

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Dallas County Mental Health Service Delivery System
for Children, Youth, and Families:

2019 SYSTEM ASSESSMENT REPORT

MARCH 2020



Contents

Executive Summary	i
Principal Findings	v
Principal Recommendations	viii
Overview.....	1
Approach to the Assessment	2
Mental Health Systems Framework for Children and Youth.....	4
Component 0: Life in the Community.....	6
Component 1: Integrated Primary Care	9
Component 2: Specialty Outpatient Care	13
Component 3: Specialty Rehabilitative Care	15
Component 4: Crisis Care.....	19
How Many Children and Youth in Dallas County Have Mental Health Needs?.....	22
Comparing the Dallas County System to the Mental Health Systems Framework for Children and Youth	32
Component 0: Dallas County's Capacity in the Community.....	32
Who Provides Health Promotion and Prevention Services?	32
Poverty Across Areas of Dallas County	33
What Are the Education Affiliated Initiatives?	39
Life in the Community Findings	47
Component 1: Dallas County's Integrated Pediatric Primary Care Capacity	48
How Accessible Are Integrated Primary Care Services?	48
How Many Children and Youth Receive Integrated Primary Care?.....	50
Who Are the Integrated Primary Care Providers?.....	50
Integrated Primary Care Findings	55
Component 2: Dallas County's Specialty Outpatient Mental Health Care Capacity	57
How Many Children and Youth Receive Specialty Outpatient Mental Health Care?.....	57
How Accessible Are Specialty Outpatient Mental Health Services?	58
Who Are the Specialty Outpatient Clinic and Counseling Center Providers?	60

Specialty Outpatient Mental Health Care Findings	74
Component 3: Dallas County's Specialty Rehabilitative Care Capacity	76
Delivery Framework for Intensive Community-based Services and Supports	77
How Accessible Are Specialty Rehabilitative Services?	79
How Many Children and Youth Receive Specialty Rehabilitative Care?	80
Who Are the Specialty Rehabilitative Care Providers?	84
Specialty Rehabilitative Care Findings	88
Component 4: Dallas County's Crisis Care Continuum	91
Crisis Intervention Providers.....	91
The Role of the Emergency Department in Dallas County's Crisis Care Continuum.....	93
The Role of Psychiatric Inpatient Care in Dallas County's Crisis Care Continuum	97
The Role of Residential Treatment in Dallas County's Crisis Care Continuum	102
Crisis Care, Inpatient, and Residential Findings.....	104
Mental Health Needs of Children and Youth in Foster Care	106
Mental Health Needs Among Children and Youth in Foster Care	106
Who Supports the Mental Health Needs of Children and Youth in Foster Care?	109
Child Welfare System Mental Health Findings	111
Mental Health Services in the Dallas County Juvenile Justice System.....	112
Mental Health Needs Among Children and Youth in the Juvenile Justice System	113
Who Supports the Mental Health Needs of Children and Youth Involved in the Juvenile Justice System?	115
Juvenile Justice System Mental Health Findings	120
Principal Findings	122
Principal Recommendations	125
Appendix A: List of Participants	134
Appendix B: Detailed List of Mapped Dallas County Providers.....	138
Appendix C: Mental Health Best Practices for Children, Youth, and Families.....	150
Appendix D: Level of Care (LOC) Overview	186

Executive Summary

The Meadows Mental Health Policy Institute (MMHPI), with the generous support of The Rees-Jones Foundation, conducted an in-depth assessment of Dallas County's mental health service delivery systems for children, youth, and families. The goals of the assessment were to inventory and analyze Dallas County's mental health systems, assess its current and potential capacity to deliver care along a continuum that provides highly responsive and clinically effective services, and offer specific recommendations to support the continued development of the system as a whole.

Each year, nearly two in five school-age children and youth (about 180,000 in Dallas County) experience a mental health need requiring clinical intervention.¹ The vast majority of these children and youth experience conditions that are mild-to-moderate in severity, and just over one quarter suffer from severe needs (termed serious emotional disturbances). The most severe mental health conditions – those that increase risk of placement outside of the home or school – affect about 2,000 young people in the Dallas community each year.²

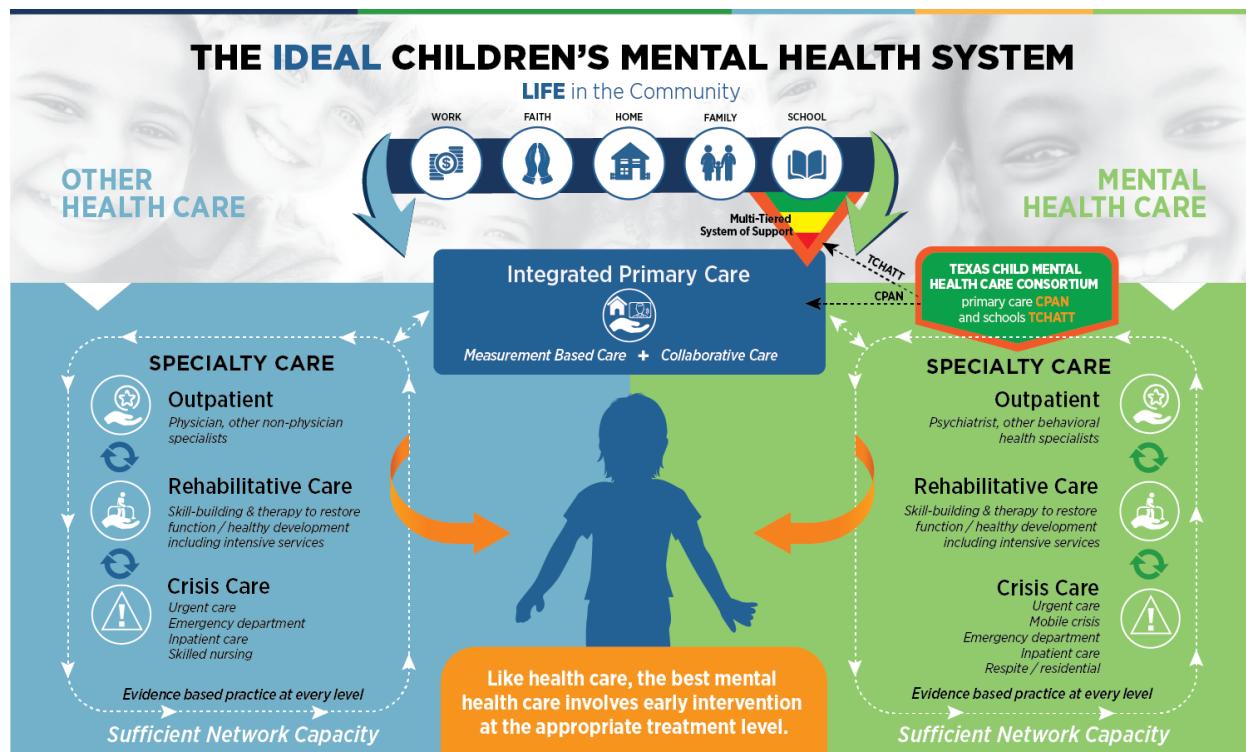
Given that half of all mental health conditions manifest by age 14,³ and that the average length of time between the initial onset of symptoms and access to needed care ranges from eight to 10 years,⁴ it is critical that we rethink the organization of health systems serving children, youth, and their families to provide care sooner and more effectively. A systems framework to provide such care would have five overall components, described in the figure that follows on the next page. As we review this ideal system, keep in mind that no community in Texas, or anywhere, currently offers this full range of care. Although examples of the best practices described below are increasingly available in communities across the nation (including Dallas County), most mental health care today is delivered without the coordinated array of supports required to detect and treat such health needs early and effectively.

¹ 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. 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.

² We estimate that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These children and youth need intensive family- and community-based services.

³ Meadows Mental Health Policy Institute. (2016, March 24). *Estimates of prevalence of mental health conditions among children and adolescents in Texas*. <http://www.texasstateofmind.org/wp-content/uploads/2016/01/MMHPI-Child-Adolescent-Prevalence-Summary-2016.03.24.pdf>

⁴ American Academy of Child and Adolescent Psychiatry Committee on Health Care Access and Economics Task Force on Mental Health. (2009). Improving mental health services in primary care: Reducing administrative and financial barriers to access and collaboration. *Pediatrics*, 123(4), 1248–1251.



- **Life in the Community** (Component 0), at the top of the figure, represents the range of community settings in which children and families live out their lives together. Health needs – including diseases affecting the brain, such as mental health disorders, as well as other pediatric health conditions, both chronic (like diabetes) or acute (like orthopedic accidents) – occur in the social context of life: home, family, schools, faith communities, foster care, juvenile justice settings, and other places where children, youth, and their families spend their time. The types of health care services that occur here are prevention and early intervention as well as supports for children, youth, and families with more severe needs who require interventions in their home and community. This includes services embedded in other child-serving organizations, including schools (note the symbol for multi-tiered systems of supports, or MTSS, which is the primary framework we describe in the report for organizing the full range of needed school-based mental health supports, from prevention to treatment).
- **Integrated Primary Care** (Component 1) are the primary places where all children should receive routine medical care and where the vast majority of children and youth with mild-to-moderate mental health needs should receive mental health care. The family doctor is in the center of the diagram above because this represents the best place to detect any health need early and successfully provide routine care. Integrating mental health treatment into pediatric primary care settings is an essential strategy for increasing access to mental health services for children and youth, treating those with most mild-to-moderate conditions in primary care, and creating referral pathways for

those in need of more specialized and intensive care.⁵ About two thirds of Dallas County children and youth suffering from mild-to-moderate anxiety, depression, attention issues, and other behavior challenges each year (120,000 total) could have their needs adequately addressed in such settings if detected early and treated with adequate supports to the primary care provider (such as the Child Psychiatry Access Network – or CPAN – program about to be launched in May 2020 by the newly established Texas Child Mental Health Care Consortium established by the Texas Legislature and all 12 state-funded medical schools in 2019), particularly if the clinical setting offers collaborative care (which pays for a behavioral health specialist in the primary care office, either in person or through telehealth).^{6,7,8,9}

- **Specialty Outpatient Care** (Component 2) is the level of the system that most people tend to think of when imagining mental health care: a mental health (or other behavioral health) specialist such as a psychiatrist, psychologist, social worker, therapist, counselor, or nurse practitioner providing care in a clinic or office. However, research clearly shows that such care is only needed for children and youth with moderate-to-severe needs in a well-functioning system with adequate primary care supports that are routinely available to the family doctor. Specialty outpatient care is essential for assessing more complex conditions and providing ongoing care for conditions such as bipolar disorder, posttraumatic stress, severe depression, and other more complex disorders that require specialized interventions beyond the capacity of integrated primary care. This includes the typical example of a clinician in an office as well as more novel approaches using telehealth, such as the new Texas Child Health Access Through Telemedicine – TCHATT – program for underserved Texas schools that will be launching in May 2020. We estimate that about one quarter of children and youth with mental health conditions (about 45,000 in Dallas County) need treatment by such specialists each year.

⁵ Straus, J. H., Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161. <https://doi.org/10.1377/hlthaff.2014.0896>

⁶ We estimate that about two out of three children and youth with mental health needs have conditions that can be successfully managed in an integrated primary care setting. This translates to between 110,000 to 120,000 children and youth.

⁷ Shippee, N. D., Mattson, A., Brennan, R., Huxsahl, J., Billings, M. L., & Williams, M. D. (2018). Effectiveness in regular practice of collaborative care for depression among adolescents: A retrospective cohort study. *Psychiatric Services*, 69(5), 536–541. <https://doi.org/10.1176/appi.ps.201700298>

⁸ Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski S. (2014). Collaborative care outcomes for pediatric behavioral health problems: A cluster randomized trial. *Pediatrics*, 133(4), e981–992.

⁹ Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA*, 312(8), 809–16. <https://doi.org/10.1001/jama.2014.9259>.

- **Specialty Rehabilitative Care** (Component 3) include the broad range of evidence-based services necessary to address conditions that are more severe and result in greater functional impairment, such as early onset psychosis and severe behavioral impairment that too often, if untreated, can lead to severe problems at home or school and even involvement in the juvenile justice system. Such care needs to address both the underlying clinical needs and the severe functional impairment in multiple life domains associated with it. About 20,000 Dallas County children and youth suffer from these more severe and often chronic needs and impairments each year. This includes intensive home and community-based services for the approximately 2,000 children and youth with the most severe needs and who face the greatest risk for out-of-home or out-of-school placement each year.
- **Crisis Care** (Component 4) is also essential to effectively respond to the acute needs of children, youth, and their families that can flare up at any level of care during the recovery process. Crisis care ideally includes mobile teams that respond to urgent needs outside the routine delivery of care, as well as a continuum of time-limited out-of-home placement options ranging from crisis respite to acute inpatient to residential care. These are not settings for ongoing care, but even with optimal levels of the right kinds of prevention, primary care, specialty outpatient, and specialty rehabilitative care, any health condition can become acute at times and require urgent intervention to respond to crises that can jeopardize a child or youth's safety and functioning.

As noted above, no community in Texas or the nation currently has a system with all of these services and supports available at full scale. Today, most care in Dallas County and every community in America is delivered – when it is delivered – in primary care settings by providers without adequate supports to detect and treat routine needs early who struggle to do their best and refer as many children and youth as possible to over-extended specialty outpatient providers. Because of the challenges accessing treatment in the current system, most families do not receive care until needs reach a crisis level and too many children and youth receive their first mental health treatment in a juvenile justice facility or an emergency department. Sadly, suicide is the second leading cause of death among American youth and rates of death from suicide are now at their highest levels ever in Dallas and across the country.

These health needs are also made more complex by social determinants, including economic stability, education, health, access to health care, and the social and community context in which children and youth live and grow.¹⁰ All of these factors have an impact on health, rates of

¹⁰ Artiga, S., & Hinton, E. (2018). *Beyond health care: The role of social determinants in promoting health and health equity*. The Henry J. Kaiser Family Foundation. <https://www.kff.org/disparities-policy/issue-brief/beyond-health-care-the-role-of-social-determinants-in-promoting-health-and-health-equity/>

illness, development, and access to needed services. Poverty, coupled with adverse childhood experiences, can have a lasting, negative effect on physical and emotional well-being.¹¹

For this report, we reviewed the range of care provided by leading mental health service providers across Dallas County and mapped available service locations. We also reviewed rates of need by severity, including mapping higher-risk areas of the county compared to overall poverty rates and known service locations to evaluate geographic barriers to care. We also looked at the range of evidence-based best practices that are available in these settings to compile the first ever systemic analysis of mental health provider capacity and treatment offerings across Dallas County for each of the five necessary systemic components described above. Our principal findings and recommendations are described below.

Principal Findings

Principal Finding #1: Integrated primary care (IPC) is increasingly available in Dallas County; however, most primary care providers do not yet offer it. Best practice use of IPC in primary care settings requires an infrastructure of universal evidence-based screening (using tools such as the PHQ-9 for depression, the GAD-7 for anxiety, and the CAPS-5 for trauma, for example, to identify needs), 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, either in person or through telehealth). Although IPC is being implemented across many settings (pediatric primary care offices, federally qualified health centers, school-based clinics), and efforts are underway to expand implementation, there is a need to accelerate deployment of measurement-based care and expand collaborative care capacity in the majority of primary care settings that do not yet offer it.

Principal Finding #2: Overall system capacity constraints result in limited referral sources for primary care providers, other specialty outpatient providers, and schools, which makes it difficult for families to obtain timely care for their children when a need is identified. These capacity constraints are particularly evident for children and youth who need a psychiatric evaluation. Several integrated care providers are offering short-term telehealth/telemedicine services to families waiting for specialty outpatient care. These integrated care providers reported that when they refer children and youth to a community-based provider, they face long waiting lists. Because of this barrier to care, they are exploring technological strategies to help bridge the gap between the short-term therapeutic services they offer while children and youth are waiting to be linked to longer-term supports in the community.

¹¹ Cronholm, P. F., Forke, C. M., Wade, R., Bair-Merritt, M. H., Davis, M., Harkins-Schwarz, M., Pachter, L. M., & Fein, J. A. (2015). Adverse childhood experiences. *American Journal of Preventive Medicine*, 49(3), 354–361. <https://doi.org/10.1016/j.amepre.2015.02.001>

Principal Finding #3: Staffing challenges limit the capacity of provider organizations to meet the demand to treat children, youth, and their families effectively. Staffing challenges include high turnover, the cost of training providers in evidence-based practices (EBPs), and recruiting and retaining staff who are culturally competent for the population the program serves (with regard to language, for example). As noted above, there is a shortage of both psychiatrists and behavioral health clinicians to meet the current needs of the community. Organizations stated they have had difficulty in retaining staff, particularly bilingual staff and those with advanced trainings and certifications (e.g., Trauma-Focused-Cognitive Behavioral Therapy, eye movement desensitization and reprocessing, Dialectical Behavior Therapy). Most clinicians do not enter employment with training and experience in delivering evidence-based practices. As a result, providers are often responsible for ensuring their staff receive the training needed to deliver effective services. Providers noted that evidence-based trainings are often expensive and, when paired with high staff turnover, can become cost prohibitive. Additionally, many providers who are culturally competent with the populations they serve stated it is difficult to find and retain staff with this same qualification.

Principal Finding #4: Health systems and community-based providers are increasingly making trainings, mental health programs and initiatives, and prevention resources available to schools. Multiple organizations throughout the community provide such supports, and many organizations are working with schools to embed services such as group skills, crisis intervention, case management, and others. Local organizations are also implementing evidence-informed mental health programs/initiatives in schools.

But despite the resources available to an increasing number of schools (including through the new TCHATT program), relationships between provider agencies and schools are often based on individual relationships, not systemically embedded. In many cases, a single person (at either a school or agency) established the relationship between the school and agency. A number of providers noted difficulty in accessing the children and youth they serve during school hours, though the level of difficulty varied among school districts and providers. Additionally, there were few formal agreements regarding service provision by external providers.

Principal Finding #5: Children and youth with the highest needs lack access to needed intensive, community-based services. Using the most current annual data that were available from providers, we estimated that just over 300 children and youth received Medicaid-funded intensive family services in the last year, such as intensive case management, rehabilitative services, and YES Waiver services, and few of these were evidence based. This number represents only about 14% of the 2,000 children and youth in Dallas County in need of such

care. Children and youth who are at risk of entering — or who are already involved in — juvenile justice and child welfare systems experience higher rates of need for these services. This directly correlates with an overreliance on more restrictive placements, such as hospitalizations or residential placements. Moreover, for children and youth released from psychiatric hospitals or residential facilities, the lack of these services means they return to the same situations they left without access to the types of support they need to thrive at home and in their communities. Barriers to providing these specialized services include the cost of hiring, training, and retaining staff; lack of services covered by private insurance; and low Medicaid reimbursement rates.

Principal Finding #6: Crisis response capacity is inadequate and fragmented across systems. Current crisis services do not function as a coordinated system, which prevents children and youth from getting the services they need when they need them. Similar to many communities across Texas and the nation, the current array of crisis services in Dallas County does not function as a system, a deficiency that contributes to gaps in care and service redundancies that limit the capacity across programs to provide children and youth with the right services at the right time.

Principal Finding #7: Systems navigation is a universal challenge for families seeking mental health services for their children, from knowing what services will best meet a need when it is initially identified to how to get support if the need becomes a crisis. Families experience better outcomes when they are connected to services and supports at the onset of symptoms. Unfortunately, because the mental health care system is difficult to navigate, many families' first encounter with treatment is in an emergency room during a crisis, which presents a unique set of system navigation challenges.

The principal findings introduce options for transforming the Dallas County mental health service delivery systems for children, youth, and their families. In addition to these findings, we identified findings that cut across all systems, disciplines, and organizations. Addressing these four cross-cutting findings could improve resource identification and quality of care at every level of care.

Cross-Cutting Finding #1: Services and supports for the whole family are lacking. Providers identified the need for expanded services for the caregivers of the children and youth they serve. They identified needs ranging from social determinants of health resources such as transportation, food, and childcare, to helping caregivers support their children's mental health needs (e.g., parenting classes, in-home coaching, and family therapy to address the complexity of family systems). Only a limited number of providers we reviewed are able to provide family therapy or parenting classes to caregivers. Providers also highlighted the need for expanded

capacity to provide behavioral health interventions to meet caregivers' own mental health or substance use disorder needs.

Cross-Cutting Finding #2: Although most providers recognize the importance of providing culturally and linguistically competent services, they often find it hard to recruit and retain staff who have these competencies. These staff shortages affect the availability of services for a significant portion of the community. Most providers identified a shortage of staff who speak the language(s) of the children, youth, and families their agencies serve. Providers especially highlighted the need for bilingual staff beyond those who speak Spanish and English since there are many groups in the county that speak other languages. Often, organizations regard cultural and linguistic competency as a strength that individual employees might bring to the agency, not as an embedded organizational value, criteria for gaining employment, or a component of agency training.

Cross-Cutting Finding #3: The faith-based community is a strong yet often untapped partner for mental health services providers. Most organizations noted the potential to have stronger partnerships with the faith-based community, recognizing it as an untapped resource that is often willing to offer help. Several faith-based organizations we reviewed identified strategies for making mental health services and supports more widely available through strategic partnerships.

Cross-Cutting Finding #4: Mental health providers described being unaware of what services other providers offer and how they can effectively partner with these providers. Providers noted a lack of coordination across components of the system and between each other, primarily because of a lack of awareness of what services or resources other providers offer in the community. Respondents from nearly every organization we reviewed expressed a desire to better understand the services and resources that are available throughout the community so they could connect the people they serve with the services that will best meet their needs.

Principal Recommendations

Principal Recommendation #1: Implement measurement-base care to strengthen the infrastructure for assessing and monitoring symptoms. Over the last 15 years, there has been considerable progress in developing reliable tools for measuring symptoms. Also, national studies show that the simple act of routinely measuring symptoms over time improves care outcomes.¹² National standards for mental health service delivery are increasingly requiring the same level of symptoms assessment and monitoring that has been routine for other health

¹² Trivedi, M. H., Rush, A. J., Gaynes, B. N., et al. (2007). Maximizing the adequacy of medication treatment in controlled trials and clinical practice: STAR*D Measurement-Based Care. *Neuropsychopharmacology*, 32, 2479–2489.

conditions like diabetes and heart disease.¹³ Accordingly, mental health and substance use care providers need to be actively developing the infrastructure to assess, diagnose, and monitor symptoms across time for the people they serve. Community providers need to implement measurement-based care for both early identification of mental health needs and improved quality of treatment. Measurement-based care is the practice of basing clinical care on client data that is collected throughout treatment.

Principal Recommendation #2: Based on the infrastructure developed by Senate Bill (SB) 11 (86th Legislature, 2019), fully implement measurement-based screening and assessment supports into primary care through the Child Psychiatry Access Network (CPAN) program. SB 11 established CPAN to support improved detection and care for mental health needs in primary care through a network of behavioral health consultation hubs located at Texas medical schools. CPANs are based on the well-established child psychiatry access program model pioneered in Massachusetts over 15 years ago, which is now available in 30 states. The Texas program will extend statewide and be the largest child psychiatry access program implementation to date, designed to reach over five million Texas children and youth once it is fully operational by 2021. The hub that will serve Dallas County will be located at The University of Texas Southwestern (UTSW) Medical Center through a partnership with Children's Health. Each hub will offer pediatric and family medicine providers with support in meeting their patients' mental health needs, including clinical consultation, care coordination assistance, and continuing education. The CPAN hub will also include a referral network of specialty outpatient providers it can share with pediatric primary care providers. The development of CPAN will expand the use of integrated pediatric primary care, simplify service navigation for families, and improve access to mental health care overall. It is critical that Dallas County leaders support UTSW in establishing relationships with every pediatric and family practice in the county, and that specialty outpatient providers be included in the database that is being developed for the referral network.

Principal Recommendation #3: Specialty outpatient behavioral health providers need to develop formal partnerships with the UTSW CPAN hub for Dallas County to create formal referral pathways. Moving forward, it is essential that community specialty outpatient behavioral health providers develop a relationship with the UTSW CPAN hub. Through the UTSW CPAN referral network, pediatricians and primary care providers will be better equipped to refer their patients to community services and supports that specifically address the behavioral health needs of children and youth. UTSW will be reaching out to key providers early in 2020 to initiate this process.

¹³ The Joint Commission. (2018, February 13). Revised outcome measures standard for behavioral health care. *R3 Report, 13*. https://www.jointcommission.org/assets/1/18/R3_Outcome_measures_1_30_18_FINAL.pdf

Principal Recommendation #4: Reframe the roles of specialty outpatient behavioral health providers to better serve the population of children and youth with moderate-to-severe mental health conditions, and increase their capacity to offer more intensive, clinic-based, evidence-based practices (EBPs). With the implementation of the UTSW CPAN, more children and youth with mild-to-moderate mental health conditions will be adequately served in primary care settings. As a result, the roles of specialty outpatient behavioral health providers will increasingly need to be refocused on the needs of children and youth with moderate-to-severe mental health conditions. In addition, since specialty outpatient behavioral health providers offer more EBPs that are focused on specific conditions, they are in a better position to provide these services than providers who offer more generic care. Optimally, specialty outpatient providers who would like to serve children and youth with mild-to-moderate needs would be deployed to integrated practice settings where they would be co-located and partner with pediatricians and primary care doctors to deliver follow-up care for children and youth whose mental health needs are identified in a primary care setting.

In order to ensure the appropriate implementation of EBPs, community organizations will need to retool, retrain, and invest in staff and infrastructure, and establish partnerships with other agencies. These agencies will need support and dedicated resources to create a plan to identify appropriate EBPs, select and train appropriate staff, implement the selected EBPs, and measure fidelity in order to ensure that the services are effective. Agency leadership will need to be committed to delivering EBPs. More broadly, the agency will need to provide an infrastructure to support EBP implementation and ensure treatment fidelity. Individual providers can develop EBP strategies alone or in collaboration with other providers. A collaborative of agencies interested in increasing the implementation of EBPs such as Dialectical Behavior Therapy and Parent-Child Interaction Therapy could be developed to efficiently use limited financial resources and embed EBPs into the infrastructure of multiple providers at the same time. Providers can address sustainability challenges by pooling together resources, sharing costs, and coordinating cross-agency trainings. Agencies and collaboratives will need to engage in advocacy with payers and incorporate outcomes-based and other reimbursement strategies to sustain these services over the long term.

Principal Recommendation #5: Increase school-based and school-linked mental health services and supports by using the full range opportunities made available in the 86th Legislative Session. 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 both targeted and intensive interventions for children and youth with more

complex mental health needs.¹⁴ The 86th Legislative Session initiated and expanded multiple legislative opportunities to help sustain and increase access to these types of services and supports. SB 11 (discussed in a later recommendation) created a new School Safety Allotment, which is administered through the Texas Education Agency. School districts can use this new funding to create supportive school environments and prevent mental and behavioral health concerns from emerging. This can be done through school partnerships with community-based organizations. Beyond this, House Bill (HB) 18, effective December 1, 2019, includes training, policy, and planning requirements for school districts related to student mental health, the use of trauma-informed practices, social and emotional skills development, and mental health education for students. Community providers can partner with schools to help them meet these requirements. Additionally, HB 19 puts a non-physician mental health professional at each of the 20 regional Education Service Centers throughout the state to focus on social and emotional well-being by supporting school personnel and facilitating their training in mental health and trauma-informed care.

Principal Recommendation #6: There is a need to develop capacity for intensive, community-based EBPs that go beyond the basic level of services funded by the Health and Human Services Commission (HHSC) and provided by the North Texas Behavioral Health Authority (NTBHA) and Medicaid managed care organizations. Currently, Mental Health Rehabilitative Services funded by HHSC through NTBHA and Medicaid must conform to the state's 2012 Texas Resilience and Recovery (TRR) framework. The TRR requirements limit Medicaid case management and specialty rehabilitative care providers' efforts to individualize their interventions to address the specific needs of the individuals and families they serve. The TRR framework is a prescriptive set of time allotment for generic interventions provided to each individual that is identified through a calculated formula to meet the need for certain care packages. For example, a provider specializing in treating children and youth involved in the child welfare system must deliver the same interventions to their caseloads as other providers working with different populations of children and youth even though there are EBPs with more well-suited with better outcomes designed for children and youth involved with the child welfare system. These limitations were designed to ration general revenue-funded care, which is inconsistent with the Medicaid entitlement and SB 58 (83rd Regular Session, 2013), which eliminated the requirement that Medicaid providers must follow the TRR and enabled them to deliver EBPs that are individualized to the populations covered by the state's Medicaid managed care program. We recommend that North Texas providers seek private and federal grant funding that can be braided with HHSC funds to support staff training and create the infrastructure needed to implement more intensive and effective EBPs so that they can provide

¹⁴ Meadows Mental Health Policy Institute. (2019, November 1). *Mental and behavioral health roadmap and toolkit for schools*. <https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf>

individualized care. In addition, providers should work with state policymakers (e.g., HHSC) to reform the TRR framework, which continues to mandate inefficient requirements and outmoded restrictions on the ability of HHSC-funded providers to deliver EBPs beyond the narrow list of interventions HHSC allows. Medicaid managed care providers need to also explore the provisions of SB 1177 (86th Regular Session, 2019), which will allow reimbursement for the provision of certain EBPs in lieu of other services.

Principal Recommendation #7: Expand access to urgent assessment and crisis stabilization supports in schools through the Texas Child Health Access Through Telemedicine (TCHATT) program. In addition to CPAN, SB 11 established TCHATT, which will also be implemented by UTSW Medical Center in partnership with Children's Health. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth with urgent mental health needs. The urgent assessments and short-term stabilization care that will be available through TCHATT will increase community-wide urgent care capacity. It will also require linkages for follow-up care to specialty outpatient mental health providers. Although TCHATT will be offered statewide, it will not be provided in every Texas independent school district (ISD) or in every school in the ISDs served by the program. In the first year of this program, UTSW and Children's Health plan to focus on working with schools with whom they have existing relationships; in the second year they will expand into new schools.

Principal Recommendation #8: Develop a coordinated crisis response system across all payers; Medicaid managed care organizations; and health, mental health, child welfare, and juvenile justice systems, including TCHATT services. The current array of crisis services in Dallas County does not function as a system. This observation is less a criticism than it is a paramount charge to collaborate and build a coordinated crisis response system across key payers and health systems over time. Many of the necessary pieces are in place, but cross-system transformation requires collaboration and a will to develop a more comprehensive system that has supportive payment protocols. One key piece of coordination is to quickly obtain an initial appointment for children and youth following a crisis episode or inpatient stay. Providers noted that it is not unusual for there to be a six-week wait for an appointment with a psychiatrist, which is especially problematic following a crisis episode or discharge from an inpatient stay. Optimally, appointments with outpatient providers should occur within seven days of discharge or a crisis event. This requires coordination between inpatient and outpatient providers while the child or youth is in the hospital, as well as the availability for an outpatient provider to schedule the appointment(s). This level of coordination does not currently exist and results in treatment delays that leave children and youth cycling through the crisis and inpatient services.

The principal recommendations introduce opportunities for transforming Dallas County's existing mental health service delivery for children and youth. In addition to these recommendations, we offer four cross-cutting strategies that could improve resource identification and quality of care, and enhance the family-centered focus of services for children, youth, and their families.

Cross-Cutting Strategy #1: Increase the emphasis on family-focused interventions, including family therapy and caregiver training and support. Providers increasingly recognize the critical importance of family-focused care when treating children and youth, something long supported by research. However, fragmented funding continues to focus more on services to the identified patient (child or youth) rather than on the family. Efforts to expand and improve family-center therapy have been hampered by misunderstandings of confidentiality limitations under the Health Insurance Portability and Accountability Act (HIPAA) and underfunded services that limit the capacity of providers to engage in the additional work necessary to involve families. For example, Medicaid- and state-funded providers are limited in providing family therapy and other family-focused interventions because of the way the public system emphasizes and reimburses individual care. Also, although privately-funded providers are more often able to provide more family-focused interventions, they often lack the capacity to provide the broader range of reimbursable services that families need, such as psychiatry, case management, and specialty rehabilitative services. Providers could increase family-focused interventions by hiring more family therapists or co-locating with providers who offer family therapy. They could also pay for their clinicians to attend certified training in evidence-based, family-focused interventions such as Parent Management Training and Family Focused Treatment for Adolescents. Providers who want to offer family-focused interventions will need to develop reimbursement strategies to support the additional costs that family-centered care entails.

Cross-Cutting Strategy #2: Develop policies and strategies to increase cultural and linguistic competence in clinical services and treatments as well as throughout entire organizations as part of a broader goal to increase behavioral health equity and reduce disparities. Providers face challenges in recruiting and retaining staff who understand the cultures and speak the languages of the children, youth, and families their agencies serve, as shown by the national

and statewide gaps in capacity to provide culturally and linguistically competent care.^{15, 16, 17} Providers face very real shortages in the availability of linguistically and culturally competent staff and this, in turn, dramatically limits access to these needed services for a significant portion of the community. Efforts to address these gaps can begin by tailoring services to the demographics of Dallas County as well as the specific cultural and linguistic needs of the children and youth served by each provider. Some providers in other communities have found that a self-assessment of their agency and policies can help them identify and address more systemic biases and barriers that may inadvertently make it more difficult for families to access or continue services. Providers can also develop core cultural and linguistic competencies for all staff, regardless of their specific cultural and linguistic knowledge and skills.¹⁸ These activities need to be embedded into organizations' policies and not limited to the competencies of each staff member to ensure that there is ongoing dialogue and attention to cultural and linguistic competence. Organizations have opportunities to address these barriers and build their internal capacity such as providing ongoing cultural competency trainings for staff, partnering with translation services, and working with local graduate schools to develop a pipeline of culturally and linguistically competent clinicians. More importantly, it is imperative that Dallas County develop a representative group of service recipients who could inform efforts to improve cultural and linguistic competency and tailor services to the unique needs of the Dallas community.

Cross-Cutting Strategy #3: Engage faith communities as partners in efforts to improve mental health system access and performance. One set of community resources that still regularly mediates between the individual and the larger society, and often has the capacity to offer ongoing community support, is the local congregation – whether it be a church, synagogue, mosque, or other faith community. In particular, communities of color are more likely to seek mental health support from their faith communities than from traditional mental health services.¹⁹ One study found that 90.4% of African Americans reported they used religious

¹⁵ Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). *The evidence base for cultural and linguistic competency in health care*. The Commonwealth Fund.

¹⁶ López, M., Hofer, K., Bumgarner, E., & Taylor, D. (2017). Developing culturally responsive approaches to serving diverse populations: A resource guide for community-based organizations. <http://www.hispanicresearchcenter.org/wp-content/uploads/2017/03/Cultural-Competence-Guide.pdf>

¹⁷ Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research* 7, 15.

¹⁸ Substance Abuse and Mental Health Services Administration. (2014). *A treatment improvement protocol: Improving cultural competence*. <https://store.samhsa.gov/system/files/sma14-4849.pdf>

¹⁹ Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work*, 45(1), 73–87. <https://doi.org/10.1093/sw/45.1.73>

coping to deal with mental health issues.²⁰ The prospects for congregations to support children, youth, and their families experiencing emotional distress are significant, especially when they collaborate with mental health providers and other agencies that can deliver evidence-based and clinically-necessary treatment and supports.

There are numerous ways to engage faith communities as partners, such as providing educational opportunities to their leaders and congregations to increase mental health literacy and awareness, establishing system-level efforts to promote faith and mental health collaboration, and embedding mental health services directly into faith communities. Faith communities can also be strong partners in efforts to prevent and reduce the stigma associated with seeking mental health treatment and support. In April 2019, we released *Bringing Faith and Mental Health Together: An Inventory of Faith and Mental Health Initiatives in San Antonio and Nationally*, which provides a compilation of the current initiatives and the network of existing (and potential) relationships in San Antonio as well as a description of exemplars in other areas of Texas and nationally.²¹

Cross-Cutting Strategy #4: Develop more formal opportunities for providers to communicate and collaborate. Providers noted a lack of coordination across components of the system and between each other, primarily because of a lack of awareness of what services or resources other providers offer in the community. Respondents from nearly every organization we reviewed expressed a desire to better understand the services and resources available throughout the community in order to connect children, youth, and families with the services that will best meet their needs. Although the CPAN program is designed to promote communication and collaboration among providers, there is a need to go further. Providers expressed a need to help families navigate different systems and learn about the best care options for the conditions that their children experience. Several groups and collaborative efforts in Dallas County connect children and youth to organizations that provide services and supports for children, youth, and their families. The most successful so far – and a promising effort to build on – is the Here for Texas resource guide developed by the Grant Halliburton Foundation.²² Through formal opportunities for communication and collaboration such as CPAN and Here for Texas, organizations could help guide future system improvements and community investments in children’s mental health. As an example, the federal Substance

²⁰ Chatters, L. M., Taylor, R. J., Jackson, J. S., & Lincoln, K. D. (2008). Religious coping among African Americans, Caribbean Blacks and Non-Hispanic Whites. *Journal of Community Psychology*, 36(3), 371–386. <https://doi.org/10.1002/jcop.20202>

²¹ Meadows Mental Health Policy Institute. (2019, April). Bringing faith and mental health together: An inventory of faith and mental health initiatives in San Antonio and nationally. <https://hebfdn.org/wp-content/uploads/sites/7/2019/08/MMHPI-HEBFDN-Faith-and-Mental-Health-Inventory-FULL-REPORT.pdf>

²² For more information, see: <https://www.herefortexas.com/index.html>

Abuse and Mental Health Services Administration (SAMHSA) has grants to build, expand, and sustain systems of care. These grants are awarded to government entities to develop and implement a system of care approach to improve outcomes for children and youth with serious emotional disturbances. Dallas area providers could advance formal collaborative efforts by joining together to submit a grant proposal to SAMHSA to create a comprehensive “system of care” for children and youth who experience significant mental health challenges.

Overview

Thanks to the generous support of The Rees-Jones Foundation, The Meadows Mental Health Policy Institute (MMHPI) conducted an in-depth assessment of Dallas County's mental health service delivery systems for children, youth, and families. The goals of this assessment were to inventory and analyze Dallas County's mental health systems, assess their current and potential capacity to deliver care along a continuum that provides highly responsive and clinically effective services, and offer specific recommendations to support the continued development of the system. The assessment, therefore, focuses on the scope and quality of services within Dallas County through the lens of our (MMHPI's) Mental Health Systems Framework for Children and Youth (framework), which has five components that we will describe more fully below and use to organize the report findings and recommendations:

- Component 0: Life in the Community,
- Component 1: Integrated Primary Care,
- Component 2: Specialty Outpatient Care,
- Component 3: Specialty Rehabilitative Care, and
- Component 4: Crisis Care.

Using this framework as a foundation, this report describes a range of best practices for each component, focusing on research-based practices and interventions that have been proven to have the best outcomes for children, youth, and their families. These best practices have proven to be effective across demographics, populations, and clinical settings.

After our description of best practices within the context of the framework, we review our assessment of Dallas County's mental health service delivery systems for children, youth, and their families by addressing the following questions:

How many children and youth in Dallas County need mental health services, including:

- Services for children and youth with mild-to-moderate conditions?
- Services for children and youth with more severe conditions?
- Children and youth affected by poverty and adverse childhood experiences?
- Children and youth with the most intensive needs?

How accessible are mental health providers, including:

- Locations of service providers for each component of the framework?
- Providers' accessibility to the children and youth who need services the most?

How many children and youth receive mental health services and:

- Do the services children and youth receive fit their needs?
- To what extent are the services best practices and evidence-based?

What is the current capacity and opportunity to further develop each component of the Children's Mental Health Systems Framework in Dallas County?

For many children and youth (and their families) who are seeking care for mental health needs, involvement in multiple formal and informal systems is a reality. To start, every child and youth develops — and manages their health needs — within the context of the family system. Families typically have their own unique strengths and challenges that influence their ability to manage these needs. Additionally, almost all children and youth have contact with systems that may address a wide range of their needs, including education, primary care, mental health, substance abuse, child welfare, and juvenile justice systems, and supports for those with intellectual and developmental disabilities. In many cases, children and youth are involved with multiple systems simultaneously, particularly if they have more serious needs or are at risk of out-of-home or out-of-school placement. Each system is governed by its own set of policies, rules and regulations, funding restrictions, and information-sharing processes — all of which complicate efforts to deliver coordinated and effective care across systems. Furthermore, these systems must address a child or youth's changing developmental needs and levels of acuity over time and throughout the course of care while aligning safety concerns and the restrictiveness of the setting (e.g., incarceration, other secure and non-secure out-of-home placements, or community-based options) with the needs of children, youth and families.

Although we recognize the efforts of these formal systems to provide and coordinate access to effective mental health services, we also recognize that the complexity of these systems, along with their limited capacities, create additional challenges for the children, youth, and families who receive their services. We hope this report provides guidance on strategies to improve access to the most effective mental health services in the right place and at the right time for Dallas County children, youth, and their families.

Approach to the Assessment

The MMHPI team involved in this assessment took an intentional approach to collecting, compiling, and analyzing data from a variety of sources. The team included experts in diverse fields that include mental health services; mental health integration in primary care; public and private health delivery systems for children, youth, and their families in communities and schools; child welfare and foster care; juvenile justice; and public policy. We began the assessment process in May 2019 by hosting a meeting that included organizations who receive funding from The Rees-Jones Foundation and who provide mental health services to children, youth, and families in Dallas County. Following the meeting, we expanded the group of engaged providers to include additional mental health services providers in the county. Collectively, the provider agencies we included in our in-depth assessments represented organizations that provide a wide range of mental health services, including integrated primary health care, specialty outpatient care, specialty rehabilitative care (intensive services), and services to special populations (e.g., children and youth who are involved in the child welfare and juvenile justice systems as well as children and youth affected by family and domestic violence and

human trafficking). This group of organizations also included faith-based providers. Our goal was to engage the broadest possible range of leading mental health providers, and in total we assessed forty-one (41) organizations that provide mental health services across Dallas County. A full list of the provider organizations that we examined can be found in Appendix A.

In addition to conducting in-depth reviews of each provider's capacity, we also incorporated multiple data sources to understand the strengths and needs of the community from a population-level standpoint. We compiled data to understand the prevalence of mental health needs and adverse childhood experiences among children and youth in Dallas County. Given that many of the organizations included in this assessment serve children, youth, and families living in poverty, we further analyzed the data to understand the prevalence of need for those living at or below 200% the federal poverty level. We also compiled data from all the provider reviews to map resources across the county, identifying service provider locations in relation to schools, physical health care providers, and bus routes.

The structure of this report reflects our intentional approach. First, we describe The Mental Health Systems Framework for Children and Youth (framework) who are in need of mental health services. Within each component of the framework, we identify best practices and evidence-based interventions that have proven positive outcomes. (For more information, Appendix C describes a wide range of evidence-based and other best practices). We then discuss the prevalence of mental health conditions among children and youth in Dallas County; the current service delivery systems and service array; and the capacity of multiple child serving systems to meet the needs of Dallas County children, youth, and their families. We also include maps showing provider locations, demonstrating geographic access to services. Within this comprehensive overview, we describe the strengths and gaps of the current service delivery systems and provide strategies that build on existing strengths. Finally, we provide systems-level findings and recommendations to support the continued development of the system as a whole.

Please note, for the purposes of this report, we use the term "children" to mean all children and pre-adolescents, and we use "youth" to refer to adolescents up to age 18. However, because some data sources and systems do not offer a precise boundary between "children" and "youth," we occasionally use "adolescent" when referring to older children and youth in order to reflect the definition used by the source we are citing.

Finally, we offer our gratitude to The Rees-Jones Foundation for commissioning this important work and we extend our appreciation to the many providers across Dallas County that generously shared their time and insights.

Mental Health Systems Framework for Children and Youth

Health care systems are an integral part of the lives of every child and family, but they are only a part of life. Although this may seem like an obvious and core truth, unfortunately too many health systems are designed without recognizing this truism and they instead focus simply on the care they are attempting to deliver as the overarching concern. But health needs — including diseases affecting the brain, such as mental health disorders, and other health conditions — occur in the context of life: home, family, faith, work, and school.

Some services might be perceived as mental health services, but are not. Schools, foster care, and juvenile justice services providers have important roles to play in identifying mental health challenges and the facilitating connection to mental health interventions, but they are not health care providers. For nearly every student, schools can help support healthy development and improve academic performance by implementing strategies for improving the social and emotional wellness of students in their care and linking those in need to care.²³ Some schools are also able to provide space for service providers on campus, greatly improving access to care for many students and their families. Additionally, although relatively few children and youth from a given community are involved in the child welfare system at any one time, those involved with this system have an array of needs and vulnerabilities, including mental health needs, which often require communities to devise ways to link these children and youth to needed services. Often, access to this care is essential to support the success of foster and permanent placements. The same is true for youth involved in the juvenile justice system. Because schools, the foster care system, and the juvenile justice system play such integral roles in identifying and addressing the mental health needs of children and youth, we often infer that they are a segment of the mental health care delivery system, but they are not. In the Mental Health Systems Framework for Children and Youth (framework), mental health services are integrated within these systems and then are well-coordinated with the broader health system. The framework is designed so that in its full implementation, children and youth would never end up in the foster care or juvenile justice system simply because of unmet mental health needs, an unfortunate reality in the system today.

In addition to clarifying the roles of various service providers within the overall mental health care delivery system, it is critical to ensure that children and youth are served at the appropriate level of care. To demonstrate this concept, consider another type of specialty outpatient care: orthopedics. If a child falls at school and sprains their wrist, there is generally no need to go to an orthopedic specialist or hospital; the child can be treated either by the school nurse or a primary care provider. However, if the fall is more severe and the child breaks

²³ Meadows Mental Health Policy Institute. (2019, November 1). Mental and behavioral health roadmap and toolkit for schools. <https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf>

their arm, they will typically need to see a specialist to get a cast or other treatment. If the child suffers a complex injury, either through sports or trauma (such as an automobile accident), they will then need more intensive care such as a brief hospitalization to undergo complex procedures. Intensive rehabilitation for an extended amount of time to support healing, reduce pain, and regain functioning may be required.

Just as a “system of care for orthopedics” comprises tiered interventions in primary care, specialty outpatient care, specialty rehabilitative care, and hospital settings, so too should a “system of care for mental health.” However, current mental health systems in every community in Texas and across the nation are often disjointed and misaligned, lacking the structure for easy navigation by those in need.

More specifically, in the current system:

- The front line of care is frequently an informal mix of law enforcement, hospitals (emergency departments and inpatient care), and out-of-home care options through the juvenile justice and foster care systems because, often times, people do not seek care until symptoms have been present for years and needs become acute.²⁴ The child welfare and juvenile justice systems are often used as default providers for mental health services. Law enforcement may also serve as first responders for other health emergencies (for example, injuries in an automobile accident).
- Discussions surrounding mental health care tend to over-emphasize the specialty outpatient care system, with mental health providers viewed as a generic solution to any and all levels of mental health need, with a lack of specificity regarding their roles in relation to primary care and more intensive specialty rehabilitative care for children and youth with more moderate to severe needs.
- Specialty rehabilitative services for mental health needs are typically only available through public sector providers, rather than being a broadly accessible resource across private and public payers. In contrast, physical rehabilitation is broadly accessible. In Texas, until 2013, only local mental health authorities were able to provide such care in the public system, and specialty rehabilitative services are rarely covered by private payers. As a result, rehabilitation tends to function principally as a separate system, rather than as part of a coordinated service structure.
- While some crisis system components exist in Dallas County across the mental health, child welfare, and juvenile justice systems, they are not well coordinated or conceptualized as a single crisis system.

²⁴ 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.

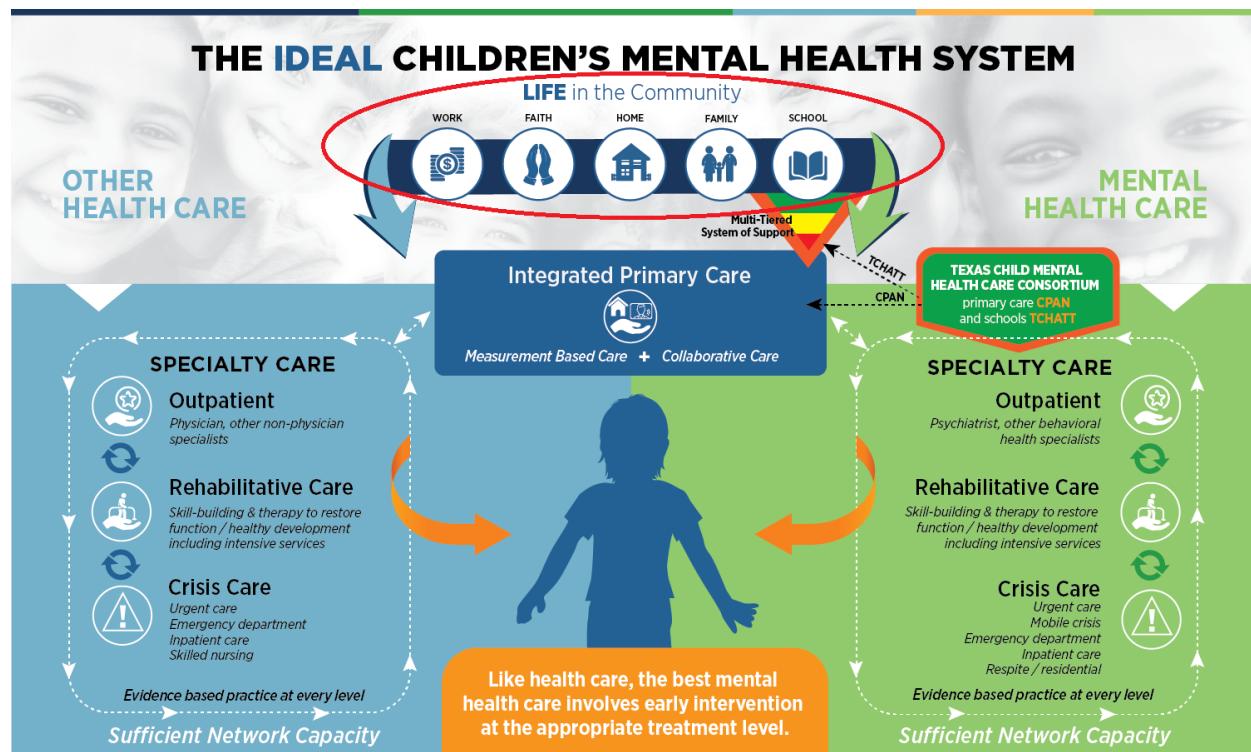
For health care providers and families across the nation, these systemic challenges create unnecessary frustration, a bottleneck to access, and inadequate case coordination — and they are not unique to Dallas County or Texas.

Fortunately, health care systems across Texas and the nation are in the early stages of improving how mental health treatment is organized and integrated into health care. We have grouped our discussion of these changes into distinct components, following our framework:

- Component 0: Life in the Community,
- Component 1: Integrated Primary Care,
- Component 2: Specialty Outpatient Care,
- Component 3: Specialty Rehabilitative Care, and
- Component 4: Crisis Care.

