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RAPID BEHAVIORAL HEALTH ASSESSMENT

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Introduction

The Meadows Mental Health Policy Institute (MMHPI), with the support of the Kronkosky Foundation and the San Antonio Area Foundation (the Foundations), carried out a rapid environmental scan of the Bexar County children and youth's behavioral health systems. The overall goals of the scan were twofold: 1) identify specific "up-stream" strategies for continued development of a highly responsive, clinically effective, and efficient community behavioral health system; and 2) recommend expected opportunities in 2019, including any specific to the 86th Legislature, to improve up-stream interventions in schools and other non-clinical settings, primary health care, and office-based specialty health care settings. We were not asked to identify strategies to improve crisis or inpatient services, but some strategies were suggested by stakeholders and included in this report when relevant.

To accomplish this, the Foundations identified local key informants with knowledge of child, youth, and family behavioral health systems. The MMHPI team interviewed these subject matter experts (see Appendix One for a list of participating people and organizations), and we also collected and summarized high-level data from the participating organizations related to their service delivery at each level of intervention addressed (see Appendix Two for additional detail on the focus group findings). The MMHPI team also conducted a focus group with high school-age youth (see Appendix Three for additional detail on the focus group findings) to document their current concerns and priorities. These interviews and supporting data provided us with important perspectives on what is working well in the current system, what is missing or needs improvement, and what each organization's top priorities are to better address behavioral health needs – inclusive of both mental health and substance use disorders – as far up-stream as possible. A draft report was shared with each of the participating organizations and feedback was solicited on both the findings and recommendations. A community forum to discuss the results and recommendations was held in mid-February. Input in response to the draft report and from the community forum were incorporated into the report. The final report summarizes current strengths and challenges, as well as recommendations to leverage community resources and potential opportunities for engaging in the upcoming legislative session. The report also describes best practices for delivering behavioral health prevention and intervention services in schools (see Appendix Four) and health systems (see Appendix Five).

Readers are reminded that this project is intended to identify up-stream opportunities. As a result, key informant interviews did not focus on intensive, crisis, or inpatient services despite the important role these services play in the overall system of care. However, because some informants addressed priorities in these areas, we did include a brief section in the report that incorporates key informant perspectives regarding intensive services. In addition, this report relies on information provided to us. The assessment was narrow in scope and did not include site visits or data reviews sufficient in scope to validate assessment findings. Instead, MMHPI relied solely on information provided through the key informant interviews.

Moving the delivery of behavioral health supports up-stream, closer to the time when symptoms first emerge, and emphasizing a range of prevention strategies to prevent or at least minimize symptom emergence is essential to both the treatment of mental illness and substance use disorders, as well as the promotion of mental wellness. Early intervention and prevention have been key to improved care for other health conditions (cardiovascular health, diabetes, and cancer), but for mental illness there is currently an average of eight years between initial onset of mental health symptoms and access to treatment.¹ Given that half of all mental health conditions manifest by age 14² (as well as a substantial proportion of substance use disorders and the conditions that can lead to them) early identification and prevention efforts are critical. In fact, intervention during the early childhood years – before symptoms and behaviors negatively affect functioning and healthy development – can positively impact a child’s developmental trajectory. In general, interventions can be more successful the earlier they are implemented, when symptoms are less severe, more treatable, and more readily prevented from escalating.

However, translating these opportunities into action requires more than improved specialty mental health and substance use disorder care and crisis supports. Advances in the treatment and prevention of other diseases has required the engagement of health and other child-serving systems more broadly to better support early identification and coordinated access to ensure the right kind of care is provided at the right time. In this report, we will discuss ways the San Antonio community can do just that. First, we describe an “Ideal System of Care” for children, youth, and families to prevent and increasingly detect and treat behavioral health needs sooner. We then describe the strengths and challenges we identified in collaboration with the participating agencies regarding the current delivery system within each component of the ideal system, based on interviews with key stakeholders. Finally, we present strategies to build on existing strengths and expected opportunities with an up-stream focus. These strategies and opportunities will be framed with the 86th Legislative Session in mind. Additional recommendations cut across all components and can be found at the end of the report.

An Ideal System of Care for Pediatric Behavioral Health

The ideal system of care for pediatric behavioral health requires the organization of interventions in primary care, specialty care, rehabilitation, and hospital/crisis settings. But behavioral health systems today – in Texas and across the nation – tend to be organized in a

¹ 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.

² Meadows Mental Health Policy Institute. (2016, March 24). Estimates of prevalence of mental health conditions among children and adolescents in Texas. Dallas, TX: Author. Retrieved from <http://www.texasstateofmind.org/wp-content/uploads/2016/01/MMHPI-Child-Adolescent-Prevalence-Summary-2016.03.24.pdf>

manner that is more fragmented, poorly organized, and too often unhelpful (and sometimes harmful). We define an “Ideal System of Care” for treating pediatric behavioral health conditions as having five main components:

- **Component 0: Life in the Community.** This refers to the broad range of prevention activities that happen outside of health care settings. There are many touchpoints for children and youth that provide opportunities to promote healthy development and prevent mental health and substance use disorders. While health care systems are an integral part of every child and family’s life, they are only a part of life. Health needs – both diseases affecting the brain, such as behavioral health disorders, and other conditions – occur in the context of life: home, daycare, school/pre-school, faith communities, and other places where children, youth, and families spend their time. Because children, youth, and families frequent them, these places can also be ideal settings for health promotion and disease prevention. In particular, schools, foster care, and juvenile justice settings have important roles to play in prevention efforts, as well as the delivery of behavioral health interventions.
- **Component 1: Integrated Behavioral Health in Pediatric Primary Care Settings** can help detect behavioral health needs sooner and successfully treat routine and even some moderately severe needs related to behavior, anxiety, and depression. Integrating behavioral health within all pediatric primary care settings is an essential strategy for increasing access to behavioral health services for children and youth, treating those with most mild to moderate conditions and coordinating referrals for those in need of specialty and more intensive care. An example of a fully scaled, statewide implementation suggests that two thirds of behavioral health care can be provided in pediatric settings with the right integration supports.³
- **Component 2: Specialty Behavioral Health Care** in routine care settings such as clinics and provider offices are often needed for those with moderate to severe needs. We estimate that about one quarter of diagnosable behavioral health conditions need treatment by specialists in such clinical settings. However, rather than being the primary focus of the delivery system – like it often is today – in the ideal system, most children and youth receive care before symptoms reach this higher level of need, and those who do require this level of specialty care receive it sooner and in a more coordinated way. If more mild to moderate anxiety and depressive disorders can be treated in integrated primary care settings, specialists would be able to focus on treatment of more complex depression, bipolar disorder, posttraumatic stress, addiction, and other conditions that require more specialized interventions.
- **Component 3: Rehabilitation and Intensive Services** are necessary for about one in ten behavioral health conditions, and these highly specialized and intensive supports should

³ Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

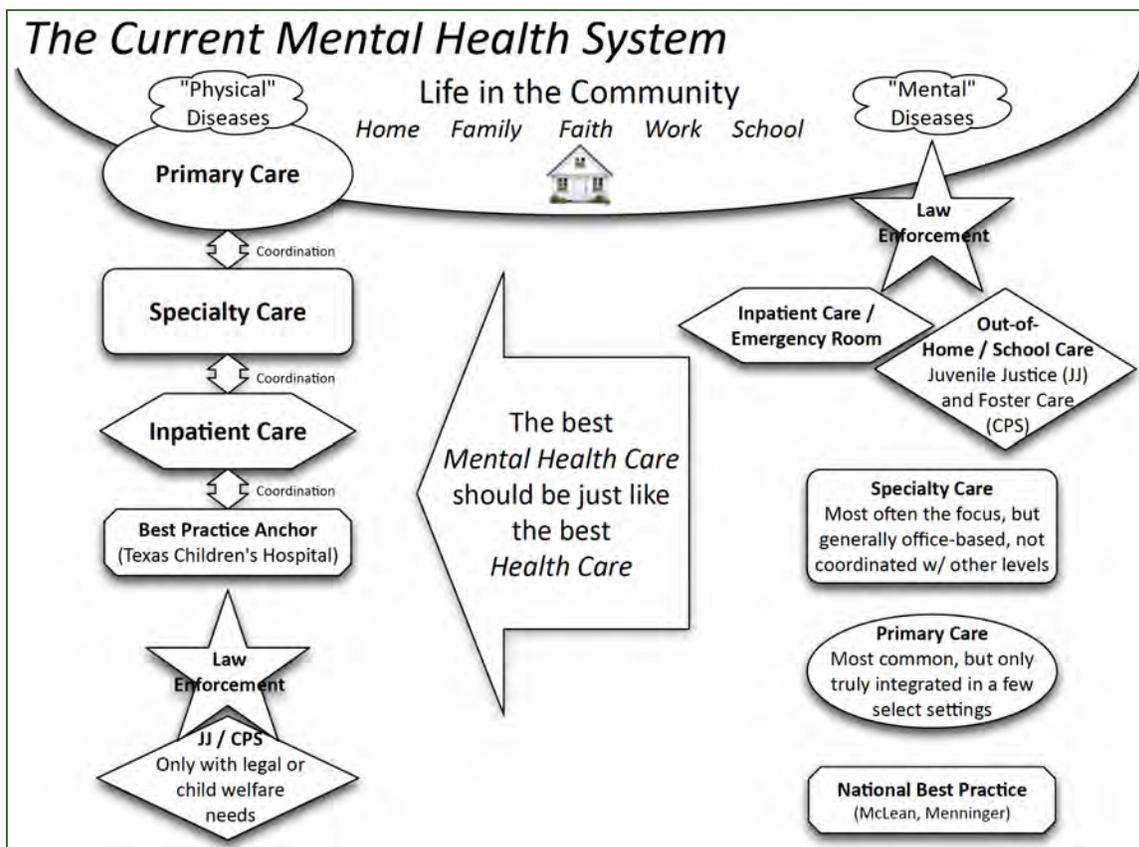
also be accessible sooner and in a more coordinated way. They should also include a broader range of evidence-based, home and community-based services for children and youth with the most severe needs. These services are needed for children and youth with behavioral health needs so severe that they impair functioning across multiple life domains and require team-based care that generally includes a prescriber, a skilled therapist, and a broader team focused on both ameliorating symptoms and building on individual, family, and community strengths to restore functioning and promote healthy development. Similar to catastrophic orthopedic injuries requiring a child to re-learn how to walk or carry out routine life activities, severe psychosis, as well as other less debilitating psychiatric conditions that today generally go untreated for years, can substantially impede day-to-day functioning and require rehabilitative care to treat both the underlying condition and the functional sequelae.

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

Readers should be mindful that the report describes an ideal system against which to benchmark current services and envision future improvements. However, no community in Texas or across the nation has a system that works like this today. Instead, most care in Texas is delivered today – when it is delivered at all – at the specialty or crisis levels of care. Far too little help is available in the primary care or rehabilitative sections of the continuum. Because of the way most behavioral health systems are currently organized, which is often siloed, most families do not seek care at all, and those who do generally have such care delayed many years until symptoms worsen. As a result, too many children and youth first receive behavioral health care services in a juvenile justice facility or an emergency room. A key premise of the report is that, if mental health needs could be detected sooner, children, youth, and families could be linked to needed care and supports earlier and create a path for healthy development.

In addition, social determinants of health, including economic stability, education, health, access to health care, and the social and community context in which children and youth live and grow, all have an impact on health, development, and morbidity. Poverty, coupled with adverse childhood experiences (ACEs), can have a lasting, negative effect on physical and

emotional well-being. The interaction of social and individual determinants of both illness and health are a major focus of the analysis in this report.



The Current System in San Antonio

How Many Children and Youth Need Help

In Bexar County, there are approximately 340,000 children and youth ages 6 to 17:⁴ 160,000 live in poverty,⁵ and 230,000 are Hispanic/Latino,⁶ representing almost 70 percent of the total child and youth population. Overall, youth of color, including Hispanic/Latino, African American, Asian American,⁷ Native American,⁸ and people with multiple racial/ethnic identities, represent almost 80 percent of children and youth in Bexar County. Based on MMHPI estimates, approximately 130,000 children and youth ages 6 to 17 have mental health and substance use disorders.⁹ Approximately 105,000 children and youth have mild to moderate behavioral health needs and about 25,000 have severe needs, often referred to as children and youth with serious emotional disturbances, or SED.¹⁰ Approximately 10,000 children and youth, ages 12 to 17, have a substance use disorder.¹¹ And in 2016, there were sadly 13 deaths by suicide for children and youth in Bexar County.¹² In addition, within Bexar County, it is estimated that

⁴ All Texas prevalence and population estimates are rounded to reflect uncertainty in the underlying American Community Survey population estimates. All percentages are calculated with unrounded figures and may not match percentages calculated with the reported rounded figures.

⁵ “In poverty” refers to the number of people below 200% of the federal poverty level for the specified region.

⁶ We use the Substance Abuse and Mental Health Services Administration’s (SAMHSA) language as a guideline for reporting race and ethnicity categories. This language was taken from the SAMHSA website on racial and ethnic minority populations, available at: <https://www.samhsa.gov/specific-populations/racial-ethnic-minority>. In some cases, we use slightly revised language and have provided further explanation in a footnote, when necessary.

⁷ The category of “Asian American” also includes people identifying as Native Hawaiians and/or Pacific Islanders. In Texas, these population numbers are very small, so we use the term “Asian American” for simplicity of reporting.

⁸ We intend “Native American” to be synonymous with “American Indian” or “Alaskan Native,” terms that are sometimes used instead of “Native American” in other states or in national reporting.

⁹ National estimates of prevalence and severity breakouts, unless otherwise cited, are drawn from Kessler, R. C., et al. (2012). Severity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication Adolescent Supplement). *Archives of Gen Psychiatry*, 62(6), 617–627. The data are from a study with youth. Kessler et al. provide estimates of mild and moderate levels of severity for youth ages 13–17. Absent any data on the severity of conditions among children and youth, this rate has been applied to all children and youth ages 6–17. However, children ages 12 and under likely have lower prevalence of mental health disorders.

¹⁰ Estimates of SMI and SED are taken from the following source: Holzer, C., Nguyen, H., & Holzer, J. (2016). *Texas county-level estimates of the prevalence of severe mental health need in 2016*. Dallas, TX: Meadows Mental Health Policy Institute. The incorporation of specific county-level demographics makes Holzer’s estimate of SED more precise than Kessler’s.

¹¹ Except where indicated, all prevalence rates were obtained from 2012–2014 National Survey on Drug Use and Health: Substate Estimates – Texas. Prevalence rates were applied to Texas Demographic Center population estimates for 2015. All estimates are rounded to reflect uncertainty. Percentages are calculated with unrounded figures and may not match percentages calculated with reported rounded figures.

¹² The number of deaths from suicide includes suicide mortality for all mental health conditions, ages 0–17, in 2016. Data obtained from Centers for Disease Control and Prevention, Underlying Cause of Death 1999–2016 on CDC WONDER Online Database. (Released December, 2017). Data are from the Multiple Cause of Death Files, 1999–2016, as compiled from data provided by the 57 vital statistics jurisdictions through Vital Statistics Cooperative Program. Retrieved, from <http://wonder.cdc.gov/ucd-icd10.html>.

50,000 children and youth,¹³ ages 0 to 17, have experienced three or more ACEs,¹⁴ putting them at higher risk for a range of health conditions, including behavioral health needs.

Using the components of the ideal system as the framework for the report, the sections that follow outline the current strengths and challenges discussed by project participants, as well as up-stream legislative and other opportunities to address them.

We start with a summary of what a group of San Antonio youth said about behavioral health and issues that most affect their lives.

Young Minds Matter Focus Group

Young Minds Matter (YMM) has been working in Bexar County for 16 years to combat the stigma associated with youth mental health by empowering youth and young adults ages 13 to 24 to convene and change community conversations about mental wellness. YMM is a program of the Health Collaborative, which first convened in 1997. In response to recommendations found in the 2016 Bexar County Community Health Assessment report, the Health Collaborative's former Youth Mental Health Council set out to provide the opportunity for meaningful child and youth engagement by creating the Youth Mental Health Advisory Council. Today, the Youth Mental Health Advisory Council is a component of YMM programming and seeks to provide opportunities for youth with personal experiences of mental health to participate in decisions related to youth mental health policy and service delivery. In late November 2018, MMHPI convened a focus group at the San Antonio Area Foundation with six members of the YMM Youth Mental Health Advisory Council. Of the participants, five identified as female (83%), and one identified as male (17%). Furthermore, five participants identified as Hispanic/Latino (83%), and one identified as African American (17%). The participants ranged in age from 14 to 23 years.

The focus group focused on two questions: participants were asked to discuss both ***what is currently going well*** and ***what needs to be improved*** for youth mental health in their communities. A rating form allowed participants to record and rate relevant themes from the discussion. Participants were asked to rate each of the themes on a four-point scale, which included the following choices: "among the most important," "important," "somewhat

¹³ To estimate adverse childhood experiences (ACEs), we apply Texas rates for children and youth, ages 0–17, with zero to three or more ACEs to American Community Survey population data. ACEs rates are obtained from Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Bethesda, Maryland: Child Trends. Retrieved from https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

¹⁴ Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Bethesda, Maryland: Child Trends. Retrieved from https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

important,” and “not as important.” A list of 25 themes emerged during the focus group. We are highlighting the themes below that led to the most substantive discussion during the focus group. For a complete account of our findings, please refer to Appendix Three in this report.

Top Theme: Trauma Broadly Defined

The participants shared their insight and perceptions regarding trauma and how they perceive it manifests at young ages. The participants defined it broadly across a range of situations, and several recalled being surprised when they encountered narratives of trauma from elementary and middle school-aged children, agreeing that these young children and youth also need to be included in conversations surrounding mental health. The range of statements included:

- Female Participant, Age 16: *“Trauma grows when you are young. Even little kids hear that there are school shootings. There are really bad things that can happen.”*
- Female Participant, Age 23: *“We went to a girls event and there were these 5-6-7-year-old girls that were talking about cyberbullying and depression. We were taken aback. They know this and have heard it, so what do we do it about? They felt comfortable talking about it. We could empower them at that point to have a conversation.”*

Top Theme: Substance Use As a Way to Cope

Substance use was also seen as important, and several of the participants linked it to trauma and social pressures, noting that these factors, when left unaddressed, can and have led to substance use among people they know. One participant summarized it particularly clearly:

- Male Participant, Age 17: *“Dealing with bullying, self-image, self-worth, and fitting in, all of these can turn into substance abuse and violence. High schools are full of cliques and gangs. And if you don’t fit into one, you are an outcast. Trying to fit in and find your group of people is hard. If you are an outcast, then you might turn to peer pressure. There are a lot of good kids, but there is substance abuse – it is around. I have friends in jail and dead because of substance use. Once you get caught up, it is hard to get out.”*

Top Theme: Fear of Not Being Taken Seriously

Participants vocalized that much of the time they feel pressure from their parents and teachers to present as “fine,” noting that they fear not being taken seriously if they develop issues that may affect their emotional and mental health. In the words of one participant:

- Female Participant, Age 23: *“When I was in school, people wouldn’t believe me. They would say, ‘she is fine,’ but because of that I couldn’t tell people that is not how it is. I*

didn't know how to ask for help because I thought people would say that I was having a bad day."

Top Theme: Peer Support Helps

Participants described the importance of support from their peers, and some noted how YMM empowers youth to help each other when dealing with issues of mental and emotional health. In particular, participants agreed that the peer aspect of the program is what drives its success.

- Female Participant, Age 14: *"When YMM meets, we all start talking and it helps us to process what we are going through, especially when you can't talk to your parents."*

More broadly, participants also discussed how helpful peer support can be outside of formal peer supports such as YMM meetings. Participants discussed how important it can be to have at least one peer who cares about you and what an impact it can make when you feel worthless.

- Male Participant, Age 17: *"I opened up to my friend over text messages . . . it was easy to talk about things that way. She assured me, "you are awesome, you know who you are." I wasn't suicidal, but you do feel worthless, you feel you can't talk to anyone. Her telling me to look in the mirror and have some confidence worked."*

Additional Insights

Focus group participants and community partners also voiced the importance of and need for peer supports in the community, especially in schools. Participants stated they appreciated when teachers and coaches at school recognized a change in their emotional well-being and took the initiative to engage with them regarding the change.

