

Senate Health & Human Services Committee

Children's Mental Health and Services for High-Needs Youth

Andy Keller, PhD | September 18, 2024

THE IDEAL CHILDREN'S MENTAL HEALTH SYSTEM

LIFE in the Community

WORK FAITH HOME FAMILY SCHOOL

OTHER HEALTH CARE

MENTAL HEALTH CARE



Integrated Primary Care



Measurement Based Care + Collaborative Care

TEXAS CHILD MENTAL HEALTH CARE CONSORTIUM
primary care CPAN
and schools TCHAT

SPECIALTY CARE



Outpatient

Physician, other non-physician specialists



Complex Care

Care for more complex, acute medical conditions in children's hospitals or centers of excellence



Urgent/Emergent

Urgent care
children's hospital ER/
inpatient hospitalization



Evidence based practice at every level

Sufficient Network Capacity

SPECIALTY CARE



Outpatient

Diagnostic Evaluation
Psychiatrists, psychologists, and
other licensed mental
health professionals



Complex Care

Comprehensive Diagnostic Evaluation
Multi-disciplinary teams in community
or hospital settings



Urgent/Emergent Care

Same Day Access
Youth Crisis Outreach Teams (YCOT)
children's hospital ER/
inpatient hospitalization

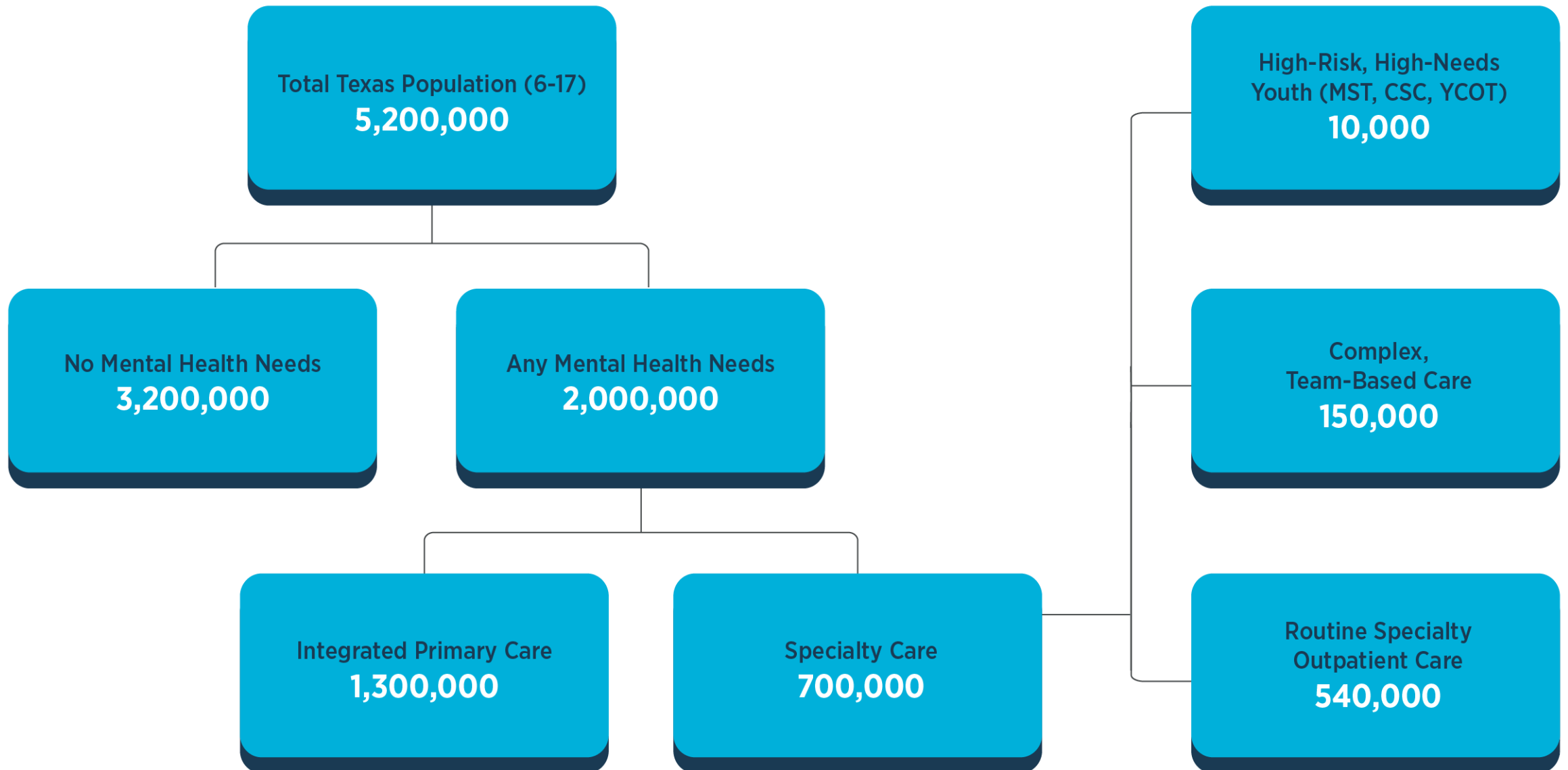


Evidence based practice at every level

Sufficient Network Capacity

Like health care, the best mental health care involves early intervention at the appropriate treatment level.

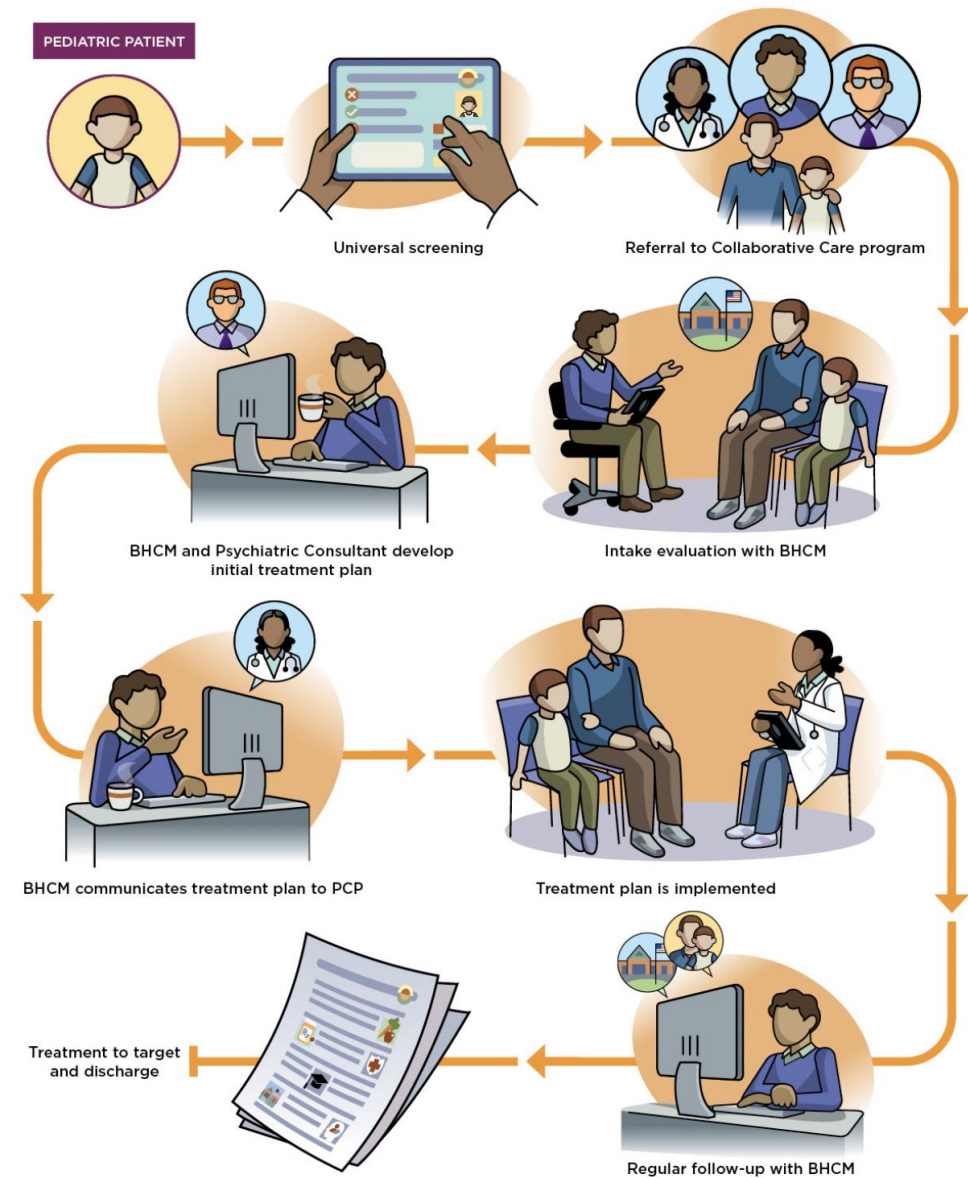
Texas Children and Youth Mental Health Needs



