiving federal housing support, but the clinic is unaffiliated with either Lubbock health system. As a result, efforts to address gaps do not benefit from the full array of available services and so paradoxically services may be both lacking and duplicative. Many of these issues can be addressed to avoid duplication of services, whereas a failure to do so will likely result in continued fragmentation of care as well as lost opportunities to bring existing resources to bear on improving care.

In response to the presentation of these findings in an earlier presentation, two stakeholders indicated that a major reason for the unilateral or bilateral nature of many of these relationships is the manner in which services are funded (crisis services was used as an example) and the competitive relationships that exist among health systems and service providers. These stakeholders suggested that these factors illustrate the need for incremental change over time rather than efforts to dramatically change provider relationships, which we support (and note below).

Crisis is still the primary point of detection for people with serious mental and behavioral health disorders. There is inadequate primary care capacity to detect needs early and inadequate broader outpatient capacity to buffer against hospitalization, jail, and emergency department utilization as the first choices for care and sustaining people in community settings after discharge. There are also inadequate step-down services. These shortfalls have an impact on community discussions and beliefs regarding the number of inpatient psychiatric beds that Lubbock requires. There are certain services (Assertive Community Treatment and Forensic Assertive Community Treatment) that have demonstrated value in reducing reliance on hospitals (ACT) and jails (FACT). StarCare operates an ACT program, but its capacity has been limited by adherence to state rules that permit but do not encourage flexibility in admission to ACT services. We estimate that approximately 100 people in Lubbock would benefit from ACT at any one time, but no more than 50 are served. There is no FACT program, though we estimate that approximately 90 people would benefit from that intervention. Furthermore, there are no intensive outpatient treatment or partial hospitalization programs available to people with commercial insurance. Given the limited array of intensive preventative services or

step-down care, coordination of and access to services after discharge from hospital care or from the jail is lacking, and routine outpatient care is not adequate to meet these more intensive needs. In addition, there is no first episode psychosis (FEP) program to identify and treat people experiencing a psychotic disorder at the earliest possible point – an important gap, especially in a community with a large college-age population.

The response of any one party to a crisis needs to be viewed within the larger frame of multiple crisis providers, whose efforts are currently not integrated. As noted, there are significant issues in the crisis response system in Lubbock, primarily because there are multiple parallel initiatives in place to respond to crises, rather than a coordinated system of responses. StarCare benefits significantly from executive leadership that is actively engaged in continuing to improve StarCare's performance. StarCare is one of the leading specialty mental health providers in Texas and has a reputation for leadership and innovation in complex matters such as outpatient competency restoration. At the same time, stakeholders we interviewed often focused on gaps in care delivery, particularly in recounting times when crisis care services were not available, delayed, or otherwise limited because people in need of care had medical and other comorbidities such as substance use disorders. In our view, these concerns seem to stem less from StarCare's functioning as a provider than from a lack of a coordinated, system-wide view of crisis response. StarCare is a single provider with a discrete array of crisis responses, but a single agency's mobile crisis team cannot cover all instances of crisis, and a free-standing mental health facility cannot be equipped to address the entire range of medical comorbidities (including medically-involved substance use disorders). Although stakeholders identified competitive pressures and funding streams as issues that push toward bilateral or unilateral initiatives rather than community-wide integration, we do believe that there are opportunities to integrate specific elements of the crisis system, which we discuss in more detail below.

An analysis of psychiatric inpatient hospitalizations suggests that there are too few inpatient beds to care for Lubbock residents close to home. Individuals from Lubbock are often transferred from Lubbock to inpatient care elsewhere, whether they are admitted through a Lubbock emergency department or not.[18] We repeatedly heard that Lubbock "needs more beds" and estimates we heard of the number of beds needed ranged as high as 80–100. Given this constant theme, we discuss this issue in greater detail than other issues. This does not reflect a preference for or emphasis on inpatient bed capacity as the most important issue for the Lubbock area. Rather, because of the importance of this issue to stakeholders, we provide granular detail that should be useful in determining the quantity, type, and location of any new beds that are in development or might be developed in the future.

[18] Hospital utilization data were obtained from the Texas Health Care Information Collection. Hospital capacity data were obtained from the American Hospital Association Annual Survey of Hospitals. Please see appendix D for a methodological summary of these sources.

Although hospitalization for mental illnesses should be a last resort, as it is for other health conditions, Lubbock data appear to support the notion that additional beds are needed.[19] As Table 3 illustrates, from April 2017 to March 2018, there were 1,799 inpatient psychiatric admissions for Lubbock County residents. Of these, 946 (53%) were admitted to local hospitals (Covenant Health and Sunrise Canyon) while 853 (47%) were admitted to hospitals outside the Lubbock County area. All 326 admissions for people age 0 to 17 years who were admitted to inpatient care (or 18% of all Lubbock County resident admissions) were hospitalized outside of the Lubbock County area. Because of the presence of TTU and other academic institutions, we also looked at admission patterns among people ages 18 to 24 years. Of the 258 admissions in this age group, 166 (or 64%) were admitted to either Covenant Health or Sunrise Canyon, whereas the remaining 92 were admitted to non-Lubbock County hospitals, including four to state hospitals. Table 3 shows the number of admissions, by age, to Lubbock County and non-Lubbock County hospitals. The table also displays the number and percentage of Lubbock County residents admitted to Lubbock and non-Lubbock hospitals, while Table 3a shows admissions of non-Lubbock residents *to* Lubbock hospitals. Table 3 includes the percentage for each age group based on the total admissions in each row. For example, of 1,799 total admissions, 18% were aged 0-17, while 82% were age 18 and older; 14% of the 1,799 were age 18 to 24 years. Map 1 then provides a graphic representation of the locations of inpatient care admissions for Lubbock residents. Much more detail about the counties and hospitals to which Lubbock area residents are admitted can be found in Table 15 in Appendix E.

Table 3. Psychiatric Inpatient Admissions of Lubbock Area Residents, by Age Group April 2017-March 2018

Hospital	Total Admissions	Admissions by Age Group			Age Group – Percentage of Row Totals		
		Age 0 to 17	Age 18 to 24	Age 18 and Older	Age 0 to 17	Age 18 and Older	Age 18 to 24
All Admissions to Psychiatric Beds	**1,799**	**326**	**258**	**1,473**	**18%**	**82%**	**14%**
Admissions to Local Hospitals	**946**	**N/A**	**166**	**946**	**0%**	**100%**	**18%**
Admissions to Covenant Health	565	N/A	109	565	0%	100%	19%
Admissions to Sunrise Canyon	381	N/A	57	381	0%	100%	15%

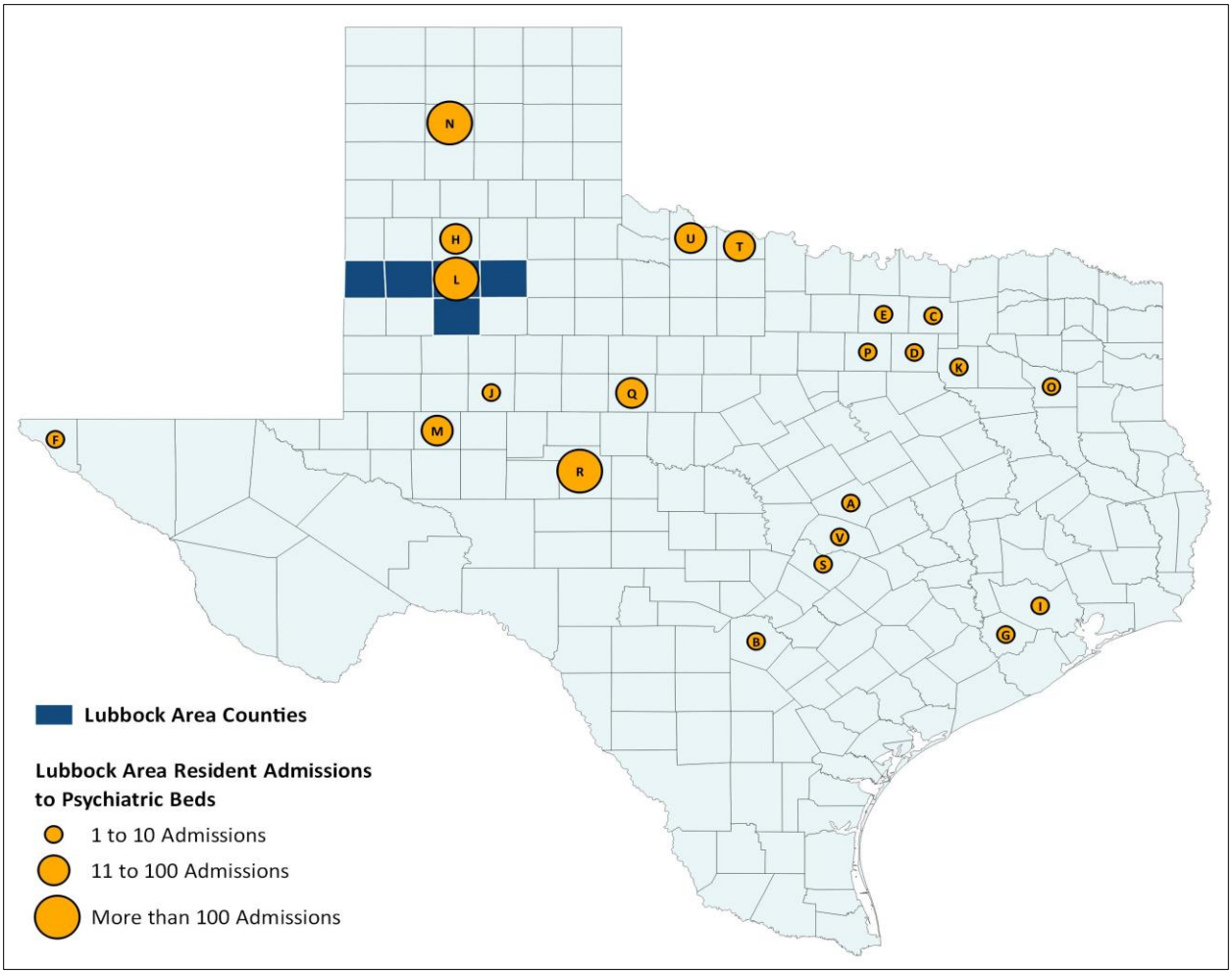
[19] Hospital utilization data were obtained from the Texas Health Care Information Collection. Hospital capacity data were obtained from the American Hospital Association Annual Survey of Hospitals. Please see appendix D for a methodological summary of these sources.

Hospital	Total Admissions	Admissions by Age Group			Age Group – Percentage of Row Totals		
		Age 0 to 17	Age 18 to 24	Age 18 and Older	Age 0 to 17	Age 18 and Older	Age 18 to 24
Admissions to Non-Local Hospitals	**853**	**326**	**92**	**527**	**38%**	**62%**	**11%**
Admissions to State Hospitals	34	14	4	20	41%	59%	12%

Table 3a. Admissions to Lubbock Psychiatric Beds by Local Versus Non-Local Counties

Hospital	Admissions to Lubbock Psychiatric Beds		
	Residents of Lubbock Area Counties	Residents of Non-Local Counties	Total Admissions
Sunrise Canyon	381 (93%)	29 (7%)	410
Covenant Health	565 (78%)	163 (22%)	728
Total	**946 (83%)**	**192 (17%)**	**1,138**

Map 1: Lubbock Area Resident Admissions to Psychiatric Beds Statewide (April 2017 to March 2018)

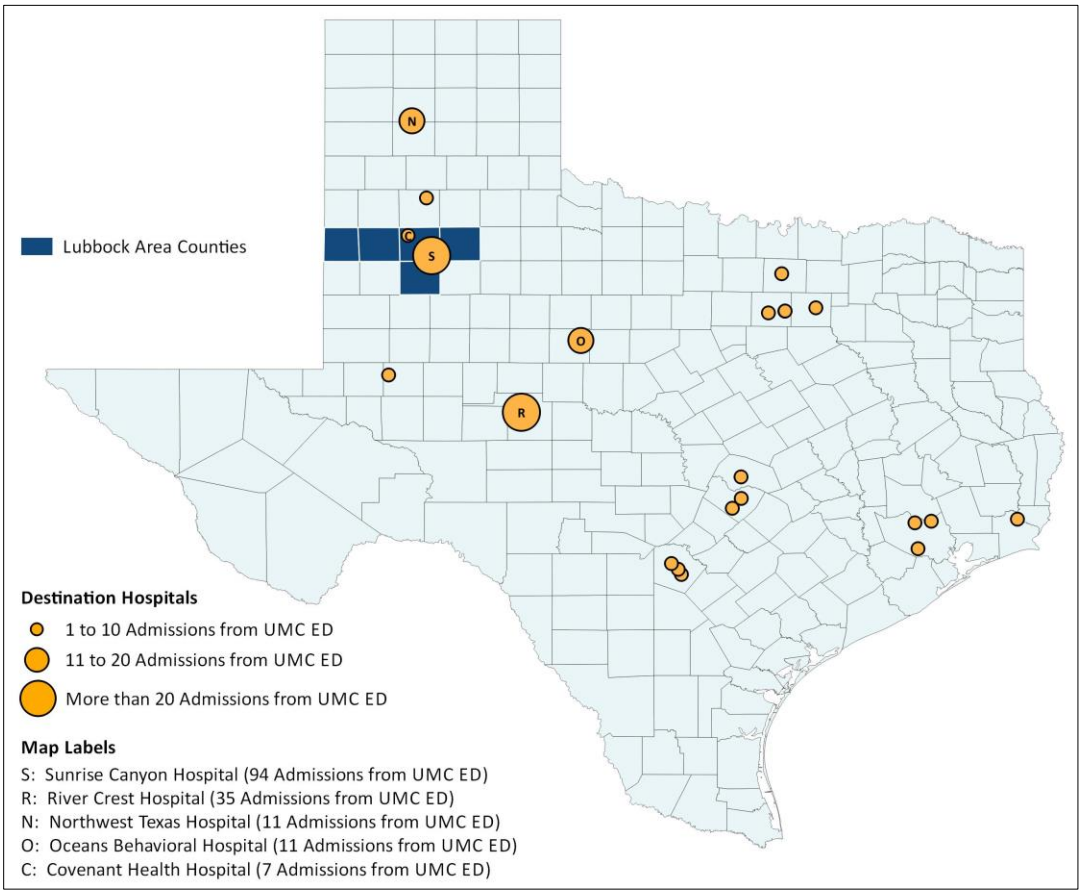


Of the 851 patients admitted to inpatient psychiatric care from Lubbock County area emergency departments (primarily Covenant Health and UMC), 204 (or 24%) were admitted to non-Lubbock County hospitals. Table 4 shows this breakdown while the maps that follow display graphic representations of the patterns of admissions from Lubbock emergency departments. For more data related to Map 2, Admissions to Psychiatric Beds from UMC Emergency Department, please see Table 16, Table 17, and Graph 1 in Appendix E. Additional data for Map 3, Admissions to Psychiatric Beds from Covenant Health Emergency Department, can also be found in Table 18, Table 19, and Graph 2 in Appendix E.

Table 4: Admissions from Local Emergency Departments (EDs) to Local Versus Non-Local Psychiatric Beds April 2017-March 2018

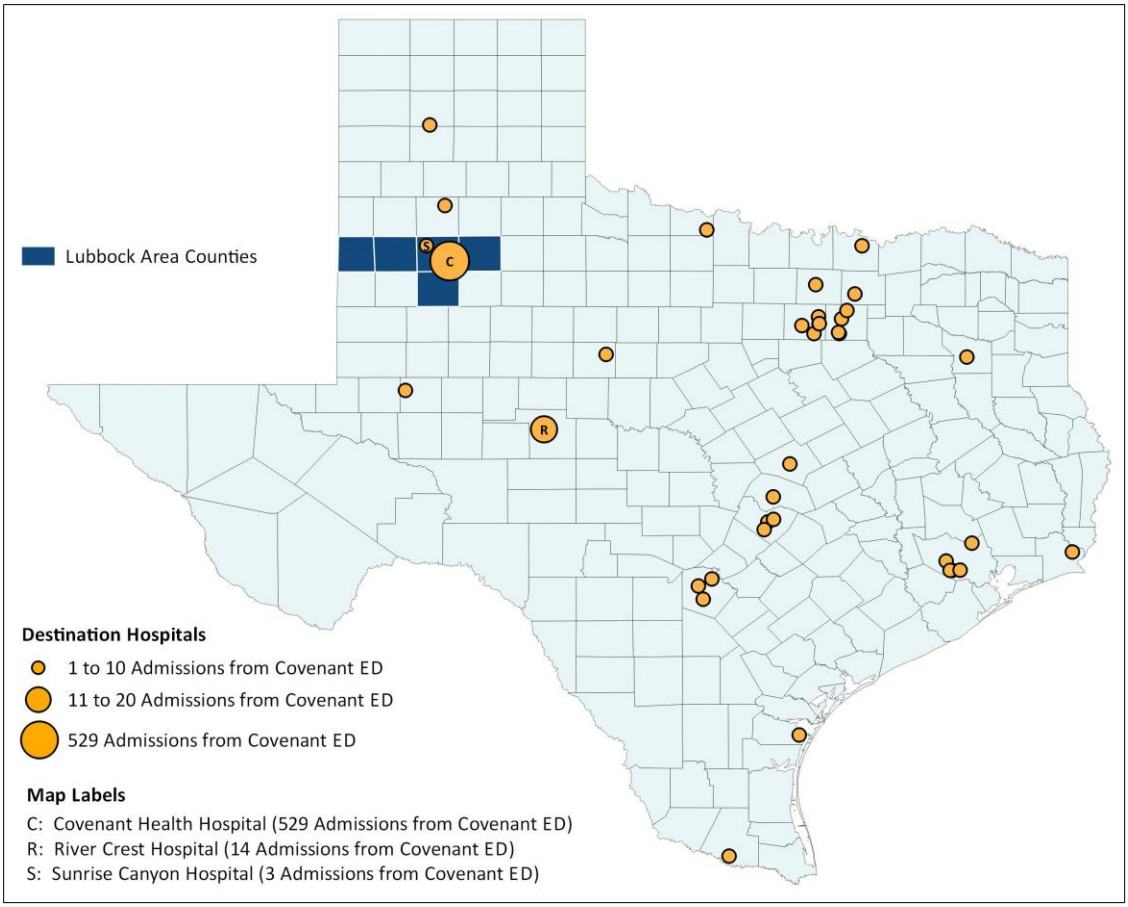
Emergency Department	Lubbock Area		Non-Lubbock Area	
	Patients Transferred to a Psychiatric Bed	% Via Law Enforcement Transport[20]	Patients Transferred to a Psychiatric Bed	% Via Law Enforcement Transport
Covenant Health	533	1%	97	3%
UMC Health	103	23%	86	9%
Other Lubbock Region EDs	11	9%	21	14%
Total Lubbock Region EDs	**647**	**4%**	**204**	**7%**

Map 2: Admissions to Psychiatric Beds from UMC Emergency Department



[20] Hospital records indicate the source of admission of people visiting the emergency department. This includes physician referrals; clinic referrals; HMO referrals; transfer from another hospital, facility, or emergency room; and court/law enforcement admissions. This column reports the number of individuals who arrived at the emergency department through a court or law enforcement admission.

Map 3: Admissions to Psychiatric Beds from Covenant Health Emergency Departments



Although we believe Lubbock needs additional inpatient capacity, there are alternative models to consider when creating additional beds and determining precisely how many beds are required, what types of beds are needed, and where these beds should be located. These decisions, which must be made locally, are also dependent on a variety of factors, including integration of existing crisis services and other initiatives, bringing ACT to scale, sustaining the StarCare extended observation unit and determining whether the site of additional beds can treat complex physical health needs, including substance use disorders (SUD). Many people with psychiatric illnesses that require hospitalization have complex physical health needs as well. Input from stakeholder interviews suggested that one driver of hospitalization outside of the region is a lack of facilities capable of assessing and treating both psychiatric disorders and other comorbid physical health needs and co-occurring SUD.[21] The next three tables illustrate

[21] In July, Lubbock lost an important substance use disorder provider when Managed Care Center for Addictive/Other Disorders closed. See Nexstar Broadcasting, Inc. (2019, July 16). *Addiction recovery center closes, leaving many without affordable care*. EverythingLubbock.com. Available at https://www.everythinglubbock.com/news/local-news/addiction-recovery-center-closes-leaving-many-without-affordable-care/

the estimated prevalence of SUD in the Lubbock County population, the number of people who were hospitalized with an SUD diagnosis either as a secondary diagnosis (with a primary psychiatric diagnosis) or as a primary diagnosis, and emergency department visits with a primary psychiatric diagnosis and secondary SUD diagnosis, or a primary SUD diagnosis and secondary psychiatric diagnosis. Because SUD disproportionately affects people living in poverty, we provided population and prevalence estimates for this population in Table 5. As Table 6 shows, 529 (or 32%) of 1,663 inpatient admissions with a primary psychiatric diagnosis had a secondary diagnosis of an SUD; 71 (or 73%) of 91 admissions with a primary SUD had a secondary psychiatric diagnosis. The extent of co-occurring disorders varies by hospital; the majority of Covenant Health psychiatric or SUD admissions included co-occurring diagnoses in secondary diagnosis fields, but only a small percentage of Sunrise Canyon admissions displayed this pattern. If the discharge records submitted by these hospitals are correct, this illustrates the critical importance of locating beds in facilities capable of treating co-occurring issues, and that all hospitals in the region are not equally prepared to treat both psychiatric and SUD conditions co-occurring in the same patient.

Table 7 illustrates the extent of co-occurring disorders in the region's emergency departments. For both emergency departments, approximately 21% of visits with a psychiatric primary diagnosis include an SUD secondary diagnosis. For emergency department visits involving a primary SUD diagnosis, approximately 44% include a psychiatric secondary diagnosis. This emergency department data provides further support for the prevalence of co-occurring disorders in patients needing crisis services.

Table 5. Substance Use Disorder (SUD) Prevalence in Lubbock County (2016)[22]

Population	Adults (Age 18+)	Youth (Age 12–17)
Total Population	**230,000**	**25,000**
Total Population in Poverty	85,000	10,000
Any Substance Use Disorder	**20,000**	**1,000**
In Poverty With SUD[xxv]	8,000	600
Comorbid Psychiatric and SUD[xxvi,xxvii]	2,000	300
Alcohol-Related SUD	**15,000**	**800**
Needing but Not Receiving Treatment for Alcohol Use	15,000	800
Illicit Drug-Related SUD	**5,000**	**900**

[22] All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

Population	Adults (Age 18+)	Youth (Age 12–17)
Needing but Not Receiving Treatment for Illicit Drug Use	5,000	900
Number of Drug Overdose Deaths in 2016[xxviii]	**37**	**N/A**
Number of Alcohol-Induced Deaths in 2016[xxix]	**61**	**N/A**

Table 6. Inpatient Psychiatric Admissions of Lubbock Area Residents with Co-Occurring Psychiatric and Substance Use Disorders April 2017 – March 2018

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
All Admissions to Local Beds	**859**	**292** (34%)	**79**	**54** (68%)
Admissions to Sunrise Canyon	357	2 (< 1%)	24	2 (8%)
Admissions to Covenant Health	502	290 (58%)	55	52 (95%)
Admissions to Non-Local Beds	**804**	**237 (29%)**	**18**	**17 (94%)**
All Admissions (to Local and Non-Local Beds)	**1,663**	**529 (32%)**	**97**	**71 (73%)**

Table 7. Emergency Department (ED) Visits of Lubbock Area Residents with Co-Occurring Psychiatric and Substance Use Disorders April 2017 – March 2018

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	ED Visits	Visits with Secondary SUD Diagnoses	ED Visits	Admissions with Secondary Psychiatric Diagnoses
All Admissions to Local EDs	**3,319**	**693 (21%)**	**1,284**	**569 (44%)**
Admissions to UMC	1,552	306 (20%)	673	179 (27%)
Admissions to Covenant Health	1,767	387 (22%)	611	390 (64%)

In addition, many people who are hospitalized for physical health reasons have comorbid psychiatric and substance use conditions. As the following table illustrates, people with behavioral health conditions are hospitalized with medical conditions often associated with poor access to care for both acute (sepsis) and chronic (chronic obstructive pulmonary disease) conditions. The purpose of this table is to identify the most common co-morbid physical conditions for people with mental health and substance use disorder diagnoses, both separately and co-occurring. There are too many different physical health conditions to list, so we limited our reporting to the top ten physical health conditions with a comorbid psychiatric or SUD diagnosis. As an example, of the 33,555 inpatient non-behavioral health hospitalizations of Lubbock area residents, 4,279 (13%) included a psychiatric co-occurring diagnosis. The most common medical diagnosis with a co-occurring psychiatric secondary diagnosis is sepsis, with 256 admissions, which is 11% of all sepsis admissions.

Table 8. Medical Inpatient Hospitalizations of Lubbock Area Residents with SUD or Co-Occurring Psychiatric and Substance Use Disorders April 2017 – March 2018

Rank	Primary Physical Health Diagnoses with the Most Psychiatric Secondary Diagnoses		Primary Physical Health Diagnoses with the Most SUD Secondary Diagnoses		Primary Physical Health Diagnoses with the Most Co-Occurring Psychiatric and SUD Secondary Diagnoses	
	Top Physical Health Diagnoses	Psych-Only Co-Occurring Admissions	Top Physical Health Diagnoses	SUD-Only Co-Occurring Admissions	Top Physical Health Diagnoses	Psych and SUD Co-Occurring Admissions
Total	33,555	4,279 (13%)	33,555	905 (3%)	33,555	414 (1%)
1	Sepsis (2,430)	256 (11%)	Sepsis (2,430)	97 (4%)	Pancreatitis (355)	26 (7%)
2	Osteoarthritis (1,332)	244 (18%)	Acute Pancreatitis (355)	51 (14%)	Sepsis (2,430)	23 (1%)
3	Respiratory Failure (746)	114 (15%)	Alcoholic or Toxic Liver Disease or Failure (106)	32 (30%)	Epilepsy (201)	18 (9%)
4	Femur Fracture (541)	98 (18%)	Digestive System Diseases (304)	30 (10%)	Alcoholic or Toxic Liver Disease or Failure (106)	10 (9%)

Rank	Primary Physical Health Diagnoses with the Most Psychiatric Secondary Diagnoses		Primary Physical Health Diagnoses with the Most SUD Secondary Diagnoses		Primary Physical Health Diagnoses with the Most Co-Occurring Psychiatric and SUD Secondary Diagnoses	
	Top Physical Health Diagnoses	Psych-Only Co-Occurring Admissions	Top Physical Health Diagnoses	SUD-Only Co-Occurring Admissions	Top Physical Health Diagnoses	Psych and SUD Co-Occurring Admissions
5	Chronic Obstructive Pulmonary Disease (400)	97 (24%)	Myocardial Infarction (620)	29 (5%)	Type 2 Diabetes (395)	9 (2%)
6	Kidney Failure (570)	90 (16%)	Cerebral Infarction (464)	26 (6%)	Acute Respiratory Failure (746)	8 (1%)
7	Cerebral Infarction (464)	81 (17%)	Hypertensive Heart Disease (440)	24 (5%)	Cellulitis (305)	8 (3%)
8	Acute Pancreatitis (355)	78 (22%)	Hypertensive Heart and Chronic Kidney Disease (605)	18 (3%)	Hypertensive Heart and Chronic Kidney Disease (605)	7 (1%)
9	Hypertensive Heart Disease (440)	75 (17%)	Pregnancy Complications (674)	17 (3%)	Myocardial Infarction (620)	7 (1%)
10	Pregnancy Complications (674)	74 (11%)	Type 1 Diabetes (231)	17 (7%)	Chronic Obstructive Pulmonary Disease (400)	7 (2%)

Finally, length of stay (LOS) for inpatient admissions varies by health provider, as illustrated by Chart 1, which shows LOS for Covenant Health and for Sunrise Canyon. Covenant Health is more likely to treat psychiatric patients for shorter periods of time, with 77% of its 728 patients hospitalized for six or fewer days, compared to 31% of Sunrise Canyon's 410 admissions. In contrast, 18% of Sunrise Canyon patients stayed 31 days or longer, whereas fewer than 1% of Covenant Health patients had lengths of stay of that duration. These lengths of stay represent one of the differences between community hospital inpatient care and specialty psychiatric inpatient care. In Appendix E, Table 20 shows a detailed breakdown of the counts of admissions, by length of stay, at each hospital. In addition, Graphs 3 and 4 show daily psychiatric utilization at these two hospitals, compared to total capacity.

Chart 1: Length of Stay of All Adult Psychiatric Inpatient Admissions to Lubbock Hospitals April 2017 – March 2018[23]

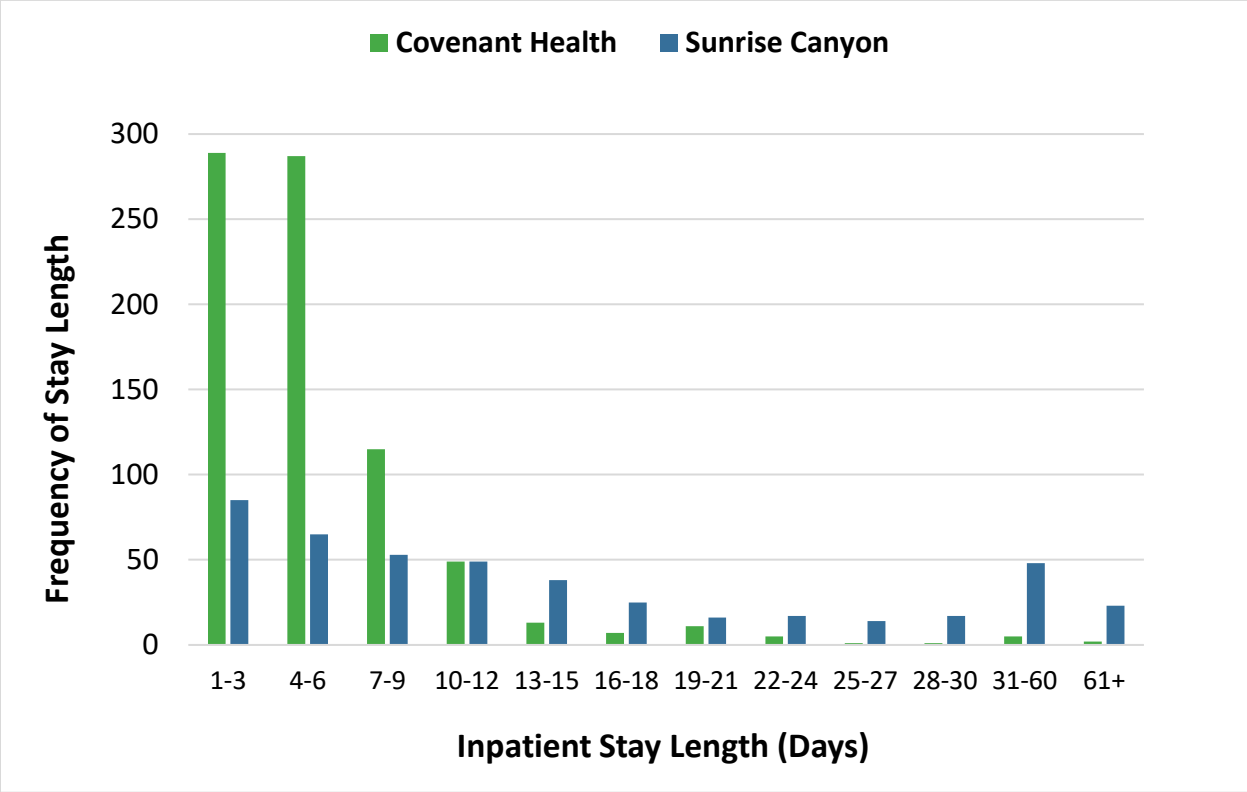


Table 9: Length of Stay of All Adult Psychiatric Inpatient Admissions to Lubbock Hospitals, April 2017 – March 2018

Length of Stay in Days	Sunrise Canyon		Covenant Health	
	Admissions	% With This LOS	Admissions	% With This LOS
1–3 Days	73	17.8%	309	42.4%
4–6 Days	57	13.9%	253	34.8%
7–9 Days	43	10.5%	90	12.4%
10–12 Days	42	10.2%	36	4.9%
13–15 Days	39	9.5%	19	2.6%
16–18 Days	22	5.4%	8	1.1%
19–21 Days	21	5.1%	<6	<1%

[23] Hospital utilization data were obtained from the Texas Health Care Information Collection. Length of stay was calculated for patients discharged between April 2017 and March 2018.

Length of Stay in Days	Sunrise Canyon		Covenant Health	
	Admissions	% With This LOS	Admissions	% With This LOS
22–24 Days	18	4.4%	<6	<1%
25–27 Days	9	2.2%	<6	<1%
28–30 Days	11	2.7%	<6	<1%
31–60 Days	51	12.4%	<6	<1%
61 or More Days	24	5.9%	N/A	<1%
All LOS (All Admissions)	**410**	**100%**	**728**	**100%**

Because both Covenant Health and Sunrise Canyon consistently operate at or near capacity, it is difficult to increase inpatient admissions within existing service capacity; if length of stay decreased significantly it would effectively increase capacity but both facilities have lengths of stay consistent with facilities of their types. Also, some people could be more comprehensively assessed and stabilized in a setting that lies between an emergency room and inpatient bed, such as an extended observation unit similar to Sunrise Canyon's unit. Through Sunrise Canyon, StarCare has effectively expanded alternative capacity to hospitalization for people in need of long-term care who otherwise would have to wait for care in a more remote (and generally inaccessible) state psychiatric hospital and for those with less acute needs who are amenable to care within its new extended observation unit.

But this still leaves a gap in capacity for people with comorbid needs as well as many more people with longer-term needs and others with subacute needs. The community needs to decide which gaps to address next and to what degree. Factors that need to be considered include:

- To what degree does Sunrise Canyon have (or will have) the capacity to provide physical health care assessments (including for substance use disorders) on site? How would this compare to the need to create additional assessment and treatment capacity within integrated health care settings such as Covenant Health or UMC? As a practical matter, because UMC relies on StarCare to provide acute psychiatric care, people with complex health needs may be transported at least twice (once to UMC's emergency department then from the emergency department to StarCare). In some cases, those clients must be transported more than twice, such as when a person has a physical health issue or substance use disorder that StarCare's free-standing mental health facility cannot address and that requires transport back to a general hospital.
- Second, Covenant Health is embarking on a plan to significantly expand its inpatient psychiatric care capacity for geriatric, child and adolescent, and adult psychiatry, and the new UMC/TTUHSC clinic for children will also expand capacity. It is anticipated that

additional outpatient services will be operational by fall 2020, with inpatient capacity operational by July 2021, ideally supported by Senate Bill 11 funding (discussed in more detail below in the section on children and youth). It is likely that the addition of these beds and community capacity over time will aid in reducing overall bed need and should further decrease the number of hospitalizations outside the Lubbock region while providing care closer to home.

- Finally, in the just completed legislative session, HHSC received funding to purchase 50 additional community psychiatric beds. If the Lubbock region can take advantage of even a limited amount of this funding, it will create additional capacity. However, the degree to which this should fund the purchase of beds in health care settings rather than creating additional free-standing capacity will need to be addressed locally.

Texas Tech University (TTU) plays a vital role in the mental health system, but that role could be substantially strengthened. The Texas Tech University Health Science Center (TTUHSC) and TTU more broadly play important roles in the service delivery system and present a critical resource and set of opportunities for the community. This role has been amplified through the creation and leadership of the Texas Tech Mental Health Institute, a collaborative venture of TTU and TTUHSC, and further strengthened by additional funding for pediatric mental health services through the 86th Texas Legislature through Senate Bill (SB) 11. The Texas Tech Mental Health Institute has already begun to play an important leadership role in convening community partners, not only for the work that resulted in this assessment, but also through its facilitation of the Justice Mental Health Collaborative (JMHC),[24] which implemented recommendations made by a sequential intercept mapping process of the criminal justice and mental health systems that was conducted in October 2018 and followed up by JMHC (discussed in more detail below). More broadly, TTUHSC has also developed a sophisticated approach to telehealth that reaches more than 100 counties for general health care. Given staffing and other shortages in the Lubbock region, this capacity could become an essential component of a redesigned service system. Finally, TTUHSC plays an important role in assessing and caring for school-age children, youth, and their families (discussed in more detail in the section on children and youth), which will be expanded through the SB 11 funding. The financial sustainability of some of TTUHSC's efforts also needs to be addressed. For example, as discussed in more detail in the section on children's care, the university currently supports the work of the Burkhart Center and Center for Superheroes but does not bill Medicaid or commercial insurance for services rendered.

Finally, there is an opportunity (and need) to substantially improve the use of data. Input from several interviews, as well as answers to our questions about data use, revealed gaps in –

[24] During our assessment, we were given different names for this group, including the Joint Mental Health Collaborative and the Justice Mental Health Collaborative. We use the latter in this report.

and opportunities for – the use of integrated data to improve services, especially for people who use services frequently. There are data-driven approaches to identifying people with the highest needs and getting them into treatment, as well as identifying gaps in services. One example is the Open Door strategy of using HMIS (Homeless Management Information System) to identify, assess, and direct people experiencing homelessness to appropriate interventions within a shared local system, which includes VetStar, The Salvation Army of Lubbock, and other providers. In addition, the Lubbock Health Department has worked with community providers to provide data on social determinants of health which as noted above are often associated with mental and emotional disorders. Conversely, there is limited information on how many mental health calls to 911 result in a dispatch of an officer, and little information about tracking outcomes of veterans' services. Stakeholders also identified the Health Insurance Portability and Accountability Act (HIPAA) as a perceived barrier to data integration, although neither HIPAA nor Texas law create barriers to data sharing that supports continuity of care. Feedback from interviews revealed a consensus that sharing data across systems could improve care for people with chronic needs who cycle between emergency departments, jail, and hospital services (known anecdotally to judges, law enforcement, and treatment providers.

System-Wide Recommendations

Lubbock County has unique advantages and opportunities to improve its mental health care system and to do so within a general health care framework. An essential ingredient to creating this change is the community's consensus that change is needed; another critical advantage is the generally cooperative attitude among key Lubbock stakeholders. There are initiatives in place that can be integrated, an infrastructure that will allow leaders to take advantage of opportunities created by the Texas Legislature, and a historical commitment in Lubbock to solving problems locally. There is no reason Lubbock cannot emerge from its efforts with one of the best mental health care systems in Texas.

One key goal of our recommendations is to take advantage of existing community strengths while enabling Lubbock leadership, over time, to further improve care for people with mental illnesses. The core recommendation that is necessary to enable all these systemic recommendations is for Lubbock leaders to empower a formal working group and charge it with improving mental health care in the area. Issue-specific work groups could then be coordinated under the umbrella of the core group to focus on improving care in specific sectors, such as the hospital/crisis services system and adult needs more broadly, the criminal justice system, the service delivery system for children and youth, and veterans' services. We first describe our recommendation for the core group, then discuss more population-specific issues and recommendations that can be addressed by the more focused work groups. As we were reminded in the responses to our summary findings and recommendations, systemic change takes time, concerted effort, and political will, but, as noted earlier, these essential elements are in place in Lubbock.