In the following subsections, we describe each of these components in greater detail.

Component 0: Life in the Community



As noted above, within Component 0 there are a broad range of child, youth, and family supports outside of health care settings that promote wellness, help prevent mental health challenges, and lead to the early detection and minimization of mental health needs. There are many touchpoints for children and youth that provide opportunities to promote healthy

development and prevent mental health and substance use disorders. Health care systems are an integral part of the lives of every child and family, but they are only one aspect of life. Health needs — including diseases affecting the brain, such as mental health disorders, and physical health conditions — occur in the context of life: home, faith communities, childcare providers, schools, foster care, juvenile justice settings, and other places where children, youth, and families spend their time. These places can also be ideal settings for health promotion and disease prevention.

While the education, foster care, and juvenile justice systems are not health care providers, they are well-positioned to prevent or minimize the occurrence of many mental health challenges by helping to support those in need with access to mental health services and key educational supports. For example, schools can help foster healthy development by implementing school-wide social and emotional wellness models that are intended to prevent some challenging behaviors while teaching the social and emotional skills that students need to succeed in school.²⁵ Schools can be the key to identifying children and youth with mental health needs and referring and linking them to services provided in the community; in some cases, schools may serve as a venue for providing mental health services. Partnerships between schools and mental health providers and other community resources can help ensure that students receive consistent and sustainable support, which is critical for overall care. There is also a need for schools to develop a liaison function to help link children and youth in need (and their families) to the appropriate levels of care. The liaison function can take on different forms in different schools and school districts, but its focus is the same — connecting students in need (and their families) to integrated primary care or specialty outpatient mental health resources. Likewise, providers within the foster care and juvenile justice systems play an important role in linking children and youth with mental health needs to care.

Although race and ethnicity are not correlated with substantial differences in the prevalence of mental health conditions, children and youth of color comprise the vast majority of children in Dallas County and therefore experience over 85% of current behavioral health needs.²⁶ Children and youth of color are also at highest risk of exclusionary school discipline (suspension and expulsion),²⁷ which is among the strongest correlates of future involvement in the juvenile

²⁵ Meadows Mental Health Policy Institute. (2019, November 1).

²⁶ All Texas 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

²⁷ Fabelo, T., Thompson, M. D., Plotkin, M., Carmichael, D., Marchbanks, M. P., & Booth, E. A. (2011, July). Breaking schools’ rules: A statewide study of how school discipline relates to students’ success and juvenile justice involvement. Council of State Governments Justice Center and the Public Policy Research Institute at Texas A&M University. Grant from the Atlantic Philanthropies and Open Society Foundations.

justice system.²⁸ This is not because suspensions increase the risk, but because the underlying factors (including untreated or inadequately treated mental illness) that lead to the suspension increase the odds of future incarceration or drop-out if left unaddressed. This emphasizes the need for recruiting and retaining linguistically and culturally competent staff to increase access and quality of services for a significant portion of the community.

Faith communities provide opportunities to connect, develop, and maintain positive social relationships and can play a significant role in supporting people with mental health conditions. This can be especially effective when faith communities collaborate with mental health providers and other agencies that deliver evidence-based and clinically-necessary treatment and supports. Faith communities can be strong partners in prevention efforts and initiatives to reduce the stigma associated with seeking mental health treatment and support. Community providers can also embed mental health services directly into faith communities.

Another important aspect of life in the community is peer relationships, particularly for youth and caregivers.²⁹ Peer support services offer another opportunity for children and youth to develop meaningful, lasting social connections. Although peer support has become widely accepted as part of formal mental health and substance abuse service delivery models for adults, it is not consistently offered to youth or caregivers. There is also a need for increased support of youth and caregiver peer support models.

There are several key support activities that can enhance the effectiveness of services and supports within Component 0:

- Strategic collection and use of data to inform approaches for health promotion and disease prevention;
- Systemic approach to recognizing the signs and symptoms of a mental health need;
- Engagement with and education of faith communities, childcare providers, schools, and other individuals and organizations that support children, youth, and families so that they are better equipped to become caring communities for people struggling with mental illness;

https://csgjusticecenter.org/wp-content/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf

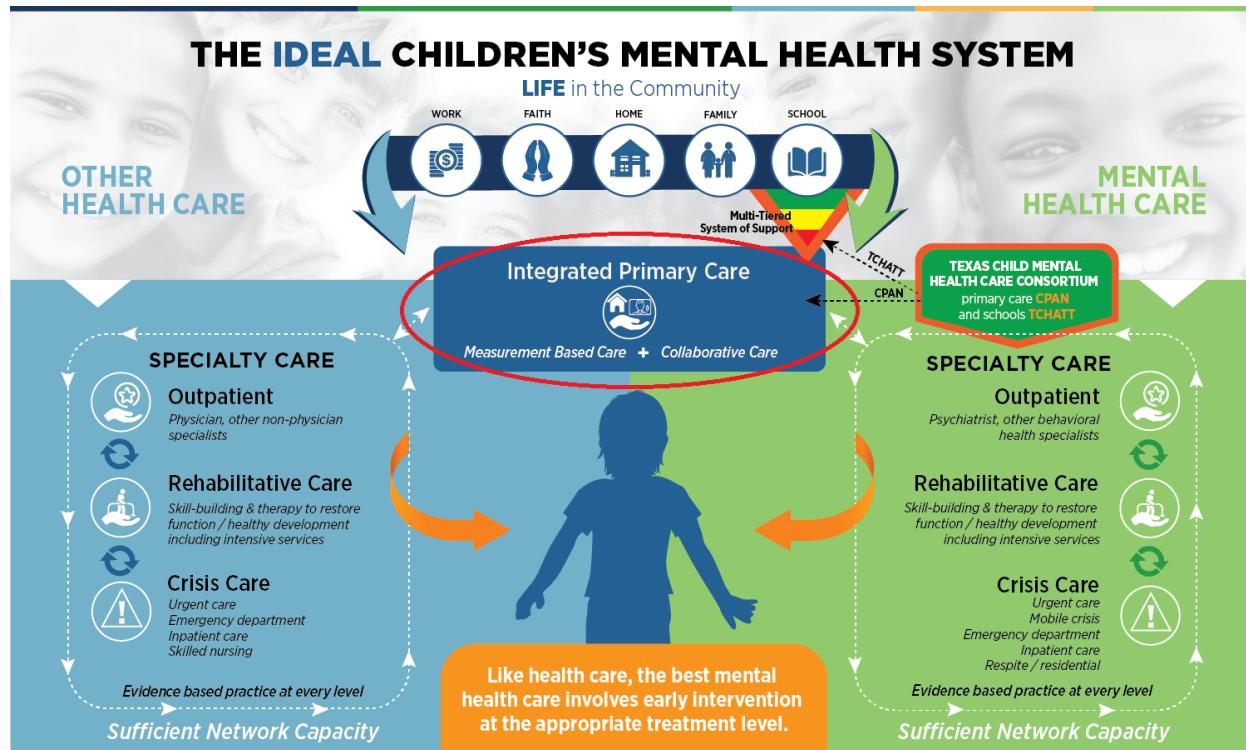
²⁸ Balfanz, R., Byrnes, V., & Fox, J. (2013). *Sent home and put off-track: The antecedents, disproportionalities, and consequences of being suspended in the ninth grade*. Paper presented at the Closing the School Discipline Gap: Research to Practice, Washington, DC. As cited in Losen, D.J. & Martinez, T. (2013). *Out of school and off track: The overuse of suspensions in American middle and high schools*. Center for Civil Rights Remedies at UCLA's Civil Rights Project. http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutofSchool-OffTrack_UCLA_4-8.pdf

²⁹ Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). *Value of peers*.

https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

- Support for the development and implementation of policies and programs that strengthen maternal and child health, parenting skills and family supports, and early care environments; and
- Primary prevention programs and instruction within school systems that support the social and emotional development of every student.

Component 1: Integrated Primary Care



The figure above depicts the front line for all health care delivery, the setting where research suggests that up to two thirds of all pediatric behavioral health needs can be met: integrated primary care. The figure highlights several key components of that care in the framework:

- Providers should conduct universal screening to achieve early identification and intervention of behavioral health needs in individuals, while also implementing a population health approach. Community providers should implement measurement-based care (MBC), thereby informing and evaluating clinical care planning, progress, and success based on client data collected throughout the treatment episode;
- Integrated primary care should be available;
- Mental health services should be available in both pediatric primary care and school settings; and
- Telehealth and telemedicine are key strategies for linking schools to primary care resources (either in clinics or at other school-based sites).

Mental health integration in pediatric primary care settings is in many ways the core component of the framework and an essential strategy for increasing access to mental health services for children and youth, particularly those with mild to moderate conditions. Currently, about 75% of children and youth with psychiatric disorders are seen in pediatric and other primary care settings.³⁰ Pediatric primary care is point of care delivery that is most likely to provide children and youth with the help they need. It is also the key to early identification of complex needs and effective referral and coordination of care to treat those needs.

Universal screening is an important component of integrating mental health into pediatric primary care settings. Universal screening can help identify children and youth with a mental health need. Once treatment is initiated and a treatment plan is created based on individual symptomology, routine measurement of symptoms is completed at each visit throughout the course of treatment, just as it is done for diseases like diabetes and heart disease. There are a myriad of measures that can be used and they vary depending on diagnosis and what the treatment is targeting. An example of such a measure is the Patient Health Questionnaire-9 modified for adolescents (PHQ-A).³¹ The PHQ-A is a validated instrument for measuring depression severity.^{32,33,34,35} The National Council for Quality Assurance (NCQA)³⁶ and The Kennedy Forum (TKF)³⁷ endorse the PHQ-A as a measure for tracking depression outcomes in adolescents age 12 years and older. Additionally, the American Psychiatric Association (APA)

³⁰ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry into the pediatric health home*.

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

³¹ The PHQ-A has minor changes from the original Patient Health Questionnaire-9 (PHQ-9) that incorporate characteristics of depression among adolescents and add age-appropriate language, including items related to irritability, weight loss, self-harm, and suicide.

³² Johnson, J. G., Harris, E. S., Spitzer, R. L., et al. (2002). The Patient Health Questionnaire for Adolescents: Validation of an instrument for the assessment of mental health disorders among adolescent primary care patients. *Journal of Adolescent Health, 30*(3), 196–204.

³³ Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014). Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA, 312*(8), 809-16. <https://doi.org/10.1001/jama.2014.9259>.

³⁴ Shaffer, D., Fisher, P., Lucas, C. P., et al. (2000). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*(1), 28–38.

³⁵ Spitzer, R. L., Kroenke, L., & Williams, J. B. (1999). Validation and utility of a self-report version of PRIME-MD: The PHQ primary care study. *JAMA, 282*(18), 1737–1744.

³⁶ NCQA. (2018). *HEDIS depression measures specific electronic clinical data systems*.
<https://www.ncqa.org/hedis/the-future-of-hedis/hedis-depression-measures-specified-for-electronic-clinical-data/>

³⁷ The Kennedy Forum. (2015). Fixing behavioral health care in America. A National call for Measurement-Based Care in the delivery of behavioral health services. https://thekennedyforum-dot-org.s3.amazonaws.com/documents/KennedyForum-MeasurementBasedCare_2.pdf

endorses the PHQ-A as an outcome measure for clinical practice with youth ages 11 to 17 years.³⁸ Validated instruments such as the PHQ-A can be used by providers when implementing MBC to help identify mental health needs early and improve the quality of treatment.

Integrating mental health care into pediatric primary care settings aligns with the concept of the “health home.” According to the American Academy of Pediatrics, the pediatric health home refers to the “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.”³⁹ The American Academy of Child and Adolescent Psychiatry further identifies key components of the mental health integration framework within the pediatric health home in its publication, *Best Principles for Integration of Child Psychiatry into the Pediatric Health Home*,⁴⁰ which include the following strategies:

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

Best Practice: Massachusetts Child Psychiatry Access Project Regional Hubs

- **Timely phone consultation**
- **Expedited face-to face psychiatric consultation**
- **Care coordination for referrals**
- **Education for primary care providers**

³⁸ American Psychological Association. (n.d). *Severity measure for depression—child age 11–17 (adapted from PHQ9 modified for Adolescents [PHQ-A])*. American Psychiatric Association.

https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/DSM/APA_DSM5_Severity-Measure-For-Depression-Child-Age-11-to-17.pdf

³⁹ American Academy of Pediatrics. (2017). *Medical home: Medical home resources*. <https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx>

⁴⁰ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*.

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

Senate Bill (SB) 11 (86th Regular Session, 2019) established the Texas Child Mental Health Care Consortium (Consortium) to foster collaboration on pediatric mental health care among medical schools in Texas.⁴¹ As described in SB 11, the Consortium is responsible for overseeing five key initiatives, one of which is the Child Psychiatry Access Network (CPAN). The establishment of the CPAN program in Texas will support pediatric primary care providers by providing them with a resource for free consultation regarding patients with a mental health concern. A similar program established in Massachusetts currently supports over 95% of the pediatric primary care providers in the state and suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.⁴² Through CPAN, pediatricians and other primary care providers can access child psychiatric and mental health consultation services through regional “hubs” supported by Texas medical schools. The hub that includes Dallas County is located at The University of Texas (UT) Southwestern Medical Center through a partnership with Children’s Health. CPAN teams include child psychiatrists, mental health clinicians, referral specialists, and program coordinators. These teams provide the following supports for pediatric primary care providers:

- Telephonic clinical consultation during business hours with a child psychiatrist or mental health clinician,
- Care coordination for assistance with referrals to community mental health services, and
- Continuing professional education designed for pediatric primary care providers.

Schools are also a natural setting for embedding integrated pediatric primary care to identify and assist children and youth who have mental health concerns. As such, provision of health and mental health services to students through school clinics is an effective strategy for addressing the mental health needs of children and youth.⁴³ Efforts to expand school-based integrated primary care across Texas are increasingly incorporating telehealth as a means to link limited provider resources to more school campuses, most notably through Children’s Health and surrounding counties. The Children’s Health school-based tele-behavioral health program connects students with licensed mental health specialists via telemedicine, addressing common mental health issues in student populations, including depression, anxiety, self-esteem, and lack of coping skills in the school setting.

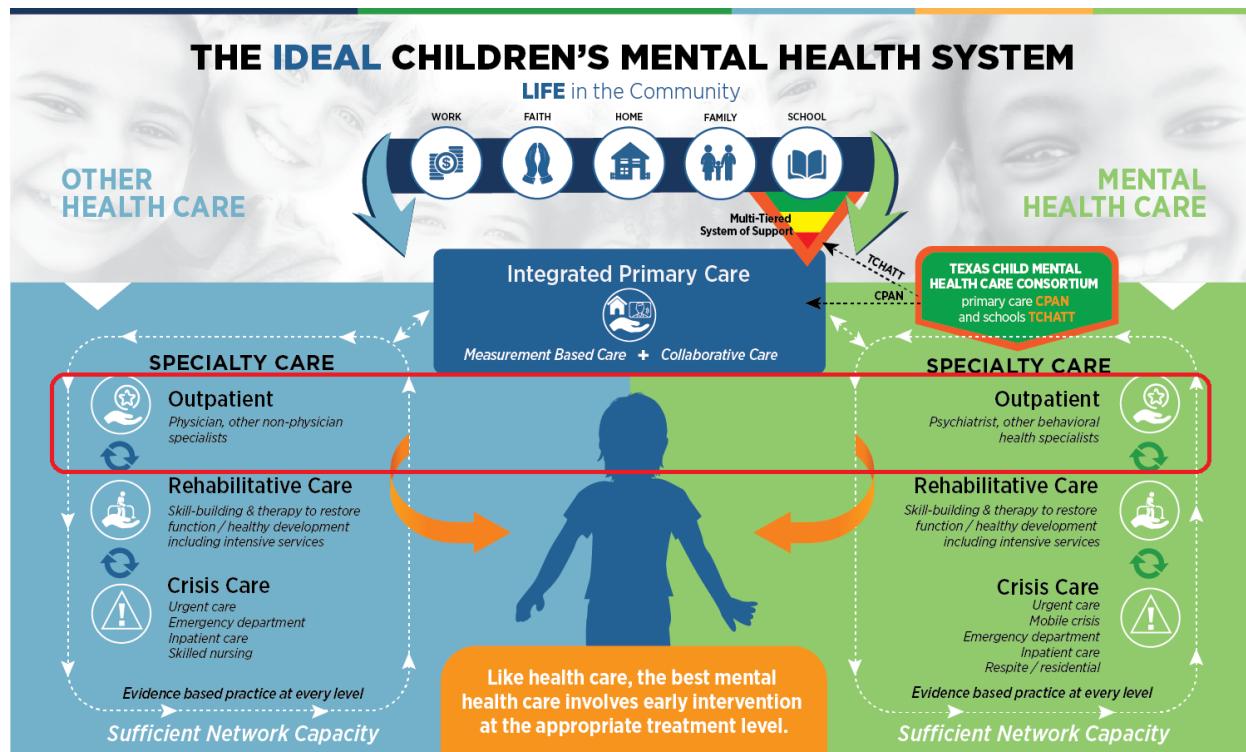
⁴¹ Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor’s SB 11.

⁴² Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

⁴³ Murphy, D., Stratford, B., Gooze, R., Bringewatt, E., Cooper, P. M., Carney, R., & Rojas, A. (2014). *Are the children well? A model and recommendations for promoting the mental wellness of the nation’s young people*. Robert Wood Johnson Foundation.

Another key initiative developed by SB 11 and assigned to the Consortium is the Texas Health Child Access through Telemedicine (TCHATT) program, which expands telemedicine or telehealth programs for identifying and assessing mental health needs and providing access to mental health care services. State funding supports these telemedicine and telehealth connections in schools. In the first year, TCHATT will utilize existing telemedicine and telehealth programs; in the second year, it will expand by establishing new programs. TCHATT will be implemented by UT Southwestern Medical Center in partnership with Children's Health.

Component 2: Specialty Outpatient Care



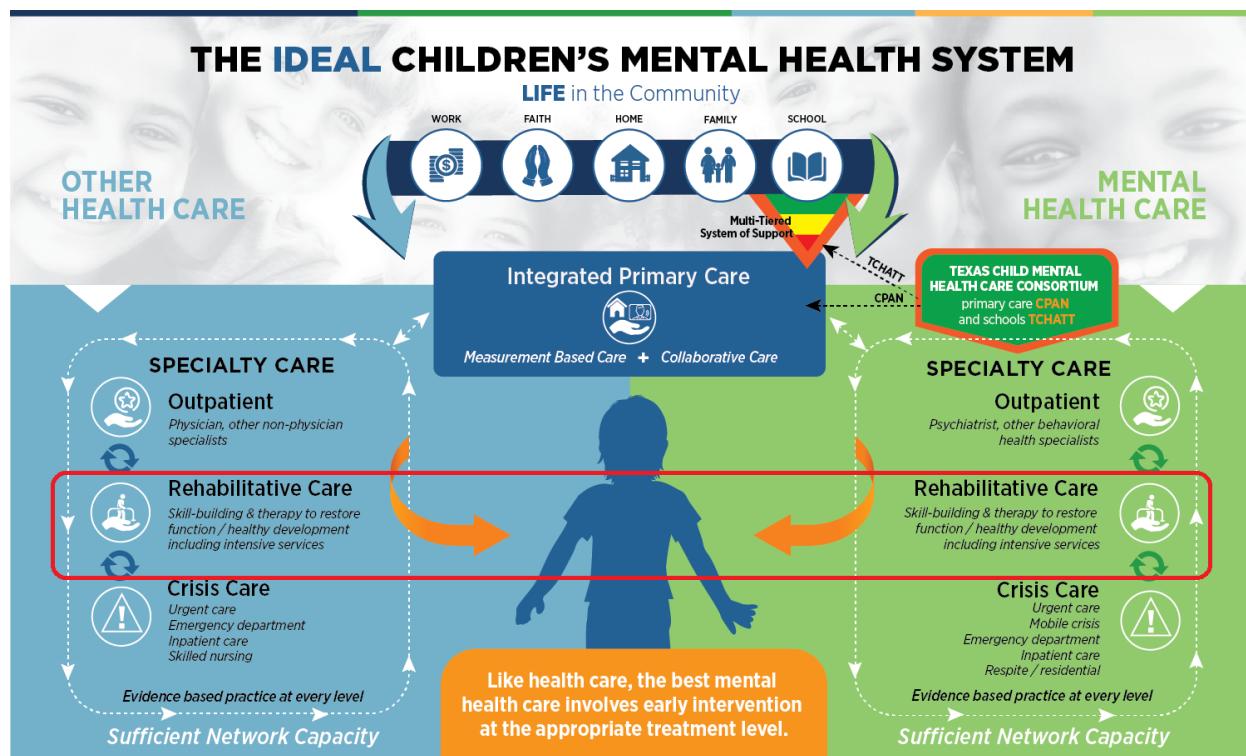
Some conditions (including psychiatric and other illnesses) require specialized interventions by providers located in separate clinical settings. Such services are the focus of specialty outpatient mental health care, the next component of the framework. In our framework, rather than being the primary treatment source of the delivery system — as is often the case today — only about one fourth of all children and youth with mental health conditions would actually need this level of specialty outpatient care. Anxiety and routine depression can be readily treated in integrated primary care settings, but specialists are needed to treat more complex depression, bipolar disorder, posttraumatic stress disorder, and other conditions that require specialized interventions. Our framework would shift a large portion of the population (those with mild to moderate mental health conditions) from over-burdened specialty outpatient mental health care settings to integrated primary care settings, allowing specialists to focus on

children and youth with more severe conditions, and re-allocating scarce resources to serve the children and youth with more intensive needs.

Providers of specialty outpatient mental health care include psychiatrists, psychologists, social workers, nurse practitioners, marriage and family therapists, professional counselors, and chemical dependency counselors in private practice, outpatient clinics, counseling centers, and school-based clinics that offer mental health services. These settings should provide individual, family, and group therapies, including a range of evidence-based, office-based treatments such as cognitive therapies (e.g., cognitive behavioral therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Dialectical Behavior Therapy). For more information, Appendix C describes a wide range of evidence-based and other best practices.

Specialty outpatient mental health care in this framework focuses just as much on parents and caregivers as it does on children and youth, as it is important for families to participate in treatment so that they are supported in creating an adaptive environment for their children. Coordination with primary care providers is essential because psychiatric conditions complicate treatment of other illnesses (e.g., diabetes). In addition, coordination with schools ensures that services that are provided are linked to and supported in the school setting. For example, Uplift Education (Uplift) partners with community organizations to fill resource and program needs within its district. Uplift partners with organizations in multiple ways, including vetted referral sources, one-time presentations, and multi-week on-campus programs. Uplift develops memorandums of understanding with community providers who offer programs and services on-campus. Uplift also maintains a list of vetted community resources and referrals to share with students and their families. Coordinating with community providers allows Uplift staff to ensure that families are aware of the appropriate referral process so that children and youth can access the care they need.

Component 3: Specialty Rehabilitative Care



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 condition. In the same way that a catastrophic orthopedic injury might require a child to re-learn to walk or carry out other routine activities of life, a severe psychiatric condition that impedes functioning (e.g., a psychosis, untreated depression) may require specialty rehabilitative care to treat the underlying condition as well as restore healthy functioning at home, in school, and around the community. Children, youth, and their families with intensive needs require:

- A continuum of specialty rehabilitative care that includes skill-building and therapeutic interventions for the child or youth, their family, and coordination with the systems in which they function in order to help those systems accommodate the needs of the child; and
- A treatment team that engages, coordinates, and supports the school in developing intervention planning tailored to that student's unique mental health needs while in the educational setting.
 - A school liaison function also plays an important role here and can help link children, youth, and families in need of intensive services to providers that offer specialty rehabilitative care.

A subset of these children, youth, and families with intensive needs will require even more support. We estimate that one in ten of these children and youth (1% of all children and youth with mental health needs) require time-limited, intensive mental health services:

- For older adolescents first experiencing psychosis, the best evidence-based intervention — Coordinated Specialty Care (CSC) — involves about two years of intensive outpatient treatment that combines effective medication, education, and skill-building for the youth and their family, encouraging them to maintain school enrollment and continue on (or regain) a healthy developmental track, as well as providing support to the youth's school or work setting in developing accommodations tailored to the youth's symptoms. There are currently 23 local mental health authorities throughout Texas that provide this service. In Dallas County, Metrocare has two teams that provide this service for youth and young adults ages 15 to 30.
- For children and youth involved in the juvenile justice system who exhibit severe externalizing symptoms (e.g., classroom disruption, angry outbursts, defiance) related to untreated/inadequately treated depression or anxiety disorders (perhaps related to trauma), a three to seven month regimen of Functional Family Therapy (FFT) or Multisystemic Therapy (MST) would offer the most effective treatment and achieve the best outcomes.
- For children and youth who are receiving child welfare services, foster care models such as Treatment Foster Care Oregon (formerly Multidimensional Treatment Foster Care) have demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for adolescents who struggle with chronic antisocial behavior, emotional disturbances, and delinquency. Treatment Foster Care Oregon emphasizes instruction in interpersonal skills and participation in positive social activities, including sports, hobbies, and other forms of recreation. Placement lasts about six months and aftercare services remain in place as determined by need and parent request, but they typically last about one year.

Intensive Home and Community-Based Evidence-Based Practices

- **Functional Family Therapy**
- **Intensive In-Home Child and Adolescent Psychiatric Services**
- **Treatment Foster Care Oregon**
- **Multidimensional Family Therapy**
- **Multisystemic Therapy**
- **Wraparound Facilitation**
- **Coordinated Specialty Care for First Episodes of Psychosis**

Sometimes a child or youth's needs are so complex that the treatment providers and child-serving agencies involved in their life (e.g., child welfare, special education, juvenile justice) are unable to identify the best treatment option for the child and family. In these cases, wraparound care coordination is necessary to help the family and involved parties pinpoint

critical needs and determine the best path forward.⁴⁴ Although wraparound is not a treatment modality, it is an essential care coordination support for the relatively small subset of children, youth, and families with particularly complex conditions and multi-agency involvement whose needs cannot be adequately met through discrete services.

Based on the best prevalence data available, we estimate that about one in ten children and youth with mental health needs requires a combination of specialized intervention and functional rehabilitation, and one in 75 requires intensive interventions. Appendix C describes the full array of intensive, evidence-based rehabilitation treatments. The Mental Health Systems Framework for Children and Youth comprises a continuum of rehabilitation options to match services to the needs of each child, youth, and family, such as home and community-based skill-building and services. In general, these services are provided directly in the child or youth's home and community. Specialty rehabilitative services are provided to children and youth at higher risk for out-of-home placement because of mental health issues or who have returned or are being discharged home from residential treatment centers or psychiatric hospitals.

The intent of these services is to provide the level, or dose, of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental trajectory within their home and community. Treatment and support services are provided in a context that is child-centered, family-focused, strengths-based, culturally competent, and responsive to each child's psychosocial, developmental, and treatment needs. When services can be provided in the home and community setting, the clinical team has the opportunity to observe the family home; identify what is important to the child/youth and family; understand the roles of language, culture, and religion; and consider whether extended family or friends are available to support the child or youth. The team can also gain information about the family's general welfare and whether the family has enough food, clothing, and other key resources that enable children to thrive. The clinical team is then able to connect the child/youth and family to resources and additional services based on what they observe.

Screening is particularly essential during the onset of severe mental illness, especially when a youth or young adult initially displays psychotic symptoms, such as hearing voices or experiencing other hallucinations or delusions. Referred to as "first episode psychosis" (or FEP) in medical terms, these symptoms most frequently occur during adolescence and in young adulthood. Many youth go untreated during these years. Services are most effective if they are

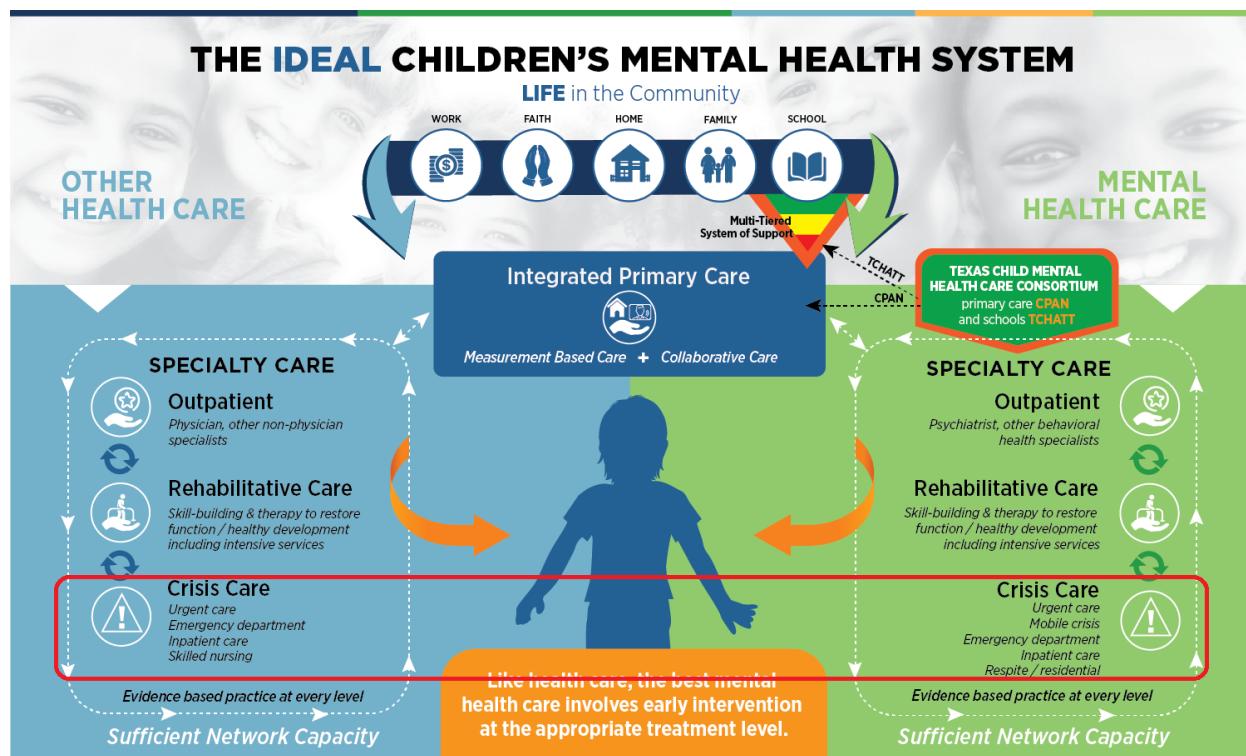
⁴⁴ Currently, the Texas Medicaid program requires wraparound service coordination for all children and youth receiving intensive home and community-based services. While the principles of wraparound should inform all intensive treatment, the evidence suggests that a wraparound facilitator and formal wraparound plan is only needed when the needs are so complex that a given type of care (e.g., CSC, FFT, or MST) is not sufficient.

initiated early in the development of mental health conditions. Treatment and early identification of mental illness for youth ages 15 and older has the potential to radically alter their developmental trajectory and their illnesses, promoting recovery without multiple hospitalizations and loss of education and skills development. Universal screening in integrated care settings, including schools, promotes early detection for children and youth who can then be connected to appropriate services. Those who are identified as having serious or complex conditions would receive the intensive services they need early on, rather than potentially deteriorating because of a lack of appropriate support and intervention in lower levels of care.

As noted earlier in this section, specialty rehabilitative care in Dallas County currently is limited to the public sector, just as it is throughout Texas and much of the rest of the nation. These services are generally available only through the local behavioral health authority — North Texas Behavioral Health Authority (NTBHA) — and the providers it contracts with as well as Medicaid providers credentialed by the Health and Human Services Commission (HHSC). The current system has very limited evidence-based treatment options, particularly for specialty rehabilitation services like CSC, MST, and FFT, which are effective alternatives to more restrictive settings such as hospitals, residential treatment centers, and juvenile justice facilities.

The Mental Health Systems Framework for Children and Youth details a vision for the future of Dallas County that would emphasize screening and early intervention; broaden access to specialty rehabilitative care beyond the public system; expand evidence-based, intensive service options in the community; and allow many children and youth who are currently relegated to intermittent episodes of inpatient psychiatric care and residential treatment services to shift to more effective home and community-based services.

Component 4: Crisis Care



As noted earlier in this report, children and youth across Texas and the nation currently end up in inpatient care and residential treatment all too often. These levels of care are not appropriate for ongoing treatment — they are specialized settings designed to address either acute needs (inpatient care) or an inability to reside at home (residential treatment). We also discussed under Component 3 how intensive, evidence-based treatment can reduce the need for inpatient and residential care. Therefore, in our framework, the goal is to use inpatient or residential treatment only in cases where safety concerns, combined with a lack of effective alternatives, requires it (similar to the role that skilled nursing care plays for children and youth with other complex medical conditions).

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

Yet evidence-based, intensive treatment is not enough. The most effective systems of care for children and youth, such as the renowned system in Milwaukee, Wisconsin, recognize that crises routinely happen during the course of care — arguments escalate, over-taxed caregivers require respite, and threats to self or others require a medical response. Our framework, therefore, requires a crisis care continuum that includes mobile teams. These teams would respond to a range of urgent needs that occur outside of normal business hours and treatment

environments as well as to situations where there is a risk of an inpatient hospital admission. This continuum also requires a range of available placement options, ranging from crisis respite to acute inpatient care.

In 2016, we collaborated with St. David's Foundation to publish a report that defined the continuum of crisis services⁴⁵ and outlined the essential values for crisis services as promoted by the Substance Abuse and Mental Health Services Administration (SAMHSA) practice guidelines.⁴⁶ These values and guidelines emphasize the following five elements: rapid response, safety, crisis triage, active engagement of the individual in crisis, and reliance on natural supports. A crisis care continuum for children and youth within our framework goes even further to include the following service components.

- A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee's Mobile Crisis Team);⁴⁷
- 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 telephone supports; and
- An array of crisis placements tailored to the needs and resources of the local systems 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),
 - Crisis stabilization (15 to 90 days) with capacity for one-to-one supervision,
 - Acute inpatient care, and
 - Linkages to a full continuum of empirically supported practices.

While this entire array does not currently exist in any county in Texas, some components exist in Dallas County within the mental health, child welfare, and juvenile justice systems, but they

⁴⁵ Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services. A component of the continuum of care*. Commissioned by St. David's Foundation.

⁴⁶ Substance Abuse and Mental Health Services Administration. (2009). *Practice guidelines: Core elements in responding to mental health crises*. Office of Consumer Affairs, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. <https://store.samhsa.gov/system/files/sma09-4427.pdf>

⁴⁷ For more information, see Wraparound Milwaukee. (n.d.). *Children's mobile crisis team*. <http://wraparoundmke.com/programs/mutt/>

are not well coordinated or conceptualized as a single crisis system. This deficiency leads to redundancies that prevent children and youth from getting the right services at the right time. Improving care delivery during crises would allow Dallas County to make the best of its current system, which relies on limited home and community-based services, inpatient services, and other high-cost resources.

This reality highlights the critical need to build a coordinated crisis response system across all payers. While many of the necessary pieces are already in place, transformation and expansion requires a will to develop a more comprehensive system and supportive payment protocols. The crisis care continuum for Dallas County could more closely align with the framework by developing and implementing a broader array of crisis intervention services aimed at supporting families and caregivers, schools, children, and youth across child-serving agencies. Although there is evidence of collaboration among different providers in the current service delivery systems (e.g., mental health, juvenile justice, child welfare), the various available crisis programs are designed to help individual target populations within each specific system. The long-term goal should be to build an organized county-wide “crisis system” capable of responding across the various service delivery systems. This could ease the navigation challenges experienced by families and caregivers. The crisis array should, ideally, be jointly funded across all payers (e.g., state, Medicaid, child welfare, juvenile justice, local, private) to better coordinate access, identify gaps in services, avoid duplication of services, and avoid silos that occur when each funding stream supports separate crisis care continuums.

Even when a full continuum of nonresidential crisis options is in place, some children and youth will still need inpatient care for acute and complex needs. As discussed earlier, although inpatient psychiatric care is not a substitute for ongoing, well-coordinated outpatient mental health care, it is an important piece of the crisis care continuum. Inpatient psychiatric hospitalizations can be helpful for acute stabilization of children and youth with complex needs, such as safety concerns or medication adjustments that require close medical monitoring. These hospitalizations should be available when needed, but generally should be brief and supported by the broader crisis array and system. For example, short-term placement in crisis foster or residential care can divert children and youth with less intense needs from inpatient settings as well as provide step-down support as they transition home from these settings. Intensive community-based services and supports can also help children, youth, and their caregivers make the transition back home after a hospitalization. In our framework, inpatient care in Dallas County would be targeted to children and youth who need this level of care rather than to children and youth with serious mental health conditions who are in crisis and simply have no place else to go.

Residential treatment represents another component of the crisis care continuum for children and youth. It is designed for children and youth whose behavior cannot be managed safely in a less restrictive setting. Residential treatment is one of the most restrictive mental health service settings provided to children and youth. As such, it should be reserved for situations where less restrictive placements are not appropriate, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who may not respond to intensive, nonresidential service approaches.⁴⁸ Across Texas and nationally, children and youth are too often placed in residential treatment because more appropriate, less restrictive community-based services are not available. When they are utilized, residential services should be brief, intensive, family-focused, and as close to home as possible. In our framework, intensive home and community-based services and other specialty rehabilitation skill-building services in Dallas County would be available sooner after a child or youth receives a mental health diagnosis to prevent out-of-home placement, except when such services cannot be safely provided.

We will return to these and other components of our Mental Health Systems Framework for Children and Youth throughout this report. In our final set of recommendations, we will present several “game-changers” to begin to shift current Dallas County mental health systems for children, youth, and families toward this framework.

How Many Children and Youth in Dallas County Have Mental Health Needs?

This section provides an overview of the prevalence of mental health conditions among children and youth living in Dallas County. We also briefly describe some of the factors that have an impact on the mental health of children and youth, including trauma and poverty.

Overall, two in five children and youth (ages six to 17 years) face mental health and substance use disorders each year.⁴⁹ Among children and youth with these diagnoses, individual needs vary in intensity from very mild to extremely acute and severe. To revisit the analogy to orthopedic care used earlier in this report, although many children and youth sprain or break their arms and legs each year, only a much smaller number suffer catastrophic injuries and traumas that necessitate rehabilitation to regain functioning. In the same way that our health

⁴⁸ 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. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

⁴⁹ Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of 12-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62, 617–709.

Kessler, R. C., et al. (2012). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication-Adolescent Supplement. *Archives of General Psychiatry*, 69, 372–380.

care systems focus on specific conditions and severity of injury to determine the level of intervention, our mental health systems should also consider condition, severity, and developmental level in determining an appropriate course of treatment for children and youth. It is important to assess if a child has a routine anxiety disorder or depression, which can be treated in an integrated primary care setting, or a more severe condition that requires specialized or intensive treatment.

To determine prevalence, we used the best available epidemiological research to provide estimates of the number of children and youth up to age 18 with mental health needs in Dallas County. As shown in Table 1 on the next page, approximately 180,000 of 460,000 (39%) Dallas County children and youth have mental health needs. The majority of these individuals have conditions that are mild to moderate in severity, while 35,000 have serious emotional disturbances (SED).

Table 1 also includes estimates of the number of children and youth who are expected to be living with specific mental health conditions at any given time. While the total number of children and youth with a mental health need may seem high, up to two thirds of children and youth with mild to moderate needs can be served by the integrated primary care models discussed throughout this report, allowing communities and health systems to focus their specialty outpatient resources on the subset of children and youth with more severe needs. Finally, the table also includes the number of children and youth with adverse childhood experiences (ACEs). Examples of ACEs include experiences of abuse or neglect, having incarcerated parents, and witnessing intimate partner violence, substance misuse, or mental illness within the home.

Table 1: Prevalence of Mental Health Disorders in Children and Youth in Dallas County (2017)⁵⁰

Mental Health Condition — Children and Youth	Age Range	Dallas County ⁵¹
Total Population	6–17	460,000
Population in Poverty ⁵²	6–17	260,000
All Mental Health Needs (Mild, Moderate, and Severe)⁵³	6–17	180,000
Mild	6–17	100,000
Moderate	6–17	40,000
Severe — Serious Emotional Disturbance (SED) ⁵⁴	6–17	35,000
SED in Poverty	6–17	25,000
At Risk for Out-of-Home/Out-of-School Placement ⁵⁵	6–17	2,000
Specific Disorders – Youth⁵⁶		
Depression	12–17	20,000
Bipolar Disorder	12–17	5,000
Posttraumatic Stress Disorder	12–17	9,000
Schizophrenia ⁵⁷	12–17	500

⁵⁰ All Texas prevalence and population estimates were 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

⁵¹ All Texas prevalence and population estimates were 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

⁵² “In poverty” refers to the estimated number of people living below 200% of the federal poverty level for the specified region.

⁵³ 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. 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.

⁵⁴ Local prevalence of SED were drawn from: Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Meadows Mental Health Policy Institute.

⁵⁵ We estimate 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.

⁵⁶ Unless otherwise specified, local prevalence estimates of specific mental health conditions among youth were drawn from the 12-month prevalence rates reported in 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(4), 372–380.

⁵⁷ Local prevalence estimates of schizophrenia are drawn from the 12-month prevalence rates reported in Androullos, C. (2012). Schizophrenia in children and adolescents: Relevance and differentiation from adult

Mental Health Condition — Children and Youth	Age Range	Dallas County ⁵¹
First Episode Psychosis (FEP) Incidence — New Cases per Year ⁵⁸	12–17	80
Obsessive-Compulsive Disorder — Children/Youth ⁵⁹	6–17	9,000
Eating Disorders ⁶⁰	12–17	2,000
Self-Injury/Harming Behaviors ⁶¹	12–17	20,000
Conduct Disorder	12–17	10,000
Number of Deaths by Suicide (2017) ⁶²	0–17	17
Specific Disorders – Children Only		
All Anxiety Disorders — Children	6–11	25,000
Depression/All Mood Disorders — Children	6–11	2,000
Children and Youth with Adverse Childhood Experiences (ACEs)⁶³		
Population with 1 or 2 ACEs	0–17	250,000
Population with 3 or More ACEs	0–17	70,000

schizophrenia. *Psychiatriki*, 23(Supl), 82–93 (original article in Greek). Androutsos estimates that among youth ages 13–18, 0.23% meet criteria for the diagnosis of schizophrenia.

⁵⁸ Local incidence estimates of first episode psychosis were drawn from the 12-month prevalence rates reported in Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry*, 174, 2.

⁵⁹ Local prevalence estimates of obsessive-compulsive disorders were drawn from the 12-month prevalence rates reported in 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 sample. *Journal of the American Academy of Child and 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 and Adolescent Psychiatry*, 34(11), 1424–1431.

⁶⁰ Local prevalence estimates of eating disorders were drawn from the 12-month prevalence rates reported in Swanson, S. A., 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 estimates for eating disorders encompasses only anorexia nervosa and bulimia nervosa.

⁶¹ Local prevalence estimates of self-harming and self-injury behaviors were drawn from the 12-month prevalence rates reported in 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*, 6(11). <https://doi.org/10.1186/1753-2000-6-10>

⁶² Death by suicide data were obtained from the Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2017 on CDC WONDER Online Database. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 are suppressed using values of “<10.”

⁶³ Local prevalence estimates of adverse childhood experiences were drawn from state-level 12-month prevalence rates reported in Sacks, V., Murphrey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Child Trends. https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

While these data are important, strictly reviewing prevalence data does not paint the full picture of need. As noted earlier, mental health conditions are often complicated by other factors, including the following:

- **Families in poverty face additional challenges related to transportation and other social determinants of health.** Economic stability, education, health, access to health care, and the social and community context in which children and youth live and grow all affect health, development, and morbidity.⁶⁴
- **ACEs can have lasting, negative effects on physical and emotional well-being.** In the last decade, we have learned that abuse and trauma fall along a continuum of ACEs, a range of traumatic and stressful events that take place in childhood and include, in addition to abuse and neglect, other toxic exposures such as witnessing crime, parental conflict, incarceration of a caregiver, and familial mental illness and substance use.⁶⁵ These stressful and traumatic events can affect a child and youth's behavior, health, and learning and are correlated with a range of health problems throughout life, including substance use, mental health, and physical health conditions.⁶⁶ Children and youth who experience three or more ACEs are at a much higher risk for all of these conditions later in life.
- Most children and youth in foster care have experienced ACEs or trauma as a result of disruptions in their family life, abuse and neglect, separation from home and siblings, school changes, and multiple foster placements. Children and youth in foster care experience an elevated incidence of developmental delays (25% in some age groups) and high rates of posttraumatic stress disorder (up to 25%). Over 80% of youth aging out of foster care have received a psychiatric diagnosis at some point.⁶⁷

⁶⁴ Office of Disease Prevention and Health Promotion. (n.d.). *Healthy people 2020*.
<https://www.healthypeople.gov/2020/topics-objectives/topic/social-determinants-health/interventions-resources>

⁶⁵ Substance Abuse and Mental Health Services Administration. (2018). *Helping Children and Youth Who Have Traumatic Experiences*.
https://www.samhsa.gov/sites/default/files/brief_report_natl_childrens_mh_awareness_day.pdf

⁶⁶ Substance Abuse and Mental Health Services Administration. (2014, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. HHS Publication No. (SMA) 14-4884. SAMHSA's Trauma and Justice Strategic Initiative. <https://store.samhsa.gov/system/files/sma14-4884.pdf>

⁶⁷ American Academy of Pediatrics. (2015). *Helping foster and adoptive families cope with trauma*.
<https://www.aap.org/en-us/advocacy-and-policy/aap-health-initiatives/healthy-foster-care-america/Documents/Guide.pdf> as cited in Salisbury A. L., Ponder, K. L., Padbury, J. F., Lester, B. M. (2009). Fetal effects of psychoactive drugs. *Clinics in Perinatology*, 36(3), 595–619.

Greeson, J. K., et al. (2011). Complex trauma and mental health in children and youth placed in foster care: Findings from the National Child Traumatic Stress Network. *Child Welfare*, 90(6), 91–108.

Salazar A. M., Keller, T. E., Gowen, L. K., & Courtney, M. E. (2012). Trauma exposure and PTSD among older youth in foster care [published online ahead of print August 17, 2012]. *Social Psychiatry and Psychiatric Epidemiology*, 48(4). <https://doi.org/10.1007/s00127-012-0563-0>

- **Children and youth of color are at higher risk of living in poverty and experiencing its negative effects on mental health.** Though race and ethnicity alone are not correlated with significant differences in the prevalence of mental health conditions, the effects of poverty are. In Dallas County, over 83% of children and youth age six to 17 identify with a race/ethnicity other than White. Of all children and youth living in poverty, 92% represent a race/ethnic category other than White, with Latino and Hispanic children and youth representing the majority of Dallas County children and youth living in poverty.⁶⁸
- **Exclusionary school discipline (suspension and expulsion) is among the strongest correlates of future involvement in the juvenile justice system.** This “school-to-prison pipeline” first manifests in the classroom. When combined with zero-tolerance policies, a decision to refer students for discipline rather than treatment can perpetuate a sequence through which students are pushed out of the classroom and placed at higher risk for entry into the juvenile justice system. Research clearly shows that a student suspended from 9th grade has three times the risk of future incarceration and two times the risk of dropping out, compared to other students.⁶⁹ This is not because suspensions increase the risk, but because the underlying factors (including untreated or inadequately treated mental illness) that lead to the suspension increase the odds of future incarceration or dropping out if left unaddressed. Students are also far more likely to be arrested at school than they were 10 years ago. This is in part related to the increased police presence in schools over that period. While the increase has been driven in part by safety concerns, the vast majority of arrests are for nonviolent offenses such as classroom disruption.⁷⁰ Being disruptive must be addressed, but so-called “zero-tolerance” policies, which set one-size-fits-all punishments for a wide range of behaviors, underlie these trends.⁷¹

We know that poverty can limit access to health care, education, affordable housing, healthy foods, and other social determinants of health that have an impact on health and development.

⁶⁸ Local prevalence of SED were drawn from: Holzer, C., Nguyen, H., & Holzer, J. (2017). *Texas county-level estimates of the prevalence of severe mental health need in 2017*. Meadows Mental Health Policy Institute.

⁶⁹ Balfanz, R., Byrnes, V., & Fox, J. (2013). *Sent home and put off-track: The antecedents, disproportionalities, and consequences of being suspended in the ninth grade*. Paper presented at the Closing the School Discipline Gap: Research to Practice, Washington, DC. As cited in Losen, D.J. & Martinez, T. (2013). *Out of school and off track: The overuse of suspensions in American middle and high schools*. Center for Civil Rights Remedies at UCLA's Civil Rights Project. http://civilrightsproject.ucla.edu/resources/projects/center-for-civil-rights-remedies/school-to-prison-folder/federal-reports/out-of-school-and-off-track-the-overuse-of-suspensions-in-american-middle-and-high-schools/OutofSchool-OffTrack_UCLA_4-8.pdf

⁷⁰ Petteruti, A. (2011, November). *Education under arrest: The case against police in schools*.
<https://www.ncjrs.gov/App/Publications/abstract.aspx?ID=264688>

⁷¹ Petteruti, A. (2011, November).

Because families living in poverty face additional challenges in accessing outpatient mental health treatment services (e.g., transportation barriers), and because most of the providers we included in this assessment serve people with reduced ability to pay for services, it is particularly critical to address the needs of the population of children and youth with SED who are living in poverty. In Dallas County, we estimate that there are about 25,000 of children and youth with SED living in poverty, which we defined as the number living in a household with incomes at or below 200% of the federal poverty level. The most severe mental health conditions — those that increase risk of placement outside of the home or school — are estimated to affect approximately 2,000 young people in the Dallas community who are living in poverty. By comparing these prevalence estimates to the counts of children and youth served by local community agencies, we are able to estimate the number of children and youth who are not receiving appropriate care.

The data presented in Table 2 on children and youth served in community settings (including integrated primary care and specialty outpatient mental health care) are particularly valuable in assessing how well available services in Dallas County can address the local need. Of the approximately 180,000 children and youth with mental health conditions, we estimate that 120,000 can be adequately managed in integrated primary care settings, while about 60,000 require specialty outpatient settings for more serious conditions (45,000 would need routine specialty outpatient behavioral health care, and about 20,000 would need specialty rehabilitative care). Of these 60,000 children and youth needing care in specialty outpatient settings, 25,000 are also living in poverty, including 2,000 with the most severe needs that may result in out-of-home or school placement if not adequately treated.

Table 2, on the next page, provides additional estimates of the prevalence of children and youth with SED living in poverty, broken down further by race/ethnicity.

- There are nearly half of a million children and youth between the ages of six and 17 years living in Dallas County, the majority of whom are Hispanic or Latino (260,000), followed by African American (100,000) then Non-Hispanic White (75,000).
- About half (260,000) of the children and youth living in the region live in poverty.
- Rates also vary by demographic group: About 70% of Hispanic or Latino children live in poverty (170,000 out of 240,000), compared to about 30% (20,000 out of 75,000) of Non-Hispanic White children.