- Male Participant, Age 17: *"I was always energetic and bubbly. My coach noticed I wasn't the same. I am [involved in a sports] team. When a lot of people know you, they can tell something is not right. I was glad he had seen it. It meant a lot to me."*

In addition to the youth, YMM program staff described a gap in connecting children and youth in need to the appropriate mental health services. YMM staff stated that while they have identified child and youth pre-diagnostic tools and self-assessments for attention deficit / hyperactivity disorder, depression, and anxiety through the help of pediatricians, it has been difficult to implement the tools in a school or community setting with adequate handoff to a medical professional, if needed.

Strengths, Challenges, and Opportunities by Level of Intervention

Through the rest of this section, we summarize the strengths, challenges, and opportunities, focusing on the three most up-stream levels noted above in our description of an ideal system of supports:

- Component 0: Life in the Community (focusing on prevention and linkages to care),
- Component 1: Integrated Behavioral Health in Pediatric Settings (focused on detection and routine care for mild to moderate conditions), and
- Component 2: Specialty Behavioral Health Care (focused on interventions for moderate to severe needs in office settings).

Because some informants also focused on more intensive supports (Components 3 and 4), we also summarize these in a fourth section below.

Component 0: Life in the Community

As noted above, Component 0 refers to community settings where prevention and early detection of behavioral health needs can occur, as well as supports that include children, youth, and families with more severe needs in home and community-based activities. This rapid assessment focused particularly on the education system (including pre-kindergarten), community initiatives, and health promotion. Other groups, such as child care providers and faith-based communities, are also a part of Component 0. We also incorporated results from a recent MMHPI report on faith-based initiatives in Bexar County. We interviewed representatives from two independent school districts (Northside Independent School District and San Antonio Independent School District); Communities In Schools (CIS) of San Antonio; Education Service Center (ESC) Region 20; Family Service Association of San Antonio, Inc. (Family Service); the National Alliance on Mental Illness (NAMI) San Antonio; Rise Recovery; P16Plus Council of Greater Bexar County (P16Plus); and the City of San Antonio's Department of Human Services, and the San Antonio Metropolitan Health District (Metro Health), which serves both the city and the county. Outlined below are the strengths, challenges, and opportunities identified from these interviews.

Another important aspect of life in the community are peer relationships, particularly for youth and caregivers.¹⁵ While peer support has become widely accepted as part of formal mental health and substance abuse service delivery models for adults, support for youth and caregiver peer support models are also needed. Bexar County currently has several initiatives that provide youth peer support for typical issues youth are dealing with as well as peer support for youth experiencing issues specifically related to mental health or substance use.

¹⁵ Substance Abuse and Mental Health Services Administration (SAMHSA). (n.d.). *Value of Peers*. Retrieved from https://www.samhsa.gov/sites/default/files/programs_campaigns/brss_tacs/value-of-peers-2017.pdf

Community Strengths

Key informants identified the following promising initiatives aimed at supporting children and youth with mental health needs in community settings like schools, early childhood, and other settings through the City of San Antonio. They also discussed the important role peers play in a young person's life, as well as the important role youth can play in helping to address the issues that most affect them.

Community Strength 1: Engagement in efforts to strengthen early childhood mental health initiatives. Stakeholders reported that from 2013 to 2018, the City of San Antonio, in collaboration with the Center for Healthcare Services, received a system of care grant from SAMHSA to create a system of care (Bexar CARES) for children ages three to eight (3 to 8). Stakeholders reported that some modest efforts were initiated to create a network of resources to address child mental health needs, which helped move positive discussions forward. Additionally, in 2013, the community initiated a First3Years chapter, which provides continuing education sessions to promote healthy development among infants and toddlers.

Community Strength 2: Responding to trauma and adverse childhood experiences (ACEs). Multiple stakeholders we interviewed identified that creating a more trauma-informed system is a priority for promoting healthy development as well as identifying children and youth with health needs related to trauma earlier and linking them to needed supports. Toward that end, Metro Health, along with Voices for Children and The Children's Shelter, have come together as tri-chairs for the Bexar County Trauma-Informed Care Collaborative (TIC Collaborative). The TIC Collaborative is working to apply a community-wide lens to trauma-informed care, as opposed to applying the framework only to specific populations. They have identified 11 sectors that interact with children as the focus for their systems approach. As an interim step, Metro Health, along with the one of the TIC Collaborative's workgroups, is currently exploring opportunities to implement screenings for adverse childhood experiences (ACEs), which would allow them to connect children and youth with four or more ACEs to mental health services. The Department of Human Services is also looking at implementing a trauma-informed care framework across the agency as well as prioritizing trauma-informed care at the 56 organizations it funds to provide early childhood intervention services. Additionally, both school districts we interviewed, as well as CIS of San Antonio and ESC Region 20, discussed efforts to implement trauma-informed care principles and practices within school settings. Northside Independent School District (ISD), for example, is bringing in a national expert on trauma for a staff development day in February and has invited other community partners to participate. Northside ISD is also piloting trauma-informed campuses in partnership with CIS of San Antonio. San Antonio ISD has trained staff members in the adverse childhood experiences (ACEs) framework to help the district better understand childhood trauma and its impact; San Antonio ISD as well as CIS have supported staff members in becoming "master trainers" in the ACEs framework in order to better sustain their efforts. While most organizations we

interviewed are in the early stages of implementation, this was a key strength upon which the community can build.

Community Strength 3: Linkages and counseling supports in schools. An additional strength identified by stakeholders is the presence of linkage and counseling supports, such as those exemplified by CIS of San Antonio, which partners with 13 school districts to make mental health services, supports, and educational opportunities available for educators, students, and caregivers. While school districts can provide similar supports through dedicated counselors and other strategies, CIS offers many examples of useful supports. CIS provides services in select schools within those 13 districts, and services vary across schools and districts, but include counseling, social emotional learning supports, social emotional support teams, group interventions (anger management, grief, mindfulness, etc.), and linkages and referrals for more intensive care.

CIS staff noted that their work is grounded in a Multi-Tiered Systems of Support (MTSS) framework, and this framework was reportedly used by some districts more broadly. The strategy is central to best practice prevention and intervention supports in schools. It is highlighted in our best practice summary for schools (see Appendix Four) and supported by the Texas Education Agency. MTSS promotes the integration of curriculums and interventions that range from those that are preventative in nature (many social emotional learning curriculums, for example) to targeted mental and behavioral health services for students with identified mental health needs. We anticipate opportunities to expand or enhance such programming through the 86th Legislative Session (described in the Community Opportunities section, below).

An additional resource for school districts is Education Service Center (ESC) Region 20, which provides training and support to Bexar County and adjacent school districts. For example, ESC Region 20 is partnering with the University of Texas San Antonio (UTSA) to offer Critical Incident Response training to school districts. This three-part training provides information on trauma, grief, and strategies and resources (e.g., community resources, parent letters, media releases) that are needed when responding to a critical incident at a school or district.

Community Strength 4: Using data-driven interventions. Often, one of the early signs of a mental health need is chronic absence from school or disciplinary involvement. Even when there is not an underlying mental health need, absenteeism and disciplinary involvement can lead to negative outcomes for children and youth. In an effort to help identify children and youth who might be at risk of negative outcomes because of absenteeism and discipline involvement, P16Plus has designed two data systems that schools can use to track students in these areas to both address the behavioral issues (absenteeism and discipline) and assess whether those behaviors are related to an underlying mental health need.

Community Strength 5: Innovative use of peer recovery support services for youth.

Rise Recovery is one organization that provides support to children and youth ages nine (9) to 17 and young adults up to age 35 who are in recovery from substance use disorders. Its model's foundation is built upon the belief that youth are most strongly influenced by their peers and that value is central to their work. Rise Recovery offers facilitated peer recovery groups, which are guided by trained peer counselors; groups are divided according to age-appropriateness. Similarly, family recovery support groups are facilitated by peer staff and led by family members who have supported someone in their recovery. The San Antonio Council on Alcohol and Drug Awareness also provides recovery support for adults age 18 and older and provides evidence-based prevention services for children and youth at a higher-than-average risk for substance use. Rise Recovery recently received a youth recovery grant that allows them to certify and train recovery coaches who are 24 years old and younger to provide peer support to youth.

Community Strength 6: Presence of youth-driven, mental wellness peer support initiatives.

Young Minds Matter is also an organization whose foundation is built upon the influence that youth have on one another. Young Minds Matter facilitates student-led conversations with their peers on topics that most affect them. Importantly, the conversation topics are developed by the youth. These conversations provide an opportunity for youth to speak with one another about issues and topics they identify as important, develop skills to continually address these issues, and create a supportive environment in which youth feel connected and supported by their peers.

Community Strength 7: Representation of youth voice on local boards and coalitions. Finally, San Antonio also elevates youth voice through a couple of boards and coalitions. The San Antonio Area Youth Commission (Commission), started by the City of San Antonio, is made up of 22 youth volunteers from each City Council District along with two mayoral appointees. The Commission provides both an opportunity for youth to respond to current situations that affect young people and a means for local leaders to hear from youth about these issues. Similarly, the Teen Advisory Board of the Alamo Area Teen Suicide Prevention Coalition prioritizes the role of youth in suicide prevention efforts.

Community Strength 8: Interest of faith community in collaborating to support mental health.

While members of the faith community were not interviewed as part of this assessment, MMHPI partnered with the H.E. Butt Foundation in 2018 to create an inventory of faith and mental health initiatives in San Antonio and more broadly across Texas. That report, which is set to be released in early 2019, found that San Antonio has embarked on an ambitious set of faith-based initiatives, including a comprehensive array of public-private partnerships aimed at enhancing quality of life by engaging faith communities and social and health services entities. These initiatives include mental health, and a Mental Health Action Team has been established

to coordinate activities. An example of this work is faith-based volunteers, such as those at the Wellness Center for Families of Faith, who work to educate congregations and equip them to become caring communities for people and families struggling with mental illnesses. More broadly, the annual Pathways to Hope conference has become an orienting event each year that features important efforts to engage faith communities and organizations that address mental health.¹⁶

Community Challenges

While stakeholders across Bexar County are taking meaningful steps to improve the way they identify and address behavioral health needs of children and youth, the organizations we interviewed identified a number of challenges that impede such efforts.

Community Challenge 1: Limited staff in the education system available to identify behavioral health needs and link students to supports. Both school districts reported that their counselor to student ratio is higher than the 1:350 ratio recommended by the Texas Counseling Association, or 1:250 recommended by the American School Counselor Association.¹⁷ Furthermore, they reported that their school counselors generally do not have the capacity to address the mental health needs of students in part because their duties do not allow time for this function (for example, they play a key role in executing required testing and academic counseling). Additionally, though services provided by community providers, like CIS of San Antonio, have helped in part to fill this gap, such supports are not available in most schools across the county. While other providers in San Antonio express a willingness to deliver services in schools, as noted above, it can be challenging for the school district and the provider to develop a partnership that meets both of their needs, as this requires both school and partner staff to execute.

Community Challenge 2: Significant barriers to accessing mental health services even when available. Key informants identified transportation, stigma, and convenience as a few of the barriers preventing children, youth, and their families from accessing available mental health services. Most agreed that if services were available at school, more students and caregivers could be reached. One of the school districts indicated that if funding were available for start-up costs and staff, it could support the additional operational costs associated with keeping buildings open evenings and Saturdays, and that staff would gladly work overtime to provide services when not in school.

¹⁶ Meadows Mental Health Policy Institute. (Draft report). *Inventory of faith and mental health initiatives*. San Antonio, TX: H.E. Butt Foundation.

¹⁷ Texas Education Agency. (n.d.). *School guidance and counseling, frequently asked questions*. Retrieved from https://tea.texas.gov/Academics/Learning_Support_and_Programs/School_Guidance_and_Counseling/School_Guidance_and_Counseling_-_FAQ/#Q12

Community Challenge 3: Lack of support for caregivers transitioning from Head Start to kindergarten. A key focus of the Head Start program is providing intensive support to caregivers in meeting their child's needs both at home and in pre-kindergarten. However, once children start kindergarten, they are no longer eligible for Head Start services. Since a similar service is not available in kindergarten, children with intense needs lose case management and other supports to help them access services they need through this transition.

Community Challenge 4: Uncertainty about how to engage youth in providing peer support. Because youth peer support is a new concept, there continues to be some uncertainty among some members of the community about how best to use youth effectively in a peer support model. As a result, there are logistical concerns that can prevent organizations from including such supports, such as how to train youth for this role, how to provide appropriate supervision, and how to ensure youth involvement is valued (i.e., not tokenized). However, agencies such as Rise Recovery are very experienced in providing peer support and engaging and supporting other agencies interested in addressing their concerns and positively engaging youth in such roles.

Community Challenge 5: Lack of funding support for peer recovery. In addition to logistical barriers, determining how to fund peer recovery efforts was identified as a challenge. Many peer recovery support services are sustained solely through grant funding, donations, or peers who are willing to volunteer their time. As a result, it can be challenging for an organization to maintain a consistent level of available peer support services, particularly as it relates to peer support for youth. While there has been improvement in insurance reimbursement, including through Medicaid, for adult peer support services, youth peer support lags behind in this respect. In addition to youth peer recovery, one key informant highlighted the value of Certified Family Partners (CFPs). A CFP is an adult who has experience raising a child with mental health needs and has successfully navigated the children's mental health delivery system¹⁸. In this role, the CFP provides peer support to caregivers as they seek to understand both their child's mental health need as well as the system from which they are seeking support. While there is a formal training and certification process for CFPs, reimbursement continues to be a challenge.

Community Challenge 6: Access to peer support is limited. As a result of the previous two challenges, access to peer support can be limited to youth who are already engaged in a system (e.g., substance use/abuse, juvenile justice, alternative education settings). While access to

¹⁸ ViaHope. (2019). *Certified family partner program*. Retrieved from <https://www.viahope.org/programs/family-partner-training-and-certification/>

Via Hope (2017, October). *Texas certified family partner program policy and procedure manual*. Retrieved from https://www.viahope.org/wp-content/uploads/2018/01/CFP_policy_and_procedure.pdf

peer support within these systems is positive, key informants discussed the potential for peer support to serve as a protective factor when it is available earlier.

Community Opportunities

Since the last legislative session, the twin tragedies of Hurricane Harvey and the more recent Santa Fe High School shooting have led to a range of state agency and legislative initiatives to improve prevention and school-based supports for Texas children, and we expect the 86th Legislative Session will have a prominent focus on children's behavioral health. These legislative opportunities, coupled with additional strategies and supports, can begin to address some of the challenges stakeholders highlighted regarding identifying and addressing the mental and behavioral health needs of children and youth in Bexar County. In addition, given the strengths present in the San Antonio community that support youth peer recovery, there also may be opportunities to help expand current efforts and address barriers.

Opportunities that intersect with the strengths and challenges noted above include the following:

Community Opportunity 1: Funding for the Safe and Healthy Schools Initiative. As part of its Legislative Appropriations Request (LAR), the Texas Education Agency (TEA) requested \$52.5 million in funding for the Safe and Healthy Schools Initiative. The Safe and Healthy Schools Initiative is built upon a Multi-Tiered Systems of Support framework and grounded in four primary pillars: 1) Mental Health Supports, 2) Positive School Culture; 3) Facility Safety, and 4) Emergency Response Coordination. If approved, funding through the first two pillars (Mental Health Supports and Positive School Culture) would be available for mental health training programs, telemedicine, trauma-informed care, and coordination of access to mental health providers, as well as to provide grants for mental health and positive school culture programs, with the goal of ensuring that students across the state have access to needed behavioral health services. This funding can be leveraged to increase mental and behavioral health supports and services provided in schools.

Community Opportunity 2: Legislation relating to mental health-specific training requirements for school employees. Chairman Four Price has filed House Bill (HB) 1069 (HB 1069 was re-issued in late February as HB 18, reflecting its high priority in the Texas House), which aims to increase and improve educator training and student education requirements related to mental health and substance use. The bill places emphasis on Positive Behavioral Interventions and Supports and grief-informed and trauma-informed care. Absent needed treatment and supports, children with mental health disorders are at greater risk of negative outcomes such as higher rates of school absence and reduced rates of timely course completion

and graduation.¹⁹ As a result, schools are challenged with supporting the mental health needs of students while promoting academic achievement. Research shows that these issues are linked and that addressing students' social, emotional, and mental health needs can lead to improved student outcomes.²⁰ To do so, many schools are changing how they approach discipline and learning by implementing approaches such as Positive Behavioral Interventions and Supports (PBIS), an evidence-based, multi-tiered prevention framework that reinforces positive behaviors while creating an environment that supports student learning.²¹ Over 25,000 schools nationwide use the PBIS framework, which teaches school-wide behavior expectations at the universal level (Tier 1), offers targeted group support for at-risk students (Tier 2), and provides intensive, individual services for the highest-need students (Tier 3).

The combination of increased funding under the Texas Education Agency exceptional item, increased school funding more broadly, and the new standards set by HB 18 could provide San Antonio school districts with an opportunity to implement a school- or district-wide PBIS framework. Under the PBIS framework, schools and districts select, implement, and monitor the effectiveness of evidence- and research-based programs and interventions aimed at meeting the academic, behavioral, social, emotional, and mental health needs of all students. Universal supports implemented under a PBIS framework—those that impact all students in a school or district—are considered preventative in nature and support a positive school culture. These efforts have the potential to support and expand current strengths in the community related to trauma-informed care and social and emotional learning.

Community Opportunity 3: Legislation relating to mental health-specific requirements for schools. Additionally, HB 18 (formerly HB 1069) requires that districts improve instruction on mental health, substance use, and substance use disorders, which also includes skills to manage mental health, positive relationships, and responsible decision making. This could provide districts with an opportunity to implement both a PBIS framework and universal curriculums that address educational needs related to mental and behavioral health specific to each school within a district.

Community Opportunity 4: Legislation to fund school-based behavioral health centers. Chair Price has also filed HB 1335, which would require the Health and Human Services Commission

¹⁹ Blackorby, J., & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In Office of Special Education, U.S. Department of Special Education, *Special education elementary longitudinal study*. Menlo Park, CA: SRI International.

²⁰ Bazelon Center for Mental Health Law. (n.d.). *Fact sheet #1: Why states and communities should implement school-wide positive behavior support integrated with mental health care*. Retrieved from <http://www.bazelon.org/wp-content/uploads/2017/01/WayToGo1.pdf>

²¹ OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports (2017). *Positive Behavioral Interventions & Supports* [Website]. Retrieved from www.pbis.org

(HHSC) to administer a grant program that would assist interested schools districts in establishing a school-based behavioral health center. If passed, school districts could use funding to hire or partner with providers to make behavioral health services available on campus. This includes assessment, counseling (individual and family), psychiatry, rehabilitative services, and other services.

Community Opportunity 5: Legislation to fund school-based mental health professionals.

Chair Price has also filed HB 1072, which, if passed, would require local mental health authorities (LMHAs) to employ a mental health professional located at each Education Service Center (ESC) to support school districts. There have also been discussions of legislation being filed to fund school-based mental health professionals. If passed, this would support school districts in hiring counselors or school psychologists who would provide mental health counseling and education. The San Antonio community should continue to monitor this potential legislation.

Community Opportunity 6: Data-driven decision making to implement youth-driven interventions.

In its 2018 report, the City of San Antonio identified 14 priorities on which it could focus investments to maximize the impact of programs and services. One priority the city identified was to better understand the needs of San Antonio youth by developing a “common pool of youth data and benchmarks” from which it can drive decision making. This priority can be further strengthened by building off of successful initiatives like P16Plus’s data systems and leveraging existing programs like Young Minds Matter to better understand the needs of San Antonio youth and to use youth, where appropriate, to intervene.