Overall Approach and the Adult Care System

Lubbock stakeholders should create a formal working group to focus on improving mental health care, with the work focused on specific areas, as discussed below.

Ideally, an existing group could be expanded and empowered to take on this work. We identified two examples in Lubbock that might be drawn upon for this task. One is the group of stakeholders that commissioned this assessment. This group includes the major health care systems, elected officials, Texas Tech University (TTU) and Texas Tech University Health Science Center (TTUHSC), and others representing the critical perspectives that are essential to improving care in Lubbock. A second example is the Justice Mental Health Collaborative (JMHC), convened and facilitated by the Texas Tech Mental Health Institute to implement recommendations from the sequential intercept planning exercise. However, in our view, that group's focus, as currently constituted, is too limited and would need to be expanded to take on a broader role.

The JMHC reportedly has grown through developing Memoranda of Understanding (MOU) with multiple groups, including StarCare, VetStar, TTU and TTHSCH, the county detention center and others. The JMHC reportedly has two sub-taskforces, including one on re-entry coordination and one focused on a Veterans Specialty Court. In this respect, the JMHC resembles structures in other Texas counties that have created behavioral health leadership teams (BHLT) as one vehicle to keep continued attention on mental health. However, in some counties, these groups have focused primarily, if not exclusively, on behavioral health and therefore miss the contributions of general health care providers.

It is the up to the local community to decide how to create a governing structure to implement system reform, including identifying participants, establishing the degree of formal authority exercised by the group, and deciding how it defines and performs its role. However, it is also important that the leaders of local health systems and elected officials are members of such a group. The group should include principals (not staff) from all major stakeholders, including elected officials and the parties that funded this assessment. As we noted, one option would be to formalize the steering group convened for this project and include a backbone entity (perhaps the Texas Tech Mental Health Institute) that would take on facilitation and convening responsibilities to support the group over time. The other option would be to take advantage of an existing group such as the JMHC and assure that its focus goes beyond criminal justice. A third would be to convene a group with broad representation that includes the major health systems as equal partners and uses an existing structure such as the JMHC to continue its work on criminal justice and crisis response, two of the primary foci that emerged from the sequential intercept mapping process.

This new leadership group should provide overall direction and integration of efforts across the entire spectrum of systemic transformation work. It will be difficult for a group of leaders to implement change over time and across populations and systems. Accordingly, we recommend that additional work groups be convened under the auspice of the core work group to focus on the adult system, with a particular focus on the hospital/crisis response system and the criminal justice system, the children's system, and an additional possible focus on systems that serve veterans. Input from multiple interviews identified that fragmented efforts and a lack of integration of initiatives are major barriers to systemic change in Lubbock. This input reinforces that it is essential to establish a formal planning process devoted to addressing these issues as they manifest in different areas.

As we noted, the work of existing groups such as the JMHC could be folded under this overall leadership structure. For example, VetStar convenes the Veterans Resource Coordination Group, a multi-party effort that meets monthly to coordinate care, which could take on this role for veterans' issues. The point is not to create a bureaucratic enterprise, but rather to have a respected group of elected officials and system leaders that could ensure that mental health reform continues to be a priority as the Lubbock mental health system is transformed over time.

A planning group that addresses adult mental health and general health should focus particularly on crisis and community care capacity as well as alternative interventions specifically designed to divert people from higher cost, less appropriate alternatives such as inpatient psychiatric hospitalization, emergency departments, and jail.

- The first opportunity to consider is whether and how to integrate the various crisis response systems that are in place and operate independently of each other. These include the various 911 call centers, Lubbock Police Department's Homeless Outreach Team and Crisis Intervention Team, StarCare's crisis response team, and the general medical transportation system. We discuss examples of such integrated crisis response teams (which take advantage of telehealth) in this report's section that addresses people involved in the criminal justice system.
- It is essential to plan for the potential loss of funding through the Medicaid 1115 waiver program, which currently funds several of StarCare's most important initiatives. However, as one stakeholder has observed, this planning should include a broader focus on multiple funding strategies that would specifically sustain and expand outpatient and extended observation capacity. Joint action among providers might also create better leverage with payers such as managed care organizations.
- A third core issue is the need to expand outpatient and related service capacity that is designed to divert people from costly and often inappropriate options such as hospitalization, emergency departments, and jails that too often serve as the default provider of care in response to crises. Examples include, but are not limited to,

expanding the capacity of the Assertive Community Treatment team (ACT) operated by StarCare, which does not meet existing need, and creating a Forensic Assertive Community Treatment team (FACT). The FACT team could provide capacity for community care as well as an intensive, supportive transition from the jail for people with a higher risk for recidivism. To help alleviate the burden of inappropriate emergency department psychiatric boarding, StarCare could establish a crisis respite program at Sunrise Canyon as a step-down from its extended observation unit and inpatient services, if space permits. Extending the time clients need to stabilize could help reduce hospital re-admissions and decrease recidivism rates for people who frequently cycle through the criminal justice system.

Providing people with the option of temporary transitional housing before they reintegrate into a more permanent setting, as well as offering extended stabilization time in a crisis respite unit, would allow community treatment teams to connect people back to resources and housing within the community, reducing the likelihood of readmission or recidivism.

Lubbock area stakeholders should also consider developing capacity and staffing for Level of Care 5 services as a component of this expanded crisis stabilization service. This level of care allows for "flexible services that assist individuals in maintaining stability, preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized, and the level of service intensity and length of stay is expected to vary dependent on individual need."[25]

- A final core issue is the potential expansion of inpatient capacity within Lubbock. **The following content is provided as an example, not as a specific recommendation, regarding the number of beds Lubbock should add.** Recognizing that length of stay differs between Sunrise Canyon and acute general hospitals, and not taking into account the type of bed (whether adult or children), an additional 25 inpatient psychiatric beds would provide significant new capacity for Lubbock. For example, using the national average length of stay for psychiatric inpatient care (10 days per admission), 25 additional beds at full capacity would permit 913 new inpatient admissions. Using the Lubbock County average length of stay of 6.7 days, 25 additional beds would allow for 1,371 new admissions. As noted earlier, 851 hospitalizations occurred outside of the Lubbock County area from April 2017 through March 2018. Although new beds must

[25] Texas Health and Human Services. (2017, June). *Texas resilience and recovery utilization management (UM) guidelines – adult services.* Retrieved from https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf

match need, this figure suggests that a comparatively small number of new beds can have a major impact on the issue of Lubbock County residents being transferred far from home for inpatient care. How many beds, what types of beds, and the location of such beds is a local decision, dependent on many of the factors (e.g., outpatient capacity, ability to address co-morbid physical health conditions and substance use disorders, length of stay) identified elsewhere in this report. As the example we provide illustrates, stakeholder estimates of the number of new beds the community needs far exceed the actual number that would have a major impact on admission patterns for Lubbock residents.

Although these issues are central to future planning for the adult mental health care system, there are other issues that our assessment revealed, which would be worth addressing as time and resources permitted. These include the following:

- Work with StarCare, TTUHSC, and community partners to develop a first episode psychosis (FEP) program, using SB 11 funding as a means to support this program. This is discussed in more detail in the section on children and youth.
- Expand the use of the existing telehealth infrastructure for physical health care to extend its use for mental health care.
- Capitalize on and expand the innovative programs that already exist in Lubbock (e.g., the use of peers) by using statewide resources such as the Military Veteran Peer Network.

Part II: Population Specific Findings and Recommendations: Criminal Justice and Veterans

Individuals Involved in the Criminal Justice System: Findings and Recommendations for Work Group Action

Leaders in the criminal justice and mental health treatment systems have been innovative and creative in addressing issues arising from the influx of people with mental illnesses into the criminal justice system, and that innovation provides an excellent foundation for future improvement. Stakeholder reports characterize StarCare's efforts in the jail and its work with the sheriff's office as outstanding, a description our observations would support. StarCare works closely not only with jail custodial and treatment staff but also with the state attorney, the Lubbock Private Defenders' Office (both advocates for better care), and various judges committed to improving care. The Lubbock Police Department has embraced the Crisis Intervention Team (CIT) response to intervening at first response to people with mental illness and has engaged a nationally known expert in crisis response, hostage negotiation, and victim services as its primary trainer (Dr. Andy Young). The Homeless Outreach Team has an excellent reputation, as well (though, as noted above, crisis initiatives are not integrated at this point).

Also of note, in 2018, Lubbock County was designated the first Stepping Up Initiative Innovator County in Texas for its efforts to collect and analyze timely data on people in jail who have a mental illness. This is consistent with law enforcement's efforts to creatively address the issue of mental illness. In addition, the community participated in sequential intercept mapping exercise in fall 2018, and the Justice Mental Health Collaboration Program was established through a Bureau of Justice Assistance grant to work closely with the Texas Tech Mental Health Institute to implement recommendations that arose from the mapping exercise.[26] The recommendations included several that are consistent with our recommendations, including clarifying responsibilities for crisis assessment in order to unburden law enforcement, sustaining the extended observation unit at Sunrise Canyon, and using data whenever possible as a tool to better integrate care.

The sequential intercept mapping report also noted – consistent with our observations – that law enforcement has difficulty navigating possible treatment options for resolving a mental health crisis situation. And as a result, a person is often booked into the jail where (in the words of a number of people we interviewed) "we know they will be safe."

A work group devoted specifically to criminal justice-related issues would focus first on opportunities to better coordinate the responses of law enforcement and other crisis responders such as StarCare and emergency medical transport. There appears to be a lack of clarity and consensus in the community regarding criteria for access to care and the potential disposition of crisis situations in which a person appears to have a mental illness. In addition, and as noted earlier, various crisis responses within Lubbock are not integrated. We have two suggestions to help remedy these issues. First, co-staffing the Lubbock Police Department's Crisis Intervention Team (CIT) with clinical staff from StarCare could help reconcile differences in approach and create a clinical arm to the CIT response. Interviews with key staff involved in the crisis response system revealed that StarCare does provide support to CIT-trained officers, but, in our view, full integration should be explored. Second, as part of revamping the crisis response, there is an excellent opportunity to take advantage of the telehealth capacity at Texas Tech University System to further integrate the initial crisis response to care.

Lubbock can draw on examples of integrated crisis care in other areas of Texas for comparison. For example, the Harris County Sheriff's Office began a telehealth crisis intervention pilot in early 2017 that was modeled from the Houston Fire Department's Project ETHAN (Emergency TeleHealth and Navigation). ETHAN connects people who have requested an ambulance for low acuity care needs directly to an emergency department physician for triage prior to and, most

[26] As of March 2019, parties to the data sharing MOU created by the JMHCP include Lubbock County, Office of Court Administration, VetStar, Texas Tech University, Texas Tech Health Science Center, Lubbock Community and Corrections Department, and the Lubbock Private Defenders Office.

often in lieu of, transport to a hospital. In the initial test phase (phase 1) of the Harris County Sheriff's Tele-Crisis Intervention Response Team (Tele-CIRT) project, five deputies were equipped with iPads connected to a telepsychiatry provider for 30 days. The University of Texas Health Science Center at Houston (UTHealth) School of Public Health completed an evaluation of the 30-day pilot and found a total cost savings of over $26,000 across 31 calls. In addition to these cost savings, 26% of people served through Tele-CIRT were diverted from hospital admission and 6.5% were diverted from jail. The program has now moved to phase 3, deploying 20 deputies supported by two telehealth clinicians employed by The Harris Center for Mental Health & IDD. With this 10 to 1 ratio between officer and clinician, the program has proven to be an immediate workforce multiplier for crisis intervention services. The Harris County program has evolved and, after a recent visit to Harris County, one Lubbock stakeholder suggested that the program as originally conceived was not sustainable. However, we still include this program here as an example of a county that has looked for ways to utilize technology to share information across systems at the point of crisis response, something permitted by both Texas and federal law.

The Rapid Integrated Group Healthcare Team (RIGHT) Care program in Dallas provides crisis response to mental health calls received through the 911 call center. RIGHT Care has been implemented in the Dallas policing district that historically generated the most mental health calls. A team composed of an emergency medical technician, a law enforcement officer (whose job is to secure the scene safely), and a mental health professional responds to designated calls. The results of this program to date have been extremely encouraging. A preliminary analysis of call data provided by the Dallas Police Department, Parkland Health and Hospital System, and the Dallas Fire-Rescue Department for the April 2, 2018, through May 5, 2019, period found that out of a total of 3,790 interactions:[27]

- The team had interacted with 1,963 unique individuals.
- The team responded to 1,294 calls for service and referrals.
- Eight hundred and fifty-one (851) interactions involved team-initiated outreach or non-crisis follow-up care by the team ("follow-up care" is defined as either subsequent phone calls or an in-person visit).

One hundred and thirty-three (133) interactions resulted in a traditional law enforcement response:

- Sixty-nine (69) arrests were for previous warrants.
- Sixty-four (64) arrests were for an offense on-scene.
- Arrests ***for new offenses accounted for fewer than 2% of total interactions.***

[27] Some individuals had more than one interaction with the team, which is why there are 3,790 total interactions.

One thousand one hundred and eleven (1,111) interactions resulted in overall linkages to immediate care, allowing diversion from jail and emergency rooms in many cases. Perhaps most remarkably, while arrests in other Dallas policing districts were increasing on average by more than 9%, arrests in the district served by RIGHT Care actually declined.

A framework should be created for linking people discharged from jail to follow-up services. One response to an earlier draft of this report suggested that a committee of the JMHC is already discussing this issue. As in many communities, there appears to be a lack of continuity of care for people discharged from jail. Development of a FACT team, as noted earlier, could help remedy this issue, but, in addition, it would be useful to create an integrated approach between care providers and law enforcement that would link people to post-incarceration care, based on the philosophy that re-entry begins at booking. At the same time, continuity of care depends on the availability of services; as Lubbock develops a more extensive service capacity in the community, it will make follow-up care from jail easier to develop.

There are additional changes that could better integrate the front-end response to care, particularly in creating a community consensus on eligibility criteria.

- Input from interviews suggested that it is important to achieve community consensus on existing policies related to a person's presentation to Sunrise Canyon for treatment and that the lack of consensus on these policies creates confusion in the disposition of individual cases. In the context of law enforcement, this should include a shared understanding of the implications for admitting people with varying blood alcohol content levels and the expectations for officers presenting a patient. It is also important to clarify and establish a common understanding of the "level of risk" that qualifies for admission when a person is expressing suicidal ideation. There is significant confusion on this issue throughout the community, confusion experienced most often (but not only) by law enforcement when attempting to resolve a situation in which a person expresses the intent to harm him or herself.
- Developing an MOU for information sharing between care providers and law enforcement, consistent with federal and state law, would permit a more integrated understanding of which people are at risk for crisis. It would also contribute to better continuity of care from the point of law enforcement contact to discharge from jail and beyond. As noted, work has begun on this front under the auspice of the JMHC.
- Relatedly, if the Lubbock County Jail refined its internal information technology infrastructure and its requirements for contractors to ensure that contracted providers of mental health care in the jail shared information, it would reduce the risk of duplicating jail care services. It would also reduce the risk of an inmate receiving multiple prescriptions from different providers, and increase continuity of care opportunities among private jail and community mental health providers.

Veteran-Specific Findings and Recommendations for Work Group Action

VetStar has created a model for veterans involved with the criminal justice system that includes grant-funded support services, and TTU has created a campus that is fully supportive of the mental health needs of veterans and their families. These initiatives provide a good foundation for expanding services for veterans in the Lubbock area. Approaching services for veterans from an integrated perspective, as discussed below, would strengthen the opportunity for Lubbock to become a true model in this area.

Although there is an excellent foundation in place for veteran-specific services, feedback from interviews suggested that such services are often siloed in a relatively few organizations with limited visibility and understanding of each other's roles in the community. There are only three veteran-specific mental health services in the Lubbock area: the U.S. Department of Veterans Affairs' (VA) Community-Based Outpatient Clinic and Vet Center, and StarCare's VetStar (TTU also has a student veteran initiative, but the counseling center does not focus solely on veteran's mental health). The limited number of service providers should make it easier for organizations to be familiar with each other and actively coordinate services; however, there appears to be no dependable system in place to create collaboration and transparency. A work group devoted to veterans' issues can help create more trust and cooperation among the existing veterans' organizations. Feedback from interviews revealed significant differences in opinion among interviewees regarding questions of transparency, access to services, and collaboration on veterans' issues. Some believed that forums already existed that were transparent, that there were no significant barriers to access, and that there already was a forum in place to assure collaboration; others, less involved in these formal processes, had significantly different views on these issues.

There are potential opportunities for veteran-specific mental health services to partner with other community mental health organizations to use federal (MISSION Act of 2018) and state (The Texas Veterans + Family Alliance, Texas Veterans Commission) funding as leverage to incorporate military-informed care and military cultural competencies into community programs. Funding opportunities exist to create an integrated approach to services for veterans, but it requires cooperation among community providers. TTU and VetStar have experience as the lead applicants for the Texas Veterans + Family Alliance collaborative projects. Taking advantage of these opportunities by building on past successes and engaging the larger mental health community could further identify Lubbock as a leading provider of veteran-specific services.

There is a paucity of data regarding veterans' services, and it is difficult to determine whether, and from whom, veterans receive care if they do not receive it from the VA. Additionally, we were told that organizations outside the veterans mental health community do not sufficiently ask about the prior or current military service of veterans or their family

members, which inhibits their ability to provide appropriate, military-informed care. Because of the lack of data from community providers, it is not clear whether and from whom veterans receive care if they are not receiving VA services. Data issues could be addressed specifically for veterans or in the larger context of data barriers and needs within the community as a whole.

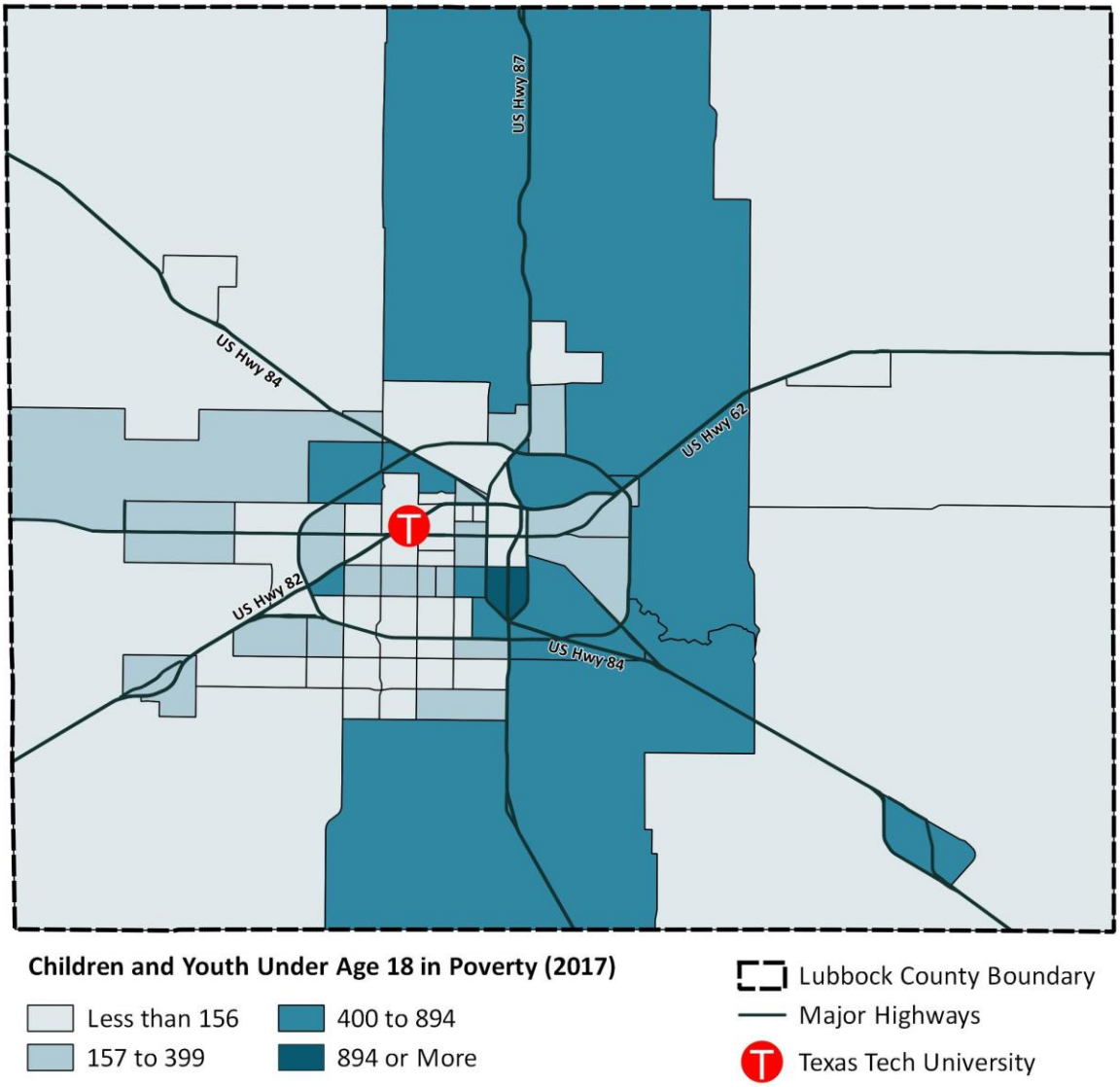
Part III: Child, Youth, and Family Findings and Recommendations for Work Group Action

Child and Youth Population Overview and Mental Health Needs

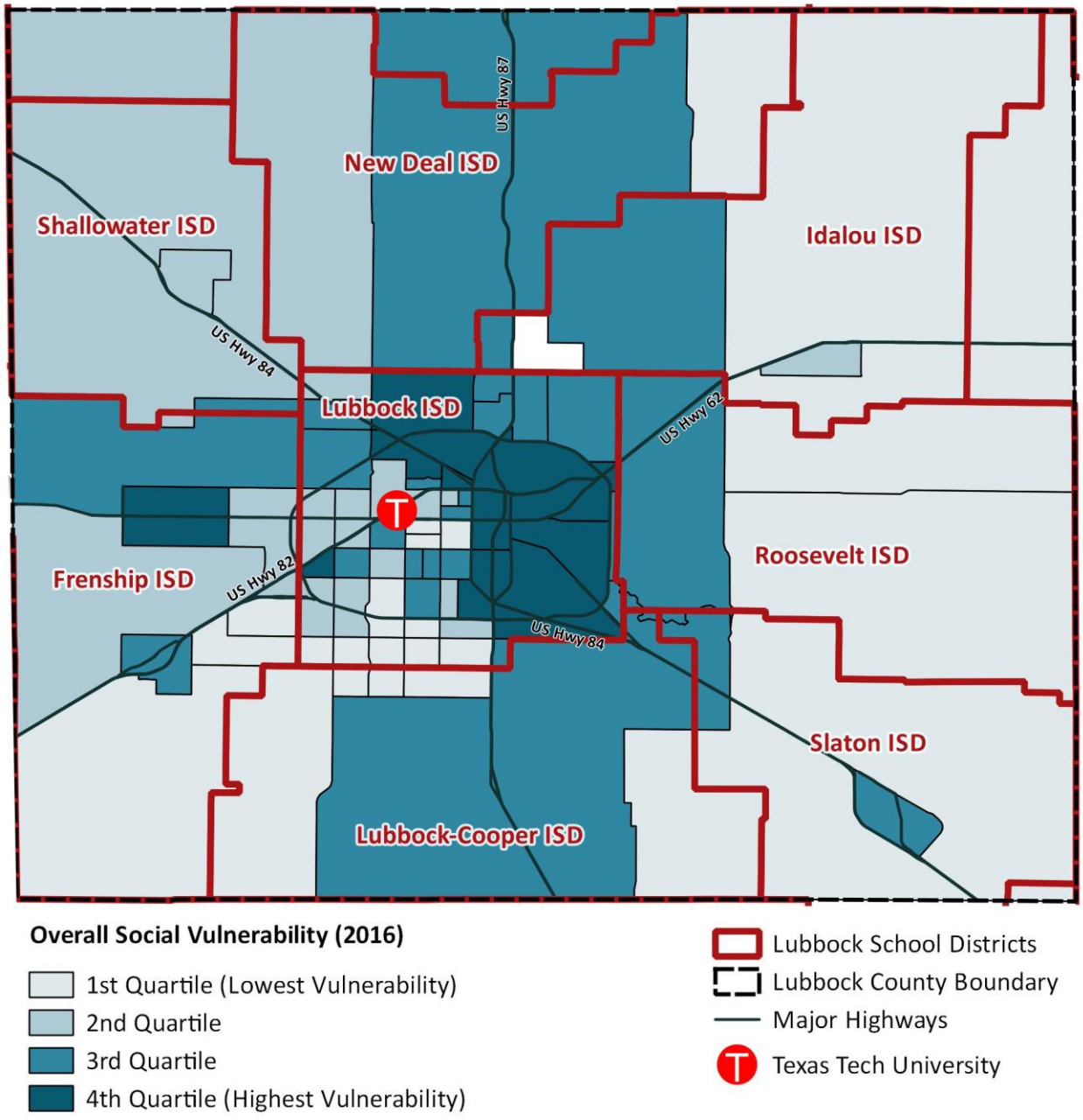
In Lubbock County, there are approximately 74,086 children and youth, 50,000 of whom are between the ages of six and 17.[28] There are seven independent school districts (ISDs) within Lubbock County, but since this assessment concentrated on the Lubbock metro area, we focused on Lubbock, Lubbock Cooper, and Frenship ISDs. Lubbock ISD is the largest, with 27,747 students, about 65% of whom are considered to be economically disadvantaged. Map 4 shows the number of children and youth under the age of 18 in poverty per census tract in Lubbock County in 2017. The dark blue upside-down pentagon bordered by Highway 84 shows the highest concentration of children and youth living in poverty, with large numbers in a semicircle stretching around the city outside the loop to the north, south, and east. Map 5 shows the boundaries of Lubbock County ISDs layered over a multi-pronged social vulnerability index provided by the U.S. Centers for Disease Control and Prevention (CDC).

[28] All Texas population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates.

Map 4: Children and Youth Under Age 18 in Poverty, by Census Tract (2017)



Map 5: Lubbock County ISD Boundaries and CDC Vulnerability Marker[29]



[29] The CDC Social Vulnerability Index uses 15 U.S. census variables at tract level to help local officials identify communities that may need support in preparing for hazards or recovering from disaster. The Lubbock data that were used to create this map are online at: https://svi.cdc.gov/Documents/CountyMaps/2016/Texas/Texas2016_Lubbock.pdf

Prevalence of Mental Health Conditions in Lubbock Children and Youth

Based on our estimates from 2016 demographic data, approximately 20,000 children and youth in Lubbock County ages six to 17 had mental health and substance use disorders.[30] About 15,000 of these children and youth had mild to moderate behavioral health needs[31] and about 4,000 had severe needs, often referred to as serious emotional disturbances, or SED (see Table 10).[32] The term SED is used to describe children and youth who experience significant, rare, multiple, or persistent mental health challenges that affect their functioning in everyday life. Additionally, an estimated 1,000 Lubbock County youth (ages 12 to 17) had substance use disorders[33] and about 7,000 children and youth (ages 0 to 17) had experienced three or more adverse childhood experiences (ACEs).[34] ACEs are traumatic experiences that occur before the age of 18 years and increase the risk of developing risks for a range of health conditions, including behavioral health conditions, later in life.

Table 10: Demographics of Children and Youth in Lubbock County (2016)

Population	Total Population	Total Population With SED	Total in Poverty[35]	Total With SED in Poverty[36]
Children and Youth (6–17)	50,000	4,000	25,000	2,000
Age				
Ages 6–11	25,000	2,000	10,000	1,000
Ages 12–17	25,000	2,000	10,000	900

[30] Kessler, R. C., et al. (2012)a. Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 372–380, and Kessler, R. C., et al. (2012)b. Severity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 69*(4), 381–389.

[31] The term "behavioral health" combines both mental health and substance use conditions or needs.

[32] Local prevalence of SED are drawn from: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute.

[33] Except where indicated, all prevalence rates were obtained from 2012–2014 National Survey on Drug Use and Health: Substate Estimates – Texas. Prevalence rates were applied to Texas Demographic Center population estimates for 2016. All estimates are rounded to reflect uncertainty. Percentages are calculated with unrounded figures and may not match percentages calculated with reported rounded figures.

[34] Local prevalence estimates of adverse childhood experiences are drawn from state-level 12-month prevalence rates reported in Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Bethesda, Maryland: Child Trends. Retrieved from https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

[35] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

[36] "In poverty" refers to the estimated number of people below 200% of the federal poverty level for the specified region.

Population	Total Population	Total Population With SED	Total in Poverty[35]	Total With SED in Poverty[36]
Sex				
Male	25,000	2,000	10,000	1,000
Female	25,000	2,000	10,000	1,000
Race/Ethnicity[37]				
Non-Hispanic White	20,000	1,000	5,000	400
African American	4,000	300	3,000	300
Asian American[38]	700	50	200	10
Native American[39]	100	9	60	5
Multiple Races	1,000	100	700	70
Hispanic/Latino	25,000	2,000	15,000	1,000

Table 1 provides more detailed information from 2016 on the severity and types of mental health conditions of children and youth in Lubbock County between the ages of six and 17 years. Robust, community-based mental health services and supports are most important for the 2,000 children and youth with SED who experience poverty.

Overview of Children's Framework

A comprehensive system for pediatric mental health requires the coordination of interventions in primary care, specialty care, rehabilitation, and hospital/crisis settings. But behavioral health systems today – in Texas and across the nation – tend to be organized in a manner that is more fragmented, uncoordinated, and too often unhelpful (and sometimes harmful). The framework we present in this section is divided into five core components for preventing, identifying, and treating pediatric mental health conditions. We summarize each component below.

- **Component 0: Life in the Community.** This component refers to the broad range of prevention activities that happen outside of health care settings. There are many touchpoints for children and youth that provide opportunities to promote healthy development and prevent mental health and substance use disorders. Although health care systems are an integral part of every child, youth, and family's life, they are only a

[37] We use the Substance Abuse and Mental Health Services Administration's (SAMHSA) language as a guideline for reporting race and ethnicity categories. This language was taken from the SAMHSA website on racial and ethnic minority populations, available at: https://www.samhsa.gov/specific-populations/racial-ethnic-minority. In some cases, we use slightly revised language and have provided further explanation in a footnote, when necessary.
[38] The category of "Asian American" also includes people identifying as Native Hawaiians and/or Pacific Islanders. In Texas, these population numbers are very small, so we use the term "Asian American" for simplicity of reporting.
[39] We intend "Native American" to be synonymous with "American Indian" or "Alaskan Native," terms that are sometimes used instead of "Native American" in other states or in national reporting.

part of life. Health needs – both diseases affecting the brain, such as behavioral health disorders, and other conditions – occur in the context of life: home, daycare, school/pre-school, faith communities, and other places where children, youth, and families spend their time. Because children, youth, and families frequent them, these places can also be ideal settings for health promotion and disease prevention. In particular, schools, foster care, and juvenile justice settings have important roles to play in prevention efforts as well as the delivery of behavioral health interventions.

- **Component 1: Integrated Behavioral Health in Pediatric Primary Care Settings.** These settings can help detect behavioral health needs sooner and successfully treat routine and even some moderately severe needs related to behavior, anxiety, and depression. Integrating behavioral health within all pediatric primary care settings is an essential strategy for increasing access to behavioral health services for children and youth, treating those with most mild to moderate conditions and coordinating referrals for those in need of specialty and more intensive care. An example of a fully-scaled, statewide implementation suggests that two thirds of behavioral health care can be provided in pediatric settings with the right integration supports.[40]
- **Component 2: Specialty Behavioral Health Care.** Specialty care in routine care settings such as clinics and provider offices is often needed for children and youth with moderate to severe mental health needs. We estimate that about one quarter of diagnosable behavioral health conditions need treatment by specialists in these types of clinical settings. However, rather than being the primary focus of the mental health care delivery system – like it often is today – in the ideal system, most children and youth would receive care before symptoms reach this high level of need, and those who do require this level of specialty care would receive it sooner and in a more coordinated way. If mild to moderate anxiety and depressive disorders can be treated in integrated primary care settings, specialists would be able to focus on treating more complex depression, bipolar disorder, post-traumatic stress, addiction, and other conditions that require more specialized interventions.
- **Component 3: Rehabilitation and Intensive Services.** These highly specialized and intensive services and supports are necessary for about one in ten behavioral health conditions and should also be accessible sooner and in a more coordinated way. They should also include a broader range of evidence-based, home and community-based services for children and youth with the most severe needs. These services are needed for children and youth with behavioral health needs so severe that they impair functioning across multiple life domains and require team-based care that generally includes a prescriber, a skilled therapist, and a broader team focused on both ameliorating symptoms and building on individual, family, and community strengths to

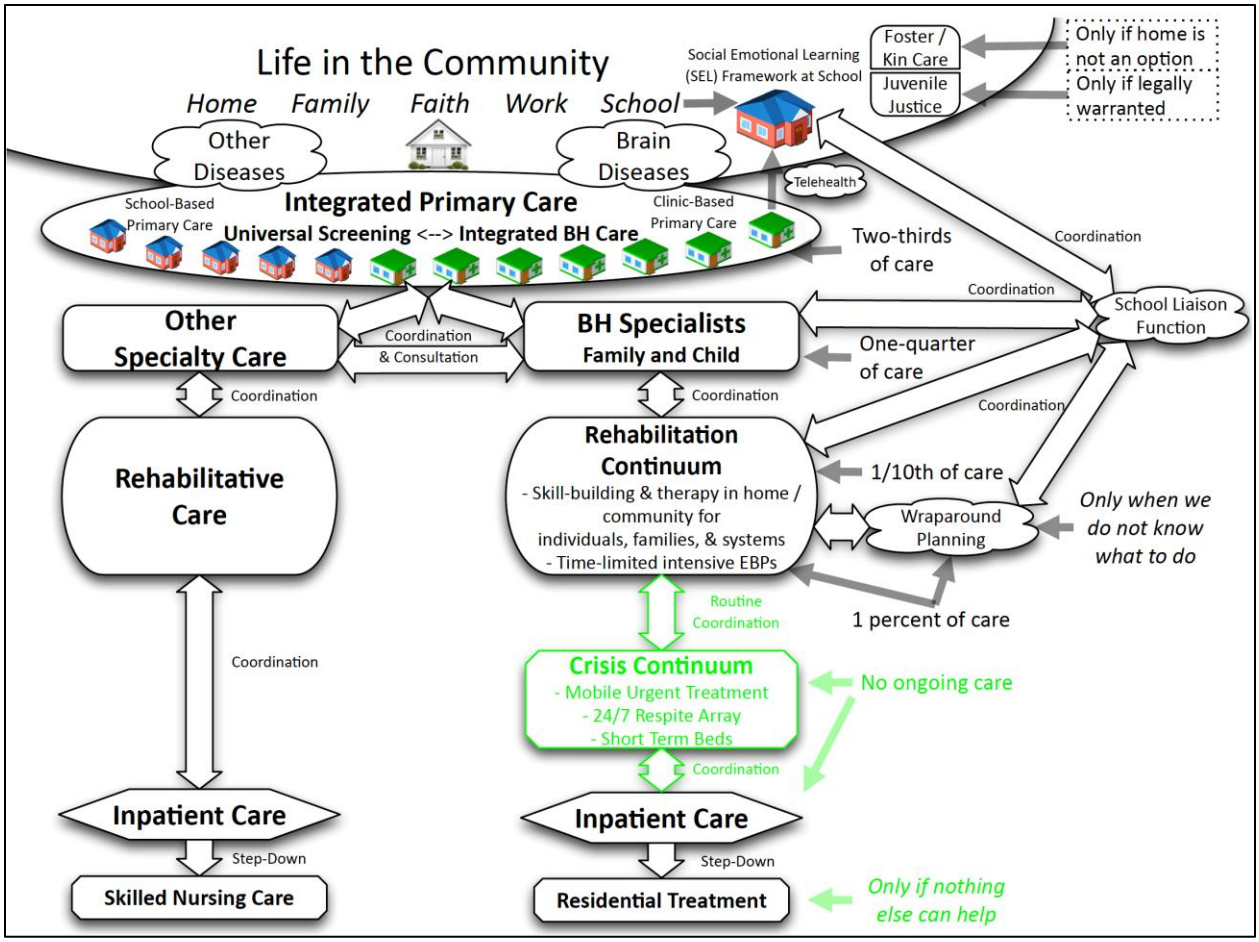
[40] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, *33*(12), 2153–2161.

restore functioning and promote healthy development. Similar to catastrophic orthopedic injuries requiring a child to re-learn how to walk or carry out routine life activities, severe psychosis, as well as other less debilitating psychiatric conditions that today generally go untreated for years, can substantially impede day-to-day functioning and require rehabilitative care to treat both the underlying condition and the functional sequelae.

- **Component 4: A Crisis Care Continuum or Psychiatric Inpatient.** Crisis care services are needed when needs require urgent stabilization. Even with optimal levels of the right kinds of prevention, primary care, specialist, and intensive services, health conditions can become acute and require urgent intervention to respond to crises that threaten both safety and functioning. Accordingly, health systems must be able to respond to the full range of episodic, intense needs that will occur over the course of care, including mobile teams that are able to respond to urgent needs outside of the normal delivery of care, as well as a continuum of placement options ranging from crisis respite to acute inpatient and residential care. These services are important, but too often today they are not provided until a person reaches a point of crisis. The emphasis in this report is on care that is provided before conditions worsen or crises emerge. However, crisis services remain critical.

Readers should be mindful that this report provides a framework for benchmarking current services and envisioning future improvements. However, as with adult care, no community in Texas or across the nation has a system that works like this today. Instead, most care in Texas is currently delivered– when it is delivered at all – at the specialty or crisis levels of care. Far too little capacity is available in the primary care or rehabilitative sections of the continuum. Because of the siloed way most behavioral health systems are currently organized, most families do not to seek care at all, and those who do generally have such care delayed many years until symptoms worsen. As a result, too many children and youth first receive behavioral health care services in a juvenile justice facility or an emergency room.

In addition, social determinants of health, which include economic stability, education, access to health care, and the social and community context in which children and youth live and grow, all affect emotional wellness, development, and even morbidity. Poverty, coupled with adverse childhood experiences (ACEs), can have a lasting, negative effect on physical and emotional well-being. Sometimes the term “emotional health” is used to distinguish how these factors affect well-being; we use the term “mental health” instead as an all-encompassing term.