This is particularly relevant information when considering the location of outpatient services. Since a higher number of children and youth of color live in poverty, it is important for providers to understand the demographics and needs of the populations they serve, particularly when considering the cultural appropriateness of services, including representing the community's ethnicity/race in hiring practices and implementing evidence-based practices

(EBPs). We provide maps in this report that highlight geographic locations with high concentrations of children and youth living in poverty. Because of the correlation between race/ethnicity and poverty, these same locations will also have concentrations of children and youth of color who would have the greatest need for access to outpatient and home and community-based mental health services.

Table 2: Demographics of Children and Youth in Dallas County (2017)⁷²

Dallas County	Total Population	Total Population with SED	Total in Poverty ⁷³	Total with SED in Poverty
Children and Youth (6–17)	460,000	35,000	260,000	25,000
Age				
Ages 6–11	240,000	20,000	140,000	15,000
Ages 12–17	220,000	15,000	120,000	10,000
Sex				
Male	230,000	20,000	130,000	10,000
Female	220,000	20,000	130,000	10,000
Race/Ethnicity				
Non-Hispanic White	75,000	5,000	20,000	2,000
African American	100,000	8,000	55,000	5,000
Asian American	20,000	2,000	7,000	600
Native American	600	50	300	30
Multiple Races	10,000	900	5,000	400
Hispanic/Latino	240,000	20,000	170,000	15,000

⁷² All Texas 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

⁷³ “In poverty” refers to the estimated number of people living below 200% of the federal poverty level for the specified region.

As Table 3 shows, based on utilization data we received from community providers and the North Texas Behavioral Health Authority (NTBHA):

- Just 11,144 children and youth have received mental health care in integrated primary care settings — this represents about 10% of the estimated 120,000 children and youth in need who could be treated in integrated primary care settings.⁷⁴
- Of the estimated 60,000 Dallas County children and youth that need specialized outpatient behavioral health care, just over half (55%, 33,882) have received it.
- Of the estimated 25,000 children and youth with mental health needs who live in poverty, approximately 49% received ongoing behavioral health specialty outpatient care through NTBHA.
- Just 14% of the estimated 2,000 children and youth with the most severe needs have received *intensive family services (Mental Health Rehabilitative Services, Targeted Case Management, and YES Waiver services)*.

Table 3: Outpatient Need Versus Treatment Received — Dallas County (2017)⁷⁵

Mental Health Provider Type	Number in Need	Number Served ^{76, 77}	Percentage of Need Met ⁷⁸
Integrated Primary Care	120,000 ⁷⁹	11,144	10% ⁸⁰

⁷⁴ We estimate that approximately 110,000 to 120,000 children and youth can be served in integrated care. When compared to the 11,144 served, we estimate that about 9% to 10% of need is met in integrated care. In order to be conservative in our estimate and not overestimate unmet need, we report that 10% of need is met through integrated care.

⁷⁵ All Texas prevalence and population estimates were 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

⁷⁶ Providers submitted one year of utilization data using the most recent complete year that they had available. Some providers submitted data for a partial year – in these cases, we multiplied the number of children and youth served in that time period by the appropriate amount to estimate the number served in a full year.

⁷⁷ The NTBHA utilization data reflects the entire local mental health authority catchment area in 2017: Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall counties. Of all children and youth in this region who are living with SED and are in poverty, 89% reside in Dallas. Thus, we estimate that approximately 89% of the utilization in the NTBHA region is by Dallas County residents.

⁷⁸ Percentages were calculated using unrounded estimates of the number in need and may not match calculations that used rounded estimates.

⁷⁹ We estimate that approximately two out of every three children with mental health needs have conditions that can be successfully managed in an integrated primary care setting. This translates to 110,000 to 120,000 children and youth.

⁸⁰ We estimate that approximately 110,000 to 120,000 children and youth can be served in integrated care settings. When compared to the 11,144 served, we estimate that about 9% to 10% of need is met in integrated care. In order to be conservative in our estimate not to overestimate unmet need, we report that 10% of need is met through integrated care.

Mental Health Provider Type	Number in Need	Number Served ^{76, 77}	Percentage of Need Met ⁷⁸
Specialty Outpatient Mental Health Care	60,000⁸¹	33,882	55%
Children and Youth in Poverty Needing Specialty Outpatient Mental Health Care	25,000 ⁸²	11,439 ⁸³	49%
Intensive Services	2,000 ⁸⁴	317	14%

Finally, Table 4 below shows the projected number of children and youth in Dallas County in five-year increments through the year 2050, alongside the percentage of change from the population in 2017. These increases in percentage represent the additional service capacity that is needed to fill gaps in care *beyond current gaps*. The timing of projected population growth would allow the possibility of adding capacity before additional need creates larger gaps in care.

Table 4: Estimated Population Projections of Children and Youth in Dallas County — 2017 through 2050^{85, 86}

Year	Children Ages 6 to 11		Youth Ages 12 to 17		All Children and Youth	
	Population	Percentage of Change from 2017	Population	Percentage of Change from 2017	Population	Percentage of Change from 2017
2017	237,162		218,825		455,987	
2020	240,861	2%	228,099	4%	468,960	3%

⁸¹ We estimate that one out of three children with mental health needs requires specialty outpatient behavioral health care to adequately manage their condition. This equates to 60,000 children and youth, including 45,000 needing routine specialty outpatient care and approximately 20,000 needing specialty rehabilitative care.

⁸² This estimate was developed using the prevalence of children and youth with serious emotional disturbance who are also living in poverty.

⁸³ This calculation is based on the number of children and youth served through the local mental health authority (LMHA). This possibly undercounts the number of children and youth served since we do not have estimates of the number of children served through Medicaid by other, non-LMHA providers.

⁸⁴ These are the children and youth with conditions that cause enough impairment that the individual is at risk of out-of-home or -school placement. We estimated 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.

⁸⁵ Estimated 2017 populations were obtained from the 2017 American Community Survey population estimates. Projected population change was obtained from the Texas Demographic Center (2018). *Projections of the population of Texas and counties in Texas by age, sex, and race/ethnicity for 2010 to 2050*.

⁸⁶ All Texas prevalence and population estimates were 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. Estimated values between 1 and 5 are rounded to “<6,” and estimated values between 5 and 9 are rounded to “<10.”

Year	Children Ages 6 to 11		Youth Ages 12 to 17		All Children and Youth	
	Population	Percentage of Change from 2017	Population	Percentage of Change from 2017	Population	Percentage of Change from 2017
2025	253,203	7%	237,382	8%	490,586	8%
2030	263,899	11%	248,071	13%	511,969	12%
2035	274,897	16%	258,146	18%	533,043	17%
2040	285,043	20%	268,209	23%	553,252	21%
2045	296,139	25%	277,933	27%	574,072	26%
2050	310,192	31%	288,401	32%	598,593	31%

Comparing the Dallas County System to the Mental Health Systems Framework for Children and Youth

In this section of the report, we combine the geographic and needs analyses described above with data on provider utilization and capacity (when available) across the entire Dallas County system. We also compare utilization to the capacity and distribution of the main types of services available for each of the five components of the Mental Health Systems Framework for Children and Youth (framework) described in the first section of this report, including treatment in integrated primary care settings, specialty outpatient mental health care (including treatment provided through the local behavioral health authority), intensive rehabilitative and residential care, crisis care/emergency room utilization for mental health needs, and psychiatric inpatient hospitalization.⁸⁷

Component 0: Dallas County's Capacity in the Community

Who Provides Health Promotion and Prevention Services?

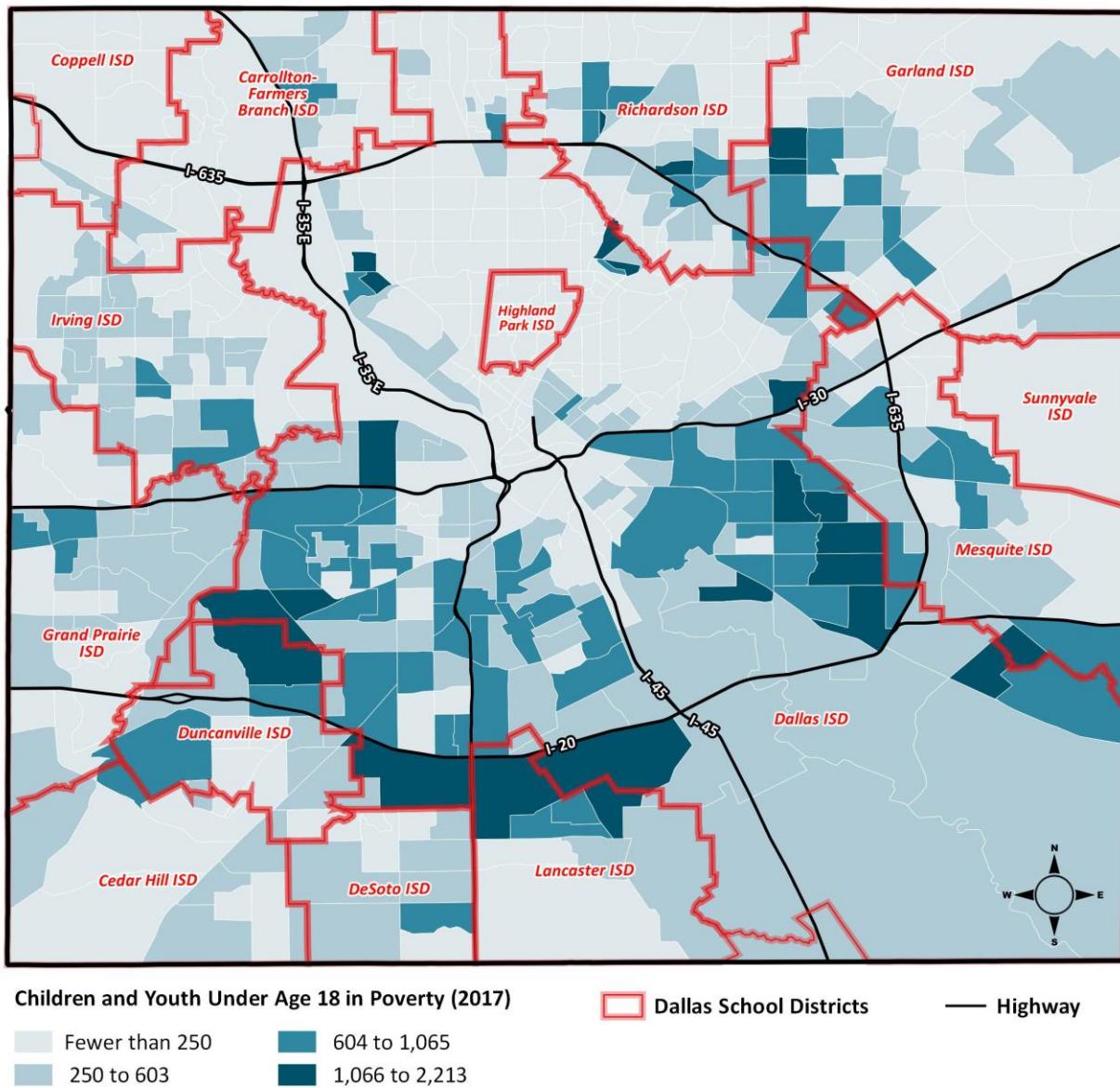
As previously noted, Component 0 refers to community settings where health promotion, prevention, and early detection of mental health needs can occur, as well as supports that serve children, youth, and families with more severe needs in home and community-based programs. Our analysis of Component 0 focuses on schools and school-affiliated providers. Childcare, foster care, and juvenile justice providers are also part of Component 0. While this is not an exhaustive assessment of Component 0 providers in Dallas County, it highlights various community initiatives that fall under this component.

⁸⁷ The utilization data for integrated and specialty outpatient care providers described in this section reflects the most recent 12 months of complete data available from each provider. When only a partial year of data were available, we adjusted it to estimate the number of children and youth served in a 12-month period. Footnotes in each provider section indicate where data were adjusted.

Poverty Across Areas of Dallas County

As highlighted in the previous section, many factors, such as poverty, contribute to the complexity of mental health issues. Map 1, on the next page, presents the number of children and youth living in poverty with an overlay of the ISD boundaries in Dallas County. There are 14 independent school districts (ISDs) and 33 charter schools in Dallas County that serve 513,577 children and youth. Schools are a natural setting to provide access to health and mental health services, but each ISD and school system has a set of local rules and policies to navigate in order to successfully implement school-based or school-linked services. The table that follows (Table 5) shows the percentage of economically disadvantaged students in each ISD or charter school.

Map 1: Children and Youth Living in Poverty, by Census Tract (2017) and Independent School Districts (ISDs)^{88, 89, 90}



⁸⁸ Poverty data were obtained from the United States Census Bureau, American Community Survey 2017 5-Year Estimates. The United States Census Bureau. (n.d.) *B17001: Poverty status in the past 12 month by sex by age – universe: Population for whom poverty status is determined*. <https://factfinder.census.gov>

⁸⁹ Highway shapefile was obtained from the United States Census Bureau, Department of Commerce. (August 2019). *TIGER/Line shapefile, 2017, nation, U.S., primary roads national shapefile*.

<https://catalog.data.gov/dataset/tiger-line-shapefile-2017-nation-u-s-primary-roads-national-shapefile>

⁹⁰ Independent School District boundaries were obtained from the Texas Education Agency Public Open Data Site (April 2019). *Current districts 2018–2019*. <http://schoolsdata2-tea-texas.opendata.arcgis.com>

Table 5: Economically Disadvantaged Students, by Independent School District or Charter School (Dallas County — 2018 to 2019 School Year)⁹¹

Independent School District (ISD) or Charter School	Total Enrollment	Economically Disadvantaged Students	
		Student Count	Percentage of Enrollment
Dallas ISD	155,119	133,697	86%
Garland ISD	55,987	36,283	65%
Mesquite ISD	40,379	31,455	78%
Richardson ISD	39,108	21,708	56%
Irving ISD	33,464	24,959	75%
Grand Prairie ISD	29,200	22,331	76%
Carrollton-Farmers Branch ISD	25,598	16,698	65%
Uplift Education	18,709	15,139	81%
International Leadership Of Texas	18,261	11,548	63%
Coppell ISD	12,925	1,290	10%
Duncanville ISD	12,700	9,935	78%
Desoto ISD	9,404	7,041	75%
Cedar Hill ISD	7,790	5,242	67%
Lancaster ISD	7,348	6,472	88%
Highland Park ISD	6,840	0	0%
Life School	5,704	3,598	63%
Texans Can Academies	5,071	4,250	84%
Trinity Basin Preparatory	3,496	3,150	90%
A. W. Brown Leadership Academy	2,084	1,318	63%
Universal Academy	2,058	648	31%
Sunnyvale ISD	1,882	285	15%
Advantage Academy	1,689	1,301	77%
Golden Rule Charter School	1,532	1,528	100%
A+ Academy	1,409	1,270	90%
Legacy Preparatory	1,390	1,069	77%

⁹¹ Texas Education Agency. (n.d.). *Student program and special populations reports – 2018 to 2019 selected countywide district totals*. <https://rptsvr1.tea.texas.gov/adhoc rpt/adspr.html>

Independent School District (ISD) or Charter School	Total Enrollment	Economically Disadvantaged Students	
		Student Count	Percentage of Enrollment
Inspired Vision Academy	1,353	1,271	94%
Winfree Academy Charter Schools	1,317	713	54%
Village Tech Schools	1,115	453	41%
La Academia De Estrellas	1,096	945	86%
Manara Academy	892	420	47%
Cityscape Schools	878	805	92%
Ume Preparatory Academy	844	298	35%
Evolution Academy Charter School	832	637	77%
Gateway Charter Academy	758	688	91%
Pegasus School Of Liberal Arts & Sciences	676	571	84%
Pioneer Technology & Arts Academy	618	370	60%
Nova Academy Southeast	616	547	89%
Education Center International Aca	595	328	55%
Richland Collegiate High School	592	131	22%
Academy For Academic Excellence	505	505	100%
Academy Of Dallas	487	487	100%
St Anthony School	309	224	72%
Trinity Environmental Academy	298	289	97%
Lumin Education	296	191	65%
Jean Massieu Academy	195	187	96%
Nova Academy	135	124	92%
Bridgeway Preparatory Academy	23	<10	<43%

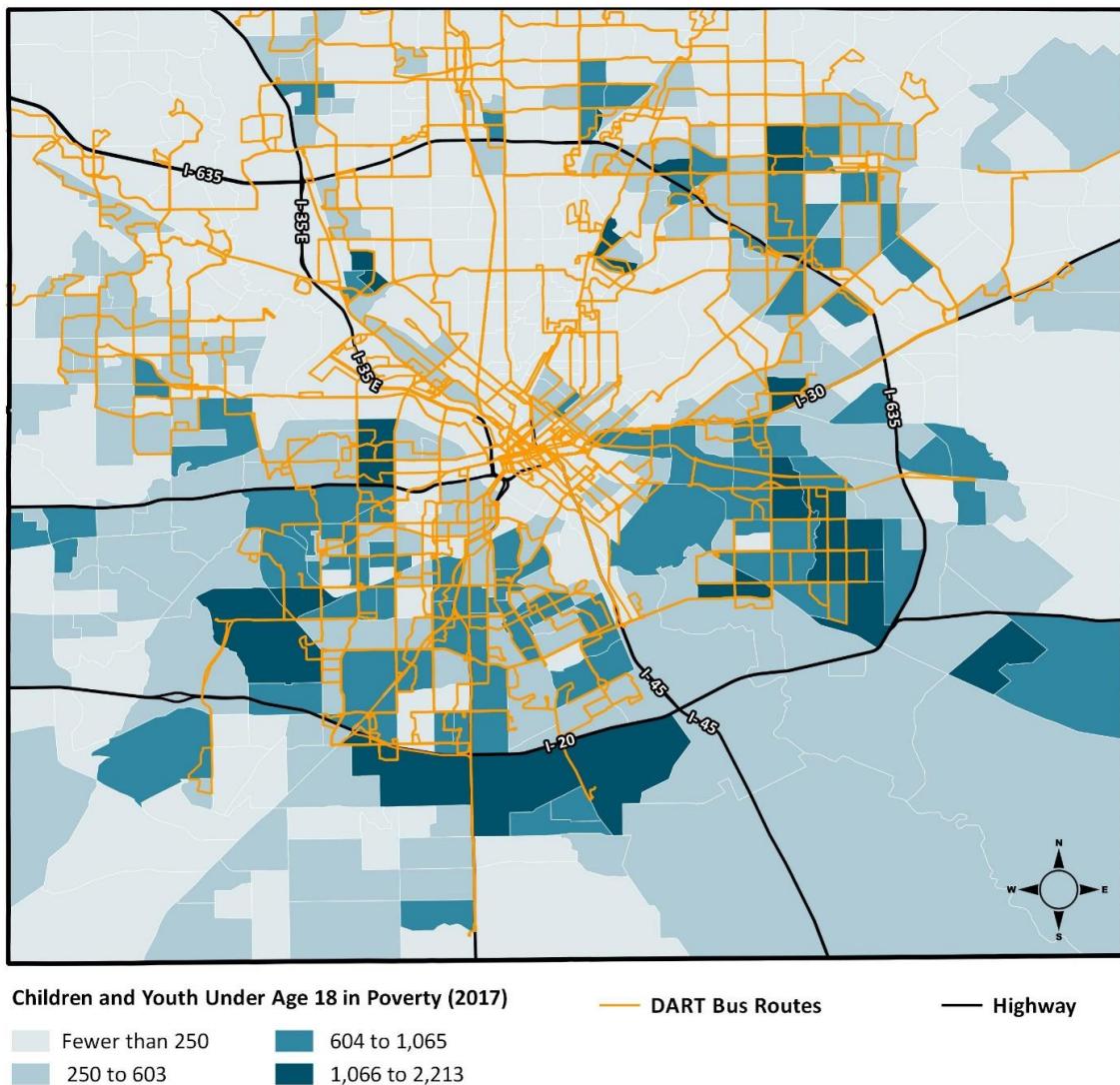
As shown in Map 1 and Table 5 above, the school districts with the highest counts of economically disadvantaged students are Dallas, Garland, Mesquite, Irving, and Grand Prairie. There are three charter schools in Dallas County with 100% of their enrollment comprising economically disadvantaged students — Academy for Academic Excellence, Academy of Dallas, and Golden Rule Charter School. Lancaster ISD and Dallas ISD have the two highest rates of economically disadvantaged students among all of the county ISDs – 88% of students at

Lancaster and 86% of students at Dallas ISD are economically disadvantaged. In contrast, Highland Park ISD has no economically disadvantaged students and Sunnyvale and Coppell ISDs both have 15% or fewer of their student body that is economically disadvantaged.

Finally, Map 2 shows that public transportation routes cover most areas of Dallas County except for far southern and southeastern Dallas, where there is a larger concentration of people living in poverty. As a result of this lack of public transportation, it may be difficult for some residents of these areas to access needed services. This is particularly important for clinic-based outpatient services such as specialty outpatient mental health services that require frequent office visits.

As noted previously, schools, foster care, and juvenile justice service providers have important roles to play in identifying mental health challenges and facilitating connections to mental health care services. Some schools, for example, are able to provide space for service providers on campus, greatly improving access to care for many children, youth, and families, thus alleviating the difficulties that a lack of transportation can create for accessing services.

Map 2: Children and Youth Living in Poverty, by Census Tract (2017) and DART Bus Routes⁹², 93, 94, 95



⁹² Poverty data were obtained from the United States Census Bureau, American Community Survey 2017 5-Year Estimates. The United States Census Bureau. (n.d.) *B17001: Poverty status in the past 12 month by sex by age – universe: Population for whom poverty status is determined*. <https://factfinder.census.gov>

⁹³ Highway shapefile was obtained from the United States Census Bureau, Department of Commerce. (August 2019). *TIGER/Line shapefile, 2017, nation, U.S., primary roads national shapefile*.

<https://catalog.data.gov/dataset/tiger-line-shapefile-2017-nation-u-s-primary-roads-national-shapefile>

⁹⁴ Dallas DART Bus Routes shapefile was obtained from Koordinates. (May 2019). *City of Dallas, Texas DART bus routes*. <https://koordinates.com/layer/101325-city-of-dallas-texas-dart-bus-routes/>

⁹⁵ Although the map only shows Dallas County, DART bus routes extend north into Denton and Tarrant counties as well.

What Are the Education Affiliated Initiatives?

We engaged representatives from Children's Health, Dallas Independent School District (ISD), The Commit Partnership, Grand Prairie ISD, Uplift Education charter school, Education Service Center Region 10, Communities In Schools of the Dallas Region, Momentous Institute, and University of Texas (UT) Southwestern Medical Center's Center for Depression Research and Clinical Care. Although these organizations' and schools' primary focus is on academic success for their students, many have recognized the crucial need for integrating support for students' mental and physical health needs either through partnership with outside providers or development of programming within their own institutions, as described below.

Children's Health

In fall 2017, recognizing that few Texas schools have mental health experts on site, Children's Health implemented its school-based tele-behavioral health program in five Dallas County schools within Carrollton-Farmer's Branch ISD. The program has since expanded to over 68 schools (14 of which are in Dallas County) and is the most successful example in the state for using school-based tele-behavioral health to improve children and youths' access to treatment.

The goal of the program is to identify and resolve common behavioral health needs before they escalate into more serious concerns. For children with mental health conditions such as depression and anxiety, the program connects students with licensed behavioral health specialists, via telemedicine, to address children's needs. Students can also receive telemedicine assessments, telephonic referral linkages, and case management follow-up. Students can be referred to the program by their teachers or counselors.

Initial results indicate that this Children's Health program has positively affected students' moods and school attendance. Children's Health plans to expand the program to additional schools in Dallas County, as well as eight other Texas counties, throughout the 2020–2021 school year. To support expansion, the telemedicine funds in SB 11 (86th Regular Session, 2019) and the Texas Education Agency Exceptional Item funding for school-based intervention more broadly can help expand these programs further across Dallas County in the next two fiscal years.

Dallas Independent School District

Dallas Independent School District (ISD) is made up of 230 school campuses, including elementary, middle, and high schools, and serves approximately 157,000 students.⁹⁶ Dallas ISD

⁹⁶ Dallas Independent School District. (2019). *General information*. <https://www.dallasisd.org/Page/336>

has around 22,000 employees, making it the largest employer in Dallas. As of 2017, Dallas ISD had an 88.3% four-year graduation rate and a 7.5% dropout rate.⁹⁷

Dallas ISD's Social and Emotional Learning (SEL) Department supports 145 school elementary, middle, and high school campuses. It provides training, planning support, and coaching for its partner campuses to support both students and adults in building SEL knowledge and skills. The long-term goal is for all Dallas ISD campuses to operate with SEL practices and continuous improvement systems for refining their campus-based approaches to SEL.

The SEL Department focuses on implementing SEL practices and approaches across four key areas: climate and culture, content integration, explicit skills instruction, and signature practices. Dallas ISD provides SEL-focused learning opportunities to students so that they can continually refine their skills in five primary competencies: self-management, self-awareness, social awareness, relationship skills, and responsible decision-making.⁹⁸

Dallas ISD's SEL Department also partners with Big Thought, Dallas Afterschool, and the Dallas Park & Recreation Department to implement SEL activities during and after school at select elementary campuses as part of a multi-year grant with The Wallace Foundation.

Dallas ISD also operates Youth and Family Centers, which we will summarize in the *Component 2: Specialty Outpatient Mental Health Care* section.

The Commit Partnership

The Commit Partnership (Commit) is a coalition of over 200 partners — including public and private schools, colleges and universities, foundations, businesses, and nonprofits — that work collaboratively to address systemic challenges across the region. Commit's primary areas of focus are improving early childhood education, preparing and retaining effective educators, increasing postsecondary completion rates, and advocating for student-focused public policy. To address these issues, Commit brings together partnering organizations to collectively develop strategies to realize their vision.

Last year (2019), over a six-month period, Commit and Early Matters Dallas (Early Matters), a group of partners dedicated to improving early childhood education, convened a workgroup of 30 district social and emotional learning (SEL) experts from nine North Texas school districts. The purpose of the workgroup was to support the development of social and emotional learning strategies for those districts to improve instructional quality in the classroom. The

⁹⁷ Dallas Independent School District. (2019).

⁹⁸ Dallas Independent School District. (n.d.) *What is social and emotional learning (SEL)?* <https://www.dallasisd.org/Page/61174>

districts learned from each other and received technical assistance from the Collaborative for Academic, Social, and Emotional Learning (CASEL) as they worked on varying implementation strategies. The districts are now piloting these SEL strategies in their respective districts.

This coalition also helps shape and advocate for legislation. Last session (86th Regular Session, 2019), they supported the passage of Senate Bill 11 and House Bill 18, which require teachers to be trained in trauma-informed strategies as part of their required continuing professional development. The legislation also requires districts to implement a policy that integrates trauma-informed practices in each school environment, including methods for increasing staff/parent awareness of trauma-informed care and for implementing trauma-informed practices and care by district/campus staff. Finally, the coalition monitors and provides input to Texas Education Agency on rulemaking and implementation of the legislation to ensure maximum impact.

Grand Prairie Independent School District

Grand Prairie ISD is made up of 43 school campuses and serves a little over 29,000 students. Grand Prairie ISD has around 4,198 employees, making it the largest employer in Grand Prairie, Texas.⁹⁹

Grand Prairie ISD has a Counseling Services Department that works to integrate SEL in all parts of students' days. Teachers, counselors, social workers, and administrators are expected to work together as a team to support healthy social and emotional development as well as create a safe and productive learning environment for all students. Grand Prairie ISD is currently working on incorporating the Sanford Harmony SEL curriculum into every elementary classroom during the 2019–2020 school year.

Grand Prairie ISD's Counseling Services Department offers an array of prevention services.¹⁰⁰ School counselors offer bullying prevention and suicide prevention programs and activities to students through integrated classroom lessons. Grand Prairie ISD also has programs to help create a positive school climate and increase connections between students. "Start with Hello" is designed to create and sustain an inclusive school culture and community by encouraging students and staff to reach out and welcome students who are alone. School social workers also run "Handprints on Hearts Mentoring," a program that allows vetted adults from the community to volunteer as mentors. Volunteer mentors are paired with a student or a small group of students from various grade levels at a campus. The mentor works to build relationships with students and offers encouragement and guidance.

⁹⁹ Grand Prairie Independent School District. (2019). *District profile*. <https://www.gpisd.org/domain/3645>

¹⁰⁰ Grand Prairie Independent School District. (2019). *Counseling services*. <https://www.gpisd.org/Page/42033>

Grand Prairie ISD also has a Student Mental Health and Safety Program that works with students who have made a violent or terroristic threat. Students with a Disciplinary Alternative Education Program (DAEP) placement receive regular counseling sessions while they are at DAEP.

Uplift Education

Uplift Education (Uplift) is the largest open-enrollment charter school network in the Dallas/Fort Worth region. Uplift has 43 primary, middle, and high schools on 21 school campuses and serves around 20,000 students, referred to as “scholars.” As of 2019, Uplift had a 100% college acceptance rate and an 89% college matriculation rate.¹⁰¹

Uplift’s Department of Student Support Services oversees the school network’s wraparound support programs, mental health and SEL initiatives, prevention efforts, and scholar discipline, which is grounded in restorative practices (a strategy that promotes inclusiveness, relationship-building, and problem-solving through restorative methods as circles for teaching conflict resolutions). The focus of Student Support Services is to offer a high-quality, school-based social and emotional experience for scholars, while also assisting families in accessing other social services and resources outside of the school setting.

Uplift implements the Second Step SEL curriculum in early learning through grade 8 classrooms, which teaches students skills to help them navigate their way through school and community. Uplift also implements the Owning Up curriculum, which teaches young people to understand their individual development in relation to group behavior, the influence of social media on their conflicts, and the dynamics that lead to discrimination and bigotry.¹⁰² Their services also include prevention programming and psycho-educational lessons designed to promote positive mental health development, support for children and youth who are homeless or in the foster care system, and additional trainings and initiatives that aim to prevent child abuse and neglect, youth dating violence, suicide, substance abuse, and bullying.

Uplift also has a Student Support Team at every school campus that provides social and mental health counseling services to both students and staff to support anyone on campus who might need special care. Uplift counselors are state-certified school counselors, licensed professional counselors (LPCs), and licensed master social workers (LMSWs). They provide responsive counseling services, crisis assessments, and additional programming.¹⁰³ Responsive counseling

¹⁰¹ Uplift Education. (2019). *About us*. <https://www.uplifteducation.org>

¹⁰² Uplift Education. (2019). *Social & emotional learning (SEL)*. <https://www.uplifteducation.org/Page/15703>

¹⁰³ Uplift Education. (2019). *Social/behavioral counseling services*. <https://www.uplifteducation.org/Page/15636>

services incorporate activities designed to meet the immediate needs and concerns of students and staff, including individual counseling, small group counseling, staff consultation, or crisis counseling.

Lastly, Uplift maintains a list of vetted community resources and referrals to share with students and their families. Uplift maintains relationships with staff at the agencies on its referral list. Maintaining relationships with points of contacts at referral agencies allows Uplift staff to ensure that families are aware of the appropriate referral process to engage with the agency, which allows Uplift to achieve high levels of coordinated care.

Education Service Center Region 10

Texas is divided into 20 regional Education Service Centers (ESCs) and each one provides leadership, training, and technical assistance in accordance with the Texas Education Agency's focus on increasing student achievement. Dallas County is served by ESC Region 10. In the 2018–2019 school year, ESC Region 10 served 865,000 students and employed 55,495 teachers, 22,600 auxiliary staff, 11,898 professional support staff, 9,604 educational aides, 3,093 campus administrators, and 1,267 central administrators in over 1,200 campuses in approximately 130 districts and charter and private schools across 10 North Texas counties.

ESC Region 10's mission is to be a trusted, student-focused partner that serves the learning community through responsive, innovative educational solutions. It provides information, support, and professional development to help districts, school campuses, and charter schools in the following areas:¹⁰⁴

- Positive Behavior Intervention Support (PBIS) — schoolwide, classroom and individual interventions;
- Teacher consultation and technical assistance — to assist in effectively managing student behavior in the classroom environment;
- Professional development in classroom management;
- Crisis prevention/intervention training for school personnel (provided at Region 10 ESC and at campus sites upon request) — to deal appropriately with behavior problems and maintain an effective instructional setting; and
- Collaboration with colleagues and districts — to plan educational and behavioral programming that will allow students maximum access to the general curriculum.

¹⁰⁴ Region 10 Education Service Center. (2019). *Positive behavior intervention and supports for classroom management*. <https://www.region10.org/programs/positive-behavior-intervention-and-supports-for-classroom-management/overview/>

ESC Region 10 participates in Community Resource Coordination Groups (CRCG). CRCGs include local partners and community members that work with parents, caregivers, students, and adults to make a service plan when the student or family has complex needs.

ESC Region 10 also has a group of counselors who provide counseling to school district counselors themselves and it has crisis counselors who will meet with communities and families after a crisis. Approximately 90% of ESC Region 10's special population services are offered to school districts for free.

Communities In Schools of the Dallas Region

Communities In Schools (CIS) of the Dallas Region, a local 501(c)(3) nonprofit organization, was founded in 1985 and is an affiliate to the national CIS. Its mission is to surround students with a community of support, empowering students to stay in school and achieve in life. CIS of the Dallas Region works with underserved students in grades kindergarten through 12 who are in need of extra assistance. Under a mandate from the Texas Education Agency, CIS of the Dallas Region is required to work with the students who are listed on a campus "at-risk" list, meaning students who are in crisis and who will most likely not complete the school year.

CIS of the Dallas Region currently partners with nine (9) area school districts and is housed in a total of 66 elementary, middle, and high school campuses.¹⁰⁵ For Dallas County specifically, CIS has a presence in 36 schools. In each of these schools, CIS provides services and supports to eligible students, including group skills, crisis intervention, case management, and others. These services and supports, which are considered supportive (as opposed to therapeutic) in nature, are limited to students who meet eligibility criteria developed in coordination with each school/district. Students who need specialized treatment for a specific mental health challenge are referred to community-based providers. CIS of the Dallas Region has formal memorandums of understanding (MOUs) with community organizations, and in 2017, it launched "Collaborate, Communicate and Coordinate (C3)" to bring CIS service partners together to discuss trends, student needs, and challenges in an effort to provide the most comprehensive, cost-effective, inclusive, and relevant services possible.

CIS of the Dallas Region has site coordinators at each campus. They are trained professionals who work with school administrators, students, and families to assess needs, develop a plan, and build a team to provide supports to schools and students. Site coordinators who identify students with more serious needs such as suicidal ideation, report these needs to CIS' Risk Assessment Team, which comprises their clinical, mobile, and community engagement staff. The clinical team includes licensed staff who are able to engage in one-on-one counseling with

¹⁰⁵ Communities In Schools of the Dallas Region. (2019). *Overview*. <http://cisdallas.org/overview/>

students and provide referrals. The mobile team provides group services on various topics, such as life skills and drug awareness education. The community engagement team works with different partners in the community.

CIS of the Dallas Region staff also provide trainings on trauma-informed care, Mental Health First Aid, Psychological First Aid, and other similar topics to school districts in the region.

Momentous Institute

Momentous Institute works with children, youth, and families to build social and emotional health through education, therapeutic services, research, and training. Momentous Institute's Momentous School is a laboratory school that serves students from pre-kindergarten through fifth grade and takes a research-based approach to integrating SEL and trauma-informed strategies with academics. Its research division follows students through high school and college to determine the longer-term impact of these early interventions. One of the Momentous Institute's goals is to share successful strategies with Dallas-area schools in an effort to increase the implementation of programs that support the social and emotional well-being and academic success of students. Additional services provided by Momentous Institute are described in Component 2 of this report.

The University of Texas (UT) Southwestern Medical Center's Center for Depression Research and Clinical Care (CDRC)

UT Southwestern Medical Center's CDRC is a nationally-recognized center of excellence in the research and treatment of mood disorders, including depression and bipolar disorder. Its mission¹⁰⁶ aims to revolutionize the understanding of the biological causes of depression and bipolar disorder as well as transform the diagnosis and treatment of mood disorders. The CDRC seeks to accelerate scientific discovery and disseminate new findings to real-world practice.

The CDRC has various programs, one of which is Youth Aware of Mental Health (YAM). YAM is an SEL curriculum offering an interactive, classroom-based program for youth that promotes discussion and education about mental health and suicide prevention and supports the development of problem-solving skills and emotional intelligence. The program avoids overwhelming students with complicated information and is designed to allow each participating group to influence the content. Participants learn from both a professional and their peers through a mix of cognitive, emotional, and experiential learning strategies. The CDRC provides YAM across the North Texas region and has had an impact on more than 9,500 students since 2016.

¹⁰⁶ UT Southwestern Medical Center. (2019). *Center for Depression Research and Clinical Care*.

<https://www.utsouthwestern.edu/education/medical-school/departments/psychiatry/research/center/>

Partnerships with Faith Communities

Several of the organizations we reviewed identified partnerships with Dallas-area faith communities and the strategies they use to increase the reach of mental health services and supports through strategic partnerships. For example, ChristianWorks for Children accepts sponsorships from congregations, school systems, and other nonprofit organizations that wish to make mental health services more accessible to the community. These sponsorships directly support counseling service fees for children, youth, and families, regardless of their religious beliefs. Harmony Community Development Corporation (Harmony CDC) was established as a 501(c)(3) nonprofit by Concord Church. Harmony CDC offers a variety of counseling programs to the community at large, services which extend well beyond its congregation. The Center for Integrated Counseling and Psychology (formerly Pastoral Counseling and Education Center) partners with various faith-based groups across Dallas County to co-locate mental health services within congregations' buildings in order to make services geographically accessible to more members in the community.

Peer Support Programs

Peer support programs intentionally put youth in roles where they will help other youth in their recovery journey. Peers can model recovery, teach skills, offer supports, and create meaningful relationships with other youth with mental health needs. Dallas County currently has a variety of initiatives in which youth provide peer education focuses on issues specifically related to mental health, domestic violence, substance use, or suicide prevention.

For example, Students Tackle Abusive Relationships (STAR) at Genesis Women's Shelter & Support is a peer support program available to high school students who are interested in raising awareness about dating and domestic violence as well as helping survivors of violence. A similar STAR program, called the Be Project, is offered at the Family Place. Through participation in the Be Project, students learn leadership skills and how to promote and implement their ideas. Additionally, Uplift Education implements peer support programs focused on dating violence and substance use as part of its school model (discussed above).

Children's Health partners with Hanna4Hope to address suicide prevention through a multi-pronged approach that utilizes a peer support model. Their workshops cover facts about suicide, the warning signs of youth suicide, how to get people the help they need, and how to be a resource to peers. Children and youth who have survived suicide are also able to share their stories of hope and how they overcame personal challenges. In addition, Hanna4Hope offers school districts the opportunity to have a Student Club curriculum for middle and high school students. Students are trained on the warning signs of suicide and can serve as student ambassadors in the fight against youth suicide. Children's Health also provides suicide

prevention trainings for youth leaders through their Suicide Prevention and Resilience at Children's program, which is specifically designed to target the risk factors associated with suicidality in youth.

Life in the Community Findings

Life in the Community (LIC) Finding #1: School mental health resources, prevention supports, and trainings are available to some schools through partnerships with community-based organizations. Research indicates that school mental health resources can provide significant advantages in helping to recognize student mental health needs early and facilitate access to services when needed.¹⁰⁷ Schools can partner with community-based organizations to integrate these resources and services within their school. There are a variety of school-linked and school-based resources available to school districts in Dallas County. As noted earlier, ESC Region 10 offers evidence-based trainings tailored to school districts. CIS of the Dallas Region has a presence in 36 schools in Dallas County and offers a variety of services and supports, including trainings on trauma-informed care, Psychological First Aid, and Mental Health First Aid training. Schools can also partner with community organizations to offer programs and services on campus. For example, Uplift Education (Uplift) has formal partnerships with community organizations to offer substance use prevention and youth dating violence prevention programming on campus. All community organizations are vetted by Uplift and enter into a formal memorandum of understanding (MOU).

Life in the Community (LIC) Finding #2: Most providers we reviewed identified the need to better partner with faith communities; those with connections to these communities named this as a strength. Faith communities can play a significant role in supporting children and youth (and their families) who struggle with emotional distress. These partnerships can be especially effective when faith communities collaborate with mental health providers and other agencies that deliver evidence-based and clinically necessary treatment and supports. Although there are some strong examples of partnerships between faith-based organizations and mental health care providers, there is an opportunity to facilitate additional connections between faith communities and mental health organizations. Most providers noted the potential to have stronger partnerships with faith communities, recognizing that these communities are an untapped resource and often willing to help. Mental health providers should engage faith communities as partners in efforts to improve the access to services and quality of care.

¹⁰⁷ Green, J. G. et al. (2013). School mental health resources and adolescent mental health service use. *Journal of the American Academy of Child & Adolescent Psychiatry*, 52(5), 501–510.
<https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3902042/>

LIC Finding #3: Peer support programs exist in pockets of Dallas County. Although there are promising examples of peer support programs in the Dallas community, these services are not present across all settings or available to all populations of youth; a more systemic incorporation of youth voice is needed.

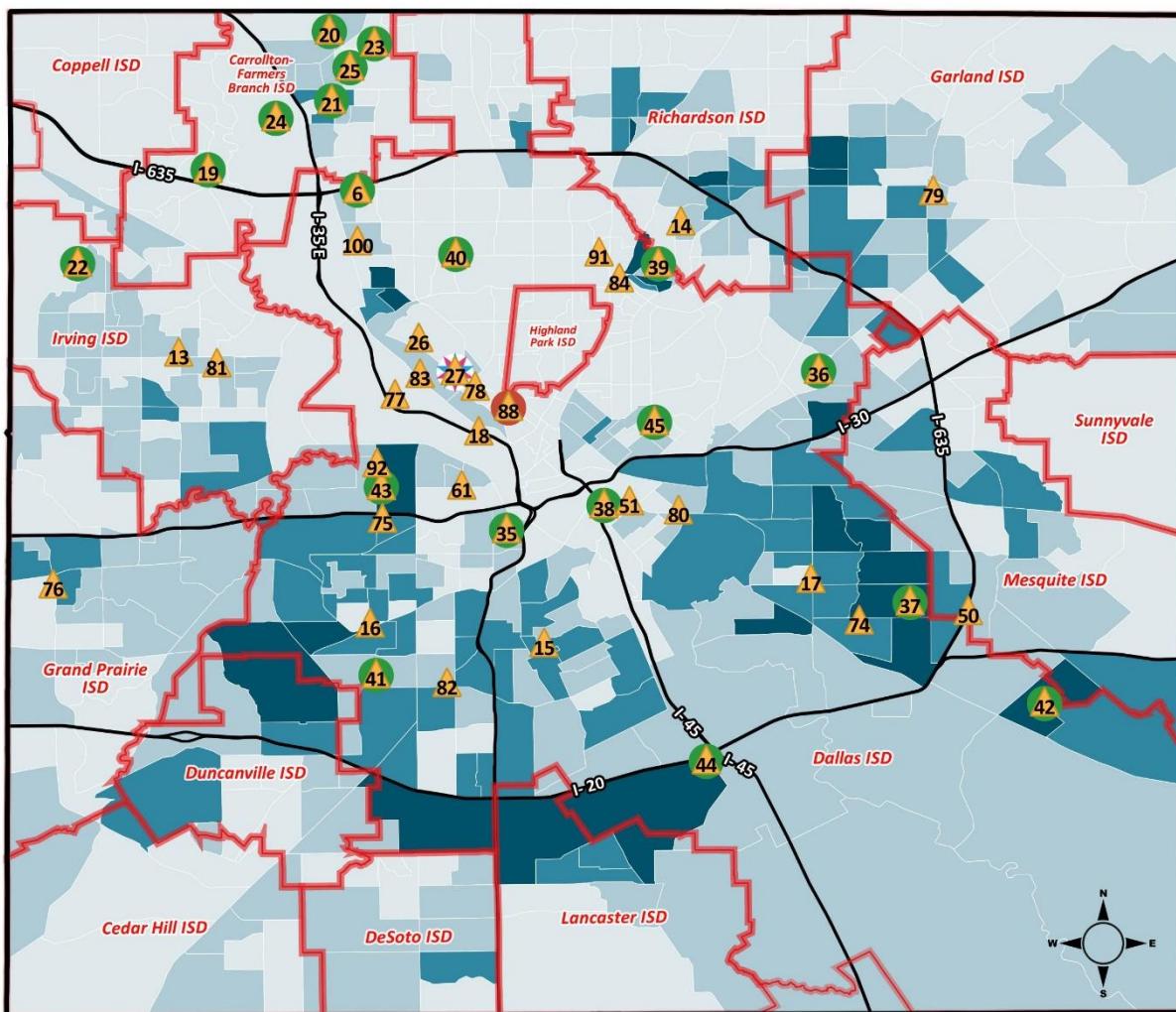
Component 1: Dallas County's Integrated Pediatric Primary Care Capacity

How Accessible Are Integrated Primary Care Services?

As we discussed in our introduction of Component 1 of the framework, across Texas and the nation, pediatric primary care is the front line for health care delivery and is the key to early identification of mental health needs, treatment for lower to moderate needs, and effective referral for care when children and youth have more intensive needs. In Dallas County, there are multiple systems at various stages of implementing integrated primary care strategies and programs. Some select programs implemented by Children's Health and Parkland Health and Hospital System (Parkland) have become fully functional while others are focused on increasing their capacity. For this assessment, we reviewed seven (7) integrated primary care programs in Dallas County, including both community- and school-based clinics.

Map 3, on the next page, shows the geographic locations of the integrated primary care providers in Dallas County. This map also identifies Dallas County school districts and provides the counts of children in poverty by census tract in 2017. It is important to identify children living in poverty since poverty often acts as a barrier to accessing care. Other challenges that impede access to treatment include a lack of reliable transportation options, distance from providers, childcare obligations, and conflicts between provider office hours and work schedules. The map shows the locations of integrated care providers in Dallas County, with most providers located in the north and central parts of the county and fewer in south and northeast Dallas County, where there are higher concentrations of people living in poverty. Additional information on providers and their locations can be found in *Appendix B: Detailed List of Mapped Dallas County Providers*.

Map 3: Integrated Primary Care Service Sites in Dallas County^{108, 109}



Child-Serving Integrated Care Providers*

- ▲ Integrated Care Provider
- School-Based
- Serves Children and Youth in Child Welfare
- ★ Contracted with NTBHA

Children and Youth Under Age 18 in Poverty (2017)

- Fewer than 250
- 250 to 603
- 604 to 1,065
- 1,066 to 2,213

— Highway

□ Dallas School Districts

*Provider locations have been slightly adjusted for visibility.

¹⁰⁸ While not depicted on the map, Parkland HOMES provides mobile outreach and integrated care services to homeless shelters in the county.

¹⁰⁹ For this map and all maps that follow, readers can use the legend to identify the type of provider represented and then locate the specific provider by matching the number to the specific provider listed in the "Map Label" column in Appendix B.

How Many Children and Youth Receive Integrated Primary Care?

Based on the prevalence estimates discussed previously, there are approximately 180,000 children and youth with mental health conditions in Dallas County, and we estimate that 120,000¹¹⁰ can be adequately managed in integrated primary care settings with the right supports. Based on data submitted by providers for this assessment, just 11,144¹¹¹ children and youth receive mental health care in integrated primary care settings — this represents about 10%¹¹² of the estimated 120,000 children and youth whose needs could be treated in an integrated primary care setting. Many of these 120,000 children and youth do receive some form of care, but not necessarily in the optimum setting. Many children and youth with mild or moderate needs end up receiving care in specialized mental health settings, and this reduces the availability of these resources for those with more severe needs that cannot be addressed in integrated primary care. Although the providers we reviewed do not represent all providers in Dallas County that deliver integrated pediatric primary health care, the data represent the major health systems and leading federally qualified health center (FQHC) providers, and we believe our findings apply more broadly.

Who Are the Integrated Primary Care Providers?

As noted above, we focused our review on the largest health systems that serve Dallas County children and youth — Children’s Health, Parkland Health and Hospital System, and Texas Health Resources — and the FQHCs, Los Barrios Unidos and Foremost Family Health. We also reviewed the UT Southwestern Family Medicine program and The Rees-Jones Center for Foster Care Excellence, which is located at Children’s Health. Each of these health systems and programs provide some level of integrated primary care and have set a firm foundation upon which to build and expand their respective programs.

Children’s Health

Children’s Health, formerly known as Children’s Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, it began an integrated primary care 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. In January 2017, the team included 10 licensed

¹¹⁰ We estimate that approximately two out of every three children with mental health needs have conditions that can be successfully managed in an integrated primary care setting. This translates to 110,000 to 120,000 children and youth.

¹¹¹ Providers submitted one year of utilization data using the most recent complete year that they had available. Some providers submitted data for a partial year – in these cases, we multiplied the number of children and youth served in that time period by the appropriate amount to estimate the number served in a full year.

¹¹² Percentages were calculated using unrounded estimates of the number in need and may not match calculations that used rounded estimates.

master's level behavioral health clinicians — licensed professional counselors (LPCs), licensed clinical social workers (LCSWs), and licensed marriage and family therapists (LMFTs) — and two clinical psychologists. A child psychiatrist consultant is also part of the team and available to primary care providers for questions regarding medication management and the presentation of their patients' mental health symptoms. The program has grown to include private practitioner medical homes outside of the Children's Health clinics as well as low-cost community clinics. Currently there are a total of 36 integrated medical practices across North Texas.

Children's Health has successfully integrated universal screening into its clinic workflow and is administering a behavioral health screening tool to identify and monitor depression for every pediatric well-child visit, starting when patients are 11 years old. Primary care providers refer any patients who may have a behavioral condition or whose family needs behavioral health services. Many of the integrated sites share an electronic medical record system that offers both primary care and specialty outpatient behavioral health providers access to patients' records, enabling better care coordination. For practices that use different patient record systems, the behavioral health clinician communicates regularly with the medical provider. 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 on topics such as depression, attention-deficit/hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case staffing discussions and treatment planning.

In addition to this integrated primary care model, Children's Health has also implemented a telemedicine program to increase access to health care and the delivery of primary care services to children and youth in local schools. They have a presence on 48 campuses across North Texas, primarily middle and high schools, but also in some elementary schools. Children's Health is planning significant growth in this program for 2020 with additional state funding.

Children's Health also offers integrated care to children and youth who receive services through its medical subspecialty areas. Regardless of presenting problem, with the integration of universal screening, a child identified with a mental health need will have quick access to mental health services, most of which are embedded into the medical subspecialty. This consultation model makes it less burdensome for the patient and family to navigate and access needed care; it also improves communication among treatment teams.