Integrated Primary Care

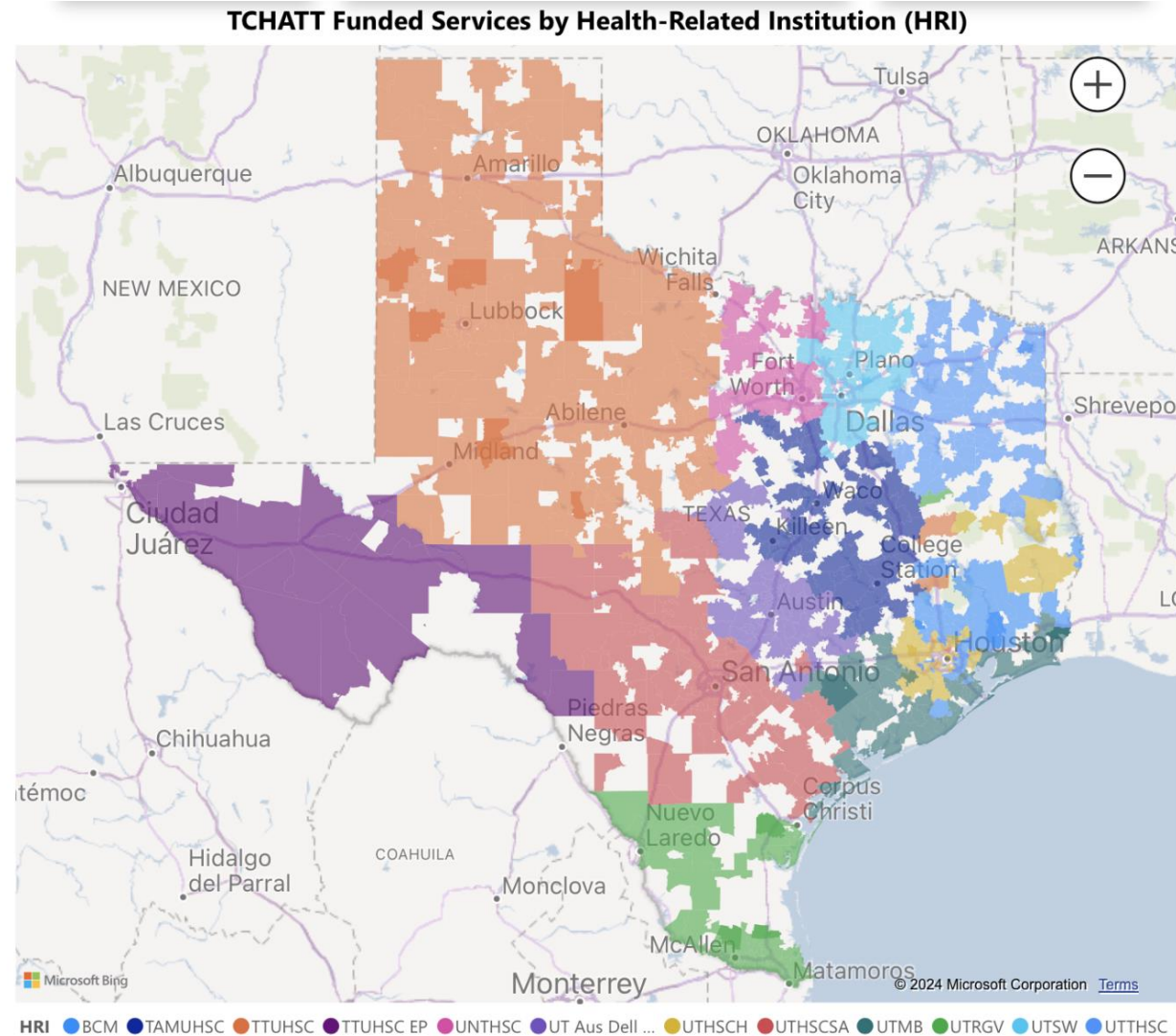
Collaborative Care (CoCM) is a proven, team-based approach to detect and treat mental illness in primary care.