Special Considerations

There are certain populations of children and youth who are more likely to need mental health services and relevant supports. These groups include children and youth in foster care, youth involved in the juvenile justice system, and youth and young adults with mental health conditions. Before describing the children's mental health framework in Lubbock, we describe some of the unique challenges these groups face as well as current community efforts to meet their needs.

Foster Care Overview

Children and youth in foster care experience unique and complex mental health challenges. These challenges stem from problems in their homes that lead to their foster care involvement, in addition to trauma associated with being removed and placed in an unfamiliar setting. In comparison to the entire child population, many children and youth in foster care also experience complex medical conditions. Table 11 below includes demographic information on children and youth who were in foster care in state fiscal year (SFY) 2018 in Department of Family and Protective Services (DFPS) Region 1 and within Lubbock. DFPS Region 1 includes Lubbock, Amarillo, and 39 additional counties across the Texas panhandle.

In SFY 2018, 44% of the children who were in foster care in Lubbock were under the age of six. Hispanic and African American children and youth were significantly overrepresented in the foster care system. U.S. Census data from 2018 indicates that 35% of Lubbock residents are Hispanic or Latino, but 55% of children and youth in foster care were Hispanic. Similarly, while African Americans make up under 8% of Lubbock residents, 17% of children and youth in foster care were African American.

Table 11: Lubbock and DFPS Region 1 Children in Foster Care Demographics (SFY 2018)[41]

Children in Foster Care	DFPS Region 1		Lubbock	
	Number in Foster Care	% of All in Foster Care	Number in Foster Care	% of All in Foster Care
All Children	1,871	100%	818	100%
Age				
0–2	481	26%	205	25%
3–5	365	20%	158	19%
6–9	353	19%	164	20%
10–13	328	18%	145	18%
14–17	344	18%	146	18%
Sex				
Female	905	48%	399	49%
Male	964	52%	419	51%
Race/Ethnicity				
African American	252	13%	137	17%
Hispanic	921	49%	450	55%
White	560	30%	183	22%
Native American	8	<1%	3	<1%
Asian	9	<1%	5	1%
Other	121	6%	40	5%

There are specific foster care trends in Lubbock that are not in keeping with state as a whole. Most notably, the number of children and youth from Lubbock and its surrounding areas who are removed from home is extremely high. Child Protective Services (CPS) is the division within

[41] Data obtained from the Texas Department of Family and Protective Services Data Book. Data retrieved from https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/default.asp

the Department of Family and Protective Services (DFPS) that is responsible for investigating and managing child welfare cases. Between state FY 2015 and 2017, there was a 77% increase in children and youth entering the foster care system from Region 1 (in contrast to the statewide average of a 15% increase during the same time period). Looking only at Lubbock County, the trends are consistent with those for Region 1 as a whole. In FY 2018, six out of 1,000 children in Lubbock were removed from their home by CPS, in contrast to the statewide average of 2.73 per 1,000 children. System strains resulting from a high number of children and youth in foster care also has had a negative impact on placement options. Also, in FY 2018, there was a 7% decrease in foster home placements and a 71% increase in residential treatment center (RTC) placements.

A large influx of children and youth who are removed from home for the first time places a strain on the local foster care system in of itself, but a high rate of placement disruptions for children already in foster care amplifies these challenges. The term "subsequent placement" is used when an initial foster placement breaks down and a child or youth has to move to one or more new placements. In FY 2017, DFPS Region 1 tied for the second highest rate of subsequent placements of all the state DFPS regions, with 24% of placements comprising subsequent removals. Placement disruptions are traumatic for children and youth who have already experienced significant instability in being removed from their homes.

There are many factors that can influence removal rates and placement breakdowns that lead to subsequent placements. The people we interviewed for this assessment who had child welfare experience attributed the high rate of removals in Lubbock to increased reporting, which possibly resulted from community training on the need to report suspected cases of child abuse. They also attributed high rates of removal to high rates of parental substance use disorders (SUD) and poverty-related neglect. Although the Region 1 DFPS office was unsure of the portion of local removals resulting from or influenced by parental substance abuse, national data indicate that the number of removals due to parental substance abuse has risen consistently in recent years.[42] In 2017, over a third of all children and youth removed from home and placed in the foster care system were removed at least in part because of parental substance abuse.[43] In the Texas, between 2016 and 2017, there was a 7% increase in children and youth removed from home because of parental substance abuse.[44] Once a child or youth has been removed from their home and placed in foster care, disruption can occur for many reasons, but the most common reason is a result of highly challenging child or youth behaviors that a foster family is not trained or supported to properly address.

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[42] Sepulveda, K., & Williams, S. C. (2017, February 26). One in three children entered foster care in 2017 because of parental drug use. *Child Trends*. Retrieved online at: https://www.childtrends.org/one-in-three-children-entered-foster-care-in-fy-2017-because-of-parental-drug-abuse

[43] Sepulveda, K., and Williams, S. C. (2017, February 26).

[44] Sepulveda, K., and Williams, S. C. (2017, February 26).

All children and youth who enter DFPS care are assigned an Assigned Service Level (ASL). ASLs are imperfect measures of exact needs, but they can be used as a general indicator of the complexity of needs for children and youth in foster care. The ASL is also used to determine the type of placement that would match a child or youth's characteristics and service needs. The Texas service level system includes four ASLs – Basic, Moderate, Specialized, and Intense (including Intensive-Plus). In Lubbock, many of the children and youth in foster care are being placed into higher ASLs, which indicates they need intensive services and supports from caregivers with specialized therapeutic, habilitative, or medical training. As a result, there is a significant need to increase foster care capacity for children and youth in the "specialized" and "intensive" levels of care. Table 12 below provides the numbers of children and youth in Lubbock and in DFPS Region 1 as a whole, by ASL and by other characteristics that identify special needs and placement considerations. For example, the "Medical" indicator is used for children with medical complexity and the "Sibling" indicator notes if a child has a sibling who is also in foster care since the best practice is to place sibling groups together.

Table 12: Children in Foster Care in Region 1, by Authorized Service Level (ASL) (March 2019)[45]

Foster Care Category	Number of Children in Foster Care in Region 1 (March 2019)	Percentage of All Children in Foster Care in Region 1
All Children in Foster Care	**1,103**	**100%**
By Authorized Service Level		
Basic	715	65%
Moderate	139	13%
Specialized	165	15%
Intense	25	2%
Psychiatric Transition	2	<1%
Treatment Foster Care	1	<1%
Blank	56	5%
By Characteristic		
Physical	7	1%
Medical	34	3%
Drug/Alcohol	72	7%

[45] These data reflect a snapshot from March 2019 of children and youth in Region 6. Data obtained from the Texas Department of Family and Protective Services – Regional Statistics About Children in DFPS Care. Retrieved from: https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

Foster Care Category	Number of Children in Foster Care in Region 1 (March 2019)	Percentage of All Children in Foster Care in Region 1
Emotional	190	17%
Learning	173	16%
Sibling	296	27%
Adolescent Parent	1	<1%

There are two major systematic changes that will have a significant impact on the delivery of foster care services in Lubbock in the next few years. Region 1 has become the fourth DFPS region to shift from the current system, in which DFPS manages almost all aspects of foster care service delivery, to the Community-Based Care (CBC) model. Through the CBC model, the community will have greater flexibility in how it designs, oversees, and provides foster care services. CBC shifts certain functions and services previously provided by DFPS to a single contractor, called a Single Source Continuum Contractor (SSCC). The SSCC is responsible for contracting with community providers, placing children and youth, and ensuring they have access to a continuum of services and supports.

Following a competitive procurement process, which began with a Request for Proposals (RFP) posted in December 2018, DFPS selected Saint Francis Ministries (SFM) to serve as the SSCC for Region 1. SFM has experience providing foster care, adoption, family preservation, and other related services in Texas, other states, and abroad; however, its experience in Region 1 will be their first time it has served as an SSCC.

In the first stage of implementation, SSCCs are responsible for developing a network of foster care providers and community supports that allow children and youth to remain in their communities and connected to their families. In the second stage, the SSCC's responsibilities expand to include case management, kinship, and reunification services. In the final phase, SSCCs are expected to meet specific performance metrics and payments will be tied to outcomes.

The 2018 passage of the federal Family First Prevention Services Act (FFPSA) also require changes and present new opportunities for the foster care system in Lubbock. FFPSA was designed to help keep families in tact by expanding access to evidence-based preventative services, including mental health and substance abuse treatment services as well as skill-based and other in-home interventions to strengthen families. It also seeks to improve the well-being of children and youth already in foster care through new regulations and incentives designed to minimize placements in congregate care settings. New funding methodologies and FFPSA requirements were initiated in October 2019; however, Texas is one of many states to request a

two-year delay in implementation. Although there are many unknowns regarding the eventual implementation of FFPSA, Senate Bill (SB) 355 (86th Texas Legislative Session, 2019) requires DFPS to create a strategic plan to implement CBC and prevention services under FFPSA.

Foster Care Strengths

There are many strong organizations, partnerships, and supports that serve children and youth in foster care in Lubbock that can address some of the key challenges in the local foster care system. Some of these organizations and initiatives include:

- The Center for Superheroes, which provides screening, assessment, and a wide range of supports and evidence-based interventions for children, youth, and families involved with the foster care system;
- The upcoming development of a community-based program through Children's Hope, which will help connect families to existing community services and establish new supports in areas in which there are currently gaps;
- The use and expansion of evidence-based interventions at Texas Boys Ranch, including Trauma-Focused Cognitive Behavior Therapy and Theraplay;
- The Children's Home of Lubbock, which completed a multi-pronged process to bill for Targeted Case Management (TCM) through Medicaid managed care;
- Strong collaborations between child welfare and faith-based organizations;
- An active Court Appointed Special Advocate (CASA) program, with 229 current volunteers who currently serve 352 children and youth from Lubbock County;
- The South Plains Coalition for Child Abuse Prevention, led by the Parenting Cottage;
- Reliable access to counseling services through Family Counseling Services; and
- Support from dedicated CPS staff, who many in the community noted are doing their best, under difficult circumstances, to support the children and youth in their care.

Foster Care Challenges

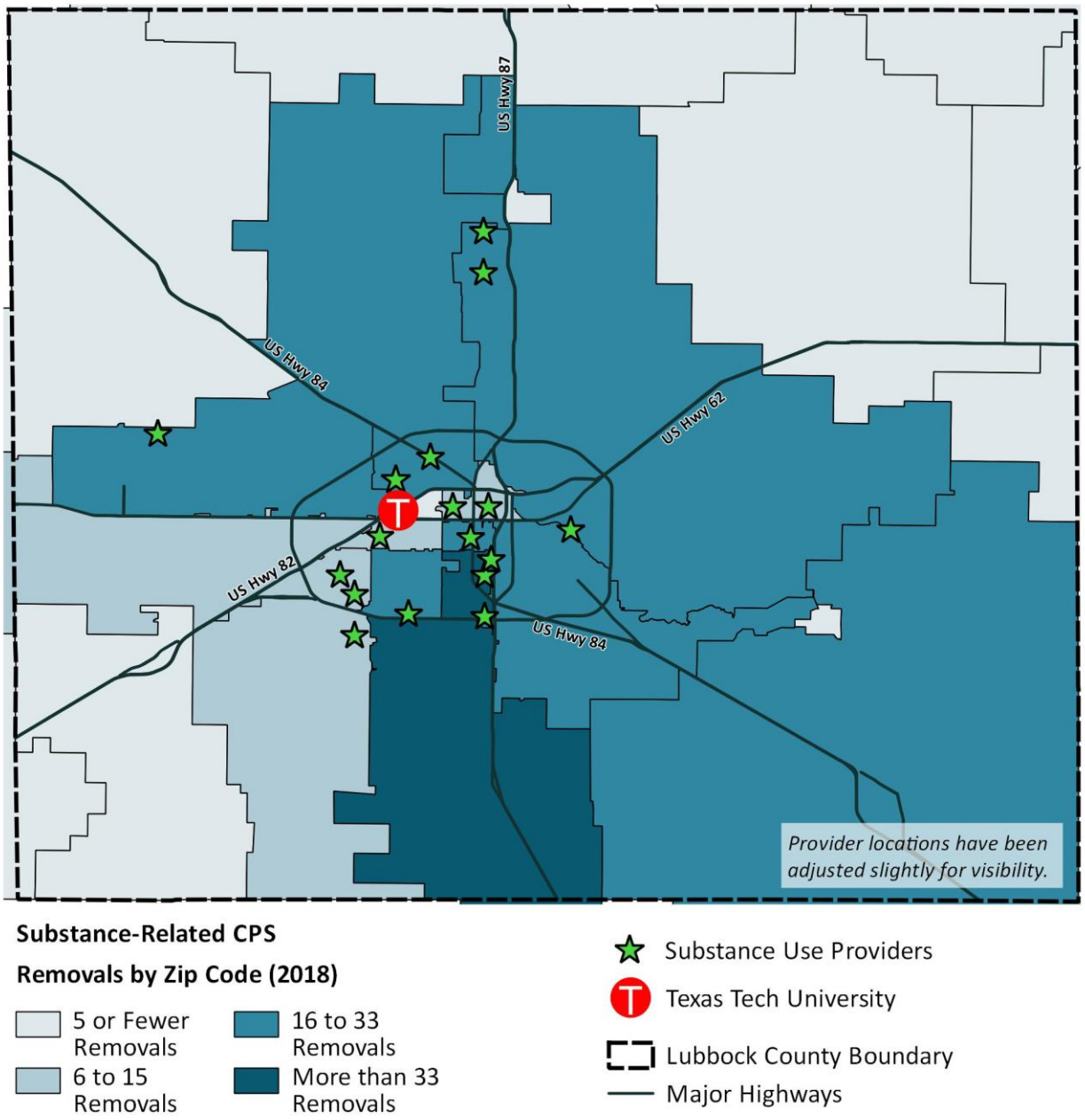
Many individuals and organizations we spoke with who are familiar with the local foster care system and the needs of children and youth in foster care mentioned numerous service challenges and system concerns. In many cases, the foster care concerns identified by knowledgeable individuals in the community were distinct from the systematic challenges identified through the qualitative review process. Some of the most pressing concerns raised by individuals we consulted for this assessment include:

- There is a lack of transportation and evening and weekend parenting support to help birth parents meet court-mandated requirements for reunification.
- The influx of children and youth being served by the foster care system in Lubbock has stretched the capacity of many service providers and led to the loss of short-term residential placement capacity for other vulnerable populations, including runaway and homeless youth.

- It is difficult to receive service authorization for Medicaid to pay for community mental health services through STAR Health, the Medicaid managed care program for children and youth in foster care. Key informants mentioned that it has been particularly challenging to get approved through STAR Health for SUD treatment and care coordination.[46]
- Higher rates of acute mental health challenges, trauma exposure, aggressive behaviors, and mental health issues are emerging at younger ages.
- There is a lack of advocacy and services to support birth families in the reunification process.
- There is an inability to provide restorative services and supports for children and youth who have been placed outside the region.
- There is an overuse of medication to control behavior among children and youth in foster care.
- There is a lack of placement options for children and youth with higher acuity mental health needs, in some cases leading to unnecessary juvenile justice involvement.
- There is a lack of access to crisis services for non-medical emergencies.
- It is difficult to recruit foster families who will parent sibling sets and older children and youth.
- High rates of SUD among birth families and few available treatment options hinder reunification. Map 6 below shows areas of the county with the highest CPS removal rates; it also shows the location of SUD providers. However, key informants noted that many locally-based SUD providers only accept private insurance, which prevents many families involved in the child welfare system from accessing care.

[46] Per the terms of the state contract with STAR Health, service coordination is required for all children and youth in foster care, and service management is required for those with more complex medical or mental health needs. These requirements are detailed in the STAR Health contract, which is available online at: https://hhs.texas.gov/sites/default/files/documents/services/health/medicaid-chip/programs/contracts/star-health-contract.pdf

Map 6: Substance Use Treatment Providers and Substance-Related CPS Removals, by Zip Code (2018)



Foster Care Opportunities

The transition to the CBC model presents new opportunities and risks for children and youth served through the foster care system in Lubbock and the surrounding areas. Many stakeholders we consulted for this project were optimistic that CBC will lead to improvements and looked forward to working in partnership with SFM. A collaborative mindset and inclusive collaborative processes will be essential for CBC to succeed. Although SFM has subject matter

expertise in foster care, it must partner with local child placement agencies (CPAs) and other child serving agencies to learn about the unique needs of children and youth in the area, build foster care placement capacity, and create a system that is responsive to a variety of needs, including the needs of children and youth in foster care, foster families, and birth families.

Ideally, a formal process would be planned or already underway to support SFM and DFPS in the transition to CBC. Collaborative efforts should address cross-agency communication, data sharing, training, foster parent recruitment, kinship care placement support, health care services, and specialized strategies to support the unique needs of the following groups of individuals:

- Those with serious mental health issues or significant behavioral challenges;
- Those with medical complexity;
- Those from groups over-represented in foster care (in Lubbock, Hispanic and African American children and youth are both over-represented);
- Children and youth who identify as LBGTQ;
- Children and youth with involvement in the justice system;
- Larger siblings groups; and
- Older youth, especially those at risk for aging out of the foster care system.

Collaborative efforts to prepare for and support CBC in Lubbock should be inclusive and highly cooperative. By drawing from the experience and expertise of the community groups and coalitions previously mentioned in this section, SFM and DFPS can also strategically address critical regional foster care challenges, including increasing the understanding of and addressing the causes for high removal rates, supporting families to prevent placement disruptions, ensuring foster care placements are in the least restrictive settings possible, keeping children and youth in foster care close to home and placed with their siblings, and identifying and supporting kinship care arrangements. Based on state and national trends that show an increase in removals due to parental substance use as well as the high rate of removals in Lubbock, it is essential that substance use disorder services experts and providers are involved with and able to contribute to collaborative planning efforts.

Juvenile Justice Overview

The Lubbock County Juvenile Justice Center (LCJJC) works with the community to serve children and youth involved in the juvenile justice system. LCJJC services include screening, investigation, supervision, counseling, and referrals for children and youth accused of a crime. Its services also include detention for youth in custody and residential treatment for those with more serious behavioral or mental health concerns. In 2018, 1,486 of the youth referred to LCJJC received some form of contact. The LCJJC residential post-adjudication facility has capacity to house up to 48 youth and includes a 12-bed unit for youth accused of a sex crime. In

2018, this residential facility served an average of 37 children and youth per day. However, there are times when the facility is at full capacity. In 2018, the center was at capacity for a total of 61 days, and during the first half of 2019, the facility was at capacity for a total of 77 days.

The LCJJC uses the Positive Achievement Change Tool (PACT) to assess children and youth for overall criminogenic risk and uses the Massachusetts Youth Screening Instrument (MAYSI) to screen for mental health issues. If ordered by a judge or attorney, or otherwise determined to be necessary, children and youth involved with LCJJC may also receive an in-depth psychological assessment. LCJJC partners with TTUHSC residents, who help perform these assessments. A recent query run through Noble Software (the host site for the PACT) showed that in 2018, 55.8% of children and youth who LCJJC assessed with the PACT were identified as having a high level of previous trauma.

Through these screenings and assessments, and its day-to-day work with youth, LCJJC noted some common mental health needs and trends among the youth it serves. These needs and trends include:

- High rates of depression,
- Post-traumatic stress disorder and other challenges related to personal trauma,
- Attention deficit / hyperactivity disorder (ADHD) and conduct disorders such as oppositional defiant disorder,
- The use of illegal and recreational drugs to cope with depression and other mental health concerns, and
- Intensifying mental health issues at earlier ages than previously observed.

Youth involved with LCJJC receive mental health services through different resources, depending on their legal status and needs. LCJJC employs three licensed in-house counselors and one licensed supervisor. It also utilizes interns from TTU for therapy services, but it faces challenges with the short-term nature of their employment, the resulting turnover, and the additional time needed to train and coach new interns. Youth on probation also have access to an in-home mental health program, which includes four licensed therapists employed directly by LCJJC and four parent support specialists. These services are extended to caregivers and siblings in the home, and can continue as long as determined necessary. For additional counseling services, LCJJC has partnerships with various community-based providers. As is true across the community, access to psychiatric services is a challenge for LCJJC. It currently contracts with Dr. Sarah Wakefield at TTUHSC, who provides onsite services once a month and office-based psychological evaluation, as needed.

Juvenile Justice Strengths

Mental health is a significant area of concern for LCJJC leadership, who believe in the importance of addressing mental health concerns and recognize that the majority of children and youth LCJJC serves have been affected by trauma. In recent years. LCJJC has engaged many organizations and individuals in the community to better meet the mental health needs of the children and youth in its care. LCJJC reports that while it has been unable to make certain connections, its relationships with many of the local schools and districts are very strong and collaborative. These relationships help schools meet the needs of their students who are involved in the juvenile justice system and support positive transitions back into the classroom.

LCJJC is also involved in a project with the Forensics Department at TTU to study if there is evidence to support the theory that children with incarcerated parents are more likely to become involved in crime. LCJJC hopes the community can use the findings to better support children and youth with a higher risk of becoming involved in the juvenile justice system involvement and to prevent this involvement from happening.

LCJJC's in-home mental health program takes a comprehensive approach to preventing children and youth on probation from becoming involved in the justice system in the future. The program provides supports for the child or youth as well as their parents and siblings. This approach aims to strengthen families as a whole, which benefits the child or youth on probation and their siblings in the home.

Finally, Dr. Wakefield's training and methods are well suited to meet the needs of children and youth who are involved with the juvenile justice system. Ideally, her methods will be shared and adopted by others who provide psychiatric support to children and youth who are served by LCJJC.

Juvenile Justice Challenges

The LCJJC staff we engaged for this assessment noted that meeting the mental health needs of youth is their greatest challenge and that, because of significant resource constraints, they struggle to identify and access services. LCJJC leadership recognizes the value and importance in creating a trauma-informed workforce and trauma-supportive policies and practices, but it struggles to find funding for additional staff training. Although LCJJC would like to adopt a formal trauma-informed approach like Trust-based Relational Intervention (TBRI), current efforts have been limited to half-day courses and a recent training on motivational interviewing because of the cost of more comprehensive trainings.

LCJJC faces unique challenges in serving youth involved in the foster care system. It struggles with child protective services (CPS) cases that are not clearly resolved, having to spend agency

funds on residential services for youth who do not have a placement, and challenges in the courts over the outcome of youth who are involved in both systems (CPS and juvenile justice). Many of the dually-involved youth LCJJC serves have experienced multiple placement breakdowns and some have been forced to remain in detention because of a lack of viable community placement options.

LCJJC staff identified that one of their top need was to provide supports for youth who are involved in both the foster care and juvenile justice. Staff also identified other top needs such as crisis stabilization capacity, locally-based psychiatric beds, and expanded access to child and adolescent psychiatrists in the community. LCJJC also experiences challenges in meeting the needs of youth with intellectual and developmental disabilities, for whom there are few resources locally and across the state as a whole.

Juvenile Justice Opportunities

Given the high rates of trauma exposure among children and youth served by LCJJC, it is critical that the all aspects of the juvenile justice system be aware of and responsive to trauma. Despite the best intentions, if front-line staff working directly with children and youth do not have the right training and ongoing support, they can inadvertently trigger past traumas and exacerbate challenging behaviors. LCJJC leadership believes expanded training on trauma would greatly benefit the children and youth LCJJC serves, but it has not identified the resources to do so in an in-depth or consistent manner. Other organizations in Lubbock can help address these concerns by partnering with LCJJC to help identify and pay for trauma-related training, which should occur locally and include ongoing opportunities to reinforce awareness and key skills. LCJJC should also consider coordinating with the Texas Juvenile Justice Department (TJJD) to access enhanced trainings to better understand and implement trauma-informed care. TJJD partnered with the National Child Traumatic Stress Network (NCTSN) to develop trauma-informed care training specifically for juvenile justice and has internal resources on TBRI.

The in-home mental health supports LCJJC provides for children, youth, and their families include components of intensive home-based service models. These supports are a system strength that can be further built upon to improve outcomes. While LCJJC provides access to high quality psychiatric treatment, counseling services, and in-home supports, many of the children and youth it serves need additional intensive therapeutic supports to address their complex mental health needs and associated behaviors. Dialectical Behavior Therapy (DBT) and Multisystemic Therapy (MST) have shown to decrease recidivism and improve overall outcomes for youth with juvenile justice experience, and are examples of evidence-based programs and practices that could build on current LCJJC interventions. DBT focuses on four core competencies to decrease conflict in relationships and help the recipient better cope with and manage painful experiences. The four competencies include mindfulness, distress tolerance, interpersonal effectiveness, and emotion regulation. MST is a family- and community-based

treatment for at-risk youth with intensive needs and their families. MST has been proven to be effective for treating youth who have committed violent offenses, have serious emotional disorders or substance abuse concerns, are at risk of out-of-home placement, and have experienced abuse and neglect.[47] MST reduces delinquent and antisocial behavior by addressing the core causes of such conduct, viewing the "client" as a network of systems that includes family, peers, school, and neighborhood.

Implementing DBT or MST will require additional resources and training. Some of the related costs may be reimbursable through Medicaid managed care "in lieu" of services, which allow service substitutions for effective practices. There are also more immediate ways to help meet the needs of the children and youth served by LCJJC who have the highest mental health needs. StarCare can work with LCJJC to help provide access to the Youth Empowerment Services (YES) waiver, which is a Medicaid program that serves children and youth between the ages of three and 18 years, who have a qualifying mental health diagnosis and are at risk for out-of-home placement. LCJJC can review, strengthen, and expand the capacity of its current intensive home and community-based services. Additionally, hiring specially-trained mental health probation officers could help meet the diverse needs of children and youth with the highest level of behavioral and mental health problems.

A common problem throughout most of the state is that children and youth with mental health issues – and often those with intellectual disabilities – are detained in the juvenile justice system when they experience a mental health crisis because there are no alternative short-term options. Establishing short-term crisis mental health beds in the community would divert children and youth with mental health issues from the juvenile justice system and could serve as a referral point to connect them with ongoing services and supports to prevent the re-occurrence of crises and future involvement in the juvenile justice system. Crisis bed capacity would not only serve children and youth who would otherwise be referred to LCJJC, it would also help reduce inpatient psychiatric admissions, prevent placement disruptions for children and youth in foster care, and could even be used to support the short-term needs of children and youth who have been commercially sexually exploited. The development of crisis beds could be funded and supported through a collaboration between many different local providers and groups, including StarCare, Covenant, UMC, and TTUSC.

Youth and Young Adults

Youth and young adults warrant special consideration when evaluating community mental health needs and service options. The youth and early adult years are often critical times for recognizing emerging mental health needs and providing consistent treatment for existing

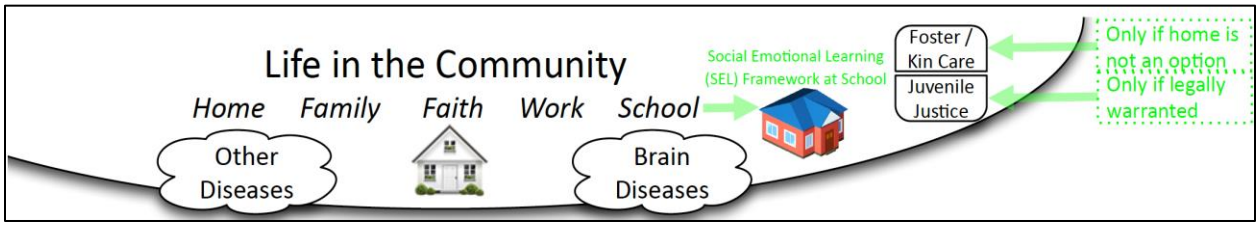
[47] Hengeller, S. W., & Shoenwald, S. K. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. *Social Policy Report, 25*(1): 1–20.

mental health issues. Many child and youth serving professionals interviewed for this project noted high needs and a lack of resources for addressing the mental health and life skills needs of youth transitioning to adulthood. StarCare noted the need for these services and is contemplating establishing a program for transition-age youth. However, StarCare does not have immediate plans to implement this program. One very positive development is that StarCare recently received approval to create a First Episode Psychosis (FEP) program. In addition, other programs that serve transition-age youth target highly specialized populations. These programs and provider groups include the Burkhart Center for Autism, the transitional living program at Children's Home of Lubbock, and the Runaway and Homeless grant through Catholic Charities. TTU also provides an array of highly accessible mental health services for its students, which include an all-hours crisis hotline, walk-in counseling services, telehealth counseling for remote students, and specialized therapies to address specific mental health needs.

Systematic Considerations

The remainder of this section focuses on the five components that together constitute the children's mental health system as a whole. For each component, we describe strengths, challenges, and opportunities. These findings are informed by numerous conversations we had with locally-based child serving organizations, combined with research on national best practice and analysis of quantitative data from available sources.

Component 0: Life in the Community



Component 0 refers to community settings that provide a broad range of child, youth, and family supports that help prevent behavioral health issues or lead to the early detection and minimization of behavioral health needs. There are many different types of individuals and organizations that support children, youth, and families at the community level. These individuals and groups range from faith-based communities to child care providers to school-affiliated organizations. Several organizations we interviewed represent community highlights for Component 0, although there are many other organizations and service providers we did not consult as part of this assessment who have key roles in strengthening life in the community for children, youth, and families in Lubbock. Organizations we interviewed that provide community-strengthening services and supports include the Parenting Cottage, Catholic Charities, Communities In Schools (CIS), Contact Lubbock, the YWCA of Lubbock, and

the three school districts included in this analysis (Frenship, Lubbock Cooper, and Lubbock). Below, we outline the strengths, challenges, and opportunities that were identified in these interviews.

Community Strengths (Component 0)

Component 0 – Community Strength 1: Lubbock is home to reputable child-serving organizations who value mental health service and are motivated to increase access to them. The Lubbock Area United Way (LAUW) supports 23 community partners, the majority of which serve children and youth. Many of these partner agencies have long-standing experience in providing or promoting early childhood supports and are widely trusted in the community. In recent years, the LAUW has recognized mental health as a top community priority and is working strategically across the community to reduce stigma, increase available mental health services, and facilitate access to those services. LAUW's many community partners share its commitment to addressing children's mental health needs. CIS, Catholic Charities, and the Parenting Cottage all address mental health in various ways, ranging from prevention to detection and referral to supports. Many of these and other LAUW partner organizations also connect young people with a supportive adult. Research indicates that having a positive and consistent relationship with an adult increases protective factors, which can reduce the chance of negative outcomes otherwise associated with the experience of multiple traumas in childhood.[48] By providing services that increase overall well-being and resiliency, and in some cases providing direct mental health support, these organizations touch the lives of thousands of local families and have a significant collective impact.

Component 0 – Community Strength 2: Many community-based organizations support students through partnerships with local schools. Since this assessment was concentrated on the metro Lubbock area, our review of school districts focused on Lubbock Independent School District (ISD), Lubbock Cooper, ISD and Frenship ISD. All three districts have schools served by the Telemedicine Wellness Intervention Triage and Referral (TWITR) project, CIS, and Catholic Charities. Contact Lubbock also provides suicide awareness trainings at schools in Frenship and Lubbock Cooper ISDs.

CIS and Catholic Charities provide the most consistent non-school-based support to students. Through a state grant program called Services to At-Risk Youth (STAR), Catholic Charities employs case managers who provide a range of support services when and where a family chooses. These services include help with decision-making, self-esteem, skill building, and stress

[48] Brown, S. M., & Shillington, A. M. (2017). Childhood adversity and the risk of substance use and delinquency: The role of protective adult relationships. *Child Abuse & Neglect, 63,* 211–221. Retrieved from: http://dx.doi.org/10.1016/j.chiabu.2016.11.006

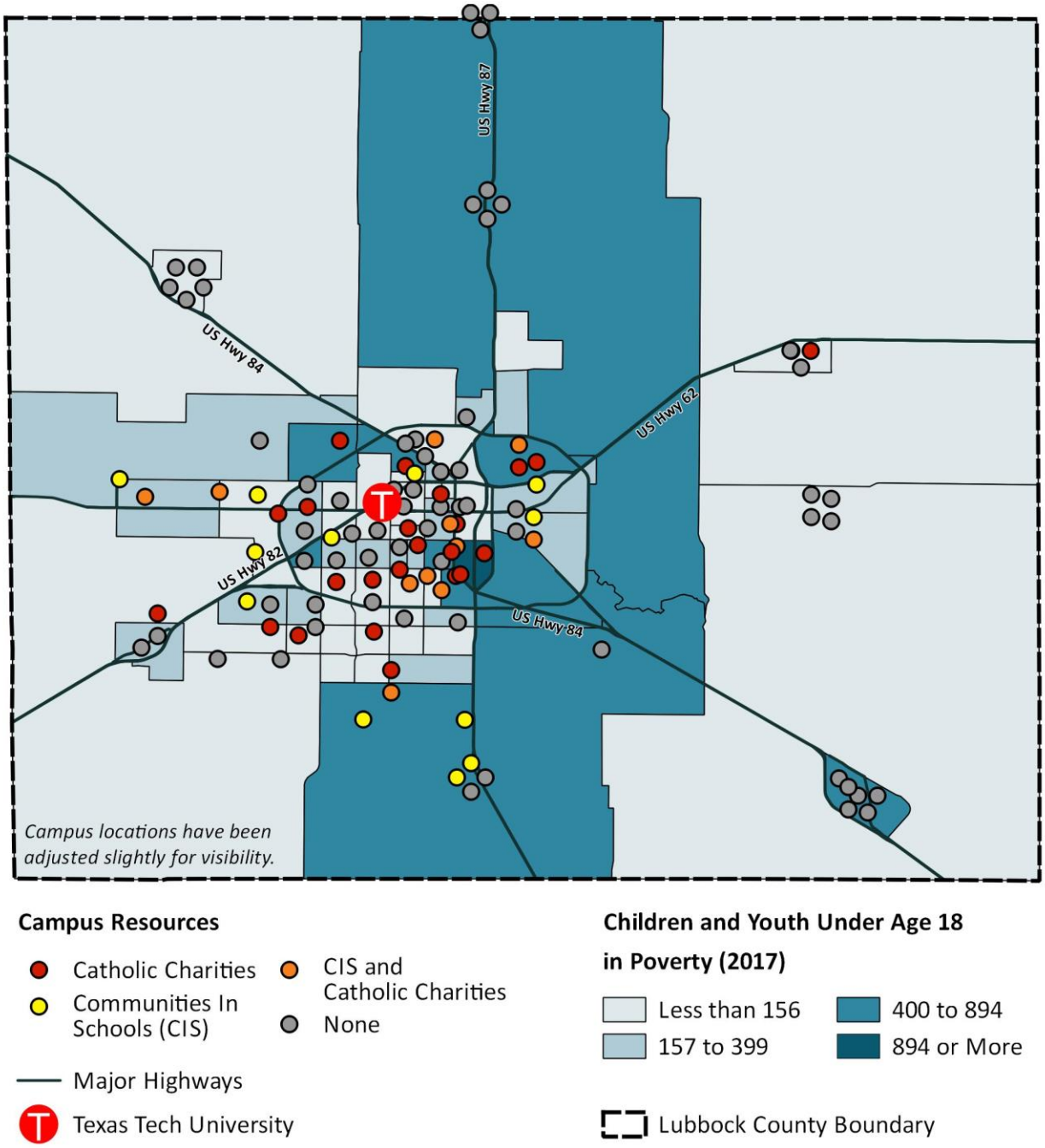
management. Catholic Charities case managers have strong relationships with local schools and frequently provide their services on school campuses.

CIS provides services to 60 area schools, 26 of which are in Frenship, Lubbock Cooper, and Lubbock ISD. While CIS has always provided supports and mentorship that contribute to positive mental health, it has recently initiated a new mental health initiative in response to an increase in need among the students it serves. Through this new effort, CIS has partnered with Rise Counseling to facilitate access to mental health services for students with immediate and persistent mental health needs. CIS reduces barriers to students in need of these services by initiating the referrals, addressing funding for the services, helping arrange transportation to services, communicating with family members and parents, communicating with school-based and community counselors to learn how to support these students while at school, and monitoring students' progress throughout the entire process. Map 7 on the next page shows the school locations for CIS and Catholic Charities, along with school campuses without these resources, layered over geographic areas representing data on the number of children and youth in poverty.

The TWITR Project, which is offered through the Institute for Rural and Community Health at TTUHSC, helps identify and screen middle and high school students at risk for mental health concerns and uses telemedicine to provide psychiatric support through the TTUHSC Department of Psychiatry. If the screening results indicate a student has a persistent or potentially significant mental health concern, the program connects the student through telemedicine technology to a board certified child and adolescent psychiatrist, who can make a diagnosis and work with others on the TWITR Project team to establish a care plan that connects the student to appropriate local services.

Map 7 shows the location of community resources where support is provided on an elementary, middle school, or high school campus. Although the TWITR Project serves many of these schools, its service data are only available by district and are not included in this map.

Map 7: Elementary, Middle, and High School Campuses in Lubbock with Community Resources



Component 0 – Community Strength 3: A growing number of local organizations are expanding their investments in prevention. The Parenting Cottage has decades of experience in providing the community with early childhood education services, including a heavy emphasis on literacy. In 2015, the Parenting Cottage received one of the Healthy Outcomes through Prevention and Early Support (HOPES) grants through the Prevention and Early

Intervention (PEI) division at DFPS. The HOPES project provides state funding to select counties to reduce child abuse and neglect through a variety of evidence-based programs that support children ages zero to five, and their families. Now in the fourth year of its five-year grant, the Parenting Cottage either directly provides services or collaborates with local partners to provide an array of services, including basic needs support, parent education, group counseling, and administration of the evidence-based program Parents as Teachers, which includes a variety of services and supports for young children and their families.

Across the board, unaddressed caregiver mental health needs presents a significant risk factor for child neglect and abuse. Of all surveyed families who received services through a HOPES grant throughout the state, 55% identified at least one caregiver with a mental health concern. Through its HOPES grant, the Parenting Cottage focuses on mothers who received pregnancy-related Medicaid and have experienced antepartum and postpartum depression. Mothers enrolled with Medicaid are more likely to experience delays in receiving treatment for postpartum depression and receive fewer related services overall than those with private insurance.[49] Women who receive pregnancy-related Medicaid also lose coverage six weeks after giving birth, which presents numerous challenges in maintaining health and mental health services. By connecting this population to ongoing mental health services, the Parenting Cottage provides a huge benefit not only for new mothers, but also for their infants, whose well-being is closely tied to that of their mother.

Strengthening families and reducing child abuse and neglect through preventative efforts are also growing priorities for Children's Hope, a local child placement agency (CPA). Recognizing that there are a host of challenges that contribute to child removals that also prevent family reunification for children in foster care, Children's Hope is planning to initiate a new community-based program, which will involve close collaboration with a network of other local providers, after it completes a local needs assessment to identify significant gaps and unmet needs. Children's Hope will build in-house capacity to help fulfill needs that are currently unmet in the community. The program will include individual and family counseling along with other services Children's Hope offers.