In 2017, Children's Health opened the Teen Recovery Program specifically for youth with co-occurring mental health and substance use disorders. It is the only program in the area with clinical curriculum that uses motivational enhanced cognitive behavioral therapy and contingency management, designed specifically for youth. The program provides individual and family therapy along with a five-week intensive outpatient treatment component.

Parkland Health and Hospital System

Parkland Health and Hospital System (Parkland) is currently rolling out an integrated care model for children and youth at its Community Oriented Primary Care Clinics (COPCs). The COPC model focuses on the core components of "assessment, prioritization, community collaboration, health care system, evaluation, and financing."¹¹³ Until recently, the 12 COPCs have primarily provided health services. Two COPCs are currently providing integrated care and Parkland is planning to implement this model at two additional clinics. Its goal is to eventually offer integrated care at all 12 COPC locations. At the sites offering integrated care now, pediatricians use the Patient Health Questionnaire (PHQ)-9 depression and a suicide risk screening tool with all of their patients; additional screenings can be administered, if indicated. Behavioral health staff are co-located with medical staff and, after a need is identified, can immediately meet with a child or youth and their family to determine the course of treatment; treatment decisions are made by the team. Pediatricians may prescribe psychiatric medications, if indicated, for mild to moderate needs, and behavioral health staff may provide outpatient counseling. For children and youth with more complex needs, staff make referrals to community-based providers. Additionally, Parkland operates 12 school-based clinics, which are co-located at Dallas ISD's Youth and Family Centers. The school-based clinics have one social worker who rotates locations to provide direct care and also offers support virtually, when needed. Dallas ISD students who present with mental health needs can obtain referrals to receive behavioral health services through the Youth and Family Centers.

Texas Health Resources

Texas Health Resources (THR) is developing integrated primary care for children and youth across its network of primary care and physician groups, which includes about 500 to 600 physicians, to better meet the needs of the population it serves and to fill a gap in service capacity in the community. Currently, THR physicians have implemented universal screening across the network; THR is aiming to integrate its physical and mental health services by the end of 2020. Consulting support is currently in place for primary care and physician groups and the organization is making strides to create formal integrated care settings. THR is also

¹¹³ Pickens, S., Boumboulian, P., Anderson, R. J., Ross, S., & Phillips, S. (2002). Community-oriented primary care in action: A Dallas story. *American Journal of Public Health, 92*(11), 1728–1732.
<https://doi.org/10.2105/ajph.92.11.1728>

implementing the Columbia Zero Suicide model across its system, requiring all emergency departments, hospitals, day surgery, inpatient treatment facilities, and day treatment programs to use this screening tool. At this time, most screenings occur in the emergency department and physicians receive crisis support and consultation there. However, as implementation expands, THR expects to see an increase in screenings among primary care physicians. Children and youth in need of ongoing mental health treatment can receive care at one of THR's outpatient clinics.

THR's implementation of training requirements also shows promise. Across its network, THR is working to change its culture regarding behavioral health by implementing stigma-reducing activities to be used with patients and providing crisis management training for practice managers and office staff.

Los Barrios Unidos Community Clinic

Los Barrios Unidos Community Clinic (LBUCC) is a federally qualified health center (FQHC) that provides health care and other services, including integrated pediatric primary care, to people who reside primarily in West Dallas, Oak Cliff, and Grand Prairie, though it is able to serve a larger geographic area. In its integrated care settings, children and youth 12 years and older are screened with the PHQ-9, which screens, diagnoses, monitors, and measures the severity of depression. Members of the team are co-located and, as part of the current model, physicians are able to consult with a behavioral health clinician immediately after a mental health need is identified. Similarly, when a behavioral health clinician suspects a medical need, they can call a physician for an evaluation. LBUCC also has a part-time pediatric psychiatrist on staff who sees patients and consults with family physicians on prescription practices for children and youth with mild-to-moderate needs; however, the psychiatrist sees patients who have complex behavioral health needs. Collaboration among team members occurs in real-time and during monthly staff meetings. Notably, LBUCC is also in the process of becoming a trauma-informed organization through a grant from the Texas Association of Community Health Centers.

Foremost Family Health Centers

Foremost Family Health Centers is an FQHC with two locations in Dallas County. It began offering integrated primary care services in 2017 and is continuing to expand these offerings. It has implemented universal screening with patients who are 12 years and older. If a patient screens positive for a mental health need, health center staff can provide short-term therapy and make referrals to community-based providers for children and youth with more complex needs. As identification of mental health needs increases in its pediatric primary care settings, Foremost Family Health Centers is expanding its capacity to serve more children and youth by hiring additional staff and exploring opportunities to collaborate with local schools, libraries, and churches. Behavioral health services are currently located at Balch Springs and Martin

Luther King centers, including collaboration with primary medical care services to ensure health care needs are addressed using a holistic, person-centered approach.

Homeless Outreach Medical Services

Homeless Outreach Medical Services (HOMES) is a joint effort between Parkland and The Children's Health Fund to provide medical, dental, and behavioral health services to children, youth, and adults who are homeless. Integrated care services are offered in mobile clinics at various shelters throughout Dallas County for families experiencing homelessness. HOMES also offers integrated services at Promise House, a program for unaccompanied youth experiencing homelessness. Children and youth receive well-child check-ups, a depression screening at each visit (universal screening), and, if indicated, further assessment. HOMES also offers children, youth, and caregivers short-term mental health services, including therapy, parenting skills training, and medication services for mild-to-moderate needs. In addition, it provides services at shelters or school-based settings (when possible). These services are available while the person is homeless and for a period of time after they have obtained housing.

The University of Texas Southwestern Family Medicine

The University of Texas (UT) Southwestern Family Medicine program provides integrated primary care services in two clinics, one through a partnership with Parkland and one through a partnership with Texas Health Presbyterian Hospital Dallas. Although the models UT Southwestern implements at these two clinics look slightly different, both offer integrated care through a training model that has medical residents working alongside physicians to provide care. At both clinics, universal screening has been integrated that includes both depression and suicide screening tools. At Texas Health Presbyterian Dallas, UT Southwestern has partnered with the family therapy program at Texas Woman's University to provide behavioral health services to children and youth who screen positive for a mental health need. The integrated care team includes physicians, a master's level trainee, a doctoral intern, and a supervising doctoral-level clinical social worker. Behavioral health services are provided on a short-term basis and treatment team members make referrals to community-based providers for patients with more complex needs. Treatment teams at both locations communicate through a shared electronic health record and regular face-to-face staffings.

The Rees-Jones Center for Foster Care Excellence

The Rees-Jones Center for Foster Care Excellence (The Rees-Jones Center), with clinics on Children's Health Dallas and Plano campuses, is a specialized integrated primary care model that addresses the needs of children and youth in foster care who often require additional services and supports. For the past three years, The Rees-Jones Center for Foster Care Excellence has been fully staffed as an integrated health care provider and is now increasing the number of children and youth it serves.

One of The Rees-Jones Center's promising practices is a structured team approach that includes primary care and behavioral health providers as well as a nurse coordinator and a child protective services (CPS) liaison. The Rees-Jones Center staff indicated that the nurse coordinator and CPS liaison positions are critical to the model. All members of the care team are co-located and fully collaborative. The team provides trauma-informed primary care services along with evidence-based therapy, including Parent-Child Interaction Therapy (PCIT), cognitive behavioral therapy (CBT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), among others. The behavioral health program also provides trauma-informed developmental and psychological assessments. Specifically, all staff are trained in trauma-informed care and the center is regularly evaluated to ensure its programming meets trauma-informed care standards.

The Rees-Jones Center for Foster Care Excellence also uses other fundamental principles of integrated team strategies, such as a shared electronic medical records system, which allows all team members to access a child's 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.

Integrated Primary Care Findings

Integrated Primary Care (IPC) Finding #1: Integrated primary care (IPC) is available in many settings across Dallas County; however, there is a growing need to expand the use of IPC. Best practice use of integrated primary care requires an infrastructure of evidence-based universal screening (e.g., using tools such as the PHQ-9 — or PHQ-A for adolescents — to identify depression-related needs), 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). While IPC is being implemented across many settings in the Dallas area (pediatric primary care offices, FQHCs, school-based clinics), and efforts are underway to scale-up implementation, additional attention should be placed on building an infrastructure that supports IPC throughout the system. An area of strength in the current system is the growing integration of evidence-based universal screening to identify mental health needs in children and youth. As a result of increased identification of patient mental health needs in primary care settings, most providers we reviewed indicated that they are ramping up their implementation of IPC to better address these needs. Thus, the current capacity of IPC implementation in Dallas County does not reflect the potential impact that current efforts to build and expand a stronger infrastructure will likely have on the overall system in a few short years. IPC providers should consider increasing their capacity to offer IPC in the most southern sections of Dallas County as there is little access to mental health care services in that area.

IPC Finding #2: Expanding partnerships with schools is especially challenging. Across Dallas County, there are a number of clinics that are co-located at schools and current and new IPC providers have expressed a growing interest to expand implementation of school-based clinics. Despite this interest in expansion, there are challenges. One challenge is putting into place the agreements necessary to proceed with a partnership between a primary care provider and a school. Providers indicated that both they and school systems have their own sets of policies, rules, and regulations to follow when setting up a practice agreement. In many cases, the layers of approval and coordination needed to establish a collaborative program can be a barrier to implementation.

IPC Finding #3: Billing constraints limit IPC expansion. Primary care practices that are providing IPC can now bill for those services using Common Procedural Technology (CPT) codes for Psychiatric Collaborative Care Management Services (99492, 99493, 99494).¹¹⁴ Medicare and some commercial insurers will cover these IPC codes. However, several providers noted that they could not sustain their IPC programs on insurance reimbursement alone because of low reimbursement rates. Also, some commercial insurers and Texas Medicaid do not reimburse for direct provider-to-provider consultation such as when a pediatric primary care provider seeks guidance from a child psychiatrist on medication management or coordinates care with multiple systems (e.g., school and child welfare systems). However, in some instances, providers can make internal adjustments to maximize billing opportunities. Billing for mental health services in a primary care setting can be challenging because it is often an unfamiliar process and can involve multiple payers and billing requirements.

IPC Finding #4: Primary care providers identified limitations in making referrals to mental health specialty outpatient providers. Often, these specialty outpatient providers do not have adequate capacity to accept all referrals in a timely manner. While mild-to-moderate mental health needs of children and youth can be addressed within pediatric primary care with the right IPC supports, pediatric primary care providers cannot manage all patient mental health needs, especially more severe mental health needs that require more intensive interventions. The IPC providers we reviewed noted challenges in referring patients to specialty outpatient care, especially to psychiatry services and bilingual clinicians, because those providers are often at capacity or there is a long wait to access their services. Because of these, many children and youth do not get the services they need and end up cycling between primary care, emergency rooms, and inpatient care, if it is available. As a result of the shortage of specialty outpatient

¹¹⁴ Behavioral Health Integration Services. (2019, May). MLN Booklet. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf>

care providers, some IPC programs are evaluating their capacity to add longer-term outpatient services and telepsychiatry to their offerings in an attempt to mitigate this challenge.

IPC Finding #5: Providers are using telehealth and telemedicine to improve access to services and are interested in expanding their use of technology to increase access to care. Most notably, some telehealth services are offered in schools, while other providers offer community-based services that incorporate tablet computers. These services improve access to care for children, youth, and their caregivers who may not otherwise be able to access services because of barriers such as transportation, work schedules, and child care. For children and youth needing longer-term services, telehealth/telemedicine can help bridge the gap while they are waiting for an appointment with a specialty outpatient care provider.

Component 2: Dallas County's Specialty Outpatient Mental Health Care Capacity

Community-based specialty outpatient mental health care often serves as the connection to restorative counseling and case management services for children and youth experiencing emotional distress, and their families. Examples of specialty outpatient mental health care include outpatient clinics, counseling centers, and school-based clinics that offer only mental health services (not primary care). These settings typically provide individual, family, and group therapies, including a range of evidence-based treatments for children, youth, and families. Clinics may also provide some Medicaid rehabilitation services (i.e., skills building — further described in the next section, *Component 3: Specialty Rehabilitative Care*). At the request of The Rees-Jones Foundation, our assessment included their nonprofit grantees who provide mental health services. This section of the report describes how Dallas County's specialty outpatient mental health programs compare with the Mental Health Systems Framework for Children and Youth.

How Many Children and Youth Receive Specialty Outpatient Mental Health Care?

Based on the best current prevalence estimates, about 45,000 Dallas County children and youth with moderate and more severe conditions would benefit from routine specialty outpatient mental health services. Providers we reviewed indicated that they serve over 30,000 children and youth in routine care, representing two thirds of the need.¹¹⁵ It is unknown, however, what proportion of these 30,000 children could be treated in primary care for mild symptomatology,

¹¹⁵ Providers submitted one year of utilization data using the most recent complete year that they had available. Some providers submitted data for a partial year – in these cases, we multiplied the number of children and youth served in that time period by the appropriate amount to estimate the number served in a full year.

Providers submitted data that indicated they served 33,882 children and youth in specialty outpatient care, including 3,294 children and youth in specialty rehabilitative care. Excluding the count of children and youth served in specialty rehabilitative care, we estimated that approximately 30,000 children and youth were served in routine specialty outpatient care.

freeing up specialty outpatient resources for children and youth with moderate to severe needs. It is therefore likely that more than one third of children and youth with moderate and severe needs are not receiving specialty outpatient mental health services. As primary care providers integrate clinical practices such as universal screening and measurement-based care, they will be able to establish treatment intensity levels based on individual data. Additionally, creating clear and efficient referral pathways will make linkage to specialty outpatient care more manageable once a child or youth is identified as having a moderate to severe condition, which, in turn, would shift capacity for appropriate needs into the appropriate settings.

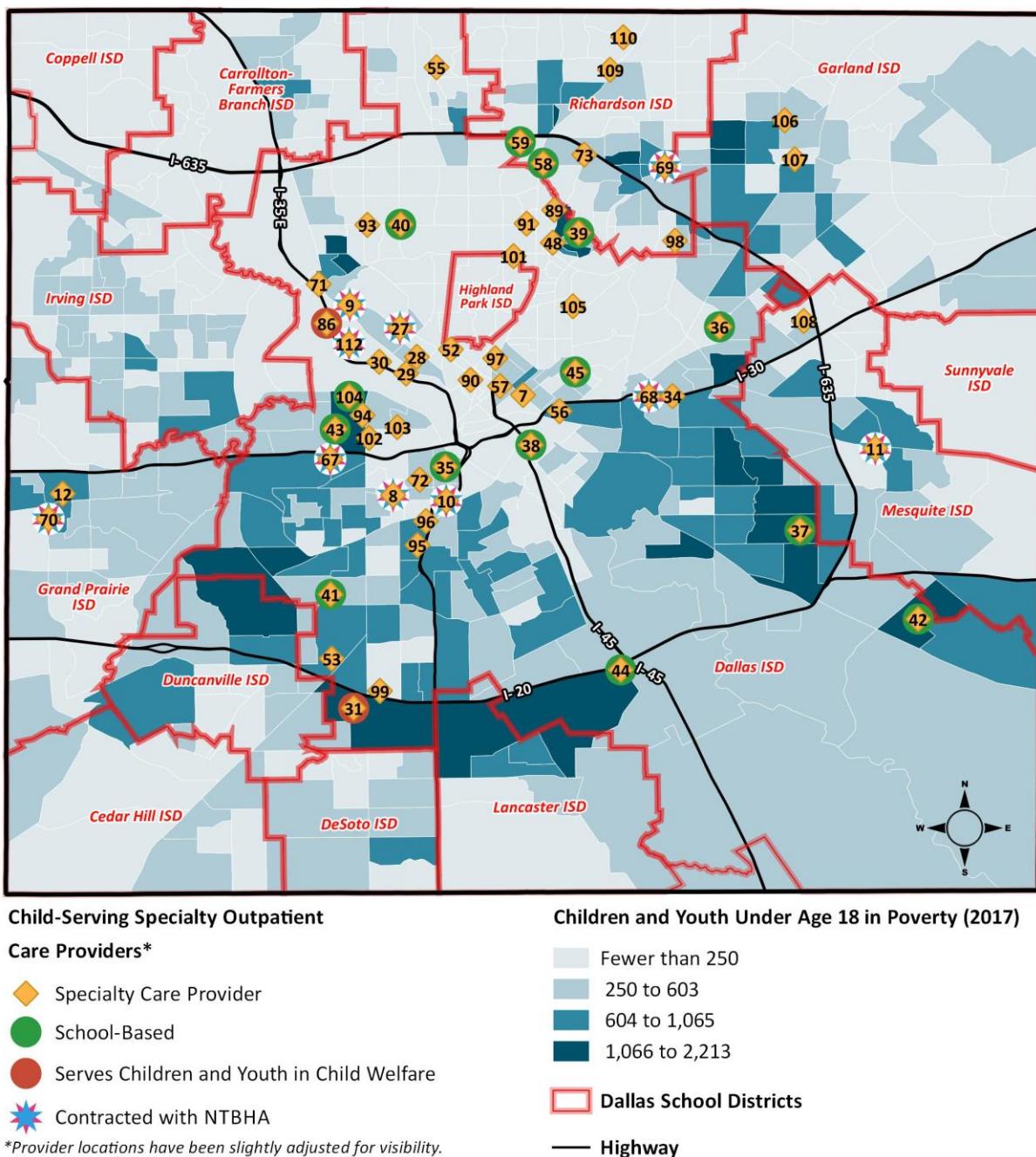
Texas and Dallas County, like most states and counties, do not maintain an unduplicated count of children and youth who are served in specialty outpatient behavioral health care settings because there are multiple funding streams for these services (e.g., Medicaid, private insurance, grant funding, and private payers). Although it is easier to obtain information for publicly-funded providers than it is for private providers, it is difficult to quantify the total number of children, youth, and families who receive services. It may be tempting to sum all of the numbers of children and youth served that are listed in this section of the report, but this still would not provide an accurate count. At this time, nobody has a comprehensive unduplicated data set for all specialty outpatient providers in Dallas County.

Many variables affect access to appropriate care for outpatient mental health services, especially in a large metropolitan area like Dallas County. Factors include insurance type, service location and transportation options, levels of outreach, waiting lists and capacity gaps, and the adequacy and effectiveness of the available service array. As shown in Map 4, finding potential providers in Central Dallas and west central Dallas County is much easier than locating providers in east central or southeast Dallas County. Yet families living in poverty, and most susceptible to transportation-related barriers, are concentrated in the south, southeast, and east of Dallas County.

How Accessible Are Specialty Outpatient Mental Health Services?

Map 4, on the following page, shows all specialty outpatient mental health clinics included in this assessment, community mental health center locations, and other leading providers we reviewed or otherwise identified. School-based locations are designated with a special symbol. The map also contrasts the geographic locations of the specialty outpatient mental health providers in Dallas County with counts of children and youth in poverty, by census tract, in 2017. It also includes providers that serve children and youth who are involved with the child welfare system, school-based providers, and providers that contract with the North Texas Behavioral Health Authority to provide services. A map key listing all providers by name and their associated map labels is provided in Appendix B.

Map 4: Specialty Outpatient Mental Health Providers in Dallas County¹¹⁶



Specialty outpatient mental health providers serve a large portion of Dallas County, often including surrounding counties. Despite their large geographic service area, their physical

¹¹⁶ Service locations for the Family Place (four in total) are not represented on this map in order to protect the safety of those accessing services as a result of domestic violence.

locations are concentrated in the central part of the county, with few locations in south and southeast Dallas County. Depending on the severity of need, some of the providers may deliver home-based care; however, most require at least one office visit prior to initiating services, which can be an obstacle for many families. The lack of provider locations in south and southeast Dallas County may make it difficult for caregivers to consistently engage in the services their children need.

The primary types of providers in south and southeast Dallas County are school-based providers. Approximately 513,577 children and youth are enrolled across the 14 ISDs and 33 charter schools in Dallas County. Given the large number of schools in the county, it was challenging to obtain information on how many campuses offer school-based or school-linked mental health services. Dallas ISD is unique in that it funds mental health services through its Youth and Family Centers for all students and families in the district. However, for children and youth who reside outside of Dallas ISD's boundaries, these school-based mental health services may not be available. Non-Dallas ISD students can be seen at the Youth and Family Centers (school-based clinics) for physical health services (through Parkland); however, those not enrolled with Dallas ISD cannot receive mental health services at these clinics and must be referred to community-based providers.

Children's Health developed a solution to the access issue in south Dallas County through an evolution and expansion of its original school-based telehealth program for acute physical health care (established in 2014). Since first implementing the school-based tele-behavioral health services in fall 2017, this Children's Health program is currently in 14 Dallas County schools. It also intends to add three more campuses (two elementary schools and an alternative campus) before the end of the 2019–2020 school year.

Additionally, Child and Family Guidance provides telehealth and telemedicine services at two schools in the county, and Communities In Schools of the Dallas Region is in 36 Dallas County schools, which represents about 5% of the public schools in the county. Moreover, Uplift Education, a charter school with locations across the county, offers both mental health services and community referrals through a department designed specifically to address the mental health needs of its students.

This is just a snapshot of specialty outpatient services provided within Dallas County schools. With 513,577 students, demand exceeds availability.

Who Are the Specialty Outpatient Clinic and Counseling Center Providers?

The providers described below comprise a set of specialty outpatient mental health providers identified by The Rees-Jones Foundation and our key informants, but there are hundreds more

independent small group and individual practitioners within Dallas County that are providing these crucial services. Some of these providers have very specialized areas of focus and most are supported through specific funding streams to focus on targeted populations, pointing to the difficulty in establishing and sustaining broader, multi-faceted, outpatient mental health programs.

The Center for Integrated Counseling and Psychology

The Center for Integrative Counseling and Psychology (The Center — formerly Pastoral Counseling) provides counseling and assessments at its main office in Dallas, 15 church partner locations, four physicians' offices, and 11 partner community-based organizations throughout North and Central Texas. The Center also collaborates with Dallas ISD to provide parent education and leadership to the Social and Emotional Health Professional Learning Community of Southern Methodist University's School Zone (a collective impact partnership for college readiness), which is part of the Budd Center. It also has a partnership with Highland Park ISD to provide social and emotional learning programs. The Center co-locates and collaborates with these partners to remove geographical barriers (from McKinney to Waco and Rockwall to Arlington), making mental health care services at these locations more accessible to the entire community as well as the people served by its community partners.

The Center provides mental health services to children, youth, and their families, including play and talk therapy, family therapy, parent workshops, and workshops for children and youth. The Center offers evidence-based services such as cognitive behavioral therapy (CBT), Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Positive Parenting Program (known as Triple-P), Eye Movement Desensitization and Reprocessing Therapy (EMDR), and others. In addition to therapeutic services, The Center also provides educational, neuropsychological, developmental, and diagnostic assessments. These assessments can identify needs related to attention-deficit/hyperactivity disorder, cognitive and developmental delays, autism spectrum disorder, learning disabilities, and emotional and behavioral challenges (e.g., oppositional defiant disorder, depression, bipolar disorder).

The Center has developed an innovative program for uninsured clients — the Partnerships for Accessible Counseling and Training (PACT), which makes psychological services accessible to underserved communities who have had little access to mental health care. Through PACT, The Center collaborates with 11 partner nonprofit organizations to provide mental health services to clients receiving services from these organizations (services range from medical services to food and clothing distribution, after-school and summer academic support, and job training). These organizations have had an historic presence in their respective communities, which has allowed The Center's clinicians to develop strong relationships with their existing clients.

Each year, The Center provides counseling and assessment services to more than 500 children and youth, including approximately 180 in Dallas County.¹¹⁷ It accepts most insurance types, including Medicaid, and to ensure that people without insurance are not turned away, it offers a sliding-fee scale.

Center for Survivors of Torture

Center for Survivors of Torture (CST), which has one location in Dallas, provides free services to asylum seekers and refugees. CST aims to provide patient-centered, trauma-informed care to address the psychological, medical, and social needs of trauma victims and facilitate healing. Given the wide range of people seeking its support, CST trains staff to be culturally competent and strives to be linguistically diverse to meet the unique needs of torture and trauma survivors.

Each year, CST serves approximately 700 survivors from over 35 countries and ranging in age from four to 80 years old. Over 200 of its clients are children and youth (approximately 32%).

For each child or youth, licensed clinicians and interns conduct an assessment to gauge if they are in crisis, vulnerable, stable, or safe. Clinicians provide home-based services and adapt all services to meet individual needs. CST uses an interdisciplinary team that includes trained interpreters, physicians, and mental health professionals to provide long-term care when there is a mild-to-moderate mental health need. It delivers evidence-based practices such as CBT and solution-focused therapy. The team makes referrals to other community-based providers for intensive mental health and crisis needs, but remains connected to the people it serves to help connect them to resources, as needed. In addition to traditional mental health services, CST also offers mentoring, tutoring, resume building, job searches, English as a second language training, and support in obtaining housing, food, and clothing as well as navigating the medical and legal systems.

Centro de Mi Salud

Centro de Mi Salud provides bilingual behavioral health care services to children, youth, and their families as well as to adults. It was founded in 1999 in response to a need to have a culturally and linguistically responsive provider for the Hispanic population in Dallas. Centro de Mi Salud serves people representing various ethnic backgrounds; ensuring cultural competence is central to their mission.

¹¹⁷ Utilization data we received from the provider were adjusted to estimate the number served in a 12-month period.

Each year, Centro de Mi Salud serves approximately 976 children and youth between the ages of three and 17 years.¹¹⁸ Its services for children, youth, and their families include psychiatric/medication services, individual and family counseling, case management, group counseling, and parenting classes as well as anger management groups for youth. Centro de Mi Salud also provides non-traditional programming such as a four-week program on mindfulness, yoga, and a meditation program; jewelry-making classes; and piñata-making classes. It does not provide intensive services (Level of Care 4) or crisis services) or crisis services (LOC-0). Additional information on level of care (LOC) services based on the Texas Resilience and Recovery (TRR) Utilization Management Guidelines can be found in Appendix D: Level of Care (LOC) Overview.

Centro de Mi Salud is a comprehensive provider that is authorized to provide Targeted Case Management and Mental Health Rehabilitative Services through the North Texas Behavioral Health Authority and regional Medicaid managed care organizations; it also accepts Children's Health Insurance Program (CHIP), private insurance, and cash payments on a sliding-fee scale.

Children First, Inc.

Children First, Inc. (Children First) provides professional counseling and therapy services for victims of child abuse, domestic violence, and other crimes. It serves children ages three years and older, youth, and adults. Children First serves approximately 255 children and youth each year.

Children First's general counseling program offers individual, family, and couples counseling as well as play and art therapy facilitated by master's level clinicians or closely supervised graduate students pursuing a degree in counseling or social work. Counseling services consist of 50-minute therapy sessions that are primarily offered once a week.¹¹⁹ Play therapy is offered to children as young as three years of age. Caregivers can be trained to practice the elements of play therapy in their homes to extend and support the therapeutic process. Many of the clinicians at Children First are trained in evidence-based practices, including EMDR, CBT, solution-focused therapy, and child-centered non-directive play therapy.

Children First also offers services specifically for youth.¹²⁰ Its First Offender Group is for first-time young offenders and offers a curriculum that addresses skill-building, decision-making, respect, responsibility, and ways to develop positive peer relationships. It also offers an Anger

¹¹⁸ Utilization data we received from the provider were adjusted to estimate the number served in a 12-month period.

¹¹⁹ Children First. (n.d.). *General counseling*. <https://www.childrenfirstinc.org/general-counseling.html>

¹²⁰ Children First. (n.d.). *Adolescent Services*. <https://www.childrenfirstinc.org/adolescent-services.html>

Management Group that teaches effective anger management techniques, communication skills, and other related skills. Finally, Children First offers a Life Skills Group for youth ages 16 to 18 years to support the transition from adolescence to adulthood. The curriculum teaches parenting, goal setting, budgeting, how to establish professional relationships, job-readiness preparation, and other relevant skills.

Lastly, Children First provides the Battering Intervention and Prevention (BIPP) program for men struggling with abusive behavior in intimate relationships (Children First also offers BIPP groups for women).¹²¹ The organization receives referrals from child protective services, police departments, and the courts. These groups offer an opportunity for those in an abusive relationship to reflect on how to maintain a safe environment for their partners and family.

Children's Health Psychiatry Programs

In general, the Department of Psychiatry at Children's Health System treats children and youth with more complex psychiatric needs. Children's Health psychiatry department provides outpatient psychiatry and psychology services, which include psychiatric and psychological assessments for children and youth; individual, family, and group therapy; and medication evaluation and management. Its three treatment areas of focus are (1) mood disorders and suicidality, (2) eating disorders, and (3) children and youth with both a psychiatric and medical diagnosis. Children's Health is one of the only providers in the region that can treat someone with co-occurring psychiatric and medical needs.

The outpatient psychiatry department at Children's Health is comprised of the Depression Clinic, the Early Childhood Mental Health Clinic, and the General Psychiatry Clinic. Evidence-based practices available through these clinics include CBT, TF-CBT, PCIT, Theraplay, and Dialectical Behavior Therapy (DBT), among others. In 2018, the clinics saw 774 new patients and had 3,751 psychiatric medication management visits and 2,231 psychological testing and therapy visits.

Children's Health also offers a day treatment program (partial hospitalization program) for children and youth who are safe to be home in the evenings, but require a higher level of care than traditional outpatient services can provide. The program has the capacity to treat 12 individuals at a time and treated 164 children and youth in 2018. In addition, Children's Health provides an intensive outpatient program called Suicide Prevention and Resilience in Children. Designed to target the risk factors associated with suicidality in children and youth, this program is based on CBT and DBT principles such as developing coping skills, including relapse prevention skills, and identifying unhelpful beliefs that are triggers for suicidal thoughts. The

¹²¹ Children First. (n.d.). *Who we are*. <https://www.childrenfirstinc.org/who-we-are.html>

program structure includes three hours of intensive group therapy each week for three cohorts of 25 youth each as well as individual and family therapy sessions. Children and youth participate in the program with their caregivers.

Lastly, Children's Health offers inpatient psychiatric care to children and youth ages five to 18 years of age who need more intensive care and who are not safe at home. For the majority of each year, this nine-bed unit is at maximum capacity and receives more requests for admission than it can accommodate. Given its location within a pediatric hospital, the program specializes in offering care to patients with co-occurring medical and psychiatric issues.

ChristianWorks for Children

ChristianWorks for Children (ChristianWorks) is an adoption agency and counseling center that provides spiritually-based counseling; adoption placement; and grief, divorce, and post-adoption support for children and youth. It serves over 400 children and youth each year.

Many of the clinicians at ChristianWorks are trained in evidence-based practices and offer various interventions, including Theraplay, Seeking Safety, CBT, TF-CBT, EMDR, play therapy, and Circle of Security. Most services are provided in an office setting; however, some group counseling services are offered in schools.

ChristianWorks offers an extensive range of services and supports, all following a set of curricula catering to clients' needs. Its counseling center, CounselingWorks, offers individual, couple, marital, premarital, and family counseling as well as play therapy for children and youth ages three and older.¹²² JustFamily is an eight-week program that provides support and services to children, youth, and parents. This program is offered twice a year, and children and youth have the opportunity to share their experiences and express themselves through play, including art, puppets, books, games, and other creative activities. JustFamily programming is led by trained facilitators.

ChristianWorks also provides free support group programs, including KIDWorks — for children and youth ages five to 18 who are dealing with their parents' divorce — and GriefWorks — for children ages five to 18, which offers a safe place for children and youth to share their stories and explore their grief. ChristianWorks also developed a free weekend camp, CampSunrise, for children ages six to 17. This camp provides a safe place for children to share their grief with peers who have also suffered the loss of a loved one. Licensed counselors and trained facilitators lead children and youth through fun, high-energy activities, which provide healthy

¹²² ChristianWorks. (n.d.). *CounselingWorks*. <https://www.christian-works.org/counseling-works/>

ways to express emotions and develop strategies for coping with and recovering from grief and loss.

A unique service provided at Christian works is AdoptionWorks, a fully licensed child-placing agency that provides infant domestic adoption services to birth families, adoptive couples, and adoptees. It offers clinical post-adoption services, including search and reunion services, individual counseling or play therapy for members of the adoption triad, and free support groups for children and youth who have been adopted, and their parents.¹²³

The Counseling Place

The Counseling Place, located in Richardson, offers both office-based and community-based counseling services to people living and working in Richardson and the surrounding areas. Licensed therapists provide counseling services to individuals (including children, youth, and adults), families, or couples. Therapists at The Counseling Place provide trauma-informed treatments such as EMDR and TF-CBT. Other types of interventions are available as well, including mindfulness, crisis intervention, and art and play therapy.

In addition to professional counseling, The Counseling Place offers community programs for children and youth, including a Juvenile First Offender Program, a Drug Awareness Program, and an Alcohol Awareness Program for minors that is a state certified, six-hour course. These programs provide services for children and youth with more serious needs. Some of The Counseling Place's community programs serve adults, too, including caregivers, first responders, and others. It also provides advocacy and a wide range of therapeutic services through its Victim's Assistance Program for victims of crime or other traumatic events. Group services at The Counseling Place focus on enhancing decision-making and coping skills. Currently, The Counseling Place is developing a prevention curriculum and continues to partner with agencies to work toward its goal of helping victims recover emotionally and emerge from crises even stronger.

The Counseling Place serves approximately 369 children and youth each year¹²⁴ and offers a sliding fee scale for its services.

Dallas Children's Advocacy Center

Dallas Children's Advocacy Center (DCAC) coordinates the investigation and prosecution of the most severe cases of child abuse in Dallas County and facilitates healing services for victims. Children and youth (and non-offending family members) who are victims of sexual abuse or

¹²³ ChristianWorks. (n.d.). *AdoptionWorks*. <https://www.christian-works.org/adoptionworks/>

¹²⁴ Utilization data were adjusted to estimate the number served in a 12-month period.

physical abuse, or who witness a violent crime, are eligible for DCAC services and supports. DCAC is co-located with six child protective services units, Dallas Police Department's Child Abuse Unit, and a Dallas County assistant district attorney, which streamlines communication and collaboration. Each year, DCAC serves over 1,200 children and youth in addition to their non-offending family members or caregivers.

Law enforcement or child protective services refer children and youth to DCAC. One of the benefits of the DCAC model is that it allows a child or youth to tell their story to one person (a DCAC forensic interviewer asking developmentally appropriate questions) who records the interview for use if the case goes to court. This streamlines the investigative process and reduces the number of times the child or youth are required to tell their story outside of a therapeutic setting.

DCAC also offers forensic services, legal assistance, psychological evaluations, psychiatric care, mental health services, family advocacy, and training for professionals. DCAC screens children and youth to determine the level of trauma and need for therapeutic intervention. Therapeutic services include individual, group, and family therapy. Some of the evidence-based practices DCAC uses are Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), Parent-Child Interaction Therapy (PCIT), Eye Movement Desensitization and Reprocessing Therapy (EMDR), and Dialectical Behavior Therapy (DBT). Additionally, it has begun to offer Problematic Sexual Behavior-CBT after identifying a gap in available providers for children and youth with problematic sexual behavior, a common symptom following exposure to intimate partner violence, harsh parenting, and sexual abuse. A family advocate is available for family members to provide case navigation and parenting support services.

Dallas ISD Youth and Family Centers

Dallas ISD operates 11 Youth and Family Centers on school campuses that offer mental health and physical health services to students across the district. The mental health services are provided by clinical staff employed by the district, with each center employing approximately seven clinicians; each location has four full-time staff and two or three part-time staff. The physical health services are provided through a partnership with Parkland, as noted earlier. Although the centers are located on specific school campuses, each is open to any Dallas ISD student and family.

Dallas ISD's Youth and Family Centers offer the following mental health services to students and their families: evaluation and assessment; individual, family, and group therapy; psychological

evaluation; and medication management.¹²⁵ The centers also provide case management, parent education, referrals, and other supportive services. All clinicians have a general knowledge and background in CBT, 10 clinicians are trained in TF-CBT, and the centers also employ clinicians trained in EMDR as well as other evidence-based treatments. The district is working to make more training in evidence-based practices available for clinical staff.

Dallas ISD's Youth and Family Centers accept Medicaid, private insurance, and cash payment on a sliding-fee scale. They also partner with the North Texas Behavioral Health Authority (NTBHA) to subsidize services for children and youth who do not have insurance that covers mental health or substance use disorder treatment. NTBHA is able to provide funding for these services through its contracted service providers and assist with applications to secure benefits such as Texas Medicaid, CHIP, TANF, etc. While the Youth and Family Centers bill insurance when possible, no child or family is turned away because of an inability to pay. Each year, Dallas ISD's Youth and Family Centers serve approximately 5,200 children and youth.

The Family Place

The Family Place is the largest provider of services to victims of family violence in North Texas. It has multiple locations that offer a range of services to children, youth, and adults, including emergency shelters; medical and dental clinics; an animal shelter (so those leaving a violent situation do not have to leave their pets behind); transitional housing; children's educational services (for children ages six weeks to second grade); counseling centers for children, youth, families, and adults; prevention programs; incest recovery programming; supervised visitation; batterer's intervention program; employment services; legal services; and community education. The Family Place currently operates three emergency shelters that provide 177 shelter beds in all.

The Family Place's Children's Counseling Program provides intensive case management and counseling services to children and youth in a residential (shelter) setting as well as in a community setting. Clinical staff use play therapy and activity-based programming to help children and youth overcome the trauma of family violence and avoid the cycle of violence as adults. All therapists in the program are trained in TF-CBT and some staff are trained in EMDR or DBT. Children and youth in the Children's Counseling Program are screened for adverse childhood experiences and posttraumatic stress disorder. Therapeutic services are then matched to meet the identified needs. Another program, the Be Project, is a primary prevention program that targets youth violence by addressing healthy communication, healthy relationships, bullying, and sexual assault.

¹²⁵ Dallas Independent School District. (n.d.). *Youth and Family Centers*.

https://www.dallasisd.org/cms/lib/TX01001475/Centricity/Domain/168/YFC_All%20Ctrs%20Flyer_Updated%2009%202019.pdf

Finally, The Family Place offers supportive services and interventions for parents and caregivers, including individual, group and family therapy; domestic violence education groups; and parenting classes (curriculums include Love and Logic, Nurturing Parenting, Circle of Security, and The Whole Brain Child Workbook). The Family Place enrolls parents and caregivers in one of these groups or classes to engage them in services as soon as possible, rather than having to wait for an individual counseling slot. It also offers adults resources to help them secure employment, obtain legal advice, and acquire assistance to meet their family's basic needs.

Last year, The Family Place served just over 400 children and youth in the Counseling Program and about 7,800 through the Be Project.¹²⁶

Family Studies Center

The Family Studies Center is part of the Department of Family and Community Medicine at UT Southwestern and provides therapy to individuals, couples, and families, with a particular focus on couples and family therapy. Although the Family Studies Center does not offer individual therapy to children and youth because of its funding, it does provide family therapy to treat a wide range of serious clinical issues, including depression, marital issues, anxiety, grief, and child-parent and blended family issues. The Family Studies Center also specializes in medical family therapy, which focuses on patients and family members dealing with chronic illnesses or disabilities and how those impact the family system.

Through its partnerships at UT Southwestern, the Family Studies Center is able to provide supervised training opportunities to residents, third-year medical students, marriage and family therapy Interns, and licensed marriage and family therapist–associates (those who have completed their master’s degree and are accumulating hours toward licensure). This model allows the Family Studies Center to offer family therapy to more families than would otherwise be possible.

The Family Studies Center also contracts with Uplift Education to provide family therapy for its students and families.

In the last reporting year, the Family Studies Center served about 200 families, each receiving an average of six sessions.

¹²⁶ Utilization data were adjusted to estimate the number served in a 12-month period.

Genesis Women's Shelter and Support

With two locations in Dallas County, Genesis Women's Shelter and Support (Genesis) provides emergency shelter, transitional housing, and counseling services to women and children who are survivors of domestic violence. Genesis has six specific program areas: advocacy, clinical, an on-site school, legal, residential services, and childcare services. It also offers a 24-hour crisis hotline. Genesis provides emergency shelter on its campus for up to six weeks to provide stabilization and education. The transitional housing program currently includes 18 apartments where women and their children can live for up to one year. Every woman, child, and youth receiving residential services from Genesis is offered an advocate to help with the transition and to access needed resources. The team at Genesis comprises family law attorneys, administrators, advocates, counselors, teachers, social workers, and childcare staff.

Genesis also offers counseling services. Since many women, children, and youth who have experienced domestic violence exhibit symptoms of posttraumatic stress disorder, Genesis uses a trauma-informed approach and its counselors are trained in trauma-informed care. Many of the counselors are trained in one or more evidence-based practices, including, Theraplay, EMDR, TF-CBT, Cognitive Processing Therapy, or Trust-Based Relational Intervention (TBRI).

Genesis also offers additional support services, including family nights where counselors work with caregivers and children on attachment-related activities. Advocates offer employment, housing, and parenting services for women. In addition, Genesis operates a school for young children that integrates a trauma-informed environment into the classroom setting. The school programming provides mindfulness practices, brain breaks, and other interventions to support healing for its students.

Each year, Genesis assists approximately 3,700 women, children, and youth and provides behavioral health services to nearly 200 children and youth in Dallas County.

The Harmony Counseling Center

The Harmony Community Development Corporation was initially developed by Concord Church to increase the community's affordable housing, employment opportunities, and social and educational services as well as combat crime. In 2007, its mission expanded to include a broader focus on social services through the Resource Center and Counseling, now known as The Harmony Counseling Center (Harmony). Harmony provides counseling services, psychoeducation, and outreach to children, youth, and adults.

In addition to counseling services, Harmony also provides a New Beginnings support group for children dealing with their parents' divorce. Harmony also offers the Family Tree Program, funded by the Department of Family and Protective Services. In partnership with The

Counseling Center of Denton, The Family Tree Program offers free family counseling for Dallas and Denton County youth and their families. Harmony also provides support and resources to foster and adoptive families (and those considering becoming foster or adoptive parents) through its Foster Adoption Ministry, including 10 scheduled support group meetings throughout the year.

Finally, a large part of Harmony's work focuses on outreach to combat the stigma of mental illness and seeking mental health services, particularly in the African American community. This work occurs largely in schools and churches where Harmony provides education about mental health, wellness, and resources available across the community.

Each year, Harmony serves approximately 100 children and youth.

Jewish Family Service of Greater Dallas

Jewish Family Service (JFS) of Greater Dallas is a nonsectarian organization that offers a wide range of mental health and social services to children, youth, adults, and older adults, including specialized services for people with mental illness and disabilities, and those facing emergencies or domestic violence. JFS of Greater Dallas offers individual, family, and group counseling and psychotherapy; behavior treatment; recovery support; family support; psychological evaluations and assessment of abilities and needs; support groups; in-school resources; speech and language therapy; psychiatry; care management; and therapeutic groups for children and youth affected by abuse. JFS of Greater Dallas also operates a transitional housing program for 21 families.

JFS of Greater Dallas also offers a variety of services specifically for children and youth, including individual counseling, play therapy, addiction counseling, and psychological evaluations. All services are provided for as long as they are needed. JFS of Greater Dallas takes a team-based approach when working with a family, often having three to four clinicians working with each family to identify and address needs. Many of the JFS of Greater Dallas clinicians are trained in evidence-based practices, including community-partnered school behavioral health, PCIT, Applied Behavior Analysis, CBT, TF-CBT, and EMDR. As an organization, JFS of Greater Dallas is also accredited in the Meichenbaum approach to cognitive behavioral modification, an integrative approach to CBT focused on shifting a person's dysfunctional self-talk from negative to positive.¹²⁷

Each year, JFS of Greater Dallas serves over 1,100 children and youth.

¹²⁷ Meichenbaum, D. (1977). *Cognitive-behavior modification*. Plenum Press.

Momentous Institute

Momentous Institute offers social and emotional learning (SEL), therapeutic services, education, research, and training. Momentous Institute takes a strengths-based, trauma-informed, family- and systems-focused, and collaborative approach to working with children, youth, and families. It works with children and youth from birth to age 15 years and their families. The median household income of families served by Momentous Institute is \$26,000. While it does not bill insurance, it does offer a sliding-scale fee structure and does not determine eligibility for services based on a family's ability to pay. There are also no geographic restrictions on who can access services at the Momentous Institute's two Dallas-based locations.

One component of the Momentous Institute is the Momentous School that was discussed in Component 0. The Momentous School educates children in pre-kindergarten through the fifth grade, implementing SEL and trauma-informed strategies along with academics in the classroom.

Momentous Institute also offers therapeutic services for children and youth from birth to age 15 years and their families. Modalities include individual, family, and group services. It uses a strengths-based and trauma-informed approach to resolve conflict, process trauma, and manage stress. Many of Momentous Institute's clinicians are bilingual and able to offer services in both English and Spanish. Clinicians are licensed in a variety of clinical areas and are trained in evidence-based practices, including early childhood mental health consultation, Theraplay, Child-Parent Relationship Therapy, behavior therapy, Brief Strategic Family Therapy, CBT, TF-CBT, and EMDR. Momentous Institute also offers psychological and psychoeducational evaluations for children. There is an early childhood assessment team that evaluates children age six years and younger who are referred from the community. For children seven years and older, evaluations are provided to existing clients or students Momentous Institute who are enrolled in its school.

Momentous Institute also has two intensive group therapy programs called Huddle Up and Launch. Huddle Up utilizes a systemic and experiential approach to empower youth to improve self-control, problem-solving, respect, mindfulness, and communication. The program lasts 10 weeks and includes five hours of group services for the youth and families each week. Launch is an intensive group therapy program for children ages three to five years who are have been (or are in jeopardy of becoming) expelled from school because of severe social and emotional difficulties. The program offers specialized treatment for children with histories of trauma and takes a systemic approach by considering all outside and environmental influences on a child's life experience.

In the last year, Momentous Institute served 4,281 children and family members. Of these, 2,364 participated in clinical services and 1,917 in parent education.

Mosaic Family Services

Mosaic Family Services provides culturally and linguistically competent services in North Texas, with the goal of supporting, educating, and empowering women, children, youth, and families. It supports unaccompanied minors, victims of crime, refugees, immigrants, and survivors of human trafficking and family violence.

Mosaic Family Services offers individual and group therapy, play therapy, sand tray and art therapy, parenting classes, and EMDR. Services are provided by a team of clinicians, clinical interns, and a clinical director. Many of the clinicians are trained in evidence-based practices, including CBT, TF-CBT, solution-focused therapy, family systems, humanistic approaches, and EMDR, among others. Mosaic Family Services offers age-related services consisting of play and expressive therapies for younger children and individual and group counseling for youth.

In addition to mental health services, the team offers case management, assistance with legal services, and help with emergency shelter and transitional housing needs. Mosaic Family Services' Economic Empowerment Program helps victims of human trafficking and domestic violence obtain safe transitional housing. This program's current capacity now enables it to offer some daycare services to women and children in its shelter.

In 2018, Mosaic Family Services directly served over 8,200 individuals and their families, including over 100 children and youth in behavioral health care.¹²⁸ Additionally, it provided outreach to over 15,000 individuals throughout the community.¹²⁹

North Texas Behavioral Health Authority (NTBHA)

The North Texas Behavioral Health Authority (NTBHA) is the local behavioral health authority (LBHA) for Dallas County and its surrounding counties. In this capacity, NTBHA oversees the provision of behavioral health services for children, youth, and adults without insurance coverage who have household incomes up to 150% of the federal poverty level for mental health services, or 200% of the federal poverty level for substance use disorder services. People receiving services must also demonstrate that they do not carry private insurance or Medicaid.

¹²⁸ The total count of people served was obtained from Mosaic Family Services. (n.d.). *2018 annual report. Support. Educate. Empower.* <https://mosaicservices.org/wp-content/uploads/2019/03/2018-Annual-Report.pdf>

¹²⁹ Mosaic Family Services. (n.d.). *2018 annual report. Support. Educate. Empower.* <https://mosaicservices.org/wp-content/uploads/2019/03/2018-Annual-Report.pdf>

Eligible children and youth can access services at any NTBHA-contracted provider location. In Dallas County, NTBHA contracts with four mental health providers — Centro de Mi Salud, Child and Family Guidance Center, Dallas Metrocare Services, and Youth Advocate Programs — that provide a continuum of services (screening, assessment, diagnosis, individual and family interventions) for children and youth. As the LBHA, NTBHA is also required to ensure the availability of a crisis hotline (24 hours a day, seven days a week) and mobile crisis outreach teams to respond to behavioral health crises across the county; it contracts with Adapt Community Solutions for these services. (More detailed descriptions of Child and Family Guidance Center, Dallas Metrocare Services, and Youth Advocate Programs are included in the Specialty Rehabilitative Care section of this report. A description of Centro de Mi Salud was included earlier in this section).

In fiscal year 2018, NTBHA reported that its providers served 11,439 children and youth, with 99 served in the most intensive levels of care.¹³⁰

Specialty Outpatient Mental Health Care Findings

Specialty Outpatient Mental Health Care (SMH) Finding #1: Specialized programs and treatments are available to children and youth with specific needs. Many nonprofits are experienced and trained to provide treatment in specialized areas (e.g., trauma, sexual violence, family violence). However, treatment modalities are often linked to an individual clinician and not embedded into the organization. Additionally, since a number of clinicians deliver specialized evidence-based practices (Parent-Child Interaction Therapy [PCIT], Dialectical Behavior Therapy [DBT], Trauma-Focused Cognitive Behavioral Therapy [TF-CBT], or Eye Movement Desensitization and Reprocessing Therapy [EMDR], for example), there may be opportunities to collaborate and embed these practices into multiple organizations by creating a learning and cross-training collaborative among organizations with specialized skill-sets.

SMH Finding #2: Mental health providers described being unaware of what services other providers offer and expressed a desire to partner with these providers to ensure clients get the services that will best meet their needs. Overwhelmingly, providers noted a lack of coordination among components of the system, primarily due to a lack of awareness of what services or resources other providers in the community offer. Despite efforts to improve awareness of treatment options such as the Grant Halliburton Foundation’s “Here for Texas” website,¹³¹ respondents from nearly every organization we reviewed for this report expressed a desire to better understand the services and resources available throughout the community in

¹³⁰ The North Texas Behavioral Health Authority reports the number of children and youth served in a six-county region. Based on county population sizes, we estimated that in fiscal year 2018, NTBHA providers served 11,439 children and youth, with 99 being served in the most intensive levels of care.

¹³¹ For more information, see: <https://www.herefortexas.com/index.html>

order to partner with other organizations and connect the people they serve with the services that will best meet their needs.

SMH Finding #3: Staff retention is an ongoing challenge and organizations often compete for the same staff. Training is costly and there is frequent staff turnover and shortages, most notably staff with proficiency in evidence-based models and those with cultural and linguistic competency. Providers stated that there is a shortage of both psychiatrists and mental health clinicians to meet the current needs in the community. They also noted they have had difficulty retaining staff, particularly bilingual staff and those with advanced trainings and certifications (e.g., TF-CBT, EMDR, and DBT). Most clinicians do not enter employment with advanced training or experience in delivering evidence-based practices. As a result, provider organizations are often responsible for ensuring their staff receive this training and experience to deliver effective services. Provider organizations noted that evidence-based trainings are often expensive and, when paired with high staff turnover, become cost prohibitive. Additionally, many provider organizations who are culturally competent with the populations they serve stated it is hard to find and retain culturally competent staff. Providers especially highlighted the need for bilingual staff beyond Spanish and English speakers as there are many languages spoken across the county.