Community Opportunity 7: Potential funding for peer-driven programs. To address youth’s needs related to substance use, several stakeholders noted the benefits that a Recovery High School could provide San Antonio youth in recovery. Recovery High Schools are designed to support youth who are in recovery from a substance use disorder by providing an educational environment in which they can have access to services like drug counselors, other therapeutic services, and sobriety maintenance programs. In the spring of 2018, the first Recovery High School opened in Houston. During the 85th Texas Legislature, HB 13 established the Community Mental Health Grant Program to support community programs providing mental health care services and treatment to people with mental illnesses. Funding for this program is currently in both the House and Senate base budgets for 2020–2021. Nonprofits and governmental entities (e.g., school districts) are eligible to apply for these funds, and proposed programs must employ one or more strategies from the Statewide Behavioral Health Strategic Plan. Such strategies include ensuring prompt access to coordinated, quality behavioral health services, including substance use disorder services, which aligns with the goals of a Recovery High School. Bexar County’s Recovery Oriented Systems of Care (ROSC) network is a natural partner to support potential development of a Recovery High School in San Antonio. This existing network has

representatives from a number of community sectors (e.g., legal, treatment, non-profit, faith-based, social services), including people in recovery, and could play a critical role in developing a Recovery High School.

Community Opportunity 8: Legislation to address adverse childhood experiences.

Representative Tan Parker filed HB 822, which, if passed, would require HHSC to collaborate with other state agencies to analyze data related to adverse childhood experiences (ACEs), and develop and implement a five-year strategic plan to address and prevent ACEs. This legislation may provide an opportunity for local communities to collaborate on the development of this plan. It may also provide an opportunity for the San Antonio community to align its ACEs planning with these state agencies' strategic plan.

Component 1: Integrated Behavioral Health in Primary Care Settings

Pediatric care, where the family doctor provides ongoing, routine care for parents, caregivers and their children, is the front line for health care delivery and the place where families are most likely to get the help they need for their children. This is the setting where childhood development is evaluated, most illnesses detected, and early identification and effective referral and coordination for more complex health needs optimally provided. All of the 340,000 children and youth ages 6 to 17 in Bexar County should be regularly screened for behavioral health needs (annually from age 12 and up). Fully scaled statewide programs based on the best current research show that about two thirds of the 130,000 children and youth each year with behavioral health needs (approximately 85,000 children and youth) could be served in a pediatric care setting with integrated behavioral health supports²² and proper training and support for pediatricians and family doctors.

Primary Care Strengths

Primary Care Strength 1: Commitment to integrated behavioral health care. Bexar County providers that are experienced in integrated behavioral health in primary care settings include federally qualified health centers (FQHCs) such as CentroMed and CommuniCare, Methodist Healthcare Ministries of South Texas (MHM) clinics, and a recently completed Texas Delivery System Reform Incentive Payment (DSRIP) funded project through The University of Texas Health Science Center at San Antonio (UTHealth SA). There was also wide agreement among stakeholders we interviewed that the concept of integrated behavioral health, where families can access both physical and mental health services within pediatric primary care settings, was a critical strategy for increasing access to behavioral health services, reducing mental health

²² Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

stigma, and providing education to promote mental wellness more broadly among children, youth, and their families.

Primary Care Strength 2: Commitment to screening tools in primary care for early identification of mental illness. CentroMed, CommuniCare, and MHM all reported that they regularly use depression screening tools to identify signs of mental illness early in children and youth in order to reduce the need for more intensive mental health services later. For example, both CentroMed and CommuniCare screen youth for depression using the PHQ-9, the validated screening tool most broadly used to help identify depression, which facilitates referrals to its internal behavioral health providers. MHM is implementing multiple integrated behavioral health strategies in its clinics and recently started using the PHQ-A, which is the PHQ-9 modified for adolescents, to initiate screening youth for depression.

Primary Care Strength 3: Prevention and education resources for families to promote healthy development, parenting, and emotional wellness. CommuniCare is focused on patient and family education and has developed educational videos on the mental health needs of youth and caregivers. Similarly, CentroMed offers monthly educational opportunities that focus on childhood development and mental health care. These classes are offered onsite and after hours, with child care, so that parents can become knowledgeable about recognizing signs or symptoms related to mental illness and can intervene sooner rather than later. MHM has also implemented parenting programs for its families as a prevention strategy to reduce family stress and provide education on healthy childhood development.

Primary Care Strength 4: Experience providing psychiatric consultation. From 2012–2016, UTHHealth SA used DSRIP funds to implement an integrated behavioral health model entitled PROXIMA (Primary Care Optimization for Excellence in Interventions Managing ADHD).²³ The purpose of the model was to support pediatricians within both pediatric primary care and specialty care clinics in the treatment of attention deficit / hyperactivity disorder (ADHD) and comorbid psychiatric conditions such as depression and aggression. These supports included co-located master's level behavioral care managers and pharmacological consultation with a child psychiatrist who was available to pediatricians for their patients' care. Positive health outcome measurements of the PROXIMA model were reported in the final year.²⁴ This

²³ The University of Texas Health Science Center at San Antonio (2013, March). *Design, implement, and evaluate projects that provide integrated primary and behavioral health care services: PROXIMA* (Primary Care Optimization for Excellence in Interventions Managing ADHD).

²⁴ The Pediatric Quality-of-Life Inventory is a metric that evaluates changes in a child's quality of life in the following four domains: physical, emotional, social, and school functioning. This inventory was given to children and youth at the PROXIMA program intake (baseline) and then again three months later. It was reported that in over 80% of those children and youth who had completed the Pediatric Quality-of-Life Inventory at baseline and three months later, there was a one-standard deviation improvement in a domain (i.e., physical, emotional, social, or school

experience will serve UHealth SA well if the envisioned Child Psychiatry Access Network component of Senate Bill 63 (now SB 10) is implemented by the 86th Legislature (more on this below).

Primary Care Strength 5: Large employers are increasingly reimbursing screening and mental health care delivery in primary care. In the fall of 2018, the National Alliance of Healthcare Purchasing Coalitions (Alliance) released a report²⁵ that documented the dire lack of access to mental health services nationwide and proposed multiple ways to address it, including more emphasis on screening and care delivery in primary care. The Alliance represents business coalitions that serve 12,000 purchasers who provide insurance coverage to 45 million Americans working for mostly mid- and large-sized employers in the private and public sectors. Many large, self-insured employers nationwide are working with the Alliance, and MMHPI has been convening these providers in the Dallas and Houston areas to identify ways to increase reimbursement in primary care settings for mental health care delivery. Similar efforts are under discussion with business leaders in Bexar County.

Primary Care Challenges

While Bexar County has a solid base of providers with experience in integrated behavioral health (IBH), the use of IBH has not yet been widely adopted outside of the settings noted above, and the providers that are implementing IBH are still in relatively early stages of its use. Many challenges remain as the community moves toward universal access to integrated care.

Primary Care Challenge 1: Broader use of IBH is needed. Best practice use of IBH in primary care also requires an infrastructure of universal evidence-based screening (using tools such as the PHQ-9/A to identify needs for all people seen), measurement-based care (repeated use of these tools to monitor symptom reduction to gauge treatment progress over time), psychiatric consultation, and collaborative care models (co-located behavioral health specialists). While the Bexar County community has experience in these approaches that it can build on, broadening the range of interventions in current settings and increasing the number of providers using IBH will require systematic education and supports over time, as well as funding reforms to promote sustainability of IBH models. Increased utilization of electronic health records (EHRs) for communication between primary care providers and behavioral health specialists within a system, as well as extraction of outcomes data, will be increasingly important in providing quality behavioral health care. Beyond EHRs, Bexar County has developed the infrastructure for a health information exchange (HIE), where health care professionals can access and share

functioning). Blader, J.C., & Pliszka, S.R. (2017, April). *Outcome measures of PROXIMA, Report of Milestones to the Texas Delivery System Reform Incentive Payment (DSRIP) program.*

²⁵ National Alliance of Healthcare Purchaser Coalitions. (2018, August). *Achieving value in mental health support: A deep dive powered by eValue8.* Retrieved from <https://nationalalliancehealth.wufoo.com/forms/s1ssab0o1u5yxwl/>

patient data confidentially with health care providers from another system for the purpose of providing safe and effective care. This is an area of focus across the country. In fact, the Office of the National Coordinator for Health Information Technology, Department of Health and Human Services, recently announced a call for provisions related to interoperability standards that have the potential to help facilitate health information exchange.²⁶

Primary Care Challenge 2: Shortages of specialists and more intensive services (rehabilitation and crisis supports) make referrals more difficult for children and youth with more severe needs. While mild to moderate mental needs of children and youth can be addressed within pediatric primary care with adequate IBH supports, pediatric primary care providers cannot manage all children's mental health needs, especially those with severe mental health disorders that require more intensive services, such as bipolar disorder, complex depression, posttraumatic stress disorder, obsessive compulsive disorder, psychotic disorders, and eating disorders. These conditions generally require specialist intervention, as described in the next section. Key informants were clear that limited access to child and adolescent psychiatrists and bi-lingual behavioral health clinicians has been particularly challenging for many children and youth and their families within the community. In addition, children and youth with more severe mental illnesses lack outpatient intensive home and community-based services. As a result, they do not get the services they need and end up cycling between primary care, emergency rooms, and inpatient care, if it is even available.

Primary Care Challenge 3: Funding-driven constraints on the expansion of IBH. Many key informants expressed concern about the future of IBH because low reimbursement for mental health services continues to be an ongoing concern for future financial sustainability, so the behavioral health component is difficult to fund. Similarly there are current limitations in reimbursement that do not support direct provider-to-provider consultation, such as when a pediatric primary care provider wants to obtain professional guidance from a child psychiatrist on medication management for one of their patients, or coordination of care that involves multiple systems (e.g., school and child welfare systems). In addition, billing for mental health services in a primary care setting can be challenging because it is often an unfamiliar process for administrative staff and can involve multiple payers and billing requirements. In particular, payment for mental health services is often subcontracted to a separate insurer or managed by a separate division of the insurer through a separate contract, which poses substantial barriers to reimbursement and requires great sophistication on the part of the practice. These and other requirements also increase the administrative burden and expenses of the practice;

²⁶ The Office of the National Coordinator for Health Information Technology (2018). *Notice of proposed rulemaking to improve the interoperability of health information*. Retrieved from <https://www.healthit.gov/topic/laws-regulation-and-policy/notice-proposed-rulemaking-improve-interoperability-health>

barriers to billing (e.g., prohibitions on seeing more than one provider per day and regulations affecting the arrangements between the providers) also exist.

Primary Care Opportunities

Despite these constraints, stakeholders also identified multiple opportunities to build on the current strengths of integrated behavioral health within Bexar County. These include the following:

Primary Care Opportunity 1: Increasing supports to pediatric providers to meet behavioral health needs (Senate Bill 63, refiled as Senate Bill 10): On November 12, 2018, the first day to prefile legislation for the 86th Legislative Session, Senator Jane Nelson (R – Flower Mound) filed 86(R) Senate Bill (SB) 63, which would establish a statewide Texas pediatric behavioral health consultation model, referred to as the Child Psychiatry Access Network (CPAN). As of mid-January 2019, every member of the Texas Senate had signed on as either an author or co-author with Senator Nelson, and Governor Abbott expressed his support for Senator Nelson’s efforts. On February 5, 2019, SB 63 was refiled as SB 10 and was designated as a priority item for the Texas Senate and a top priority for Governor Abbott as an emergency item. SB 10 would enable pediatric primary care providers to consult with child psychiatrists at Texas medical schools for assistance in better meeting the behavioral health needs of children and youth through telephone consultation, professional education opportunities, and care coordination assistance. A state-funded CPAN would allow any pediatric primary care provider to access free behavioral health consultation through a designated child psychiatry academic hub. House leaders have also expressed interest in such programs and included information about them in last year’s school safety house interim reports.^{27, 28} In late February, House Public Health Committee Chair Senfronia Thompson (D – Houston) filed HB 10 and House Joint Resolution (HJR) 5 that fund similar supports. Since HB 10 and HJR 5 were just filed, our discussion below focuses just on SB 10.²⁹

UTHealth San Antonio is best positioned to develop the CPAN for Bexar County and the surrounding region. The CPAN model being considered would target the establishment of hubs that would support all primary care practices in a region for at least 500,000 children and

²⁷ House Committee on Public Education, Texas House of Representatives. (2018, September 4). *Preliminary report on school safety*. Retrieved from https://house.texas.gov/_media/pdf/committees/HPE-Preliminary-Report-on-School-Safety.pdf

²⁸ House Committee on Public Health, Texas House of Representatives. (2018, December). *Interim report to the 86th Legislature* [See Section: Additional Charge Assigned – Children’s Mental Health and School Safety, pp. 85–94]. Retrieved from https://house.texas.gov/_media/pdf/committees/reports/85interim/Public-Health-Committee-Interim-Report-2018.pdf

²⁹ Since HB 10 and HJR 5 were filed as this report was being finalized, we do not include analysis of their potential impact. Accordingly, the focus in this report remains on SB 10. We will all see during the remainder of the legislative session how the two chambers work out the differences in the two approaches.

youth; the region for this CPAN would need to be broader than just Bexar County and would need to include all primary care providers. Building relationships with that many primary care practices will take time, and the proposed model contemplates ramping up funding for six months in year one and full funding in year two, with an initial focus in the first four years of engaging all of the interested primary care practices in the region, as well as specialty care providers as referral sources (one of the functions of the CPAN is care coordination and referrals for complex cases that cannot be adequately treated in primary care settings).

While screening children and youth for mental health concerns is increasingly being covered, establishing supports for new mothers is also important. As of July 1, 2018, postpartum depression screenings are covered by Medicaid or the Children's Health Insurance Program (CHIP) and a child's physician can be paid for one exam per eligible child over a 12-month period.³⁰ This supports the idea that in a pediatric primary care setting, the health and mental health of caregivers is equally important to the health and mental health their children. By identifying a potential mental health need, such as postpartum depression, physicians can assist new parents in accessing the services and supports they need and also support the healthy development of the child, as the caregiver's wellness is critical to healthy development.

Primary Care Opportunity 2: Expand telemedicine and telehealth programs through SB 10. SB 10 also proposes to establish or expand telemedicine and telehealth programs, which could both fill gaps in care and improve engagement in mental health treatment by reducing the need for transportation, an access barrier identified by key informants here in Bexar County. The CPAN provider would also need to provide this service. SB 10 specifically contemplates the provider doing so in collaboration with community mental health providers who can provide the medical school lead with additional bandwidth for both telepsychiatry and specialty telehealth services. The goal of the funding is to build capacity that could also leverage Medicaid and commercial payers, as well as philanthropic investments, to build a coordinated network of specialty care via telehealth to dramatically increase the availability of care. Ideally, much of this care would be developed in primary care and school settings that are more easily and frequently accessed by children, youth, and their families.

Primary Care Opportunity 3: Develop a learning collaborative to expand use of IBH models in primary care. As noted above, all of the primary care providers we interviewed are implementing some form of IBH, but none are implementing all components: universal evidence-based screening (using tools such as the PHQ-9/A to identify needs for all people seen), measurement-based care (repeated use of these tools to monitor symptom reduction to gauge treatment progress over time), psychiatric consultation, and collaborative care models

³⁰ Doolittle, David. (2018, July 10). *Postpartum Depression Screening Now Covered by Texas Medicaid*. Retrieved from <https://www.texmed.org/TexasMedicineDetail.aspx?id=48072>

(co-located behavioral health specialists). While the community has experience in these approaches that it can built on, as we noted in the challenges section, broadening the range of interventions in current settings and increasing the number of providers using IBH will require systematic education and supports over time, as well as funding reforms.

This effort should include employers. MMHPI is currently working on funding reforms with the state and large employers in Dallas and Houston, and these could be expanded to San Antonio and South Texas. However, our primary recommendation would be to convene leading primary care providers (such as those involved in this rapid assessment) as leaders in a community-wide learning collaborative to identify strategies to both expand the range and effectiveness of their offerings, as well as broaden the use of the strategies noted above to other providers. Some of the strategies (for example, universal use of measurement-based care) should also be implemented by specialty care, rehabilitation, and inpatient providers, in accord with emerging standards of care, such as those by the Joint Commission.³¹

Component 2: Specialty Behavioral Health Care

Examples of specialty behavioral health care include outpatient clinics, counseling centers, and school-based clinics that offer mental health and substance use disorder (SUD) services, primarily in office settings. This level of care typically offers individual, family, and group therapies and, ideally, a range of evidence-based treatments for specific childhood, adolescent, and familial conditions, such as cognitive therapies and Dialectical Behavior Therapy. Clinics may also provide some rehabilitation services (i.e., skills building – further described in the section on Component 3, Intensive Services). Based on the best current prevalence estimates and the ideal system of care, about one-quarter of the total number of children and youth with mental health needs, or just over 30,000 children and youth in Bexar County, need specialty behavioral health care services each year.

Specialty Care Strengths

Key informants connected to specialty care services identified a broad array of strengths in supporting children and youth in Bexar County.

Specialty Care Strength 1: Collective commitment to children and youth among specialty mental health providers. Many specialty mental health providers within Bexar County indicated that one of the strengths within the community is the network among leading specialty providers. They reported that organizations often reach out to one another to match

³¹ The Joint Commission. (2019). *New outcomes measures standard*. Retrieved from https://www.jointcommission.org/accreditation/bhc_new_outcome_measures_standard.aspx
Lavin, P., Berry, L., & Williams. (2017, April 11). *Measurement-based care in behavioral health* [Webinar]. The Joint Commission. Retrieved from https://www.jointcommission.org/assets/1/6/bhc_Joint_Commission_measures_webinar_041117.pdf

the most appropriate mental health treatment for a child or family's needs. Key informants indicated that the capacity to work collaboratively exists because of their aligned missions to help meet the mental health needs of children and youth. These relationships stem from common interests and are generally informal, but they include formal activities such as an upcoming free event for parents and caregivers who want to learn about community resources, sponsored in partnership with Jewish Family Service and Rise Recovery along with participation from additional agencies.

Specialty Care Strength 2: Some existing relationships with schools. Several specialty mental health providers reported being called upon during mental health crisis situations, such as school suicides or school violence, or to provide education on topics such as bullying, which not only benefits the overall mental health of the children and youth within a particular school, but also strengthens community relationships. Providers reported working with schools to provide resource support and training for counselors, faculty, and crisis teams; low-cost counseling at locations close to campuses to reduce the burden of transportation; and student-focused workshops on anti-bullying and suicide. Regarding trauma and school safety, the Ecumenical Center was part of the crisis response for the Santa Fe High School shooting in 2018 as well as the church shooting in Sutherland Springs in 2017, and has particular expertise in these issues. For their part, some schools reported requesting educational information on topics such as bullying, depression, and suicide to help inform their students and staff.

Specialty Care Strength 3: Training opportunities for the future behavioral health workforce. Several providers reported offering training for physicians and behavioral health specialists more broadly. Clarity Child Guidance Center is a training site for UTHealth SA child and adolescent psychiatry fellows, in addition to nursing students through the University of the Incarnate Word (UIW) nursing program. Clarity Child Guidance Center also trains psychology postdoctoral students and is actively involved with the Baylor pediatric physician mental health training program. UT Health SA is one of the eight current training sites for child and adolescent psychiatry fellowships within Texas. In addition to its own child psychiatry outpatient clinic, UT Health SA works with a number of community agencies within Bexar County to provide a wide variety of training opportunities for future child and adolescent psychiatry fellows, and to support training for the existing workforces within these respective agencies.

Specialty Care Strength 4: Specialty mental health nonprofit agencies strive to provide affordable, outpatient mental health services for children and youth in the community, including people who are uninsured. This is a particular value of Ecumenical Center, Jewish Family Service, and MHM, and a value more broadly for providers such as Clarity Child Guidance Center. While other providers offer a similar range of care, the commitment to access to affordable care among these agencies is notable. General information on the range of specialty behavioral health providers in the community is provided in Appendix Two.

Specialty Care Strength 5: Providers offer evidence-based care. Several community providers reported delivering evidence-based practices. Some of those practices include Parent Child Interaction Therapy (PCIT), cognitive behavioral therapy (CBT), and Problem-Solving Therapy (PST). Additionally, as described earlier, the Bexar County Trauma-Informed Care Collaborative (TIC Collaborative) has been helping providers and others apply a community-wide lens to trauma-informed care. Toward that end, several providers deliver Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), as well.

Specialty Care Challenges

Since specialty mental health providers have had multiple cross-system interactions, either through referrals from primary care or interactions with schools, they provide a unique perspective with respect to identifying gaps within the mental health system and developing solutions. Many specialty mental health providers agreed that prevention strategies and early identification of mental health disorders is becoming increasingly important for children and youth. Specialty providers reported that too often they evaluate children and families when they are in a mental health crisis, or symptoms indicating mental illness have not been addressed for years and, therefore, advance in severity and require more intensive mental health services that are not easily accessible. More specific gaps identified by specialty mental health providers are listed below.