Lubbock ISD also integrates preventative and universal supports into many of its schools and, over the past three years, has increased district- level training support for related. These supports include faculty and staff training on how to identify and support students with histories of trauma. Lubbock ISD has also implemented restorative circles at 22 out of its 52

[49] Sherman, L. J., & Ali, M. M. (2018). Diagnosis of postpartum depression and timing and types of treatment received differ for women with private and Medicaid coverage. *Women's Health Issues, 28*(6). Retrieved from https://doi.org/10.1016/j.whi.2018.08.007

campuses and reports positive outcomes and experiences from the students who are involved in these services.

Community Challenges (Component 0)

Component 0 – Community Challenge 1: Students are dealing with diverse and significant mental health challenges. Input we received from two focus groups with local high school students and interviews with school personnel and others working in schools, along with our analysis of available Texas and local data sources, all suggest similar findings: mental health problems among school-age children and youth are a source of major concern and appear to be emerging at younger ages.

Statewide, mental health issues among students are alarming. The Texas Youth Risk Behavior Survey is a classroom-administered test, conducted in alternating years, that is designed to identify major health and behavioral risks. Results from the most recent Texas Youth Risk Behavior Survey conducted in September 2018 indicate that 17.8% of surveyed high school students seriously thought about suicide, 14.5% made a plan, and 12.3% made an attempt.[50]

Catholic Charities has witnessed an increase in complex mental health needs and suicidal outcries among the children and youth it serves. Pediatricians, school personnel, and community organizations we interviewed for this project reported similar concerns – that mental and behavioral health challenges are emerging at younger ages and the number of children and youth experiencing crises have increased substantially within the past five to ten years.

Many key informants cited certain themes in the mental health concerns they have observed in children and youth in their communities. Some of these themes include difficulty in engaging parents or caregivers of children and youth who are in distress, difficulty in motivating parents and caregivers to seek mental health services on behalf of their children, an increase in suicidal outcries, a lack of access to prescribed medications or a failure to continue taking them, an increase in anxiety among school-age children, and an increase in disruptive and defiant behaviors.

Component 0 – Community Challenge 2: Many schools are open to engaging with outside groups to help address mental health, but many of these contacts are intermittent, which inhibits trust.

Through their consistent presence onsite, school counselors often serve as a known presence, which makes it easier for students to build trust. Research indicates that school mental health

[50] Texas Department of State Health Services. (2019, April 1*). Texas youth risk behavior surveillance system*. Texas Health and Human Services Commission. Retrieved from: https://www.dshs.texas.gov/chs/yrbs/default.shtm

resources can provide significant advantages in helping to recognize student mental health needs early, and in facilitating access to services, when needed.[51] Multiple students who participated in a school focus group at Frenship High School stated they would go to their school counselor if they were in distress. However, local school counselors are often responsible for supporting at least 400 students, including their testing and college preparation needs, leaving little room to provide the type of mental health support students need. These ratios are in stark contrast to the 1:250 ratio recommended by the American School Counselor Association and the 1:350 ratio recommended by the Texas Counseling Association.

Other than their school counselors, Lubbock schools have few consistent onsite resources who are positioned to build student trust and responsible for identifying and creating linkages to resources that address student mental health needs. As of December 2018, Lubbock ISD also employed three social workers and one staff coordinator, who focuses on service connections for homeless students.

While CIS and Catholic Charities are a known presence at the schools they serve, interactions with TWITR, Contact Lubbock, and StarCare are case-based and generally short term. Although Frenship and Lubbock Cooper ISDs recognize and share concerns about the mental health of their students, they do not have any school social workers or psychologists. Lubbock ISD partners with Texas Tech to provide students and parents with counseling services, but resource constraints prevent the ISD from being able to connect all referred students to services. Having consistent and dedicated onsite mental health providers or liaisons would enable earlier identification of more students who have emerging mental health needs, help transcend traditional barriers to care such as stigma and transportation challenges, and increase access to services. Onsite mental health resources could also provide support to teachers who are challenged to meet the needs of students with defiant, disruptive, or otherwise problematic behaviors.

Component 0 – Community Challenge 3: Children and youth in Lubbock County experience an array of community-level risk factors, including high rates of child abuse and neglect.
To maximize the limited number of dollars available through the HOPES grant, counties were ranked by five different factors that increase risk for abuse and neglect. These factors included child abuse and neglect fatalities, child poverty, substance abuse convictions and treatment facility admissions, domestic violence convictions, and adolescent pregnancy rates. Of the 33 counties that were evaluated, Lubbock County was ranked as having the ninth highest overall risk based on the five factors.

[51] Green, J. G. et al. (2013, May). School mental health resources and adolescent mental health service use. *Journal of the American Academy of Child & Adolescent Psychiatry , 52* (5) , 501–510.

Between 2013 and 2017, over a third (34.2%) of children in Lubbock County were being raised by a single parent.[52] There were also slightly more children in Lubbock County who lived in poverty than in Texas as a whole (22% vs. 21%).[53] Adolescent births have also been a significant risk factor in Lubbock. In 2015, about 8% of all births in Texas were to an adolescent mother, but in the same year, almost 10% of births in Lubbock County were to adolescent mothers.[54]

These factors can all contribute to family instability, which increases risks for child abuse, domestic violence, and substance abuse. As we referenced in the previous discussion on the local foster care system, child abuse and neglect are significant concerns in Lubbock. In 2015, the statewide rate of confirmed victims of child abuse (for children ages 0 to 17 years) was 9.1 to every 1,000 children. The same year, there were 15.4 confirmed victims of child abuse in Lubbock County for every 1,000 children.[55]

Community Opportunities (Component 0)

Component 0 – Community Opportunity 1: Implement a Multi-tiered System of Supports (MTSS) framework at local schools to support improvements in student outcomes and well-being. The three school districts we consulted for this assessment (Lubbock ISD, Frenship ISD, and Lubbock Cooper ISD) have leaders who recognize the importance of addressing student mental health in order to maximize student outcomes. The combination of leadership investment in school mental health and recent investments through the Texas Education Agency creates a tremendous opportunity for expanding school-linked mental health prevention and support services. An ideal range of school mental health services and supports includes mental health promotion and prevention that reaches all students, combined with screening, assessment, and targeted and intensive interventions for students with more

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[52] Kids Count Data Center. (n.d.). *Children in single-parent families in Texas.* The Annie E. Casey Foundation. Retrieved from https://datacenter.kidscount.org/data/tables/3059-children-in-single-parent-families?loc=45&loct=5#detailed/5/6515-6768/false/1691,1607,1572,1485,1376,1201,1074,1000,939,11/any/8192,8193

[53] Kids Count Data Center. (n.d.). *Poverty (0–17) in Texas.* The Annie E. Casey Foundation. Retrieved from https://datacenter.kidscount.org/data/tables/3065-poverty-0-17?loc=45&loct=5#detailed/5/6515-6768/false/871,870,573,869,36,868,867,133,38,35/any/8190,8191

[54] Kids Count Data Center. (n.d.). *Births to teens (Age 19 and younger) in Texas*. The Annie E. Casey Foundation. Retrieved from https://datacenter.kidscount.org/data/tables/8117-births-to-teens-age-19-and-younger?loc=45&loct=5#detailed/2/any/false/573,869,36,868,867,133/any/15580,15581
Kids Count Data Center. (n.d.). Births to teens (Age 19 and younger) in Lubbock. The Annie E. Casey Foundation. Retrieved from https://datacenter.kidscount.org/data/tables/8117-births-to-teens-age-19-and-younger?loc=45&loct=5#detailed/5/6666/false/573,869,36,868,867,133/any/15580,15581

[55] Kids Count Data Center. (n.d.). *Confirmed victims of child abuse in Lubbock.* The Annie E. Casey Foundation. Retrieved from https://datacenter.kidscount.org/data/tables/3150-confirmed-victims-of-child-abuse?loc=45&loct=5#detailed/5/6666/false/573,869,36,868,867,133,38,35,18,17/any/8251,8252

complex mental health needs.[56] This comprehensive approach is described as a Multi-tiered System of Supports (MTSS). MTSS brings together the two long-established, research-supported school practices of Response to Intervention (RtI) and Positive Behavioral Interventions and Supports (PBIS), linking both the academic needs RtI aims to address with the behavioral support identified within the PBIS framework.

The MTSS framework includes universal mental health promotion strategies for all students (Tier 1),[57] targeted services and supports for a smaller group of students experiencing a mental health challenge or identified as being at risk for a mental health concern (Tier 2), and specialized and individualized services for the small number of students with complex mental health needs that Tier 1 or Tier 2 programs cannot adequately meet (Tier 3). Universal supports and interventions (Tier 1) are implemented for all students within the school building and are intended to establish expectations for the delivery of core content and curriculum, prevent some challenging behaviors, and build the social and emotional skills all students need. Targeted supports and interventions (Tier 2) target a subset of students with similar, mild to moderate mental and behavioral health needs or academic deficits to support their success in the school setting and minimize their risk for undesirable outcomes (these students require targeted supports in addition to universal supports). Intensive supports and interventions (Tier 3) are highly individualized interventions for students with complex mental and behavioral health needs and/or academic deficits (these students require intensive supports in addition to targeted and universal supports). For a more in-depth discussion of MTSS and examples of Tier 1, 2, and 3 interventions, please see our report, *Mental and Behavioral Health Roadmap and Toolkit for Schools*.

While ideal to do so, schools do not have to implement the full range of MTSS programming to have a profound impact on students. Research indicates that a sense of connectedness – meaning the belief that staff, faculty, and peers care about students – can have a significant benefit on student outlook and outcomes.[58] For example, the implementation of a targeted Tier 1 intervention to foster relationships and a sense of community may alone result in positive outcomes such as improved school attendance rates, reduced bullying, and increases in on-time grade level completion. Youth Mental Health First Aid aims to increase the availability of

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[56] American Institutes for Research. (2017, September*). Mental health needs of children and youth: The benefits of having schools assess available programs and services*. Retrieved from: https://www.air.org/sites/default/files/downloads/report/Mental-Health-Needs-Assessment-Brief-September-2017.pdf

[57] A description of programs for children and youth with emotional disorders is included in our report, *Mental and Behavioral Health Roadmap and Toolkit for Schools, which* can be found at https://www.texasstateofmind.org/wp-content/uploads/2019/10/Roadmap_and_Toolkit-for-Schools_R4b.pdf

[58] Centers for Disease Control and Prevention. (2009, July). *Fostering school connectedness: Improving student health and academic achievement.* Retrieved from https://www.cdc.gov/healthyyouth/protective/pdf/connectedness_administrators.pdf

trained people within a school system who can provide a sense of connectedness. This program cross-trains participants on what to do and say to make a difference when interacting with a student who is experiencing a mental health challenge.

Contact Lubbock also helps foster relationships and a sense of community. Although its interactions with students is limited, Contact Lubbock asks all students it contacts to identify if there is one person in their life they trust and could go to if they experienced a crisis. If the student indicates they do not have a single trusted adult in their lives, school counselors follow up with the student. This seemingly simple action is an excellent way to help identify students who may be at risk. Research on protective factors that promote resiliency in the face of emotional hardship shows that having just one supportive and stable relationship with an adult can have a profound positive impact.[59]

Component 0 – Community Opportunity 2: Invest in school-based or school-linked mental health resources. As we previously mentioned, there are numerous benefits to having consistent, dedicated onsite mental health resources for students. Some of the local school personnel we consulted for this project stated if they could do anything to improve support for student mental health needs, they would prioritize obtaining an onsite mental health liaison who could respond when a peer or teacher identified a student with a known or potential mental health concern. Many individuals we consulted for this project also stated that parental confusion about available mental health services hindered access to care for students with mental health needs. A school-based mental health liaison could support parents, teachers, and students by helping families connect to the most appropriate mental health resources in the community.

Schools do not have to shoulder the entire burden of hiring their own mental health supports. Texas House Bill (HB) 19 (86th Legislative Session, 2019) supports this concept by requiring local mental health authorities (LMHAs) to provide a mental health professional at all of the Education Service Centers (ESCs) in Texas to help support mental health-related training and consultation for local districts and schools. Partnerships with community-based providers like StarCare and Covenant Health could also create new school-linked mental health resources, including trainings on trauma, development of school health curriculum on mental health, or outreach and support to parents and caregivers when a mental health concern is identified.

Component 0 – Community Opportunity 3: Address childhood trauma as a community. Understanding and recognizing the prevalence of adverse childhood experiences (ACEs) helps to recognize and treat trauma. ACEs are traumatic or stressful events that take place in

[59] National Scientific Council on the Developing Child (2015). *Supportive Relationships and Active Skill-Building Strengthen the Foundations of Resilience: Working Paper No. 13*. Retrieved from www.developingchild.harvard.edu.

childhood and can potentially have enduring and damaging effects on a child's health and well-being. There are many types of childhood traumas (or ACEs), including economic hardship, abuse and neglect, neighborhood or domestic violence, growing up with a parent who has a mental illness or a substance use disorder, incarceration of a parent, or parental divorce. Without appropriate intervention, the more ACEs a child experiences, the higher their risk is for social and health problems later in life.[60]

A trauma-informed approach acknowledges the prevalence and impact of trauma and attempts to create a sense of safety for all people, whether or not they have experienced trauma. Becoming trauma-informed requires re-examination of policies and procedures that may result in participants feeling a loss of control, training staff to be welcoming and non-judgmental, and modifying physical environments. Becoming trauma-informed also involves minimizing perceived threats, avoiding re-traumatization, and supporting recovery.

Because there are likely to be children and youth with a history of trauma in every setting, there are many child serving organizations that could improve how they support children and youth by becoming more aware of trauma and integrating trauma-informed practices into their policies, procedures, and interpersonal interactions. In order to meet these objectives, organizational staff must understand how trauma affects behaviors, be trained to help identify child and youth needs, and identify the services and supports required to meet these needs.

There are several existing opportunities that can be used or expanded to increase trauma-informed practices for children and youth in Lubbock. The recent passage of HB 18 (86th Texas Legislature, 2019) requires that school districts adopt and implement plans to integrate trauma-informed practices in school environments and district improvements plans. The plans must include trauma training for teachers and staff, increase parent awareness on trauma and its consequences, and provide training on trauma awareness and trauma-informed practices, based on a list of research-based programs maintained by the Texas Education Agency. Districts and schools are encouraged to partner with their LMHA to help support training efforts, if possible and appropriate.

Partnering with StarCare or an ESC is one of many ways that schools and child-serving organizations in Lubbock could increase access to training on trauma for their staff. The Center for Superheroes offers an outstanding opportunity unique to Lubbock for accessing information on trauma. The Center for Superheroes was founded with a core mission focused on addressing trauma. Its approach includes treatment, training, and research, and it has expertise in the application of evidence-based practices (EBPs), parent training, secondary trauma, and

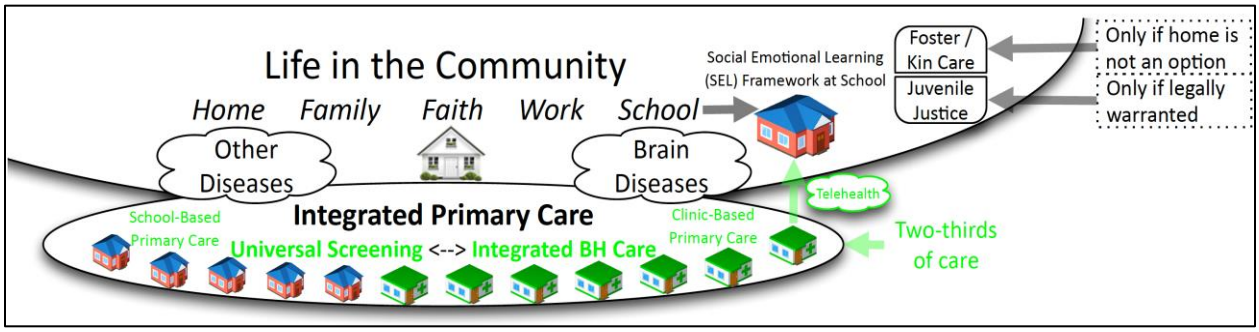
[60] Centers for Disease Control and Prevention. (2016, March). *Adverse childhood experiences (ACEs).* Retrieved from https://www.cdc.gov/violenceprevention/acestudy/.

workforce development. Notably, the Center for Superheroes is also intentional about integrating youth voice into its work, which is a trauma-informed practice that ensures the population being served has a voice not only in the care they receive but also in the organization's overall practices. The Center for Superheroes already provides services, training, and support to several local organizations, but with additional resources, it would be an excellent local hub for expanding trauma-focused training.

Component 0 – Community Opportunity 4: Increase and formalize community collaboration on child and youth mental health and integrate youth voice in the process. There are several groups and collaborations that bring child and youth serving organizations together in Lubbock, but most are limited in terms of scope or purpose, and none that were included in this assessment are focused on mental health as a whole. All of the dozens of stakeholders we consulted for this assessment who were involved with child and youth services recognized child and youth mental health as an essential, though extremely complex, issue. These organizations could establish a formal coalition or collaborative that could develop a child and youth mental health plan to help guide future community investments in children and youth mental health. The group could also address other important topics such as how to effectively partner with Texas Tech to increase local retention of graduates in mental health-related fields, expand trauma-informed care practices, or improve care coordination so young people have access to a full continuum of mental health services and supports. The *Travis County Plan for Children's Mental Health* provides one such example.

Youth have unique insights into the stressors and triggers that affect them and their peers. They also have concrete ideas about systems improvements to address their concerns. The students in the high school focus groups we convened as part of this study provided useful and realistic strategies that could be implemented at their school to ease their anxiety and improve their well-being. It is important to integrate youth voice into the process of developing a community collaborative on children's mental health, whatever form it takes.

Component 1: Integrated Behavioral Health



Pediatric primary care is the front line for health care delivery and the place where families are most likely to obtain clinical care. These settings provide services that are generally affordable, accessible, and easy to identify and navigate. Specialty mental health providers do not have the capacity to screen and treat all children and youth with a mental health disorder, and connections to specialty mental health providers are not always made. Today, about 75% of children and youth with psychiatric disorders are seen in pediatric and other primary care settings.[61] Training and supporting these providers is an effective strategy for expanding access and connecting children and youth to appropriate services and mental health interventions.

Pediatricians and other primary care providers have traditionally had difficulty delivering mental health services because of limited time with each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and limited access to behavioral health specialists. However, a combination of recent policies and funding opportunities, technological advances, and a growing awareness of the connection between physical and mental health has led to numerous advances in the successful integration of mental health care into primary care practices. When pediatricians and other pediatric primary care providers are trained and positioned to help identify and respond to potential mental health concerns, children and youth receive improved mental health care through earlier detection and intervention. Furthermore, when primary care practices are trained and supported to respond to mild to moderate mental health needs, overtaxed mental health providers such as child and adolescent psychiatrists can focus on treating the needs of children and youth with more complex and urgent needs. Research shows in states with fully-scaled statewide integrated care programs and properly trained pediatricians and other primary care providers, about two thirds of children and youth with behavioral health needs can be effectively served in a pediatric care setting with integrated behavioral health supports.[62] New opportunities for using telehealth and telemedicine can further increase access to mental health care and the overall quality of care.

There are currently few concerted efforts in Lubbock to integrate mental health care into pediatric primary care, but the community has numerous attributes that could support the expansion of these practices in the future. Ideally, integrated care efforts include an infrastructure of universal evidence-based screening (using tools such as the Patient Health Questionnaire–9 or –Adolescent to identify needs for all people seen in a practice),

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

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

measurement-based care (repeated use of these tools to monitor symptom reduction and gauge treatment progress over time), psychiatric consultation, and collaborative care models (co-located behavioral health specialists). Drawing from research and national practice models on integrated behavioral health, we identified seven core components of integrated care, any of which could be adopted at the individual practice level to advance care in Lubbock. These core components include:[63]

1. Integrated organizational culture,
2. Population health management,
3. Structured use of a team approach,
4. Integrated behavioral health staff competencies,
5. Universal screening for physical and behavioral health conditions,
6. Integrated and person-centered planning, and
7. Systematic use of evidence-based clinical models.

Community Strengths (Component 1)

Component 1 – Community Strength 1: Individual practitioners have established informal coordinated care arrangements to help their patients. Two pediatric practices we consulted for this assessment have created their own collaborative arrangements by combining their awareness of mental health needs with their personal relationships with one or more child and adolescent psychiatrists. Through these partnerships, pediatricians work with psychiatrists and other mental health professionals to create care plans for children and youth who are waiting for a psychiatric appointment. Years of experience in the community has also enabled these practitioners to hone the referrals they make for counseling and substance abuse services and provide highly individualized mental health referrals. While these arrangements are currently informal, they demonstrate the potential of using existing resources to provide coordinated care for children and youth in Lubbock.

Component 1 – Community Strength 2: Lubbock has outstanding models in place for providing coordinated care. The Center for Superheroes and the Burkhart Center for Autism Education & Research are TTU-based state-of-the-art models for providing comprehensive, interdisciplinary care. Both centers provide screening and assessment, evidence-based clinical practices, case management and service coordination, and meaningful parenting and family supports, along with many other services. Although they serve specialized populations (children with foster care involvement and individuals with autism), these centers provide an excellent model for the community as to what is possible in providing coordinated care through a single provider group.

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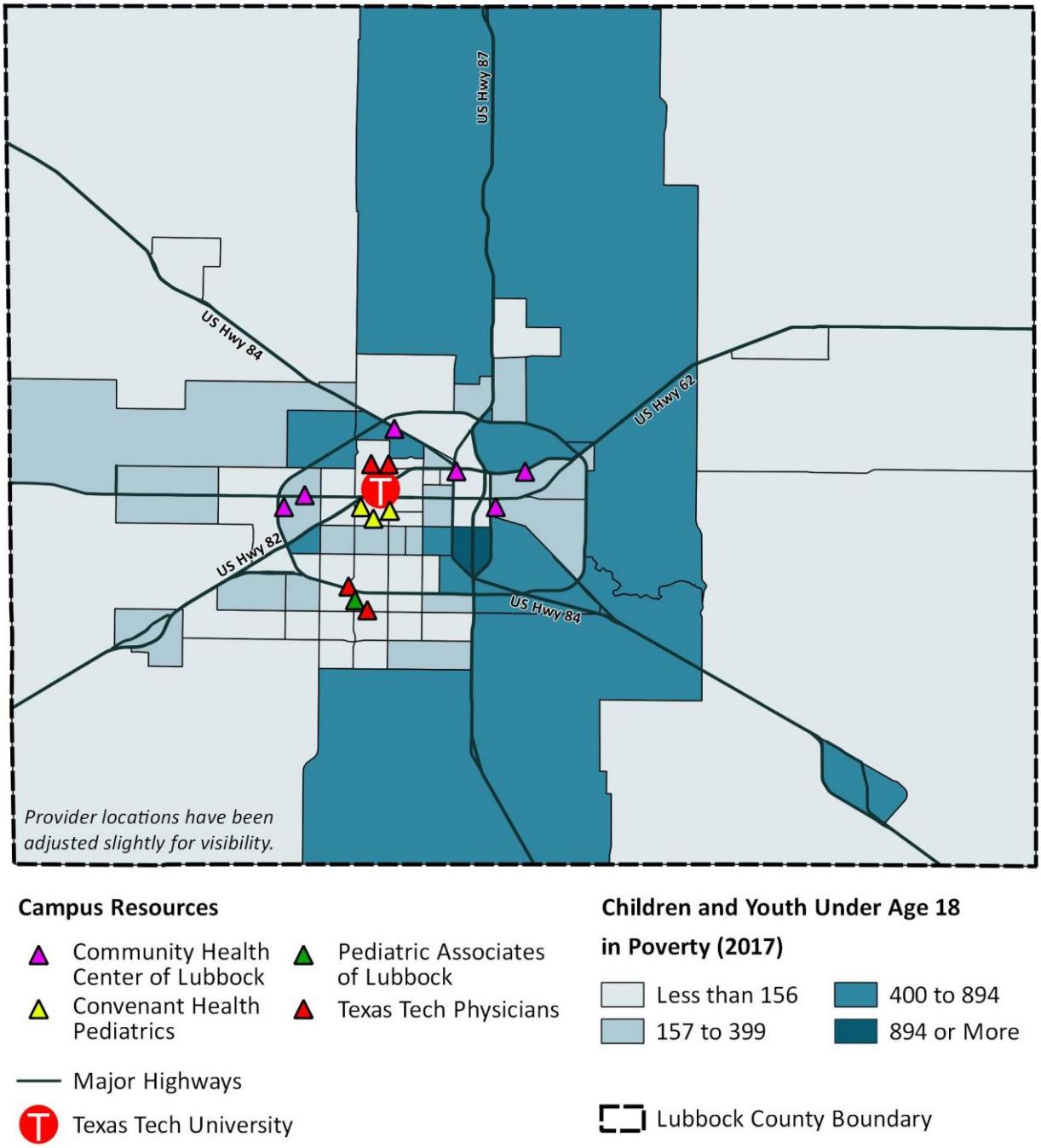
[63] Meadows Mental Health Policy Institute. (2016, August). *Best practices in integrated behavioral health*. Available online at: https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.pdf

Community Challenges (Component 1)

Component 1 – Community Challenge 1: There are no formalized pediatric integrated care programs currently in operation. The majority of children and youth in Lubbock receive primary care through Texas Tech Physicians of Lubbock, Covenant Health Pediatrics, Pediatric Associates of Lubbock, and Community Health Center of Lubbock. None of the stakeholders we interviewed who had knowledge of these practices were aware of any integrated care programs or consistent use of any evidence-based mental health screenings at any of the local pediatric practices. As we mentioned, there are providers within these practices that have taken it upon themselves to offer mental health screenings for their patients or provide their own versions of care coordination, but none of these efforts are currently being scaled or supported at an institutional level. To provide a sense of the potential geographic reach of integrated pediatric care in Lubbock, Map 8 shows the location of the highest-volume pediatric primary care practices in Lubbock, layered over geographic areas representing data on the number of children and youth in poverty.

Map 8: Pediatric Primary Care and Children in Poverty, by Census Tract (2017)



Component 1 – Community Challenge 2: Pediatric primary care settings lack mental health supports, which can delay the detection of and intervention for mental health concerns. Because primary care practices do not have training, staff, or protocols in place to support early detection of and establish linkages to care for emerging behavioral health conditions, identification and treatment of these conditions is frequently delayed, which can result in the need for more intensive care. For example, a parent or child may present in their pediatrician's

office with an emerging mental health need. Without the training or resources required to clearly identify the need, the pediatrician is likely to make a referral to a psychiatrist. Because of the shortage of child and adolescent psychiatrists in Lubbock (as discussed in Component 2), the family is likely to wait between four and six months for an appointment. One knowledgeable key informant we consulted for this project noted it is common for a psychiatrist to quickly ascertain that the child does not need psychiatric care, but rather completely different types of services such as counseling, case management, or substance abuse treatment. In these scenarios, the inability of the primary care provider to assess needs and direct care leads to long delays in treatment, family frustration with accessing services, and often the unnecessary use of scarce psychiatric resources. Although there are some pediatric primary care providers who have developed a knowledge of different types of mental health needs and appropriate referral sources for children and youth to meet those needs, such arrangements are relationship-based, which make them difficult to replicate or establish to scale.

Component 1 – Community Challenge 3: Some community providers have reservations about implementing integrated care. There are many perceived barriers that can make individuals and systems reluctant to support integrated care. These beliefs include concerns that mental health screening will take too long in already over-burdened primary care practices, children and youth are already receiving the services they need if they have multiple providers, no appropriate mental health services are available, and mental health is outside of the scope of primary care.

Despite these reservations, the benefits of integrated care and coordinated care are well documented. Mental and physical health are deeply intertwined, and untreated mental health concerns affect physical health.[64] Over 80 rigorous studies have established the efficacy of collaborative care, and most insurers are now paying for this service.[65] Studies show that coordinated care contributes to increased patient access to behavioral health services, successful service integration, programmatic satisfaction among pediatricians, and an overall decrease in spending on emergency behavioral health services.

Fully integrated care models include formal and ongoing partnerships between primary care and licensed mental health professionals, resulting in the greatest patient benefits. However, elements of integrated care can be incorporated into primary care practices in simple and time-efficient ways, including through the adoption and use of mental health screening tools and the

[64] Ader, J. (2015). The medical home and integrated behavioral health: Advancing the policy agenda. *Pediatrics*, *135*(5). Retrieved from: https://pediatrics.aappublications.org/content/pediatrics/135/5/909.full.pdf.

[65] Alter, C. et. al. (July 2019) Wider implementation of coordinated care is inevitable. *American Psychiatric Association*. Retrieved from: https://psychnews.psychiatryonline.org/doi/10.1176/appi.pn.2019.6b7

use of psychiatric consultation programs (as discussed in the "Community Opportunities" section of Component 1).

Community Opportunities (Component 1)

Component 1 – Community Opportunity 1: Plan and collaborate to maximize opportunities presented through recently passed legislation. Provisions included in Senate Bill (SB) 11 (86th Legislative Session, 2019) will establish the Texas Child Mental Health Care Consortium to foster collaboration among state medical schools, promote and coordinate mental health research, and help address workforce issues. SB 11 establishes the following under the Consortium's oversight:

- Child Psychiatry Access Network (CPAN) – a network of comprehensive child psychiatry access centers that provide consultation services and training opportunities for pediatricians and primary care providers who are operating in the center's geographic region to better care for children and youth with behavioral health needs.
- Texas Child Health Access Through Telemedicine (TCHATT) – telemedicine or telehealth programs for identifying and assessing behavioral health needs and providing access to mental health care services for children and youth.
- Child Psychiatry Workforce Expansion – funding for psychiatrists who treat children and adolescents to serve as academic medical directors for community mental health providers, as well as new resident rotation positions under the academic medical director's supervision.
- Child and Adolescent Psychiatry Fellowships – funding for physician fellowship positions that will lead to a medical specialty in child and adolescent psychiatry.

The legislature appropriated $100 million in state funding in the 2020–2021 biennium to support the Consortium and its activities. Between the expertise gained through the TWITR Project, numerous resources associated with the Texas Tech University Health Sciences Center (TTUHSC), and the broad reach of the two large health systems (Covenant Health and UMC), Lubbock is poised to take advantage of the opportunities established and funded through SB 11. However, the success of this approach as a whole will depend on diverse community buy-in, collaboration, and ongoing support. Later in this section (and in Component 3), we include recommendations for implementing specific aspects of SB 11.

Component 2 – Community Opportunity 2: Re-envision the role of primary care and specialty care. Specialty care in most fields of medicine is mediated by the primary care practitioner, using a coordinated, team-oriented approach. Mild to moderate physical health needs are addressed at the primary care level, with no involvement of specialists, for routine presentations of conditions such as diabetes and orthopedic injuries as well as screening and care for more complex conditions. Psychiatry is in the midst of such a shift and, even for those

who maintain an overreliance on specialists, the shortage of specialty providers who serve children and youth is not expected to change in the foreseeable future. These circumstances reinforce the need to expand pediatric primary care providers' abilities and capacity to detect and treat mild to moderate mental health conditions. Along with this shift, specialty behavioral health providers need to rethink their roles as more children, youth, and families with mild to moderate mental health conditions are served in integrated primary care settings. Specialty providers will increasingly need to focus on even more specialized and intensive services for children and youth with moderate to severe mental health conditions, or collaborate more with integrated care practices to serve those with mild to moderate needs (or pursue both strategies).

There will continue to be a need for behavioral health specialists to treat more complex depression, bipolar disorder, post-traumatic stress disorder, and other conditions that require specialized interventions. But the anticipated impact of SB 11 over time will shift care for much of the population with mild to moderate mental health conditions from specialty behavioral health care settings to integrated primary care settings, allowing specialists to focus on children and youth with moderate to more severe conditions and re-allocating scarce resources to serve children and youth with more intensive needs. Similar efforts that were initiated in 2013 in Massachusetts have had a profound effect, according to a five-year study recently published in the journal *Pediatrics*.[66]

Shifting the responsibilities of primary care and behavioral health specialty care will require them to re-envision their roles. Fortunately, there are historical reasons that indicate Lubbock will be receptive to these changes. A previous program (known as SUPPort – Services Uniting Pediatrics and Psychiatry Outreaching to Texas) that was implemented in TTUHSC physician's offices enabled pediatric offices to hire master's level behavioral health professionals. When a patient presented with a potential behavioral health concern, the attending physician and behavioral health professional would collaborate to determine the most appropriate course of action. Together, the team would decide if psychiatric consultation was necessary and, if so, they had direct access to a child and adolescent psychiatrist, also through TTUHSC. Over a three-year period, the program connected 2,179 patients to behavioral health support through the onsite behaviorist. An evaluation of the program showed a decrease in behavioral health symptoms among its patients and high satisfaction among participating providers.[67] Despite the success of this program, there was not a sustainable funding source to support the program and it ended in August 2011. However, pediatricians who participated in the program have

[66] Walter, H. J. et al. (2019, July) Five-year outcomes of behavioral health integration in pediatric primary are. *Pediatrics, 144*(1).

[67] Pliszka, S., Robinson, V. et al. (2012, August). *Services uniting pediatrics and psychiatry outreaching to Texas*. Final report presented to the Frew Advisory Committee.

maintained confidence in when they need to seek psychiatric support and most have ongoing collaborative relationships with Dr. Sara Wakefield at TTUHSC.

Component 1 – Community Opportunity 2: Expand the use of psychiatric consultation to enhance the early detection and treatment of mental health concerns in pediatric primary care settings. Many efforts already underway in Lubbock have laid the groundwork for successful SB 11 implementation. Staff with the Department of Psychiatry at TTUHSC are experienced in providing psychiatric consultation to remote sites through the TWITR program and working relationships with various local pediatric practices. By becoming a hub site through CPAN, TTUHSC can support a large network of primary care practices by creating a formal process for accessing consultation from pediatric psychiatrists, behavioral health clinicians, and referral specialists. CPAN hub services would include a dedicated hotline that pediatric primary care providers could call to access the CPAN team, assistance from care coordination, and continuing professional education for primary care offices and teams.

Component 1 – Community Opportunity 3: Establish a formalized pediatric integrated care program. Implementation of the CPAN model will greatly improve primary care practices' ability to identify and manage about two thirds of pediatric mental health needs. Lubbock is large enough that it could further improve mental health access and treatment by establishing integrated clinics that provide onsite access to primary care and behavioral health services.

The first step necessary for integrating behavioral health into pediatric primary care is community buy-in. To achieve recognition and support for integrating care, leaders and key players need to view the practice as "feasible, sustainable, affordable, and effective."[68] One way to develop trust and investment in integrated care is to model the practice at the community level. TTU is well positioned to do this in Lubbock through one or more of its pediatrics offices at Texas Tech Physicians, or in partnership with Covenant Health.

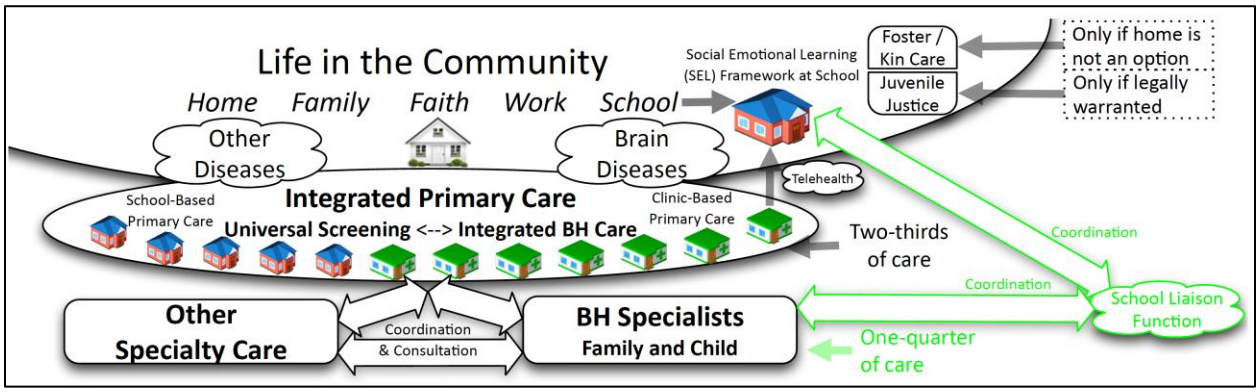
Together or separately, Texas Tech Physicians or Covenant Health could establish an integrated care clinic to test and model key elements of integrated care practice, including any of the core components previously mentioned in this report. Natural community partners for the clinic could be StarCare or TTUHSC. The success of the model would likely inspire expansion in other clinical settings and lessons learned from this model could be incorporated into any expanded efforts.

Component 1 – Community Opportunity 4: Establish supports for new mothers in integrated care efforts. New mothers are a priority population for mental health screening in primary care

[68] Kwan B. M., Nease D. E. (2013). The state of the evidence for integrated behavioral health in primary care. In: M. Talen, V. A. Burke (Eds.), *Integrated behavioral health in primary care* (pp. 65–98). New York, NY: Springer.

settings because of their high risk for depression and other mental health needs, and the influence their wellness has on their children's well-being. As of July 1, 2018, postpartum depression screenings were covered by Medicaid or the Children's Health Insurance Program (CHIP), and a child's physician can be paid for one exam per eligible child over a 12-month period.[69] This supports the idea that in a pediatric primary care setting, the health and mental health of caregivers is equally important to the health and mental health their children. By identifying a potential mental health need, such as postpartum depression, physicians can help new parents access the services and supports they need and also support the healthy development of the child, as the caregiver's wellness is critical to healthy development.

Component 2: Specialty Behavioral Health Care



While anxiety and routine depression can often be effectively addressed through integrated primary care, complex and more severe mental health issues need treatment in specialized mental health settings. Examples of specialty behavioral health care include outpatient clinics, counseling centers, and school-based clinics that offer mental health and substance use disorder (SUD) services, primarily in office settings. This level of care typically offers individual, family, and group therapies and, ideally, a range of evidence-based treatments for specific childhood, adolescent, and familial conditions, such as cognitive therapies and Dialectical Behavior Therapy. Clinics may also provide some rehabilitation services (e.g., skill building – further described in the section on Component 3: Intensive Services). Based on the best current prevalence estimates, about one-quarter of the total number of children and youth with mental health needs, or about 18,520 children and youth in Lubbock, need specialty behavioral health care services each year.

Community Strengths (Component 2)

Component 2 – Community Strength 1: Efforts to triage and better streamline specialty care have been successful. Lubbock is home to some outstanding child and adolescent mental

[69] Doolittle, D. (2018, July 10). *Postpartum depression screening now covered by Texas Medicaid*. Retrieved from https://www.texmed.org/TexasMedicineDetail.aspx?id=48072

health providers and those providers have enormous reach, providing training and direct services in a variety of community settings. However, the demand for these providers' services exceeds their capacity. Dr. Sarah Wakefield is a child and adolescent psychiatrist who has been with the Psychiatry Department at the Texas Tech University Health Sciences Center (TTUHSC) since 2014, and was recently appointed as department chair. When she first began her practice in the community, wait times for an appointment with a child and adolescent psychiatrist could take a full year and services were sometimes completely unavailable to new patients. Over the past five years Dr. Wakefield implemented a variety of strategies and protocols to streamline service delivery.