SMH Finding #4: Integration of specialty outpatient mental health care in schools is often based on individual relationships, not on systemic policies and procedures. While there are notable exceptions, some providers reported difficulty in being able to serve children and youth in school settings. The level of difficulty varied among school districts and providers. Often, relationships between providers and schools are informal and based on relationships developed by individuals, not between systems. When individual clinicians leave an organization, the relationships with schools often end as well.

SMH Finding #5: Services and supports for the whole family are lacking. Providers overwhelmingly identified the need for expanded services for the caregivers of the children and youth they serve. They described needs ranging from resources to help caregivers support their children's mental health needs (e.g., parenting classes or in-home coaching) to clinical services to meet caregivers' own mental health or substance use disorder needs.

SMH Finding #6: Treatment is complicated because basic needs are unmet. Nearly every provider stated that transportation limitations are a major barrier to accessing treatment, particularly if the family lives on the outer edges of Dallas County. Families also struggle with food insecurity, child care, housing/homelessness, and other difficulties. According to providers we engaged (and consistent with the research on social determinants of health), these basic

needs often take precedence over mental health treatment. Additionally, providers noted that fears about immigration status prevent caregivers from seeking support.

SMH Finding #7: The stigma associated with mental illness limits access to care. Some providers are actively reaching out to specific communities — the African American community in particular — where there is increased stigma associated with accessing mental health services. However, most providers named stigma as a barrier to people seeking mental health services.

SMH Finding #8: The provider community as a whole is very aware of trauma. While the level of availability of trauma-focused evidence-based interventions varies, nearly every provider discussed the high numbers of children and youth they serve who have experienced trauma. This awareness of the pervasiveness of trauma provides a solid foundation upon which the provider community can develop a community-wide, trauma-informed framework.

Component 3: Dallas County's Specialty Rehabilitative Care Capacity

In our framework, rehabilitative care includes services for children and youth with intensive mental health needs that impair their functioning at home, school, or their communities. Children and youth in need of intensive services, and their families, benefit from evidence-based rehabilitation and specialized treatment of their mental health conditions. Services and supports that address these conditions are ideally provided through evidence-based intensive home and community-based services as described in Appendix C and listed in the box to the right. These services are available in Dallas County, but they are only provided by a handful of providers and are not available to all of the children and youth who need them.

When available and provided to fidelity, intensive home and community-based mental health services can reduce the need and use for costly crisis services, inpatient psychiatric hospitalization, and residential treatment programs, which are unnecessarily restrictive for many and often fail to address the root cause of their needs. These services are also critical as step-down services following crisis events and hospitalization.

In Texas, most intensive home and community-based mental health services are not covered by private insurance. While some (not all) providers allow families to self-pay, services are often

Evidence-Based Intensive Home and Community-Based Services

- Functional Family Therapy
- Intensive In-Home Child and Adolescent Psychiatric Services
- Treatment Foster Care Oregon
- Multidimensional Family Therapy
- Multisystemic Therapy
- Wraparound Facilitation
- Coordinated Specialty Care for First Episodes of Psychosis

too costly for most families to pay out of pocket. The relevant services that are paid for are funded by Texas' Medicaid program or other public sources. In this section, we describe the need for these services and where they are currently available in Dallas County. However, because they are most often provided through Medicaid or other public funding, we begin by describing the regulatory framework through which the services are delivered. This context is important because it affects who receives the services, how the services are provided, and the data available to help us better understand service needs and trends.

Delivery Framework for Intensive Community-based Services and Supports

Because most private insurance does not pay for intensive services, the financial burden for the most effective and expensive evidence-based practices for children and youth with the highest needs' falls to Medicaid and other public payers. Since 2013, the Texas Medicaid program and its contracted managed care organizations have begun to expand the number of providers who are credentialed to provide Medicaid Mental Health Rehabilitative services and Targeted Case Management (TCM). Medicaid Mental Health Rehabilitative Services focus on skill building while TCM is a care coordination function. Prior to 2013, these services could only be delivered by providers who were contracted with local mental health authorities (LMHAs) to deliver them. Now, providers who are credentialed through Medicaid or who contract with LMHAs can provide these services.

The Texas Health and Human Services Commission (HHSC) oversees eligibility for and utilization of these publicly-funded services, using the Texas Resilience and Recovery (TRR) Utilization Management Guidelines for Medicaid and indigent care. The TRR guidelines determine eligibility for services. The TRR framework requires the use of the Child and Adolescent Needs and Strengths (CANS) decision-support tool to determine treatment and the intensity of services needed, also referred to as level of care (LOC). As required by the TRR guidelines, results from the CANS are also used for service planning and monitoring the child or youth's improvement. Under the TRR framework, most intensive community-based mental health services and supports are provided to individuals determined by the CANS to qualify for a higher LOC (LOC-3 or higher). Additional information on level of care (LOC) services based on the TRR Utilization Management Guidelines can be found in *Appendix D: Level of Care (LOC) Overview*. Services provided under TRR LOC-3 complex services, LOC-4, intensive family services (wraparound), and LOC-YES (Youth Empowerment Services Waiver) are considered specialty rehabilitative services in our framework and are summarized below.

Complex Services (LOC-3)

This level of care provides routine case management, skills training, and counseling to children and youth with complex behavioral and emotional needs, including caregiver needs, that affect their ability to function in multiple life domains, as identified on the CANS. Children and youth

may need multiple interventions or interventions aimed at preventing involvement in the juvenile justice system, expulsion from school, out-of-home placements, or worsening symptoms or behaviors. Services are expected to be provided in locations and during times that are most convenient for children or youth and their families. The average monthly utilization standard for this level of care is five (5) hours.

Intensive Family Services (LOC-4)

This higher level of service intensity is generally for children and youth with significant involvement with multiple child-serving systems. It includes intensive family-focused treatment coordinated through the formal wraparound planning process and is usually delivered in the home or community. The child or youth must be experiencing serious functional challenges with a high risk of involvement in the juvenile justice system, expulsion from school, out-of-home placement, hospitalization, residential treatment, serious injury to self or others, or death, along with significant caregiver needs and behavioral and emotional needs. Core services include intensive case management (wraparound), support from Certified Family Partners, counseling, and skills training. The average monthly utilization standard for this level of care is 7.5 hours.

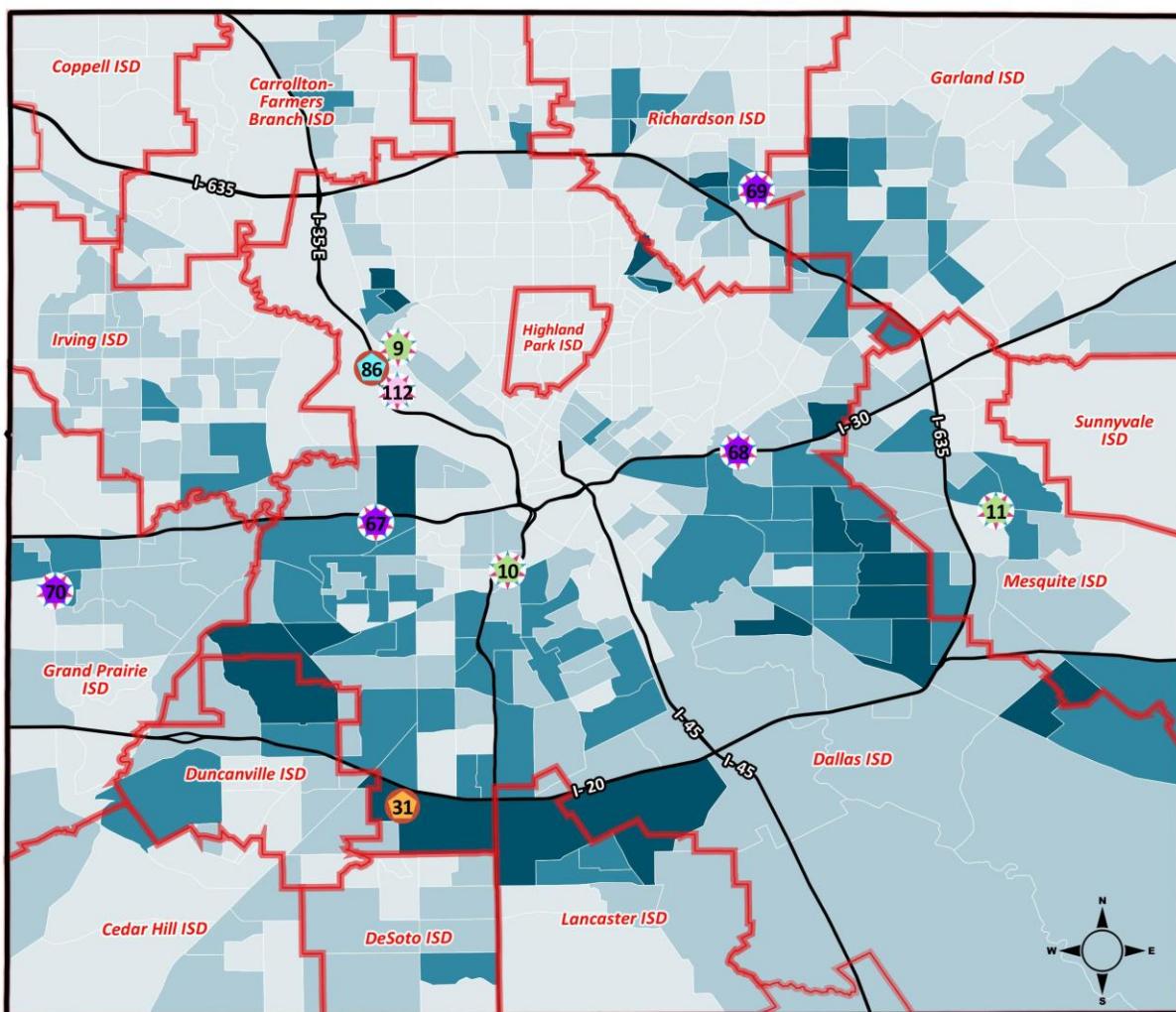
Youth Empowerment Services (YES) Waiver (LOC-YES)

This is a Medicaid program with specialized services available to children and youth ages three to 18 years whose mental health needs are so serious that they would otherwise need institutional care, or whose parents would turn to state custody for care. The YES Waiver level of care includes all of the services available to traditional Medicaid clients under the TRR as well as other services specific to this Medicaid program, described below. Children, youth, and families receive services that are identified through the wraparound planning process, coordinated by a designated provider. In Dallas County, the North Texas Behavioral Health Authority contracts for the “designated provider” role with the Child and Family Guidance Center (CFCG). As the designated provider, CFGC administers the YES Waiver and manages the YES Waiver inquiry line, in addition to providing wraparound process planning (case management) and specialty rehabilitative care. Dallas Metrocare and CK Family Services are designated by the state as comprehensive waiver providers and they provide the non-case management and rehabilitation YES Waiver services in Dallas County. These services include respite care, adaptive aids and supports, community living supports, family supports, minor home modifications, non-medical transportation, paraprofessional services, professional services, supportive employment services, supportive family-based alternatives, and transitional services.

How Accessible Are Specialty Rehabilitative Services?

The map, on the next page, shows the locations of the specialty rehabilitative care providers; some providers have more than one clinic location. While there are a sparse number of providers in this category, they appear to be geographically distributed evenly throughout the county and some services are delivered in home and community settings, so clients are not limited to the locations shown on the map.

Map 5: Specialty Rehabilitative Care Providers



Child-Serving Specialty Rehabilitative Care Providers*

- Child and Family Guidance
- CK Family Services
- Metrocare
- Pathways Youth & Family services
- Youth Advocate Programs

- Serves Children and Youth in Child Welfare
- ★ Contracted with NTBHA

Children and Youth Under Age 18 in Poverty (2017)

- Fewer than 250
- 250 to 603
- 604 to 1,065
- 1,066 to 2,213

— Highway

□ Dallas School Districts

*Provider locations have been slightly adjusted for visibility.

How Many Children and Youth Receive Specialty Rehabilitative Care?

Of the estimated 35,000 children and youth with serious emotional disturbances (SED) in Dallas County, about 20,000 will experience impaired functioning in multiple life domains and require

specialty rehabilitative care. Based on one year of utilization data submitted by providers, just 3,294 of these children and youth received services through specialty rehabilitative care providers, representing only 19% of the total need for ongoing specialty rehabilitative care.

Moreover, of the estimated 2,000 children and youth with the most severe needs who will require intensive, evidence-based interventions, just 317 (approximately 14%) received *intensive services and YES Waiver* services. Based on these data, there are significant gaps in the provision of services for the children and youth in Dallas County with a SED and for the smaller subset of youth with the most severe mental health conditions — those that increase the risk of placement outside of the home or school.

Table 6: Mental Health Specialty Rehabilitative Care – Utilization Details^{132,133}

Mental Health Provider Type	Children and Youth Served by Dallas County Providers
Level of Care (LOC)-3 (Complex Services)	2,977
LOC-4 (Intensive Family Services)	139
LOC-YES (Youth Empowerment Services Waiver)	178
All Specialty Rehabilitative Care	3,294

Challenges Providing Intensive Home and Community-Based Services

Dallas County's current capacity for intensive home and community-based services is very limited. HHSC's TRR Utilization Management Guidelines require all Medicaid TCM and Mental Health Rehabilitative Services providers to offer a comprehensive array of services, including intensive or routine targeted case management, psychiatric diagnostic examination, pharmacological management, skills training, medication training support, counseling services, and crisis services. Through TRR, HHSC designates specific evidence-based practices to be delivered; as a result, the TRR framework is not conducive to the delivery of a wide range of individualized evidence-based practices. Further, for each level of care, these utilization management guidelines include a minimum and maximum number of units of service for children and youth in that level of care. This is interpreted by many providers across the state as a requirement — the number of units of service(s) that must be delivered to each child or youth (and no more). Providers are prevented from delivering the amount and type of care

¹³² Providers submitted one year of utilization data using the most recent complete year that they had available. Some providers submitted data for a partial year – in these cases, we multiplied the number of children and youth served in that time period by the appropriate amount to estimate the number served in full year.

¹³³ Additional information on level of care (LOC) services based on the Texas Resilience and Recovery (TRR) Utilization Management Guidelines can be found in Appendix D: Level of Care (LOC) Overview.

they believe their clients need because of the perceived limit on the amount of service they can deliver, the limited number of evidence-based practices that are reimbursed, and the lack of full reimbursement for these evidence-based practices.

Additionally, TCM and Mental Health Rehabilitative Services are not available outside of the public system and are not reimbursed through private insurance. Some providers prefer to rely on foundation funds, grants, or other resources rather than billing Medicaid because of the constraints they believe it places on their service delivery. In our reviews, we discovered that providers find it difficult, and time and resource intensive, to become credentialed to provide Medicaid TCM and Mental Health Rehabilitative Services.

Moreover, agencies must make initial financial investments for training and credentialing staff, which can be very costly. This training and credentialing process must occur before they can provide services and bill Medicaid, and trainings for certain evidence-based practices are not always available frequently enough. One organization estimated that training for each staff member is about 80 hours, which does not include the organization's orientation. Providers also incur additional costs for updating their billing system when they add a new service. Based on our experience and meetings with providers who have developed such capacity, we estimate that it costs about \$5,000 per child capacity slot to implement TCM and Mental Health Rehabilitative Services. Related to this, there is the challenge of hiring and retaining qualified staff who are willing and able to provide services in home and community settings.

Another barrier to providing intensive evidence-based services for smaller agencies is a calculation related to the number of children and youth who will receive the new service. Smaller agencies must make a determination if they will be able to provide services to a large enough number of children and youth to make the investment worthwhile to them. Many intensive services, including wraparound facilitation, require small caseloads to ensure that clinicians have the time to work more intensively with families. Given that smaller agencies tend to have overall smaller caseloads agency wide, it may be difficult for them to identify enough children and youth with more intensive needs who could benefit from intensive services. Because these intensive practices are more costly to implement, providers do not believe that they can make the investment to hire, train, and credential staff unless they can provide services to enough children and youth to cover their costs.

Additionally, while larger organizations are able to identify enough children and youth to fill a caseload, many have reported that the current reimbursement rates for intensive services do not support the cost of providing the service. For example, some interventions, like cognitive behavioral therapy (CBT), require highly trained clinicians. At the current Medicaid reimbursement rate, providers are unable to cover the cost of providing this evidence-based

therapy. Moreover, only providers designated by HHSC as comprehensive providers — or providers of Medicaid Targeted Case Management (TCM) and Mental Health Rehabilitative Services — may provide HHSC-designated evidence-based practices such as CBT.

Providers who do not have the comprehensive provider designation to provide TCM and Mental Health Rehabilitative Services can receive Medicaid reimbursement for providing any type of counseling service. However, the Medicaid reimbursement rate is the same for all counseling services and does not vary if the service is evidence-based or provides a higher intensity level of care.

At times, providers find that caregivers are not willing to participate in more intensive services. Although they try to educate families at the start of services about the level of commitment required for intensive services, providers sometimes find that families do not engage (or fully engage) in services because of other commitments such as long working hours or negative experiences with other providers or interventions in the past.

Public mental health providers noted that there is a challenge in helping youth transition to the adult mental health system when they reach age 18. Although children and youth may be eligible for Medicaid until age 21, public mental health services, including TCM and Mental Health Rehabilitative Services, end at age 18 and YES Waiver services end at age 19. Young adults who no longer qualify for Medicaid must receive their care from public mental health providers. The eligibility criteria in the adult public mental health system is different than the eligibility criteria in the child and youth mental health system and, therefore, youth with less severe conditions are not eligible for adult mental health services. The eligibility criteria for the adult public mental health system includes diagnoses of schizophrenia or bipolar disorder. Adults with other mental health diagnoses must have evidence of significant difficulty in functioning across one or more life areas such as school or work in order to qualify for services. For youth with more intensive needs, services and programs in the adult mental health system do not align with the services children and youth receive.

Other barriers to implementing intensive evidence-based practices include ongoing supervision that is required to meet the fidelity standards of evidence-based practices, along with low Medicaid reimbursements for these services. Implementation of evidence-based practices such as wraparound requires indirect coordination activities with other providers. Although indirect costs are built into the Medicaid rates, providers report having to absorb those costs because the rate does not support the level of coordination that is actually required. Other intensive evidence-based therapies such as Multisystemic Therapy require frequent sessions with the child or youth and family at the beginning of treatment that are not reimbursed by Medicaid.

New Opportunities to Increase Capacity

Senate Bill (SB) 1177,¹³⁴ which took effect on September 1, 2019, offers an opportunity for making more evidence-based practices available for children and youth with intensive mental health needs. Through SB 1177, intensive evidence-based practices with known positive outcomes are available to children and youth who are eligible for Medicaid managed care programs. The evidence-based practices would be used in lieu of other mental health services and could serve as alternatives to residential and inpatient care. A list of all evidence-based practices that may be used in Medicaid managed care programs will be adopted and administered by HHSC in 2020. The grant funds that were established through SB 74 HHSC Budget Rider 172 (Rider 172), which cover provider start-up costs in order to increase access to intensive Mental Health Rehabilitative Services and TCM for underserved children and youth in the child welfare system, became available in September 2019 and providers are ramping up those services.

Who Are the Specialty Rehabilitative Care Providers?

Child and Family Guidance Center

Child and Family Guidance Center (CFGC) is a provider of psychiatric, case management, and counseling services. It also provides skills training and evidence-based services, and it oversees the YES Waiver in Dallas County (described above). CFGC provides all services available under the TRR framework, from medication management (LOC-1 Medication Management) to the highest intensity services offered (e.g., Level of Care 4, Intensive Family Services). Additional information on the TRR level of care services can be found in *Appendix D: Level of Care (LOC) Overview*.

CFGC's skills training services are curriculum-based, although the specific curriculum delivered depends on the child or youth's needs and goals. Curriculums the CFGC offers include Seeking Safety, Nurturing Parenting Programs, aggression replacement techniques and socials skills (Skillstreaming), Preparing Adolescents for Young Adulthood, and Barkley's Defiant Child and Barkley's Defiant Teen.

CFGC has contracted with HHSC to be the Dallas County administrator of YES Waiver services and manages the inquiry line, which is the number families call to request YES Waiver services. CFGC uses the CANS (as described earlier) to determine children and youth's eligibility for YES Waiver services and sends these results to HHSC for final determination and authorization for services. For eligible children and youth and their families, CFGC implements the wraparound planning process and helps the family identify its treatment team, which will help the family

¹³⁴ Senate Bill 1177, 86th Texas Legislature, Regular Session (2019)

<https://capitol.texas.gov/Search/DocViewer.aspx?ID=86RSB011775B&QueryText=%22SB+1177%22&DocType=B>

develop an Individual Plan of Service. CFGC provides psychiatric and case management services and makes referrals to Metrocare or CK Family Services for non-traditional services (e.g., equine, art, or music therapy; respite).

CFCG serves just over 5,000 children and youth per year, including 773 in Mental Health Rehabilitative Services and 117 in intensive services in the past year.

CK Family Services

CK Family Services (CK) provides behavioral health services; YES Waiver services; foster care, adoption, and post-adoption programming; treatment foster care services; and its Family Assessment Program. CK began providing behavioral health services in 2003 and, in 2015, was the first child-placing agency in Texas to obtain a contract to provide Medicaid Mental Health Rehabilitative Services and Targeted Case Management services to children and youth in foster care.

CK offers a full range of services from TRR LOC-1 (Medication Management) through LOC-4 (Intensive Family Services).¹³⁵ Its behavioral health services (community support services) include Mental Health Rehabilitative Services and TCM for children (from age three), youth, young adults, and their families, along with skills training and high-fidelity wraparound case management services. Evidence- and research-based interventions include High Fidelity Wraparound case management, Nurturing Parenting Program, Barkley's Defiant Teen & Defiant Child, Skillstreaming, aggression replacement techniques, and Preparing Adolescents for Young Adulthood. The majority of the children and youth CK serves are in the foster care system, but about a third of the youth they serve are not.

CK is a YES Waiver contracted provider and offers traditional mental health services and specialized therapies (described below) to children and youth identified and referred by CFGC. CK has a liaison that works with CFGC to receive YES Waiver referrals and provide them to CK program managers for assignment. As part of the YES Waiver services, CK provides respite, community living supports, specialized therapies (e.g., art, music, recreational), family supports, employee assistance, supported employment, adaptive aids and supports, minor home modifications, non-medical transportation, paraprofessional services, supportive family-based alternatives, and transition assistance.

CK also has a specialty treatment foster care team for children and youth with the most acute needs. This team provides behavioral health, medication management, therapy, skills training,

¹³⁵ Additional information on level of care (LOC) services based on the Texas Resilience and Recovery (TRR) Utilization Management Guidelines can be found in Appendix D: Level of Care (LOC) Overview.

and wraparound services. These services are provided through a foster care contract. CK's goal for this team is to develop capacity to serve up to 200 children, with the intention of keeping children and youth in the community and out of residential treatment facilities.

This past year, CK served 387 Dallas County children and youth, including 106 in Mental Health Rehabilitative Services and 70 in intensive family services (LOC-4).

Metrocare

As noted in the previous section, Metrocare provides a range of mental health services, from medication monitoring to intensive services. Metrocare uses the Child and Adolescent Needs and Strengths (CANS) tool to determine the level of care for each child or youth it serves.¹³⁶ Metrocare's service array includes diagnostic interviews, medication management, individual and family therapy, intensive and routine case management, and skills training. As part of its specialty care provision, Metrocare also offers juvenile justice services, wraparound, and YES Waiver services.

As a provider for YES Waiver services in Dallas County, Metrocare receives all referrals from CFGC. Metrocare contracts with other providers for certain non-traditional services and respite care. It has contracts with about 15 providers and continues to grow the number and types of contract providers, with a focused effort on recruiting additional respite care providers as this is an often-requested service.

If a youth is receiving services from Metrocare and becomes eligible for YES Waiver services, they must discharge from Metrocare and transfer their medication monitoring and case management services to CFGC. Metrocare then functions as a network provider of the non-traditional interventions offered through the YES Waiver program. This transfer of care can pose a dilemma for children and youth and their families who may prefer to continue all of their outpatient services with Metrocare, but recognize the benefit of receiving non-traditional interventions offered through the YES Waiver program.

Metrocare provided complex care (LOC-3 Complex Services) to 1,697 children and youth between September 1, 2017, and August 30, 2018. Wraparound process planning, which requires a certified facilitator, is a key component of the intensive family services level of care (LOC-4). In order to become a certified wraparound facilitator, clinicians must complete a series of trainings on the wraparound planning process within one year of employment. As soon as they complete the first training of the series, they can begin facilitating wraparound. As of

¹³⁶ Additional information on level of care (LOC) services based on the Texas Resilience and Recovery (TRR) Utilization Management Guidelines can be found in Appendix D: Level of Care (LOC) Overview.

August 2019, Metrocare had three wraparound facilitators, two of whom were fully certified to provide wraparound in LOC-4 (Intensive Family Services) services, and had the capacity to provide LOC-4 services to 50 children and youth at a time. It served 100 youth in total in LOC-4 (Intensive Family Services) between September 1, 2017, and August 30, 2018. Metrocare has routinely had two wraparound-certified employees on staff at a given time, with other staff working toward certification. Metrocare has been awarded a grant to expand wraparound services to children and youth most in need, with a focus on providing care to children and youth in foster care. It plans to expand wraparound services by hiring of additional positions and providing wraparound training to staff, which will increase its capacity of certified staff to serve children and youth with the most needs. In addition to supporting facilitator and clinical positions, the expansion grant will allow Metrocare to add two family partners. Metrocare is in the process of hiring all positions.

Metrocare also offers the Enhanced Program for Early Psychosis (ePEP), which can serve youth as young as age 15 and young adults. The early onset psychosis program is composed of two teams, each with a licensed therapist serving as the team lead. The other members of the team are a case manager, a Supportive Employment/Education specialist, and a peer. Services are provided at the frequency and duration that is clinically indicated, with services averaging five hours per month per individual served. These teams collaborate and work closely with other providers in the youth or young adult's life, such as doctors and school staff, and may address work or housing issues. The program has the capacity to serve 60 individuals at a time; however, because the number of youth and young adults enrolled in ePEP has exceeded the program's capacity, the state has requested that Metrocare submit a proposal to add a third team to the program. If approved, this third team will focus primarily on serving youth.

Pathways Youth and Family Services

Pathways Youth and Family Services (Pathways) provides foster care, adoption, and community-based services throughout Texas. The agency has been providing foster care services since 1992 and behavioral health services since 1998.

In Dallas County, Pathways has a behavioral health team and a child placement agency team. Behavioral health services are provided through its Mosaic Consulting branch (Note: Pathway's Mosaic Consulting brand is a separate entity from the Mosaic Family Services provider discussed in Component 2). The Mosaic Consulting program provides psychiatric services, telemedicine, counseling, and skills training services to children, youth, and families served through the foster care system. Community-based services include individual, family, and group counseling; skills training; and routine case management provided by licensed therapists, therapist interns, and qualified mental health professionals. Skills training is provided through

curriculums, including Nurturing Parenting Program, Seeking Safety, STARS skills training, and Preparing Adolescents for Young Adulthood.

Although staff are trained to provide wraparound, and the agency has provided it in the past, they are currently focused on providing skills training instead. They cite challenges in providing high-fidelity wraparound under the current reimbursement system as one of their reasons for moving away from providing this service in Dallas County at this time.

In the past year, Pathways served 152 youth, including 54 in Medicaid Mental Health Rehabilitative Services; a smaller number (fewer than 5) received intensive services.

Youth Advocate Programs, Inc.

Youth Advocate Programs (YAP) is a national and international nonprofit organization founded in 1976 that serves children, youth, and families in the behavioral, child welfare, juvenile justice, and education systems. YAP provides services in 26 states, including Texas. In Texas, YAP offers services in Brazos County, Dallas County, Harris County, Tarrant County, Tom Green County, and Williamson County. Its specific services vary by location.

The behavioral health services that YAP provides in Dallas County include psychiatric services, bio-psychosocial assessments, counseling, and skills training by qualified mental health professionals. YAP individualizes services to children, youth, and family needs and provides services in locations chosen by the families (e.g., their homes and the community). YAP takes a family-focused approach to services, where families are the experts in their own care and drive the language and goals included in recovery plans. The agency has a strengths-based philosophy, and it helps the families build on what is already working. YAP recruits staff from the neighborhoods and the communities in which it provides services.

YAP provides intensive Medicaid Mental Health Rehabilitative Services and wraparound. Through these intensive services, it provides all of the services a family may need.

In the past year, YAP served over 400 children and youth.

Specialty Rehabilitative Care Findings

In Dallas County, 3,294¹³⁷ children and youth received specialty rehabilitative services through Medicaid. For the most part, this care is not organized into evidence-based programs, nor is it

¹³⁷ Providers were asked to submit data for the most recent 12 months of data available. All 12-month ranges identified were between September 2017 and August 2019. One provider did not include a date range for their data.

intensive enough to meet the needs of the children, youth, and families seeking services. In addition to specialty rehabilitative care, other intensive services that are being provided include Coordinated Specialty Care for people experiencing a first episode of psychosis, Functional Family Therapy for families with children and youth involved in the juvenile justice system, Metrocare's Texas Corrections Office of Offenders with Medical and/or Mental Impairments (TCOOMMI) Youth and Family Program for youth involved with the juvenile justice system, wraparound facilitation, and YES Waiver services. Additionally, some non-profits such as those discussed in Component 2, provide Dialectical Behavior Therapy, Eye Movement Desensitization and Reprocessing Therapy, and cognitive behavioral therapy.

This finding, consistent with our prior work in North Texas and other communities in Texas, reflects a substantial, statewide gap in the availability of intensive, home and community-based services for children and youth with complex needs. This is part of a broader, systemic gap: Texas communities, including Dallas County, have little to offer children, youth, and their families who (1) need mental health services that are more intensive than routine outpatient visits, but that do not require the restrictiveness of residential or inpatient care, or (2) are stepping down from more restrictive services such as residential or inpatient care.

Specialty Rehabilitative Care (SRC) Finding #1: Only five providers deliver intensive community-based Medicaid services in Dallas County. Child and Family Guidance, CK Family Services, Metrocare, Pathways Youth and Family Services, and Youth Advocate Programs are the only providers credentialed for Medicaid-funded intensive community-based services. Together, they serve just under 3,300 children and youth in a given year, which includes about 3,000 in Mental Health Rehabilitative Services and 300 in intensive family services (LOC-4) and YES Waiver services (LOC-YES). While these services are effective and high quality, there is more need than what the current capacity can serve. Two of the providers — CK Family Services and Pathways Youth and Family Services — primarily serve children and youth in the child welfare system; however, more children and youth in that system need this intensity of services to succeed in their current placement or when they transition out of placements.

SRC Finding #2: Specialty rehabilitative care is not available outside the publicly-funded system. Children and youth with private insurance do not have access to specialty rehabilitative care unless they qualify for the YES Waiver program. Private insurance plans do not include specialty rehabilitative care in their benefit plans and, therefore, do not pay providers to deliver these services. It is important to widen access beyond the publicly-funded system to children and youth whose families' income is too high to qualify for public benefits. Youth who are on their parent's insurance and do not qualify for publicly-funded services also experience debilitating mental health conditions that impair functioning across multiple life domains and require specialized treatment and evidence-based rehabilitation services.

SRC Finding #3: The shortage of credentialed Medicaid TCM and Mental Health Rehabilitative Services providers can be attributed to barriers to the credentialing process and the high costs associated with establishing these services. A burdensome credentialing process that includes a narrow list of approved evidence-based practices and overly prescriptive training requirements has resulted in fewer credentialed providers than anticipated. Moreover, Medicaid programs do not currently cover startup costs to phase in these services. Furthermore, current reimbursement rates do not cover the cost of providing these services.

SRC Finding #4: There is limited capacity and long wait times for intensive services, including YES Waiver services. Providers identified limited capacity for all services, especially for children and youth with the most intensive needs. Intensive services require smaller caseloads in order to offer the level of care needed, which naturally limits the number of children and youth who can be served at any given time. Issues discussed earlier in this report such as training requirements and staff turnover also contribute to capacity issues across the county.

SRC Finding #5: There is an insufficient amount of evidence-based services for children and youth with the most serious needs. Providers expressed a desire to offer intensive evidence-based practices, but cited a lack of reimbursement and the limitations the TRR system places on service delivery as barriers. Medicaid reimbursement is not sufficient to fund many evidence-based practices. At this time, the TRR system does not endorse a specific evidence-based practice for intensive services, which limits the availability of these services. Providers cannot deliver evidence-based practices tailored to the needs of the children and youth they serve since they are required to provide only the specific evidence-based practices available under HHSC's TRR Utilization Management Guidelines. Most evidence-based practices have guidelines and timeframes for achieving the best outcomes and should not be constrained by rigid utilization management requirements. However, recent legislation allows managed care organizations to offer case rates (or other payment arrangements) for providers to offer intensive evidence-based practices in lieu of other mental health services.

SRC Finding #6: The high cost of training and supervision for intensive services and evidence-based practices limits availability. Evidence-based practice trainings are often expensive and, when paired with high staff turnover, become cost prohibitive. In addition, intensive evidence-based practices usually require more frequent supervision to ensure fidelity to the model.

SRC Finding #7: Senate Bill (SB) 1177 offers a new opportunity for Dallas County by increasing the number of evidence-based practices that can be reimbursed through Medicaid. SB 1177 offers an opportunity to make more evidence-based practices available for children and youth with mental health needs. This initiative, which will be administered by HHSC, makes intensive,

evidence-based practices with known positive outcomes for children and youth available in Medicaid managed care programs. The allowed evidence-based practices adopted by the Medicaid Managed Care Advisory Committee can be used in lieu of other mental health services and hospitalization.

Component 4: Dallas County's Crisis Care Continuum

Earlier in this report, we outlined in more detail the three distinct service types necessary for an ideal continuum of crisis services:

1. **A range of community-based crisis intervention services**, including mobile crisis outreach response teams that have the capacity to provide limited ongoing in-home supports, case management, and direct access to short-term out-of-home crisis supports (e.g., crisis respite, emergency shelter);
2. **Acute inpatient care** for children and youth whose needs cannot be met in a community-based setting; and
3. **Residential treatment facilities** for children and youth with intensive needs who cannot be safely treated in any other setting. As noted earlier in this report, residential treatment should be reserved for children and youth with the most severe needs and only until they can be safely transitioned to community-based services.

Because crisis services are often the point of entry into the mental health care system and the services provided during a crisis can prevent the recurrence or exacerbation of a mental health need, it is important to have a crisis care continuum that is responsive to the needs of the community. This section of the report addresses the need, capacity, and utilization of each of these levels of crisis care in Dallas County, and compares them to our overarching framework.

Crisis Intervention Providers

We reviewed the crisis intervention services in Dallas County and interviewed representatives from Adapt Community Solutions (ACS) and ACH Child and Family Services (Turning Point Program). Although crisis supports are generally available for people with specific needs and for specific populations (e.g., children and youth involved in the child welfare system), aside from ACS, no other organization in Dallas County provides county-wide, comprehensive, community-based crisis intervention services to the general population. A number of providers we reviewed, however, indicated that they provide crisis intervention services to the children or youth they serve on an as needed basis. They reported that if they are unable to resolve a crisis,

Crisis Intervention Options:

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

they call the mobile crisis outreach team (MCOT) for an assessment or, more commonly, refer the child/youth and their family to the nearest emergency department for evaluation. In this section, we will describe the crisis services that are offered by the providers noted above.

Adapt Community Solutions — Mobile Outreach and Telephone-Based Crisis Intervention

Through its contract with the North Texas Behavioral Health Authority (NTBHA), Adapt Community Solutions (ACS) operates an integrated crisis hotline and mobile crisis outreach teams (MCOT) across Dallas County. ACS is required to provide crisis hotline and MCOT services 24 hours a day, seven (7) days a week to all individuals, regardless of their insurance status or type. The crisis hotline, accredited by the American Association of Suicidology, provides telephone-based crisis support as well as access to mobile crisis response and stabilization services for children, youth, and their caregivers and families.

MCOT teams are staffed by both licensed professionals of the healing arts and qualified mental health professionals who are all trained in crisis intervention best practices. MCOT teams respond to calls from a variety of sources, including parents/caregivers, schools, youth, law enforcement, or community-based providers. When responding to calls, MCOT teams provide screening, crisis stabilization, supportive services, and referrals to community-based providers. ACS averages about 928 crisis hotline calls per month from an average of 425 unique children, youth, or caregivers. Mobile crisis outreach teams provide services in person to an average of 141 children and youth per month.

ACS typically staffs three or four MCOT teams per shift and uses telehealth technology when possible to provide a more immediate response, particularly when distance or staff safety may be a concern. In an effort to respond to the needs of the community, ACS has also co-located its services at sites that tend to see higher volumes of calls during certain times. For example, it is currently co-located at Parkland Health and Hospital System's (Parkland) emergency department during its peak time of 8:30 a.m. to 5:00 p.m.

Turning Point

Turning Point, a program managed by ACH Child and Family Services, offers emergency assessment and 24/7 crisis intervention to children and youth in kinship care and foster care, and their caregivers. The program is funded through STAR Health, the contracted Medicaid managed care organization for children and youth in foster care. The goal of Turning Point is to prevent unnecessary hospitalization for children and youth in foster care and to prevent placement disruptions. The program addresses the crisis the child, youth, or caregiver are experiencing through a 24-hour crisis information line, mental health assessment, counseling and consultation, an alternative care setting for eligible children and youth, and in-home crisis support and intervention planning.

The Turning Point program is available in Dallas County, though it is experiencing low utilization. This is likely because Turning Point is a newer service and foster families may not be fully aware of it.

The Role of the Emergency Department in Dallas County's Crisis Care Continuum

As noted above, many providers report that they refer children and youth to the emergency department for crisis care. These providers gave various reasons for referring to the emergency department, including the urgency of the crisis, lack of appropriate space for the child/youth to wait for MCOT, the need to keep other scheduled appointments, and the length of time the child or youth and caregiver would be waiting for MCOT to respond to a non-emergent request. Although we ideally want children and youth in crisis to be served in the community, wherever they are in crisis, emergency departments are often the first point of entry into the mental health system. Therefore, it is important to acknowledge the role they play in the crisis care continuum.

Emergency departments play an important role in the crisis care continuum. However, their role is often made more significant because of a lack of community-based alternatives or a lack of awareness about the available alternatives. Certainly, the emergency department should not be the first place — or the only place — where children, youth, and their families receive mental health care. Emergency departments often lack access and connections to available community-based mental health services,¹³⁸ which may mean that children and youth make repeat visits to the emergency department for mental health care instead of receiving ongoing treatment. This pattern of use by children and youth with mental health conditions, and their families, can result in a significant economic and resource burden on already overloaded emergency departments.¹³⁹ Furthermore, a review of the data compiled by the National Hospital Ambulatory Medical Care Survey, which tracked mental health visits to emergency departments between 2001 and 2011, revealed that emergency room patients (of all ages) with a mental health condition were more likely to be admitted to the hospital than patients with a medical condition. Also, children and youth are more likely to be affected by this

¹³⁸ Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services: A component of the continuum of care*. https://www.texasstateofmind.org/wp-content/uploads/2017/01/MMHPI_CrisisReport_FINAL_032217.pdf

¹³⁹ Leon, S. L., Cloutier, P., Polihronis, C., Zemek, R., Newton, A. S., Gray, C., & Cappelli, M. (2017, March). Child and adolescent mental health repeat visits to the emergency department: A systematic review. *Hospital Pediatrics*, 7(3), 177–186. <http://hosppeds.aappublications.org/content/7/3/177>

discrepancy.¹⁴⁰ Taken together, these dynamics have resulted in the frequent overutilization of an expensive component of the crisis care continuum.¹⁴¹

There are 19 emergency departments in Dallas County that see children and youth for mental health and substance-related emergencies. From April 2017 to March 2018, there were just over 2,600 emergency department visits by children and youth for behavioral health-related emergencies. The vast majority of these visits (2,360 in total, 89%) were for psychiatric emergencies and 11% (294 in total) were for substance-related emergencies. Out of all children and youth in the county, regardless of need, this translates to about 5.8 behavioral health-related visits per 1,000 children and youth.

Children's Health is the emergency department used most often for behavioral health concerns, and it had nearly 1,300 visits for children and youth (49% of all behavioral health visits) for psychiatric and substance-related emergencies in the reported year. Parkland Health and Hospital System, Green Oaks, and Medical City Dallas Hospitals also experienced a large volume of behavioral health-related emergency department visits. Table 7, on the next page, shows all behavioral health-related emergency department visits for children and youth in the reported year and Map 6 providers further information on their locations.

¹⁴⁰ Luthra, S. (2016). Kaiser Health News. *Scarcity of mental health care means patients—especially kids—land in ER.* <https://khn.org/news/scarcity-of-mental-health-care-means-patients-especially-kids-land-in-er/>

¹⁴¹ Leon, S. L., Cloutier, P., Polihronis, C., Zemek, R., Newton, A. S., Gray, C., & Cappelli, M. (2017, March). Child and adolescent mental health repeat visits to the emergency department: A systematic review. *Hospital Pediatrics*, 7(3), 177–186. <http://hosppeds.aappublications.org/content/7/3/177>

Table 7: Behavioral Health-Related Emergency Department (ED) Visits in Dallas County (April 2017 – March 2018)

Map Label	Admitting Emergency Department	Psychiatric Visits	SUD* Visits	All BH** Visits	Percentage of Total BH Visits
1	Baylor Scott & White Medical Center – Irving	71	9	80	3%
2	Baylor Scott & White Medical Center – Garland	34	26	60	2%
3	Baylor University Medical Center	31	18	49	2%
4	Baylor Surgical Hospital at Las Colinas	5	N/A	5	0%
5	Baylor Scott & White Medical Center White Rock	23	8	31	1%
27	Children's Health	1,201	90	1,291	49%
32	Crescent Medical Center Lancaster	6	1	7	0%
46	Dallas Regional Medical Center	20	12	32	1%
47	Dallas Medical Center	10	4	14	1%
49	First Texas Hospital	3	N/A	3	0%
60	Las Colinas Medical Center	21	6	27	1%
62	Green Oaks Hospital	385	3	388	15%
63	Medical City Dallas Hospital	191	44	235	9%
64	Methodist Charlton Medical Center	61	18	79	3%
65	Methodist Richardson Medical Center	52	N/A	52	2%
66	Methodist Dallas Medical Center	36	17	53	2%
85	Parkland Health and Hospital System	164	22	186	7%
91	Texas Health Presbyterian Hospital Dallas	41	16	57	2%
110	UT Southwestern University Hospital – St Paul	5	N/A	5	0%
Total Child and Youth Visits to Dallas EDs		2,360	294	2,654	100%

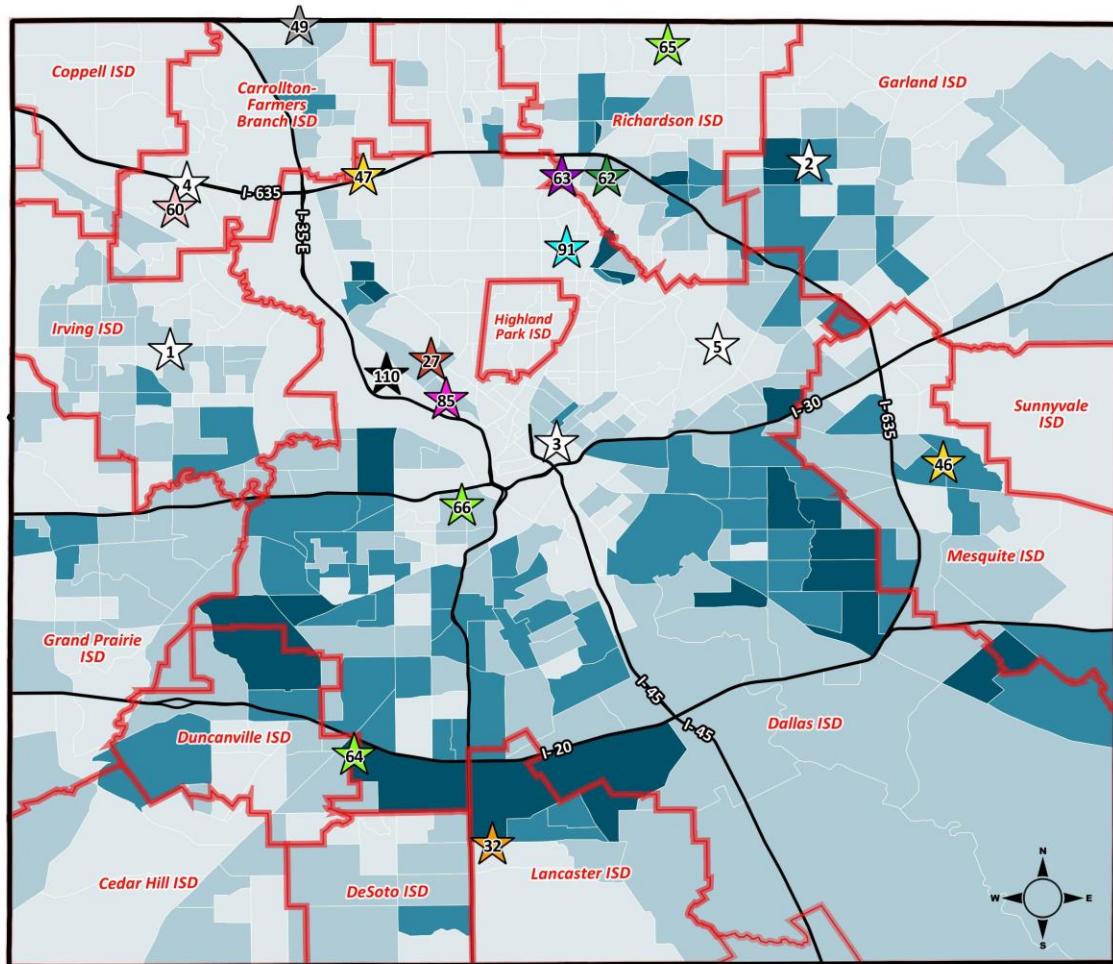
*SUD = substance use disorder

**BH = behavioral health, includes all psychiatric and SUD visits

By design, emergency departments do not require a referral and are always accessible. Since emergency departments are used to assess and stabilize children and youth in immediate crisis, it is important that they are located in areas that are easily accessible to large populations of children and youth with behavioral health needs. The map, on the next page, shows the broad distribution of the emergency departments that serve children and youth, including those near

locations with concentrations of children living in poverty. Southeast Dallas is one area with concentrations of children living in poverty, but without a nearby emergency department.

Map 6: Locations of Child-Serving Emergency Departments for Mental Health Crises



Children and Youth Under Age 18 in Poverty (2017)

Fewer than 250	604 to 1,065	Highway
250 to 603	1,066 to 2,213	Dallas School Districts

Crisis and Emergency Provider Locations*

- | | | |
|---------------------------------|------------------------------|------------------------------|
| ★ Baylor Scott & White | ★ First Texas Hospital | ★ Methodist Health System |
| ★ Children's Health | ★ Las Colinas Medical Center | ★ Parkland |
| ★ Crescent | ★ Medical City Green Oaks | ★ Texas Health Resources |
| ★ Dallas Medical Center (Prime) | ★ Medical City Dallas | ★ UT Southwestern University |

*Provider locations have been slightly adjusted for visibility.

The Role of Psychiatric Inpatient Care in Dallas County's Crisis Care Continuum

Access to high-quality community-based services and supports (e.g., mobile crisis response, crisis follow-up services such as case management and time-limited follow-up care, respite options) can reduce the need for crisis services, such as emergency department and inpatient psychiatric settings, and ease the transition for children, youth, and their families as they adjust to being home after a hospitalization. While inpatient hospitalization is not a substitute for ongoing, well-coordinated outpatient mental health care, it can be beneficial for children and youth with complex or acute safety needs that cannot be met in a less restrictive setting. Hospitalizations for these reasons should be available when needed, but, generally, should be brief and supported by the broader array of services along the crisis care continuum.

Currently, four hospitals provide inpatient care to children and youth in Dallas County — Hickory Trail Hospital; Medical City Green Oaks Hospital; Dallas Behavioral Healthcare Hospital, LLC; and Children's Health. One inpatient hospital, Perimeter Behavioral Hospital of Dallas, opened in late October 2019 and is increasing the number of available beds by using a phased approach. There are other inpatient hospitals in the larger region; however, they were excluded from this analysis. Although children and youth may access inpatient treatment at those facilities, they likely present geographic barriers for caregivers wishing to participate in treatment. In general, when hospitalization is necessary, it should occur as close as possible to the child or youth's family and residence.

Table 8, on the next page, shows psychiatric inpatient hospitals in Dallas County that admit children and youth. Although the table reflects utilization going back to January of 2016, hospitals that are currently closed (Timberlawn and Sundance) are not included. Dallas Behavioral Healthcare has the highest average utilization (46 children and youth on any given day), followed by Hickory Trail Hospital (17), then Children's Health (8) and Medical City Green Oaks (7). While we were unable to assess the percentage of days with available beds at Dallas Behavioral Healthcare because of missing capacity information, a comparison of utilization versus capacity county-wide shows that the other inpatient hospitals have beds available on most days of the year. In addition, Perimeter Behavioral Hospital of Dallas opened in October 2019 with 20 inpatient treatment beds available for children ages five to 12 years. In January 2020, it increased its capacity to a total of 60 beds for ages five to 17. When all phases are complete (anticipated to be summer 2020), it will have 100 beds for children and youth.