- Coverage: Medicare since 2017, most commercial since 2019 (90%)
- 87(R) SB 672 authorized Medicaid reimbursement in Texas.
- Cost saver: ***Up to 6 to 1 in total medical costs in Medicare and Medicaid settings***
- **Workforce** multiplier: up to 8.3x
- The **Texas Child Mental Health Care Consortium** leveraged American Rescue Plan Act (ARPA) funding to expand pediatric CoCM access.



Texas Child Health Care Access Through Telemedicine (TCHATT) Coverage: September 2024

- Currently available on 6,506 school campuses, covering nearly 4.1 million Texas students.
- Schools are not health care providers but are well-positioned to connect families to care.
- TCHATT can only be accessed with parental consent.
- 86(R) SB 11 directed TCHATT to “focus on the behavioral health needs of at-risk children and adolescents.”



Targeted Interventions for High-Needs Youth

The Texas Legislature continues building out the continuum of care of intensive, evidence-based services for high-needs youth. This includes:

Program	Goal	Capacity	Estimated Need
Youth Crisis Outreach Team (YCOT)	Support youth in crisis and their families, which will reduce pressure on the foster care system and hospital emergency rooms .	Eight (8) new teams Total statewide capacity: 8 teams	40 teams
Multisystemic Therapy (MST)	Treat youth who have committed violent offenses , have serious mental health or substance use concerns and/or are at risk of out-of-home placement .	15 new teams Total statewide capacity: 24 teams	140 teams
Coordinated Specialty Care (CSC)	Provide the gold standard of care for people experiencing a first episode of psychosis .	Six (6) new teams Total statewide capacity: 48 teams (mostly funded with federal block grants)	100 teams

Tracking Outcomes

- **CoCM** requires the incorporation of **Measurement-Based Care (MBC)**: the use of **repeated, validated assessments** (e.g., PHQ-9, GAD-7) to track symptoms and outcomes in clinical settings.
- **TCHATT** policy requires an **assessment** (e.g., CIS, SCARED, GAD-7 PHQ-9a) before the first appointment and provides guidelines for **re-administration** based on time and clinical indication.
- **YCOT** contracts include **screening, assessment, and follow-up performance measures**. *Successful YCOT programs in other states led to numerous benefits such as hospital diversion, reduced juvenile justice involvement, reduced foster care entry and foster care placement disruptions, and decreased truancy and missed school days.*
- **MST** tracks the percent of youth **living at home, in school/working**, and with **no new arrests**, all with overall target measures of **90%**.

Questions?



Appendix

YCOT in Practice

YCOTs are considered the best-practice model for addressing immediate and crisis-level mental health needs among children, youth, and families.