Dr. Wakefield's multi-pronged approach to triaging care includes patient strategies to reduce no show appointments and implementation of workforce solutions that maximize her own productivity through relationships with local pediatricians and the support of advanced practice nurses in her office. With a scarcity of pediatric psychiatrists in most communities, a common frustration is that children and youth with the most serious and urgent needs wait equal amounts of time for an appointment as those with less critical needs. To address this concern Dr. Wakefield established a set of parameters for accepting patients into her care. These parameters require referring entities to re-engage with a child or youth once they are stable and to limit referrals to children and youth with a suspected serious mental illness or who have failed treatment in other care settings. As a result of these efforts, wait times for psychiatric consultation have been reduced to between three and four months, depending on the time of year.

Component 2 – Community Strength 2: The Center for Superheroes uses a multi-faceted approach to address some of the most complex needs in the community. Texas Tech University's Center for Superheroes provides an array of evidence-driven mental health and support services to children, youth, and families involved with the foster care system. The Center is led by Dr. Michael Gomez, a licensed psychologist with extensive training and background in working with individuals with complex histories of trauma. Dr. Gomez and his team take a comprehensive approach to providing tailored and coordinated care for the families they serve. They also utilize evidence-based practices, like Trauma-Focused Cognitive Behavioral Therapy, which is a best practice for treating young people with complex trauma histories and mood disorders.

All aspects of the Center for Superheroes have been developed with the understanding that sustainable programming requires community engagement, local workforce development, and continuous improvement. In addition to its direct clinical work, the Center provides community education and training, conducts research and evaluation on clinical practice, and carefully measures and tracks outcomes.

Component 2 – Community Strength 3: Access to free and low-cost counseling services is available to families with limited income. If a family knows where to look, Lubbock has a substantial supply of licensed professional counselors (LPCs) for providing child, youth, and family counseling. Graduate-level interns are widely available in the community and they provide very low-cost services. While many licensed providers do not see patients with Medicaid, Family Counseling Services maintains availability for these clients and will see people who can pay on a sliding scale or with Medicaid. Family Counseling Services employs 10 LPCs who are supported by LPC interns and master's level counseling interns. To accommodate working families, Family Counseling Services also offers appointments outside traditional working hours.

Additionally, on August 1, 2019, the Children's Behavioral Health Clinic opened at the UMC Children's Hospital. The clinic is a jointly supported by TTU. It was conceived with the idea of providing support to children, youth, and families following a medical trauma, but is open to all families with mental health needs, regardless of ability to pay. Services are provided by graduate-level students from the Couple, Marriage, and Family Therapy program at TTU, who work under the supervision of clinical faculty TTU. At the time this report was being finalized, the clinic was only days old, so many details are still being developed. However, over time, Dr. Brian Payne, the Chief Medical Officer for UMC children's hospital, hopes to provide the following:

- Screening and assessment,
- Telemedicine services,
- Play therapy,
- Cognitive behavior therapy,
- Addiction and recovery services for youth and families. and
- Ongoing research on program effectiveness.

Community Challenges (Component 2)

Component 2 – Community Challenge 1: Lack of clarity regarding accessible services and providers hinders families from obtaining services. Schools and child serving organizations we consulted for this project have established their own mental health provider lists that they provide to the families they serve. These lists are extremely helpful given the fragmented nature of behavioral health services in Lubbock, but they are difficult to maintain and generally do not convey relevant details such as insurances accepted by providers, their areas of specialty, and if the practice is accepting new patients. Key informants also expressed confusion about what services were provided through StarCare, which are not clearly described on the agency's website.

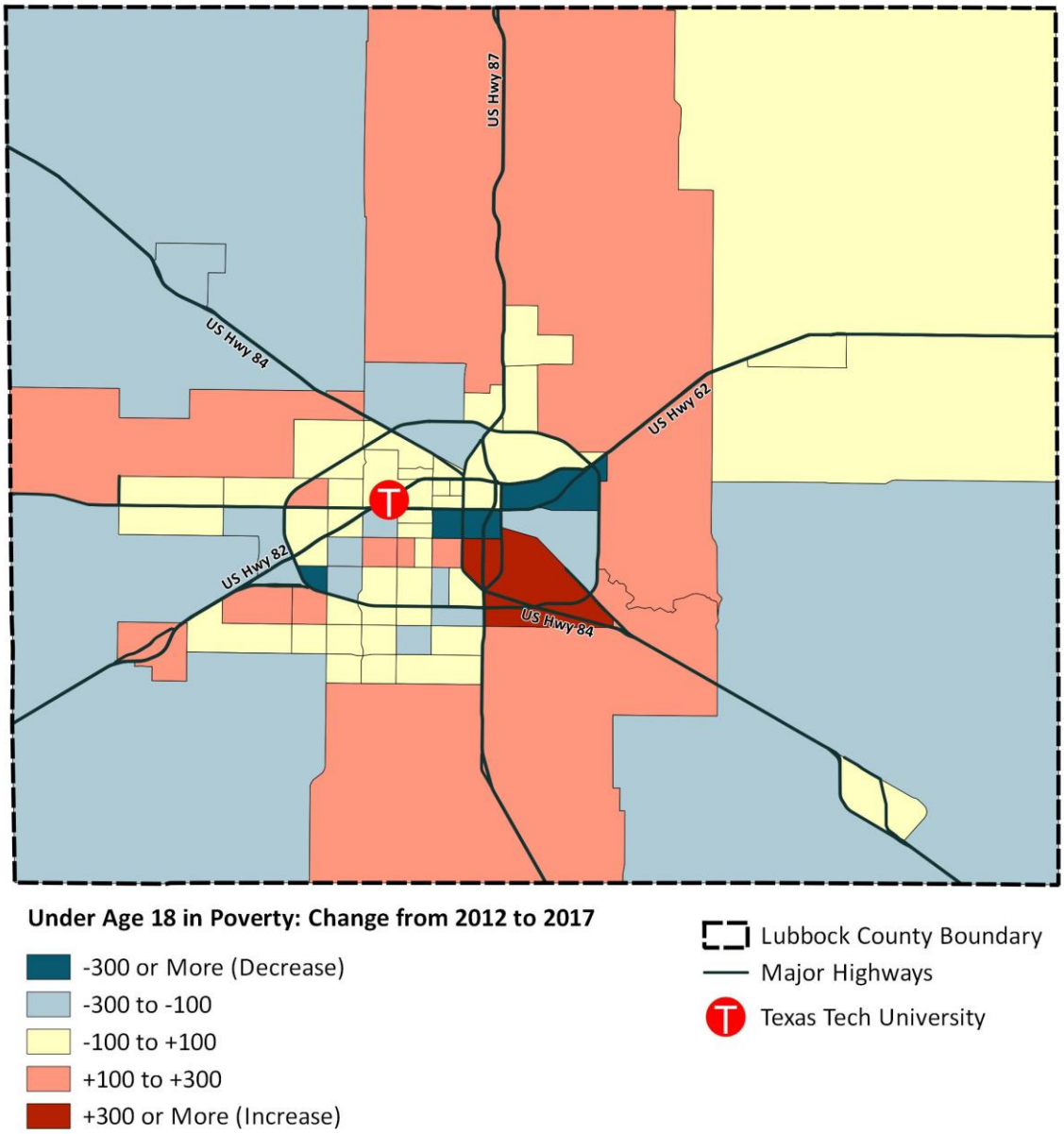
With the exception of specialized centers that serve specific populations (Center for Superheroes and the Burkhart Center), Lubbock lacks a comprehensive behavioral health service provider. The local mental health system is fragmented and, as a result, there is no clear "front door" for families to enter to obtain services. As the local mental health authority (LMHA), StarCare provides services to many families, but its capacity and service offerings are limited. Notably, StarCare does not provide counseling services and must refer families to other providers for that service. Multiple key informants were not clear on what services were available through StarCare. Others expressed positive service connections between clients and StarCare when they had a personal contact at StarCare whom they could directly reach out to.

The effects of system fragmentation are exacerbated by a shortage of mental health providers who will treat Medicaid and CHIP clients. This is a significant challenge because 44% of children and youth in Lubbock County under age 18 are insured by Medicaid or CHIP (in contrast to 38% statewide). For example, StarCare provides crisis support through its crisis hotline and mobile crisis support through Mobile Crisis Outreach Teams (MCOT), but ongoing StarCare services require clients to establish eligibility. The wait to see a child psychiatrist is estimated between four and six months. During this waiting period, families must seek out therapy elsewhere as StarCare does not offer counseling to children and youth. These dynamics lead to numerous challenges for parents and caregivers who are seeking care on behalf of their children and likely result in postponed care.

Component 2 – Community Challenge 2: Financial sustainability is a concern for existing programs. Although they provide many Medicaid reimbursable services, the Center for Superheroes and the Burkhart Center do not currently bill for any of the services they provide. Likewise, UMC's Children's Behavioral Health Clinic does not have an immediate plan to bill for the services it provides. Relying solely on grant funding jeopardizes long-term sustainability. Several key informants interviewed for this project noted past examples of clinics and programs that were extremely beneficial to the community but closed when grant funding ended.

Component 2 – Community Challenge 3: Transportation is a barrier for many families. Multiple key informants reported that transportation is frequently a challenge for families because of the cost and the time they spend traveling to appointments. Transportation was noted as a particularly difficult challenge for people in the rural areas surrounding Lubbock who must come to the city for services. Transportation challenges are also a function of demographic shifts. Most available services are clustered in the central western portion of the city, but population growth is occurring to the north, west, and south of the city center. As exhibited in Map 9, there are also growing concentrations of children and youth in poverty to the east of the city, where services are especially sparse.

Map 9: Children and Youth Under Age 18 Change in Poverty, by Census Tract (2012 to 2017)



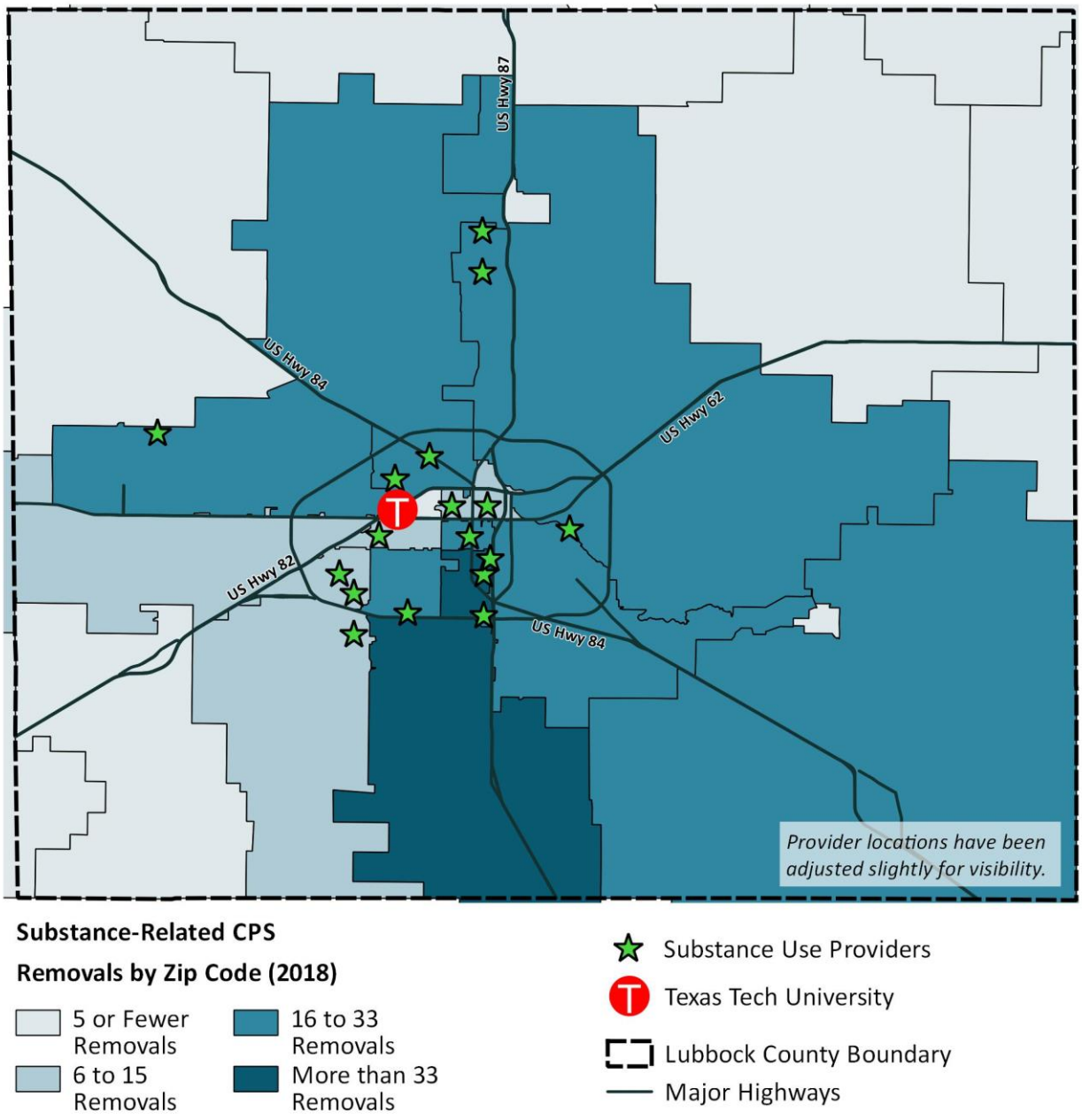
Component 2 – Community Challenge 4: Stigma surrounding mental health may be diminishing, but it still prevents some families from seeking services for their children. Several community providers noted that a lack of parental buy-in was a barrier to children and youth receiving mental health services. In some cases, key informants shared that parents had unrealistic expectations for how much change could occur with clinical intervention if the family did not participate in the care plan. In other cases, parents were noted as being reluctant to seek care because of their unwillingness to accept their child was in need of mental health supports.

Component 2 – Community Challenge 5: While student interns are a source of care for those with limited ability to pay, their reach is limited by the short-term nature of their employment and lack of experience. Families without insurance or with Medicaid coverage are more likely to rely on graduate interns for counseling since there are few fully licensed practitioners in the community who provide low-cost or Medicaid-covered services. Although interns expand access to needed care, their tenure within an office tends to be short-term and they lack the experience to serve people with more complex needs.

Component 2 – Community Challenge 6: There are few accessible, community-based substance use disorder treatment options for youth and parents. Stakeholders identified that substance use has increased in Lubbock, though there are limited services for people with substance use disorders (SUD), especially for those who are uninsured or have limited means. Research suggests that with proper supports, approximately half of SUD needs can be successfully treated in a primary care setting.[70] However, these supports are not currently available in Lubbock, therefore most people receive no care and those who do usually only receive treatment when their conditions worsen and require specialty intervention. As we discussed in the special consideration addressing foster care, untreated SUD is also a significant factor in child welfare removals. Map 10 contrasts rates of CPS removals with the location of local SUD treatment providers to lend insight on where service gaps may be most problematic.

[70] Madras, B. K. et al. (2008). Screening, brief interventions, referral to treatment (SBIRT) for illicit drug and alcohol use at multiple health care sites: Comparison at intake and 6 months later. *Drug & Alcohol Dependence , 99*(1) , 280–295.

Map 10: Substance Use Disorder Treatment Providers and Substance-Related CPS Removals, by Zip Code (2018)



Component 2 – Community Challenge 7: Few evidence-based preventative and mental health treatments are available in Lubbock. The availability of mental health services in a community is only one maker of the strength of the system. Generally, even more important than the amount of services offered is the quality of care provided. Providing evidence-based interventions, implemented to fidelity with the appropriate population, is the most effective way to ensure positive outcomes. However, in Lubbock, the use of evidence-based treatments and approaches is extremely limited. The evidence-based treatments that are available are

limited to children and youth with direct foster care involvement, leaving many other populations with significant needs without access to the most appropriate forms of care.

Community Opportunities (Component 2)

Component 2 – Community Opportunity 1: Increase access to care through embedded services. There are several significant efforts underway in Lubbock to centralize services and expand pediatric specialty mental health services. Once operational, these efforts will simplify service navigation for families and improve access to care. One potentially transformative effort planned between Covenant Children's Hospital and TTUHSC is the creation of a child and adolescent behavioral health unit at Covenant Children's Hospital. Beginning in the summer of 2020, the unit will provide an array of outpatient behavioral health services, with the longer-term plans to deliver more intensive outpatient services and open a limited number of inpatient beds for short-term use. The vision for the unit is extremely comprehensive and will involve collaboration between multiple departments at TTU and various community-based providers. The goals of the unit are to:

1. Establish collaborative clinical services using evidence-based medicine,
2. Assemble experts to collaborate to identify research opportunities, and
3. Support and engage the community.

The unit will also provide an excellent training opportunity for fellows and offer a new opportunity for increasing the number of child and adolescent psychiatrists in the area. The planned unit will incorporate many best practices, including use of social workers for screenings and service coordination, telemedicine, and meaningful connections to local schools. The unit will also employ child and adolescent psychologists with diverse areas of expertise, including trauma, neurology, family dynamics, and autism spectrum disorders.

In the current system, many children and youth are referred directly from their primary care provider to a psychiatrist. They then wait for months to be seen, during which time their needs intensify. Then the psychiatrist who finally sees them realizes they need a different type of support such as counseling, skills training, or substance abuse treatment. Through the planned clinical model, families will be much more likely to receive the appropriate level of care in a timely fashion because pediatricians will have more support in determining which cases they can treat, and overall pediatric behavioral health proficiency and capacity will increase. Additionally, if the clinic becomes a part of the CPAN network, its reach will significantly expand through support it can provide to pediatric offices across the Panhandle.

The YMCA of Lubbock offers another initiative aimed at embedding care in settings where children and youth spend time. As discussed above, the YWCA of Lubbock serves close to 1,000 children and youth in Lubbock each day through its afterschool, early childhood, and youth programs. YMCA staff frequently interact with children, youth, and families, so they are highly

aware of the mental health challenges and needs these people face. Recognizing the barriers that prevent children, youth, and families from accessing behavioral health services, the YWCA and Covenant Health are entering into an agreement to establish a dedicated space for mental health care at the YWCA and to hire an onsite counselor to work directly with families. The presence of mental health professional in a trusted setting like the YWCA will offer many benefits, including reducing stigma associated with accessing mental health services, overcoming transportation challenges, and providing timely access to support when it is needed.

Many children and youth who access the counselor will be able to have all of their mental health needs met through the onsite service, others will require additional supports, including access to EBPs. The counseling services based at the YWCA will be provided by the Covenant Outreach Counseling Center. The YWCA onsite counselor will therefore be part of a larger Covenant Health care team, which will ensure access to other resources at Covenant Health, when needed. Ideally, these relationships will be maximized through additional coordination with primary care practices, which will ensure continuity of care even when counseling services are no longer necessary.

Component 2 – Community Opportunity 2: Increase access to specialty mental health services through expanded use of telemedicine, telehealth, and teleconsultation. As we discussed in Component 1, SB 11 establishes the Texas Child Health Access Through Telemedicine (TCHAT) program through the Texas Child Mental Health Care Consortium. TCHAT is designed to provide support for telemedicine and telehealth programs to identify and assess mental health needs and help provide access to appropriate services. SB 11 also includes funding to build capacity that could also use Medicaid and commercial payers and philanthropic investments as leverage to build a coordinated network of specialty care via telehealth to dramatically increase the availability of care. Ideally, much of this care would be developed in primary care and school settings that are more easily and frequently accessed by children, youth, and their families.

Telemedicine, and specifically telepsychiatry, have many attributes that can improve access to care. Telepsychiatry has the potential to incorporate mental health services in natural settings such as schools and primary care, which reduces transportation barriers and can help address the negative stigma associated with going to a mental health provider. Studies also indicate that the clinical services provided through telepsychiatry are comparable in quality to services provided in an office setting.[71]

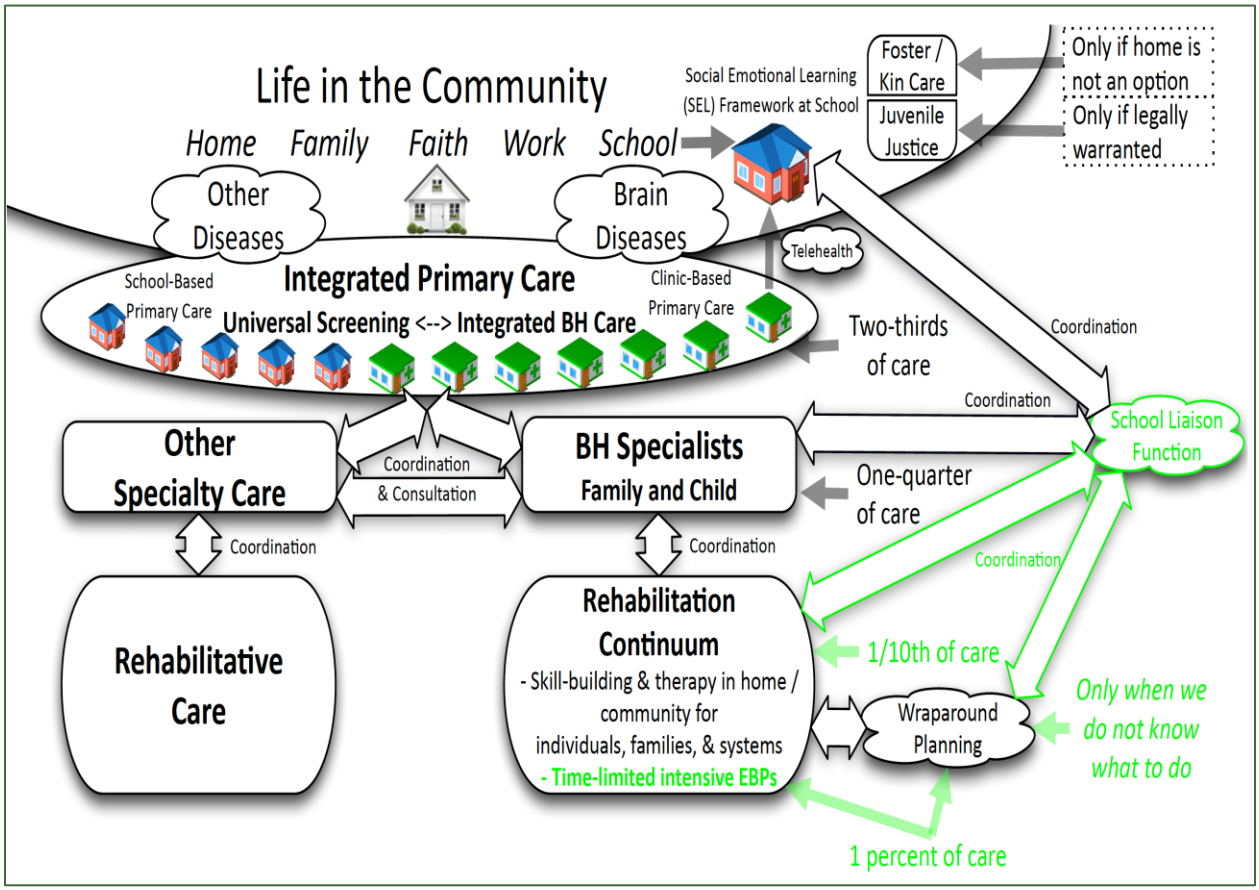
[71] Hubley, S. (2106, June). Review of key telepsychiatry outcomes. *Journal of World Psychiatry, 6*(2): 269–282. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4919267/

Telemedicine services are also reimbursable through Medicaid and recently passed legislation simplifies requirements for providing this service. SB 670 (86th Legislative Session, 2019) allows for Medicaid reimbursement of telemedicine services provided on a school campus without the onsite presence of a health professional, provided the distant site clinician is a Medicaid enrolled provider. This presents an opportunity for school districts to partner with providers to make psychiatric services more available to children and youth in a school setting.

Given the support provided through TCHAT, additional support through Medicaid, expanded local capacity through the partnership between TTUHSC and Covenant Health, and the experience gained through the TWITR program, Lubbock is in an excellent position to significantly expand its telemedicine capabilities. The TTUHSC/Covenant Health pediatric behavioral health clinic will include several small rooms for telemedicine consultations and a larger room for hub-to-hub communication. These combined resources will enable training, consultation, and telemedicine support, with the potential to serve children and youth in a greatly expanded service area. These resources will also enable the addition of services to complement or, in some cases, supplement telepsychiatry. Such services include school trainings for teachers and staff on how to effectively support students with mental health needs or challenging behaviors, community service referrals, and improved detection of students with emerging mental health concerns.

Component 2 – Community Opportunity 5: Expand the use of EBPs. Resources are needed to establish evidence-based treatment practices, but they are the best way to universally improve outcomes. The Center for Superheroes currently provides Trauma-Focused Cognitive Behavioral Therapy and Parent-Child Interaction Therapy, both of which are evidence-based and highly effective interventions. Expanded use of EBPs by providers across the community would not only improve outcomes for children and youth, but could also position providers to receive reimbursements that could become available with the recent passage of SB 1177. This bill allows managed care organizations the option of providing reimbursement to providers for evidence-based practices delivered in lieu of other Medicaid mental health services. In addition to the EBPs named above, interventions that are proven effective for children and youth with complex needs are Multisystemic Therapy (MST) and Family Functional Therapy (FFT). Evidence-based practices like these and others are vital for addressing gaps in services, particularly for children and youth with complex needs.

Component 3: Rehabilitation and Intensive Services



Some mental health conditions are so severe that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. Similar to other rehabilitation services, psychiatric rehabilitation involves a combination of medical treatment (generally medication), focused therapies (such as therapies to reduce the effects of trauma), and skill building (including work with the family and other important people in the child or youth's life to help them optimally support the child or youth in their recovery). Below, we list examples of symptoms and appropriate intensive interventions to treat those symptoms:

- For an older youth first experiencing a psychosis, the best evidence-based intervention, called Coordinated Specialty Care (CSC), involves about two years of intensive, outpatient treatment that combines effective medication, family education, and skill building to help the youth stay in school and continue on or regain a healthy developmental track. It also includes supports to help the school or employer accommodate the youth's symptoms.
- For children and youth involved in the juvenile justice system who display severe symptoms, such as classroom disruption, angry outbursts, or defiance related to untreated or undertreated depression or severe anxiety, a three- to seven-month

regimen of Functional Family Therapy (FFT) or Multisystemic Therapy (MST) has proven to be most effective.

Rehabilitation and intensive community-based services fall outside of a typical care continuum and require specialized provider training and payment mechanisms to support. Even large metropolitan areas in Texas are very limited in terms of these offerings. As a result, it is not surprising that few such services currently exist in Lubbock; however, current (Center for Superheroes) and planned (Covenant Health/TTUHSC pediatric behavioral health clinic) initiatives provide a solid foundation for future growth.

Community Strengths (Component 3)

Component 3 – Community Strength: The Youth Empowerment Services (YES) waiver provides an array of community-based services and supports to children and youth with serious emotional disorders (SEDs). As mentioned in the juvenile justice section, the YES waiver is a community-based Medicaid waiver program overseen and coordinated in Lubbock by StarCare. Children and youth must be between the ages of three and 18 years, have a qualifying mental health diagnosis, and be at risk for out-of-home placement in order to qualify for the program. Services provided through the YES waiver are arranged through a strengths-based, team planning process known as wraparound, which supports the child or youth, their family, and other involved parties to identify and coordinate how various needs can best be accommodated. Through the wraparound planning process, children and youth enrolled in the Yes waiver are provided with a plan of care, which often includes a variety of traditional and non-traditional services paid for through the waiver. These services include family supports, respite, community living supports, non-medical transportation, and specialized therapies.

The number of YES waiver program slots available through StarCare are allocated by the state on an annual basis. In recent years, StarCare has been able to serve between 14 and 17 enrollees at a time. StarCare currently employs one full-time wraparound facilitator, who manages a caseload of ten program enrollees, and two other staff members, who are trained as wraparound facilitators and manage a mixed case load. The StarCare YES waiver program has been in operation since 2015 and has consistently remained at capacity.

Component 3 – Community Strength 2: Through StarCare, children and youth with complex needs receive services and supports that complement other mental health services. For children and youth with Medicaid, Targeted Case Management (TCM) allows providers to bill the program for comprehensive service coordination. Additionally, the Mental Health Rehabilitative Services (MHRS) benefit covers a range of services and supports for children and youth with complex mental health needs, including skill straining, medication management, psychosocial rehabilitation services, and crisis intervention and support. These services are unique in that they provide the flexibility and resources needed to support a range of individual

needs, many of which cannot be addressed through traditionally reimbursable office-based clinical services. In fiscal year (FY) 2018, STAR Care provided TCM to 388 children and youth and MHRS services to 337 children and youth.

Community Challenges (Component 3)

Component 3 – Community Challenge 2: Insufficient community-based mental health services result in negative mental health outcomes and overly restrictive care. There is a common perception in Lubbock that inpatient psychiatric care (hospitalization) is the appropriate type of care for children and youth with complex or urgent mental health needs. Between April 2017 and March 2018, 326 children and youth from Lubbock (see Table 3 on page 13) were hospitalized for psychiatric reasons, although many of those could have been effectively treated in the community with access to the appropriate services. The YES waiver is designed specifically to reduce the need for hospitalization, but capacity is limited. Likewise, the Center for Superheroes provides services and supports for young people with complex needs who are at risk for hospitalization, but its capacity is limited in terms of size and to those who are, or have been, involved in the foster care system. TCM and MHRS can also help prevent out-of-home placement, but local service capacity is limited and the services are restricted to those with Medicaid.

Community Opportunities (Component 3)

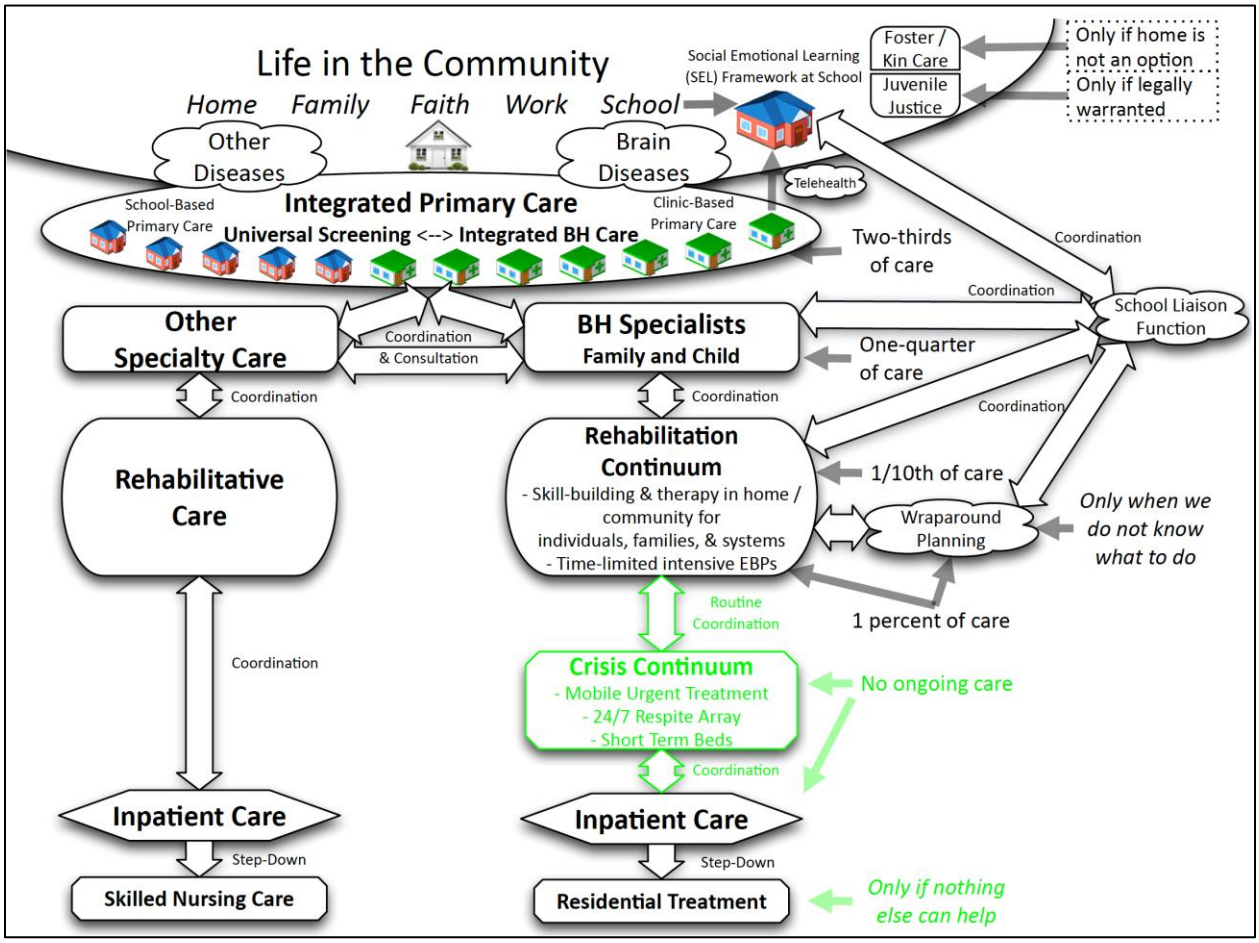
Component 3 – Community Opportunity 1: The development of the pediatric behavioral health clinic through Covenant Health and TTUHSC has great potential to expand intensive community-based mental health services for children and youth in Lubbock, but sustainability must be carefully addressed. Many of the services and supports envisioned for the Covenant Health/TTUHSC pediatric behavioral health clinic will benefit children and youth with serious and complex mental health needs. While Medicaid pays for a minimum level of intensive supports, private insurance will cover even less and many related costs such as training are unlikely to be reimbursed by any payor source. Although the clinic will receive startup funds through Covenant Health and its parent companies (Providence St. Joseph Health), to remain viable over the long-term, the clinic will need to diversify its funding sources by maximizing billing opportunities through Medicaid and private insurance as well as grants, philanthropy, and community support.

Also, because Medicaid is a critical partner, Medicaid managed care organizations will need to participate in planning efforts to ensure clinic programs target the highest priority needs and to potentially develop value-based purchasing arrangements to support service delivery. It may also be possible to access additional Medicaid support for any cost-effective alternative services that can be approved on a case-specific basis. SB 1177 (86th Legislative Session, 2019) allows intensive, EBPs that are known to have positive outcomes for children and youth with mental

health needs to be available in Medicaid managed care programs. The EBPs have to be optional for both the managed care organization and the patient and used in lieu of other Medicaid mental health services. Appendix F contains a detailed description of EBPs for children, youth, and families.

Component 3 – Community Opportunity 2: Increase access to comprehensive community-based mental health services through Medicaid reimbursable services for children and youth with intensive needs. Until 2014, the only providers allowed to bill Medicaid for TCM and Mental Health Rehabilitative Services were local mental health authorities such as StarCare. Today, private and non-profit providers are allowed to provide the services through Medicaid if they meet specified training requirements. While the Medicaid requirements entail upfront investments in staff training, the ability to bill the program for a range of intensive supports enables community-based providers to better support children and youth with complex needs and to receive a sustainable funding source for their efforts. The Children's Home of Lubbock is in the process of being credentialed to provide TCM through Medicaid. The Children's Home of Lubbock currently provides robust case management services, but it will be much more likely to sustain its ability to do so by billing Medicaid. As of June 2019, it had served 115 individuals and 20 families, and its capacity is likely to grow by accessing a new stream of Medicaid funding.

Component 4: Crisis Care Continuum



The mental health crisis care continuum described in Component 4 includes three levels: 1) a range of crisis intervention options, including mobile crisis teams capable of immediate and ongoing crisis intervention and supported by a range of crisis respite and in-home supports; 2) acute psychiatric inpatient facilities for needs that are too dangerous or complex to address in less intensive treatment settings; and 3) residential treatment facilities for children and youth with subacute needs that cannot be safely treated in any other setting. This section of the report addresses the capacity and utilization of each of these levels of crisis care in Lubbock.

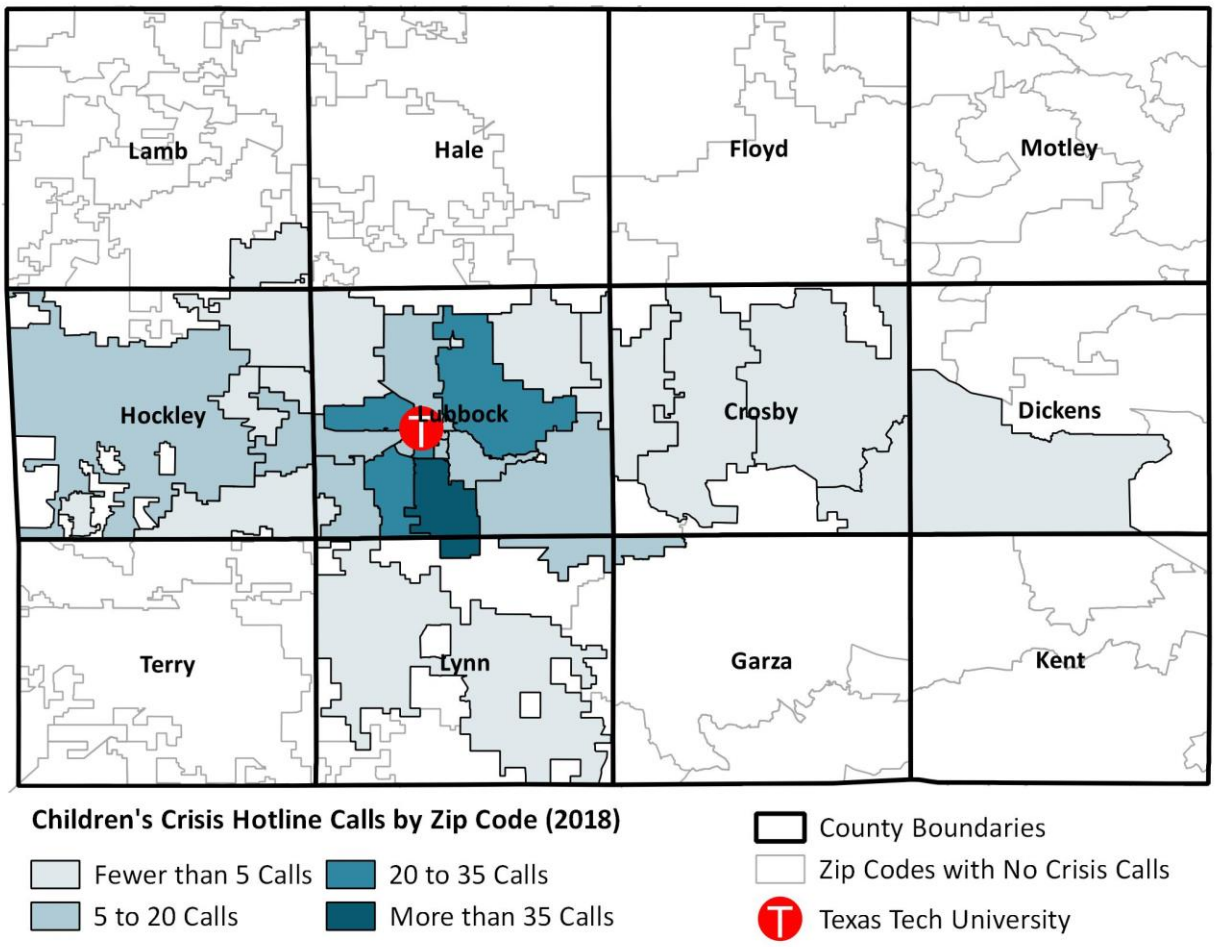
Community Strengths (Component 4)

Component 4 – Community Strength 1: StarCare runs a crisis respite program designed to prevent unnecessary out-of-home placements and support families who are experiencing a mental health crisis. The StarCare crisis respite program supports children and youth who are experiencing a mental health crisis and provides temporary care relief for caregivers when needed. Crisis respite services are flexible and accommodate children, youth, and families in their natural settings, including in the home and at school. The program is available to

individuals who already receive services through StarCare. When a child is connected to the program, StarCare initiates services by assigning case managers who develop treatment and safety plans. According to data provided by StarCare staff, in FY 2018, 69 children and youth were served through the StarCare crisis respite program.