Specialty Care Challenge 1: Limited interaction with pediatric primary care providers.

Although the specialty providers reported that they often evaluate children and youth who have a pediatric primary care provider, many also agreed that increased and more routinized communication with primary care providers is needed to better coordinate care, including informing evaluations with previous medical workups and documented developmental concerns.

Specialty Care Challenge 2: Limited linkages and coordination with school districts, both generally and for individual crisis episodes. Specialty mental health providers, like the Center for Healthcare Services, are sometimes called upon when a child or youth is experiencing a mental health crisis during school hours. However, there is often limited coordination between the crisis team and school personnel, and that can impact the overall evaluation experience and outcome for both the student and school staff. More generally, there is a distinct lack of formal connection between school districts and specialty providers, which both increases the opportunity for a lack of optimal response in crisis situations and reduces the options more broadly for schools when pre-crisis specialty needs exceed the expertise or resources of their in-school services. In general, specialty behavioral health providers have not yet been integrated into the otherwise well designed multi-tiered systems of supports being developed by the school districts involved in this rapid assessment. Please see Appendix Four for

excerpted content from MMHPI's 2018 School Behavioral Health Roadmap,³² which provides more information on best practices for coordinating specialty behavioral health services with schools.

Specialty Care Challenge 3: Limited access to mental health services due to a general workforce shortage of pediatric specialists, but in particular child and adolescent psychiatrists and Spanish-speaking bicultural behavioral health clinicians. The national workforce shortage among child and adolescent specialists is generally seen as permanent condition of health care delivery worldwide, and it is generally agreed that the shortage will require restructuring of services to rely more on primary care (see MMHPI's detailed analysis of this regarding mental health systems for children and youth in Harris County, as well as the American Academy of Pediatrics and American Academy of Child and Adolescent Psychiatry sources noted above and in Appendix Five.³³ It is a truism nationally that specialty behavioral health providers have long waitlists that delay access to mental health services, and this was also observed in Bexar County. Specific gaps were noted for prescribers and Spanish-speaking, bicultural clinicians. In addition, many key informants indicated that most specialty mental health providers (other than the non-profit agencies noted above) within the community have practices that do not take insurance.

Specialty Care Challenge 4: Stigma associated with mental illness and gaps in caregiver mental health knowledge. Because of the stigma associated with mental health and substance use disorders among most individuals and families from various cultures and socioeconomic status – not just in San Antonio, but across Texas³⁴ and the nation more broadly – many families are hesitant to openly discuss concerns they may have regarding their children's mental health. This results in delays and gaps in opportunities to have conversations about their children's emotional development and mental wellness, which in turn can limit the ability of caregivers to

³² Meadows Mental Health Policy Institute. (2018, November 1). *Mental and behavioral health roadmap and toolkit for schools*. Dallas, TX: Author. Available at https://www.texasstateofmind.org/wp-content/uploads/2018/11/Roadmap_and_Toolkit-for-Schools_R4b.pdf

³³ Meadows Mental Health Policy Institute. (2018, November 1). *Harris County mental health services for children, youth, and families: 2017 system assessment and extended report*. Houston, TX: Houston Endowment.

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.

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

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

³⁴ MMHPI carried out a large survey in 2014 among Texas voters and found high rates of stigma, with higher rates among people with less income and less education, as well as differences across racial and ethnic groups.

recognize early signs and symptoms associated with mental health needs. Informants reported that this stigma was highly associated with the fear of negative judgement from others, as well as realistic legal concerns related to some substance use disorders. In addition, it was also noted that many families have concerns that acknowledging mental illness and substance use could lead to involvement of child protective services. This mix of stigma and realistic concerns works together to limit caregiver knowledge and action on behalf of their children.

Specialty Care Challenge 5: Limited knowledge of available care (including available evidence-based treatments) outside of their organizations. Despite the strong informal relationships and focused joint activities (such as community trainings) noted above in the discussion of strengths, the majority of stakeholders we interviewed expressed a lack of knowledge of available mental health services for children and youth across other providers and other child and family-serving systems within Bexar County. This limits opportunities for care coordination and access to optimally matched mental health services.

Specialty Care Challenge 6: Limited communication across agencies and systems of care. Both primary care providers and mental health specialty care providers reported that routine gaps in communication across provider agencies and broader health systems impede collaboration and in particular make mental health evaluations for children more challenging and less efficient. They reported that even when appropriate Health Insurance Portability and Accountability Act (HIPAA) and Family Educational Rights and Privacy Act (FERPA) consents are obtained from parents and guardians, collecting health information across systems is challenging and labor intensive.

Specialty Care Challenge 7: Transportation is a barrier for many families. Multiple key informants reported that transportation is frequently challenging for families because of cost and the time spent traveling to appointments. Primary care providers noted that, even when patients are provided with referrals to appropriate mental health service providers, there can be high no-show rates due to difficulty with transportation.

Specialty Care Challenge 8: Financial challenges for specialty mental health providers serving children, youth, and families who have Medicaid or who are uninsured. Multiple key informants expressed concern over financial sustainability over time, particularly for mental health services with low reimbursement rates from insurance, such as Medicaid. In addition, many non-profit specialty mental health providers offer outpatient services on a sliding scale in order to make mental health services affordable for children and families who are uninsured, which is a continuing challenge to the organizations' financial stability.

Specialty Care Challenge 9: Limited substance use prevention programs and direct services. The San Antonio Council on Alcohol and Drug Awareness (SACADA) is one of few organizations

involved in the rapid assessment that provides education, youth prevention programs, and services focused on alcohol and drug abuse prevention. More broadly, key informants reported that access to mental health services for youth with substance use disorders or co-occurring mental health and substance use disorders is very limited and poorly reimbursed. This includes the full range of care, from outpatient to inpatient.

Specialty Care Opportunities

There are multiple opportunities to build on the current strengths of specialty behavioral health within Bexar County and address current gaps, including the following:

Specialty Care Opportunity 1: Continue to realign scarce specialty capacity. As noted above, the long-standing shortage of specialty child and adolescent providers is not going to change in the foreseeable future, and systems must expand pediatric primary care providers' capacity to treat mild to moderate mental health conditions, such as lower levels of anxiety and routine depression. Along with this shift, specialty behavioral health providers must rethink their roles as more children, youth, and families with mild to moderate mental health conditions are served in integrated care settings. Specialty providers will increasingly need to focus on even more specialized and intensive services for children and youth with moderate to severe mental health conditions or collaborate more with integrated care practices to serve those with mild to moderate needs (or pursue both strategies). Behavioral health specialists will continue to be needed for the treatment of more complex depression, bipolar disorder, posttraumatic stress disorder, and other conditions that require specialized interventions. But the anticipated impact of CPAN over time, if successful, as it has been in over 20 other states, will shift care for much of the population with mild to moderate mental health conditions from specialty behavioral health care settings to integrated primary care settings, allowing specialists to focus on children and youth with moderate to more severe conditions, re-allocating scarce resources to serve children and youth with more intensive needs. Additionally, CPAN has the capacity to reduce the severity of mental illness for children and youth over time and potentially reduce demand over the longer term.

Specialty Care Opportunity 2: Expansion of telemedicine and telehealth programs. As mentioned in the primary care opportunities, SB 10 also proposes funding to establish or expand specialty behavioral health services delivered via telemedicine and telehealth to identify, assess, and provide access to mental health care. In addition to having potential to address capacity gaps, if linkages are made directly to primary care and school settings that are more routinely accessible to children, youth, and families (and accessible with less perceived stigma), this could also address concerns over the lack of engagement in mental health treatment within the community because of difficulty with transportation and other barriers related to off-site referrals.

Specialty Care Opportunity 3: Use the HB 13 Community Mental Health Grant Program to address gaps in care. The 85th Texas Legislature passed and funded House Bill (HB) 13, establishing the Community Mental Health Grant Program. The grant program helps local communities address gaps identified in the Texas Statewide Behavioral Health Strategic Plan³⁵ by delivering locally-driven mental health services and treatment. HB 13 was funded at \$10 million in fiscal year (FY) 2018 and \$20 million in FY 2019; MMHPI expects the 86th Texas Legislature to provide additional funding for HB 13 for the FY 2020–21 biennium (and this is currently in both the House and Senate budgets at \$40 million for FY 2020–21). This could be an opportunity for eligible Bexar County entities to apply for funding to support the expansion of behavioral health services, and the community should plan to maximize use of this program if it is reauthorized in the next round of grants later in 2019.

Components 3 (Rehabilitation and Intensive) and 4 (Crisis and Inpatient)

While not a primary focus of this rapid assessment, some key informants did highlight needs and opportunities for these “down-stream” services. Since this assessment focused on up-stream interventions in children’s mental health, this section of the report only provides a brief overview of the strengths and challenges of intensive services in Bexar County based on our key informant interviews. Overall in Bexar County, as well as across Texas and most of the nation, there is an over-reliance on crisis services, inpatient psychiatric hospitals, and the more restrictive and costly residential treatment programs. Additionally, there are too few intensive home and community-based services for those with the most severe needs. Of the 25,000 school-age children and youth in Bexar County with serious emotional disturbances (SEDs), noted above, we estimate that about 1,000 children and youth will require intensive, evidence-based interventions in their homes and communities because they face the greatest risk for out-of-home or out-of-school placement.³⁶

It should be noted that considerable attention was given to these issues as part of the planning for the San Antonio State Hospital (SASH). In 2017, the 85th Texas Legislature recognized the need for improvements to the deteriorating conditions, outdated building designs, and insufficient information technology systems of the state hospital system. In response, the legislature appropriated \$300 million and authorized the Texas Health and Human Services

³⁵ Statewide Behavioral Health Coordinating Council. (2016, May). *Texas statewide behavioral health strategic plan*. Austin, TX: Texas Health and Human Services Commission. Available at: <https://hhs.texas.gov/sites/default/files/050216-statewide-behavioral-health-strategic-plan.pdf>

³⁶ MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These children and youth need intensive family- and community-based services. In the 2016 Bexar County Report, this number was previously reported as 2,200. Our estimates for the number of children and youth at risk of out-of-home or out-of-school placement is based on a proportion of the number of children and youth with severe emotional disturbance (SED). We now exclude children ages 0–5 from our SED estimates, which results in a lower estimate of the number of children and youth needing intensive services.

Commission (HHSC) to develop a master plan for each state hospital catchment area, in partnership with public or private entities, for the design of neuropsychiatric healthcare delivery systems in the area.

Recommendations for the SASH catchment area, including recommendations related to inpatient capacity for children and youth, were recently released.³⁷ These include: focusing SASH resources on people who need extended inpatient treatment, utilizing inpatient resources closer to patient home communities for acute hospitalizations, improving school-based services on campus, utilizing more peer support services, and making overnight lodging available for families that are traveling from afar. Several informants noted that it would be beneficial for children and youth mental health service providers within Bexar County to convene and discuss further the SASH recommendations to promote ongoing collaboration on this new development for the community in order to inform further development of resources in Bexar County.

Intensive, Crisis, Inpatient, Residential (ICIR) Challenges

ICIR Challenge 1: A lack of rehabilitative services and evidence-based care in both the private and public sectors. This is a statewide and, more broadly, a national problem, but it still affects Bexar County. These services have in general only been developed in the public sector across Texas and the nation, often without adequate attention to the requirements of evidence-based models with demonstrated efficacy.

ICIR Challenge 2: Crisis response needs to be coordinated across systems within a community.

Key informants indicated that if crisis response was more coordinated across the systems that interface with children and youth, such as schools and the local mental health authority, it would lead to more efficient access to these services and a more positive experience for children and their families. It was also mentioned that more attention should be placed on the modality of transportation for children and youth during a crisis. At times, it was mentioned that children are often transported by police cars in handcuffs, which is not an appropriate or therapeutic intervention for children and youth.

ICIR Challenge 3: Limitations in access to inpatient care and concern about inpatient capacity for children and youth.

While children and youth experience challenges in accessing inpatient care, the issues described to us appear to be related to a broader array of factors than simply insufficient inpatient capacity. While it would take a systematic quantitative analysis of current

³⁷ Blader, J.C., & Pliszka, S.R., for the Executive Committee for the Redesign of San Antonio State Hospital. (2018, December). *Planning report for the redesign of San Antonio State Hospital and reinvigoration of behavioral health care in South Texas*. San Antonio, TX: The University of Texas Health Science Center at San Antonio. Available at <http://bit.ly/SASHPlan>

capacity to more fully understand this issue (similar to what was conducted for the planning of the Austin State Hospital, but was not conducted for the San Antonio State Hospital planning), some of the issues noted by stakeholders included:

- A lack of resources for inpatient care for children and youth without insurance or with limited insurance;
- The need for more coordination among inpatient, crisis, and emergency room providers at a system level;
- Utilization peaks during the school years and lower levels during vacation times;
- Zero-tolerance and school exclusion policies that result in increased pressure on inpatient systems when schools are in session;
- Too few appropriate alternatives for crisis diversion and intensive, evidence-based home and community-based interventions for children and youth (especially those in the child welfare and juvenile justice systems);
- Lack of specialized inpatient services for children and youth with complex needs, including co-occurring mental health and intellectual disabilities; and
- Lack of transition services to return to community-based settings.

Intensive, Crisis, Inpatient, Residential (ICIR) Opportunities

Opportunities to build off of the current strengths of intensive, crisis, inpatient, and residential services within Bexar County as well, as fill in current gaps, include the following:

ICIR Opportunity 1: Build on the SASH plan. As noted above, a comprehensive, regional plan was developed regarding child and adolescent inpatient care as part of the SASH planning. Stakeholders interviewed for this project echoed many of the same points noted in that analysis. In particular, they identified an overreliance on SASH beds for acute care needs, potentially due to a lack of available beds in the community. Stakeholders should build on recommendations in the SASH report to address this issue. Additionally, the community should provide input to the Center for Health Care Services on the selection of and access to community beds purchased with funds appropriated for this purpose by the Texas Legislature. HHSC has requested \$39.4 million in additional funding, which is enough to purchase an additional 56,000 bed days (75 more beds per day). While most of this will likely go to adult bed purchases, some may be available for children and youth.

ICIR Opportunity 2: Build on the crisis coordination capacity of STCC or another system-level crisis coordination collaborative. As explored more in the system level analysis below, the Southwest Texas Crisis Collaborative (STCC) is an effort focused on ending ineffective utilization of services for the safety net population at the intersection of chronic illness, mental illness, and homelessness in the City of San Antonio and Bexar County. While primarily focused on adults, it has begun to focus to some degree on child, youth, and family issues. These efforts should be

continued and accelerated to see if STCC can provide the needed system level crisis coordination supports. This is discussed more broadly below.

ICIR Opportunity 3: Expand Coordinated Specialty Care for first-episode psychosis.

Coordinated Specialty Care (CSC), a team-based approach for first-episode psychosis, starts assertive and intensive treatment as soon after the initial emergence of psychosis as possible. We estimate that about 60 new cases of first-episode psychosis per year among youth in Bexar County could benefit from such care.³⁸ Texas currently has 12 CSC teams located at 10 community centers across the state, and the Center for Health Care Services is the site for CSC in San Antonio. HHSC is in the process of expanding CSC access and focusing increasingly on youth ages 18 and younger. In addition, in this upcoming legislative session, the HHSC Legislative Appropriations Request (LAR) is seeking an additional \$7.9 million in both FY 2020 and FY 2021 (GR) to fund Coordinated Specialty Care expansion (Item 19). This could be a potential opportunity to expand CSC capacity through existing HHSC funds, or the exceptional item, if funded by the legislature.

ICIR Opportunity 4: Expand evidence-based practices to include Multisystemic Therapy (MST) services.

Multisystemic Therapy (MST) is a proven family and community-based treatment for at-risk youth with intensive needs and their families.³⁹ It has proven most effective for treating youth who have committed violent offenses, have serious mental health or substance abuse concerns, are at risk of out-of-home placement, or have experienced abuse and neglect.⁴⁰ Because of limitations in Medicaid and other funding for youth mental health services, there is currently no MST capacity in Bexar County and only limited programs in other parts of the state. However, there may be an opportunity to work with STAR Health and other Medicaid managed care organizations to develop a pilot for such services.

ICIR Opportunity 5: Improve rehabilitation services and evidence-based care more broadly across both the private and public sectors. As the quality of rehabilitative services improve, it will be important to widen access beyond children and youth in poverty. Thousands of families

³⁸ Kirkbride, J. B., Jackson, D., Perez, J., Fowler, D., Winton, F., Coid, J. W., Murray, R. M., & Jones, P. B. (2013). A population-level prediction tool for the incidence of first-episode psychosis: Translational epidemiology based on cross-sectional data. *BMJ Open*, 3(2), 1–12. Estimates of the incidence of first-episode psychosis are extrapolated from studies by Kirkbride and colleagues that used a range of ages (14–35 years) during which the first episode of psychosis is likely to occur.

³⁹ Henggeler, S. W., & Shoenwald, S. K. (2011). Evidence-based interventions for juvenile offenders and juvenile justice policies that support them. *Social Policy Report*, 25(1): 1–20.

⁴⁰ MST Services. (2018). *MST research at a glance*. Retrieved from https://cdn2.hubspot.net/hubfs/295885/MST%20Redesign/Marketing%20Kit/Marketing%20Kit%20Collateral%20Digital%20Files/Case%20Study%20and%20Reports/Report%20-%20RAAG_Short_outcomestudies_summary_2018.pdf

with incomes too high to qualify for public benefits also experience mental health conditions so debilitating – either a severe psychiatric condition such as a psychosis or a less severe condition that goes untreated for years – that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying mental health disorder. The 85th Texas Legislature enacted HB 10, which expands the state’s parity enforcement authority to ensure that mental health coverage is treated the same as physical health coverage, and established an ombudsman position to ensure access to behavioral health care services. Texans can now file complaints at the state level to document barriers to effective care related to a lack of compliance with Texas parity laws. This should serve as a means of bringing attention to the relative lack of access to evidence-based care options, which are often more available for other health conditions.

System Level Findings and Recommendations

There are several system-level findings that apply across all of the components within the ideal system of care. Many of these cross-cutting concepts were mentioned by key informants and include the following: trauma-informed care, recovery, health equity and cultural competency, telehealth/telemedicine, collaboration, and population health data.

Trauma-Informed Care

Understanding and recognizing the prevalence of adverse childhood experiences (ACE)s helps identify risk factors and treat a range of disorders. ACEs are traumatic or stressful events that take place in childhood and can potentially have enduring and damaging effects on a child’s health and well-being. They can affect children and youth of all backgrounds, economic classes, and geographic locations,⁴¹ but they pose greatest risks for children and youth in poverty, children and youth of color, and sexual minorities.⁴² ACEs come in many forms, including economic hardship, abuse and neglect, neighborhood violence or domestic violence, growing up with a parent who has a mental illness or a substance use disorder, incarceration of a parent, or parental divorce. Nationally, economic hardship is the most commonly reported ACE.⁴³ A child who has experienced ACEs is more likely to experience learning or behavioral issues and to develop a wide range of health problems, including obesity, alcoholism, and drug use.

⁴¹ American Academy of Pediatrics (2014). *Adverse childhood experiences and the lifelong consequences of trauma*. Retrieved from: https://www.aap.org/en-us/Documents/ttb_aces_consequences.pdf

⁴² Merrick MT, Ford DC, Ports KA, Guinn AS. (2018). Prevalence of Adverse Childhood Experiences From the 2011-2014 Behavioral Risk Factor Surveillance System in 23 States. *JAMA Pediatrics*. 2018;172(11):1038–1044.