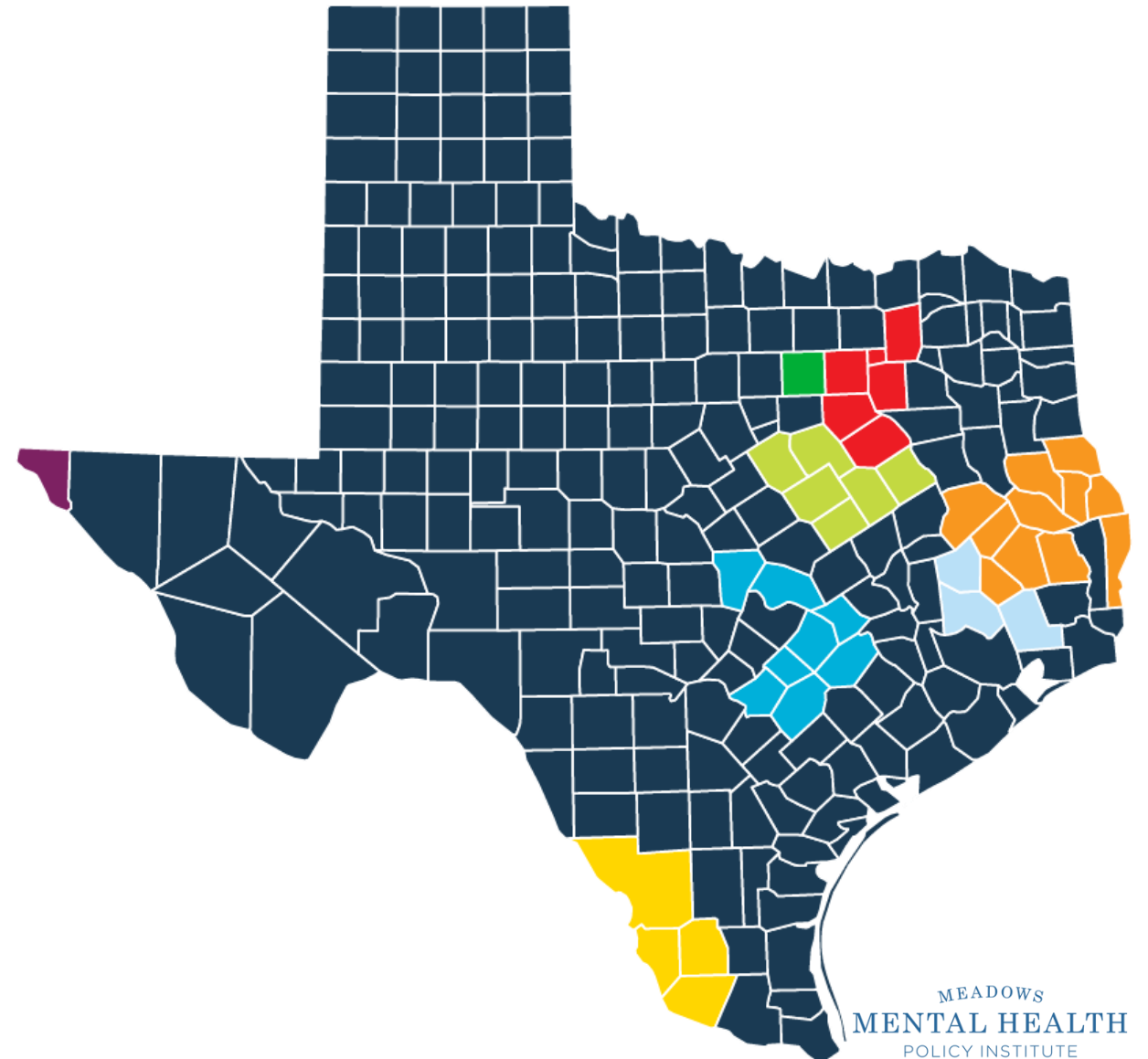
- Designed to work with families to **stabilize high-risk situations** (urgent and emergent) and provide a **30-to-90-day bridge** to engage in ongoing care.
- Staffed by professionals who know how to **work with families and child-serving systems**.
- Staffed intensively to not just **stabilize crises**, but also to **engage pre-crisis** and **provide follow-up**.