Component 4 – Community Strength 2: The StarCare crisis hotline and Mobile Crisis Outreach Team (MCOT) provide important community-based crisis supports to children, youth, and families. The StarCare crisis line is staffed 24 hours a day, seven (7) days a week, year-round. StarCare is engaged in active efforts to increase public awareness about its crisis line and conducts outreach at local schools and among local law enforcement agencies. One youth we consulted for this project shared they frequently call the crisis line when in distress and have had positive experiences. In FY 2018, 455 calls to the StarCare crisis line were made by or made on behalf of children and youth. The location of these callers in the StarCare catchment area is shown below in Map 11.

Map 11: Crisis Calls, by Zip Code, in the Lubbock Region (2018)



MCOT services are delivered in the community, often at the site of the crisis. The primary goals of MCOT are to provide crisis services and supports to help the child, youth, or adult return to a more stable level of functioning and to link the person to ongoing services to reduce the likelihood of the crisis re-occurring. Mobile crisis interventions include behavioral health and risk assessments to evaluate the potential for self-harm and to identify what triggered the crisis. MCOTs also develop a crisis plan based on the child, youth, or adult's strengths. This plan addresses crisis triggers, community services, crisis resolution strategies, and the creation of a safety plan. MCOT can provide crisis stabilization services for 90 days after its initial crisis response.

Community Challenges (Component 4)

Component 4 – Community Challenge 1: The current funding source for the StarCare crisis respite program was scheduled to end on September 1, 2019. StarCare's crisis respite program is funded through the 1115 Texas Healthcare Transformation and Quality Improvement Program Medicaid waiver (1115 Medicaid waiver). Recent changes at the federal level to Medicaid will result in the loss of 1115 Medicaid waiver funding for the crisis respite program. Loss of the program may result in an increase in crises. A lack of crisis options can also contribute to children and youth experiencing increased child protective services and juvenile justice involvement, classroom removal, and unnecessary use of residential and psychiatric inpatient use because of lack of alternative options. These issues are exacerbated by barriers to and long waits for receiving community-based psychiatric care. As mentioned, waitlists for a routine psychiatric intake can be more than six months, which puts children and youth at risk of decompensating while they wait.

Component 4 – Community Challenge 2: Community perception, understanding, and knowledge of MCOT is mixed. While some schools reported frequent use of and appreciation for MCOT services, others expressed confusion about when they could access the services or frustration about services being unavailable. Other people we interviewed indicated uncertainty about the role of MCOT and when the service could be called upon. Increasing public awareness about MCOT availability can be somewhat paradoxical because of its limited capacity. So, while additional community outreach about MCOT could increase clarity, it is also possible that an increase in awareness would result in service demand outpacing service availability.

Component 4 – Community Challenge 3: A lack of intensive community-based services, and beliefs that mental health crises can only be addressed in an inpatient setting, leads to the overuse of overly restrictive inpatient care. Staff from a local emergency department reported that the number of children and youth presenting with a mental health crisis is growing, but local hospitals do not have the resources to meet their needs. When children and youth present in the emergency room for a mental health crisis, they generally receive a psychological

assessment from hospital staff or clinical staff from StarCare. Because of the lack of hospital-based or -affiliated intensive community-based services, children and youth in these situations are often sent home without supports or are referred to an inpatient facility.

Hospitals are not the only source of inpatient referrals. Several key informants we interviewed for this assessment expressed the view that many children and youth are sent to inpatient facilities because of a lack of awareness about other types of community-based services or because the only services they could get authorized through Medicaid were inpatient services.

Component 4 – Community Challenge 4: Over-utilization of inpatient care is especially concerning in Lubbock because there are no local pediatric inpatient beds, which presents numerous challenges for children, youth, and families who access this type of care. The lack of pediatric psychiatric beds within the community means that children and youth who are hospitalized are placed in other areas of the state, creating multiple challenges for their families, their personal sense of continuity, and for their return home. Based on utilization data obtained from the Texas Health Care Information Collection (THCIC) between April 2017 and March 2018, 326 children and youth under the age of 18 and 258 youth ages 18 to 24 from Lubbock were admitted to a psychiatric hospital. The locations for these admissions are shown below in Table 13.

Table 13: Lubbock Area Resident Admissions to Statewide Psychiatric Beds – Children, Youth, and College-Age Youth (April 2017 – March 2018) [72]

County and Hospital of Psychiatric Admission	Ages 0 to 11	Ages 12 to 17	Age 18 to 24	Total Admissions
Bell	**N/A**	**N/A**	**<6**	**<6**
Metroplex Hospital	N/A	N/A	<6	<6
Scott & White Memorial Hospital	N/A	N/A	<6	<6
Bexar	**N/A**	<6	**<6**	**<6**
Clarity Child Guidance Center	N/A	<6	N/A	<6
Laurel Ridge Treatment Center	N/A	N/A	<6	<6
San Antonio Behavioral Healthcare Hospital	N/A	N/A	<6	<6
Collin	**N/A**	**<6**	**<6**	**<6**
Eating Recovery Center	N/A	N/A	<6	<6

[72] Utilization data were obtained from the Texas Health Care Information Collection (THCIC) January 2017 – February 2018 discharge records. Counts of fewer than six (6) hospitalizations are obscured to prevent identification of individual patients.

County and Hospital of Psychiatric Admission	Ages 0 to 11	Ages 12 to 17	Age 18 to 24	Total Admissions
Texas Health Seay Behavioral Health Center	N/A	<6	<6	<6
Dallas	**N/A**	**<6**	**N/A**	**<6**
Children's Medical Center – Dallas	N/A	<6	N/A	<6
Denton	**N/A**	**N/A**	**<6**	**<6**
University Behavioral Health – Denton	N/A	N/A	<6	<6
El Paso	**N/A**	**N/A**	**<6**	**<6**
El Paso Behavioral Health System	N/A	N/A	<6	<6
Fort Bend	**N/A**	**N/A**	**<6**	**<6**
Westpark Springs	N/A	N/A	<6	<6
Harris	**N/A**	**<6**	**<6**	**<6**
Behavioral Hospital – Bellaire	N/A	N/A	<6	<6
Kingwood Pines Hospital	N/A	<6	N/A	<6
Lubbock	**N/A**	**N/A**	**166**	**166**
Covenant Children's Hospital	N/A	N/A	109	109
Sunrise Canyon	N/A	N/A	57	57
Midland	**N/A**	**46**	**6**	**52**
Oceans Behavioral Hospital of the Permian Basin	N/A	46	6	52
Potter	**<6**	**54**	**8**	**<68**
Northwest Texas Hospital	<6	54	8	<68
Tarrant	**N/A**	**<6**	**N/A**	**<6**
Texas Health Arlington Memorial Hospital	N/A	<6	N/A	<6
Taylor	**<6**	**34**	**13**	**<53**
Oceans Behavioral Hospital Abilene	<6	34	13	<53
Tom Green	**21**	**136**	**45**	**202**
River Crest Hospital	21	136	45	202
Wichita	**<6**	**11**	**<6**	**<20**
North Texas State Hospital	N/A	<6	<6	<6
Red River Hospital	<6	9	<6	12
Wilbarger	**N/A**	**12**	**<6**	**<18**

County and Hospital of Psychiatric Admission	Ages 0 to 11	Ages 12 to 17	Age 18 to 24	Total Admissions
North Texas State Hospital – Vernon	N/A	12	<6	<18
Williamson	**N/A**	**N/A**	**<6**	**<6**
Rock Springs	N/A	N/A	<6	<6
Total	**28**	**298**	**258**	**584**

The data on psychiatric hospital use for children and youth from Lubbock include the distances families must travel for inpatient services. These distances are especially problematic for low-income and working families who may lack the transportation or flexibility to transport or visit their children. One source shared that it is not uncommon for families to reject inpatient services because of the distance to the facility. Table 14, below, shows that over 60% of children between the ages of 0 and 11 years who were recently hospitalized were covered by Medicaid, indicating the majority of families of hospitalized children are experiencing economic strain.

Table 14: Lubbock Area Resident Admissions to Psychiatric Beds, by Payer – Children Ages 0 to 11 (April 2017 – March 2018)

County and Hospital of Psychiatric Admission	Medicaid	Self-Pay	Commercial Insurance
Northwest Texas Hospital (Potter County)	N/A	N/A	100%
Oceans Behavioral Hospital Abilene (Taylor County)	N/A	50%	50%
Red River Hospital (Wichita County)	N/A	N/A	100%
River Crest Hospital (Tom Green County)	81%	5%	14%
Total	**61%**	**7%**	**21%**

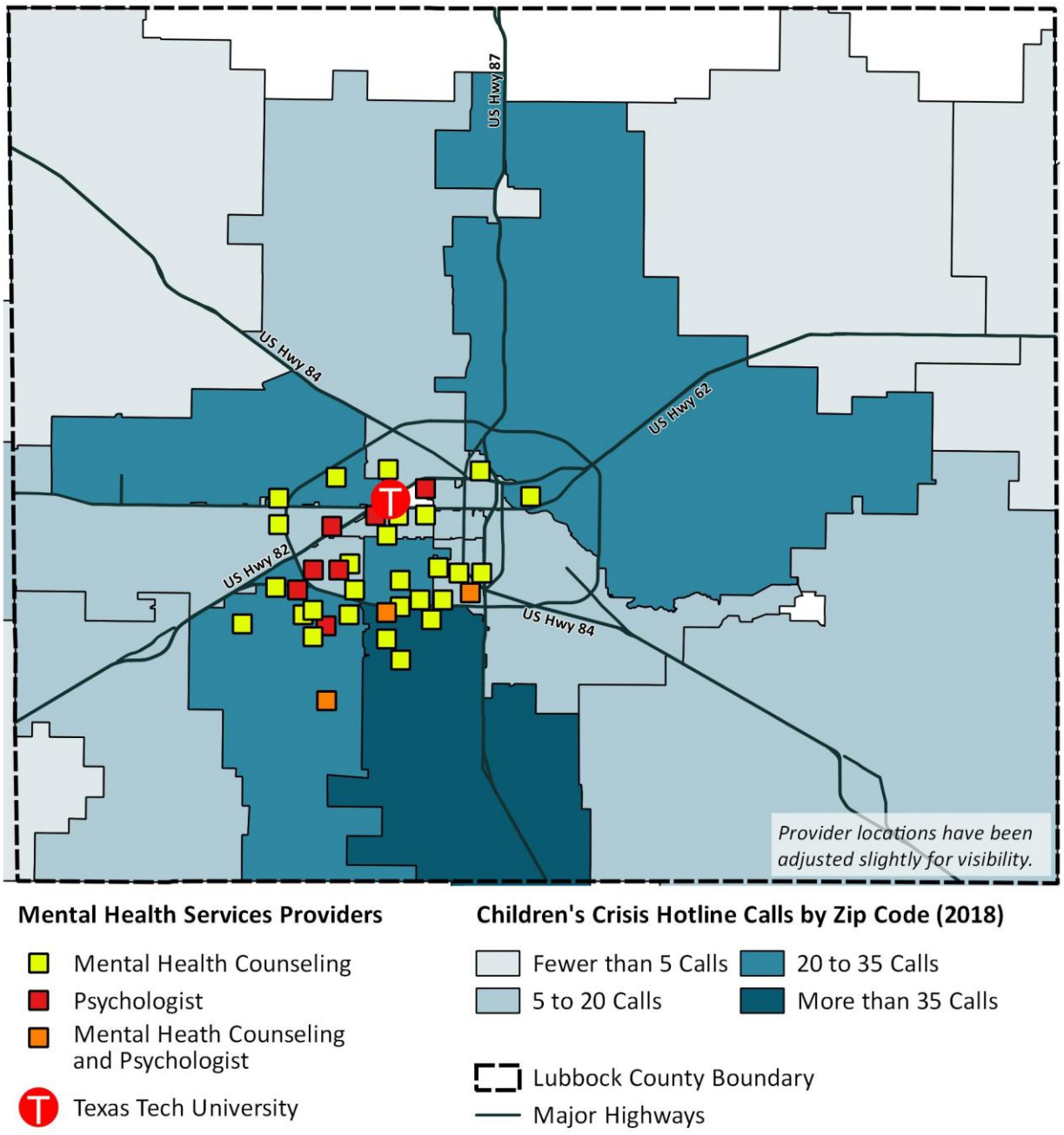
When children and youth who have been hospitalized return to the community, they face additional challenges and their families receive little to no information about what to expect or how to continue care at home. There are no formal agreements with any inpatient facilities for aftercare support, so returning children and youth are likely to remain in the same situations they were in prior to hospitalization, without a care plan or connection to a community-based service provider. To highlight this challenge, one youth-serving organization noted a recent example in which a child was released from an inpatient hospital with a temporary supply of medication. However, the child's family was provided with no instructions on how to refill the medication, which led to discontinuation of the medication when the supply ran out.

Component 4 – Community Challenge 5: Residential capacity is increasingly dedicated to a growing number of children and youth in foster care, which presents challenges for youth who are homeless or experiencing crises. Relative to its size, Lubbock has a fair amount of residential capacity through emergency shelters and other types of General Residential Operations (GROs). However, the substantial increase in children and youth entering foster care in recent years has strained the capacity of these facilities, which are increasingly filled to capacity with children and youth who are in state conservatorship. This has resulted in few residential options for homeless and runaway youth, and other youth in crisis. In the absence of a placement option at a state licensed GRO, more youth in the area are likely to resort to unsafe living situations.

Community Opportunities (Component 4)

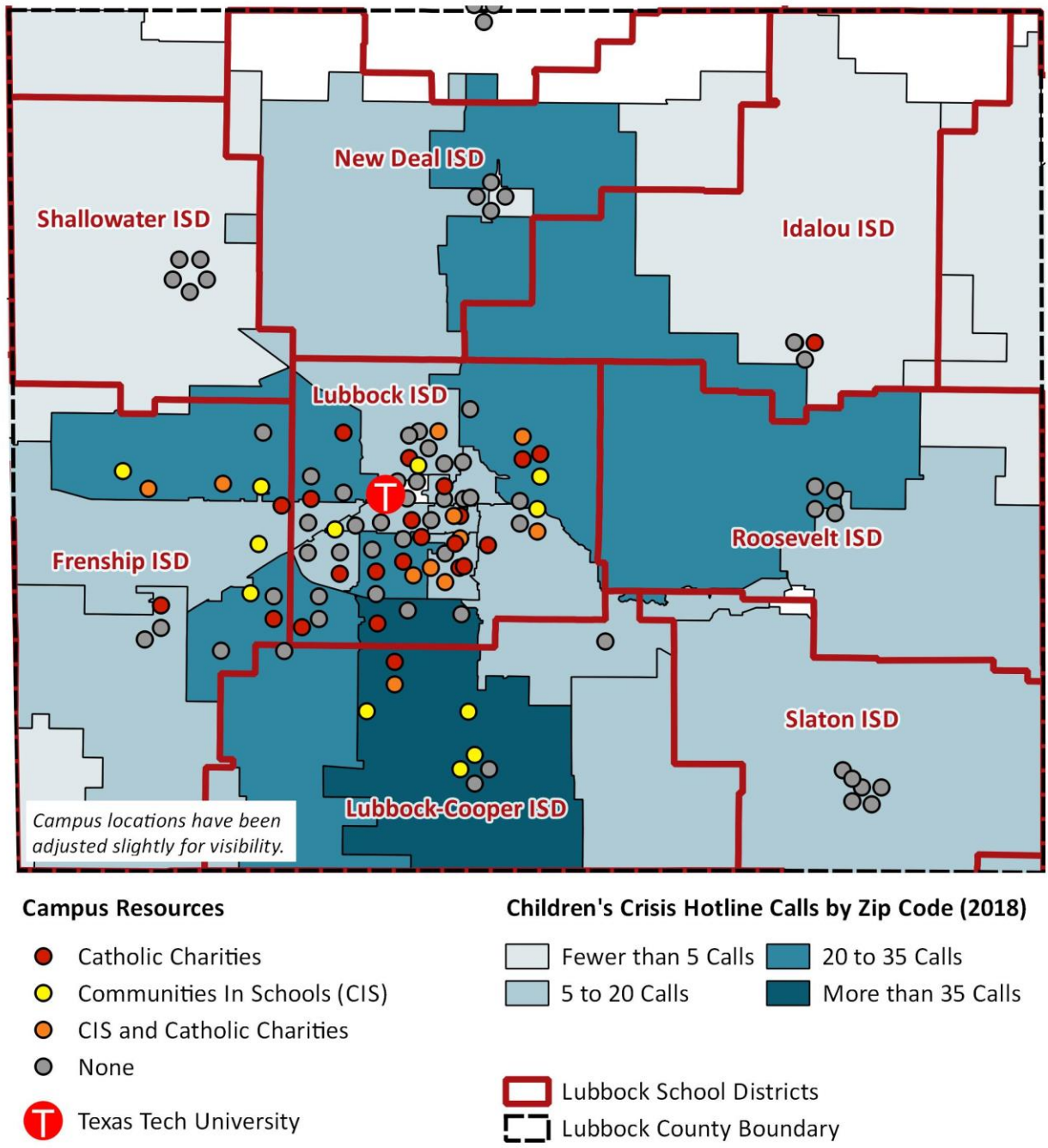
Component 4 – Community Opportunity 1: Strengthen the crisis support system through collaborative efforts. Current crisis supports in Lubbock are disconnected and often limited to specific populations of children and youth. Crisis care could be improved through collaborative agreements with StarCare, schools, and local non-profit service providers, in coordination with juvenile justice and CPS. Map 12 shows the location of calls to the StarCare crisis hotline for children and youth and the location of many local mental health providers. Map 13 displays the same data on calls to the StarCare crisis hotline, but in relation to local ISDs and school-based resources. These considerations may be of interest to any collaborative effort to extend the reach or availability of crisis services.

Map 12: Mental Health Services Providers and Crisis Calls, by Zip Code, in the Lubbock Region (2018)[73]



[73] Provider locations were obtained from the school district. Providers may not accept all payment types.

Map 13: Children's Crisis Calls, by Zip Code and School Campuses with Community Resources[74]



Component 4 – Community Opportunity 2: Expand availability of intensive, evidence-based services and supports in the community to prevent inpatient hospitalizations and crisis

[74] Masked Zip Code Level CPS Statistics were obtained via data request from the Texas Department of Family and Protective Services in February 2019.

events. The Center for Superheroes, Texas Boys Ranch, Children's Hope, and Children's Home of Lubbock are all committed to utilizing and expanding EBPs, but all primarily serve children and youth who are involved in the foster care system. Other service providers, such as Family Counseling Services, StarCare, and Texas Tech/Covenant Health, could help fill the gap for children and youth who are not in state conservatorship.

Component 4 – Community Opportunity 3: Expand support for community re-entry post hospitalization. There is pressing need to establish care standards for children and youth who are returning to the community after inpatient hospitalization. Post-hospital care could be arranged through collaborative agreements between the main inpatient hospitals that are utilized by children and youth from Lubbock (Oceans Behavioral Hospital of the Permian Basin, River Crest Hospital, and Northwest Texas Hospital) and StarCare, or through a collaborative agreement with a local non-profit service provider. For children and youth with Medicaid, arrangements could be made with their Medicaid managed care organization to help facilitate and support a re-entry plan.

Component 4 – Community Opportunity 4: Incorporate crisis respite beds at the Covenant/TTHSC clinic when feasible. Those who are involved with planning efforts for the Covenant Health/TTHSC pediatric behavioral health clinic hope to eventually establish capacity for crisis respite beds as well as short-term inpatient and partial inpatient beds. However, they wisely recognize the need to prioritize their outpatient service array in order to decrease the reliance on inpatient beds. Once the outpatient program is sustainable, the use of crisis respite beds could help offset the potential loss of the StarCare crisis respite program and prevent the unnecessary use of distant inpatient services.

Component 4 – Community Opportunity 5: Increase Medicaid provider enrollment and billing with current intensive home and community-based service providers. In order to achieve long-term sustainability, any provider delivering intensive home and community-based services should become enrolled as a Medicaid provider and bill Medicaid, as well as private insurance, to the fullest extent possible for services that have historically been limited to grant funding. Many local non-profit service providers expressed a willingness to provide home visits if the services could be reimbursed. There is an opportunity to obtain reimbursement for crisis services through Medicaid. Intensive home and community-based service providers could enroll to become Medicaid providers to access reimbursement for billable services like mental health rehabilitation (this can be a nine- to 12-month process), explore partnership models for providers who do not have the administrative resources to bill Medicaid, or establish a referral process.

Conclusion for Child, Youth, and Family Findings and Recommendations

Although there is some overlap, most of the findings in this report are most relevant to one of the five systematic components we previously mentioned and are categorized and described accordingly (community-level, integrated primary care, specialty care, intensive and rehabilitative, and crisis and inpatient services). However, the relationships and level of coordination between these components is an essential aspect of the overall health and efficacy of a child and youth mental health system. Communication and coordination between providers in different parts of the system, and the ability for families to navigate seamlessly across each component, are key markers of the strength of the overall system.

Lubbock is on the brink of experiencing a significant increase in available mental health services for children, youth, and families. In partnership with TTU, the two major health care systems, UMC and Covenant Health, are opening pediatric behavioral health clinics. There are also state and federal policy changes soon to take effect that will bring about changes and new opportunities to fund certain mental health services. These include:

- Texas Senate Bill (SB) 11 (86th Legislative Session, 2019), which, among other things, will support expert psychiatric consultation in primary care settings and the expansion of telehealth to support mental health needs;
- The transition to the Community-Based Care foster care model we previously mentioned; and
- The eventual implementation of the federal Family First Prevention Services Act (FFPSA), which is expected to expand the opportunity for reimbursing evidence-based mental health services to children, youth, and families who are at risk of child welfare involvement.

With the right type community-wide coordination and planning, the addition of new services and reimbursement opportunities can potentially produce significant improvements in access to mental health services and in the quality of care provided to children, youth, and families. However, without a deliberate and inclusive strategy for expanding the capacity of the pediatric mental health system, the lack of long-term sustainability, use of ineffective treatments, and duplication of efforts are all major concerns. Although Lubbock has local inter-disciplinary groups that focus on specific aspects related to children's mental health, it currently lacks a cross-system coalition focused on the overarching goal of improving the quality, sustainability, and availability of mental health services for children, youth and their families.

Given the current and planned expansion of children's mental health services, historical challenges in sustaining certain mental health programs, and new funding opportunities, it is critical that Lubbock forms a community-wide coalition focused on the mental health system that serves children, youth, and their families. This group should be multi-disciplinary,

egalitarian, and inclusive; include all departments at TTU that offer mental health services and programs; and include experts in the implementation of evidence-based practices.

The community of mental health care providers that serve children and youth in Lubbock has a strong will to address and improve children and youth's mental health. For this strength to result in significant improvements in the care families receive, it must be coupled with a coordinated and planned approach to expanding evidence-driven services. For a community its size, Lubbock has a great deal of resources and if those resources are well managed and coordinated, Lubbock will be in a position in which it stands out as a key leader in children's mental health.

Summary

Lubbock has unique advantages and opportunities to improve its mental health care system and to do so within a general health care framework. The community consensus that change is needed is an essential ingredient to create change, and the generally cooperative attitude among key stakeholders is another critical advantage. There are initiatives in place that can be integrated, an infrastructure that will allow stakeholders to take advantage of opportunities created by the Texas Legislature, and a legacy of commitment in Lubbock to solving problems locally. There is no reason Lubbock cannot emerge from its efforts with one of the best mental health care systems in Texas.

Appendix A: List of Key Informants

In addition to the key informants listed below, we held seven focus groups from stakeholders who we felt could share information best in a group format: five groups with Lubbock Police Department officers across all shifts assigned to patrol, including one group of shift supervisors, departmental leadership, and mental health program (Crisis Intervention Trained) officers; and two student groups, one from Lubbock Independent School District and one from Frenship Independent School District.

StarCare Specialty Health System (StarCare)

Name	Title	Organization
Brenda Cantu	Clinic Administrator of Outpatient Services	StarCare Specialty Health System
Robyn Johnston	Chief of Staff	StarCare Specialty Health System
Bobby Carter	Crisis Director	StarCare Specialty Health System
Michella Tanner	Director of Mental Health Services	StarCare Specialty Health System
Lisa Alamanza	Sunrise Canyon Director	StarCare Specialty Health System
Amanda Gore	Children's Director	StarCare Specialty Health System
Sarah Dingus	Forensic Mental Health Director	StarCare Specialty Health System
Marle Antu	Behavioral Health Division Director	StarCare Specialty Health System
Beth Lawson	Chief Executive Officer	StarCare Specialty Health System
Debbie Mitchell	Certified Peer Specialist	StarCare Specialty Health System
J. Brad Joy	Certified Peer Specialist	StarCare Specialty Health System
Kevin Lonn Baker	Peer Support Supervisor	StarCare Specialty Health System
Donna Moore	Physician Assistant, Forensic Services	StarCare Specialty Health System

Name	Title	Organization
Alyssa Willis	Director of Adult Intensive Mental Health Services	StarCare Specialty Health System
Meredith Edwards	YES Waiver Team Lead	StarCare Specialty Health System Children's Program
Rachelle Lock	Case Manager and Crisis Respite Worker	StarCare Specialty Health System Children's Program
Carley Pierce	Case Manager and Crisis Respite Worker	StarCare Specialty Health System Children's Program
Greg Gittner, USA (Ret.)	Director of Veteran Services	VetStar (StarCare Specialty Health System)
Andrew Gilpin	Military Veteran Peer Network Services Coordinator	VetStar (StarCare Specialty Health System)

Law Enforcement/Legal

Name	Title	Organization
Dean Stanzione	Director of Court Administration	Office of Court Administration
Cryctal Spradley	Assistant Director of Court Administration	Office of Court Administration
Gary Vaughn	Division Chief	Lubbock Fire Rescue
Steve Henderson	Director	Lubbock-Crosby County Community Supervision and Corrections Department
Gregory Stevens	Chief Police	Lubbock Police Department
Mr. Kelly Rowe	Sheriff	Lubbock County Sheriff's Office
Kim Howell	Assistant Chief Deputy	Lubbock County Sheriff's Office
Cody Scott	Chief Deputy of Detention Operations	Lubbock County Sheriff's Office
Rae Brockman	LPC in Charge	Lubbock County
Honorable Mark J. Hocker	Judge	Lubbock County
Sunshine Stanek	Criminal District Attorney	Lubbock County
Ashley Davis	Assistant District Attorney	Lubbock County
Johnny Jaquess	Watch Commander	Lubbock County Detention Center, Detention, Justice and Mental Health Collaboration Program (JMHCP) grant

Name	Title	Organization
Cynthia Fry	Behavioral Health Coordinator	Lubbock County Juvenile Justice Center
William Carter II	Director/Chief Juvenile Probation Officer	Lubbock County Juvenile Justice Center
Eddie McBride	President and CEO	Lubbock Chamber of Commerce
Jim Bethke	Executive Director	Lubbock Private Defenders Office
Shannon Cavasos	Executive Assistant	Lubbock Private Defenders Office
Cynthia Chavez	Mental Health Program Director	Lubbock Private Defenders Office
Jon Caspell	Assistant Chief of Police	Lubbock Police Department
Neal Barron	Assistant Chief in Charge of the Bureau of Operations	Lubbock Police Department
Misti Snodgrass	Lieutenant	Lubbock Police Department
John Wilhelm	Crisis Intervention Team Officer	Lubbock Police Department
Jon Thompson	Crisis Intervention Team Officer	Lubbock Police Department
Kimberly Crain	Crisis Intervention Team Officer	Lubbock Police Department
Dr. Andy Young	Crisis Negotiator and Behavioral Health Director	Lubbock Police Department

Hospitals/Mental Health Providers

Name	Title	Organization
Walt Cathey	President and Chief Executive Officer	Covenant Health System
Amy Thompson	Chief Executive Officer	Covenant Health System
Char Rantz	Certified Case Manager, Team Leader	Covenant Health System
Elizabeth Ellis	Supervisor Over Case Management	Covenant Health System
Lee Turner	Vice President of Mission Integration	Covenant Health System
Tavia Hatfield	Covenant Health Regional Director, Community Investment Partnerships	Covenant Health System
Kirby Wood	Lead Therapist	Center for Superheroes
Mackenzie Hughes	Staff Therapist	Center for Superheroes

Name	Title	Organization
Alexandrea Fuller	Staff Therapist	Center for Superheroes
Leah Peterson	Medical Services Administrator	Lubbock County Detention Center
Beverly Greiner	Manager of Mental Health Clinic	Lubbock VA Outpatient Clinic
Linda McMurry	Executive Director	Larry Combest Health and Wellness Center
Douglass Klepper	Pediatrician	Pediatric Associates of Lubbock
Dr. Rafael Ruiz	Former Regional Mental Health Medical Director at John Montford Psychiatric Facility	Private psychiatry practice
Joe Dell Patterson	Mental Health Services Supervisor	University Medical Center
Dr. Mike Ragain	Executive Vice President and Chief Medical Officer	University Medical Center
Timothy Howell	Senior Vice President, Patient Care Services, Surgery and Trauma	University Medical Center
Dr. Chris Piel	Emergency Department Director	University Medical Center
Dr. Brian Payne	Chief Medical Officer	University Medical Center Children's Hospital
Jeffrey Hill	Senior Vice President Support Services	University Medical Center Health System
Kevin Waddington	**Emergency Medical Technician – Paramedic**	Lubbock County Detention Center; Correct Care Solutions
John Sigle	President	Texas Boys Ranch
Beth Robinson	Counselor	Texas Boys Ranch
Shalana Jacoby	Clinical Director	Texas Boys Ranch
Kaylee Hendriex	Children's Shelter Program Director	Texas Boys Ranch

Nonprofit Organizations

Name	Title	Organization
Jade Dominguez	Director of Advocacy	CASA of the South Plains
Lauren Westerberg	Chief Program Officer	CASA of the South Plains
Rachel Faz	Youth and Family Director	Catholic Charities of Lubbock
Jennifer Lopez	STAR Case Manager	Catholic Charities of Lubbock
Melissa Wood	Clinical Director	Children's Hope

Name	Title	Organization
Tami Swoboda	Vice President of Programs and Grants	Community Foundation of West Texas
Bryan Moffitt	Executive Director	Family Counseling Services
Glenn Cochran	President/CEO	Lubbock United Way
Chad Wheeler	Executive Director	Open Door
Carla Olsen	Executive Director	Parenting Cottage
Ashley Ammons	Community Impact Director	United Way
Carolyn Simpson	Community Impact Associate	United Way
Amy Berry	Senior Vice President Donor Relations	United Way
Glenda Mathis	Executive Director	YWCA of Lubbock
Eloisa Vigil	Chief Program Officer	Communities In Schools
Sharnice Perez	Site Director	Communities In Schools
Sara Cavio	Site Director	Communities In Schools
Alexis Milligan	Site Director	Communities In Schools
Jimmy Moore	President	Children's Home of Lubbock
Sharron Davis	Executive Director	Contact Lubbock

Government

Name	Title	Organization
W. Jarrett Atkinson	City Manager	City of Lubbock
Katherine Wells	Director of Public Health	City of Lubbock
Latrelle Joy	Council Member	City of Lubbock
Dan Pope	Mayor	City of Lubbock
Judge Melissa McNamara	Judge	Lubbock County
Curtis Parrish	County Judge	Lubbock County
Bill McCay	County Commissioner	Lubbock County
Marlise Boyles	Assistant District Attorney	Lubbock County Assistant District Attorney
Margaret Lair	Vet Center Director	Lubbock Vet Center
Erin McGann	Justice-Involved Veterans Coordinator	Texas Veterans Commission
Norman Bearden	Veterans Resource & Referral Specialists	Texas Veterans Leadership Program, Texas Workforce Commission (Workforce Solutions Panhandle)

Name	Title	Organization
Harry Carroll	Department Service Officer	Disabled American Veterans (Lubbock), Department of Texas
John Reagan	Department Service	Disabled American Veterans (Lubbock), Department of Texas
Robert Simmons	Commander	Disabled American Veterans (Lubbock), Department of Texas
Leigh Ann Eaten	Program Strategy Division	Department of Family and Protective Services
Shawn Vandygriff	Child Protective Investigations Regional Director, Regions 1&2	Department of Family and Protective Services
Hector Ortiz	Child Protective Services Regional Director, Region 1&2	Department of Family and Protective Services
Cortney Harris	CRCG Chair	Department of Family and Protective Services

School Districts

Name	Title	Organization
Julie Pratt	Counseling Coordinator	Frenship ISD
Amy Smallwood	Lead Counselor, Frenship High School	Frenship ISD
Dr. Keith Bryant	Superintendent	Lubbock-Cooper ISD
Dr. Kathy Rollo	Superintendent	Lubbock ISD
Doyle Vogler	Associate Superintendent	Lubbock ISD
Lynn Akin	Assistant Superintendent for Student Services	Lubbock ISD
Martha Dodge	Coordinator of Leadership and Professional Development	Lubbock ISD
Charlotte Sessom	Director of Counseling and College/Career Readiness	Lubbock ISD
Charnice Perez	Site Coordinator with Communities In Schools	Lubbock-Cooper ISD

Higher Education

Name	Title	Organization
Annette Gary	Co-chair	Lubbock Mental Health Coalition
Dr. John Opperman	Vice Chancellor for Academic Affairs	Texas Tech University System

Name	Title	Organization
Susan Calloway	Associate Professor, School of Nursing	Texas Tech University Health Sciences Center
Dr. Brian Shannon	Paul Whitfield Horn Professor	Texas Tech University System, School of Law
Dr. Billy Philips	Executive Vice President & Director	Texas Tech University Health Sciences Center
Kary Blair	Senior Clinical Department Administrator	Texas Tech University Health Sciences Center
Tammy Camp	Associate Professor of Pediatrics; Residency Program Director	Texas Tech University Health Sciences Center
Dr. Sarah Wakefield	Assistant Professor, Director of Child and Adolescent Psychiatry Services	Texas Tech University Health Sciences Center
Dr. Michael Gomez	Assistant Professor	Texas Tech University Health Sciences Center, Center for Superheroes
David J. Lewis, USAF (Ret.)	Director, Strategic Studies	Texas Tech University Department of Political Science
Dr. Charles Seifert	Senior Executive Associate Dean, School of Pharmacy	Texas Tech University Health Sciences Center
Dr. Thomas McGovern	Psychiatry Professor	Texas Tech University Health Sciences Center
Keino McWhinney	Director	Texas Tech Mental Health Institute
Dr. Terry McMahon	Department Chair, Psychiatry	Texas Tech University Health Sciences Center
Dr. Joy Wang	Assistant Professor	Texas Tech University College of Education
Bobbi Britton-Stroud	Senior Administrator/Case Manager	Texas Tech University Student Counseling Center
Kyle Schindler	Staff Psychologist; Coordinator of MindSpa Services	Texas Tech University Student Counseling Center
Debra Crosby	Director	Texas Tech University Military & Veterans Programs
Wes Dotson	Director	Burkhart Center

Professional Society

Name	Title	Organization
Dr. Kimberly Thompson	President	South Plains Association of Psychologists

Appendix B: Interview Guide Questions

Key Informant Interview Questions

1. **What are your goals for this assessment?**

2. **What are the primary strengths the community has in meeting the mental health needs of the community?**
   a. Why are these components of the system working well?
   b. How do these components affect service delivery?
   c. Are there any changes that could be made to improve these components?

3. **What are the community's primary weaknesses and gaps in meeting the mental health needs of the community?**
   a. Why are these components within the system of care not working?
   b. How do these inadequacies affect service delivery?
   c. What problems do these inadequacies create for you within your role in the service system?
   d. From your perspective, what strategies or solutions could be used to overcome these inadequacies?
   e. How would these solutions improve service provision to all populations treated within the Lubbock area?

4. **What are one or two things that would most significantly improve the community's ability to meet the mental health needs of the community?**
   a. Which services/capacity could be added and what would it take to do so?

5. **What other general comments would you like to offer?**

6. **When thinking of your community leaders and elected officials, who do you believe is someone that should provide feedback to this assessment?**

Appendix C: Qualitative Data Collection Methods

Engagement Process

The Meadows Mental Health Policy Institute (MMHPI) worked with Community Foundation of West Texas and Texas Tech Mental Health Institute (TTMHI) in addition to the six core parties – Texas Tech University Health Sciences Center, Covenant Health System, StarCare Specialty Health System, Lubbock County, the City of Lubbock, and University Medical Center – to engage stakeholders throughout the Lubbock area. Through ongoing collaboration and dialogue with the core parties, key stakeholders were identified and invited to participate in focus groups and key informant interviews to identify issues relevant to the mental health needs in Lubbock.

The key areas of stakeholder engagement include: nonprofit, law enforcement and legal representatives, hospitals and mental health providers, StarCare Specialty Health System, higher education, government, and school districts.

Each key informant interview (individual or small group) or larger focus group session was moderated or co-led by project leads from MMHPI; notes were taken by MMHPI staff. Sessions were hosted with the assistance of TTMHI staff.