Table 8: Inpatient Hospital Capacity and Utilization – Dallas County (2016 through 2018)¹⁴²

Hospital Name	Pediatric Psychiatric Beds	Average Daily Utilization ¹⁴³	Percentage of Days with Available Beds
Hickory Trail Hospital	22	17	71%
Medical City Green Oaks Hospital	18	7	70%
Dallas Behavioral Healthcare Hospital, LLC	N/A	46	N/A
Children's Health	9 to 12	8	59% based on 9-bed capacity 98% based on 12-bed capacity

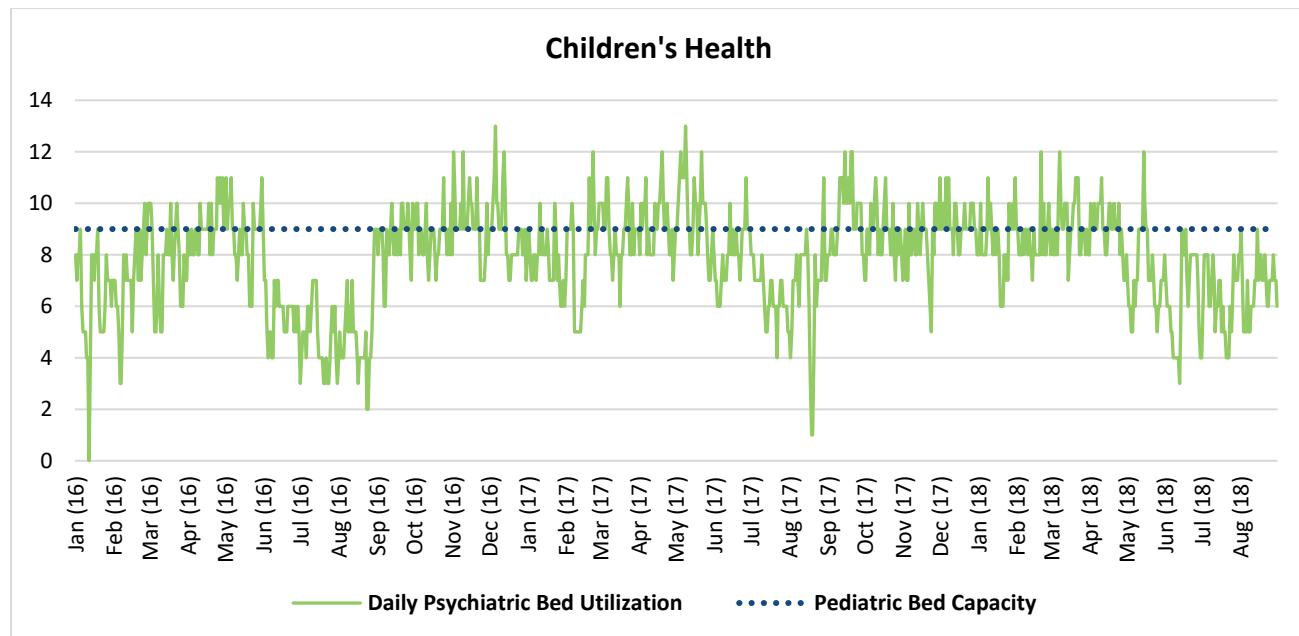
Providers we reviewed expressed a perceived need for additional inpatient beds, citing the closure of Timberlawn and Sundance as contributing to the perceived shortage. The opening of Perimeter Behavioral Hospital of Dallas should help relieve some of the concern about local capacity.

Graphs 1 through 4, on the following pages, compare daily utilization from January 2016 through August 2018 to reported capacity for Children's Health; Dallas Behavioral Healthcare Hospital, LLC; Hickory Trail Hospital; and Medical Center Green Oaks Hospital. These graphs are helpful in assessing whether Dallas County has sufficient inpatient capacity to serve the needs of local residents on a daily or seasonal basis. The relationship between utilization and capacity is represented in the graphs below, which are also summarized.

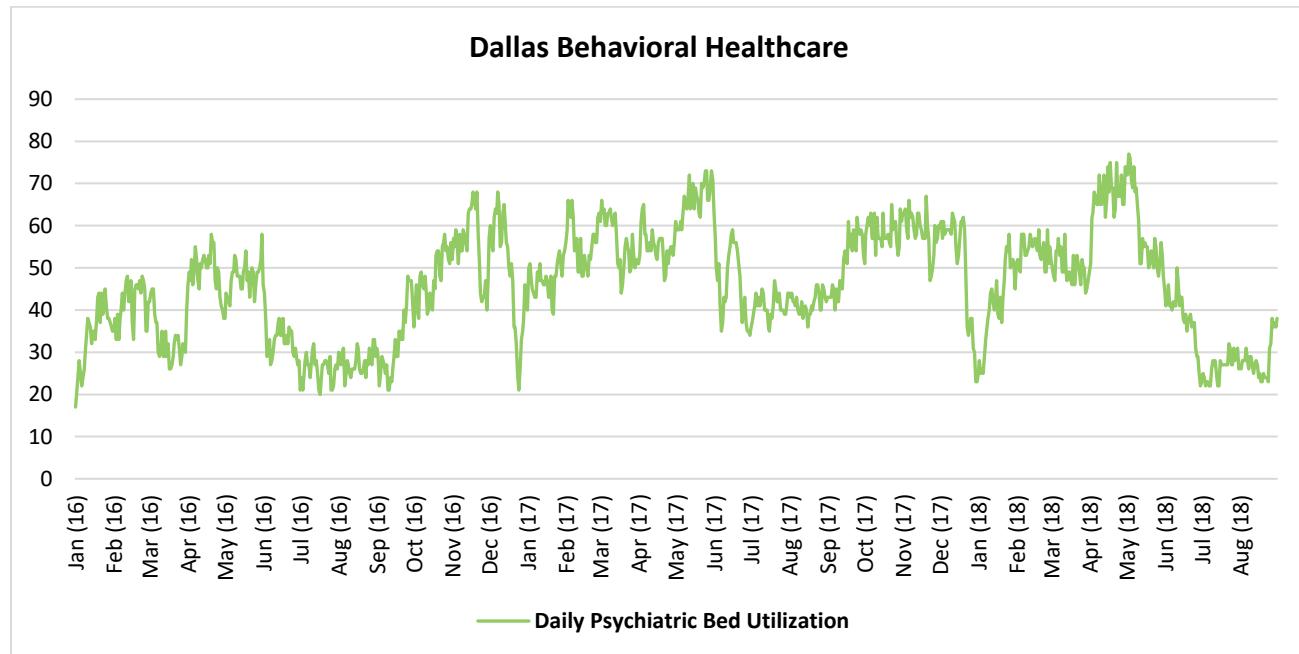
¹⁴² Hospital capacity for Hickory Trail (22) and Medical City Green Oaks (8) was obtained from the 2017 American Hospital Association Annual Survey of Hospitals. Medical City Green Oaks hospital reported that its current capacity is 18 beds, so we have used this number for the last year of data available (2018). Children's Health reported that it has between nine and 12 beds available, depending on need. We were unable to obtain an accurate count of pediatric psychiatric beds available at Dallas Behavioral Healthcare.

¹⁴³ Based on utilization from January 1, 2016 through August 31, 2018.

Graph 1: Children's Health Daily Child and Youth Psychiatric Bed Utilization (January 2016 to August 2018)

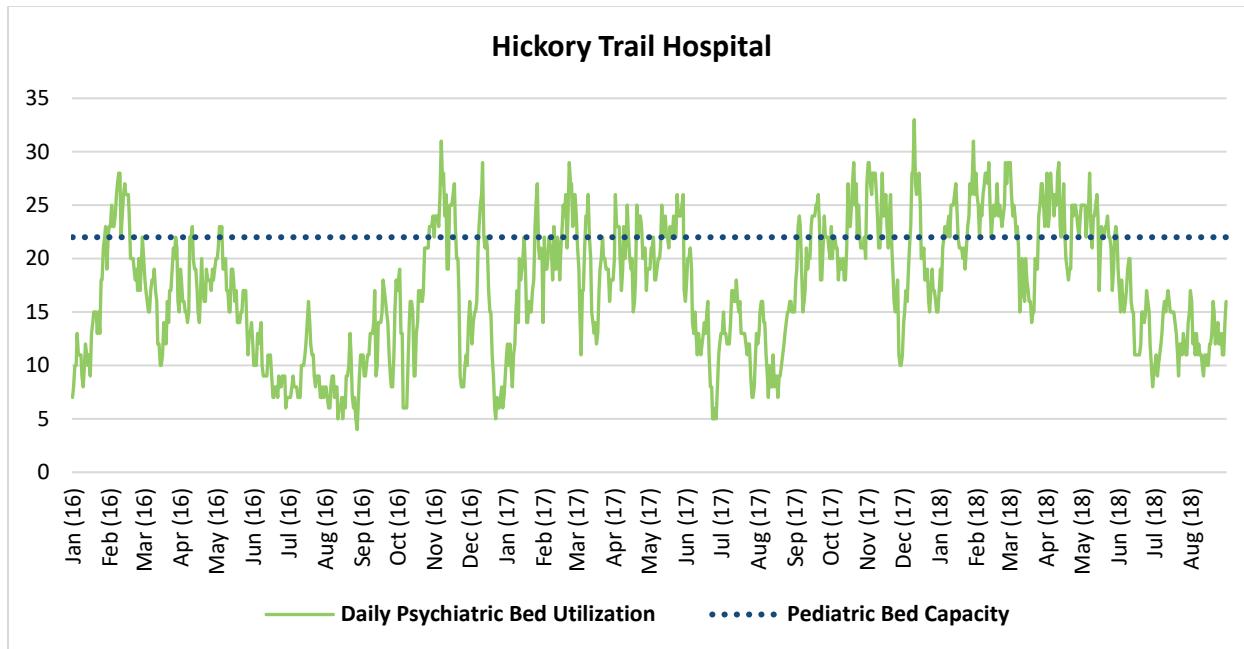


Graph 2: Dallas Behavioral Healthcare Daily Child and Youth Psychiatric Bed Utilization (January 2016 to August 2018)¹⁴⁴

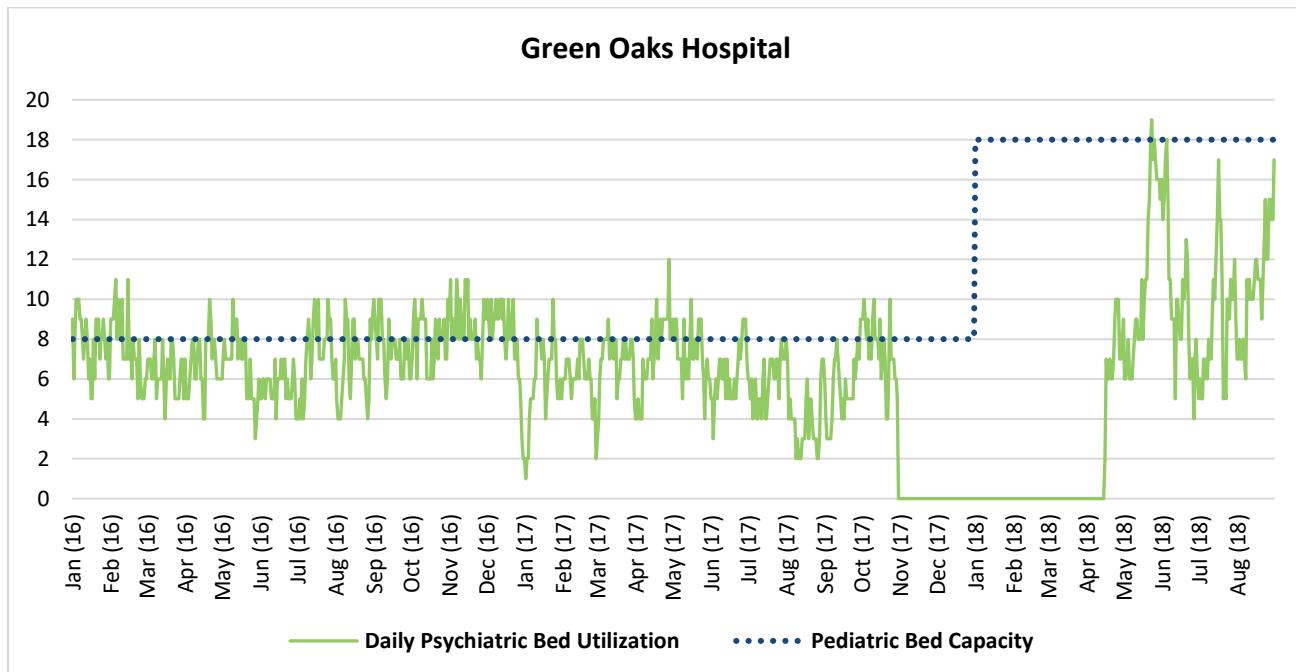


¹⁴⁴ According to the American Hospital Association 2017 Annual Survey of Hospitals, Dallas Behavioral Healthcare had 14 pediatric psychiatric beds. However, this count seems inaccurate when compared to the overall daily utilization at the hospital (46 beds in use), so we have chosen not to use this reported capacity.

Graph 3: Hickory Trail Hospital Daily Child and Youth Psychiatric Bed Utilization (January 2016 to August 2018)



Graph 4: Medical Center Green Oaks Daily Child and Youth Psychiatric Bed Utilization (January 2016 to August 2018)



Graphs 1 through 4 show the daily utilization of psychiatric beds compared to local capacity in Dallas County. The relationship between utilization and capacity can help us understand the

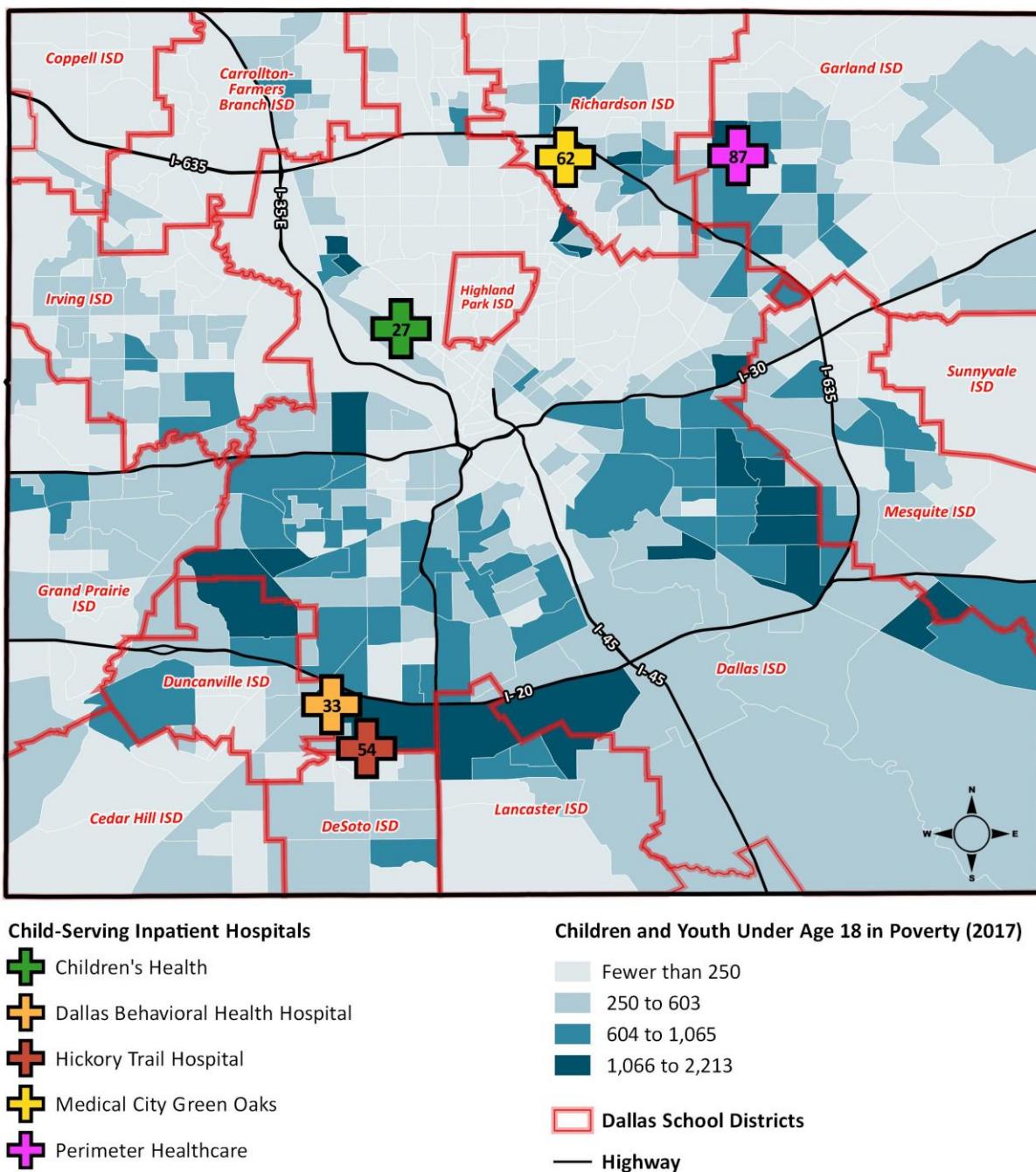
extent to which Dallas County can meet the needs of the children and youth in the community. If psychiatric inpatient beds are generally full and facilities are unable to take additional patients throughout the year at all hospitals, this suggests the need to provide either other crisis options (such as very short-term crisis stabilization facilities), additional outpatient programs that reduce the need for inpatient beds (e.g., Multisystemic Treatment, Functional Family Therapy), other services available through intensive family services (LOC-4) or YES Waiver services (LOC-YES), or additional inpatient beds. However, if hospitals are only full during certain periods and otherwise have unused capacity, a solution may involve making bed use more flexible instead of simply adding capacity. Although were not able to include utilization data for Perimeter Behavioral Hospital of Dallas since it is new to the system, it is anticipated that the addition of 100 beds will have an impact on overall capacity in the community.

Across all hospitals, utilization for children and youth peaks in the late spring (April/May) and in the early winter months (November/December), and is typically at a low in the late summer months (August/September). Children's Health, Green Oaks, and Hickory Trail Hospital all operate at or above capacity during the peak months and below capacity in late summer. As Table 8 showed, from 2016 to 2018, a pediatric psychiatric bed in Dallas County was available for use for more than half of the time, while there was no availability during certain peak times.

Another factor related to pediatric inpatient hospital accessibility is geographic location. When looking at the geographic distribution of beds, it is important to consider areas where people experience a lack of transportation and other socioeconomic challenges. This proximity is most important for community-based outpatient and emergency department services. Because inpatient psychiatric beds should only be used for a small number of children and youth, it is impractical to attempt to achieve the same degree of close physical proximity to all concentrations of children and youth in need.

Map 7, on the next page, shows the locations of the hospitals in relation to counts of children in poverty. Although the current geographic distribution appears acceptable, future additional inpatient resources placed in eastern Dallas County would most effectively resolve geographic barriers to accessing care. It is important, however, for inpatient and outpatient providers alike to consider the difficulty caregivers may face in participating in their child's inpatient treatment because of the significant transportation barrier that has been identified.

Map 7: Inpatient Psychiatric Hospitals in Dallas County



The Role of Residential Treatment in Dallas County's Crisis Care Continuum

Residential treatment represents an important component of the continuum of care for children and youth and should be accessible, when necessary. Residential treatment centers serve children or youth whose mental and behavioral health needs cannot be safely managed in the community. Some residential treatment centers serve children and youth who are involved

in specific systems such as the child welfare or juvenile justice systems. Others may serve children or youth who have ongoing behavioral health needs or youth whose parents have kicked them out of the home. Among these treatment centers, some may serve only girls or boys or have limitations based on age. With all of the different types of residential treatment centers, it is understandably confusing to find a placement for a child or youth, especially given that the type of treatments vary as does the quality of care. Recognizing that the quality of residential treatment varies across the nation, the Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Building Bridges Initiative (BBI).¹⁴⁵ BBI's aim is to ensure community and residentially-based service providers work together to ensure that a full range of mental health services and supports are available to children, youth, and their families. The Sanctuary Model is another approach supported by SAMHSA through its National Child Traumatic Stress Network.¹⁴⁶ The Sanctuary Model is a trauma-informed, responsive approach that focuses on organizational change in order to create an environment where adverse or traumatic experiences, in addition to mental health needs, can be addressed. Implementation of the Sanctuary Model can result in less violence, better emotional management (for clients and staff), clearer boundaries, better communication, and lower staff turnover, among others. Further, the passage of the Family First Prevention Act (Family First) in 2018 aims to improve child welfare systems cross the country by offering states incentives to improve the quality of care, including residential treatment. Specifically, the bill will provide funding for services for children, youth, and their families and motivate states to reduce the placement of children in congregate care.

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. Across Texas (and the nation), children and youth are too often placed in residential treatment because more appropriate community-based services are not available. When it is utilized, residential services should be brief, intensive, family-based, and as close to home as possible. Safety should be the primary determinant in selecting out-of-home treatment as an option since the evidence-based community interventions described in Appendix C allow for even the most intensive treatment services to be delivered in community settings.

Across providers, there was a sense that there are few psychiatric residential treatment options for the general population of children and youth in Dallas County. However, there are

¹⁴⁵ 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. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

¹⁴⁶ Bloom, S. L. (n.d.) The Sanctuary Model outcomes and research.

<http://sanctuaryweb.com/TheSanctuaryModel/OUTCOMES.aspx>

residential facilities for children and youth who require out-of-home placement in the foster care system in Dallas County, as well as those involved in the juvenile justice system. The closest residential facility for children and youth with mental health needs appears to be the state-operated Waco Center for Youth in Waco, Texas, over 100 miles away. Although national experts do not agree on a definitive number of residential beds needed for children and youth, the absence of residential treatment options is an important missing piece in Dallas County's crisis care continuum. Because the research demonstrates that residential treatment is generally not an effective model for ongoing care, residential services should be brief, intensive, family-centered, and, importantly, close to home, which is not an option for Dallas County youth in need of this level of care.

Crisis Care, Inpatient, and Residential Findings

Crisis Care/Inpatient/Résidential Findings (CCIR) Finding #1: System navigation for caregivers is especially challenging during crises. Providers identified a lack of formal support for caregivers who are seeking services for their children during or after a mental health crisis. During a crisis, the first place many caregivers turn to is an emergency department, in part because they do not know where else to go or who to call. It is also important to note that law enforcement may also transport a child or youth to the emergency department during a mental health crisis. This is especially likely if a caregiver has called 9-1-1 for help, again, because they do not know where else to seek help. Although caregivers often leave the crisis encounter with referrals for ongoing services, many of the referrals end up having waiting lists that are weeks long. Many providers we reviewed noted that the sense of urgency to obtain treatment juxtaposed with the lack of readily available services adds to caregivers' frustration and contributes to families giving up on ongoing care after the initial crisis has passed. These factors can contribute to the crisis system remaining the default provider of mental health services for many families.

CCIR Finding #2: There is a shortage of short-term, acute crisis services that, if they were available, could help reduce the number of children and youth entering more restrictive settings. Providers we reviewed noted a shortage of community-based outpatient services, which may contribute to an overreliance on inpatient hospitalization for children and youth with acute needs or experiencing a psychiatric crisis. Increasing the availability of more intensive community-based services like Multisystemic Therapy, Functional Family Therapy, and Parent-Child Interaction Therapy would decrease the use of more restrictive treatment options and remove critical barriers to appropriate care.

CCIR Finding #3: Perceived access to inpatient services may differ from actual capacity and utilization. Providers reported that, when children and youth require inpatient hospitalization, they are often sent to facilities outside of the county because of limited capacity at local

hospitals. This experience leads many people to recommend increasing the number of inpatient beds in the community. However, this perception of a local shortage of inpatient beds for children and youth is not supported by the data we collected from the three main inpatient hospitals we reviewed — they all had beds available more than half of the time. One possibility is that these providers tried to access inpatient services at the specific times of year when we found that utilization peaks (April/May and November/December) and inpatient facilities are operating at capacity. It is also possible that these negative experiences stand out more than in times when admission was readily available. Whatever the explanation, between the data in this assessment that reflect bed availability on most days, and the fact that Perimeter Behavioral Hospital of Dallas opened in October 2019 and added inpatient treatment capacity to the area, the perceptions about access to inpatient services should improve. However, the community should continue to monitor the use of inpatient beds to prevent increasing overreliance on this level of service intensity.

CCIR Finding #4: Lack of coordination among crisis services limits access to follow-up care.

Many providers noted that parents and caregivers experience difficulty in obtaining an initial appointment for their children following a crisis episode or inpatient stay. They described a need for more immediate care and coordination support to ensure access to ongoing services after discharge. Current crisis services do not function as a coordinated system, which prevents children and youth from getting the services they need when they need them. This speaks to the need for better coordination across the components of the crisis system (i.e., crisis intervention services, acute inpatient care, and residential treatment) as well as the need for a broader range of intensive, community-based services to support the crisis system. A best practice after a crisis service is to ensure a warm handoff. Providing a list of referrals might be considered a “warm handoff.” Ideally, though, crisis providers would continue to follow-up with families until they have had an appointment with a service provider. And, depending on the level of care from which the child or youth is being discharged, immediate step-down options should be available. For example, a child or youth being discharged from an inpatient setting or residential treatment center should already have appointments scheduled with community providers scheduled and probably needs to be in an intensive level of care.

CCIR Finding #5: Providers identified a lack of residential treatment options for children and youth. The providers we reviewed uniformly reported a lack of residential treatment facilities for children and youth with the most intensive needs. Although there are residential treatment beds for children and youth with mental health needs who are involved in the child welfare or juvenile justice systems, the nearest known residential treatment facility for those not involved in those systems is in Waco, Texas. The lack of regional residential treatment centers — or lack of awareness of them — results in youth being placed in residential treatment centers in communities far away from their families. This distance is likely to be a barrier to family

participation in care for children and youth who need these services. Residential treatment is a necessary component in a comprehensive crisis system; the absence of a facility accessible to Dallas County residents represents a gap in the crisis system. However, there can be a risk of overreliance on residential treatment beds because of the absence of intensive, community-based outpatient services discussed earlier. Rather than adding residential treatment facilities, the community may be better served by first implementing more robust home and community-based intensive and crisis services and then assessing additional needs.

Mental Health Needs of Children and Youth in Foster Care

When considering approaches for meeting the mental health needs of children and youth in foster care, it is necessary to be mindful of systemic changes occurring in the child welfare system. Texas is in the process of transitioning from a state-led foster care model to a semi-privatized system called Community-Based Care (CBC). CBC shifts foster care and case management functions previously administered centrally through Child Protective Services at the Department of Family and Protective Services (DFPS) to a locally-driven model. This model includes a regional Single Source Continuum Contractor (SSCC) that is responsible for contracting with child placement agencies as well as coordinating and delivering services to children and youth in foster care, and their foster families, in the region. The SSCC is also responsible for developing foster care capacity and engaging the community, with the goal of achieving positive outcomes for the children, youth, and families that are served.

Many of Dallas County's neighboring counties in DFPS Region 3W are already being served through the CBC model provided by Our Community, Our Kids at ACH. DFPS has not yet determined when CBC will be implemented in Region 3E, where Dallas County is located; however, community-driven efforts are underway to begin preparation. In partnership with the Texas Center for Child and Family Studies (TACFS), we are leading an environmental assessment to help Dallas County and eleven other counties in DFPS Region 3W and 3E prepare for CBC. The environmental assessment and strategic planning process led by TACFS will give the community an understanding of its capacity to serve local children and youth in foster care as well as identify areas for change and considerations for developing the foster care system under CBC.

Mental Health Needs Among Children and Youth in Foster Care

Across child welfare systems, more than two thirds of the children and youth entering foster care have a documented history of maltreatment.¹⁴⁷ A majority have been exposed to violence,

¹⁴⁷ Szilagyi, M. A.; Rosen, D. S.; Rubin, D.; Zlotnick, S.; the Council on Foster Care, Adoption, and Kinship Care; the Committee on Adolescence; & the Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, 136, 4, e1142–1166.

including domestic violence, and many have parents with histories of substance use, criminal justice involvement, and mental illness.¹⁴⁸ For many children and youth in care, these traumatic experiences are compounded by factors that include homelessness, unsafe neighborhoods, poor schools and school attendance, poor child care, and a lack of normal childhood experiences. These traumatic experiences and adversities can result in poor emotional regulation, aggression, hyperactivity, inattention, impulsivity, and dissociation between thoughts and emotions.¹⁴⁹ Further, removal from home and placement in foster care can be traumatic — loss of contact with family and friends, separation from siblings, changes in school, and unstable foster care placements can result in emotional and behavioral problems.

In fiscal year 2019, there were over 4,000 (4,475) children and youth (ages 0 to 17) under the legal responsibility of CPS through DFPS in Dallas County.¹⁵⁰ Of these children and youth, 2,313 were males and 2,162 were females. Almost half (48% or 2,130) of these children and youth were African American, 33% (1,468) were Hispanic, and 600 children and youth were White. These Dallas County children and youth spent an average of 17.8 months in foster care prior to exiting care and experienced an average of 2.1 placements prior to exiting.

In Texas, system-wide data on the number of children and youth in the child welfare system who receive mental health services is not publicly available. DFPS provides the number of children and youth in foster care with certain identified characteristics, including “physical,” “medical,” “emotional,” “drug/alcohol,” and “learning” needs. Although the “emotional” and “drug/alcohol” characteristics are based on caseworker notes, not diagnostic interviews, they are the best available measure of the number of children with behavioral health conditions. Therefore, we use the “emotional” characteristic as a measure of serious emotional disturbance (SED) and the “drug/alcohol” characteristic as a measure of substance use disorder (SUD). Using counts of children and youth in foster care with these characteristics across all months of data in fiscal year (FY) 2018, we obtained a rate to approximate SED and SUD among the entire foster care population (ages 0 to 17). We then applied these rates to the foster care population of Dallas County and Region 3 in FY 2018. See Table 9 on the following page.

¹⁴⁸ Szilagyi, M. A.; Rosen, D. S.; Rubin, D.; Zlotnick, S.; the Council on Foster Care, Adoption, and Kinship Care; the Committee on Adolescence; & the Council on Early Childhood. (2015, October). Health care issues for children and adolescents in foster care and kinship care. *Pediatrics*, 136, 4, e1142–1166.

¹⁴⁹ Szilagyi, M. A., et.al. (2015, October).

¹⁵⁰ Texas Department of Family and Protective Services. (n.d.). *Data book: Child Protective Services (CPS) conservatorship children in DFPS legal responsibility during the fiscal year*.
https://www.dfps.state.tx.us/About_DFPS/Data_Book/Child_Protective_Services/Conservatorship/Children_in_Conservatorship.asp

Table 9: Prevalence of SED and SUD Among Children and Youth in Foster Care (FY 2018)¹⁵¹

Population	Dallas County	Region 3
Children and Youth in Foster Care (0 to 17) ¹⁵²	3,141	7,745
with Emotional Characteristic (SED) ^{153,154}	500	1,000
with Drug/Alcohol Characteristic (SUD) ¹⁵⁵	200	600

Across all children and youth in foster care from Dallas County, we estimate that 1,000 children and youth in foster care in Region 3 (both 3W and 3E) have SED, 500 of whom reside in Dallas County. One significant limitation is that age breakouts were not included in foster child characteristics data, so we used the total foster care population to calculate rates and applied this to that total population. SED prevalence studies were based on older children and youth and, because of challenges in accurately diagnosing pre-verbal children, we anticipated much lower rates of diagnosis for very young children. We do not know how many children identified by DFPS with an “emotional” characteristic were under the age of six, if any. Therefore, by using the total number of children in foster care (all ages) in our calculation, we likely underreported the rate of children in foster care with SED. If we include only children in foster care ages six to 17 in our calculation, we estimate that 30% have an SED.¹⁵⁶ In comparison, approximately 8% of all children and youth age six to 17 in the region have an SED.

¹⁵¹ Estimated number of children and youth with emotional and drug/alcohol characteristics are rounded to reflect uncertainty. The estimates were calculated using average rates across 12 months of data from fiscal year 2018 and applied to yearly totals of children and youth in foster care in the respective regions.

¹⁵² Data are based on actual counts, obtained from <https://data.texas.gov/Social-Services/CPS-8-2-Foster-Care-Placements-By-Fiscal-Year-And-/sxssx-qqtg>

¹⁵³ These estimates are based on month-to-month counts of children in foster care with an emotional characteristic from September 2017 through August 2018 in Region 3. Emotional characteristics were added by the child’s caseworker. DFPS Management Reporting and Statistics created a list of composite indicators that group together related characteristics. Emotional needs included reactive attachment disorder, bipolar disorder, depression, eating disorder, emotionally disturbed – DSM, oppositional defiant disorder, posttraumatic stress syndrome, among others. See: The Stephen Group (2015). *Meeting the needs of high needs children in the Texas Child Welfare System*. https://www.dfps.state.tx.us/About_DFPS/Reports_and_Presentations/CPS/documents/2015/2015-12-03_Stephen_Group_High_Needs_Assessment.pdf

¹⁵⁴ An SED rate was calculated using these data from each month in 2018 and was then applied to the count of children in foster care in FY 2018. Data obtained from

https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

¹⁵⁵ These estimates are based upon month-to-month counts of children in foster care with a drug/alcohol characteristic for all months in 2018 in Region 3. The SUD rate was then applied to the count of children in foster care in FY 2018. Data obtained from https://www.dfps.state.tx.us/Doing_Business/Regional_Statistics/default.asp

¹⁵⁶ The number of foster care youth with an emotional characteristic was not broken out by age, therefore we cannot intentionally exclude young children from our calculation. However, given the low rates of SED among young children, our calculation assumed that children under the age of six do not have an emotional characteristic. That age group (0 to five) was therefore excluded from the denominator (all children and youth in the foster care system).

We also estimate that 600 children and youth in foster care struggle with substance use conditions, about 200 of whom reside in Dallas County. Again, we do not have age breakouts to understand the age distribution of foster children with this characteristic. If we exclude children under the age of 10 from our calculation, the rate of SUD among youth in foster care is 19%.¹⁵⁷ In comparison, we estimate that 4% of all adolescents ages 12 to 17 in Dallas County have a substance use disorder.

It is not surprising that the estimated rates of SED and SUD are higher among children and youth in foster care than in the general population. Experiencing abuse or neglect, having incarcerated parents or caregivers with mental illness, as well as witnessing intimate partner violence or substance misuse within the home are all considered adverse childhood experiences. These types of stressful and traumatic events correlate with a range of health problems throughout a person's life, including substance use, mental health, and physical health conditions.¹⁵⁸

Who Supports the Mental Health Needs of Children and Youth in Foster Care?

Several of the providers we spoke with serve children and youth in the child welfare system. A list of the providers that focus on serving children and youth who are involved in the child welfare system is presented below. Some of these providers are described in other sections of this report since they specialize in other service areas, as well. We interviewed representatives from ACH Child and Family Services, CK Family Services, Pathways Youth and Family Services, Turning Point, and Dallas CASA.

ACH Child and Family Services

ACH Child and Family Services is a nonprofit agency with a mission of "Protecting Children and Preserving Families." This agency offers advocacy, prevention services, residential services, foster care and adoption services, including therapeutic foster care; and behavioral health services to children and youth who have been abused or neglected; it is also the Single Source Continuum Contractor (SSCC) in DFPS Region 3b. Children and youth in Dallas County also have access to its youth emergency shelter in Fort Worth.

¹⁵⁷ The number of youth in foster care who had a substance use characteristic was not broken out by age, therefore we cannot intentionally exclude young children from our calculation. However, given the low rates of SED among young children, we assumed that children under the age of 10 do not have a substance use characteristic.

Therefore, we excluded that age group (0 to 9) from the denominator (all children and youth in the foster care system).

¹⁵⁸ Substance Abuse and Mental Health Services Administration (2015, July). *SAMHSA's concept of trauma and guidance for a trauma-informed approach*. <https://store.samhsa.gov/system/files/sma14-4884.pdf>

CK Family Services

In addition to its functions as a child placement agency, CK Family Services provides an array of behavioral health and other supports and services for children and youth in foster care, and their families. One especially noteworthy program is its Treatment Foster Care (TFC) initiative. TFC aims to expand home-based capacity for children and youth placed in an residential treatment center or hospital because of a lack of traditional foster care or kinship care placements. These children and youth often have complex behavioral challenges and would be most successful in a well-supported and trained foster home. The CK Families TFC program is supported by specialized oversight, support staff, and professionally trained foster parents. The TFC program provides behavioral health, medication management, therapy, skills training, and wraparound services.

Pathways Youth and Family Services

Pathways Youth and Family Services provides foster care, adoption, and community-based services throughout Texas. Its full provider profile is listed under the *Component 3: Dallas County's Specialty Rehabilitative Care Capacity* section of this report.

Turning Point

Turning Point is an ACH Child and Family Services program that offers emergency assessment and 24/7 crisis intervention to children and youth in kinship care and foster care, and their caregivers. The program is funded through STAR Health, the contracted Medicaid managed care organization for children and youth in foster care. The goal of Turning Point is to prevent unnecessary hospitalization for children and youth in foster care and to prevent placement disruptions. The program addresses crises the child, youth, or caregiver experience by providing a 24-hour crisis information line, mental health assessments, counseling and consultation, an alternative care setting for eligible children and youth, and in-home crisis support and intervention planning.

Dallas CASA

Although Dallas CASA is not a provider of direct mental health services, it works closely with children and youth in the child welfare system. CASA (court-appointed special advocates) volunteers are trained advocates that make connections with and get to know children and youth so that they can make recommendations to judges about placements, services, and care. As advocates for a child or youth's mental health, they may communicate with therapists, review therapy notes, attend treatment planning meetings, and advocate for the therapeutic needs of children and youth inside and outside of court settings. In 2018, the program served 3,328 children and youth whose cases were heard in Dallas County.

Child Welfare System Mental Health Findings

Child Welfare (CW) Finding #1: There is a lack of intensive evidence-based practices (EBPs) available for children and youth with the most serious needs. Providers expressed a desire to provide intensive EBPs such as treatment foster care. However, reimbursement for such services does not exist in most places and, where it does, the rate is not sufficient to make implementation financially sustainable. The availability of and reimbursement for intensive EBPs is a key component of an effective children's mental health system, particularly for children and youth involved in the child welfare system. The availability of treatment foster care and additional intensive services would help alleviate the need for more restrictive placements such as shelters, residential treatment facilities, and psychiatric inpatient hospitals.

Legislation passed during the 86th Regular Legislative Session (Senate Bill 1177) grants managed care organizations (MCOs) the ability to offer reimbursement to providers for additional EBPs delivered in lieu of more restrictive placements. This provides an excellent opportunity for MCOs to support providers who want to deliver community-based services that can be used as an alternative to more restrictive settings.

CW Finding #2: The child welfare system as a whole needs a more systemic approach to address trauma and grief, both in the treatments that are offered and in the training that is provided to foster families and other care providers. Given the traumatic experiences that many children and youth in the child welfare system have experienced, a more systemic approach to addressing and responding to trauma is needed. The providers we reviewed expressed an understanding of trauma and its impact on children, youth, and families, but many also acknowledged their own limitations in making trauma-informed services available. Many foster care providers described experiences with foster family breakdowns that could have been prevented had foster families been better prepared to anticipate a child or youth's behaviors and how those behaviors were related to their history of trauma.

CW Finding #3: Foster parents need to receive better preparation on the signs, symptoms, and behaviors associated with trauma in children and youth. Providers also acknowledged the need to better equip foster parents to address behaviors in the home. Placement disruptions are more likely to occur when foster parents and kinship foster parents are not equipped to anticipate and address the trauma, behavioral challenges, and mental health needs of the children and youth in their care. Foster parents and kinship foster parents receive a limited amount of training and few services to support new placements. This training generally occurs toward the beginning of a new placement, before real-life challenges have occurred.

CW Finding #4: Caregivers — both biological families and foster families — need more support than the system currently provides. Providers also reported that more services should

be available to caregivers, foster parents, and kinship foster parents to support them with their own needs as well as to help them learn how to address their children's or foster children's needs and behaviors. They indicated that parents might have better outcomes, and reunifications might increase, if biological parents had more services available to them such as mental health treatment, substance use disorder treatment, help in navigating the system, and help with transportation or other barriers that get in the way of their own treatment. Expansion of services such as Turning Point, which provides 24/7 crisis intervention to children and youth, in foster care, and their foster families, can ensure placements do not break down.

CW Finding #5: Youth aging out of the child welfare system need more support. Providers reported that youth need more independent living resources and help with social determinants of health, including affordable housing, assistance with transportation, and meaningful employment opportunities. There are also challenges in accessing adult mental health services as youth transition into adulthood, and respondents pointed out that sometimes youth do not want to continue receiving mental health services because they do not think they need them or are tired of having providers in their lives.

CW Finding #6: More integrated care is needed such as services The Rees-Jones Center for Foster Care Excellence provides to children and youth involved with in the child welfare system. Providers indicated that care becomes fragmented when there are not intentional efforts to integrate services. Outside of a treatment setting such as The Rees-Jones Center for Foster Care Excellence (described in *Component 1: Dallas County's Integrated Pediatric Primary Care Capacity*), the different providers often do not communicate or coordinate about a child or youth's needs. Children and youth served in the child welfare system may be moved from placements, for example, and this can interrupt services and have an impact on the care they receive. Establishing locations and practices that address both medical and mental health needs for this population is important for ensuring continuity of care.

Mental Health Services in the Dallas County Juvenile Justice System

Children and youth with juvenile justice system involvement have access to behavioral health services offered through the Dallas County Juvenile Department (DCJD). These services include mental health and substance abuse services and supports, offered through DCJD's Clinical Services division. Within the Clinical Services division, the Substance Abuse Unit (SAU) is responsible for substance abuse services and the Psychology Unit oversees mental health care. Services offered through the SAU include chemical dependency assessments, drug Intervention classes, a Supportive Outpatient Program (SOP), and Intensive Outpatient Programs (IOP). Children and youth who receive services through SOP and IOP also receive aftercare services to help support their successful reintegration into the community following treatment.

Through the Psychology Unit, DCJD also provides comprehensive psychiatric and psychological services for youth in detention and residential facilities. These facilities include:

- Medlock,
- Youth Village,
- Letot Residential Treatment Center,
- Letot Shelter,
- Residential Drug Treatment, and
- An inpatient program for youth with problematic sexual behaviors.

Psychiatric monitoring and services for children and youth in these facilities are provided through a psychiatrist employed by the Parkland Health and Hospital System.

Children and youth in the community who are on probation, and those attending the Juvenile Justice Alternative Education Program (JJAEP) or involved with the Day Reporting Center (DRC), also may receive mental health supports through the Psychology Unit. These services are provided at no cost the young person or their family.

Mental Health Needs Among Children and Youth in the Juvenile Justice System

Dallas County Juvenile Department (DCJD) data is not publicly available and the most recent data we could obtain directly from the Department was from 2016. Despite being four years old, the data we received still provides meaningful context to help understand what populations of children and youth with juvenile justice system involvement are likely to experience mental health challenges and which populations we can expect will have the highest needs. In 2016, 3,729 males and 1,491 females were referred to DCJD.¹⁵⁹ DCJD uses the Massachusetts Youth Screening Instrument 2 (MAYSI-2) to screen all children and youth at intake to determine if they have a mental health need. Children and youth with elevated scores on the MAYSI-2 undergo further assessment or are referred to services.

Pre-adjudicated children and youth are served at the Dr. Jerome McNeil Jr. Detention Center (Detention Center), Letot Shelter, and Hill Center. Table 11, on the following page, shows the number of unduplicated youth who were served at each facility and the number of those youth with mental health needs.

¹⁵⁹ Dallas County Juvenile Department. (n.d.). *Juvenile delinquency in Dallas County: Referrals (by sex) from 2015–2017*. https://www.dallascounty.org/Assets/uploads/docs/juvenile/data/JuvenileReferralsbySex_2015-2017.pdf

Table 11: Pre-Adjudicated Youth in Dallas County (2016)

Pre-Adjudication	Detention Center	Letot Shelter	Hill Center
Total number of beds	272	32	62
Average length of stay (LOS) in days among all youth	21	37	35
Average LOS (days) among all youth with mental health needs	31	41	35
Average daily population among all youth	159	19	32
Average daily population among all youth with mental health needs	130	6	27
Total unduplicated youth served	2,127	203	343
Total unduplicated youth with mental health needs served	1,135	50	286

In 2016, youth who were adjudicated were placed in several DCJD residential facilities. These included Letot Residential Treatment Center, Medlock Enhancing Positive Identity and Choices (EPIC), Medlock Successful Thinking and Responsible Sexuality (STARS), Residential Drug Treatment (RDT), Short Term Adolescent Residential Treatment (START), Youth Village, and Youth Village Youthful Offenders. The vast majority of children and youth served by these programs had a mental health need. Table 12 shows unduplicated youth served in each program and of those youth, how many had a mental health need.

Table 12: Post-Adjudicated Youth in Dallas County (2016)

Post-Adjudication	Letot RTC	Medlock – EPIC	Medlock – STARS	RDT	START	Youth Village	Youth Village – Youthful Offenders
Total unduplicated youth served	37	118	54	166	149	146	15
Total unduplicated youth with mental health needs served	34	112	42	153	143	142	9

In contrast to those served in post-adjudication facilities, children and youth served through DCJD community-based programs in 2016 had lower rates of an identified mental health need. About 55% of the youth served in these programs were identified as having mental health needs.

Table 13: Juvenile Justice Community-Based Programs and Services for Children and Youth in Dallas County (2016)

Community -Based Programs and Services	
Total unduplicated served	2,672 Youth
Total unduplicated with mental health needs served	1,471 Youth

Who Supports the Mental Health Needs of Children and Youth Involved in the Juvenile Justice System?

The Clinical Services department team at DCJD includes clinical coordinators and clinicians that are primarily psychologists, licensed professional counselors (LPC), licensed psychological associates (LPA), and licensed clinical social workers (LCSW). All of the counselors providing substance use services are licensed chemical dependency counselors (LCDC) and all sex offender therapists are licensed sex offender treatment providers (LSOTP). The Psychology Unit also includes a Functional Family Therapy (FFT) program. The behavioral health assessments, programs, and services provided by the clinical team at DCJD are described below.

DCJD Mental Health Screening and Assessment Process

Upon intake into the Dr. Jerome McNeil Jr. Detention Center, DCJD screens all children and youth using the Massachusetts Youth Screening Instrument 2 (MAYSI-2). The MAYSI-2 is a self-report screening instrument designed to help identify possible mental health concerns for children and youth with juvenile justice system involvement. If scores are elevated, staff from the Detention Center crisis team will meet with the child or youth to determine if they need a safety plan or monitoring. The team will also make additional referrals for psychiatric services or individual therapy, if needed.

The DCJD Psychology Department conducts about 150 to 200 court-ordered psychological assessments per month. Most children and youth receive a psychological evaluation, which includes a mental status exam, clinical interview, IQ testing, and achievement testing. These reports help inform service planning. Judges may also order a certification evaluation when a youth have serious offense that may require being transferred into the adult criminal justice system. This assessment examines if the youth is amenable to treatment or a risk to the community. Judges may also order a competency evaluation when a child or youth has significant known mental health problems or intellectual disabilities to determine if they understand the court process and can assist their attorney in their defense. Family assessments focus more on family dynamics and a judge may require that the Psychology Department conduct one if there are concerns of abuse or dysfunction in the home before the child or youth can return home. Specialty assessments are also conducted with children and youth who have

sexual offenses. These assessments, completed by staff in the Psychology Department, focus on the child or youth's sexual knowledge and level of risk to the community.

DCJD Mental Health Services and Supports

DCJD provides several in-house mental health and substance abuse services. Children and youth in detention can receive individual counseling, crisis management, psychiatric care, and psychological assessments. Children and youth in residential placements receive individual therapy, group therapy, crisis management, and family therapy. Children, youth, and families in the community can participate in Functional Family Therapy or services provided by the Substance Abuse Unit. They can also engage in individual therapy, family training, anger management, and positive development groups. All clinical services can be provided in English and Spanish. All therapists are trained in cognitive behavioral therapy. About 75% of staff are trained in trauma-informed therapies such as Trauma-Focused Cognitive Behavioral Therapy and Dialectical Behavior Therapy. DCJD also has several specialty and diversion courts. The following section describes some of the community-based and residential programs that address mental health needs as well as program goals and populations served.

Specialty Courts

Mental Health Court. Mental Health Court aims to divert children and youth with a mental health disorder who are first-time offenders from further justice system involvement. Children and youth served by this program are assigned a probation officer and participate in weekly court hearings, in-home therapy with Functional Family Therapy, and psychiatric services through Dallas Metrocare. Children and youth who participate in Mental Health Court learn coping strategies to prevent further system involvement and address the issues that led them into the juvenile justice system.

E.S.T.E.E.M. Court (Experiencing Success Through Empowerment, Encouragement and Mentoring). E.S.T.E.E.M. is a diversion program for girls that is targeted specifically at reducing the potential for sexual exploitation and trafficking among girls considered at risk. The program includes intensive supervision, weekly court hearings, individual and group therapy, in-home family therapy, and mentorship with community leaders.

Diversion Male Court (D.M.C.). D.M.C. is a diversion program for first-time offending males from communities of color whose offenses include misdemeanors or burglary, theft, assault, criminal trespassing, or similar offenses. The program goal is to reduce the disproportionate representation of these children and youth in the juvenile justice system. Probation officers and community service providers work together to help D.M.C. participants focus on prosocial

behaviors and link them to case management, mentoring programs, and other services they might need to address their individual needs.

Drug Court. Drug Court is a diversion program for children and youth with first-time misdemeanor drug offenses. The purpose of the court is to divert children and youth with only substance abuse issues into treatment and away from entering the criminal justice system.

Outpatient Programming

Functional Family Therapy (FFT). FFT is an evidence-based, clinical counseling model in which licensed counselors help children, youth, and their families learn to communicate and address family dynamics. The services are home-based and offered to children and youth who are on probation and participating in some diversion programs. DCJD currently has eight FFT therapists, including a supervisor.

Special Needs Diversionary Program (SNDP). SNDP provides mental health treatment and specialized supervision to rehabilitate juvenile offenders and prevent them from penetrating further or returning to the criminal justice system. The program is administered through a collaboration between the Texas Juvenile Justice Department and the Texas Correctional Office on Offenders with Medical and Mental Impairments. The program provides mental health services and specialized supervision to children and youth on probation who have significant mental health needs. In Dallas County, this program is provided through a partnership with Metrocare.

Outpatient STARS. The STARS program stands for Successful Thinking and Responsible Sexuality. This program is for children and youth who have problematic sexual behaviors and have been adjudicated on a sexual offense. Therapists provide weekly group therapy for these children and youth in the community. The goals of the group focus on taking responsibility, repairing relationships, and building trust as well preventing relapse. Children and youth who participate in the STARS program are required to undergo polygraph testing as part of their treatment.

Detention and Residential Treatment

The Henry Wade Building houses the Detention Center, Hill Center, Residential Drug Treatment Program, and Inpatient STARS program.

Dr. Jerome McNeil Jr. Detention Center and The Marzelle Hill Transition Center. The Detention Center and the Hill Center house children and youth who have been arrested and charged with an offense or who have violated conditions of their probation. Staff gather

information from children and youth to help the court make decisions about next steps and service needs. While children and youth are detained, the centers provide necessary medical and dental care, psychological testing and consultation, crisis stabilization and counseling, and educational assessment and instruction.

Residential Drug Treatment (RDT). RDT is a 40-bed program for adjudicated children and youth who struggle with substance abuse issues. These children and youth participate in 90 days of intensive substance abuse treatment, which includes individual therapy, group therapy, and family therapy. The program uses A New Direction curriculum, which is an evidenced-based substance abuse program for children and youth involved in the juvenile justice system.