Successful YCOT programs lead to numerous benefits, such as hospital diversion, reduced juvenile justice involvement, reduced foster care entry and foster care placement disruptions, and decreased truancy and missed school days.

YCOT Capacity in Texas

Eight new HHSC-funded teams

- Bluebonnet Trails:**
 - Bastrop County
 - Burnet County
 - Caldwell County
 - Fayette County
 - Gonzales County
 - Guadalupe County
 - Lee County
 - Williamson County
- Border Region Behavioral Health Center:**
 - Jim Hogg County
 - Starr County
 - Zapata County
 - Webb County
- Burke Center:**
 - Angelina County
 - Houston County
 - Nacogdoches County
 - Newton County
 - Polk County
 - Sabine County
 - San Augustine County
 - San Jacinto County
 - Shelby County
 - Trinity County
 - Tyler County
- Emergence Health Network:**
 - El Paso County
- Heart of Texas:**
 - Bosque County
 - Falls County
 - Freestone County
 - Hill County
 - Limestone County
 - McLennan County
- My Health My Resources of Tarrant County:**
 - Tarrant County
- North Texas Behavioral Health Authority (NTBHA):**
 - Dallas County
 - Ellis County
 - Hunt County
 - Kaufman County
 - Navarro County
 - Rockwall County
- Tri-County Behavioral Healthcare:**
 - Liberty County
 - Montgomery County
 - Walker County



MST in Practice

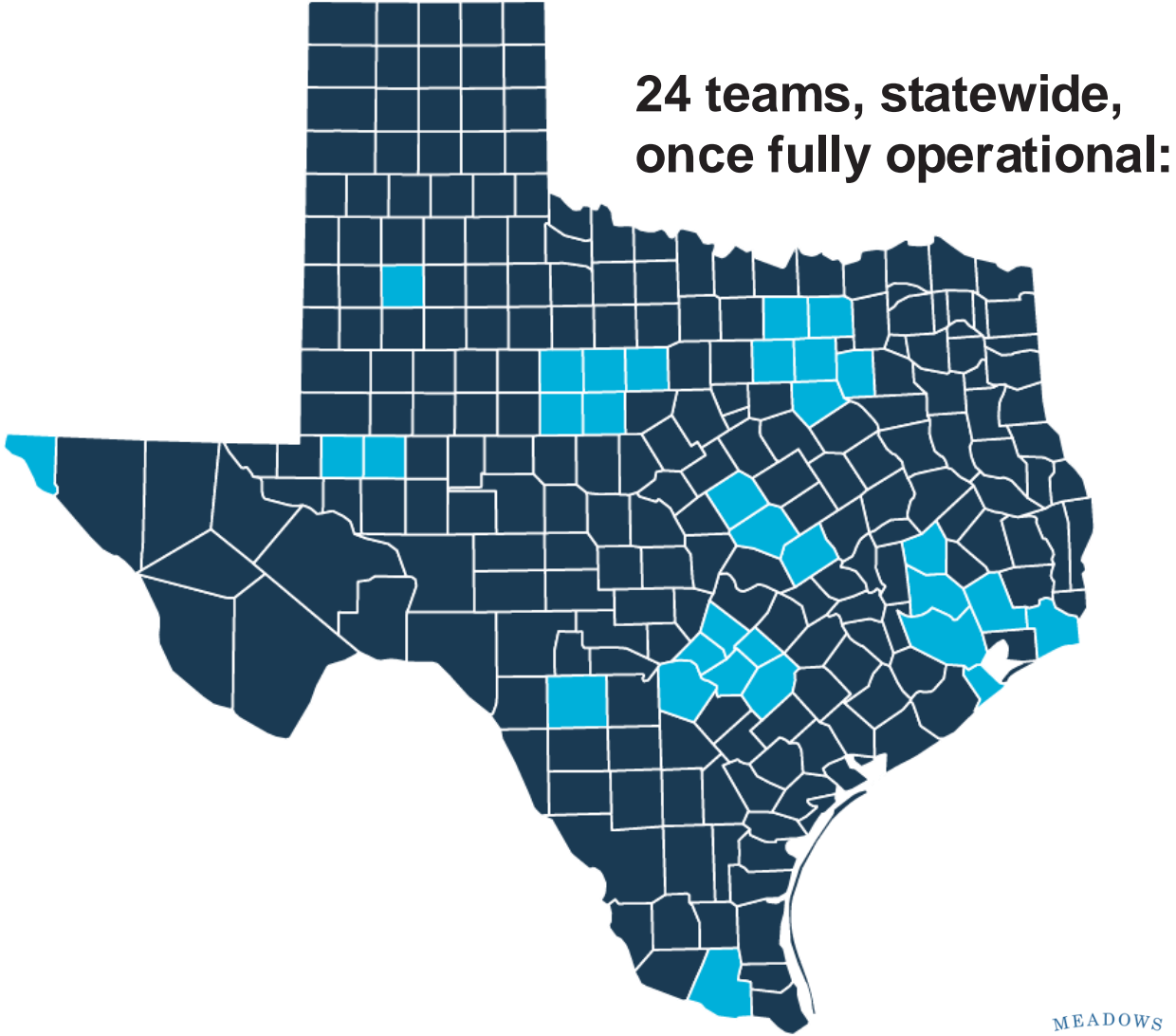
MST is a proven, community-based treatment for at-risk youth (ages 12 to 17) with intensive needs and their families.