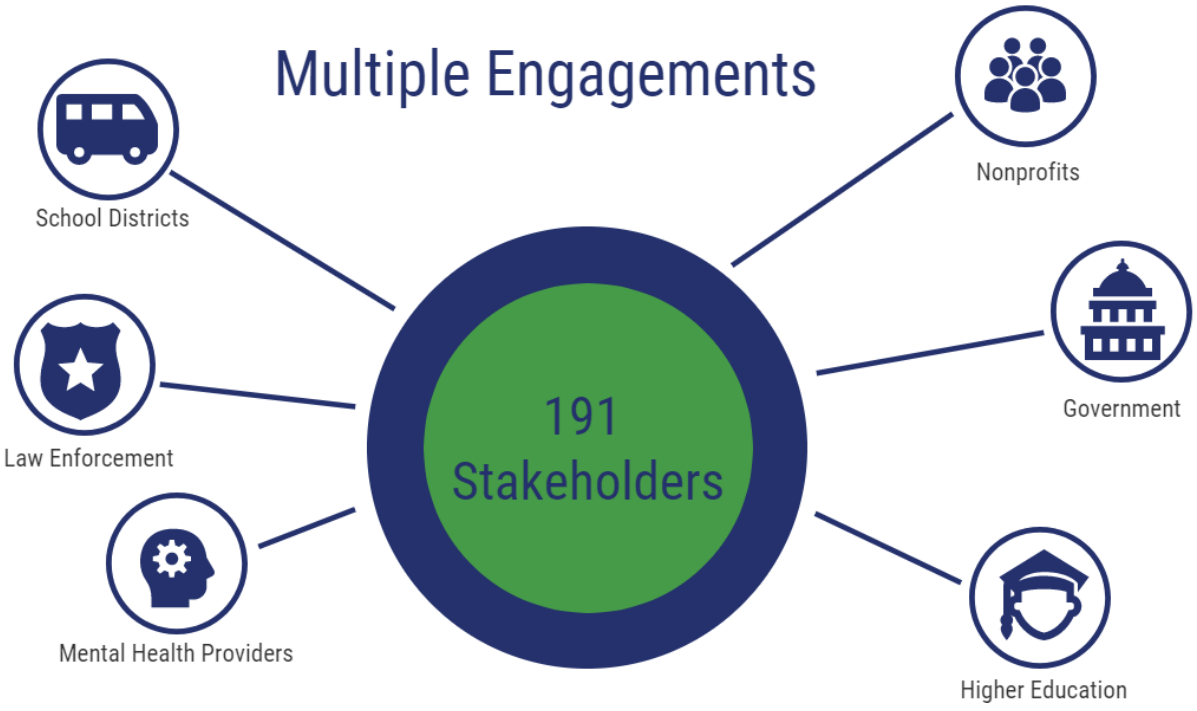
- **Guide Questions:** MMHPI staff created an interview framework (see Appendix B) as a guide for one-on-one sessions. Often our MMHPI content experts went beyond this guide to ask more focused questions, gaining further information as deemed most appropriate by the interviewer. These questions became more focused as the interview permitted. Open-ended questions covered local, systemic, and institutional issues and experiences in various areas – from local innovative programming developed to divert people from hospitalization and incarceration to changes in the collaborative efforts of mental health-engaged agencies over time. We also added questions to further identify needed system changes, gaps in services, and resources that might be expanded or used strategically in an improved service system.
- **Key Informant Interviews:** With assistance from the TTMHI and the core parties, we conducted key informant interviews from December 2018 through May 2019, in addition to other types of engagement, described below. All interviews were conducted by phone or in person. The information we gathered from these interviews is interspersed throughout this report and detailed in the body of the report. In our efforts to engage as many stakeholders as possible, we collaborated with key informants who were identified by leadership from the core parties and TTMHI, and introduced by TTMHI to create a local initial connection for MMHPI staff. As we interviewed, we asked for further recommendations, enabling us to achieve a diverse pool of participants representative of the Lubbock area and its community members.

- **Focus Group Interviews**: We held seven focus groups for stakeholders who we felt could share information best in a group format: five groups with Lubbock Police Department officers across all shifts assigned to patrol, including one group of shift supervisors, departmental leadership, and mental health program (Crisis Intervention Trained) officers; and two student groups, one from Lubbock Independent School District and one from Frenship Independent School District.

Core Parties Collaborative Planning Meetings: The core parties met repeatedly over the course of the stakeholder engagement period to focus on the progress of the needs assessment, share initial findings, and review the planning work that has gone into the project. MMHPI, with the hosting assistance of TTMHI, reported on the information shared at these meetings and collected feedback to further review.

Figure 1: Stakeholder Engagement Participants

Note that we interviewed a total of 191 stakeholders during the engagement process, the figure below reflects both total engaged stakeholders and those separately engaged during a focus group interview.



A full list of the people who were interviewed is provided in Appendix A; the key informant interview question guide is provided in Appendix B.

Appendix D: Hospital Utilization and Capacity Data Methodology

We drew our data for inpatient psychiatric bed use from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on the client's age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer, and source of admission, among other variables.

These THCIC discharge records were used to analyze psychiatric inpatient and emergency department utilization in the Lubbock area and across Texas, as depicted in the maps and data tables in this report. While we currently have data from 2015 through the second quarter of calendar year (CY) 2018, the data in the maps and tables are limited to a single full year of data – April 2017 through March 2018, with the exception of the daily utilization graphs, which report utilization as far back as January 2015. In some instances, data were aggregated into records reflecting the "Lubbock Area" – these include Lubbock area residents and Lubbock area hospitals. In both instances, "Lubbock Area" refers to the catchment area of the local mental health authority (LMHA) – StarCare Specialty Health System – which serves Cochran, Crosby, Hockley, Lubbock and Lynn counties. Discharge records were aggregated across all age groups.

Hospital capacity data were obtained from the American Hospital Association's (AHA) 33rd Annual Survey of Hospitals (for year 2017). We reported the number of beds that are staffed for use by the hospital. However, if the hospital reported an alternate number of available beds in the most recent in-person interviews, we used that reported capacity in lieu of the AHA reported capacity.

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

[ii] National estimates of prevalence and severity breakouts, unless otherwise cited, are drawn from Kessler, R. C., et al. (2012). Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement). *Archives of Gen Psychiatry, 62*(6), 617–627. The data are from a study with youth. Kessler et al. provide estimates of mild and moderate levels of severity for youth ages 13–17 years old. Absent any data on the severity of conditions among children and youth, this rate has been applied to all children and youth ages 6–17. However, children aged 12 and under likely have lower prevalence of mental health disorders.

[iii] Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer's estimate of SED more precise than Kessler's.

[iv] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

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

disorder; we used other sources for estimating prevalence of those and other conditions not reported in Kessler et al., 2012.

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

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

[viii] Kirkbride, J. B., Jackson, D., Perez, J., Fowler, D., Winton, F., Coid, J. W., Murray, R. M., & Jones, P. B. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*(2), 1–12. Estimates of the incidence of first episode psychosis are extrapolated from studies by Kirkbride and colleagues that used a range of ages (14–35 years) during which the first episode of psychosis is likely to occur.

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

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

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

[xii] The number of deaths from suicide includes suicide mortality for all mental health conditions, ages 0–17 years, in 2016. Data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2016 on CDC WONDER Online Database. (Released December, 2017). Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through Vital Statistics Cooperative Program. Retrieved May 30, 2018, from http://wonder.cdc.gov/ucd-icd10.html

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

[xiv] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS_R). *Archives of Gen Psychiatry, 62*(6), 617-627. The data are from a study with adults.

[xv] Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer's estimate of SMI more precise than Kessler's.

[xvi] Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer's estimate of SMI more precise than Kessler's. "In poverty" refers to the number of people below 200% of the federal poverty level for the specified region.

[xvii] These adults are at the highest risk for repeated use of emergency rooms, hospitals, and jails. Cuddeback and colleagues (2006, 2008) have estimated that 7.7% of adults with SMI need Assertive Community Treatment, Forensic Assertive Community Treatment, or both. See Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*, 1803–1806; and Cuddeback, G. S., Morrissey, J. P., & Cusack, K.J . (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205–208. It is unnecessary to specify the income levels among the population

of adults with complex needs and high utilization of public services because a significant percentage of them live in poverty.

[xviii] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of Gen Psychiatry, 62*(6), 617–627. The data are from a study with adults.

[xix] Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute.

[xx] Merikangas, K., et al. (2007). Lifetime and 12-month prevalence of bipolar spectrum disorder in the National Comorbidity Survey Replication. *Archives of Geeraln Psychiatry, 5*(64), 543–552.

[xxi] Substance use disorder prevalence rates were obtained from 2012–2014 National Survey on Drug Use and Health: Substate Estimates – Texas Regions 4, 5, and 6a. Prevalence rates were applied to Texas Demographic Center population estimates for 2016. All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts.

[xxii] McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76, p. 70. Literature on the prevalence of schizophrenia in adolescents is very sparse, perhaps non-existent. Based on the fact that estimates of the incidence (new cases) of schizophrenia include adolescents, we have roughly estimated 0.2% of the adolescent population has schizophrenia over a 12-month period.

[xxiii] Kirkbride, J. B., et al. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open, 3*, 1–12.

[xxiv] The number of deaths from suicide includes suicide mortality for all mental health conditions, ages 18 and older, in 2016. Data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2016 on CDC WONDER Online Database. (Released December, 2017). Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through Vital Statistics Cooperative Program. Retrieved May 30, 2018, from http://wonder.cdc.gov/ucd-icd10.html

[xxv] The percentage of adults and youth in poverty with an SUD is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2014. The percentage was applied to the estimated number of adults and youth in poverty in Texas. Poverty estimates are based on the American Community Survey 2015 poverty proportions, applied to the Texas Demographic Center's 2015 population estimates.

[xxvi] The estimates of co-occurring psychiatric and substance abuse disorders (COPSD) in the adult population of each county in Texas were based on the national rates of comorbidity of any mental illness (AMI) with substance use disorders (SUD) found in SAMHSA's 2015 report, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50), and the 2014–2015 National Survey on Drug Use and Health (NSDUH) rates of AMI and SMI for Texas. The AMI prevalence rate was multiplied by the rate of comorbidity with SUD. This rate (AMI/SUD) was then multiplied by the Texas Demographic Center's estimates of 2015 adult population for each county, resulting in the COPSD estimates by county for AMI/SUD.

[xxvii] The estimate for comorbid psychiatric and substance use disorders for youth were based on national rates of comorbidity between major depressive episodes (MDE) and SUD among youth ages 12–17 years, found in SAMHSA's 2015 report, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50) and the 2014–2015 National Survey on Drug Use and Health (NSDUH) rates of MDE for Texas. The MDE prevalence rate was multiplied by the respective rate of comorbidity with SUD. This rate was then multiplied by the Texas Demographic Center's estimates of 2015 youth population for Texas, resulting in the comorbid MDE and SUD estimate.

[xxviii] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html. Overdose deaths are classified using underlying cause-of-death ICD-10 codes: X40-44, X60-64, X85, and Y10-Y14.

[xxix] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2016 on CDC WONDER Online Database, released December 2017. Data are from the Multiple Cause of

Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html. Alcohol induced deaths are classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes."

Appendix E: Supplementary Data Tables

Table 15: Lubbock Area Resident Admissions to Psychiatric Beds – All Ages (April 2017 to March 2018)

Map Label	County and Hospital	Psychiatric Admissions	% Via Law Enforcement	% SUD
A	**Bell County**	**<6**	**33%**	**33%**
	Metroplex Hospital	<6	100%	100%
	Scott & White Memorial Hospital	<6	0%	0%
B	**Bexar County**	**8**	**0%**	**38%**
	Clarity Child Guidance Center	<6	0%	0%
	Laurel Ridge Treatment Center	<6	0%	33%
	Nix Health Care System	<6	0%	0%
	Nix Specialty Health Center	<6	0%	0%
	San Antonio Behavioral Healthcare Hospital	<6	0%	100%
	University Hospital	<6	0%	100%
C	**Collin County**	**<6**	**0%**	**50%**
	Columbia Medical Center–McKinney	<6	0%	100%
	Eating Recovery Center	<6	0%	0%
	Texas Health Seay Behavioral Health Center	<6	0%	50%
D	**Dallas County**	**8**	**25%**	**25%**
	Children's Medical Center–Dallas	<6	0%	0%
	Dallas Behavioral Healthcare Hospital	<6	0%	100%
	Green Oaks Hospital	<6	100%	0%
	Hickory Trail Hospital	<6	0%	50%
	Sundance Hospital Dallas	<6	100%	0%
	UT Southwestern University Hospital–Zale Lipshy	<6	0%	0%
E	**Denton County** – University Behavioral Health (Denton)	**<6**	**0%**	**100%**
F	**El Paso County** – El Paso Behavioral Health System	**<6**	**0%**	**50%**
G	**Fort Bend County** – Westpark Springs	**<6**	**0%**	**0%**
H	**Hale County** – Allegiance Behavioral Health Center (Plainview)	**88**	**0%**	**<7%**
I	**Harris County**	**6**	**17%**	**17%**
	Behavioral Hospital–Bellaire	<6	50%	50%

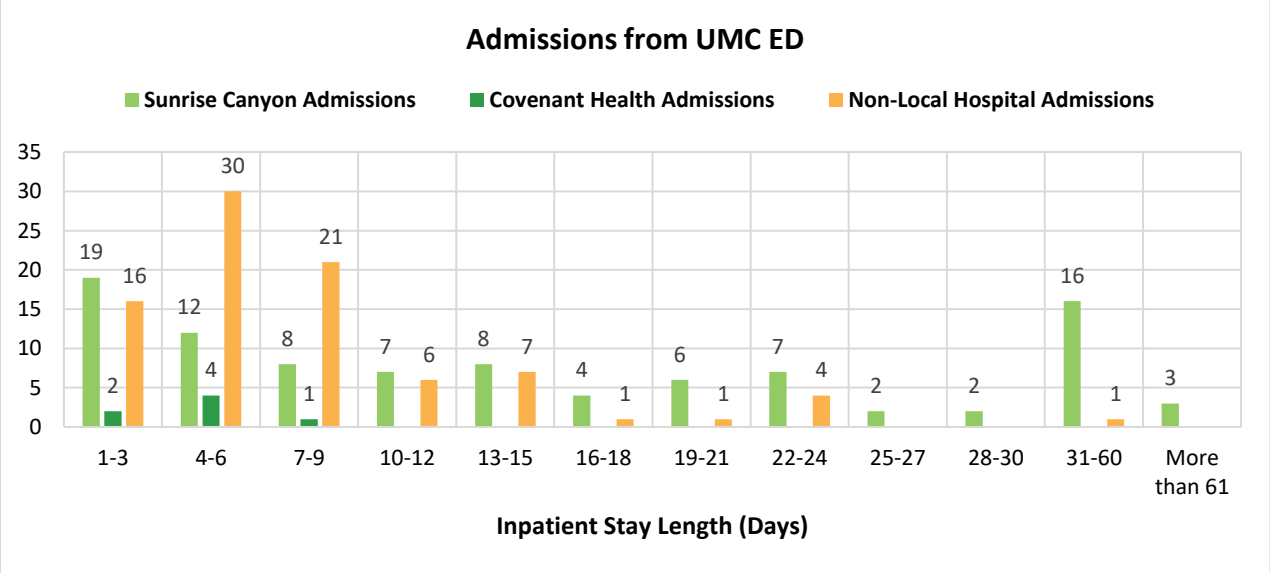
Map Label	County and Hospital	Psychiatric Admissions	% Via Law Enforcement	% SUD
	Kingwood Pines Hospital	<6	0%	0%
	Menninger Clinic	<6	0%	0%
J	**Howard County** – Big Spring State Hospital	**<6**	**100%**	**0%**
K	**Kaufman County** – Terrell State Hospital	**<6**	**100%**	**0%**
L	**Lubbock County**	**946**	**11%**	**40%**
	Covenant Hospital	565	0%	62%
	Sunrise Canyon	381	27%	7%
M	**Midland County** – Oceans Behavioral Hospital of the Permian Basin	**92**	**1%**	**26%**
N	**Potter County** – Northwest Texas Hospital	**111**	**0%**	**33%**
O	**Smith County** – East Texas Medical Center	**<6**	**0%**	**0%**
P	**Tarrant County**	**<6**	**0%**	**50%**
	John Peter Smith Hospital	<6	0%	100%
	Mesa Springs	<6	0%	0%
	Sundance Hospital	<6	0%	100%
	Texas Health Arlington Memorial Hospital	<6	0%	0%
Q	**Taylor County** – Oceans Behavioral Hospital Abilene	**97**	**15%**	**26%**
R	**Tom Green County**	**<372**	**2%**	**41%**
	River Crest Hospital	366	1%	41%
	Shannon West Texas Memorial Hospital	<6	100%	0%
S	**Travis County**	**<6**	**0%**	**25%**
	Austin Oaks Hospital	<6	0%	0%
	Seton Shoal Creek Hospital	<6	0%	0%
	Texas NeuroRehab Center	<6	0%	100%
T	**Wichita County**	**26**	**38%**	**15%**
	North Texas State Hospital	10	100%	10%
	Red River Hospital	16	0%	19%
U	**Wilbarger County –** North Texas State Hospital (Vernon)	**19**	**100%**	**0%**
V	**Williamson County**	**<6**	**0%**	**0%**
	Georgetown Behavioral Health Institute	<6	0%	0%
	Rock Springs	<6	0%	0%

Map Label	County and Hospital	Psychiatric Admissions	% Via Law Enforcement	% SUD
	Total Lubbock Area Resident Admissions	**1,799**	**9%**	**35%**
	Admissions to Lubbock Hospitals	**946**	**11%**	**40%**
	Admissions to Non-Lubbock Hospitals	**853**	**7%**	**30%**
	Admissions to State Hospitals	**34**	**100%**	**3%**

Table 16: Admissions to Psychiatric Beds from University Medical Center (UMC)

Admitting Hospital	Admissions from UMC ED	Payer Percent				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Covenant Health	**7**	**14%**	**43%**	**N/A**	**43%**	**N/A**
Law Enforcement (LE) Transport	N/A	N/A	N/A	N/A	N/A	N/A
Sunrise Canyon	**94**	**17%**	**11%**	**62%**	**9%**	**N/A**
LE Transport[75]	24	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Local Hospitals	**86**	**28%**	**17%**	**5%**	**13%**	**38%**
LE Transport	7	57%	N/A	N/a	14%	29%

Graph 1: Admissions to Psychiatric Beds from UMC Emergency Department (ED) – Length of Stay Details (April 2017 to March 2018)



[75] Because payer percentages for Sunrise Canyon are based on all admissions in aggregate, we cannot estimate the unique payer percentages for admissions that occurred via law enforcement transport.

Table 17: Length of Stay of Admissions from UMC ED to Psychiatric Beds

Admissions from UMC ED to Psychiatric Beds			
Length of Stay in Days	**Admissions to Sunrise Canyon**	**Admissions to Covenant Health**	**Admissions to Non-Local Hospitals**
1 to 3 Days	19	2	16
4 to 6 Days	12	4	30
7 to 9 Days	8	1	21
10 to 12 Days	7	N/A	6
13 to 15 Days	8	N/A	7
16 to 18 Days	4	N/A	1
19 to 21 Days	6	N/A	1
22 to 24 Days	7	N/A	4
25 to 27 Days	2	N/A	N/A
28 to 30 Days	2	N/A	N/A
31 to 60 Days	16	N/A	1
More than 61 Days	3	N/A	N/A
Percent Staying for Less than 2 Weeks	**53%**	**100%**	**90%**
Percent Staying for Longer than 2 weeks	**47%**	**0%**	**10%**

Table 18: Admissions to Psychiatric Beds from Covenant Health's Lubbock ED

Admitting Hospital	Admissions from Covenant ED	Payer Percent				
		Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
Covenant Health	**529**	**14%**	**18%**	**6%**	**36%**	**26%**
LE Transport	1	100%	N/A	N/A	N/A	N/A
Sunrise Canyon	**3**	**17%**	**11%**	**62%**	**9%**	**N/A**
LE Transport	2	**N/A**	**N/A**	**N/A**	**N/A**	**N/A**
Non-Local Hospitals	**97**	**27%**	**4%**	**11%**	**19%**	**40%**
LE Transport	3	33%	N/A	N/A	N/A	67%

Graph 2: Admissions to Psychiatric Beds from Covenant ED – Length of Stay Details (April 2017 to March 2018)[76]

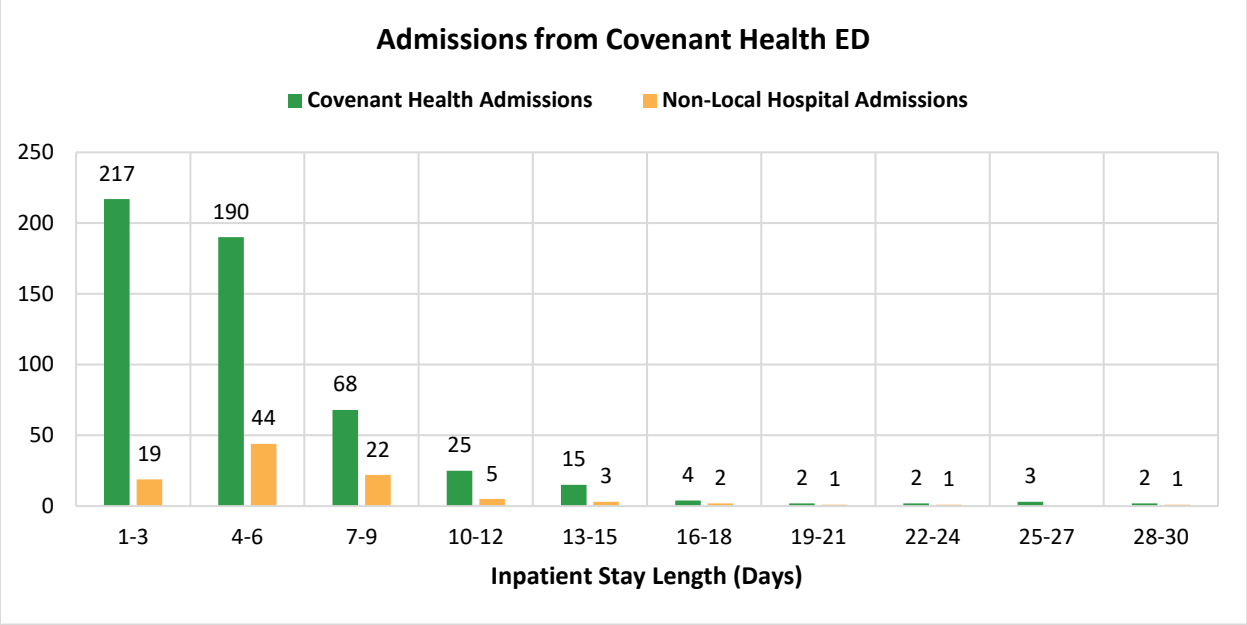


Table 19: Length of Stay of Admissions from Covenant ED to Psychiatric Beds

Admissions from Covenant ED to Psychiatric Beds			
Length of Stay in Days	**Admissions to Sunrise Canyon**	**Admissions to Covenant Health**	**Admissions to Non-Local Hospitals**
1 to 3 Days	1	217	19
4 to 6 Days	N/A	190	44
7 to 9 Days	N/A	68	22
10 to 12 Days	N/A	25	5
13 to 15 Days	N/A	15	3
16 to 18 Days	N/A	4	2
19 to 21 Days	N/A	2	1
22 to 24 Days	N/A	2	1
25 to 27 Days	N/A	3	N/A
28 to 30 Days	N/A	2	1
31 to 60 Days	1	1	N/A
More than 61 Days	1	N/A	N/A

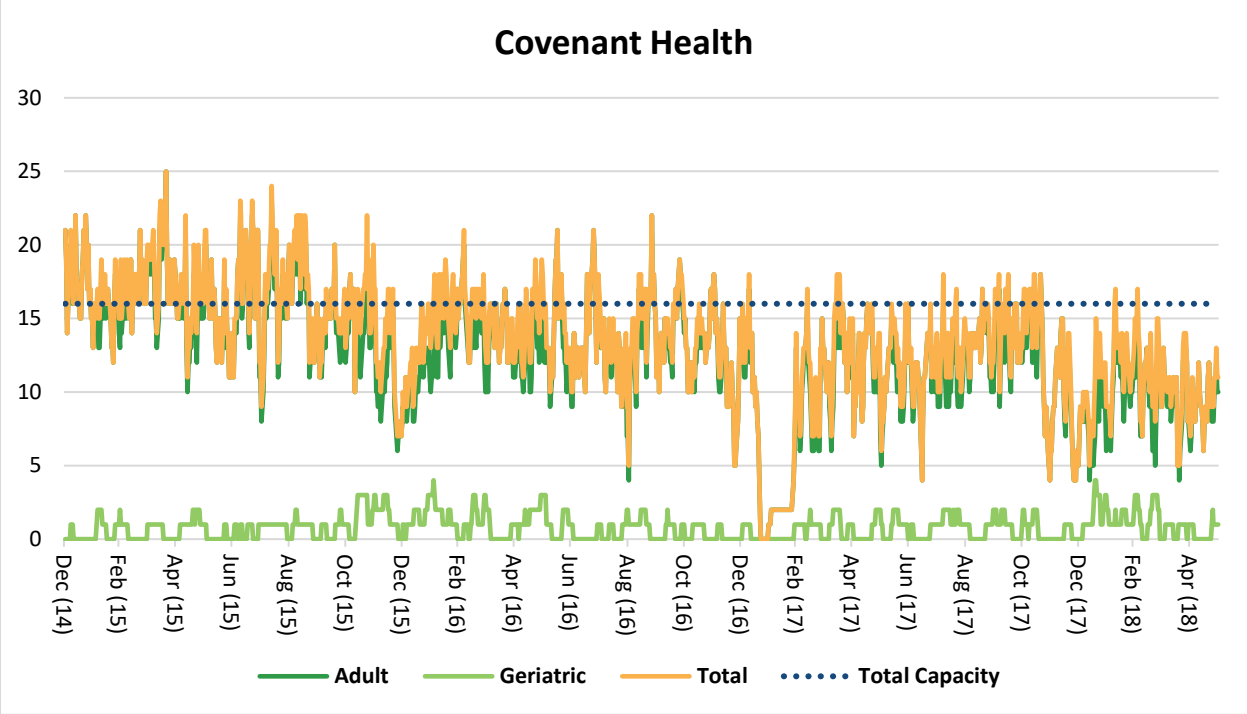
[76] Graph does not include three admissions to Sunrise Canyon. Of those three admissions, one had a length of stay of one to three days, one had a length of stay of 31 to 60 days, and one had a length of stay of more than 61 days.

Admissions from Covenant ED to Psychiatric Beds			
Length of Stay in Days	**Admissions to Sunrise Canyon**	**Admissions to Covenant Health**	**Admissions to Non-Local Hospitals**
Percent Staying for Less than 2 Weeks	**33%**	**97%**	**95%**
Percent Staying for Longer than 2 weeks	**67%**	**3%**	**5%**

Table 20: Admissions to Sunrise Canyon and Covenant Health – Length of Stay Frequencies (April 2017 to March 2018)

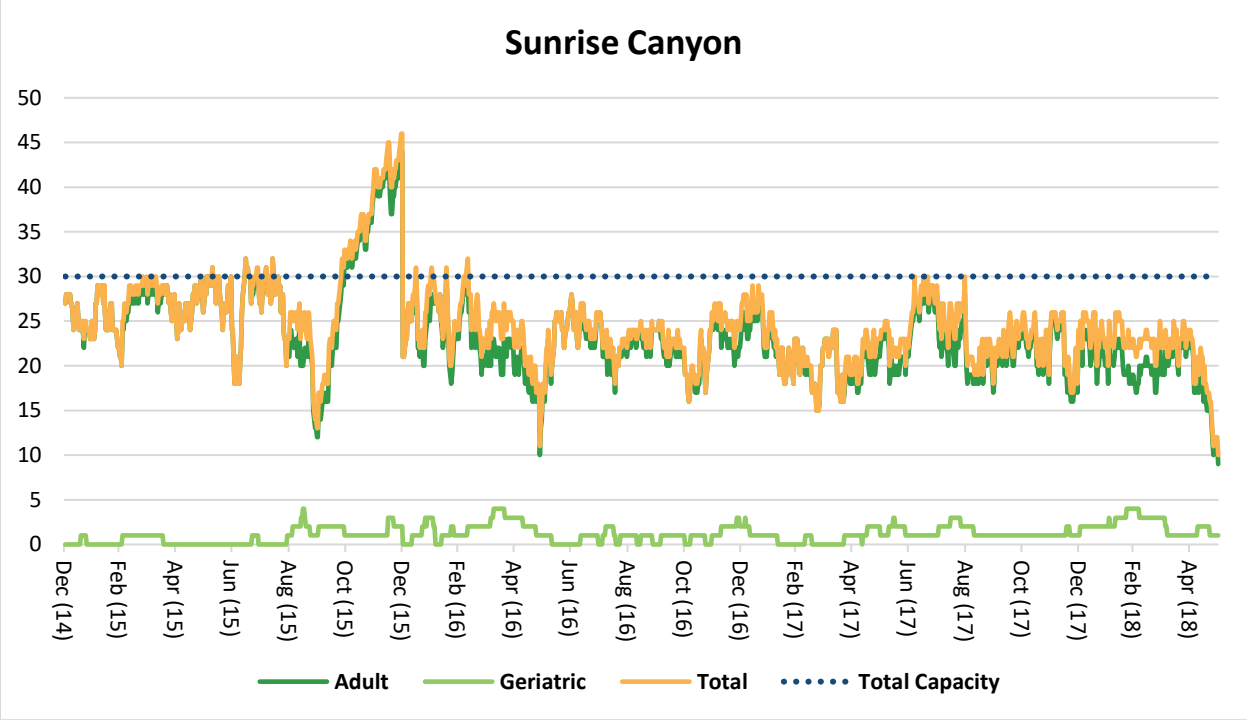
Length of Stay in Days	Sunrise Canyon		Covenant Health	
	Admissions	% With This LOS	Admissions	% With This LOS
1 to 3 Days	73	17.8%	309	42.4%
4 to 6 Days	57	13.9%	253	34.8%
7 to 9 Days	43	10.5%	90	12.4%
10 to 12 Days	42	10.2%	36	4.9%
13 to 15 Days	39	9.5%	19	2.6%
16 to 18 Days	22	5.4%	8	1.1%
19 to 21 Days	21	5.1%	<6	<1%
22 to 24 Days	18	4.4%	<6	<1%
25 to 27 Days	9	2.2%	<6	<1%
28 to 30 Days	11	2.7%	<6	<1%
31 to 60 Days	51	12.4%	<6	<1%
More than 61 Days	24	5.9%	N/A	<1%
All LOS (All Admissions)	**410**	**100%**	**728**	**100%**

Graph 3: Daily Psychiatric Bed Utilization Versus Capacity at Covenant Health (December 2014 to April 2018)[77]



[77] Utilization data were obtained from the Texas Health Care Information Collection (THCIC) January 2015 – July 2017 discharge records. Data represent discharge records for the following THCIC facilities: Covenant Medical Center (THCIC ID #465000), Covenant Medical Center – Lakeside (THCIC ID #109000), and Covenant Children's Hospital (THCIC ID #686000).

Graph 4: Daily Psychiatric Bed Utilization Versus Capacity at Sunrise Canyon (December 2014 to April 2018)[78]



[78] Utilization data were obtained from the Texas Health Care Information Collection (THCIC) January 2015 – July 2017 discharge records. Data represent discharge records for Sunrise Canyon (THCIC ID #804000). Psychiatric Bed Capacity was obtained from the American Hospital Association 2015 and 2016 Annual Surveys. For the purposes of visualization, the reported 2015 and 2016 psychiatric bed capacity was assumed to remain unchanged through 2017.

Appendix F: Mental Health Best Practices for Children, Youth, and Families

Defining Best Practices

There are hundreds of evidence-based practices available for mental health (MH) and substance use disorder (SUD) treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP).[79] The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, "not exhaustive," it is the most complete source on evidence-based practices available. The NREPP refers to all practices in the registry as "evidence-based," using the following definition: "Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation." The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed "promising" are now included in the NREPP, albeit with lower scores in some domains.

Successful best-practice promotion also requires understanding of the real-world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best-practice promotion effort. This process is sometimes called "using practice-based evidence" to inform implementation and is a core feature of continuous quality improvement. The reasons for stakeholder concerns at the "front line" implementation level are well documented and significant.[80] One major issue is that the literature prioritizes randomized clinical trials (RCTs) that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America[81] and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships. Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted

[79] The NREPP's searchable database can be found at: http://www.nrepp.samhsa.gov/

[80] Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. *Evidence-Based Mental Health, 8*, 60–62.

[81] U.S. Surgeon General. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships.[82] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices – and one that is certainly highly relevant for a state as diverse as Texas – involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base regarding diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter daily. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across culture.[83] Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that best practices be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major best practices.[84] There is also increasing recognition of best practices for refugee and immigrant communities.[85]

It is also, therefore, critical to ground best-practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[86] were adopted in 2001 by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual

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[82] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

[83] U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

[84] See http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx

[85] American Psychological Association, Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. Retrieved from http://www.apa.org/topics/immigration/immigration-report.pdf

[86] U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (2001, March). *National Standards for Cultural and Linguistically Appropriate Services in Health Care*. Washington, DC: Author. Retrieved from https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

needs of all patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available,[87] but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African-American, Asian-American / Pacific Islander, Hispanic / Latino, and Native-American / American-Indian groups is also available.[88] Guidance for multicultural applications is also available.[89]

Major Evidence-Based Practices for Children, Youth, and Families

This section describes select evidence-based practices (EBPs) at five levels: prevention approaches, integrated primary care, school-based mental health services, office and community-based interventions, and out-of-home treatment options. In addition, it attempts to differentiate approaches by age group, where applicable. This is not an exhaustive list and we expect it to change over time as new programs emerge and more is learned about the short- and long-term efficacy of treatments for various populations.

Prevention

Many EBPs are available to increase parenting skills, with an emphasis on early childhood (up to age 12). These include the following:

- **The Incredible Years:**[90] The Incredible Years program focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors in children, targeting infancy to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and teaching of social skills). This curriculum particularly targets risk factors for conduct disorder and promotes a positive environment for the child both in the home and at school.

[87] The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf

[88] USDHHS, Substance Abuse and Mental Health Services Administration. (2001). Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups. Rockville, MD: Author.

[89] See http://www.cimh.org/Services/Multicultural.aspx for the overall site and http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx for specific best practices demonstrated in California.

[90] Webster-Stratton, C. (1984). A randomized trial of two parent-training programs for families with conduct-disordered children. *Journal of Consulting and Clinical Psychology, 52(4),* 666–678.

- **Positive Parenting Program (Triple-P):**[91] This program is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials to 8–10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theory, in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues.

Integrated Primary Care

Integrated-behavioral health programs provide the opportunities to improve outcomes and promote culture of medical care to include both physical and behavioral health in treatment approaches. Annual well-child care visits with primary care providers provide an opportunity for children and youth to access both physical and behavioral healthcare, especially within the comprehensive setting of integrated primary care settings. Collaborative care programs where primary care providers, care managers, and behavioral health specialists work as a team to provide patient care can have a positive impact. A 2015 meta-analysis in the *Journal of the American Medical Association (JAMA) Pediatrics* indicated that "the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care." [92]

A Meadows Mental Health Policy Institute 2016 report[93] proposes that integrated behavioral health programs should include the following seven core components:

- Integrated organizational culture,
- Population health management,
- Structured use of a team approach,
- IBH staff competencies,
- Universal screening for the most prevalent primary health and behavioral health conditions,
- Integrated person-centered treatment planning, and
- Systematic use of evidence-based clinical models.

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[91] Sanders, M.R., Markie-Dadds, C., Tully, L.A., & Bor, W. (2000). The Triple-P positive parenting program: A comparison of enhanced, standard, and self-directed behavioral family intervention for parents of children with early onset conduct problems. *Journal of Consulting and Clinical Psychology, 68 (4),* 624–640.

[92] Asarnow, J. R., Rozenman, M., Jessica Wiblin, J., Zeltzer, L. (2015, October). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics*. 169(10): 929–937. Retrieved from http://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331

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

Effective integrated-behavioral health programs utilize evidence-based treatment interventions to achieve better outcomes and more cost-effective care. They track primary health and behavioral health outcomes and use health information technology to manage population outcomes in order to use interventions that ensure quality care.

Behavioral health integration in primary care settings increases behavioral health services for children and youth with mild to moderate conditions. About 75% of children and youth with psychiatric disorders could be seen in the pediatrician's office.[94] But these visitations generally have significant limitations. Pediatricians typically do not deliver mental health services due to limited time during each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.[95] However, a fully scaled implementation example suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.[96]

Behavioral health integration in primary care settings also aligns with the concept of the "medical home." The pediatric health home – sometimes called the "pediatric medical home" – refers, according to the American Academy of Pediatrics (AAP), to "delivery of advanced primary care with the goal of addressing and integrating high quality health promotion, acute care, and chronic condition management in a planned, coordinated, and family-centered manner."[97]

Providing additional perspective, the American Academy of Child and Adolescent Psychiatry (AACAP) has developed "Best Principles for Integration of Child Psychiatry into the Pediatric Health Home." AACAP identifies key components of the behavioral health integration

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[94] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[95] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrived from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

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

[97] American Academy of Pediatrics. (2017). Medical home. Retrieved from https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx

framework within the pediatric medical home.[98] These components include the following strategies:[99]

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

Examples of integrated primary care models include the following:

- **The Massachusetts Child Psychiatry Access Project** (MCPAP) offers one promising approach to integrated care. Established in 2004, MCPAP is a national leader and model that has inspired many other states to create such programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each comprising a child-psychiatrist, a licensed therapist, and a care coordinator. Each hub also operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers (PCP). In 2014, following a MCPAP consultation, primary care providers reported managing 67% of the types of problems that they typically would have referred to a child psychiatrist before they enrolled in the program. The MCPAP model was so instrumental in providing accessible behavioral health care for children and youth that the Massachusetts Child Psychiatry Access Project expanded to develop MCPAP for Moms. Created in 2014, MCPAP for Moms is a collaborative model that involves obstetricians, internists, family physicians, and psychiatrists. Its mission is to

[98] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrived from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

[99] American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrived from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

promote maternal and child health for pregnant and postpartum women for up to one year after delivery to prevent, identify, and manage mental health and substance use.[100]

- **Seattle Children's Partnership Access Line (PAL)** is another leading model of behavioral healthcare integration into primary care for children and youth. PAL is a telephone-based mental health consultation system that provides services to Washington and Wyoming. It is available to primary care physicians, nurse practitioners, and physician assistants. Users of this model obtain a child mental healthcare guide and advice from a child psychiatrist that includes a sample letter with a summary of the consult conversation. In addition, the PAL program includes a social worker who can provide a list of local resources tailored to an individual patient and his or her insurance. If a child needs to be evaluated in-person, PAL helps link families to providers in their respective communities. PAL can also assist with providing locations in which telemedicine appointment are available. The PAL team also provides educational presentations to primary care providers to increase their ability to manage behavioral health issues in the primary care setting. Primary care providers reported that in 87% of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements experienced a 132% increase in outpatient mental health visits after the consultation call. Primary care provider feedback surveys also reported "uniformly positive satisfaction" with PAL.[101] In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half. [102]
- A promising approach in Texas is provided by Dallas Children's Health, formerly Children's Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, it began an integrated behavioral health program within its pediatric outpatient clinics. In July 2015, the Integrated Behavioral Health Care Management program was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. As of January 2017, the team comprised 10 licensed master's level behavioral health clinicians (LPCs, LCSWs, and LMFTs) and two clinical psychologists. The behavioral health team provides consultation and direct treatment to patients who obtain their care from primary care providers within these clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11. Implementation of these tools

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

[101] Hilt, R. J., Romaire, M. A., McDonell, M. G., Sears, J. M., Krupski, A., Thompson, J. N., & Trupin, E. W. (2013, February). The partnership access line evaluating a child psychiatry consult program in Washington State. *JAMA Pediatrics*, 167(2), 162–168.