Inpatient STARS program. The inpatient STARS program is similar to the outpatient program. The 36-bed residential program is for children and youth who have been charged with a serious sexual offense. Treatment goals are similar to the outpatient STARS program. However, treatment is much more intensive, with weekly individual therapy, groups three times a week, and family therapy and groups. The Inpatient STARS program utilizes the Pathways curriculum, which is an evidenced-based program for people who have committed sexual offenses.

Letot Residential Treatment Center (RTC). The Letot RTC is a 96-bed residential program for post-adjudicated girls. The facility specializes in trauma therapy and gender-responsive programming. The children and youth in this program participate in individual therapy, family therapy, and group therapy. Crisis intervention is available, if needed. All of the therapists at the RTC are trained in Trauma-Focused Cognitive Behavioral Therapy and Dialectical Behavior Therapy. Some of the groups that are offered include Art Expression, My Life My Choice, Coping Skills, and Girls Circle. The facility houses a residential drug treatment program for girls and soon will open a treatment unit for female children and youth who have been charged with a sexual offense.

Letot Shelter. This residential facility has capacity for 24 girls and eight boys in three dormitories. The facility provides an intake assessment unit; individual, group, and family therapy; and crisis intervention services. Therapeutic groups focus on truancy, anger management, setting boundaries, and runaway prevention. Services are focused on helping children and youth learn to make healthy decisions, build positive relationships, and manage their emotions and stress. Children and youth who are treated in this facility typically are from the community and do not have a criminal offense.

Medlock Treatment Center. Medlock is a secure facility that serves up to 72 adjudicated males who have committed serious offenses. Program participants must demonstrate successful

social skills and concepts for change and rehabilitation. The program addresses thinking errors that led to the child or youth's placement and uses Aggression Replacement Training (ART) to decrease violent and maladaptive behaviors. Children and youth in this program receive individual, family, and group therapy.

Youth Village. Youth Village is a 72-bed, non-secure placement for males who have lower level offenses. In addition to receiving individual, group and family therapy, many of the youth in this program benefit from vocational programming. For example, youth in this facility can earn certificates and receive training in culinary skills, working a forklift, surveying, or welding.

Dallas Juvenile Parole Department

The Dallas Juvenile Parole Department (DJPD) is responsible for helping children and youth make the transition back home and integrate into their communities after discharge from treatment-based facilities. The department pays for community-based aftercare services that children and youth may need, including drug and alcohol, mental health, and sex offender treatment. Many children and youth being served by the parole department have substance use and mental health needs, but often do not want to participate in treatment. The department finds that children and youth are often more willing to participate in services for substance use issues than in mental health treatment. Children and youth on parole also face the challenge of returning to the environment they lived in when they committed their offenses. They may return to communities where they experience pressure to re-engage in gang activities or behaviors from their previous lifestyle.

All Texas Juvenile Justice Department programs, including juvenile parole, are shifting to implement a trauma-informed model. The parole department staff in Dallas County are being trained in the Effective Practices in Community Supervision (EPICS) model. This evidenced-based model is helping staff take a more therapeutic and treatment-based approach when interacting with the children and youth they serve.

Table 14, below, provides a summary of children and youth served through the parole department and the number that have mental health needs.

Table 14: Mental Health Services for Children and Youth on Parole (September 2018 to September 2019)

Children and Youth on Parole	All Children and Youth	Children and Youth with Mental Health Needs
Children and youth paroled in Dallas County	40	16
On parole and placed in residential facility	2	2

Children and Youth on Parole	All Children and Youth	Children and Youth with Mental Health Needs
Placed out of county	0	0

Juvenile Justice System Mental Health Findings

Juvenile Justice (JJ) Finding #1: DCJD provides many clinical services to children and youth, but these services are limited to those who are on probation or have been detained. Once children and youth are no longer in the department's jurisdiction, they are no longer eligible for department-funded services, which makes it challenging to connect to accessible community mental health services. There is a shortage of available providers who could provide services to children and youth after they exit the probation system, and families struggle to navigate the service system. Children, youth, and their families may not have transportation to get to community programs. There are also long waiting lists for services in the community, including psychiatric services for youth who are involved in the juvenile justice system. Community services for uninsured youth are especially limited.

The Dallas Juvenile Parole Department is able to use its resources to provide services to children and youth, and their families, who are involved in its program, but children and youth who complete parole may face challenges in accessing services in the community because of the limited availability of services or because they no longer want to continue receiving services.

JJ Finding #2: There is limited availability or long wait times for intensive services, including YES Waiver services. Children and youth who are served by the juvenile justice system, especially those with severe mental health needs, may benefit from intensive services, but they often have to wait several weeks to access these services. DCJD staff reported that much can happen while they wait for services and their mental health needs may quickly worsen without adequate supports. Children and youth may end up in crisis and needing more restrictive services such as hospitalization.

JJ Finding #3: More support is needed for children and youth transitioning out of the juvenile justice system, especially if they are also involved with the child welfare system. If children and youth cannot return home, they have few places to go when they are discharged from the juvenile justice system, especially if they recently reached the age of majority (18) and no longer qualify for child welfare services. In some cases, parental rights are terminated while children and youth are in facilities or residential placements. In these instances, if the child or youth is under age 18, they are referred to child protective services and then consequently placed into foster care or other residential facilities. Often in these cases, the child or youth is

not eligible or accepted for placements at certain facilities or in foster homes because of the complexity of their needs or their histories of trauma.

For youth who have turned 18, there are limited housing options upon exiting the juvenile justice system. In these instances, their parents are no longer legally bound to care for them and often do not allow them to return home. While DJPD makes efforts to provide the supports youth need to live independently in the community, it reports that youth struggle to successfully live independently.

For this report, we reviewed leading service providers across Dallas County to closely examine provider capacity and treatment offerings across all components of the system. The principal findings and recommendations that follow offer specific recommendations to support the continued development of the system as a whole.

Principal Findings

Our principal findings for improving children and youth's mental health services in Dallas County are described below.

Principal Finding #1: Integrated primary care (IPC) is increasingly available in Dallas County; however, most primary care providers do not yet offer it. Best practice use of integrated primary care settings requires an infrastructure of universal evidence-based screening (using tools such as the PHQ-9 for depression, the GAD-7 for anxiety, and the CAPS-5 for trauma, for example, to identify needs), 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, either in person or through telehealth). Although IPC is being implemented across many settings (pediatric primary care offices, federally qualified health centers, school-based clinics), and efforts are underway to expand implementation, there is a need to accelerate deployment of measurement-based care and expand collaborative care capacity in the majority of primary care settings that do not yet offer it.

Principal Finding #2: Overall system capacity constraints result in limited referral sources for primary care providers, other specialty outpatient providers, and schools, which makes it difficult for families to obtain timely care for their children when a need is identified. These capacity constraints are particularly evident for children and youth who need a psychiatric evaluation. Several integrated care providers are offering short-term telehealth/telemedicine services to families waiting for specialty outpatient care. These integrated care providers reported that when they refer children and youth to a community-based provider, they face long waiting lists. Because of this barrier to care, they are exploring technological strategies to help bridge the gap between the short-term therapeutic services they offer while children and youth are waiting to be linked to longer-term supports in the community.

Principal Finding #3: Staffing challenges limit the capacity of provider organizations to meet the demand to treat children, youth, and their families effectively. Staffing challenges include high turnover, the cost of training providers in evidence-based practices (EBPs), and recruiting and retaining staff who are culturally competent for the population the program serves (with regard to language, for example). As noted above, there is a shortage of both psychiatrists and behavioral health clinicians to meet the current needs of the community. Organizations stated

they have had difficulty in retaining staff, particularly bilingual staff and those with advanced trainings and certifications (e.g., Trauma-Focused-Cognitive Behavioral Therapy, eye movement desensitization and reprocessing, Dialectical Behavior Therapy). Most clinicians do not enter employment with training and experience in delivering evidence-based practices. As a result, providers are often responsible for ensuring their staff receive the training needed to deliver effective services. Providers noted that evidence-based trainings are often expensive and, when paired with high staff turnover, can become cost prohibitive. Additionally, many providers who are culturally competent with the populations they serve stated it is difficult to find and retain staff with this same qualification.

Principal Finding #4: Health systems and community-based providers are increasingly making trainings, mental health programs and initiatives, and prevention resources available to schools. Multiple organizations throughout the community provide such supports, and many organizations are working with schools to embed services such as group skills, crisis intervention, case management, and others. Local organizations are also implementing evidence-informed mental health programs/initiatives in schools.

But despite the resources available to an increasing number of schools (including through the new TCHATT program), relationships between provider agencies and schools are often based on individual relationships, not systemically embedded. In many cases, a single person (at either a school or agency) established the relationship between the school and agency. A number of providers noted difficulty in accessing the children and youth they serve during school hours, though the level of difficulty varied among school districts and providers. Additionally, there were few formal agreements regarding service provision by external providers.

Principal Finding #5: Children and youth with the highest needs lack access to needed intensive, community-based services. Using the most current annual data that were available from providers, we estimated that just over 300 children and youth received Medicaid-funded intensive family services in the last year, such as intensive case management, rehabilitative services, and YES Waiver services, and few of these were evidence based. This number represents only about 14% of the 2,000 children and youth in Dallas County in need of such care. Children and youth who are at risk of entering — or who are already involved in — juvenile justice and child welfare systems experience higher rates of need for these services. This directly correlates with an overreliance on more restrictive placements, such as hospitalizations or residential placements. Moreover, for children and youth released from psychiatric hospitals or residential facilities, the lack of these services means they return to the same situations they left without access to the types of support they need to thrive at home and in their communities. Barriers to providing these specialized services include the cost of

hiring, training, and retaining staff; lack of services covered by private insurance; and low Medicaid reimbursement rates.

Principal Finding #6: Crisis response capacity is inadequate and fragmented across systems.

Current crisis services do not function as a coordinated system, which prevents children and youth from getting the services they need when they need them. Similar to many communities across Texas and the nation, the current array of crisis services in Dallas County does not function as a system, a deficiency that contributes to gaps in care and service redundancies that limit the capacity across programs to provide children and youth with the right services at the right time.

Principal Finding #7: Systems navigation is a universal challenge for families seeking mental health services for their children, from knowing what services will best meet a need when it is initially identified to how to get support if the need becomes a crisis. Families experience better outcomes when they are connected to services and supports at the onset of symptoms. Unfortunately, because the mental health care system is difficult to navigate, many families' first encounter with treatment is in an emergency room during a crisis, which presents a unique set of system navigation challenges.

The principal findings introduce options for transforming the Dallas County mental health service delivery systems for children, youth, and their families. In addition to these findings, we identified findings that cut across all systems, disciplines, and organizations. Addressing these four cross-cutting findings could improve resource identification and quality of care at every level of care.

Cross-Cutting Finding #1: Services and supports for the whole family are lacking. Providers identified the need for expanded services for the caregivers of the children and youth they serve. They identified needs ranging from social determinants of health resources such as transportation, food, and childcare, to helping caregivers support their children's mental health needs (e.g., parenting classes, in-home coaching, and family therapy to address the complexity of family systems). Only a limited number of providers we reviewed are able to provide family therapy or parenting classes to caregivers. Providers also highlighted the need for expanded capacity to provide behavioral health interventions to meet caregivers' own mental health or substance use disorder needs.

Cross-Cutting Finding #2: Although most providers recognize the importance of providing culturally and linguistically competent services, they often find it hard to recruit and retain staff who have these competencies. These staff shortages affect the availability of services for a significant portion of the community. Most providers identified a shortage of staff who speak

the language(s) of the children, youth, and families their agencies serve. Providers especially highlighted the need for bilingual staff beyond those who speak Spanish and English since there are many groups in the county that speak other languages. Often, organizations regard cultural and linguistic competency as a strength that individual employees might bring to the agency, not as an embedded organizational value, criteria for gaining employment, or a component of agency training.

Cross-Cutting Finding #3: The faith-based community is a strong yet often untapped partner for mental health services providers. Most organizations noted the potential to have stronger partnerships with the faith-based community, recognizing it as an untapped resource that is often willing to offer help. Several faith-based organizations we reviewed identified strategies for making mental health services and supports more widely available through strategic partnerships.

Cross-Cutting Finding #4: Mental health providers described being unaware of what services other providers offer and how they can effectively partner with these providers. Providers noted a lack of coordination across components of the system and between each other, primarily because of a lack of awareness of what services or resources other providers offer in the community. Respondents from nearly every organization we reviewed expressed a desire to better understand the services and resources that are available throughout the community so they could connect the people they serve with the services that will best meet their needs.

Principal Recommendations

The major principal recommendations for improving mental health services for Dallas County children, youth, and their families are described below.

Principal Recommendation #1: Implement measurement-base care to strengthen the infrastructure for assessing and monitoring symptoms. Over the last 15 years, there has been considerable progress in developing reliable tools for measuring symptoms. Also, national studies show that the simple act of routinely measuring symptoms over time improves care outcomes.¹⁶⁰ National standards for mental health service delivery are increasingly requiring the same level of symptoms assessment and monitoring that has been routine for other health conditions like diabetes and heart disease.¹⁶¹ Accordingly, mental health and substance use care providers need to be actively developing the infrastructure to assess, diagnose, and

¹⁶⁰ Trivedi, M. H., Rush, A. J., Gaynes, B. N., et al. (2007). Maximizing the adequacy of medication treatment in controlled trials and clinical practice: STAR*D Measurement-Based Care. *Neuropsychopharmacology*, 32, 2479–2489.

¹⁶¹ The Joint Commission. (2018, February 13). Revised outcome measures standard for behavioral health care. *R3 Report*, 13. https://www.jointcommission.org/assets/1/18/R3_Outcome_measures_1_30_18_FINAL.pdf

monitor symptoms across time for the people they serve. Community providers need to implement measurement-based care for both early identification of mental health needs and improved quality of treatment. Measurement-based care is the practice of basing clinical care on client data that is collected throughout treatment. This helps improve patient outcomes by monitoring treatment progress, symptom reduction, readiness for change, and quality of life. Integrating practices such as collaborative care models and utilizing these CPT codes supports the sustainability of MBC within practices and health systems. Additionally, recent software options that include screening, decision support for physicians, and patient registries and alerts can be easily integrated into and modified to fit within electronic health records, thereby enabling pediatricians and family doctors to execute MBC with ease. The Joint Commission has recently incorporated MBC as a requirement for accreditation of behavioral health care programs.¹⁶² National efforts by groups such as the National Alliance of Healthcare Purchaser Coalitions¹⁶³ and Shatterproof¹⁶⁴ are insisting on MBC as a way to ensure high-value, effective treatment. Providers reported the importance of being person- and family-centered — MBC enhances this person-driven treatment model because the direction and development of the treatment is specific to the individual or family and their progress throughout treatment.

Principal Recommendation #2: Based on the infrastructure developed by Senate Bill (SB) 11 (86th Legislature, 2019), fully implement measurement-based screening and assessment supports into primary care through the Child Psychiatry Access Network (CPAN) program. SB 11 established CPAN to support improved detection and care for mental health needs in primary care through a network of behavioral health consultation hubs located at Texas medical schools. CPANs are based on the well-established child psychiatry access program model pioneered in Massachusetts over 15 years ago, which is now available in 30 states. The Texas program will extend statewide and be the largest child psychiatry access program implementation to date, designed to reach over five million Texas children and youth once it is fully operational by 2021. The hub that will serve Dallas County will be located at The University of Texas Southwestern (UTSW) Medical Center through a partnership with Children's Health. Each hub will offer pediatric and family medicine providers with support in meeting their patients' mental health needs, including clinical consultation, care coordination assistance, and continuing education. The CPAN hub will also include a referral network of specialty outpatient providers it can share with pediatric primary care providers. The development of CPAN will

¹⁶² The Joint Commission. (2018, February 13). Revised outcome measures standard for behavioral health care. *R3 Report, 13*. https://www.jointcommission.org/assets/1/18/R3_Outcome_measures_1_30_18_FINAL.pdf

¹⁶³ National Alliance of Healthcare Purchaser Coalitions. (2019). The Path Forward for Mental Health and Substance Use. <https://www.nationalalliancehealth.org/www/initiatives/initiatives-national/workplace-mental-health/pathforward>

¹⁶⁴ Shatterproof. (2019). Shatterproof National Principles of Care. <https://www.shatterproof.org/shatterproof-national-principles-care>

expand the use of integrated pediatric primary care, simplify service navigation for families, and improve access to mental health care overall. It is critical that Dallas County leaders support UTSW in establishing relationships with every pediatric and family practice in the county, and that specialty outpatient providers be included in the database that is being developed for the referral network.

Principal Recommendation #3: Specialty outpatient behavioral health providers need to develop formal partnerships with the UTSW CPAN hub for Dallas County to create formal referral pathways. Moving forward, it is essential that community specialty outpatient behavioral health providers develop a relationship with the UTSW CPAN hub. Through the UTWS CPAN referral network, pediatricians and primary care providers will be better equipped to refer their patients to community services and supports that specifically address the behavioral health needs of children and youth. UTSW will be reaching out to key providers early in 2020 to initiate this process.

Principal Recommendation #4: Reframe the roles of specialty outpatient behavioral health providers to better serve the population of children and youth with moderate-to-severe mental health conditions, and increase their capacity to offer more intensive, clinic-based, evidence-based practices (EBPs). With the implementation of the UTSW CPAN, more children and youth with mild-to-moderate mental health conditions will be adequately served in primary care settings. As a result, the roles of specialty outpatient behavioral health providers will increasingly need to be refocused on the needs of children and youth with moderate-to-severe mental health conditions. In addition, since specialty outpatient behavioral health providers offer more EBPs that are focused on specific conditions, they are in a better position to provide these services than providers who offer more generic care. Optimally, specialty outpatient providers who would like to serve children and youth with mild-to-moderate needs would be deployed to integrated practice settings where they would be co-located and partner with pediatricians and primary care doctors to deliver follow-up care for children and youth whose mental health needs are identified in a primary care setting.

In order to ensure the appropriate implementation of EBPs, community organizations will need to retool, retrain, and invest in staff and infrastructure, and establish partnerships with other agencies. These agencies will need support and dedicated resources to create a plan to identify appropriate EBPs, select and train appropriate staff, implement the selected EBPs, and measure fidelity in order to ensure that the services are effective. Agency leadership will need to be committed to delivering EBPs. More broadly, the agency will need to provide an infrastructure to support EBP implementation and ensure treatment fidelity. Individual providers can develop EBP strategies alone or in collaboration with other providers. A collaborative of agencies interested in increasing the implementation of EBPs such as Dialectical Behavior Therapy and

Parent-Child Interaction Therapy could be developed to efficiently use limited financial resources and embed EBPs into the infrastructure of multiple providers at the same time. Providers can address sustainability challenges by pooling together resources, sharing costs, and coordinating cross-agency trainings. Agencies and collaboratives will need to engage in advocacy with payers and incorporate outcomes-based and other reimbursement strategies to sustain these services over the long term.

Principal Recommendation #5: Increase school-based and school-linked mental health services and supports by using the full range opportunities made available in the 86th Legislative Session. 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 both targeted and intensive interventions for children and youth with more complex mental health needs.¹⁶⁵ The 86th Legislative Session initiated and expanded multiple legislative opportunities to help sustain and increase access to these types of services and supports. SB 11 (discussed in a later recommendation) created a new School Safety Allotment, which is administered through the Texas Education Agency. School districts can use this new funding to create supportive school environments and prevent mental and behavioral health concerns from emerging. This can be done through school partnerships with community-based organizations. Beyond this, House Bill (HB) 18, effective December 1, 2019, includes training, policy, and planning requirements for school districts related to student mental health, the use of trauma-informed practices, social and emotional skills development, and mental health education for students. Community providers can partner with schools to help them meet these requirements. Additionally, HB 19 puts a non-physician mental health professional at each of the 20 regional Education Service Centers throughout the state to focus on social and emotional well-being by supporting school personnel and facilitating their training in mental health and trauma-informed care.

Principal Recommendation #6: There is a need to develop capacity for intensive, community-based EBPs that go beyond the basic level of services funded by the Health and Human Services Commission (HHSC) and provided by the North Texas Behavioral Health Authority (NTBHA) and Medicaid managed care organizations. Currently, Mental Health Rehabilitative Services funded by HHSC through NTBHA and Medicaid must conform to the state's 2012 Texas Resilience and Recovery (TRR) framework. The TRR requirements limit Medicaid case management and specialty rehabilitative care providers' efforts to individualize their interventions to address the specific needs of the individuals and families they serve. The TRR framework is a prescriptive set of time allotment for generic interventions provided to each

¹⁶⁵ Meadows Mental Health Policy Institute. (2019, November 1). *Mental and behavioral health roadmap and toolkit for schools*. <https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf>

individual that is identified through a calculated formula to meet the need for certain care packages. For example, a provider specializing in treating children and youth involved in the child welfare system must deliver the same interventions to their caseloads as other providers working with different populations of children and youth even though there are EBPs with more well-suited with better outcomes designed for children and youth involved with the child welfare system. These limitations were designed to ration general revenue-funded care, which is inconsistent with the Medicaid entitlement and SB 58 (83rd Regular Session, 2013), which eliminated the requirement that Medicaid providers must follow the TRR and enabled them to deliver EBPs that are individualized to the populations covered by the state's Medicaid managed care program. We recommend that North Texas providers seek private and federal grant funding that can be braided with HHSC funds to support staff training and create the infrastructure needed to implement more intensive and effective EBPs so that they can provide individualized care. In addition, providers should work with state policymakers (e.g., HHSC) to reform the TRR framework, which continues to mandate inefficient requirements and outmoded restrictions on the ability of HHSC-funded providers to deliver EBPs beyond the narrow list of interventions HHSC allows. Medicaid managed care providers need to also explore the provisions of SB 1177 (86th Regular Session, 2019), which will allow reimbursement for the provision of certain EBPs in lieu of other services.

Principal Recommendation #7: Expand access to urgent assessment and crisis stabilization supports in schools through the Texas Child Health Access Through Telemedicine (TCHATT) program. In addition to CPAN, SB 11 established TCHATT, which will also be implemented by UTSW Medical Center in partnership with Children's Health. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth with urgent mental health needs. The urgent assessments and short-term stabilization care that will be available through TCHATT will increase community-wide urgent care capacity. It will also require linkages for follow-up care to specialty outpatient mental health providers. Although TCHATT will be offered statewide, it will not be provided in every Texas independent school district (ISD) or in every school in the ISDs served by the program. In the first year of this program, UTSW and Children's Health plan to focus on working with schools with whom they have existing relationships; in the second year they will expand into new schools.

Principal Recommendation #8: Develop a coordinated crisis response system across all payers; Medicaid managed care organizations; and health, mental health, child welfare, and juvenile justice systems, including TCHATT services. The current array of crisis services in Dallas County does not function as a system. This observation is less a criticism than it is a paramount charge to collaborate and build a coordinated crisis response system across key payers and health systems over time. Many of the necessary pieces are in place, but cross-

system transformation requires collaboration and a will to develop a more comprehensive system that has supportive payment protocols. One key piece of coordination is to quickly obtain an initial appointment for children and youth following a crisis episode or inpatient stay. Providers noted that it is not unusual for there to be a six-week wait for an appointment with a psychiatrist, which is especially problematic following a crisis episode or discharge from an inpatient stay. Optimally, appointments with outpatient providers should occur within seven days of discharge or a crisis event. This requires coordination between inpatient and outpatient providers while the child or youth is in the hospital, as well as the availability for an outpatient provider to schedule the appointment(s). This level of coordination does not currently exist and results in treatment delays that leave children and youth cycling through the crisis and inpatient services.

The principal recommendations introduce opportunities for transforming Dallas County's existing mental health service delivery for children and youth. In addition to these recommendations, we offer four cross-cutting strategies that could improve resource identification and quality of care, and enhance the family-centered focus of services for children, youth, and their families.

Cross-Cutting Strategy #1: Increase the emphasis on family-focused interventions, including family therapy and caregiver training and support. Providers increasingly recognize the critical importance of family-focused care when treating children and youth, something long supported by research. However, fragmented funding continues to focus more on services to the identified patient (child or youth) rather than on the family. Efforts to expand and improve family-center therapy have been hampered by misunderstandings of confidentiality limitations under the Health Insurance Portability and Accountability Act (HIPAA) and underfunded services that limit the capacity of providers to engage in the additional work necessary to involve families. For example, Medicaid- and state-funded providers are limited in providing family therapy and other family-focused interventions because of the way the public system emphasizes and reimburses individual care. Also, although privately-funded providers are more often able to provide more family-focused interventions, they often lack the capacity to provide the broader range of reimbursable services that families need, such as psychiatry, case management, and specialty rehabilitative services. Providers could increase family-focused interventions by hiring more family therapists or co-locating with providers who offer family therapy. They could also pay for their clinicians to attend certified training in evidence-based, family-focused interventions such as Parent Management Training and Family Focused Treatment for Adolescents. Providers who want to offer family-focused interventions will need to develop reimbursement strategies to support the additional costs that family-centered care entails.

Cross-Cutting Strategy #2: Develop policies and strategies to increase cultural and linguistic competence in clinical services and treatments as well as throughout entire organizations as part of a broader goal to increase behavioral health equity and reduce disparities. Providers face challenges in recruiting and retaining staff who understand the cultures and speak the languages of the children, youth, and families their agencies serve, as shown by the national and statewide gaps in capacity to provide culturally and linguistically competent care.^{166, 167, 168} Providers face very real shortages in the availability of linguistically and culturally competent staff and this, in turn, dramatically limits access to these needed services for a significant portion of the community. Efforts to address these gaps can begin by tailoring services to the demographics of Dallas County as well as the specific cultural and linguistic needs of the children and youth served by each provider. Some providers in other communities have found that a self-assessment of their agency and policies can help them identify and address more systemic biases and barriers that may inadvertently make it more difficult for families to access or continue services. Providers can also develop core cultural and linguistic competencies for all staff, regardless of their specific cultural and linguistic knowledge and skills.¹⁶⁹ These activities need to be embedded into organizations' policies and not limited to the competencies of each staff member to ensure that there is ongoing dialogue and attention to cultural and linguistic competence. Organizations have opportunities to address these barriers and build their internal capacity such as providing ongoing cultural competency trainings for staff, partnering with translation services, and working with local graduate schools to develop a pipeline of culturally and linguistically competent clinicians. More importantly, it is imperative that Dallas County develop a representative group of service recipients who could inform efforts to improve cultural and linguistic competency and tailor services to the unique needs of the Dallas community.

Cross-Cutting Strategy #3: Engage faith communities as partners in efforts to improve mental health system access and performance. One set of community resources that still regularly mediates between the individual and the larger society, and often has the capacity to offer ongoing community support, is the local congregation – whether it be a church, synagogue, mosque, or other faith community. In particular, communities of color are more likely to seek mental health support from their faith communities than from traditional mental health

¹⁶⁶ Goode, T. D., Dunne, M. C., & Bronheim, S. M. (2006). *The evidence base for cultural and linguistic competency in health care*. The Commonwealth Fund.

¹⁶⁷ López, M., Hofer, K., Bumgarner, E., & Taylor, D. (2017). Developing culturally responsive approaches to serving diverse populations: A resource guide for community-based organizations. <http://www.hispanicresearchcenter.org/wp-content/uploads/2017/03/Cultural-Competence-Guide.pdf>

¹⁶⁸ Bhui, K., Warfa, N., Edonya, P., McKenzie, K., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research* 7, 15.

¹⁶⁹ Substance Abuse and Mental Health Services Administration. (2014). *A treatment improvement protocol: Improving cultural competence*. <https://store.samhsa.gov/system/files/sma14-4849.pdf>

services.¹⁷⁰ One study found that 90.4% of African Americans reported they used religious coping to deal with mental health issues.¹⁷¹ The prospects for congregations to support children, youth, and their families experiencing emotional distress are significant, especially when they collaborate with mental health providers and other agencies that can deliver evidence-based and clinically-necessary treatment and supports.

There are numerous ways to engage faith communities as partners, such as providing educational opportunities to their leaders and congregations to increase mental health literacy and awareness, establishing system-level efforts to promote faith and mental health collaboration, and embedding mental health services directly into faith communities. Faith communities can also be strong partners in efforts to prevent and reduce the stigma associated with seeking mental health treatment and support. In April 2019, we released *Bringing Faith and Mental Health Together: An Inventory of Faith and Mental Health Initiatives in San Antonio and Nationally*, which provides a compilation of the current initiatives and the network of existing (and potential) relationships in San Antonio as well as a description of exemplars in other areas of Texas and nationally.¹⁷²

Cross-Cutting Strategy #4: Develop more formal opportunities for providers to communicate and collaborate. Providers noted a lack of coordination across components of the system and between each other, primarily because of a lack of awareness of what services or resources other providers offer in the community. Respondents from nearly every organization we reviewed expressed a desire to better understand the services and resources available throughout the community in order to connect children, youth, and families with the services that will best meet their needs. Although the CPAN program is designed to promote communication and collaboration among providers, there is a need to go further. Providers expressed a need to help families navigate different systems and learn about the best care options for the conditions that their children experience. Several groups and collaborative efforts in Dallas County connect children and youth to organizations that provide services and supports for children, youth, and their families. The most successful so far – and a promising effort to build on – is the Here for Texas resource guide developed by the Grant Halliburton Foundation.¹⁷³ Through formal opportunities for communication and collaboration such as

¹⁷⁰ Taylor, R. J., Ellison, C. G., Chatters, L. M., Levin, J. S., & Lincoln, K. D. (2000). Mental health services in faith communities: The role of clergy in Black churches. *Social Work*, 45(1), 73–87. <https://doi.org/10.1093/sw/45.1.73>

¹⁷¹ Chatters, L. M., Taylor, R. J., Jackson, J. S., & Lincoln, K. D. (2008). Religious coping among African Americans, Caribbean Blacks and Non-Hispanic Whites. *Journal of Community Psychology*, 36(3), 371–386. <https://doi.org/10.1002/jcop.20202>

¹⁷² Meadows Mental Health Policy Institute. (2019, April). Bringing faith and mental health together: An inventory of faith and mental health initiatives in San Antonio and nationally. <https://hebfdn.org/wp-content/uploads/sites/7/2019/08/MMHPI-HEBFDN-Faith-and-Mental-Health-Inventory-FULL-REPORT.pdf>

¹⁷³ For more information, see: <https://www.herefortexas.com/index.html>

CPAN and Here for Texas, organizations could help guide future system improvements and community investments in children's mental health. As an example, the federal Substance Abuse and Mental Health Services Administration (SAMHSA) has grants to build, expand, and sustain systems of care. These grants are awarded to government entities to develop and implement a system of care approach to improve outcomes for children and youth with serious emotional disturbances. Dallas area providers could advance formal collaborative efforts by joining together to submit a grant proposal to SAMHSA to create a comprehensive "system of care" for children and youth who experience significant mental health challenges.

Appendix A: List of Participants

Organization	Name	Title
ACH Child and Family Services	Wayne Carson, PhD	Chief Executive Officer
Adapt Community Solutions	Preston Looper, MS, LPC-S	Chief of Clinical Innovations
Center for Survivors of Torture	Celia VanDeGraaf, MA	Executive Director
Centro de Mi Salud	Norma Westurn	Chief Executive Officer
Child and Family Guidance Center	Alicia Begarney, LCSW	Director of Mental Health Services
Child and Family Guidance Center	Andy Wolfskill	Chief Executive Officer
Child and Family Guidance Center	Jeff Keehn	Chief Financial Officer
Child and Family Guidance Center	Todd Wright	Chief Operating Officer
Children First Counseling Center	Darcy Harris	Executive Director
Children First Counseling Center	Eleanor Moser, LPC	Interim Clinical Director
Children First Counseling Center	Lizette Garcia, LPC	Clinical Leadership Team
Children's Health System of Texas	Jeanne Nightingale, RN, MS	Senior Director of Psychiatry
Children's Health System of Texas	Sue Schell	Vice President and Clinical Director of Behavioral Health
ChristianWorks for Children	Janet Johnston, MS, LCSW	Clinical Director
ChristianWorks for Children	Rob Pine	Executive Director
ChristianWorks for Children	Stephanie Trest	Director of Development
CK Family Services	Diane Partin, LPC-S	Associate Director of Behavioral Health
CK Family Services	Larry Partin, LPC-S	Director of Mental Health Services
CK Family Services	Lori Fangue	Clinical Liaison
CK Family Services	Shawn Wilson	Chief Business Development Officer
Communities In Schools of the Dallas Region	Monica Ordonez	Chief Strategy Officer
Dallas CASA	Kathleen LaValle	President and Chief Executive Officer
Dallas Children's Advocacy Center	Katrina Cook, PhD	Director of Clinical Services
Dallas Children's Advocacy Center	Kelly Slaven, LCSW-S	Chief Clinical Officer

Organization	Name	Title
Dallas County Juvenile Probation	Leilani Hinton, PhD	Interim Director of Clinical Services
Dallas Independent School District	Yael Lipnik, LCSW	Quality Assurance Manager for Youth and Family Centers
Education Service Center Region 10	Jana Burns, EdD	Deputy Executive Director
Education Service Center Region 10	April Estrada, EdD	Director of Special Populations
Foremost Family Health	Amber Griffin, MSW, LCSW	Behavioral Health Manager
Genesis Women's Shelter & Support	Jennifer Livings, PhD, LPC-S	Senior Director of Programs and Client Services
Genesis Women's Shelter & Support	Jordyn Lawson, LPC-S	Director of Residential Services
Genesis Women's Shelter & Support	Ruth Guerreiro, LCSW	Director of Clinical and Professional Services
Grand Prairie Independent School District	Elizabeth Hummert, LCSW	Student Mental Health and Safety Advisor
Harmony Counseling Center	Brenda Richardson-Rowe, PhD, LPC-S	Director of Counseling
Harmony Counseling Center	Tizita Seifu, LPC	Licensed Professional Counselor
Jewish Family Service of Greater Dallas	Ariela Goldstein, LCSW	Clinical Director
Jewish Family Service of Greater Dallas	Cathy Barker	Chief Executive Officer
Jewish Family Service of Greater Dallas	Deizel Sarte	Chief Operating Officer
Los Barrios Unidos	Stella Rodriguez	Behaviorist
Methodist Dallas Medical Center	Martin Koonsman, MD, FACS	President and Chief Medical Officer
Metrocare Services	Kelly Laos, LCSW	Vice President of Provider Services
Momentous Institute	Jessica Gomez, PsyD	Director of Clinical Innovation
Momentous Institute	Laura Vogel, PhD	Director of Therapeutic Services
Mosaic Family Services, Inc.	Brittany Mumford, LPC-I	Clinical Counselor I

Organization	Name	Title
North Texas Behavioral Health Authority	Carol Lucky	Chief Executive Officer
Parkland Health and Hospital System	Kenneth Rogers, MD, MSPH, MMM	Chief of Psychiatry
Parkland Hospital and Hospital System	Celeste Johnson, DNP, APRN, PMHCNS	Vice President of Nursing, Behavioral Health
Parkland Health and Hospital System, COPC–Population Health Program	Rebecca Corona, PhD	Lead Psychologist
Parkland Health and Hospital System, COPC–Population Health Program	Rhonda Russell, MD	Lead Psychiatrist
Parkland Health and Hospital System, COPC–WISH-HOMES Programs	Jeanette Dominguez, LPC	Lead Mental Health Counselor
Parkland Health and Hospital System, HOMES Program	Aretha Fisher, PhD	Psychologist
Parkland Health and Hospital System, HOMES Program	Andres Moran, LPC-S	Mental Health Counselor
Pathways Youth and Family Services	Brad Brush	State Director of Family Services
Pathways Youth and Family Services	Courtney Messina	Clinical Director
Pathways Youth and Family Services	Dan Johnson	Chief Executive Officer
Pathways Youth and Family Services	John Echavarria	Program Coordinator for Child Placement Foster Care
Texas Health Resources	Sandy Potter, LCSW, MBA	Vice President
Texas Juvenile Justice Department	Tony Roberts	Regional Parole Manager
The Center for Integrative Counseling and Psychology	Brad Schwall, DMin	President and Chief Executive Officer
The Counseling Place	Beka Mullins, MA, LPC-I	Therapist
The Counseling Place	Carrie Leafblad, MA, LPC-I	Therapist
The Counseling Place	Deborah Dobbs, MA	Executive Director
The Counseling Place	Mary Reid, MA, LPC-I	Therapist
The Family Place	Elizabeth Ferrigno, LCSW	Senior Director of Clinical Services

Organization	Name	Title
The Rees-Jones Center for Foster Care Excellence	Jill Mcleigh	Director of Research, Policy and Advocacy
The Rees-Jones Center for Foster Care Excellence	Laura Lamminen, PhD, ABPP	Lead Psychologist
The University of Texas Southwestern Center for Depression Research and Clinical Care	Jennifer Hughes, PhD, MPH	Assistant Professor
The University of Texas Southwestern Center for Depression Research and Clinical Care	Madhukar Trivedi, MD	Founding Director
The University of Texas Southwestern Family Medicine Clinic	Angela Hiefner, PhD	Assistant Instructor
The University of Texas Southwestern Family Medicine Clinic	Sarah Woods, PhD	Director of Behavioral Health, Department of Family and Community Medicine
The University of Texas Southwestern Family Studies Center	Connie Cornwell, MA	Senior Supervisor
Uplift Education	Tony Walker, PhD, LPC-S	Senior Director of Student Support Services
Uplift Education	Michelle Cox Chiara	Manager of Prevention and Support Services
Youth Advocate Programs, Inc.	Kerina Kaltenborn, MS	Assistant Director for North Texas Behavioral Health Services
Youth Advocate Programs, Inc.	Naomi Chargeis-Edwards, MS	Southwest Regional Director of Behavioral Health Services

Appendix B: Detailed List of Mapped Dallas County Providers

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
1	Baylor Scott & White	Emergency Department – Irving				X				
2	Baylor Scott & White	Emergency Department – Garland				X				
3	Baylor Scott & White	Emergency Department – University Medical Center				X				
4	Baylor Scott & White	Emergency Department – Las Calinas				X				
5	Baylor Scott & White	Emergency Department – White Rock				X				
6	Carrolton–Farmers Branch Independent School District (ISD)/Parkland	Vivian Youth and Family Health Center	X					X		
7	Center for Survivors of Torture	Center for Survivors of Torture		X						
8	Centro de Mi Salud	Centro de Mi Salud		X						X
9	Child and Family Guidance	Harry Hines		X	X					X

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
10	Child and Family Guidance	McManus		X	X					X
11	Child and Family Guidance	Mesquite		X	X					X
12	Children First	Children First Counseling Center		X						
13	Children's Health – Integrated	MD KIDS at MacArthur (Irving)	X							
14	Children's Health – Integrated	MD KIDS at Lake Highlands	X							
15	Children's Health – Integrated	MD KIDS at Lancaster Kiest	X							
16	Children's Health – Integrated	MD KIDS at Oak Cliff	X							
17	Children's Health – Integrated	MD KIDS at Pleasant Grove	X							
18	Children's Health – Integrated	CHPG Medical District	X							
19	Children's Health – Integrated	Ranchview High School	X					X		
20	Children's Health – Integrated	Newman Smith High School	X					X		

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
21	Children's Health – Integrated	RL Turner High School	X					X		
22	Children's Health – Integrated	Early College at Brookhaven	X					X		
23	Children's Health – Integrated	Bea Salazar Learning Center (alternative education)	X					X		
24	Children's Health – Integrated	Mary Grimes Education Center (alternative education)	X					X		
25	Children's Health – Integrated	Polk Middle School	X					X		
26	Children's Health Center for Autism & Developmental Disabilities (CADD)	CADD and Applied Behavioral Analysis Clinics	X							
27	Children's Health	Children's Medical Center Dallas	X	X		X	X			X
28	Children's Health	Children's Health Specialty Center Cityville		X						
29	Children's Health	Children's Health Specialty Center Dallas Campus		X						

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
30	Children's Health	Children's Health Specialty Center Bass Center		X						
31	CK Family Services	CK Family Services		X	X				X	
32	Crescent Medical Center Lancaster	Emergency Department				X				
33	Dallas Behavioral Health Hospital	Dallas Behavioral Health Hospital					X			X
34	Dallas Children's Advocacy Center	Dallas Children's Advocacy Center		X						
35	Dallas ISD/Parkland	Adamson Youth and Family Center	X	X				X		
36	Dallas ISD/Parkland	Amelia Flores Youth and Family Center	X	X				X		
37	Dallas ISD/Parkland	Balch Springs Youth and Family Center	X	X				X		
38	Dallas ISD/Parkland	Eddie Bernice Johnson Youth and Family Center	X	X				X		
39	Dallas ISD/Parkland	Fair Oaks Youth and Family Center	X	X				X		
40	Dallas ISD/Parkland	Kiosco Youth and Family Center	X	X				X		

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
41	Dallas ISD/Parkland	Redbird Youth and Family Center	X	X				X		
42	Dallas ISD/Parkland	Seagoville Youth and Family Center	X	X				X		
43	Dallas ISD/Parkland	West Dallas Youth and Family Center	X	X				X		
44	Dallas ISD/Parkland	Wilmer-Hutchins Youth and Family Center	X	X				X		
45	Dallas ISD/Parkland	Woodrow Youth and Family Center	X	X				X		
46	Dallas Medical Center (Prime Healthcare)	Emergency Department – Dallas Regional Medical Center				X				
47	Dallas Medical Center (Prime Healthcare)	Emergency Department – Dallas Medical Center				X				
48	Family Studies Center	Family Studies Center		X						
49	First Texas Hospital	Emergency Department				X				
50	Foremost Family Health	Foremost Family Health Center – Balch Springs	X							

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
51	Foremost Family Health	Foremost Family Health Center – Martin Luther King Jr.	X							
52	Genesis Women's Shelter & Support	Genesis Women's Shelter & Support		X						
53	Harmony Counseling	Harmony Counseling		X						
54	Hickory Trail Hospital	Hickory Trail Hospital					X			X
55	Jewish Family Service of Greater Dallas	Jewish Family Service (JFS)		X						
56	Jewish Family Service of Greater Dallas	JFS at Jubilee Park		X						
57	Jewish Family Service of Greater Dallas	JFS at Roseland		X						
58	Jewish Family Service of Greater Dallas	Akiba Academy of Dallas/Yavneh Academy		X				X		
59	Jewish Family Service of Greater Dallas	Mesorah High School for Girls		X				X		
60	Las Colinas Medical Center	Emergency Department				X				
61	Los Barrios Unidos Community Clinic	Los Barrios Unidos Community Clinic	X							
63	Medical City Dallas	Emergency Room				X				

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
62	Medical City Green Oaks	Medical City Green Oaks				X	X			X
64	Methodist Health System	Emergency Department – Charlton				X				
65	Methodist Health System	Emergency Department – Richardson				X				
66	Methodist Health System	Emergency Department – Dallas Medical Center				X				
67	Metrocare	Westmoreland Child and Adolescent Center		X	X					X
68	Metrocare	Samuell Child & Adolescent Center		X	X					X
69	Metrocare	Skillman Center		X	X					X
70	Metrocare	Grant Prairie Center		X	X					X
71	Momentous Institute	Momentous		X						
72	Momentous Institute	Momentous		X						
73	Mosaic Shelter	Mosaic		X						
74	Parkland Health & Hospital System (Parkland)	COPC Behavioral Health – Southeast Dallas Health Center	X							

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
75	Parkland	COPC Behavioral Health – deHaro-Saldivar Health Center	X							
76	Parkland	COPC Behavioral Health – E. Carlyle Smith Jr Health Center	X							
77	Parkland	COPC Behavioral Health – Employee Physician Office	X							
78	Parkland	COPC Behavioral Health – Medicine	X							
79	Parkland	COPC Behavioral Health – Garland Health Center	X							
80	Parkland	COPC Behavioral Health – Hatcher Station Health Center	X							
81	Parkland	COPC Behavioral Health – Irving Health Center	X							
82	Parkland	COPC Behavioral Health – Oak West Health Center	X							

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
83	Parkland	COPC Behavioral Health – Pediatric Primary Care Center	X							
84	Parkland	COPC Behavioral Health – Vickery Health Center	X							
85	Parkland	Emergency Department				X				
86	Pathways Youth & Family Services	Mosaic		X	X				X	
87	Perimeter Healthcare	Perimeter – Garland					X			
88	The Rees-Jones Center for Foster Care Excellence	The Rees-Jones Center for Foster Care Excellence	X							X
89	Texas Health Resources	Behavioral Health Clinic		X						
90	Texas Health Resources	Outpatient Clinic Uptown		X						
91	Texas Health Resources	Texas Health Presbyterian Hospital Dallas	X	X		X				
92	The Center	The Center at Brother Bill's Helping Hands	X							

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
93	The Center	The Center at Buckner Bachman Lake		X						
94	The Center	The Center at Buckner West Dallas		X						
95	The Center	The Center at Buckner's Wynnewood Family Hope Center		X						
96	The Center	The Center at Cliff Temple Baptist Church		X						
97	The Center	The Center at Incarnation House		X						
98	The Center	The Center at Lake Highlands United Methodist Church (UMC)		X						
99	The Center	The Center at New Covenant Christian Fellowship Church		X						
100	The Center	The Center at North Dallas Shared Ministries	X							
101	The Center	The Center at Northway Christian Church		X						

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
102	The Center	The Center at Trinity River Mission		X						
103	The Center	The Center at Wesley Rankin Community Center		X						
104	The Center	The Center at West Dallas Community School		X				X		
105	The Center	The Center at Wilshire Baptist Church		X						
106	The Center	The Center at Buckingham UMC		X						
107	The Center	The Center at First UMC Garland		X						
108	The Center	The Center at St. Stephen UMC		X						
109	The Center	The Center at First UMC Richardson		X						
110	The Counseling Place	The Counseling Place		X						
111	The University of Texas Southwestern University Hospital – St. Paul	Emergency Department					X			

Map Label	Agency Name	Clinic Name	Provider Type(s)					Other Designation		
			Integrated Primary Care	Specialty Outpatient Mental Health Care	Specialty Rehabilitative Care	Crisis Care	Inpatient	School-Based	Child Welfare	NTBHA Contract
112	Youth Advocate Programs	North Texas Behavioral Health Services		X	X					X
N/A ¹⁷⁴	The Family Place	Central Dallas Counseling Center		X						
	The Family Place	Southern Dallas Counseling Center		X						
	The Family Place	Collin County Counseling Center		X						
	The Family Place	Metrocrest Counseling Center		X						

¹⁷⁴ Service locations for the Family Place are not represented on maps in this report in order to protect the safety of those accessing services.

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

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of its “Crossing the Quality Chasm”¹⁷⁵ report, which became the first in a series of IOM publications that have underscored the need to fundamentally shift operational priorities and the commitment from health care delivery organizations to ongoing quality improvement. In many ways, the premise of the report is quite simple: the health care industry must move from a traditional “command and control” model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008¹⁷⁶).

The “Quality Chasm” report and subsequent IOM reports built upon prior reports from the late 1990s to demonstrate the serious quality gaps in the U.S. health care system. Many of these quality gaps have been associated with the shift in treatment to greater numbers of chronic illnesses (versus acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children and youth. The series of IOM reports focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The “Quality Chasm” report argues convincingly that these quality gaps cost the U.S. upwards of \$750 billion in 2009 in poor, inefficient, wasteful, and ineffective care. The need for systematic change was clear and stark.

In 2006, the IOM focused its attention on mental health and substance use disorders,¹⁷⁷ documenting severe system-level quality gaps and describing a framework for improving them. The resulting report was explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most mental health/substance use disorder delivery systems in effectively promoting it:

Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences – for people who have the

¹⁷⁵ Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st Century*. The National Academies Press.

¹⁷⁶ For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf

¹⁷⁷ Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. The National Academies Press.

*conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.*¹⁷⁸

The report notes that the challenges facing mental health/substance use disorder systems are, in many ways, more severe than those facing the broader health system because of “a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace.”¹⁷⁹ Nonetheless, the IOM recommended clearly that the advised shift from command and control models of quality assurance to customer-oriented quality improvement was both necessary and possible within behavioral health systems; these systems have capacity similar to that of health care systems to produce better outcomes with lower costs.

The implications of the IOM’s recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery; it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm report and related report series.¹⁸⁰ The report states the matter in its characteristically direct manner, as quoted below:

Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:

- If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
- If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
- If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

¹⁷⁸ Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. The National Academies Press.

¹⁷⁹ Institute of Medicine. (2006).

¹⁸⁰ Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. The National Academies Press.

The point is not that health care can or should function in precisely the same way as all other sectors of people's lives; each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

- Records were immediately updated and available for use by patients;
- Treatments were proven reliable at the core and tailored at the margins;
- Patient and family needs and preferences were a central part of the decision process;
- All team members were fully informed in real time about each other's activities;
- Prices and total costs were fully transparent to all participants;
- Payment incentives were structured to reward outcomes and value, not volume;
- Errors were promptly identified and corrected; and
- Results were routinely captured and used for continuous improvement.¹⁸¹

Defining Best Practices

There are hundreds of evidence-based practices (EBPs) available for mental health and substance use disorder treatment, and the most definitive listing of these practices was provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-Based Programs and Practices (NREPP).¹⁸² While much of the NREPP website was discontinued as of 2018, it has been replaced by the Evidence-Based Practices Resource Center, which now provides information and tools to incorporate evidence-based practices into community or clinical settings rather than a comprehensive listing of EBPs. Other definitive listings of EBPs are provided by the Society of Clinical Child and Adolescent Psychology,¹⁸³ Evidence-Based Behavioral Practice,¹⁸⁴ Blueprints for Health Youth Development,¹⁸⁵ and, for child welfare populations, the California Evidence-Based Clearinghouse for Child Welfare.¹⁸⁶ Additionally, with the passage of the Family First Prevention Services Act (FFPSA), the federal Administration of Children and Families (ACF) is also developing and populating a clearinghouse on evidence-based and promising practices.¹⁸⁷

¹⁸¹ Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. The National Academies Press.

¹⁸² The NREPP's database was located at <https://www.samhsa.gov/ebp-resource-center>

¹⁸³ The Society of Clinical Child and Adolescent Psychology's website is located at <https://effectivechildtherapy.org/therapies/>

¹⁸⁴ The Evidence-Based Behavioral Practice's website is located at <https://ebbp.org/>

¹⁸⁵ The Blueprints for Health Youth Development's website is located at <https://www.blueprintsprograms.org/>

¹⁸⁶ The California Evidence-Based Clearinghouse for Child Welfare's website is located at <https://www.cebc4cw.org/search/by-topic-area/>

¹⁸⁷ The Administration of Children and Families' website is located at <https://preventionservices.abtsites.com>

The terms “evidence-based practice,” “evidence-based treatment,” or “empirically-supported treatment” are meant to refer to psychological treatments that have undergone scientific evaluation. There are five levels used to evaluate the evidence base for psychosocial treatments for children and adolescents.^{188, 189} On the first level are “well-established” treatments that have undergone at least two randomized clinical trials (RCTs) and have been studied by independent teams working at different research settings. The second level includes “probably efficacious” treatments that have strong research support, but treatment may not have been tested by independent teams; or, only one study shows the treatment is much more effective than a well-established treatment; or, if at least two studies show it is better than no treatment. Interventions in the third level are treatments considered “possibly efficacious” in that there may be one study showing that the treatment is better than no treatment, or there may be a number of smaller clinical studies without highly rigorous methodological and procedural controls (e.g., randomization). The fourth level contains treatments considered “experimental” in that they have not been studied carefully, and the fifth level are treatments that have been tested and do not work.