- **Primary goals of MST:** (1) reduce **severe criminal activity, including violence**; (2) reduce other types of **antisocial behavior**; and (3) **save taxpayer dollars** by reducing incarceration and out-of-home placement.
- Proven to **reduce violent crimes by 75%**, compared to routine congregate and other care as usual, including **RTCs**.
- MST professionals **work with the family throughout the week** and are on call and available **24 hours a day, seven (7) days a week**.
- MST requires the full participation of parents or caregivers.
- Average length of treatment is **three to five months**.

MST Capacity in Texas

Initial seven HHSC-funded teams:

Reporting Period: March 2024 – May 2024	
Number of Referrals Received	145
Number of Cases Served	145
Total number of cases with opportunity for full course of treatment	56
Number of Discharges	67
Percent of youth living at home	83.93%
Percent of youth in school/working	87.50%
Percent of youth with no new arrests	91.07%



CSC in Practice

CSC – the “gold standard” of care – is a team-based approach that starts intensive treatment as soon after an initial psychosis as possible.

- The sooner CSC is accessed following the onset of psychotic symptoms, the better. One study of CSC found that people who began treatment **within 17 months of the onset of symptoms** had better outcomes.
- A first episode of psychosis can be **detected by law enforcement, in emergency rooms, and in hospitals**. Screening can also occur in **primary care practices, schools, and even faith communities**, if training is provided.
- The duration of CSC treatment is about **two years, on average**.

Recommendations for the 89th Legislature

1. Pass legislation that **adds CoCM as a benefit for ERS and TRS health plans** to ensure covered employees *and their dependents* have access to integrated care in primary care settings. Like 87(R) SB 672, this should have no fiscal note due to cost savings.
2. Partner **Child Psychiatry Access Network (CPAN) psychiatrists** with **pediatric health systems in their regions** to provide the **psychiatric consultation needed for CoCM**.
3. Continue the **ARPA pediatric CoCM initiative** at the Texas Child Mental Health Care Consortium to **expand CoCM to additional pediatric health systems**.
4. Fully fund the **Texas Child Mental Health Care Consortium's TCHATT request** to ensure parents have access to services they want for their children.

Recommendations for the 89th Legislature

5. Fund **additional MST teams** through a competitive procurement open to nonprofit and governmental entities.
6. Pass legislation to **authorize Medicaid reimbursement for MST services** provided to youth (see 88(R) HB 2638), helping reduce general revenue expenditures. **19 states** cover MST in their Medicaid programs.
7. Fund an **MST adaptation at DFPS**, like **MST-BSF** or **MST-CAN**, which are developed to address specific child welfare system needs.
8. Fund **additional YCOTs** through a Needs and Capacity Assessment and allow providers to define narrower catchment areas.

Thank You!

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