[102] Barclay, R. P., Penfold, R. B., Sullivan, D., Boydston, L., Wignall, J., & Hilt, R. J. (2017, April). Decrease in statewide antipsychotic prescribing after implementation of child and adolescent psychiatry consultation services. *Health Services Research*, 52(2), 561–578.

has contributed to studies that have shown excellent results, such as more than a 50% reduction in symptoms of depression. One strength of the program includes a shared electronic medical record system that offers both primary care and specialty behavioral health providers' access to a patient's records, enabling better care coordination. In addition, members of the behavioral health team are co-located with their primary care colleagues in the pediatric clinic setting, increasing accessibility to behavioral health care. The behavioral health team conducts educational presentations for primary care providers that include topics such as depression, attention-deficit hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case discussions and treatment planning. Using telemedicine for delivery of primary care services to children and youth in local schools also increases access.

- The **Rees-Jones Center for Foster Care Excellence**, located at Children's Health in Dallas is another best-practice program. The Rees-Jones Center for Foster Care Excellence is a specialized integrated health care model that addresses the needs of children and youth in foster care, who often need additional supports. A promising practice includes structured use of a team approach with a care team that comprises primary care and behavioral health providers as well as a nurse coordinator and a Child Protective Services (CPS) liaison. All members of the care team are co-located and fully collaborative; they provide evidence-based, trauma-informed primary care and therapeutic strategies. Center staff described the nurse coordinator and CPS liaison positions, specifically, as central and critical to the model. Other core integrated behavioral health components of the Center are the use of a shared electronic medical records system, which allows all team members to access a child or youth's record and document clinical observations and recommendations in one place; implementation of daily and weekly formal case discussions and treatment planning; and regular staff trainings.

School-Based Mental Health Services

Prevention efforts shift as children enter school (ages 6–12) to increase positive social interactions, decrease aggression and bullying, and increase academic motivation. The education and mental health systems in the United States have a long history of providing mental health services to children. With the passage of the Education of All Handicapped Children Act in 1975 (reauthorized in 1990 as the Individuals with Disabilities Act, or IDEA), education systems were given greater responsibility to meet the mental health needs of students with emotional disturbances.[103] Schools provide a natural setting for mental health

[103] Pumariega, A. J., & Vance, H. R. (1999). School-based mental health services: The foundation for systems of care for children's mental health. *Psychology in the Schools*, 36, 371-378. Cited in Kutash, K., Duchnowski, A., & Lynn, N. (2006, April). *School-based mental health: An empirical guide for decision-makers*. Tampa, FL: University of South

services, including prevention.[104] In fact, studies show that, for many children, schools seem to be their primary mental health system (one finding showed that for children who receive any type of mental health service, over 70% receive the service from their school).[105] School-wide prevention and services that promote behavioral health reduce violence and create a positive school climate benefit all students.[106]

School-based behavioral health and prevention are best be implemented through a public health model approach.[107] The following model could provide a framework that spans the broad range of age groups and problems seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

- Implement school-wide prevention programs and acknowledge that this will require new roles for community workers and school staff.
- Improve the educational outcomes of students by using evidence-based and empirically supported selective and indicated prevention programs with particular attention to the academic needs of students with emotional disturbances served in special education

Other sources point out emerging trends and practices in school mental health that highlight successful collaboration between schools, communities, and families.[108] As such, several EBPs build on prevention efforts and provide diverse community-based approaches to addressing mental health needs within a school environment. These include the following:

Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies, Research and Training Center for Children's Mental Health.

[104] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). *Community-partnered school behavioral health: State of the field in Maryland*. Baltimore, MD: Center for School Mental Health. Retrieved from http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Resources/Briefs/FINALCP.SBHReport3.5.15_2.pdf

Adelman, H.S., & Taylor, L. (2006, March). The current status of mental health in schools: A policy and practice analysis. Los Angeles: UCLA Center. Retrieved from http://files.eric.ed.gov/fulltext/ED501379.pdf

[105] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

[106] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

[107] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

[108] Weist, M. D., & Murray, M. (2007). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, Inaugural Issue,* 2-12. doi: http://dx.doi.org/10.1080/1754730X.2008.9715740. Cited in Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

- **Community-Partnered School Behavioral Health** (CP-SBH) is a framework for supporting student behavioral health along the full prevention-intervention continuum. It brings together community behavioral health providers with schools and families to augment existing school resources in order to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.[109] These partnerships allow schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge. Comprehensive service provision through CP-SBH can include selective prevention for students identified at risk for behavioral health problems and specialized intervention services such as clinical assessment and treatment. CP-SBH programs share several best-practice policies and procedures for program, including establishing and maintaining effective partnerships; integrating community-partnered school behavioral health into multi-tiered systems of support (universal prevention, targeted prevention, individualized intervention and supports, specialized support for substance use and abuse problems); and utilizing empirically supported treatments. In addition, CP-SBH programs also focus on facilitating family-school-community teaming; collecting, analyzing, and utilizing data; and obtaining, sustaining, and leveraging diverse funding streams.[110] Some of the advantages of this approach include improved access to behavioral health services, reducing the stigma of seeking services, being able to generalize treatment to the child's school environment, and having an impact on educational outcomes.
- School-wide initiatives such as **Positive Behavioral Interventions and Supports (PBIS)** have significantly decreased aggressive incidents among students and have increased the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant – while making desired behavior more functional. PBIS has three primary features: 1) functional (behavioral) assessment, 2) comprehensive intervention, and 3) lifestyle enhancement.[111] The value of school-wide PBIS integrated with mental health,

[109] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). Community-partnered school behavioral health: State of the field in Maryland. Baltimore, MD: Center for School Mental Health.
[110] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). Community-partnered school behavioral health: State of the field in Maryland. Baltimore, MD: Center for School Mental Health.
[111] Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist*, 33, 135–152.

according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80%) of students fall into the first tier. For them, school-wide PBIS creates "a social environment that reinforces positive behavior and discourages unacceptable behaviors."[112] A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it "easier to identify students who require early intervention to keep problem behaviors from becoming habitual" and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family.

- **Multi-tiered System of Supports (MTSS)** is an approach based on a problem-solving model that documents students' performance after changes to classroom instruction have been made as a way to show that additional interventions are needed. It ensures that instruction and interventions are matched to student needs. PBIS is consistent with the principles of MTSS, which include research-based instruction in general education, universal screening to identify additional needs, a team approach to the development and evaluation of alternative interventions, a multi-tiered application of evidence-based instruction determined by identified need, and continuous monitoring of the intervention and parent involvement throughout the process.[113]
  - In Colorado, MTSS is a prevention-based framework for improving the outcomes of all students. It includes a multi-tiered system of supports. The essential components include team-driven shared leadership; data-based problem solving; partnerships with families, schools and communities; layered continuum of supports matched to the student's need from universal to targeted, to intensive; and with instruction, assessment, and intervention that are evidence-based.[114]
  - In California, MTSS organizes its resources and initiatives to address all students' needs. The framework organizes academic, behavioral, and social-emotional learning into an integrated system of supports for all students. It encompasses Response to Instruction and Intervention efforts and PBIS and aligns those supports

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Horner, R.H., & Carr, E.G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. *Journal of Special Education*, 31, 84–104.
Koegel, L.K., Koegel, R.L. & Dunlap, G. (Eds.). (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Baltimore, MD: Paul H. Brookes.
Positive Behavior Interventions and Supports website: http://www.pbis.org/main.htm.

[112] Bazelon Center. (2006). Way to go: School success for children with mental health care needs. Retrieved from http://bazelondev.org/wp-content/uploads/2017/01/Way_to_Go.pdf

[113] Positive Behavioral Interventions and Supports OSEP Technical Assistance Center. (n.d). Multi-tiered System of Supports (MTSS) & PBIS. Retrieved from https://www.pbis.org/school/mtss.

[114] Colorado Department of Education. (n.d.). Multi-tiered System of Supports (MTSS). Retrieved from https://www.cde.state.co.us/mtss

to better serve each student.[115] The model integrates data collection and assessment to inform decisions.

- **The Interconnected Systems Framework** (ISF) brings together Positive Behavioral Interventions and Supports (PBIS) and school mental health services in a framework that enhances both approaches, extends the array of mental health supports for students and families, and meets the need for an over-arching framework for implementing evidence-based interventions through collaboration between schools and community providers.[116] ISF addresses limitations related to PBIS not having sufficient development in the areas of targeted prevention and specialized intervention for students with more complicated behavioral health concerns. As for school mental health services, ISF targets the lack of structure in the implementation of services (which contributes to high variability in services and school staff not being aware of these services), the poor use of data, and their general disconnection from targeted prevention and specialized intervention services.[117]
- **Restorative Justice** is a practice based on an intervention from the criminal justice field that holds people convicted of crimes accountable by having them face the people they have harmed. Within schools, restorative justice programs use a similar process of holding students accountable for their behavior and providing them with opportunities for making amends and repairing relationships. The overall goals of this practice are to help decrease misbehavior among students and reduce rates of suspensions.[118]
  - One example of a model restorative justice program is Restorative Justice for Oakland Youth (RJOY), created in 2005 to support collaboration in developing restorative practices in schools, the juvenile justice system, and the greater Oakland community. RJOY engages families and communities to positively impact school discipline, racial disparities, and school climate in order to interrupt punitive school discipline and justice policies. This program provides education, training, and technical assistance and, since 2010, has focused on helping schools build capacity

[115] California Department of Education. (n.d). Multi-tiered System of Supports (MTSS). Retrieved from http://www.cde.ca.gov/ci/cr/ri/

[116] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

[117] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf

[118] Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

for their own restorative justice programs.[119] Outcomes for RJOY include the following:

- During the 2010–11 and 2011–12 school years, 19 Oakland Unified School District schools that received RJOY training reduced the suspension rate of African-American boys by at least 20%.
- According to state and local data, RJOY's West Oakland Middle School pilot project eliminated expulsions and reduced suspensions by 87%.
- At Ralph Bunche High School, student suspension rates fell by 74% and referrals for violence dropped by 77% from the 2010–11 school year to the 2012–13 school year.
- In 2010, the Oakland Unified School District adopted restorative justice as a system-wide alternative to zero-tolerance practices, largely influenced by RJOY.[120]

– The Denver Public Schools Restorative Justice Project also serves as an example of effective implementation of restorative justice programming.[121] Recently, over 1,000 referrals were made for restorative justice services (unduplicated count of 812 students), with almost 180 of these cases being provided in lieu of suspension or for reduced out-of-school suspension as a result of the referral. Students, parents, and teachers all gave strong endorsement for the restorative justice process, noting its fairness and helpfulness with resolving conflicts as well as its influence on students' improvements in listening skills, empathy, anger control, respect, and appropriate reparative action planning. All schools showed reductions in out-of-school suspensions and expulsions compared to the prior year's total.[122]

- **The Cognitive Behavioral Intervention for Trauma in Schools (CBITS**) program aims primarily at reducing symptoms of PTSD, depression, and behavioral problems for children and youth in grades 3 through 8. CBITS, which was first used in the 2000–2001 school year, adopts a school-based group and intervention focus. In addition to its goal of reducing some mental health symptoms, CBITs integrates cognitive and behavioral theories of adjustment – as well as cognitive-behavioral techniques such as relaxation, psychoeducation, and trauma narrative development – to improve peer and parent support and improve coping skills, especially among students exposed to significant

[119] Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

[120] Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

[121] Baker, M.L. (2008). DPS restorative justice project executive summary. Denver, CO: Denver Public Schools.

[122] Baker, M.L. (2008). DPS restorative justice project executive summary. Denver, CO: Denver Public Schools.

trauma.[123] Although primarily directed toward younger children, CBITS has been expanded to include high school students who have experienced notable trauma. Structurally, the program uses a mix of session formats, featuring group sessions, individual student sessions, parent psychoeducational sessions, and a teacher educational session. The program is administered by mental health clinicians and claims effectiveness with multicultural populations.[124]

Office, Home, and Community-Based Interventions

There is growing evidence that, in most situations, children and youth can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that, except for youth with highly complex needs or dangerous behaviors (e.g., fire setting or repeated sexual offenses), programs in community settings are more effective than those in institutional settings, with intensive, community-based, and family-centered interventions being the most promising. Even children and youth with serious emotional disturbances and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and youth has rapidly developed in recent years. The ideal system would have treatment protocols offered in clinics, schools, or homes with the objectives of 1) decreasing problematic symptoms and behaviors, 2) increasing youth's and parents' skills and coping, and 3) preventing out-of-home placement. Core components of some of these interventions should also be used as part of an individualized treatment plan for a child of any age who is receiving intensive intervention in a day treatment program. The following examples of evidence-based and other best-practice treatments are offered as examples of the types of services needed in the ideal system and are not intended to be an exhaustive inventory of potential community-based interventions and EBPs.

During the preschool years, parent/caregiver participation in treatment is an essential part of success. An ideal service array should include interventions, such as the following:

- **Parent-Child Interaction Therapy (PCIT)** has strong support as an intervention for use with children ages' three to six who are experiencing oppositional disorders or other

[123] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Cognitive Behavioral Intervention for Trauma in Schools. Retrieved from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=153
[124] Treatment and Services Adaption Center (n.d.). Cognitive Behavioral Intervention for Trauma in Schools. Retrieved from https://traumaawareschools.org/cbits

problems.[125] PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. To improve the parent-child attachment through behavior management, the PCIT program integrates structural play and specific communication skills to teach parents and children constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their children direction towards positive behavior. A therapist guides parents through education and skill-building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native-American families.

- **Early Childhood Mental Health Consultation** in early childhood settings, such as child care centers, emphasizes problem solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.[126] Early childhood mental health consultation aims to build the capacity (improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six and their families. Two types of early childhood mental health consultation are generally discussed: program level and child/family level. The goals of program-level mental health consultation seek to improve a program's overall quality and address problems that affect more than one child, family, or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children. Child/family-centered consultation seeks to address a specific child's or family's difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child's needs and may participate in

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[125] Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology*, 72(3), 500–510.
Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) *Encyclopedia of Clinical Child and Pediatric Psychology*. New York: Plenum.
Querido, J. G., Eyberg, S. M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. *Journal of Clinical Child Psychology*, 20, 253–261.

[126] Brennan, E.M., Bradley, J. R., Allen, M. D., Perry, D. F., & Tsega, A. (2006, February). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. Presented at the 19th Annual Research Conference, A System of Care for Children's Mental Health, Tampa, FL.
Child Health and Development Institute of Connecticut, Inc. (2005, April). Creating a statewide system of multi-disciplinary consultation for early care and education in Connecticut. Farmington, CT.
Cohen, E. & Kaufmann, R. (2005). Early childhood mental health consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from http://store.samhsa.gov/shin/content/SVP05-0151/SVP05-0151.pdf
Gilliam, W. (2005, May). Pre-kindergarteners left behind: Expulsion rates in state pre-kindergarten programs. Foundation for Child Development Policy Brief Series No. 3. New York: Foundation for Child Development. Retrieved from https://www.fcd-us.org/assets/2016/04/ExpulsionCompleteReport.pdf

observation, meet with the parents of the child, and, in some cases, refer the child and family for mental health services.

- **Theraplay** is a form of parent-child psychotherapy, used with both biological and foster families, which aims to create a "secure, attuned, joyful relationship between children and youth and their parents or primary caregivers."[127] It is used with children and youth from birth to age 18 years who are displaying behaviors such as withdrawal, non-compliance, trauma histories, attachment difficulties, and attention deficit and hyperactivity disorders. It can be used in a variety of settings with the goal of creating a connection between the child and a caregiver. Therapists guide caregivers through play and nurturing activities. Theraplay is delivered in 18 to 25 weekly sessions with quarterly follow-up sessions.
- **Applied Behavior Analysis (ABA)** has good support for the treatment of autism, particularly in young children.[128] ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months. ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20–40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.
- **Preschool Posttraumatic Stress Disorder Treatment** is an approach adapted from trauma-focused cognitive behavioral therapy (TF-CBT – see the next section) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.

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[127] Substance Abuse and Mental Health Services Administration. (2016, December 27). Theraplay. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=156.

[128] Harris, S. L., & Delmolino, L. (2002). Applied behavior analysis: Its application in the treatment of autism and related disorders in young children. *Infants and Young Children*, 14(3):11–17.
Smith, T., Groen, A. D. & Wynn, J. W. (2000). Randomized trial of intensive early intervention for children with pervasive developmental disorder. *American Journal on Mental Retardation*, 105 (4), 269–285.
McConachie, H. & Diggl, T. (2006). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. J*ournal of Evaluation in Clinical Practice*. (Early release).
Sallows, G. O. & Graupner, T. D. (2005). Intensive behavioral treatment for children with autism: Four-year outcome and predictors. *American Journal on Mental Retardation*, 110 (2), 417–438.
Eikeseth, S., Smith, T., Jahr, E., & Eldevik, E. (2002). Intensive behavioral treatment at school for 4- to 7-year-old children with autism: A 1-year comparison controlled study. *Behavior Modification*, 26 (1), 49–68.
Shook, G. L., & Neisworth, J. T. (2005). Ensuring appropriate qualifications for applied behavior analyst professionals: The behavior analyst certification board. *Exceptionality*, 13(1), 3–10.

- **Child Parent Relationship Therapy** (CPRT) aims to address behavioral, emotional, social, and attachment disorders through a play-based treatment program founded on the premise that a child's well-being hinges on a secure parent-child relationship. As such, CPRT administration focuses on weekly, two-hour group sessions with five to eight (5 to 8) parents. These sessions include didactic, supervision, and group process components and work in two key stages. The first stage, which involves the first 3 of the program's 10 group sessions, helps parents learn child-centered play therapy skills, concepts, and attitudes. The final 7 sessions invite parents to practice those skills with their children in a supervised environment. Trained mental health professionals also provide parents with feedback and guidance for these sessions.[129] Although geared primarily for children ages 3–8, CPRT has expanded to include toddlers and pre-youth. Given that CPRT practice originates in the 1980s, the program has been the subject of significant evaluation and study with studies pointing to significant reduction in children's behavioral problems and parental stress. Likewise, there is substantial evidence pointing to increased parental empathy.[130]
- **Early Pathways** is a home-based, mental health services program designed with a specific interest in addressing the externalizing behaviors of young children living in poverty. The program comprises four core elements that aim at strengthening parent-child relationship (using, when possible, child-led play), helping parents maintain developmentally appropriate expectations for their children, helping parents and families use positive reinforcement to establish routines and strengthen child behavior, and decreasing challenging child behavior through limit-setting strategies.[131] Program duration ranges from 8 to 10 sessions, with sessions designed to strengthen and reinforce the four core components. The initial session, for example, includes observed play sessions between parent and child, which are rated for the level and quality of parent-child interaction.[132] Subsequent sessions include developing a treatment plan, establishing appropriate behavioral expectations, providing methods for positive reinforcement, and examining home routines. When appropriate or necessary, additional problem solving sessions may be added.[133]

[129] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Child Parent Relational Therapy. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=196

[130] Center for Play Therapy (n.d.). CPRT overview. Retrieved from http://cpt.unt.edu/cprt-certification/cprt-overview

[131] Harris, S. E., Fox, R. A., & Love, J. R. (2015). Early pathways therapy for young children in poverty: A randomized controlled trial. *Counseling Outcome Research and Evaluation*, 6(1), 3–17.

[132] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Early pathways. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=36

[133] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Early pathways. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=36

For young children, individual cognitive behavioral techniques are effective, parent work is still important, and some group therapy can begin. Examples include the following:

- **Behavior Therapy** has support for the treatment of attention and hyperactivity disorders, substance abuse, depression, and conduct problems. Typically, behavior therapy features behavior management techniques taught to teachers and parents to aid the child in replacing negative behaviors with more positive ones.[134]
- **Brief Strategic Family Therapy (BSFT)** is a problem-focused, family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and youth 6 to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations.[135]
- **Cognitive Behavior Therapy (CBT)** is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.[136] It is sometimes applied in group as well as individual settings. "CBT" can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder. CBT can be used for anxious and avoidant disorders, depression, substance abuse, disruptive behavior, and ADHD. It can be used with family intervention. Specific pediatric examples include Coping Cat and the Friends Program. CBT works with individuals to understand their behaviors in the context of their environment, thoughts, and feelings. The premise is that people can change the way they feel or act despite the environmental context. CBT programs can include several components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

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[134] Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for ADHD. *Journal of Clinical Child Psychology*, 27, 190–205.

[135] Szapocznik J. & Williams R. A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review*, 3(2), 117–135.

Szapocznik J. & Hervis O.E. (2001). Brief Strategic Family Therapy: A revised manual. In *National Institute on Drug Abuse Treatment Manual*. Rockville, MD: NIDA. BSFT has support for use with Hispanic families.

[136] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337–363.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** has strong support for efficacy with children and youth aged 3 to 18 years old and their parents.[137] It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem, and other symptoms related to traumatic experiences. TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as intrusive thoughts of the traumatic event, avoidance of reminders of the trauma, emotional numbing, excessive physical arousal/activity, irritability, and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and youth, and some of its assessment instruments are available in Spanish.[138]
- **Modular Approach to Therapy for Children and Youth with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)** is a collection of therapeutic components for children and youth ages 8–13 years with anxiety, depression, trauma, or conduct problems. MATCH-ADTC was developed from a review of meta-analyses of evidence-based treatments and includes components of cognitive behavior therapy, parent training, coping skills, problem solving, and safety planning.[139] The modules provide a collection of treatment options that can be individualized depending on the child's needs. The program also includes family involvement in developing treatment plan goals.

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[137] Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 42–50.
King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1347–1355.
Mannarino, A. P., & Cohen, J. A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment*, 1(3), 246–260.
Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trail. *Journal of the American Medical Association*, 290(5), 603–611.

[138] Ford, J. D., Steinberg, K. L., Hawke, J., Levine, J., & Zhang, W. (2012). Randomized trial comparison of emotion regulation and relational psychotherapies for PTSD with girls involved in delinquency. *Journal of Clinical Child & Adolescent Psychology*, 41(1), 27–37.

[139] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=64

- **Problem-Solving Therapy (PST)** is a brief intervention for youth 13 and older who are experiencing depression and distress related to difficulties with problem-solving.[140] Through the model, patients learn to identify problems, utilize problem-solving skills, and manage their symptoms. The patient identifies a solution to his or her problem through the PST process, which includes seven stages. Clients learn to evaluate their solutions and outcomes and are guided to develop a relapse-prevention plan during the final sessions. The intervention is delivered in 4 to 12 sessions.
- **Trauma Affect Regulation: Guide for Education and Therapy** (TARGET) is an educational and psychotherapeutic intervention directed toward the prevention and treatment of various stressors and disorders, including traumatic stress disorders, addictive disorders, and adjustment disorders. TARGET aims towards providing youth with skills for processing and managing trauma, stress, and trauma-related reactions to these situations.[141] TARGET includes three key components (education about the biological and behavioral aspects of SUDs and PTSD, guided processing and self-regulation skills, and development of an autobiographical narrative that comprises the relevant trauma or disorder).[142] To address these components, the program employs a manualized protocol and brief, time-limited sessions, which can be administered through group or individual psychotherapy in diverse settings.[143] As such, the length that any individual adolescent may be in the program may range from six months to multiple years.

For youth, the same EBPs as above should be available in outpatient and school-based clinics, as should the following programs for teens with severe difficulties, including those that may be at risk for out-of-home placement.

- **Wraparound Service Coordination** (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth involved with multiple systems and at the highest risk for out-of-home placement.[144] Wraparound is not a

[140] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Problem Solving Therapy. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=108

[141] National Institute of Justice. (2011). Program profile: Trauma Affect Regulation: Guide for Education and Therapy. Retrieved from https://www.crimesolutions.gov/ProgramDetails.aspx?ID=145

[142] National Institute of Justice. (2011). Program profile: Trauma Affect Regulation: Guide for Education and Therapy. Retrieved from https://www.crimesolutions.gov/ProgramDetails.aspx?ID=145

[143] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Trauma Affect Regulation: Guide for Education and Treatment. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1222

[144] Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University. Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime.* Olympia: Washington State Institute for Public Policy.

treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members; these are joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family.[145]

- **Dialectical Behavior Therapy (DBT) Approaches for Youth** is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives.[146] DBT for youth often includes parents or other caregivers in the skills-training group. This inclusion allows parents and caregivers to both coach youth in skills and improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions: help consumers develop new skills, address

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Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

[145] For additional information on the phases of the wraparound process, see information at http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf

[146] Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal youth receiving DBT. *Cognitive & Behavioral Practice*, 7, 183–187.

Rathus, J.H. & Miller, A.L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. *Suicide and Life-Threatening Behavior*, 32, 146-157.

Trupin, E., Stewart, D., Beach, B., & Boesky, L. (2002). Effectiveness of a Dialectical Behavior Therapy program for incarcerated female juvenile offenders. *Child and Adolescent Mental Health,* 7(3), 121–127.

motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

- **Functional Family Therapy (FFT)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at-risk youth and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[147] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.[148]
- **Multidimensional Family Therapy (MDFT)** is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African-American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban, and rural settings.[149] Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including adolescent and parents individually, family as an interacting system, and individuals in the family relative to their interactions with influential social systems (e.g., school,

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[147] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT).* Boulder, CO: Center for the Study and Prevention of Violence.

[148] Rowland, M., Johnson-Erickson, C., Sexton, T., & Phelps, D. (2001). A statewide evidence based system of care. Paper presented at the 19th Annual System of Care Meeting. Research and Training Center for Children's Mental Health.

[149] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.
Hogue, A. T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young youth: Immediate outcomes. *Journal of Community Psychology*, 30(1), 1–22.
Liddle H. A., Dakof, G. A., Parker K., Diamond G. S., Barrett K., Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal of Drug and Alcohol Abuse*, 27, 651–687.

juvenile justice) that impact the adolescent's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.

- **Multisystemic Therapy (MST)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.[150] In addition, the developers are currently working to form specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive, home-based service model provided to families in their natural environment at times convenient to the family. MST has low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context and was developed to address major limitations in serving juvenile offenders, focusing on changing the determinants of youth anti-social behavior.[151] At its core, MST assumes that problems are multi-determined and that, to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children and youth, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation.[152] **MST-Psychiatric (MST-P)** is an approach similar to MST but adapted for teens with serious emotional disorders.
- **Coordinated Specialty Care (CSC)** for first-episode psychosis (FEP) is delivered by a multi-disciplinary team of mental health professionals, including psychiatrists, therapists and substance use disorder counselors, employment specialists, and peer specialists. Early detection is important, as people with psychoses typically do not receive care and

[150] Huey, S. J. Jr., Henggeler, S. W., Brondino, M. J., &, Pickrel, S. G. (2000). Mechanisms of change in multisystemic therapy: Reducing delinquent behavior through therapist adherence and improved family and peer functioning. J*ournal of Consulting and Clinical Psychology*, 68 (3), 451–467.
Schoenwald S. K., Henggeler S. W., Pickrel S. G., & Cunningham, P. B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, (pp. 317–332). Mahwah, NJ: Lawrence.

[151] Henggeler S. W., Weiss, J., Rowland M. D., Halliday-Boykins, C. (2003). One-year follow-up of Multisystemic therapy as an alternative to the hospitalization of youths in psychiatric crisis. *Journal of the American Academy of Child & Adolescent Psychiatry,* 42(5), 543–551.

[152] Huey, S. J. Jr., Henggeler, S. W., Rowland, M. D, Halliday-Boykins, C. A., Cunningham, P. B., Pickrel, S. G., Edwards, J. (2004). Multisystemic therapy effects on attempted suicide by youths presenting psychiatric emergencies. *Journal of the American Academy of Child & Adolescent Psychiatry*, 43(2):183–190.

treatment until five years after first onset.[153] Community education activities and the development of strategic partnerships with key entities in the community is critical, and the team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person and it actively engages the family in supporting recovery from early psychosis. Effective treatments, such as medication management, individual therapy, and illnesses management are provided, as well as other less common evidence-based approaches that are known to help people with serious mental illnesses retain or recover a meaningful life in the community, such as Supported Education and Supported Employment. The ultimate goal of CSC is to provide effective treatment and support as early in the illness process as possible so that people can remain on a healthy developmental path. In Kane and colleagues report on the multi-site RAISE study (conducted across 34 clinics in 21 states) in the *American Journal of Psychiatry* in 2016, the authors noted that, especially when receiving CSC within the first 17 months of psychosis onset, participants had better quality of life and were more involved in work and school.[154] CSC was better than care-as-usual at helping people remain on a normal developmental path. Researchers have also examined the costs of CSC versus care-as-usual and found that CSC was less expensive per unit of improvement in quality of life.[155] According to the CSC model on which the two RAISE programs are based,[156] teams should, at a minimum, consist of the following:[157]

- A team leader or coordinator (PhD or master's degree), who is responsible for the client's overall treatment plan and programming as well as the team's coordination and functioning;
- A psychiatrist[158] trained in treatment of early psychosis, who provides medication management, actively monitors and helps ameliorate medication side effects, and coordinates treatment with primary care and other specialty medical providers;

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

[154] Kane, J.M., et al. (2015). Comprehensive versus usual community care for first episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry*, ajp in Advance, 1-11.

[155] Rosenheck, R., et al. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin* (Advance Access, doi: 10.1093/schbul/sbv224)

[156] McNamara, K. et al. (n.d.) *Coordinated specialty care for first episode psychosis, manual I: Outreach and treatment*. Rockville, MD: National Institute of Mental Health. Retrieved on July 30, 2016 from http://www.nimh.nih.gov/health/topics/schizophrenia/raise/csc-for-fep-manual-i-outreach-and-referral_147094.pdf

[157] Please note that these models only describe an outpatient or community-based team. All teams will need to develop collaborative working relationships with inpatient providers that will enable them to ensure continuity of care as well as timely and comprehensive discharge planning.

[158] Some programs might choose to utilize advanced psychiatric nurse practitioners, but the UTSW Psychosis Center plans to employ psychiatrists in this important role.

  - A primary clinician (PhD or master's degree), who provides in-depth individual and family support, suicide prevention planning, and crisis management, and, along with the team leader and other clinicians, assists with access to community resources and supports as well as other clinical, rehabilitation, and case management-related services; and
  - A Supported Employment specialist (occupational therapist or master's level clinician) to help consumers re-enter school or work.
  - Recent developments in FEP Care have increasingly led to the expectation that a peer specialist should also be included on the team.[159] This position should be filled by a person who has experienced serious mental illness and has been able to recover from it or to develop a productive and satisfying life while continuing to receive treatment.
- **Assertive Community Treatment (ACT) for Transition-Age Youth** uses a recovery/resilience orientation that offers community-based, intensive case management, and skills building in various life domains. It also includes medication management and substance abuse services for youth ages 18–21 with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. Most ACT services are delivered to the consumer within his or her home and community rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment),

[159] Dr. Nev Jones (personal communication, July 6, 2016). For a comprehensive explication of the role of peers in FEP Care programs, see: Jones, N. (2015, September). *Peer involvement and leadership in early intervention in psychosis services: From planning to peer support and evaluation*. Rockville, MD: SAMHSA/CMHS. DOI: 10.13140/RG.2.1.4898.3762

and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[160, 161]

- **The Intensive In-Home and Child and Adolescent Psychiatric Services (IICAPS)** model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide 24-hour/seven-days-a-week emergency crisis response.
- **HOMEBUILDERS** is an intensive family preservation program designed for children and youth from birth to age 17 years, with an imminent risk of out-of-home placement or who are scheduled to reunify with families within a week.[162] The program uses intensive, on-site intervention aimed at teaching families problem-solving skills that might prevent future crises. HOMEBUILDERS is structured around a quality enhancement system, QUEST, which supports a three-part methodology (delineation of standards, measurement and fidelity of service implementation, and development of quality enhancement plans), offers training for state agencies, and claims a significant success rate (86%) of children and youth who have avoided placement in state-funded foster care and other out-of-home care.[163] HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service, on a flexible schedule.[164]
- **Partners with Families & Children: Spokane** (Partners) is a service that relies on referrals from child welfare, law enforcement, or other public health agencies. As such, Partners' main goal is to assist children, youth, and their families in situations of persistent child neglect or those in which briefer interventions are unlikely to be effective.[165] The program is a community-based, family treatment program based on wraparound principles and focused on enhancing parent-child relationships while

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[160] Allness, D. J., & Knoedler, W. H. (2003). *A manual for ACT start-up*. Arlington, VA: National Alliance for the Mentally Ill.

[161] Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R.E. Drake, M. R. Merrens, & D.W. Lynde (eds.). *Evidence-based mental health practice: A textbook*.

[162] Washington State Department of Social and Health Services. (n.d.). Homebuilders intensive family preservation. Retrieved from https://www.dshs.wa.gov/node/3303

[163] Institute of Family Development. (n.d.). Programs: Homebuilders – IFPS. Retrieved from http://www.institutefamily.org/programs_ifps.asp

[164] NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). HOMEBUILDERS. Retrieved from http://legacy.nreppadmin.net/ViewIntervention.aspx?id=277

[165] Substance Abuse and Mental Health Services Administration. (2016, July 8). Partners with Families & Children: Spokane. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=114

providing case management, substance abuse and mental health services, parenting resources, and an individualized family care team. These components aim to better assist the whole family in the cessation or prevention of neglect and maltreatment, working toward recovery through the combined efforts of an assigned Family Team Coordinator, a core team (which involves partnerships in community organizations such as schools and Head Start programs), and family team meetings.[166] The Partners approach, then, is designed to emphasize parents at the center of a teamwork-driven mechanism that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.[167]

The Crisis Continuum and Out-of-Home Treatment Options

Treatment of children and youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states, "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children and youth with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection, and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors are not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors (e.g., fire setting) that may not respond to intensive, nonresidential service approaches.[168] Yet, on a national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

Nevertheless, youth do sometimes need to be placed outside of their homes for their own safety or the safety of others. Safety should be the primary determinant in selecting out-of-

[166] Clearinghouse for Military Family Readiness. (n.d.). Partners with Families and Children: Spokane. Retrieved from http://www.militaryfamilies.psu.edu/programs/partners-families-and-children-spokane

[167] Substance Abuse and Mental Health Services Administration. (2016, July 8). Partners with Families & Children: Spokane. Retrieved from http://nrepp.samhsa.gov/ProgramProfile.aspx?id=114

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

home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the situation is temporary, due to a crisis, or for longer term care, the ideal service system should include an array of safe places for children and youth as supported by the following approaches:

- **A family-driven, youth-guided, community-based plan** should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.
- **A full continuum of crisis response**, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial, and behavioral health interventions for youth and their families should include the following:
  - A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team/MUTT);[169]
  - Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation resources, supported by protocols and electronic systems to communicate results across professionals and systems to determine the appropriate level of services;
  - Coordination with emergency medical services;
  - Crisis telehealth and phone supports; and
  - An array of crisis placements tailored to the needs and resources of the local system of care, including an array of options such as:
    - In-home respite options;
    - Crisis foster care (placements ranging from a few days up to 30 days),
    - Crisis respite (one to 14 days), and
    - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision;
  - Acute inpatient care; and
  - Linkages to a full continuum of empirically supported practices.
- **A residential continuum of placement types**, grounded in continued connections and accountability to the home community, is needed. This continuum should offer a focus on specialized programming, including specialized residential programming for youth with gender-identity issues and for gender-responsive services (those intentionally, not superficially, serving female youth and that include a continuum of out-of-home treatment options for young women with behavioral health needs, including histories of

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

sexual maltreatment). It should also provide residential placement options that vary by intensity of service provided, primary clinical needs addressed, and targeted length of stay, emphasizing acute-oriented programs to serve as an inpatient alternative in which children and youth can have behaviors that require longer than a typical acute inpatient stay to be stabilized, complex needs evaluated, and treatment begun while transition planning back to a more natural environment takes place.

- **Treatment foster care** is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African-American, and American-Indian youth and families.[170] There is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents want, but typically last about one year.
  - **Keeping Foster and Kin Parents Supported and Trained (KEEP)** was developed by the developers of the TFCO model. KEEP is a skills development program for foster parents and kinship parents of children ages 0 to 5 years and youth (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to 7 to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of parents and children.[171] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[172] Child care and snacks are provided as part of the sessions. A small study of the program funded by the U.S. Department of Health and Human Services Children's Bureau showed fewer placement breakdowns, fewer behavioral and emotional problems, and greater prevention of

[170] Chamberlain P, Reid J. B. (1991). Using a specialized foster care community treatment model for children and youth leaving the state mental hospital. *Journal of Community Psychology*, 19, 266–276.
Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.
Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and youth*. New York: Guilford Press.
Weisz, J. R., Doss, J. R., Jensen, A., & Hawley, K. M. (2005). Youth psychotherapy outcome research: A review and critique of the evidence base. *Annual Review of Psychology*, 56, 337–363.
[171] Oregon Social Learning Center. (n.d.). KEEP Based on Research Conducted at OSLC. Retrieved from http://www.oslc.org/projects/keep/
[172] Child Trends. (n.d). Keep Program. Retrieved from https://www.childtrends.org/programs/keep-program/

foster parents dropping out from providing care.[173] A larger randomized study in San Diego showed that biological or adoptive parents who participated in the KEEP program were reunified with their children more frequently. The study also showed fewer placement disruptions from foster placements. KEEP has been implemented in Oregon, Washington, California, Maryland, New York City, four regions in Tennessee, and in Sweden and Great Britain.

When residential treatment is provided, there should be extensive involvement of the family. Residential (and community-based) services and supports must be thoroughly integrated and coordinated, and residential treatment and support interventions must work to maintain, restore, repair, or establish youths' relationships with family and community.

Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

[173] KEEP Supporting Foster and Kinship Families. (n.d.). Effectiveness. Retrieved from http://www.keepfostering.org/program-effectiveness/