⁴³ Sacks, V., Murphy, D., & Moore, K. (2014). *Adverse childhood experiences: National and state level prevalence* (Research Brief Publication #2014-28). Retrieved from Child Trends website: https://www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Stakeholders broadly endorsed the importance of incorporating ACEs and becoming trauma-informed more broadly for caregivers, school personnel, physicians, and behavioral health providers across the various components of the ideal system of care to embrace a trauma-informed approach and create a culture of non-judgement. Becoming trauma-informed helps minimize perceived threats, avoids re-traumatization, and supports recovery. In 2017, MMHPI completed a comprehensive review of trauma-informed care options in Texas for the Supreme Court of Texas Children’s Commission that can serve as a resource in expanding such options.⁴⁴

Recovery and Peer Support

Recovery is a process of change through which people improve their health and wellness, live a self-directed life, and strive to reach their full potential. Recovery supports include a range of social and environmental supports that enhance the process of change through which people improve their health and wellness. Recovery supports are not treatment programs and they should be available throughout the ideal system of care, embedded wherever possible. Closely related to this process are peer relationships, both for youth and caregivers. Research on peer support has demonstrated increases in consumer engagement of care services,⁴⁵ reduced inpatient and emergency room care, and reduced substance use.⁴⁶ While peer support has become widely accepted as part of formal mental health and substance abuse service delivery models for adults, support for youth and caregiver peer support models are also needed.

Among the stakeholders we interviewed, recovery supports were often mentioned in the context of substance use disorders (SUD) and youth peer support. Currently, youth access to certified peer recovery specialists and designated peer mentors/recovery coaches is mostly limited to SUD specialty settings and is underutilized in all of the ideal system components. We explore opportunities for expanding this further below. But stakeholders were clear that recovery supports should be an essential part of all services. In particular, self-help recovery programs targeted to members of cultural and linguistic minority communities (more on this in the next subsection) and to people with co-occurring mental health and health conditions are less well developed. As the state continues to disseminate mechanisms for billing for peer support (including recovery coaching in 2019), more of a focus on youth and families will need to be incorporated.

⁴⁴ Meadows Mental Health Policy Institute. (2017, July 26). *Trauma-informed care: Final report*. Dallas, TX: Author. Retrieved from <http://texaschildrenscommission.gov/media/83503/trauma-informed-care-final-report.pdf>

⁴⁵ Davidson, L., Bellamy, C., Guy, K., & Miller, R. (2012, June). Peer support among persons with severe mental illnesses: a review of evidence and experience. *World Psychiatry, 11*(2):123–128.

⁴⁶ Hogg Foundation for Mental Health. October, 2014. Peer Support Services Outcomes.

Health Equity and Cultural Competency

While race and ethnicity are not correlated with substantial differences in the prevalence of mental health conditions, we noted in the early sections of this report that children and youth of color comprise the vast majority of children in Bexar County and therefore experience over 80% of current behavioral health needs. Youth of color are also at highest risk of exclusionary school discipline (suspension and expulsion),⁴⁷ which is among the strongest correlates of future involvement in the juvenile justice system.⁴⁸ 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. One of the biggest concerns about service provision noted by stakeholders – and one that is certainly highly relevant for a community as diverse as Bexar County – involves application of practices to children, youth, and families of color. This must be addressed across all recommendations.

Telehealth/Telemedicine

Efforts to expand school-linked health care through the use of telemedicine and telehealth are currently underway in several school districts across Texas. In Bexar County, many of the specialty mental health providers we interviewed are exploring other methods of service delivery, such as telehealth, to increase engagement with children and youth and their families. Efforts discussed in this report (specifically, Senate Bill 10) to expand consultation for primary care practices also make use of such models. Telemedicine and telehealth can be key strategies for linking people to providers of health care services, such as primary care, counseling, psychiatry, and other services, through web-based software and equipment. Telemedicine⁴⁹ refers to medical services provided through advanced telecommunication technology by a physician, or provided by a health professional under the supervision of a physician. Telehealth services are non-physician services provided through advanced telecommunication technology

⁴⁷ 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. Retrieved from https://csgjusticecenter.org/wp-content/uploads/2012/08/Breaking_Schools_Rules_Report_Final.pdf

⁴⁸ 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. Retrieved from 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

⁴⁹ Telemedicine and telehealth services are defined by the Texas Government Occupation Code, Section 111.001. These definitions can be found at the following link: <https://statutes.capitol.texas.gov/Docs/OC/htm/OC.111.htm#111.001>

by a licensed or certified health professional; for behavioral health services, this is typically a licensed social worker, counselor, marriage and family therapist, or specialist in school psychology.

Collaboration

There was wide consensus among stakeholders that collaboration and partnership among child- and family-serving agencies are key to successful programs, policies, and practices. Bexar County has a unique spirit of collaboration and willingness to work together to solve problems. Stakeholders described numerous collaboratives that are successfully bringing multiple providers and partners to the table, and they unanimously shared how much they value the collaboration that exists in their community and how they want to continue to collaborate and partner to be successful.

Stakeholders shared many successful collaborative efforts currently taking place in Bexar County, including collaboration on trauma-informed care (Bexar County Trauma Informed Care Collaborative), cross-system collaboration that developed after the Sutherland Springs tragedy, Bexar County's Recovery Oriented Systems of Care (ROSC), and the South Texas Regional Advisory Council (STRAC). The efforts range in focus, from a population health focus for the Bexar County Trauma-Informed Care Collaborative, to a focus on recovery from substance use disorders for the ROSC, and a focus on tertiary prevention and acute care coordination through the STRAC, which serves as a platform for process improvement and standardization across various entities providing crisis care for the community. The combination of gaps identified in the behavioral health system and STRAC's foundation of system work in the community led to a natural transition for proposed solutions to be guided by STRAC and what is now known as the Southwest Texas Crisis Collaborative (STCC). STCC is an effort focused on ending ineffective utilization of services for the safety net population at the intersection of chronic illness, mental illness, and homelessness in the City of San Antonio and Bexar County. While primarily focused on adults, it has begun to focus to some degree on child, youth, and family issues.

Despite current successful collaboration efforts, many stakeholders shared that they would like even more coordination. It was also noted that no single collaboration forum today currently addresses children's mental health needs comprehensively. We also observed that many stakeholder were not aware of other stakeholders' key programs and priorities. Stakeholders talked about the need for communication across systems, including education, primary care, specialty mental health and substance abuse services systems, hospital systems, child welfare, and juvenile justice.

System Level Recommendations

System Level Recommendation 1: Develop more formal opportunities for providers to communicate and collaborate. Strengthening collaboration efforts would position San Antonio to take advantage of opportunities resulting from the upcoming legislative session. For example, the new statewide Child Psychiatry Access Network (CPAN) program proposed through SB 10 would be funded through medical schools, and The University of Texas Health Science Center at San Antonio (UTHealth SA) would be well positioned to take the lead for the region that includes Bexar County. Since the program includes care coordination and a need to facilitate referrals to outpatient community mental health specialty services, it would be mutually beneficial for the regional CPAN lead to develop an outreach strategy to increase awareness of CPAN and create formal linkages with primary care providers regarding their needs as well as community mental health specialty providers regarding their specialty care and evidence-based treatment capacity. Increased communication and rapport building among pediatric primary care providers, specialty behavioral health providers, and the CPAN lead will be essential to the CPAN model's level of success in improving access to mental health services.

The topic of collaboration was discussed in nearly every stakeholder interview, both as a strength of the community and as a challenge. There are a number of successful collaborations; however, there is no organizing entity to ensure all the efforts are moving towards achieving collectively determined, system-wide goals. One recommendation that came out of the mid-February community forum was for the community to develop a crosswalk of all existing collaboratives to determine whether they can move forward with the recommendations outlined in this report. This is an important first step, but, based on the experience of collaboratives MMHPI has worked with in other communities, we strongly recommend that the community ensure that one entity holds the population framework, perhaps with an upstream focus, in order to coordinate and support the multiple efforts.

Another idea suggested by people we interviewed was to establish a central repository (ideally a website) that brings together information and ideas across all collaboratives to better serve the community. Existing data systems, such as those developed by P16Plus, could also be used to develop and track metrics. The public health activities of the City of San Antonio's Metro Health Department could also provide key supports.

MMHPI's 2016 community mental health assessment made more specific recommendations regarding the establishment of a formal community-wide collaborative, and these recommendations were implemented for adult crisis and high-need cases. The community should consider whether such a collaborative would be helpful for children's services. Based on our review, no current collaborative takes such an overarching, cross-system view. The recommendations in 2016 included:

- Local leaders should develop a locally driven, empowered behavioral leadership team to lead collaborative efforts and efficiently direct system improvement efforts. This initiative should build on emerging collaborative efforts across the system, but it would require both a deeper commitment of key local leaders and an aligned and efficient operational infrastructure to transform itself into a trusted and effective forum for local system planning and coordination.
- Local leader should develop and articulate a vision for what the behavioral health system should look like if it were taken to scale. The results of this rapid assessment should inform that vision; however, the vision cannot be established by an external review – it must be developed collaboratively by the local leadership team.
- Once the vision is established, the local leadership team should establish a prioritized timeline for incremental development to address system gaps over a multi-year period (e.g., five years), based on the findings of this report and other data prioritized by participants.
- A common agenda for the 86th Legislative Session among just the participants in this rapid assessment related to up-stream services (prevention, school-based, primary care, and routine specialty care) for children, youth, and families might be a place to begin.

System Level Recommendation 2: Build on efforts to establish a common trauma-informed care framework. The establishment of the Bexar County Trauma Informed Care Collaborative might offer a platform to build on for the prior recommendations. Numerous key informants discussed their interest in the implementation of a system-wide trauma informed care (TIC) framework. With multiple community partners aligning towards achieving this goal, individual efforts would be strengthened. For example, providers could share the cost of trainings and establish a community-wide network to ensure there are trauma-informed care trainers in the community. The community would further benefit from this process by establishing a common language and shared vision for what it means to be trauma informed. MMHPI’s comprehensive review of trauma informed care options in Texas for the Supreme Court of Texas Children’s Commission⁵⁰ could inform those efforts, among other sources.

System Level Recommendation 3: Include the existing infrastructure that supports youth voice and involvement in system-wide collaborative efforts. As discussed above, Bexar County has an active community of youth that is committed to reducing the stigma surrounding behavioral health and providing support to its peers. Not only are youth creating opportunities to provide informal support to their peers through organizations like Young Minds Matter, but stakeholders reported that they also provide input to community leaders about issues that impact them. Including youth (as well as family representatives) in cross-system collaborative

⁵⁰ Meadows Mental Health Policy Institute. (2017, July 26). *Trauma-informed care: Final report*. Dallas, TX: Author. Available at <http://texaschildrenscommission.gov/media/83503/trauma-informed-care-final-report.pdf>

efforts should be considered. One activity related to cross-system collaboration that could be considered would be a mechanism for obtaining youth feedback on current behavioral health services available within Bexar County, including their satisfaction with these services. Additionally, a number of stakeholders identified stigma as a barrier to care, and many organizations are addressing stigma through multiple avenues, including use of MMHPI's Okay to Say™ framework. Community strengths related to the involvement of youth could also serve as a foundation to help shape a more coordinated public health campaign to address stigma associated with mental health and substance use disorders across San Antonio.

Appendix One: List of Participants

| Name | Title | Organization |
|---------------------------------------|---|---------------------------------------|
| Melissa Tijerina, LMSW | Vice President Child Behavioral Health and Long Term Care, Child Behavioral Health and Long Term Care | The Center for Health Care Services |
| Ernesto Gomez, PhD | President & CEO | CentroMed |
| Anna Serrano, DrPH, MBA | VP & Chief Population Health Officer | CentroMed |
| Rhonda Thompson, DNP, MBA, RN, NEA-BC | Chief Nursing Officer | Children’s Hospital of San Antonio |
| Elena Mikalsen, PhD | Pediatric Psychologist | Children’s Hospital of San Antonio |
| Jessica Dovalina, BS, MPA | Assistant Director – Department of Human Services Early Head Start, Head Start, Child Care Services, and Human and Workforce Development Services Consolidated Funding Cycle | City of San Antonio |
| Carol Carver, MSN | Senior Vice President Chief Operating Officer | Clarity Child Guidance Center |
| Chris Bryan, MBA | Vice President Information Technology and Public Policy | Clarity Child Guidance Center |
| Paul Nguyen, MHA | President & CEO | CommuniCare Health Centers |
| Jessica Weaver, BSW | CEO | Communities In Schools of San Antonio |
| Lauren Geraghty, BA, MA | Director of Strategic Impact Initiatives | Communities In Schools of San Antonio |
| Mary Beth Fisk | CEO/Executive Director | Ecumenical Center |
| Darlene Redclift, MS | Coordinator III Special Education | Education Service Center, Region 20 |
| Tracy Reinen, MS | Consultant – Counseling, Postsecondary and Student Services | Education Service Center, Region 20 |
| Cheri Kahn, MS | Consultant – Behavior and Discipline | Education Service Center, Region 20 |
| Cindi Bowling, MS | Consultant – Behavior and Discipline | Education Service Center, Region 20 |
| Fred Cardenas, LMSW | Manager – Early Childhood Well Being (ECWB) | Family Service Association |
| April Gonzalez, BS | Manager of Behavioral Health | Family Service Association |

Bexar County Children and Youth Rapid Behavioral Health Assessment

| Name | Title | Organization |
|-------------------------------|---|--|
| Talli Dolge, MS | CEO | Jewish Family Service San Antonio |
| Nissa Shakocius, LCSW-S | Clinical Director | Jewish Family Service San Antonio |
| Brian Skop, MD | Senior Vice President of Behavioral Health Services | Methodist Health Care Ministries |
| Terri Mabrito, MA | Executive Director | National Alliance on Mental Illness (NAMI), San Antonio Coordinator, Alamo Area Teen Suicide Prevention Coalition / Teen Advisory Board |
| Don Schmidt, BA, BBA, MS | Assistant Superintendent for Student, Family & Community Services | Northside Independent School District |
| Kimberly Ridgley, MA, EdD | Director of Guidance & Counseling Services | Northside Independent School District |
| Coleman Heckman, PsyD, LSSP | Director of Psychological Services | Northside Independent School District |
| Adriana Felts, MA, LPC | Safe Schools Prevention Counselor | Northside Independent School District |
| Jackie Redding, MS, CSC | Safe Schools Prevention Counselor | Northside Independent School District |
| Ryan Lugalía-Hollon, PhD | Executive Director | P16Plus Council of Greater Bexar County |
| Evita Morin, LMSW | Executive Director | Rise Recovery |
| Victoria Bustos | Executive Director | San Antonio Independent School District |
| M. Estella Garza, LMSW, SSWS | Director – Family & Student Support Services | San Antonio Independent School District |
| Gyna Juarez, MPA ACPS | Senior Director – Prevention/Intervention and Recovery Services | San Antonio Council on Alcohol & Drug Awareness |
| Mary Almendarez, MPS-HR, ACPS | Youth Prevention Program Director – Substance Use Prevention and Recovery | San Antonio Council on Alcohol & Drug Awareness |
| Colleen M Bridger, MPH, PhD | Director | San Antonio Metropolitan Health |
| Steven R. Pliszka, MD | Dielmann Distinguished Professor and Chair – Department of Psychiatry UT Health San Antonio | UT Health Science Center – San Antonio |

Appendix Two: Table of Information on Organizations

Below, please find information on organizations we interviewed for the Bexar County Rapid Assessment.

| Organization | Number of Individuals Served ⁵¹ | | | Conditions Served | | Levels of Services Provided | | | | Counties Served | | |
|---|--|-------|-------------------|-------------------|------------------------|---|-------------------------|-----------------------------|---|-----------------|----------|-------|
| | Children | Youth | Families / Adults | Mental Health | Substance Use Disorder | Prevention and/or Non-Clinical Services | Integrated Primary Care | Office-Based Specialty Care | Intensive Services (Rehab / Crisis / Inpatient) | Bexar | Adjacent | Other |
| The Center for Health Care Services | 8,317 | | | x | x | | | x | x | x | | |
| CentroMed | 5,057 | | | x | x | | x | | | x | x | |
| Children’s Hospital of San Antonio | 500 | | | x | | | | x | | x | | |
| City of San Antonio | 19,454 | | | x | | x | | | | x | x | x |
| Clarity Child Guidance Center ⁵² | 5,735 | | | x | | | | x | x | x | | |
| CommuniCare Health Centers | 3,000 | | | x | | | x | | | x | | |
| Communities In Schools (CIS) of San Antonio | 8,533 | | | x | | x | | | x | x | x | |
| Ecumenical Center ⁵³ | 12,000 | | | x | | | x | x | x | x | x | x |

⁵¹ All figures were provided directly by the provider organizations and are annual for calendar or fiscal year 2017 or 2018 (unless otherwise specified).

⁵² The majority of the children, youth, and families served (86 percent) reside in Bexar County, with approximately 22 percent of those from outside the City of San Antonio.

⁵³ Integrated primary care services were provided for adults only.

Bexar County Children and Youth Rapid Behavioral Health Assessment

| Organization | Number of Individuals Served ⁵¹ | | | Conditions Served | | Levels of Services Provided | | | | Counties Served | | |
|---|--|-------|-------------------|-------------------|------------------------|---|-------------------------|-----------------------------|---|-----------------|----------|-------|
| | Children | Youth | Families / Adults | Mental Health | Substance Use Disorder | Prevention and/or Non-Clinical Services | Integrated Primary Care | Office-Based Specialty Care | Intensive Services (Rehab / Crisis / Inpatient) | Bexar | Adjacent | Other |
| Education Service Center, Region 20 ⁵⁴ | N/A | | | | | x | | | | x | x | x |
| Family Service Association | 1,094 | | | x | x | x | | x | | x | | x |
| Jewish Family Service San Antonio | 2,037 | | | x | | | | x | | x | x | |
| Methodist Health Care Ministries | 365 | | | x | | | x | x | | x | | |
| National Alliance of Mental Illness (NAMI), San Antonio ⁵⁵ | | | 4,000 | x | | x | | | | x | | |
| Northside Independent School District ^{56, 57} | 106,066 | | | x | | x | | | x | x | | |
| P16Plus Council ⁵⁸ | N/A | | | | | x | | | | N/A | | |

⁵⁴ Not a direct service provider; however, ESC 20 conducts regional mental health trainings, including Youth Mental Health First Aid, having trained 540 people in Bexar County as of February 6, 2019.

⁵⁵ Serves Bexar County as well as surrounding communities, as capacity allows.

⁵⁶ Also contracts with CIS.

⁵⁷ Of this total amount, 12,591 students were served in special education services.

⁵⁸ Not a direct service provider.

Bexar County Children and Youth Rapid Behavioral Health Assessment

| Organization | Number of Individuals Served ⁵¹ | | | Conditions Served | | Levels of Services Provided | | | | Counties Served | | |
|---|--|-------|-------------------|-------------------|------------------------|---|-------------------------|-----------------------------|---|-----------------|----------|-------|
| | Children | Youth | Families / Adults | Mental Health | Substance Use Disorder | Prevention and/or Non-Clinical Services | Integrated Primary Care | Office-Based Specialty Care | Intensive Services (Rehab / Crisis / Inpatient) | Bexar | Adjacent | Other |
| Rise Recovery ⁵⁹ | 742 | | 693 | x | x | x | | | | x | | |
| San Antonio Independent School District ^{60, 61} | 48,719 | | | x | | x | | | x | x | | |
| San Antonio Council on Alcohol & Drug Awareness | 60,000 | | | | x | x | | | | x | x | x |
| San Antonio Metropolitan Health ⁶² | N/A | | | | | | | | | x | | |
| UT Health Science Center ⁶³ | 6,574 | | | x | | | | | x | x | | |

⁵⁹ Primarily serves Bexar County area, however do not limit access to anyone who seeks services.

⁶⁰ Also contracts with CIS.

⁶¹ Of this total amount, 5,361 students were served in Special Education Services.

⁶² Not a direct service provider.

⁶³ This estimate is combined for the UT Health Science Center Child Psychiatry Outpatient Clinic, Clarity Child Guidance UT Outpatient Clinic, the Juvenile Detention Center, Krier Juvenile Probation Residential Treatment Center, and University Hospital Consult Service.

Appendix Three: Young Minds Matter Focus Group

During the course of the focus group, youth participants were asked to complete a focus group rating form. The rating form allowed participants to identify and record relevant themes from the discussion and then rate each theme on its overall importance. Based on the focus group, 25 themes emerged for ranking and discussion (Table 1).

Themes were rated on a four-point, Likert-type scale, which included the following choices: “among the most important,” “important,” “somewhat important,” and “not as important.” Lower scores reflect more importance.