Successful promotion of best practices 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 such concerns at the “front line” implementation level are well documented and significant.¹⁹⁰ One major issue is that the literature prioritizes 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 America¹⁹¹ and centers on the much more complex realities that practitioners face in the field. Research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, inconsistent quality of providers’ training, and inconsistent fidelity to existing models) is lacking, and the emphasis on RCTs is not

¹⁸⁸ Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. *Journal of Consulting and Clinical Psychology*, 66, 7–18.

¹⁸⁹ Chorpita, B. F., Daleiden, E. L., Ebetsutani, C., Young, J., Becker, K. D., Nakamura, B.J. & Starace, N. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. *Clinical Psychology: Science and Practice*, 18, 154–172.

¹⁹⁰ Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children’s mental health. *Evidence-Based Mental Health*, 8, 60–62.

¹⁹¹ U.S. Surgeon General. (1999). *Mental health: A report of the Surgeon General*. 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.

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 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.¹⁹² 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 cultures.¹⁹³ Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense to implement best practices 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.¹⁹⁴ There is also increasing recognition of best practices for refugee and immigrant communities.¹⁹⁵

It is 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 underrepresented groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)¹⁹⁶ were

¹⁹² 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, 1179–1189.

¹⁹³ U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General*. 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.

¹⁹⁴ For more information, see: https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf

¹⁹⁵ American Psychological Association, Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. <http://www.apa.org/topics/immigration/immigration-report.pdf>

¹⁹⁶ 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*. <https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

adopted in 2001 by the U.S. Department of Health and Human Services' Office of Minority Health 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 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." Updated in 2013, the CLAS Standards now include 15 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence;¹⁹⁷ 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 American Indian groups is also available.¹⁹⁸ Guidance for multicultural applications is available as well.¹⁹⁹

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

Integrated Primary Care

Integrated primary care (IPC) programs provide the opportunities to improve outcomes and promote a broader culture of medical care that includes physical, emotional, and behavioral health in treatment approaches. Annual well-child visits with primary care providers provide an excellent opportunity for children and youth to access both physical and behavioral health care, especially within comprehensive 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."²⁰⁰

¹⁹⁷ U.S. Department of Health and Human Services. (2013). *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care.*

<https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf>

¹⁹⁸ USDHHS, Substance Abuse and Mental Health Services Administration. (2001). Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups.

¹⁹⁹ For more information, see: <https://www.cibhs.org/overview/adopting-culturally-competent-practices-accp-project-for-the-overall-site-and> and https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf for specific best practices demonstrated in California.

²⁰⁰ 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. <http://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331>

A Meadows Mental Health Policy Institute 2016 report²⁰¹ proposed that IBH 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.

Effective IBH 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 access to behavioral health services for children and youth with mild-to-moderate mental health conditions. About 75% of children and youth with psychiatric disorders can be seen in the pediatrician's office.²⁰² Importantly, however, there are often significant limitations. Pediatricians typically do not deliver mental health services because of limited time during each patient visit, minimal training and knowledge of behavioral health disorders, concern about prescribing psychotropic medications, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.²⁰³ 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.²⁰⁴

Behavioral health integration in primary care settings also aligns with the concept of the “medical home.” According to the American Academy of Pediatrics, the pediatric health home — sometimes called the “pediatric medical home” — refers to “delivery of advanced primary

²⁰¹ Meadows Mental Health Policy Institute (2016, June). *Best practices in integrated behavioral health: Identifying and implementing core components*. http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf

²⁰² American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. 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

²⁰³ American Academy of Child and Adolescent Psychiatry. (2012, June).

²⁰⁴ Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

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.”²⁰⁵

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 framework within the pediatric medical home.²⁰⁶ These include the following strategies:²⁰⁷

- 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 outcomes at both an individual and delivery-system level.

Examples of Integrated Primary Care Models

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 similar programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each with 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. 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 it

²⁰⁵ American Academy of Pediatrics. (2017). *Medical home*. <https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx>

²⁰⁶ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*.

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

²⁰⁷ American Academy of Child and Adolescent Psychiatry. (2012, June).

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 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 disorders.²⁰⁸

Seattle Children's Partnership Access Line (PAL) is another leading model of integrating behavioral health care 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 receive a child mental health care guide and advice from a child psychiatrist that includes 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 their insurance. If a child needs to be evaluated in person, PAL helps link families to providers in their respective communities. PAL can assist with identifying locations that have telemedicine appointment available. The PAL team also provides educational presentations to primary care providers on aspects of managing 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. Feedback from primary care provider surveys also reported “uniformly positive satisfaction” with PAL.²⁰⁹ In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State’s Medicaid program decreased by nearly half.²¹⁰

The **Health Care Management** program at Children’s Health in Dallas, formerly Children’s Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, Children’s Health began an IBH program within its pediatric outpatient clinics. In July 2015, it was fully implemented with care managers covering all 18 Children’s Health Pediatric Group clinics. As of January 2017, the team included 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 receive primary care in the outpatient clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11.

²⁰⁸ Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

²⁰⁹ 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.

²¹⁰ 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.

Implementation of these tools 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 is 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 on 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. Finally, the program uses telemedicine to deliver primary care services to children and youth in local schools to increase access.

The Rees-Jones Center for Foster Care Excellence, located at Children's Health in Dallas, is another Texas-based best practice program. The Rees-Jones Center for Foster Care Excellence uses a specialized integrated health care model that addresses the needs of children and youth in foster care as they often need additional supports. One of its promising practices is the structured use of a team approach with a care team of 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, and they provide evidence-based, trauma-informed primary care and therapeutic services. Center staff described the nurse coordinator and CPS liaison positions, specifically, as central and critical to the model. Other core IBH components of The Rees-Jones Center for Foster Care Excellence include 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 (ages six to 12) enter school to focus on increasing positive social interactions, decreasing aggression and bullying, and increasing 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 needs of students with mental and behavioral health concerns.²¹¹ Schools provide a natural setting for mental health services,

²¹¹ 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 as cited in Kutash, K., Duchnowski, A., & Lynn, N. (2006, April). *School-based mental health: An empirical guide for decision-makers*. University of South Florida, The

including prevention.^{212, 213} In fact, studies show that for many children and youth, 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).²¹⁴ Schoolwide prevention and services that promote behavioral health reduce violence and create a positive school climate that benefits all students.²¹⁵

School-based behavioral health and prevention are best implemented through a public health approach.²¹⁶ The public health model could provide a framework that spans the broad range of age groups and challenges seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

- Implement schoolwide 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.²¹⁷ As such, several EBPs build on prevention efforts and provide diverse community-based approaches for addressing mental health needs within a school environment. These approaches are summarized below.

Community-Partnered School Behavioral Health (CP-SBH) is a term used for supporting student behavioral health along the full prevention-intervention continuum by bringing

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

²¹² 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*. Center for School Mental Health. http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Resources/Briefs/FINALCP.SBHReport3.5.15_2.pdf

²¹³ Hoover, S., Bracey, J., Lever, N., Lang, J., & Vanderploeg, J. (2018). Healthy students and thriving schools: A comprehensive approach for addressing students' trauma and mental health needs. Child Health and Development Institute of Connecticut. <https://www.chdi.org/index.php/publications/reports/impact-reports/health-students-and-thriving-schools>

²¹⁴ Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. <https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support>

²¹⁵ Barrett, S., Eber, L., & Weist, M. (2013).

²¹⁶ Barrett, S., Eber, L., & Weist, M. (2013).

²¹⁷ Weist, M. D., & Murray, M. (2007). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, Inaugural Issue*, 2-12. <http://dx.doi.org/10.1080/1754730X.2008.9715740>. as cited in Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. <https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support>

together community behavioral health providers with schools and families. These community providers augment existing school resources to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.²¹⁸ 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 screening prevention for students identified as 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, 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.²¹⁹ Some of the advantages of this approach include improving 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 attendance and educational outcomes.

Schoolwide 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 (schoolwide), 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.^{220, 221, 222, 223} The value of schoolwide PBIS integrated with mental health services

²¹⁸ 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.

²¹⁹ Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015).

²²⁰ Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist*, 33, 135–152.

²²¹ 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.

²²² Koegel, L. K., Koegel, R. L. & Dunlap, G. (Eds.). (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Paul H. Brookes.

²²³ Positive Behavior Interventions and Supports website is located at <https://www.pbis.org>

and supports, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80%) of students fall into the first tier. For them, schoolwide PBIS creates “a social environment that reinforces positive behavior and discourages unacceptable behaviors.”²²⁴ 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”²²⁵ and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can receive intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family. For more information about this approach and its specific interventions, see: <https://www.pbis.org/>.

Multi-Tiered System of Supports (MTSS) is an approach based on a problem-solving model that documents students’ performances 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, continuous monitoring of the intervention, and parent involvement throughout the process.²²⁶

- In Colorado, MTSS is a prevention-based framework for improving the outcomes of all students. The essential components of this multi-tiered approach include team-driven shared leadership; data-based problem solving; partnerships with families, schools, and communities; a layered continuum of supports matched to the student’s need (from universal to targeted to intensive); and instruction, assessment, and intervention that are evidence-based.²²⁷
- In California, the MTSS framework has resources and initiatives to address all students’ needs. It organizes academic, behavioral, and social and emotional learning into an integrated system of supports for all students. It encompasses Response to Instruction

²²⁴ Bazelon Center. (2006). *Way to go: School success for children with mental health care needs*. http://www.bazelon.org/wp-content/uploads/2017/01/Way_to_Go.pdf

²²⁵ Bazelon Center. (2006).

²²⁶ Positive Behavioral Interventions and Supports OSEP Technical Assistance Center. (n.d.). *Tiered framework*. <https://www.pbis.org/pbis/tiered-framework>

²²⁷ Colorado Department of Education. (n.d.). *Multi-tiered System of Supports (MTSS)*. <https://www.cde.state.co.us/mtss>

and Intervention and PBIS, and aligns those supports to better serve each student.²²⁸ The model integrates data collection and assessment to inform decisions.

The Interconnected Systems Framework (ISF) helps expand the MTSS framework by including community providers in key roles, such as decision-making, selection and implementation of EBPs, monitoring, and ongoing coaching. ISF brings together Response to Intervention,²²⁹ PBIS, and school mental health services in a framework that enhances all approaches, extends the array of mental health supports for students and families, and meets the need for an overarching framework for implementing evidence-based interventions through collaboration between schools and community providers.²³⁰ ISF addresses limitations of PBIS' insufficient development in targeted prevention and specialized intervention for students with more complicated behavioral health concerns. ISF also targets the lack of structure in the implementation of school mental health services (which contributes to high variability in services and school staff not being aware of these services), the poor use of data, and the general disconnect between mental health and targeted prevention and specialized intervention services.²³¹

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 challenging behaviors among students and reduce rates of suspensions.²³²

- 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 criminal justice policies. This program provides education, training, and technical

²²⁸ California Department of Education. (2019, July). *Definition of MTSS*.

<https://www.cde.ca.gov/ci/cr/ri/mtsscomprti2.asp>

²²⁹ Response to Intervention is an approach that assists in the identification of students with learning and behavioral needs. For more information, see: <https://www.cde.ca.gov/ci/cr/ri/>

²³⁰ Barrett, S., Eber, L., & Weist, M. (2013). *Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support*. <https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support>

²³¹ Barrett, S., Eber, L., & Weist, M. (2013).

²³² Owen, J., Wettach, J., & Hoffman K. C. (2015). *Instead of suspension: Alternative strategies for effective school discipline*. Duke Center for Child and Family Policy and Duke Law School.

https://web.law.duke.edu/chilledlaw/schooldiscipline/downloads/instead_of_suspension.pdf

assistance and, since 2010, has focused on helping schools build capacity for their own restorative justice programs.²³³ Outcomes for RJOY include the following:²³⁴

- Since the 2011–12 school years, Oakland Unified School District schools that received RJOY training reduced the suspension rate of African American boys by 25%.
- According to state and local data, RJOY’s West Oakland Middle School pilot project eliminated expulsions and reduced suspensions by over 75%.
- In 2010, the Oakland Unified School District adopted restorative justice as a systemwide alternative to zero-tolerance practices, largely influenced by RJOY.
- The Denver Public Schools Restorative Justice Project also serves as a model example.²³⁵ In the 2007–2008 school year, 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. Over half (52%) of the cases resulted in a “restorative agreement.” 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 participating schools showed reductions in out-of-school suspensions and expulsions compared to the prior year’s total.²³⁶

Interpersonal Psychotherapy for Adolescents Skills Training (IPT-AST) is a manualized program delivered by mental health clinicians at schools. The program aims to decrease depressive symptoms by helping youth improve their relationships and interpersonal interactions. The psychotherapy group teaches youth communication strategies and interpersonal problem-solving skills that they can apply to their relationships. In order to implement IPT-AST to fidelity, training must be received through the treatment developers. For more information about IPT-AST, see: <https://policylab.chop.edu/people/jami-young>.

The **Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** program focuses primarily on reducing symptoms of posttraumatic stress disorder, depression, and behavioral problems for children and youth in grades three through eight. CBITS, which was first used in the 2000–2001 school year in the Los Angeles Unified School District, adopts a school-based group and intervention focus. Although primarily directed toward younger children, CBITS has been

²³³ RJOY. (n.d.). *About us. Our history.* <https://rjoyoakland.org/about-us/>

²³⁴ Jain, S., Bassey, H., Brown, M., & Kalra, P. (2014). Restorative justice in Oakland schools: An effective strategy to reduce racially disproportionate discipline, suspensions and improve academic outcomes.

<https://www.ousd.org/cms/lib/CA01001176/Centricity/Domain/134/OUSD-RJ%20Report%20revised%20Final.pdf>

²³⁵ Baker, M. L. (2008). *DPS restorative justice project executive summary.* Denver Public Schools.

²³⁶ Baker, M. L. (2008).

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.²³⁷ In order to implement CBITS to fidelity, training and certification must be received through the treatment developers. For more information about CBITS, see: <https://cubitsprogram.org/>.

Teacher-Child Interaction Therapy (TCIT) is a professional development, train-the-trainer-model designed to strengthen teacher-child relationship skills for children with disruptive behavior or those at risk of developing disruptive behavior. It is a prevention and intervention program. TCIT is implemented in elementary schools or early childcare settings. In order to implement TCIT to fidelity, training and certification must be received through the treatment developers. For more information about TCIT, see: <http://www.tcit.org> or <https://pcit-training.com/teacher-child-interaction-training-training-calendar/>.

Promoting Alternative Thinking Strategies (PATHS) is a program designed to reduce aggressive behavior and increase social competencies in children ages four to 12 years. The curriculum is designed to be used by educators to help children with poor classroom behavior and performance. Although primarily focused on the school setting (small groups and classroom), information and activities are also included for use with parents. In order to implement PATHS to fidelity, training and certification must be received through the treatment developers. For more information about PATHS, see: <http://www.pathstraining.com/main/>.

Think:Kids is a program that uses a collaborative problem solving approach with students in a school environment. The program teaches skills related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures; instead, it focuses on building helping relationships and teaching children and youth the skills they need to succeed. Documented outcomes included reductions in time out of the classroom, detentions, suspensions, injuries, teacher stress, and alternative school placement. In order to implement Think:Kids to fidelity, training and certification must be received through the model developers. For more information about Think:Kids, see: <http://www.thinkkids.org/train/certification/>.

Clinic and Home-Based Interventions

²³⁷ Treatment and Services Adaption Center (n.d.). *Cognitive behavioral intervention for trauma in schools*. <https://traumaawareschools.org/cbits>

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 children and 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; intensive, community-based, and family-centered interventions are the most promising.²³⁸ 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 expanded in recent years. The ideal system would have well-established treatment protocols offered in clinics, schools, or homes with the objectives of (1) decreasing problematic symptoms and behaviors, (2) increasing youth and parent skills and coping, and (3) preventing out-of-home placement. This section describes EBPs for specific referral problems. This list is not meant to be exhaustive; rather, it provides examples that can be used as resources. In addition, a host of clinical trials are underway and treatment protocols are being developed that will continually inform and improve the use of EBPs in the months and years to come. The EBPs discussed below fall under the umbrella categories of behavioral therapy or cognitive behavioral therapy in that the focus of intervention is on the cognitions, emotions, or behaviors of the child, youth, caregiver, or teacher, and on the variables that predict these outcomes.

Disruptive Behaviors

The Incredible Years²³⁹ focuses on reducing disruptive behavior and preventing conduct problems, targeting infants 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 instruction 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. In order to implement the Incredible Years program to fidelity, training and certification must be received through the treatment developers. For more information about the Incredible Years, see: <http://www.incredibleyears.com/>.

²³⁸ Blau, G. M., Caldwell, B., & Lieberman, R. (eds.) (2014). Residential interventions for children adolescents and families: A best practice guide. Routledge Press.

²³⁹ 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)²⁴⁰ is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems in their children. Triple P includes five levels of varying intensity (from the dissemination of printed materials to eight- to 10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive behavioral, and developmental theories 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. In order to implement Triple P to fidelity, training and certification must be received through the treatment developers. For more information about Triple P, see: www.triplep.net.

Parent Management Training – The Oregon Model (PMTO) promotes social skills and prevents, reduces, and reverses the development of moderate-to-severe conduct problems in children and youth. PMTO focuses on parent training, classroom behavior management, and peer interventions. In order to implement PMTO to fidelity, training and certification must be received through the treatment developers. For more information about PMTO, see: <https://www.generationpmto.org/>.

Coping Power Program reduces disruptive behavior in school and home settings. Originally it was developed as a school-based program and has since been adapted to be delivered in outpatient mental health settings. The program is offered to late elementary and middle school students. Its curriculum components focus on skills to enhance emotional awareness, organizational skills, problem solving, goal setting, and social skills. These skills are taught in cognitive behavioral group sessions provided in schools, individual sessions at clinics, and behavioral training groups for parents and guardians. In order to implement the Coping Power Program to fidelity, training and certification must be received through the treatment developers. For more information about the Coping Power Program, see: <https://www.copingpower.com>.

Problem Solving Skills Training (PSST) reduces oppositional, aggressive, and antisocial behavior in children ages seven to 14 years. The program uses a cognitive behavioral method to teach parents and children more skillful behavior. Children are typically given homework to help them practice implementing these skills. Most sessions are individual, but parents may be brought in to observe and to learn how to assist in reinforcing new skills. In order to implement PSST to fidelity training must be received through the treatment developers. For more information about PSST, see: <https://yaleparentingcenter.yale.edu/>.

²⁴⁰ 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.

Parent-Child Interaction Therapy (PCIT) has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders.^{241, 242, 243} PCIT works by improving parent-child attachment by coaching parents on how to manage their child's behavior. It uses structural play and specific communication skills to help parents implement constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while an interaction is occurring. In addition, parents learn how to give their children direction toward positive behavior. A therapist guides parents through education and skill-building sessions and oversees practice sessions with the child. PCIT has been adapted for use with Hispanic/Latino and American Indian families. In order to implement PCIT to fidelity, training and certification must be received through the treatment developers at PCIT International. For more information about PCIT, see: <http://www.pcit.org/>.

Multisystemic Therapy (MST) is a well-established EBP for youth living at home with more severe behavioral problems related to willful misconduct and delinquency, and it has proven outcomes and cost benefits when implemented with fidelity.^{244, 245} In addition, the developers are currently working to create specialized supplements to meet the needs of specific subgroups 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. It 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 antisocial behavior in youth.²⁴⁶ 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 by helping parents improve how they monitor their children, reducing familial conflict, improving communication,

²⁴¹ 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.

²⁴² Eyberg, S. M. (2003). Parent-child interaction therapy. In T. H. Ollendick & C. S. Schroeder (Eds.) *Encyclopedia of Clinical Child and Pediatric Psychology*. Plenum.

²⁴³ 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.

²⁴⁴ 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. *Journal of Consulting and Clinical Psychology*, 68(3), 451–467.

²⁴⁵ 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*, 317–332. Lawrence.

²⁴⁶ 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.

and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and reducing their association with "deviant" peers, primarily through parental mediation.²⁴⁷ **MST-Psychiatric** (MST-P) uses a similar approach to MST but is adapted for youth with serious emotional disorders. In order to implement MST and MST-P to fidelity, training and certification must be received through the treatment developers at MST Services. For more information about MST, see: <http://www.mstservices.com/>.

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat a range of problem behaviors in youth, such as "substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties."²⁴⁸ MDFT has good support for White, African American, and Hispanic/Latino youth between the ages of 11 and 18 across urban, suburban, and rural settings.^{249, 250, 251} Treatment usually lasts 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: (1) with the youth and parents individually, (2) with the family as an interacting system, and (3) with individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that affect the youth'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 standalone 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. In order to implement MDFT to fidelity, training and certification must be received through the treatment developers. For more information about MDFT, see: <http://www.mdft.org/>.

Treatment Foster Care Oregon (TFCO) is a program that provides youth with (1) a consistent reinforcing environment where they are mentored, (2) daily structure, (3) close supervision of their whereabouts, and (4) help to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships. TFCO also has program versions for children and youth ages three to 18 years. In

²⁴⁷ 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.

²⁴⁸ For more information see: <http://www.mdft.org/MDFT-Program/What-is-MDFT>

²⁴⁹ 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.

²⁵⁰ 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.

²⁵¹ 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.

order to implement TFCO to fidelity, training and certification must be received through the treatment developers. For more information about TFCO, see: <https://www.tfcoregon.com>.

Autism Spectrum Disorders

Applied Behavior Analysis (ABA) has good support for the treatment of autism, particularly in young children.^{252, 253, 254, 255, 256, 257} ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for anywhere from two weeks to 11 months. ABA is one of the most widely used approaches with children and youth with autism. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills through the use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training for therapists, extensive time spent in ABA therapy (20 to 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 involved in helping generate these 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. In order to implement ABA to fidelity, ABA therapists must obtain certification as a Board Certified Behavior Analyst® (BCBA® or BCBA-D). For more information about ABA, see: <https://www.bacb.com>.

Anxiety

Cognitive Behavioral Therapy (CBT) has demonstrated significant and enduring treatment outcomes, and effects lasting for a minimum of one year after treatment.²⁵⁸ Furthermore, researched CBT interventions showed the greatest amount of diversity among study participants, treatment format, treatment setting, and therapist background. CBT is most

²⁵² 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.

²⁵³ 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.

²⁵⁴ McConachie, H. & Diggle, T. (2007). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. *Journal of Evaluation in Clinical Practice*, 13(1), 120–129.

²⁵⁵ 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.

²⁵⁶ 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.

²⁵⁷ 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.

²⁵⁸ Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2015). Evidence-based update: 50 years of research on treatment for children and adolescent anxiety. *Journal of Clinical Child & Adolescent Psychology*, 45(2), 91–113. <http://www.tandfonline.com/doi/full/10.1080/15374416.2015.1046177>

frequently provided in individual or group therapy, parent training, or teacher consultation. These protocols involve a *cognitive* component — sessions dedicated to psychoeducation, recognizing the physical signs of anxiety, direct work on cognitive distortions, and instructions on coping skills. These protocols also involve a *behavioral* component, which is referred to as exposure and response prevention. Generally, the younger the child, the more parent training is involved in these protocols. There is typically more emphasis on exposure and response prevention than on cognitions, which can be difficult to assess in young children.

CBT protocols are effective for many different kinds of anxiety disorders (e.g., separation anxiety, phobias, obsessive-compulsive disorder). For these different diagnoses, the focus of the treatment differs, but all of the protocols will gradually and systematically help children approach their fears and decrease their avoidance (e.g., avoiding separation from caregivers in the case of separation anxiety, or avoiding social situations in the case of social anxiety).

- Social Effectiveness Therapy for Children and Adolescents (SET-C)²⁵⁹ is an exposure and response prevention protocol for children and youth ages seven to 17 years that targets social phobia. This protocol includes group social skills training, peer generalization sessions, and individual exposure therapy sessions.
- FRIENDS²⁶⁰ is a family-based, group cognitive-behavioral treatment for children and youth ages seven to 16 years who meet criteria for depression or generalized anxiety disorder, social phobia, or separation anxiety disorder. Although primarily developed for implementation in a group format by trained mental health providers, it can also be delivered in individual session format and implemented by teachers, counselors, and youth workers who have undergone accredited training.
- Coping Cat Parents²⁶¹ is a 16-session, cognitive behavioral protocol for children ages seven to 13 years who meet criteria for generalized anxiety disorder, social phobia, or separation anxiety disorder. The protocol involves individual sessions with the child or youth, and parent training sessions. There is an adolescent version of this protocol (C.A.T. Project) for youth ages 14 to 17 years.
- Acceptance and Commitment Therapy (ACT)²⁶² is considered a “third wave” CBT protocol. This approach differs from traditional CBT in that the aim is not better control

²⁵⁹ Beidel, D. C., Turner, S. M., Sallee, F. R., Ammerman, R. T., Crosby, L. A., et al. (2007). SET-C versus fluoxetine in the treatment of childhood social phobia. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46, 1622–1632.

²⁶⁰ Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program. *Journal of Clinical Child Psychology*, 30, 525–535.

²⁶¹ For more information about Coping Cat Parents, see: <https://www.copingcatparents.com>

²⁶² Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. *Behavior Modification*, 31(6), 772–799.

of thoughts, emotions, sensations, memories, but rather mindfulness to and acceptance of these private experiences. ACT demonstrates greater changes in psychological flexibility, mindfulness, and valued living as compared to CBT. ACT has been studied in youth with social anxiety, obsessive-compulsive spectrum disorders, and depression. There are a variety of protocols for ACT depending on the setting or target population.

These protocols are most frequently taught in doctoral programs for clinical child psychologists. Continuing education in CBT for already licensed professionals can be obtained through the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (<https://beckinstitute.org/certification/>),
- The Academy of Cognitive Therapy (<https://www.academyofct.org/page/Certification>), and
- The National Association of Cognitive-Behavioral Therapists (<http://www.nacbt.org/certifications-htm>).

Mood Disorders

CBT^{263, 264, 265} has been the most widely researched treatment for **adolescent depression**. There are many individual protocols for CBT for youth. These protocols are most frequently taught in doctoral programs for clinical child psychologists. As noted above, continuing education in CBT for already licensed professionals can be obtained via the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (<https://beckinstitute.org/certification/>),
- The Academy of Cognitive Therapy (<https://www.academyofct.org/page/Certification>), and
- The National Association of Cognitive-Behavioral Therapists (<http://www.nacbt.org/certifications-htm>).

Family Focused Treatment for Adolescents (FFT-A) is a psychosocial treatment for youth with bipolar disorder that consists of 21 sessions (12 weekly, six biweekly, and three monthly) for nine months. Sessions involve the youth with bipolar disorder, their parents, and available

²⁶³ March, J., Silva, S., Petrycki, S., et al. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. *Journal of the American Medical Association*, 292(7), 807–20.

²⁶⁴ March, J., Silva, S., Petrycki, S., et al. (2007). The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. *Archives of General Psychiatry*, 64(10), 1132–1143.

²⁶⁵ Klein, J., Jacobs, R., & Reinecke, M. (2007). Cognitive-behavioral therapy for adolescent depression: A meta-analytic investigation of changes in effect-size estimates. *Journal of the American Academy of Child and Adolescent Psychiatry*, 46(11), 1403–1413.

siblings. The focus of the first seven to 10 sessions is psychoeducation. Later, the focus is on communication enhancement training and problem-solving skills training. In order to implement FFT to fidelity, training must be received through the treatment developer at **David Miklowitz, PhD**, who can be contacted at dmiklowitz@mednet.ucla.edu.

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is an eight-session (90 minutes per session) group treatment for children ages eight to 12 years old with mood disorders. Sessions begin and end with children and parents together; the bulk of each session is run separately for parents and children. In order to implement MF-PEP to fidelity, training must be received through the treatment developer Mary A. Fristad, PhD, ABPP, whose background and contact information can be found at this link: <https://wexnermedical.osu.edu/neurological-institute/researchers/mary-fristad-phd-abpp>.

Interpersonal Psychotherapy for Adolescents (IPT-A) is a treatment for adolescent depression that focuses on how interpersonal issues are related to the onset or maintenance of depressive symptoms. The treatment addresses emotion regulation, communication, and problem-solving skills. In order to implement IPT-A to fidelity, training must be received through the treatment developer Laura Mufson, PhD, whose background and contact information can be found at this link: <https://www.columbiapsychiatry.org/profile/laura-mufson-phd>.

Trauma-Related Disorders

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has strong support for efficacy with children and youth ages three to 18 years and their parents.^{266, 267, 268, 269} 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. This treatment intervention is 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 to enhance children and youth's interpersonal trust and re-empowerment. TF-CBT has been

²⁶⁶ 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.

²⁶⁷ 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.

²⁶⁸ 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.

²⁶⁹ 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 trial. *Journal of the American Medical Association*, 290(5), 603–611.

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.²⁷⁰ In order to implement TF-CBT to fidelity, training and certification must be received through the treatment developers at the TF-CBT National Therapist Certification Program: <https://tfcbt.org/>.

Prolonged Exposure Therapy for Adolescents (PE-A) is a treatment that facilitates adolescents' processing of trauma through in vivo and imaginal exposure techniques. PE-A emphasizes psychoeducation and behavioral relaxation training. In order to implement PE-A to fidelity, training and certification must be received through the treatment developers at: https://www.med.upenn.edu/ctsa/pe_certification.html.

Cognitive Processing Therapy is a treatment for trauma that uses cognitive modification, exposure, and behavioral activation techniques. In order to implement cognitive processing therapy to fidelity, training and certification must be received through the treatment developers at: <https://cptforptsd.com/achieving-provider-status/>.

Suicidal and Self-Injurious Behaviors

Dialectical Behavior Therapy (DBT) is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and behaviors. DBT is well supported for adults and adolescents (DBT-A),^{271, 272, 273} and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to coach their adolescents in developing skills and also improve their own skills for interacting with their adolescent. Therapy sessions usually occur twice a week. DBT strategies include both acceptance-oriented (validation) and more change-oriented (problem-solving) approaches. DBT proposes that comprehensive treatment needs to help children and youth

²⁷⁰ 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.

²⁷¹ 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.

²⁷² Rathus, J. H. & Miller, A. L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. *Suicide and Life-Threatening Behavior*, 32, 146–157.

²⁷³ 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.

develop new skills, address motivational obstacles to implementing these skills, and generalize what they learn to their daily lives. It also needs to keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed through four different modes that support treatment delivery: group skills training, individual psychotherapy, telephone coaching between sessions, and a therapist consultation team meeting. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: <https://behavioraltech.org/>.

Eating Disorders

Dialectical Behavior Therapy: Specific adaptations of the original DBT model have been developed for eating disorders. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: <https://behavioraltech.org/>.

Family-Based Therapy (FBT or “Maudsley Approach”) is an intensive outpatient treatment where parents play an active role in helping their youth restore their weight to normal levels. In order to implement FBT to fidelity, training and certification must be received through the treatment developers at: <http://train2treat4ed.com/fbt-for-anorexia-nervosa>.

Substance Abuse

Multidimensional Family Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: <http://www.mdft.org/>.

Multisystemic Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: <http://www.mstservices.com/>.

Dialectical Behavior Therapy: See our summary in the Suicidal and Self-Injurious Behaviors subsection for more details. Specific adaptations of DBT have been developed for substance abuse. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: <https://behavioraltech.org/>.

Brief Strategic Family Therapy is a problem-focused, family-based approach to eliminating substance abuse risk factors. It targets problem behaviors in children and youth ages six to 17 years and strengthens family functioning. Brief Strategic Family Therapy provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies to strengthen family relationships. It targets conduct problems, associations with anti-social peers, early substance use, and

problematic family relations; it also has support for use with Hispanic families.^{274, 275} In order to implement Brief Strategic Family Therapy to fidelity, training and certification must be received through the treatment developers at: <http://www.bsft.org/>.

Functional Family Therapy (FFT) is a short-term (approximately 30 hours) family therapy intervention and juvenile diversion program for children and youth ages of 11 and 18 who are at risk of substance abuse, and their families, targeting a range of behavior problems, including violence, drug use/abuse, and conduct disorder as well as family conflict. FFT targets intervention toward multiple areas of family functioning and ecology and features well-developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.²⁷⁶ FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout from services. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.²⁷⁷ In order to implement FFT fidelity, training and certification must be received through the treatment developers at: <https://www.fftllc.com/>.

Motivational Interviewing (MI) is an evidence-based approach to help people address their ambivalence to change. There are four core principles: express empathy, roll with resistance, develop discrepancy, and support self-efficacy.²⁷⁸ Multiple disciplines use MI and much of the literature focuses on reducing the use of substances and addressing co-occurring (mental health and substance use) disorders.²⁷⁹

Risk of Out-of-Home Placement

Parents play a major role in these empirically-supported treatment protocols. Without a stable caregiver, many of the protocols described above would be difficult to implement effectively.

²⁷⁴ 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.

²⁷⁵ Szapocznik, J., Hervis, O., Schwartz, S. (2003). Therapy manuals for drug addiction. Brief strategic family therapy for adolescent drug use. U.S. Department of Health and Human Services. <http://www.nida.nih.gov/pdf/Manual5.pdf>

²⁷⁶ Alexander, J., Barton, C., Gordon, D., Grotjepeter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT)*. Center for the Study and Prevention of Violence.

²⁷⁷ 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.

²⁷⁸ Cole, S., Bogenschutz, M., & Hungerford, D. (2011). Motivational interviewing and psychiatry: Use of addiction treatment, risky drinking and routine practice. *Focus: The Journal of Lifelong Learning in Psychiatry*, (9)1, 42-54. <https://focus.psychiatryonline.org/doi/abs/10.1176/foc.9.1.foc42>

²⁷⁹ Cole, S., Bogenschutz, M., & Hungerford, D. (2011).

Therefore, for children and youth who are at risk for out-of-home placement, the following programs should be considered in addition to the EBPs discussed above.

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 who are at the highest risk for out-of-home placement.^{280, 281, 282} Wraparound is not a 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 child or 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 children and youth and their family members. Finally, there is an emphasis on integrating children and 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, who 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 that are involved with the family, with the family and child/youth ultimately driving the process. The wraparound process involves multiple phases, with responsibility for care coordination increasingly shifting from the wraparound facilitator and the CFT to the family.²⁸³

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

²⁸⁰ 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*. National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University.

²⁸¹ Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime*. Washington State Institute for Public Policy.

²⁸² 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, 1179–1189.

²⁸³ 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](http://www.nwi.pdx.edu/NWI-book/Chapters/Walker-4a.1-(phases-and-activities).pdf)

detection of psychosis is important since people with psychoses typically do not receive care and treatment until five years after the onset of symptoms.²⁸⁴ The CSC team provides community education activities and develops strategic partnerships with key entities in the community, which are critical elements of the program. 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 experiencing early psychosis and it actively engages the family in supporting recovery. CSC provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management as well as other less common evidence-based approaches such as Supported Education and Supported Employment that are known to help people with serious mental illnesses retain or recover a meaningful life in the community. 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. A 2016 study by Kane and colleagues on the multi-site Recovery After an Initial Schizophrenia Episode (RAISE) study (conducted across 34 clinics in 21 states) showed that study participants had a better quality of life and were more involved in work and school, especially when they received CSC within the first 17 months of the onset of psychosis.²⁸⁵ CSC was better than care as usual at helping people remain on a normal developmental path. Researchers have also compared the costs of CSC to care as usual and found that CSC was less expensive per unit of improvement in quality of life.²⁸⁶ According to the CSC model on which the two RAISE programs are based,²⁸⁷ teams should, at a minimum, consist of the following:²⁸⁸

- 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;

²⁸⁴ 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.

²⁸⁵ 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.

²⁸⁶ 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, <https://doi.org/10.1093/schbul/sbv224>)

²⁸⁷ McNamara, K., et al. (n.d.) *Coordinated specialty care for first episode psychosis, manual I: Outreach and treatment*. 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

²⁸⁸ 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.

- A psychiatrist²⁸⁹ 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;
- 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.²⁹⁰ This position should be filled by a person who has experienced serious mental illness and has been able to recover from it or 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 to 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 their 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

²⁸⁹ Some programs might choose to utilize advanced psychiatric nurse practitioners, but the University of Texas Southwestern (UTSW) Psychosis Center plans to employ psychiatrists in this important role.

²⁹⁰ 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*. SAMHSA/CMHS. <https://doi.org/10.13140/RG.2.1.4898.3762>

functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).^{291, 292, 293}

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 who are at risk of requiring out-of-home care because of 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 emergency crisis response 24 hours a day, seven days a week.

HOMEBUILDERS is an intensive family preservation program designed for children and youth from birth to 17 years who are at imminent risk of out-of-home placement or scheduled to reunify with their families within a week. 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.²⁹⁴ HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service on a flexible schedule.²⁹⁵

Partners with Families & Children: Spokane (Partners)²⁹⁶ is a service that relies on referrals from child welfare, law enforcement, or 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.²⁹⁷ The program is a community-based

²⁹¹ Allness, D. J., & Knoedler, W. H. (2003). *A manual for ACT start-up*. National Alliance for the Mentally Ill.

²⁹² 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*. W. W. Norton & Co.

²⁹³ Center for Evidence-Based Practices. (n.d.). *Practices: Assertive Community Treatment*. Case Western Reserve University. <https://www.centerforebp.case.edu/practices/act>

²⁹⁴ Institute of Family Development. (n.d.). *Programs: HOMEBUILDERS – IFPS*. http://www.institutefamily.org/programs_ifps.asp

²⁹⁵ Institute of Family Development. (n.d.). *Training for Practitioners*. http://www.institutefamily.org/training_practitioners.asp

²⁹⁶ Partners with Families & Children. (n.d.). *About us*. <https://partnerswithfamilies.org/about-us>

²⁹⁷ Partners with Families & Children. (n.d.).

family treatment program based on wraparound principles and focused on enhancing parent-child relationships through case management, substance abuse and mental health services, and parenting resources provided by 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 with community organizations such as schools and Head Start programs), and family team meetings.²⁹⁸ Partners' approach is designed to place parents at the center of a teamwork-driven model that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.²⁹⁹

Out-of-Home Treatment

Residential treatment is no longer considered the most beneficial way to treat children and youth 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."³⁰⁰

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors cannot be managed effectively in a less restrictive setting. However, as residential treatment is among the most restrictive mental health services provided to children and youth, this level of intervention 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.³⁰¹ Yet, on a national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

²⁹⁸ Partners with Families & Children. (n.d.). *About us*. <https://partnerswithfamilies.org/about-us>

²⁹⁹ Partners with Families & Children. (n.d.).

³⁰⁰ U.S. Department of Health and Human Services. (1999). *Mental Health: A Report of the Surgeon General*. 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.

³⁰¹ 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. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Building Bridges Initiative (BBI) to identify and promote best practices and policies.³⁰² BBI is now an independent 501(c)3 organization devoted to developing strong and closely coordinated partnerships and collaborations between families, youth, community- and residential-based treatment and service providers, advocates, and policymakers.³⁰³ Resources, tip-sheets and tools to ensure best practices can be found at: www.buildingbridges4youth.org.³⁰⁴

Although it is typically preferable to treat children and youth in their homes and communities, they 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-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 child or youth is facing a temporary situation or a crisis or requires longer-term care, the ideal residential intervention should be based on the core values and principles outlined in the BBI Joint Resolution, which focus on the following:

- Family-driven and youth-guided care and engagement,
- Cultural and linguistic competence,
- Clinical excellence and quality standards,
- Accessibility and community involvement,
- Transition planning,
- Workforce development, and
- Evaluation and continuous quality improvement.³⁰⁵

When residential treatment is provided, there should be extensive family involvement. Residential (and community-based) services and supports need to be thoroughly integrated and coordinated, and residential treatment and support interventions need to work to maintain, restore, repair, or establish relationships between the child/youth and their 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.

³⁰² 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. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

³⁰³ Stroul, B. (2007).

³⁰⁴ Stroul, B. (2007).

³⁰⁵ Building Bridges Initiative. (2006). Building bridges between residential and community-based service delivery providers, families and youth: Joint resolution to advance a statement of shared core principles. <http://www.buildingbridges4youth.org/sites/default/files/BB-Joint-Resolution.pdf>

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.^{306,307,308,309} 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 choose, but typically last about one year. In order to implement TFCO to fidelity, training and certification must be received through the program developers at:

[https://www.tfcoregon.com/index.php/implementation/.](https://www.tfcoregon.com/index.php/implementation/)

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 zero to five years and youth (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to seven 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.³¹⁰ The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.³¹¹ 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 fewer foster parents dropping out from providing care.³¹² 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 disruptions from foster placements. KEEP has been

³⁰⁶ 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.

³⁰⁷ 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, 1179–1189.

³⁰⁸ Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and youth*. Guilford Press.

³⁰⁹ 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.

³¹⁰ Oregon Social Learning Center. (n.d.). KEEP – based on research conducted at OSLC. <http://www.oslc.org/projects/keep/>

³¹¹ Child Trends. (n.d.). *KEEP Program*. <https://www.childtrends.org/programs/keep-program/>

³¹² KEEP. (n.d.). *Outcomes*. <https://www.keepfostering.org/outcomes-2/#research>

implemented in Oregon, Washington, California, Maryland, New York City, and four regions in Tennessee, as well as in Sweden and Great Britain. In order to implement KEEP to fidelity, training and certification must be received through the program developers at: <https://www.keepfostering.org/>.

The Crisis Continuum

Developing a full continuum of crisis response has been shown to keep children and youth safely in their homes, schools, and communities and helps avoid unnecessary placements in hospitals and residential settings.³¹³ Examples of crisis response includes warm lines; 24 hours a day, seven days a week hotlines; mobile crisis supports; short- to intermediate-term in-home supports; and local out-of-home options such as respite care, 23-hour stabilization/observation beds, and short-term residential interventions.

Often, the first strategy to address a behavioral health crisis is the use of phone support or telehealth support. In these situations, it is important that the service provider has the ability to screen, assess, and triage as well as the capacity to provide ongoing consultation, time-limited follow-up care, and linkages to transportation resources. These activities should be supported by protocols and electronic systems that communicate results to professionals and systems to determine the appropriate level of services.

In some circumstances, it may be necessary to provide a mobile response. A mobile crisis service has the capacity to go into the community to begin the process of assessment and safety and treatment planning. Mobile crisis teams should also have 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.³¹⁴ Mobil crisis service teams should also have the ability to link and coordinate with emergency medical personnel, as needed.

Summary Statement

The focus of this appendix is on the use of evidence-based practices (EBPs) in children's mental health. Its purpose is to help clinicians, agencies, and decision-makers identify what works when treating various mental health conditions and disorders. As demonstrated in this appendix, there are many programs, practices, and techniques that have evidence of effectiveness, and using these EBPs have been shown to improve outcomes. The list of EBPs is always changing as new research is conducted and new data are obtained. Currently, there are

³¹³ Substance Abuse and Mental Health Services Administration. (2014). *Crisis services: Effectiveness, cost effectiveness, and funding strategies*. HHS Publication No. (SMA)-14-4848.

³¹⁴ For more information, see: <http://wraparoundmke.com/programs/mutt/>

a host of clinical trials underway that will continue to add information to this growing field. The good news is that we are getting better at knowing what works. Unfortunately, knowing what works and doing what works are two separate issues. The goal is for practitioners and policymakers to have the best available scientific evidence to make informed decisions about what to do and when.

Appendix D: Level of Care (LOC) Overview

A brief overview of the Texas Resilience and Recovery (TRR) Utilization Management Guidelines is presented below. For a full description, please see *Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services* at:

<https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf>.

Level of Care (LOC)	Population/Purpose	Services
LOC-0: Crisis Services	<p>Population: A child or youth experiencing a mental health crisis who is not currently enrolled in services. A Child and Adolescent Needs and Strengths (CANS) assessment is not required.</p> <p>Purpose: Brief interventions provided in the community to treat and stabilize a mental health crisis and prevent utilization of more intensive services.</p> <p>Services authorized for seven days.</p>	Brief community-based crisis intervention services.
LOC-1: Medication Management	<p>Population: Children and youth whose only identified treatment need is medication management.</p> <p>Purpose: To maintain stability while developing natural supports and, when possible, transitioning to a community provider.</p> <p>Monthly Average Utilization: 0.5 hours</p>	<p>Medication management is the only routine service provided in LOC-1.</p> <p>Additional services include:</p> <p>Core Services</p> <ul style="list-style-type: none"> • Psychiatric diagnostic interview examination • Pharmacological management <p>Adjunct Services</p> <ul style="list-style-type: none"> • Medication training • Routine case management • Parent support group • Family partner support • Family case management

Level of Care (LOC)	Population/Purpose	Services
LOC-2: Targeted Services	<p>Population: Children and youth who have an emotional <u>or</u> behavioral need with low to no life domain functioning needs.</p> <p>Purpose: To improve mood symptoms <u>or</u> address behavioral needs.</p> <p>Monthly Average Utilization: three hours</p>	<p>All services in LOC-1 are available to children and youth in LOC-2, but they can be delivered at a greater frequency.</p> <p>Additional Core Services</p> <ul style="list-style-type: none"> • Counseling (individual, group, family) <u>or</u> skills training & development (individual, group) • Routine case management <p>Additional Adjunct Services</p> <ul style="list-style-type: none"> • Engagement activity • Caregiver skills training & development • Family training & development (individual, group)
LOC-3: Complex Services	<p>Population: Children and youth with identified behavioral and emotional needs who exhibit a moderate degree of risk behaviors or impairments in basic life functioning, and require multiple service interventions from multiple providers.</p> <p>Purpose: To stabilize symptoms and risk behaviors, improve overall functioning, and build strength and resiliency in the child/youth and caregiver so the child/youth can transition to a lower level of care.</p> <p>Monthly Average Utilization: five hours</p>	<p>The majority of the services in LOC-3 are the same as in LOC-2. However, services are delivered more frequently and children and youth can receive both counseling and skills training & development services.</p> <p>Additional Core Services</p> <ul style="list-style-type: none"> • Counseling (individual, group, family) • Skills training & development (individual, group) • Routine case management <p>Additional Adjunct Services</p> <ul style="list-style-type: none"> • Flexible funds • Family partner supports • Community-based respite services • Program-based respite services

Level of Care (LOC)	Population/Purpose	Services
LOC-4: Intensive Family Services (wraparound)	<p>Population: Children and youth who have been identified as having behavioral and/or emotional treatment needs and have significant involvement with multiple service systems. These children and youth are likely to be at risk for out-of-home placement and their behavior or mood symptoms may result in or have resulted in juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, serious injury to self or others, or death.</p> <p>Purpose: To reduce or stabilize symptoms and risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver through a team approach. Caregiver resiliency is fostered by building on strengths and natural supports and linking to community resources using the wraparound planning process.</p> <p>Average Monthly Utilization: 7.5 hours</p>	<p>Services from LOC-3 are available to children and youth in LOC-4 at a higher frequency because of a higher level of need.</p> <p>Additional Core Services</p> <ul style="list-style-type: none"> • Intensive case management (wraparound) • Family partner supports • Individual, group, and family counseling <p>Additional Adjunct Services</p> <p>Additional services available in LOC-4 include:</p> <ul style="list-style-type: none"> • Stronger emphasis on family partner services and integrated care • Flexible community supports • Routine case management • Additional adjunct services for transition-age youth <p>Texas Department of State Health Services (DSHS) has identified the National Wraparound Initiative (NWI) model for wraparound for the delivery of intensive case management services. This model requires a treatment team member to provide crisis response 24 hours a day, seven days a week (24/7). In addition, a wraparound team meeting is required within 72 hours of any crisis.</p>

Level of Care (LOC)	Population/Purpose	Services
LOC-YES: Youth Empowerment Services (YES) Waiver	<p>Population: Children and youth ages three to 18 years who would need institutional care or whose parents would turn to state custody for care.</p> <p>Purpose: To improve clinical and functional outcomes for children and youth, reduce or stabilize symptoms and risk behaviors, improve functioning, and build strengths and resiliency through a team approach and a continuum of flexible community-based services and supports.</p> <p>Clinical Eligibility: 365 days</p>	<p>All TRR Medicaid services are available in LOC-YES, as well as services outside of TRR, such as:</p> <ul style="list-style-type: none"> • Community living supports • Specialized therapies • Respite • Adaptive aids • Transition assistance • Employment services • Family support • Minor home modifications <p>Texas DSHS has identified the NWI model for wraparound for the delivery of intensive case management services. This model requires a treatment team member to provide 24/7 crisis response. In addition, a wraparound team meeting is required within 72 hours of any crisis.</p>
LOC-5: Transitional Services	<p>Population: Children and youth who have been discharged from LOC-0 and need continued support to prevent further crisis while they are engaged in appropriate services and supports.</p> <p>Purpose: To maintain stability and prevent further crisis events.</p>	<p>This level of care is highly individualized. The level of service intensity and length of stay varies based on individual needs. All services are available at this level.</p>

Level of Care (LOC)	Population/Purpose	Services
LOC-CEO: Children Early Onset	<p>Population: Youth ages 15 to 17 years who have a diagnosis that includes psychotic features; individuals needs will vary in terms severity and needs. The youth must live in the service areas of the pilot program site.</p> <p>Purpose: To stabilize symptoms and maintain stability while the youth develops additional skills to work toward recovery and gain or maintain meaningful educational opportunities or employment.</p>	<p>Core Services</p> <ul style="list-style-type: none"> ● Psychiatric diagnostic interview ● Pharmacological management ● Individual and group skills training & development ● Supportive Employment and Education ● Supportive housing ● Individual and group medication training and support services ● Individual psychotherapy ● Family counseling ● Multiple family psychotherapy ● Group counseling ● Family partner services ● Case management for youth and their family ● Family training ● Parent support group ● Engagement activity ● Flexible funds ● Flexible community supports ● All services within the crisis array

Level of Care (LOC)	Population/Purpose	Services
LOC-TAY: Transition-Age Youth	<p>Population: Youth ages 16 to 20 years who may undergo tremendous changes in all life domains.</p> <p>Purpose: To provide access to evidence-based assessments, treatment models, and recovery services by strengthening the existing service model for this group of youth/young adults. A transition plan should be developed in collaboration with the youth and their identified supports.</p>	<p>Core Services</p> <ul style="list-style-type: none"> ● Psychiatric diagnostic interview examination ● Intensive case management ● Skills training & development ● Peer support ● Pharmacological management ● Administration of an injection ● Medication training & support services ● Family counseling ● Individual psychotherapy ● Group counseling ● Supported housing ● Supported Employment ● Flexible funds <p>Adjunct Services</p> <ul style="list-style-type: none"> ● Flexible community supports ● Family partner support