Average scores should be interpreted as follows: 1 to 1.5 = “among the most important,” 1.6 to 2.5 = “important,” 2.6 to 3.5 = “somewhat important,” and 3.6 or higher = “not as important.”

Table 1

| Focus Group Responses, in Order of Emergence | |
|--|---|
| Theme | Average Importance (1 = among the most important, 4 = not as important) |
| 1. Peers | 1.5 |
| 2. Self-image | 2.2 |
| 3. Self-worth | 1.5 |
| 4. Feeling worthless | 1.2 |
| 5. Bullying | 1.7 |
| 6. Fitting in | 2.5 |
| 7. Peer pressure | 2.3 |
| 8. Violence | 2.4 |
| 9. Substance use | 1.4 |
| 10. Gangs | 2.4 |
| 11. Trauma | 1.2 |
| 12. Personal stories | 2.3 |
| 13. Stigma | 1.7 |
| 14. Something positive to do | 2 |
| 15. School leader support | 2.2 |
| 16. Peer-to-peer mediation | 2.2 |
| 17. Peer-to-peer communication | 1.8 |
| 18. Adult who cares | 2.3 |

| Focus Group Responses, in Order of Emergence | |
|--|-----|
| 19. Friend who cares | 1.8 |
| 20. Being labeled (by adults/parent) | 2.0 |
| 21. Time to care from adults | 2.0 |
| 22. Fear of not being taken seriously | 1.3 |
| 23. Pressure to be fine | 1.5 |
| 24. Someone for younger kids to talk to | 1.3 |
| 25. Empowerment | 1.7 |

From the list of 25 themes that emerged during the focus group, the top eight themes are identified below in Table 2. Each of the top eight themes have average importance scores equal to or less than 1.5, which is consistent for themes that are considered “among the most important.”

Table 2

| Top Focus Group Responses, In Order of Average Importance | |
|---|---|
| Theme | Average Importance (1 = among the most important, 4 = not as important) |
| Feeling worthless | 1.2 |
| Trauma | 1.2 |
| Fear of not being taken seriously | 1.3 |
| Someone for younger kids to talk to | 1.3 |
| Substance use | 1.4 |
| Peer | 1.5 |
| Self-Worth | 1.5 |
| Pressure to be fine | 1.5 |

Appendix Four: Mental and Behavioral Health Roadmap and Toolkit for Schools

— ABRIDGED SUMMARY —

MENTAL AND BEHAVIORAL HEALTH ROADMAP AND TOOLKIT FOR SCHOOLS

— NOVEMBER 1, 2018 —



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Executive Summary

The purpose of the *Mental and Behavioral Health Roadmap and Toolkit for Schools* is to provide Texas schools and school districts with information on research-driven, evidence-based practices and practical guidance to help school leaders, teachers, and staff more effectively assess and address student mental and behavioral health needs to improve educational and life outcomes for students. The primary purpose of school is to help students learn, and academic goals are more difficult to achieve when the mental and behavioral health needs of students and staff are not addressed. A well designed, proactive, and responsive effort to create a positive school climate can have a positive impact on school safety and school performance, including grade completion, attendance, and academic achievement.

Mental health challenges are common in children and youth. An estimated one in five children and youth under the age of 18 will experience a diagnosable mental health disorder during any given year. Of those who experience a diagnosable mental health disorder in their lifetime, about half experience the onset of the disorder by age 14 and three-quarters by young adulthood. In 2017, about 31.5% of surveyed high school-aged youth reported that they felt sad or hopeless almost daily for two or more weeks within the past year, and 17.2% seriously considered attempting suicide. The vast majority of children and youth with mental health disorders do not receive treatment, and those that do receive care do not receive it in a timely way (the delay from symptom onset to treatment averages eight years).

Untreated child and youth mental health conditions are linked to higher rates of school absence and reduced rates of timely grade completion and graduation. Untreated mental health symptoms also have a negative effect after leaving school on employment, marital stability, and other factors related to being a productive member of society. Students with unaddressed mental and behavioral health symptoms can also disrupt the learning environment for other students.

Creating a positive school climate and providing resources in schools to identify students with mental and behavioral health challenges and connect them to effective treatment has broad implications for schools, school districts, and communities. While schools are not health care providers, they are well positioned to prevent or minimize the occurrence of many mental health challenges by identifying and helping support those in need with both access to medical services and needed educational supports. In some cases, schools may also serve as a venue for providing health services, including mental health care, and they can also be the key to effective need identification, referral, and linkage to services provided in the community.

A Multi-tiered System of Supports and Interconnected Systems Framework

The framework of Multi-tiered System of Support (MTSS) provides an over-arching framework for organizing plans to address student needs broadly through early identification and intervention. It is also the optimal approach for organizing efforts to meet mental and behavioral health needs. MTSS takes into account that districts, schools, and students have different needs and resources, and helps schools to identify and address the unique needs of students through the resources of local communities. MTSS builds on frameworks already widely used for decades in school settings, bringing together Response to Intervention (RtI) and Positive Behavioral Interventions and Supports (PBIS) frameworks to organize the full array of mental and behavioral health (M/BH) supports in the service of academic performance.

The model supports the development of prevention efforts for all students, as well as more targeted interventions for students with greater needs affecting academic performance. The MTSS framework includes universal mental health promotion strategies for all students (Tier 1), targeted services and supports for the subset of students currently experiencing a M/BH challenge or identified as being at risk for a M/BH concern (Tier 2), and specialized and individualized services for the relatively small number of students with more complex M/BH needs that Tier 1 or Tier 2 programs cannot adequately meet (Tier 3).

Tier 1 interventions, also referred to as universal supports and interventions, are provided to all students in a school and are intended to be the core curriculum for all students. These supports prevent some challenging behaviors while teaching the social and emotional skills that students need to succeed in school. Tier 1 interventions meet the needs of about 80% of students. Approximately 10% to 20% of students also need **Tier 2 interventions**, also known as targeted supports and interventions. Students who display mild to moderate M/BH needs continue to receive Tier 1 interventions along with Tier 2 targeted interventions, such as evidence-based individual or group supports to provide the support these students need to keep them from having more serious academic and behavioral difficulties. Students who do not respond to Tier 2 are provided Intensive supports and interventions (**Tier 3 interventions**) in addition to universal and targeted supports. These individualized supports generally need to be provided to about 3% to 5% of the student population with more complex M/BH needs. Student supports should move up or down among the tiers, depending on the student's needs, development, and circumstances over time.

The specific interventions offered through an MTSS framework vary across districts and schools because they are determined by the needs, resources, and priorities identified in each district, as well as on each campus. Local variability in interventions, however, are organized by the the MTSS framework's foundational elements, that include: strong and engaged leadership; evidence-based practice implementation; data-driven problem solving and decision making;

and student, family, and community involvement.

MTSS effectiveness is further optimized when implemented in the context of the Interconnected System Framework (ISF), which applies implementation science to embed the resources of the MTSS framework within a cross-system collaboration between school professionals and community mental health providers, with the goal of providing students with access to more services and supports. The main components of ISF include: (1) teams of mental health providers, youth, and families; (2) data-based decision making; (3) processes for selecting and implementing evidence-based practices; (4) prompt access to supports after screening; (5) fidelity monitoring; and (6) ongoing system- and practice-level training and coaching to support practice effectiveness.

The ISF expands the MTSS framework by providing a structure and process for education and community mental health systems to interact in an efficient and effective way to improve educational and life outcomes for students. ISF enhances the MTSS framework by including community providers in both leadership and operational levels, including system leadership teams, data-based decision making, selection and implementation of appropriate EBPs, progress monitoring, and ongoing training and coaching. ISF ideally helps incorporate mental health expertise at all tiers of the MTSS framework. The mental and behavioral health of students is shared by all, and everyone is expected to contribute to an integrated plan.

Schools and school districts can maximize the effectiveness and efficiency of M/BH services provided on campus and facilitate referrals and linkages to the full array of health care services provided in their community. They can also use frameworks such as MTSS and ISF as a guide for assessing needs, identifying resources, and selecting evidence-based interventions to meet student needs and improve academic performance.

| Multi-Tiered System Frameworks | |
|---|--|
| Approach | Description |
| Response to Intervention (RtI) | RtI is a multi-level prevention framework intended to increase student achievement and reduce problem behaviors. Assessment and intervention are integrated within the framework. Data gathered through assessments are used to identify students at risk of learning and behavior problems, monitor outcomes, determine the needed intervention, and adjust the intervention. |
| Positive Behavioral Support and Interventions (PBIS) | PBIS is a M/BH-focused framework for helping school staff select, adopt, and organize evidence-based interventions to enhance the social, emotional, behavioral and academic outcomes for students. |

| Multi-Tiered System Frameworks | |
|---|---|
| Approach | Description |
| Multi-tier System of Supports (MTSS) | MTSS is a broader framework for delivering practices and systems for enhancing student academic and behavioral outcomes through a three tier system of M/BH and other academic supports. |
| Interconnected Systems Framework (ISF) | ISF brings together RtI, PBIS, and MTSS in a community-based, collaborative framework that enhances all approaches, extends the array of mental health supports for students and families. It provides an over-arching framework for implementing evidence-based interventions through collaboration between schools and community providers. |

Introduction

Schools that have a system of mental health services and supports in place can help identify and address the mental health concerns of students and staff promptly, before they intensify and result in decreased academic performance and success and increased absenteeism and disciplinary issues. Schools with formal mental health protocols in place can quickly and proactively respond to student, staff, and faculty mental health needs following disasters like Hurricane Harvey or a tragedy like the Santa Fe High School shootings. In the May 2018 *School and Firearm Safety Action Plan*, Governor Greg Abbott's response to the Santa Fe High School shootings, the Governor emphasizes that effectively identifying and treating children with mental health issues can help prevent the loss of critical developmental, academic, and emotional maturity.¹ Our goal for this *Mental and Behavioral Health Roadmap and Toolkit for Schools* is to provide Texas schools and school districts with research, evidence-based practices, and information to help them effectively assess and address students' mental and behavioral health needs in order to improve educational and life outcomes for students.

Need and Benefits Associated with School-Linked Mental and Behavioral Health Strategies and Services

An estimated 95% of children between the ages of 7 and 17 years attend school.² School-aged children and youth spend a significant portion of their waking hours interacting with one another and with faculty and staff in the school setting. As a result, the overall experience a student has at school has significant bearing on their wellbeing, readiness to learn, and overall mental health.

Creating an environment that is conducive to learning and maximizes student potential requires efforts to recognize and take steps to meet the emotional needs of students and staff. The primary purpose of school is learning, and academic goals are difficult to achieve when the mental health needs of students and staff are not addressed. A well designed, proactive, and responsive effort to create a positive school climate can have a positive impact on school safety, grade completion, attendance, sense of community and connectedness, and academic achievement.

However, a proactive and prevention-oriented school climate alone cannot meet the needs of every student. Individual mental health challenges are common in children and youth. An

¹ Office of the Texas Governor. (2018, May 30). *School and firearm safety action plan*. Retrieved from https://gov.texas.gov/uploads/files/press/School_Safety_Action_Plan_05302018.pdf

² National Center for Education Statistics. (n.d.). Table 103.20. Percentage of the population 3 to 34 years old enrolled in school, by age group: Selected years, 1940 through 2015. Digest of Education Statistics. Retrieved from https://nces.ed.gov/programs/digest/d16/tables/dt16_103.20.asp

estimated one in five children and youth under age 18 will experience a diagnosable mental health disorder over the course of any given year. Of those who experience a diagnosable mental health disorder in their lifetime, about half experience onset by age 14.³ In 2017, about 31.5% of surveyed high school age youth reported that they felt sad or hopeless almost daily, and 17.2% seriously considered attempting suicide.⁴

Despite the relative frequency of mental health concerns among school-age children and youth, the vast majority do not receive treatment, and those that do receive care do not receive it in a timely way. A recent joint position paper by the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry reported that only 20–25% of children and youth in the United States that suffer from a diagnosable mental disorder receive treatment, and the average delay between symptom emergence and treatment for those who do is eight years.⁵ However, school settings are one of the most likely places for treatment to occur. While most children and youth receive mental health services in primary care settings, almost as many youth between the ages of 12 and 17 received mental health services in school as those who received the services in a specialty behavioral health setting.⁶

Many students may experience increased risk factors for mental illness. For example, students who experience ongoing poverty are at heightened risk of experiencing chronic stress and trauma. These experiences affect academic performance, decision-making, and health outcomes. Additional increased risk factors include involvement in the foster care system, homelessness, and juvenile justice involvement. Children and youth of military families are also at somewhat elevated risk.

Untreated child and youth mental health conditions are linked to higher rates of school absence and reduced rates of timely course completion and graduation.⁷ Untreated mental health

³ Kessler, R. C., Berglund, P., Demler, O., Jin, R., Merikangas, K. R., & Walters, E. E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of General Psychiatry*, 62(6), 593–602. <https://doi.org/10.1001/archpsyc.62.6.593>

⁴ Kann, L., McManus, T., Harris, W. A., et al. (2018, June 15). Youth risk behavior surveillance – United States, 2017. *Morbidity and Mortality Weekly Surveillance Summaries*, 67(8). Retrieved from: <https://www.cdc.gov/healthyyouth/data/yrbs/pdf/2017/ss6708.pdf>

⁵ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry into the pediatric health home*. Retrieved on September 25, 2018, from https://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf

⁶ Center for Behavioral Health Statistics. (n.d.). Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health. Retrieved from <https://www.samhsa.gov/data/sites/default/files/NSDUH-FFR1-2016/NSDUH-FFR1-2016.htm#mhuse3>

⁷ Blackorby, J., & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In Office of Special Education, U.S. Department of Special Education, *Special education elementary*

symptoms also have a negative effect on employment, marital stability, and other factors that are relevant to one’s ability to be a productive member of society. Student mental and behavioral health concerns not only affect the student experiencing the concern, they also have an impact on the people that surround them. Students with unaddressed mental and behavioral health symptoms can also disrupt the learning environment for other students.⁸

For all of these reasons, creating a positive school climate and providing resources in schools to identify and connect students to mental and behavioral health treatment has broad implications for schools, school districts, and communities. While schools are not health care providers, schools are well positioned to prevent or minimize the occurrence of many mental health challenges, and identify and help support those in need. In many cases, schools serve as a venue for providing some mental health services; they can also be extremely effective at providing referrals and linkages to other services provided in the community.

School personnel are often the first to detect important changes in student behavior and able to recognize trends or shifts within the broader school culture. Because of their frequent interactions with and knowledge of students and their environment, school administrators and personnel provide a critical link for promoting mental health and well-being, identifying mental health concerns, and facilitating connection to important mental health services.

A thoughtfully designed and supported school mental and behavioral health strategy may include multiple benefits, including:

- Earlier intervention, resulting in a reduction of complicated symptoms and associated treatment costs;⁹
- The ability to overcome traditional barriers to care, including challenges with transportation, finding a qualified mental health provider, and adhering to appointment times;¹⁰
- Support for staff and teachers, which may reduce turnover and improve overall teaching quality;¹¹

longitudinal study. Menlo Park, CA: SRI International.

⁸ Gottfried, M. A., Egalite, A., & Kirksey, J. J. (2016). *Does the presence of a classmate with emotional/behavioral disabilities link to other students' absences in kindergarten?* Retrieved from <https://www.sciencedirect.com/science/article/pii/S0885200616300205?via=ihub>

⁹ Karoly, L. A., Kilburn, M. R., & Cannon, J. S. (2005). *Proven benefits of early childhood interventions*. Santa Monica, CA: RAND Corporation. Retrieved from https://www.rand.org/pubs/research_briefs/RB9145.html

¹⁰ Suldo, S. M., Gormley, M. J., DuPaul, G. J., & Anderson-Butcher, D. (2014). The impact of school mental health on student and school-level academic outcomes: Current status of the research and future directions. *School Mental Health, 6*(2), 84–8.

¹¹ Suldo, S. M., Gormley, M. J., DuPaul, G. J., & Anderson-Butcher, D. (2014).

- A reduction in negative student outcomes, including suspensions, expulsions, juvenile justice involvement, and institutionalization;¹² and
- Reduced classroom disruptions resulting from challenging student behaviors.¹³

Introduction to Multi-tiered System of Supports (MTSS) Framework and Interconnected Systems Framework (ISF)

Each school campus and district has distinctive mental and behavioral health needs that require tailored strategies to address them. An ideal range of school mental / behavioral health (M/BH)¹⁴ services and supports include M/BH promotion and prevention that reaches all students, combined with screening, assessment, and targeted and intensive interventions for those with more complex M/BH needs.¹⁵ This comprehensive approach is described as Multi-tiered System of Supports (MTSS). MTSS brings together the two long-established, research-supported school practices of Response to Intervention (RtI) and Positive Behavioral Interventions and Supports (PBIS), linking both the academic needs RtI aims to address with the behavioral support identified within the PBIS framework. This Roadmap uses the MTSS framework to convey information because its multi-layered approach outlines a process for identifying and addressing specific M/BH related objectives.

| Multi-Tiered System Frameworks | |
|---------------------------------------|--|
| Approach | Description |
| Response to Intervention (RtI) | RtI is a framework within a multi-level prevention system, whose goal is to increase student achievement and reduce problem behaviors. Assessment and intervention are integrated into the framework. Data gathered through assessments are used to identify students at risk of learning and behavior problems, monitor outcomes, determine the needed intervention, and adjust the intervention. ¹⁶ |

¹² Sander, M. A., Everts, J., & Johnson, J. (2011, January). Using data to inform program design and implementation and make the case for school mental health. *Advances in School Mental Health Promotion*, 4(4), 13–21.

¹³ Hussey, D.L., & Guo, S. (2003, November). Measuring behavior change in young children receiving intensive school - based mental health services. *Journal of Community Psychology*, 31(6), 629–639.

¹⁴ In this report, we refer to the range of mental health and substance use disorder needs of children and youth with the broad term “mental / behavioral health” so as to be inclusive of the full range of applicable health needs.

¹⁵ American Institutes for Research. (2017, September). *Mental health needs of children and youth: The benefits of having schools assess available programs and services*. Retrieved from <https://www.air.org/sites/default/files/downloads/report/Mental-Health-Needs-Assessment-Brief-September-2017.pdf>

¹⁶ National Center on Response to Intervention. (2010, April). *Essential components of RtI – a closer look at response to intervention*. Retrieved from https://rti4success.org/sites/default/files/rtiessentialcomponents_042710.pdf

| Multi-Tiered System Frameworks | |
|--|---|
| Approach | Description |
| Positive Behavioral Interventions & Supports (PBIS) | PBIS is a framework for helping school staff select, adopt, and organize evidence-based interventions to enhance the social, emotional, behavioral, and academic outcomes for students. ¹⁷ |
| Multi-Tier System of Supports (MTSS) | MTSS is a framework for delivering practices and systems for enhancing student academic and behavioral outcomes. ¹⁸ |

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

While ideal to do so, schools do not have to implement the full range of MTSS programming to have a profound impact on students. For example, research indicates that a sense of connectedness – meaning the belief that staff, faculty, and peers care about students – can have a significant benefit on student outlook and outcomes.¹⁹ For example, the implementation of a targeted Tier 1 intervention to foster relationships and sense of community may alone

¹⁷ OSEP Technical Assistance Center on Positive Behavioral Interventions and Supports. (2018). *PBIS frequently asked questions*. Retrieved from <https://www.pbis.org/school/swpbis-for-beginners/pbis-faqs>

¹⁸ U.S. Department of Education, Office of Special Education Programs, OSEP Technical Assistance Center (2015, October). *Positive Behavioral Interventions and Supports implementation blueprint: Part1 – foundational and supporting information*. Eugene, OR: University of Oregon. Retrieved from <https://www.pbis.org/blueprintguidestools/blueprint/implementation-blueprint>

¹⁹ Centers for Disease Control and Prevention. (2009, July). *Fostering school connectedness: Improving student health and academic achievement*. Retrieved from https://www.cdc.gov/healthyyouth/protective/pdf/connectedness_administrators.pdf

result in positive outcomes such as improved school attendance rates, reduced bullying, and increases in on-time grade level completion.

Layout of Mental and Behavioral Health Roadmap and Toolkit for Schools

This document is meant to serve as a resource for district and school leadership to partner with community providers to support students through a multi-tiered system of supports that links education and mental health. This resource is divided into two main sections:

1. The Roadmap provides an overview of definitions, research, evidence-based practices, and information needed to implement school-linked mental and behavioral health supports.
2. The Toolkit contains detailed and practical information to support the implementation of school-linked mental and behavioral health programming.

The *School-linked Mental and Behavioral Health Roadmap and Toolkit* includes a number of links to external websites. These external links are intended to be informational and do not represent an endorsement by MMHPI. For information about any of the initiatives we have listed, please contact the sponsoring organization directly.

Below please find the summarized contents of the Roadmap and Toolkit. The full resource including the sections below can be viewed on our [website](#)



Roadmap

How to Use this Roadmap

Education and Mental Health – Aligning the Frameworks

Issues Impacting Education and Mental Health

Implementation Science

Multi-tiered System of Supports Framework Overview

Universal Supports and Interventions (Tier 1)

Targeted Supports and Interventions (Tier 2)

Intensive Supports and Interventions (Tier 3)

Implementing MTSS: Considerations for District and School Leadership

Strengthening MTSS and School-based Mental Health Initiatives through Community Collaborative Frameworks



Toolkit

How to Use this Toolkit

Funding Opportunities

State Legislation

Trauma-Informed Care in Schools

Mental Health First Aid (MHFA) and Youth Mental Health First Aid (YMHFA)

Staff Self Care

Types of Mental Health Personnel and Providers in Schools

State and Community Providers, Coalitions, and Partnerships

Telemedicine and Telehealth

Stakeholder List

Appendix Five: 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 their “Crossing the Quality Chasm”⁶⁴ report, which became the first in a series of subsequent IOM publications that have helped shape understanding of the need for a fundamental shift in operational priorities and health care delivery organization commitment 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 9001:2008⁶⁵).

The “Quality Chasm” report and subsequent IOM reports built upon prior reports in the late 1990s demonstrating the serious quality gaps in the U.S. health care system, many associated with the shift in treatment to greater numbers of chronic illnesses (vs. acute illnesses), an important subset of which includes addictions, serious mental illnesses for adults, and serious emotional disturbances for children and youth. The series focuses on applying the broader framework of performance and quality improvement to the delivery of health care services. The 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 is clear and stark.

In 2006, the IOM focused its attention on mental health (MH) and substance use disorders (SUD),⁶⁶ 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 MH/SUD 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 conditions; for their

⁶⁴ Institute of Medicine. (2001). *Crossing the quality chasm: A new health system for the 21st Century*. Washington, DC: The National Academies Press.

⁶⁵ For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf

⁶⁶ Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: The National Academies Press.

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

The report notes that the challenges facing MH/SUD systems are in many ways more severe than those facing the broader health system due to “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.”⁶⁷ Nonetheless, the IOM recommended clearly that the advised shift from “command and control” models of quality assurance to customer-oriented quality improvement was not only necessary but possible within behavioral health systems, with similar capacity as in health care 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 series.⁶⁸ The report states the matter in the series’ 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.*

⁶⁷ Institute of Medicine. (2006). *Improving the quality of health care for mental and substance-use conditions*. Washington, DC: The National Academies Press.

⁶⁸ Institute of Medicine. (2012). *Best care at lower cost: The path to continuously learning health care in America*. Washington, DC: 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*
- *care delivered was care 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.*

Defining Best Practices

There are hundreds of evidence-based practices available for mental health (MH) and substance use disorder (SUD) treatment, and the most definitive listing of these practices is provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-based Programs and Practices (NREPP).⁶⁹ The NREPP includes MH and SUD treatment approaches ranging from prevention through treatment. While the NREPP is, in its own description, “not exhaustive,” it is the most complete source on evidence-based practices available. The NREPP refers to all practices in the registry as “evidence-based,” using the following definition: “Approaches to prevention or treatment that are based in theory and have undergone scientific evaluation.” The NREPP then rates each program and practice on a multi-point scale across multiple domains to characterize the quality of the evidence underlying the intervention. Thus, many approaches formerly termed “promising” are now included in the NREPP, albeit with lower scores in some domains.

Successful best-practice promotion also requires understanding of the real-world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best-practice promotion effort. This process is sometimes called “using practice-based evidence” to inform implementation and is a core feature of continuous quality improvement. The reasons for stakeholder concerns at the “front line” implementation level are well documented and significant.⁷⁰ One major issue is that the

⁶⁹ The NREPP's searchable database can be found at: <http://www.nrepp.samhsa.gov/>

⁷⁰ Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. *Evidence-Based Mental Health, 8*, 60–62.

literature prioritizes randomized clinical trials (RCTs) that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This “efficacy-effectiveness gap” was clearly defined in the 1999 U.S. Surgeon General’s report on mental health services in America⁷¹ and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships. Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted 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.⁷² Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices – and one that is certainly highly relevant for a state as diverse as Texas – involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base regarding diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter daily. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across culture.⁷³ Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that best practices be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of

⁷¹ U.S. Surgeon General. (1999). *Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

⁷² 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.

⁷³ U.S. Surgeon General. (2001). *Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

major best practices.⁷⁴ There is also increasing recognition of best practices for refugee and immigrant communities.⁷⁵

It is also, therefore, critical to ground best-practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of ethnic minority groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)⁷⁶ were adopted in 2001 by the U.S. Department of Health and Human Services' (HHS) Office of Minority Health (OMH) with the goals of “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.” They include 14 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence. A range of standards for specific populations is also available,⁷⁷ but the CLAS standards are most widely recognized in the broader health field. In mental health, a set of SAMHSA standards for African-American, Asian-American / Pacific Islander, Hispanic / Latino, and Native-American / American-Indian groups is also available.⁷⁸ Guidance for multicultural applications is also available.⁷⁹

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

This section describes evidence-based practices (EBPs) at five levels: prevention approaches, integrated primary care, school-based mental health services, office and community-based interventions, and out-of-home treatment options. In addition, it attempts to differentiate approaches by age group, where applicable.

⁷⁴ See <http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx>

⁷⁵ American Psychological Association, Presidential Task Force on Immigration. (2012). *Crossroads: The psychology of immigration in the new century*. Retrieved from <http://www.apa.org/topics/immigration/immigration-report.pdf>

⁷⁶ U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (2001, March). *National Standards for Cultural and Linguistically Appropriate Services in Health Care*. Washington, DC: Author. Retrieved from <https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf>

⁷⁷ The New York City Department of Health and Mental Hygiene has compiled a helpful listing of various sources that are readily accessible: <http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-ccpriority-resources.pdf>

⁷⁸ USDHHS, Substance Abuse and Mental Health Services Administration. (2001). *Cultural competence standards in managed care mental health services: Four underserved/underrepresented racial/ethnic groups*. Rockville, MD: Author.

⁷⁹ See <http://www.cimh.org/Services/Multicultural.aspx> for the overall site and <http://www.cimh.org/Services/Multicultural/ACCP-Project.aspx> for specific best practices demonstrated in California.

Prevention

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

- **The Incredible Years:**⁸⁰ The Incredible Years program focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors in children, targeting infancy to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and teaching of social skills). This curriculum particularly targets risk factors for conduct disorder and promotes a positive environment for the child both in the home and at school.
- **Positive Parenting Program (Triple-P):**⁸¹ This program is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials to 8–10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theory, in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children’s behavioral issues.

Integrated Primary Care

Integrated-behavioral health programs provide the opportunities to improve outcomes and promote culture of medical care to include both physical and behavioral health in treatment approaches. Annual well-child care visits with primary care providers provide an opportunity for children and youth to access both physical and behavioral healthcare, especially within the comprehensive setting of integrated primary care settings. Collaborative care programs where primary care providers, care managers, and behavioral health specialists work as a team to provide patient care can have a positive impact. A 2015 meta-analysis in the *Journal of the American Medical Association (JAMA) Pediatrics* indicated that “the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care.”⁸²

⁸⁰ 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.

⁸¹ 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.

⁸²Asarnow, J. R., Rozenman, M., Jessica Wiblin, J., Zeltzer, L. (2015, October). Integrated medical-behavioral care compared with usual primary care for child and adolescent behavioral health: A meta-analysis. *JAMA Pediatrics*. 169(10): 929–937. Retrieved from <http://jamanetwork.com/journals/jamapediatrics/fullarticle/2422331>

A Meadows Mental Health Policy Institute 2016 report⁸³ proposes that integrated behavioral health programs should include the following seven core components:

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

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

Behavioral health integration in primary care settings increases behavioral health services for children and youth with mild to moderate conditions. About 75% of children and youth with psychiatric disorders could be seen in the pediatrician's office.⁸⁴ But these visitations generally have significant limitations. Pediatricians typically do not deliver mental health services due to limited time during each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.⁸⁵ 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.⁸⁶

⁸³ Meadows Mental Health Policy Institute (2016, June). *Best practices in integrated behavioral health: Identifying and implementing core components*. Retrieved from http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf

⁸⁴ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

⁸⁵ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatric_health_home_2012.pdf

⁸⁶ Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

Behavioral health integration in primary care settings also aligns with the concept of the “medical home.” The pediatric health home – sometimes called the “pediatric medical home” – refers, according to the American Academy of Pediatrics (AAP), to “delivery of advanced primary care with the goal of addressing and integrating high quality health promotion, acute care, and chronic condition management in a planned, coordinated, and family-centered manner.”⁸⁷

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.⁸⁸ These components include the following strategies:⁸⁹

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

Examples of integrated primary care models include the following:

- **The Massachusetts Child Psychiatry Access Project (MCPAP)** offers one promising approach to integrated care. Established in 2004, MCPAP is a national leader and model that has inspired many other states to create such programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each comprising a child-psychiatrist, a licensed

⁸⁷ American Academy of Pediatrics. (2017). Medical home. Retrieved from <https://www.aap.org/en-us/professional-resources/practice-transformation/medicalhome/Pages/home.aspx>

⁸⁸ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf

⁸⁹ American Academy of Child and Adolescent Psychiatry. (2012, June). *Best principles for integration of child psychiatry in the pediatric health home*. Retrieved from http://www.aacap.org/App_Themes/AACAP/docs/clinical_practice_center/systems_of_care/best_principles_for_integration_of_child_psychiatry_into_the_pediatic_health_home_2012.pdf

therapist, and a care coordinator. Each hub also operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers (PCP). In 2014, following a MCPAP consultation, primary care providers reported managing 67% of the types of problems that they typically would have referred to a child psychiatrist before they enrolled in the program. The MCPAP model was so instrumental in providing accessible behavioral health care for children and youth that the Massachusetts Child Psychiatry Access Project expanded to develop MCPAP for Moms. Created in 2014, MCPAP for Moms is a collaborative model that involves obstetricians, internists, family physicians, and psychiatrists. Its mission is to 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.⁹⁰

- **Seattle Children’s Partnership Access Line (PAL)** is another leading model of behavioral healthcare integration into primary care for children and youth. PAL is a telephone-based mental health consultation system that provides services to Washington and Wyoming. It is available to primary care physicians, nurse practitioners, and physician assistants. Users of this model obtain a child mental healthcare guide and advice from a child psychiatrist that includes a sample letter with a summary of the consult conversation. In addition, the PAL program includes a social worker who can provide a list of local resources tailored to an individual patient and his or her insurance. If a child needs to be evaluated in-person, PAL helps link families to providers in their respective communities. PAL can also assist with providing locations in which telemedicine appointment are available. The PAL team also provides educational presentations to primary care providers to increase their ability to manage behavioral health issues in the primary care setting. Primary care providers reported that in 87% of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements experienced a 132% increase in outpatient mental health visits after the consultation call. Primary care provider feedback surveys also reported “uniformly positive satisfaction” with PAL.⁹¹ In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State’s Medicaid program decreased by nearly half.⁹²

⁹⁰ Straus, J. H., & Sarvet, B. (2014, December). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. *Health Affairs*, 33(12), 2153–2161.

⁹¹ Hilt, R. J., Romaine, 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.

⁹² 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.

Bexar County Children and Youth Rapid Behavioral Health Assessment

- A promising approach in Texas is provided by Dallas Children's Health, formerly Children's Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, it began an integrated behavioral health program within its pediatric outpatient clinics. In July 2015, the Integrated Behavioral Health Care Management program was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. As of January 2017, the team comprised 10 licensed master's level behavioral health clinicians (LPCs, LCSWs, and LMFTs) and two clinical psychologists. The behavioral health team provides consultation and direct treatment to patients who obtain their care from primary care providers within these clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11. Implementation of these tools has contributed to studies that have shown excellent results, such as more than a 50% reduction in symptoms of depression. One strength of the program includes a shared electronic medical record system that offers both primary care and specialty behavioral health providers' access to a patient's records, enabling better care coordination. In addition, members of the behavioral health team are co-located with their primary care colleagues in the pediatric clinic setting, increasing accessibility to behavioral health care. The behavioral health team conducts educational presentations for primary care providers that include topics such as depression, attention-deficit hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case discussions and treatment planning. Using telemedicine for delivery of primary care services to children and youth in local schools also increases access.
- **The Rees-Jones Center for Foster Care Excellence**, located at Children's Health in Dallas is another best-practice program. The Rees-Jones Center for Foster Care Excellence is a specialized integrated health care model that addresses the needs of children and youth in foster care, who often need additional supports. A promising practice includes structured use of a team approach with a care team that comprises primary care and behavioral health providers as well as a nurse coordinator and a Child Protective Services (CPS) liaison. All members of the care team are co-located and fully collaborative; they provide evidence-based, trauma-informed primary care and therapeutic strategies. Center staff described the nurse coordinator and CPS liaison positions, specifically, as central and critical to the model. Other core integrated behavioral health components of the Center are the use of a shared electronic medical records system, which allows all team members to access a child or youth's record and document clinical observations and recommendations in one place; implementation of daily and weekly formal case discussions and treatment planning; and regular staff trainings.

School-Based Mental Health Services

Prevention efforts shift as children enter school (ages 6–12) to increase positive social interactions, decrease aggression and bullying, and increase academic motivation. The education and mental health systems in the United States have a long history of providing mental health services to children. With the passage of the Education of All Handicapped Children Act in 1975 (reauthorized in 1990 as the Individuals with Disabilities Act, or IDEA), education systems were given greater responsibility to meet the mental health needs of students with emotional disturbances.⁹³ Schools provide a natural setting for mental health services, including prevention.⁹⁴ In fact, studies show that, for many children, schools seem to be their primary mental health system (one finding showed that for children who receive any type of mental health service, over 70% receive the service from their school).⁹⁵ School-wide prevention and services that promote behavioral health reduce violence and create a positive school climate benefit all students.⁹⁶

School-based behavioral health and prevention are best implemented through a public health model approach.⁹⁷ The following model could provide a framework that spans the broad range of age groups and problems seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

- Implement school-wide prevention programs and acknowledge that this will require new roles for community workers and school staff.

⁹³ Pumariega, A. J., & Vance, H. R. (1999). School-based mental health services: The foundation for systems of care for children's mental health. *Psychology in the Schools*, 36, 371-378. Cited in Kutash, K., Duchnowski, A., & Lynn, N. (2006, April). *School-based mental health: An empirical guide for decision-makers*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies, Research and Training Center for Children's Mental Health.

⁹⁴ Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015). *Community-partnered school behavioral health: State of the field in Maryland*. Baltimore, MD: Center for School Mental Health. Retrieved from http://csmh.umaryland.edu/media/SOM/Microsites/CSMH/docs/Resources/Briefs/FINALCP.SBHReport3.5.15_2.pdf

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

⁹⁵ Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from <http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf>

⁹⁶ Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from <http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf>

⁹⁷ Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from <http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf>

- 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.⁹⁸ As such, several EBPs build on prevention efforts and provide diverse community-based approaches to addressing mental health needs within a school environment. These include the following:

- **Community-Partnered School Behavioral Health (CP-SBH)** is a framework for supporting student behavioral health along the full prevention-intervention continuum. It brings together community behavioral health providers with schools and families to augment existing school resources in order to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.⁹⁹ These partnerships allow schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge. Comprehensive service provision through CP-SBH can include selective prevention for students identified at risk for behavioral health problems and specialized intervention services such as clinical assessment and treatment. CP-SBH programs share several best-practice policies and procedures for program, including establishing and maintaining effective partnerships; integrating community-partnered school behavioral health into multi-tiered systems of support (universal prevention, targeted prevention, individualized intervention and supports, specialized support for substance use and abuse problems); and utilizing empirically supported treatments. In addition, CP-SBH programs also focus on facilitating family-school-community teaming; collecting, analyzing, and utilizing data; and obtaining, sustaining, and leveraging diverse funding streams.¹⁰⁰ Some of the advantages of this approach include improved access to behavioral health services, reducing the stigma of seeking services, being able to generalize treatment to the child's school environment, and having an impact on educational outcomes.
- School-wide initiatives such as **Positive Behavioral Interventions and Supports (PBIS)** have significantly decreased aggressive incidents among students and have increased

⁹⁸ Weist, M. D., & Murray, M. (2007). Advancing school mental health promotion globally. *Advances in School Mental Health Promotion, Inaugural Issue*, 2-12. doi: <http://dx.doi.org/10.1080/1754730X.2008.9715740>. Cited in Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. Retrieved from

<http://www.pbis.org/common/pbisresources/publications/Final-Monograph.pdf>

⁹⁹ 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.

¹⁰⁰ 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.

the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant – while making desired behavior more functional. PBIS has three primary features: 1) functional (behavioral) assessment, 2) comprehensive intervention, and 3) lifestyle enhancement.¹⁰¹ The value of school-wide PBIS integrated with mental health, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80%) of students fall into the first tier. For them, school-wide PBIS creates “a social environment that reinforces positive behavior and discourages unacceptable behaviors.”¹⁰² A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it “easier to identify students who require early intervention to keep problem behaviors from becoming habitual” and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family.

- **Multi-tiered System of Supports (MTSS)** is an approach based on a problem-solving model that documents students’ performance after changes to classroom instruction have been made as a way to show that additional interventions are needed. It ensures that instruction and interventions are matched to student needs. PBIS is consistent with the principles of MTSS, which include research-based instruction in general education, universal screening to identify additional needs, a team approach to the development and evaluation of alternative interventions, a multi-tiered application of evidence-based

¹⁰¹ Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. *Educational Psychologist*, 33, 135–152.

Horner, R.H., & Carr, E.G. (1997). Behavioral support for students with severe disabilities: Functional assessment and comprehensive intervention. *Journal of Special Education*, 31, 84–104.

Koegel, L.K., Koegel, R.L. & Dunlap, G. (Eds.). (1996). *Positive behavioral support: Including people with difficult behavior in the community*. Baltimore, MD: Paul H. Brookes.

Positive Behavior Interventions and Supports website: <http://www.pbis.org/main.htm>.

¹⁰² Bazelon Center. (2006). Way to go: School success for children with mental health care needs. Retrieved from http://bazelondev.org/wp-content/uploads/2017/01/Way_to_Go.pdf

instruction determined by identified need, and continuous monitoring of the intervention and parent involvement throughout the process.¹⁰³

- In Colorado, MTSS is a prevention-based framework for improving the outcomes of all students. It includes a multi-tiered system of supports. The essential components include team-driven shared leadership; data-based problem solving; partnerships with families, schools and communities; layered continuum of supports matched to the student’s need from universal to targeted, to intensive; and with instruction, assessment, and intervention that are evidence-based.¹⁰⁴
- In California, MTSS organizes its resources and initiatives to address all students’ needs. The framework organizes academic, behavioral, and social-emotional learning into an integrated system of supports for all students. It encompasses Response to Instruction and Intervention efforts and PBIS and aligns those supports to better serve each student.¹⁰⁵ The model integrates data collection and assessment to inform decisions.
- **The Interconnected Systems Framework (ISF)** brings together Positive Behavioral Interventions and Supports (PBIS) and school mental health services in a framework that enhances both approaches, extends the array of mental health supports for students and families, and meets the need for an over-arching framework for implementing evidence-based interventions through collaboration between schools and community providers.¹⁰⁶ ISF addresses limitations related to PBIS not having sufficient development in the areas of targeted prevention and specialized intervention for students with more complicated behavioral health concerns. As for school mental health services, ISF targets the lack of structure in the implementation of services (which contributes to high variability in services and school staff not being aware of these services), the poor use of data, and their general disconnection from targeted prevention and specialized intervention services.¹⁰⁷
- **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

¹⁰³ Positive Behavioral Interventions and Supports OSEP Technical Assistance Center. (n.d). Multi-tiered System of Supports (MTSS) & PBIS. Retrieved from <https://www.pbis.org/school/mtss>.

¹⁰⁴ Colorado Department of Education. (n.d.). Multi-tiered System of Supports (MTSS). Retrieved from <https://www.cde.state.co.us/mtss>

¹⁰⁵ California Department of Education. (n.d). Multi-tiered System of Supports (MTSS). Retrieved from <http://www.cde.ca.gov/ci/cr/ri/>

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

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

have harmed. Within schools, restorative justice programs use a similar process of holding students accountable for their behavior and providing them with opportunities for making amends and repairing relationships. The overall goals of this practice are to help decrease misbehavior among students and reduce rates of suspensions.¹⁰⁸

- One example of a model restorative justice program is Restorative Justice for Oakland Youth (RJOY), created in 2005 to support collaboration in developing restorative practices in schools, the juvenile justice system, and the greater Oakland community. RJOY engages families and communities to positively impact school discipline, racial disparities, and school climate in order to interrupt punitive school discipline and justice policies. This program provides education, training, and technical assistance and, since 2010, has focused on helping schools build capacity for their own restorative justice programs.¹⁰⁹ Outcomes for RJOY include the following:
 - During the 2010–11 and 2011–12 school years, 19 Oakland Unified School District schools that received RJOY training reduced the suspension rate of African-American boys by at least 20%.
 - According to state and local data, RJOY’s West Oakland Middle School pilot project eliminated expulsions and reduced suspensions by 87%.
 - At Ralph Bunche High School, student suspension rates fell by 74% and referrals for violence dropped by 77% from the 2010–11 school year to the 2012–13 school year.
 - In 2010, the Oakland Unified School District adopted restorative justice as a system-wide alternative to zero-tolerance practices, largely influenced by RJOY.¹¹⁰
- The Denver Public Schools Restorative Justice Project also serves as an example of effective implementation of restorative justice programming.¹¹¹ Recently, over 1,000 referrals were made for restorative justice services (unduplicated count of 812 students), with almost 180 of these cases being provided in lieu of suspension or for reduced out-of-school suspension as a result of the referral. Students, parents, and teachers all gave strong endorsement for the restorative justice process, noting its

¹⁰⁸ Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

¹⁰⁹ Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

¹¹⁰ Owen, J., Wettach, J., & Hoffman K.C. (2015). Instead of suspension: Alternative strategies for effective school discipline. Durham, NC: Duke Center for Child and Family Policy and Duke Law School. Retrieved from https://law.duke.edu/childedlaw/schooldiscipline/downloads/instead_of_suspension.pdf

¹¹¹ Baker, M.L. (2008). DPS restorative justice project executive summary. Denver, CO: Denver Public Schools.

fairness and helpfulness with resolving conflicts as well as its influence on students' improvements in listening skills, empathy, anger control, respect, and appropriate reparative action planning. All schools showed reductions in out-of-school suspensions and expulsions compared to the prior year's total.¹¹²

- **The Cognitive Behavioral Intervention for Trauma in Schools (CBITS)** program aims primarily at reducing symptoms of PTSD, depression, and behavioral problems for children and youth in grades 3 through 8. CBITS, which was first used in the 2000–2001 school year, adopts a school-based group and intervention focus. In addition to its goal of reducing some mental health symptoms, CBITS integrates cognitive and behavioral theories of adjustment – as well as cognitive-behavioral techniques such as relaxation, psychoeducation, and trauma narrative development – to improve peer and parent support and improve coping skills, especially among students exposed to significant trauma.¹¹³ Although primarily directed toward younger children, CBITS has been expanded to include high school students who have experienced notable trauma. Structurally, the program uses a mix of session formats, featuring group sessions, individual student sessions, parent psychoeducational sessions, and a teacher educational session. The program is administered by mental health clinicians and claims effectiveness with multicultural populations.¹¹⁴

Office, Home, and Community-Based Interventions

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

The development and dissemination of evidence-based psychosocial interventions for children and youth has rapidly developed in recent years. The ideal system would have treatment protocols offered in clinics, schools, or homes with the objectives of 1) decreasing problematic symptoms and behaviors, 2) increasing youth's and parents' skills and coping, and 3) preventing

¹¹² Baker, M.L. (2008). DPS restorative justice project executive summary. Denver, CO: Denver Public Schools.

¹¹³ NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Cognitive Behavioral Intervention for Trauma in Schools. Retrieved from <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=153>

¹¹⁴ Treatment and Services Adaption Center (n.d.). Cognitive Behavioral Intervention for Trauma in Schools. Retrieved from <https://traumaawareschools.org/cbits>

out-of-home placement. Core components of some of these interventions should also be used as part of an individualized treatment plan for a child of any age who is receiving intensive intervention in a day treatment program. The following examples of evidence-based and other best-practice treatments are offered as examples of the types of services needed in the ideal system and are not intended to be an exhaustive inventory of potential community-based interventions and EBPs.

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

- **Parent-Child Interaction Therapy (PCIT)** has strong support as an intervention for use with children ages' three to six who are experiencing oppositional disorders or other problems.¹¹⁵ PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. To improve the parent-child attachment through behavior management, the PCIT program integrates structural play and specific communication skills to teach parents and children constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their children direction towards positive behavior. A therapist guides parents through education and skill-building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native-American families.
- **Early Childhood Mental Health Consultation** in early childhood settings, such as child care centers, emphasizes problem solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.¹¹⁶ Early childhood mental health consultation aims to build the capacity

¹¹⁵ Chaffin, M., Silovsky, J., Funderburk, B., Valle, L., Brestan, E., Balachova, T., Jackson, S., Lensgraf, J., & Bonner, B. (2004). Parent-child interaction therapy with physically abusive parents: Efficacy for reducing future abuse reports. *Journal of Consulting and Clinical Psychology, 72*(3), 500–510.

Eyberg, S.M. (2003). Parent-child interaction therapy. In T.H. Ollendick & C.S. Schroeder (Eds.) *Encyclopedia of Clinical Child and Pediatric Psychology*. New York: Plenum.

Querido, J. G., Eyberg, S. M., & Boggs, S. (2001). Revisiting the accuracy hypothesis in families of conduct-disordered children. *Journal of Clinical Child Psychology, 20*, 253–261.

¹¹⁶ Brennan, E.M., Bradley, J. R., Allen, M. D., Perry, D. F., & Tsega, A. (2006, February). The evidence base for mental health consultation in early childhood settings: Research synthesis addressing staff and program outcomes. Presented at the 19th Annual Research Conference, A System of Care for Children's Mental Health, Tampa, FL. Child Health and Development Institute of Connecticut, Inc. (2005, April). Creating a statewide system of multi-disciplinary consultation for early care and education in Connecticut. Farmington, CT. Cohen, E. & Kaufmann, R. (2005). Early childhood mental health consultation. DHHS Pub. No. CMHS-SVP0151. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration. Retrieved from <http://store.samhsa.gov/shin/content/SVP05-0151/SVP05-0151.pdf>

(improve the ability) of staff, families, programs, and systems to prevent, identify, treat, and reduce the impact of mental health problems among children from birth to age six and their families. Two types of early childhood mental health consultation are generally discussed: program level and child/family level. The goals of program-level mental health consultation seek to improve a program's overall quality and address problems that affect more than one child, family, or staff member. Consultants may assist the setting in creating an overall approach to enhance the social and emotional development of all children. Child/family-centered consultation seeks to address a specific child's or family's difficulties in the setting. The consultant provides assistance to the staff in developing a plan to address the child's needs and may participate in observation, meet with the parents of the child, and, in some cases, refer the child and family for mental health services.

- **Theraplay** is a form of parent-child psychotherapy, used with both biological and foster families, which aims to create a “secure, attuned, joyful relationship between children and youth and their parents or primary caregivers.”¹¹⁷ It is used with children and youth from birth to age 18 years who are displaying behaviors such as withdrawal, non-compliance, trauma histories, attachment difficulties, and attention deficit and hyperactivity disorders. It can be used in a variety of settings with the goal of creating a connection between the child and a caregiver. Therapists guide caregivers through play and nurturing activities. Theraplay is delivered in 18 to 25 weekly sessions with quarterly follow-up sessions.
- **Applied Behavior Analysis (ABA)** has good support for the treatment of autism, particularly in young children.¹¹⁸ ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months. ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills

Gilliam, W. (2005, May). Pre-kindergarteners left behind: Expulsion rates in state pre-kindergarten programs. Foundation for Child Development Policy Brief Series No. 3. New York: Foundation for Child Development. Retrieved from <https://www.fcd-us.org/assets/2016/04/ExpulsionCompleteReport.pdf>

¹¹⁷ Substance Abuse and Mental Health Services Administration. (2016, December 27). Theraplay. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=156>.

¹¹⁸ Harris, S. L., & Delmolino, L. (2002). Applied behavior analysis: Its application in the treatment of autism and related disorders in young children. *Infants and Young Children*, 14(3):11–17.

Smith, T., Groen, A. D. & Wynn, J. W. (2000). Randomized trial of intensive early intervention for children with pervasive developmental disorder. *American Journal on Mental Retardation*, 105 (4), 269–285.

McConachie, H. & Diggl, T. (2006). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. *Journal of Evaluation in Clinical Practice*. (Early release).

Sallows, G. O. & Graupner, T. D. (2005). Intensive behavioral treatment for children with autism: Four-year outcome and predictors. *American Journal on Mental Retardation*, 110 (2), 417–438.

Eikeseth, S., Smith, T., Jahr, E., & Eldevik, E. (2002). Intensive behavioral treatment at school for 4- to 7-year-old children with autism: A 1-year comparison controlled study. *Behavior Modification*, 26 (1), 49–68.

Shook, G. L., & Neisworth, J. T. (2005). Ensuring appropriate qualifications for applied behavior analyst professionals: The behavior analyst certification board. *Exceptionality*, 13(1), 3–10.

through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20–40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.

- **Preschool Posttraumatic Stress Disorder Treatment** is an approach adapted from trauma-focused cognitive behavioral therapy (TF-CBT – see the next section) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.
- **Child Parent Relationship Therapy (CPRT)** aims to address behavioral, emotional, social, and attachment disorders through a play-based treatment program founded on the premise that a child’s well-being hinges on a secure parent-child relationship. As such, CPRT administration focuses on weekly, two-hour group sessions with five to eight (5 to 8) parents. These sessions include didactic, supervision, and group process components and work in two key stages. The first stage, which involves the first 3 of the program’s 10 group sessions, helps parents learn child-centered play therapy skills, concepts, and attitudes. The final 7 sessions invite parents to practice those skills with their children in a supervised environment. Trained mental health professionals also provide parents with feedback and guidance for these sessions.¹¹⁹ Although geared primarily for children ages 3–8, CPRT has expanded to include toddlers and pre-youth. Given that CPRT practice originates in the 1980s, the program has been the subject of significant evaluation and study with studies pointing to significant reduction in children’s behavioral problems and parental stress. Likewise, there is substantial evidence pointing to increased parental empathy.¹²⁰
- **Early Pathways** is a home-based, mental health services program designed with a specific interest in addressing the externalizing behaviors of young children living in poverty. The program comprises four core elements that aim at strengthening parent-child relationship (using, when possible, child-led play), helping parents maintain developmentally appropriate expectations for their children, helping parents and families use positive reinforcement to establish routines and strengthen child behavior,

¹¹⁹ NREPP SAMHSA’s National Registry of Evidence-Based Programs and Practices. (n.d.). Child Parent Relational Therapy. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=196>

¹²⁰ Center for Play Therapy (n.d.). CPRT overview. Retrieved from <http://cpt.unt.edu/cprt-certification/cprt-overview>

and decreasing challenging child behavior through limit-setting strategies.¹²¹ Program duration ranges from 8 to 10 sessions, with sessions designed to strengthen and reinforce the four core components. The initial session, for example, includes observed play sessions between parent and child, which are rated for the level and quality of parent-child interaction.¹²² Subsequent sessions include developing a treatment plan, establishing appropriate behavioral expectations, providing methods for positive reinforcement, and examining home routines. When appropriate or necessary, additional problem solving sessions may be added.¹²³

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

- **Behavior Therapy** has support for the treatment of attention and hyperactivity disorders, substance abuse, depression, and conduct problems. Typically, behavior therapy features behavior management techniques taught to teachers and parents to aid the child in replacing negative behaviors with more positive ones.¹²⁴
- **Brief Strategic Family Therapy (BSFT)** is a problem-focused, family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and youth 6 to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations.¹²⁵
- **Cognitive Behavior Therapy (CBT)** is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.¹²⁶ It is sometimes applied in group as well

¹²¹ Harris, S. E., Fox, R. A., & Love, J. R. (2015). Early pathways therapy for young children in poverty: A randomized controlled trial. *Counseling Outcome Research and Evaluation*, 6(1), 3–17.

¹²² NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Early pathways. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=36>

¹²³ NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Early pathways. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=36>

¹²⁴ Pelham, W. E., Wheeler, T., & Chronis, A. (1998). Empirically supported psychosocial treatments for ADHD. *Journal of Clinical Child Psychology*, 27, 190–205.

¹²⁵ Szapocznik J. & Williams R. A. (2000). Brief strategic family therapy: Twenty-five years of interplay among theory, research and practice in adolescent behavior problems and drug abuse. *Clinical Child and Family Psychology Review*, 3(2), 117–135.

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

¹²⁶ Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

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

as individual settings. “CBT” can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder. CBT can be used for anxious and avoidant disorders, depression, substance abuse, disruptive behavior, and ADHD. It can be used with family intervention. Specific pediatric examples include Coping Cat and the Friends Program. CBT works with individuals to understand their behaviors in the context of their environment, thoughts, and feelings. The premise is that people can change the way they feel or act despite the environmental context. CBT programs can include several components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** has strong support for efficacy with children and youth aged 3 to 18 years old and their parents.¹²⁷ It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem, and other symptoms related to traumatic experiences. TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as intrusive thoughts of the traumatic event, avoidance of reminders of the trauma, emotional numbing, excessive physical arousal/activity, irritability, and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including

¹²⁷ Cohen, J. A., & Mannarino, A. P. (1996). A treatment outcome study for sexually abused preschool children: Initial findings. *Journal of the American Academy of Child & Adolescent Psychiatry*, 35(1), 42–50.

King, N., Tonge, B., Mullen, P., Myerson, N., Heyne, D., Rollings, S., Martin, R., & Ollendick, T. (2000). Treating sexually abused children with posttraumatic stress symptoms: A randomized clinical trial. *Journal of the American Academy of Child & Adolescent Psychiatry*, 39(11), 1347–1355.

Mannarino, A. P., & Cohen, J. A. (1996). A follow-up study of factors that mediate the development of psychological symptomatology in sexually abused girls. *Child Maltreatment*, 1(3), 246–260.

Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trial. *Journal of the American Medical Association*, 290(5), 603–611.

substance use. TF-CBT has been adapted for Hispanic/Latino children and youth, and some of its assessment instruments are available in Spanish.¹²⁸

- **Modular Approach to Therapy for Children and Youth with Anxiety, Depression, Trauma, or Conduct Problems (MATCH-ADTC)** is a collection of therapeutic components for children and youth ages 8–13 years with anxiety, depression, trauma, or conduct problems. MATCH-ADTC was developed from a review of meta-analyses of evidence-based treatments and includes components of cognitive behavior therapy, parent training, coping skills, problem solving, and safety planning.¹²⁹ The modules provide a collection of treatment options that can be individualized depending on the child’s needs. The program also includes family involvement in developing treatment plan goals.
- **Problem-Solving Therapy (PST)** is a brief intervention for youth 13 and older who are experiencing depression and distress related to difficulties with problem-solving.¹³⁰ Through the model, patients learn to identify problems, utilize problem-solving skills, and manage their symptoms. The patient identifies a solution to his or her problem through the PST process, which includes seven stages. Clients learn to evaluate their solutions and outcomes and are guided to develop a relapse-prevention plan during the final sessions. The intervention is delivered in 4 to 12 sessions.
- **Trauma Affect Regulation: Guide for Education and Therapy (TARGET)** is an educational and psychotherapeutic intervention directed toward the prevention and treatment of various stressors and disorders, including traumatic stress disorders, addictive disorders, and adjustment disorders. TARGET aims towards providing youth with skills for processing and managing trauma, stress, and trauma-related reactions to these situations.¹³¹ TARGET includes three key components (education about the biological and behavioral aspects of SUDs and PTSD, guided processing and self-regulation skills, and development of an autobiographical narrative that comprises the relevant trauma or disorder).¹³² To address these components, the program employs a manualized protocol and brief, time-limited sessions, which can be administered through group or

¹²⁸ 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.

¹²⁹ NREPP SAMHSA’s National Registry of Evidence-Based Programs and Practices. (n.d.). Modular Approach to Therapy for Children with Anxiety, Depression, Trauma, or Conduct Problems. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=64>

¹³⁰ NREPP SAMHSA’s National Registry of Evidence-Based Programs and Practices. (n.d.). Problem Solving Therapy. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=108>

¹³¹ National Institute of Justice. (2011). Program profile: Trauma Affect Regulation: Guide for Education and Therapy. Retrieved from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=145>

¹³² National Institute of Justice. (2011). Program profile: Trauma Affect Regulation: Guide for Education and Therapy. Retrieved from <https://www.crimesolutions.gov/ProgramDetails.aspx?ID=145>

individual psychotherapy in diverse settings.¹³³ As such, the length that any individual adolescent may be in the program may range from six months to multiple years.

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

- **Wraparound Service Coordination** (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth involved with multiple systems and at the highest risk for out-of-home placement.¹³⁴ 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 youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members; these are joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound

¹³³ NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). Trauma Affect Regulation: Guide for Education and Treatment. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=1222>

¹³⁴ Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group. (2004). *Ten principles of the wraparound process*. Portland, OR: National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University.

Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). *The comparative costs and benefits of programs to reduce crime*. Olympia: Washington State Institute for Public Policy.

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.

process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family.¹³⁵

- **Dialectical Behavior Therapy (DBT) Approaches for Youth** is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives.¹³⁶ DBT for youth often includes parents or other caregivers in the skills-training group. This inclusion allows parents and caregivers to both coach youth in skills and improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions: help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.
- **Functional Family Therapy (FFT)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at-risk youth and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.¹³⁷ FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities and aims for obtainable

¹³⁵ 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)

¹³⁶ Miller, A. L., Wyman, S. E., Huppert, J. D., Glassman, S. L., & Rathus, J. H. (2000). Analysis of behavioral skills utilized by suicidal youth receiving DBT. *Cognitive & Behavioral Practice, 7*, 183–187.

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

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

¹³⁷ Alexander, J., Barton, C., Gordon, D., Grotpetter, J., Hansson, K., Harrison, R., et al. (1998). *Blueprints for violence prevention series, book three: Functional family therapy (FFT)*. Boulder, CO: Center for the Study and Prevention of Violence.

change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.¹³⁸

- **Multidimensional Family Therapy (MDFT)** is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African-American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban, and rural settings.¹³⁹ Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including adolescent and parents individually, family as an interacting system, and individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.
- **Multisystemic Therapy (MST)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency.¹⁴⁰ In addition, the developers are currently working to form specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive, home-based service model provided to families in their natural environment at times convenient to the family. MST has low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring

¹³⁸ 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.

¹³⁹ Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. *Psychiatric Services*, 52, 1179–89.

Hogue, A. T., Liddle, H.A., Becker, D., & Johnson-Leckrone, J. (2002). Family-based prevention counseling for high-risk young youth: Immediate outcomes. *Journal of Community Psychology*, 30(1), 1–22.

Liddle H. A., Dakof, G. A., Parker K., Diamond G. S., Barrett K., Tejada, 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.

¹⁴⁰ 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.

Schoenwald S. K., Henggeler S. W., Pickrel S. G., & Cunningham, P. B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), *Model programs in child and family mental health*, (pp. 317–332). Mahwah, NJ: Lawrence.

context and was developed to address major limitations in serving juvenile offenders, focusing on changing the determinants of youth anti-social behavior.¹⁴¹ At its core, MST assumes that problems are multi-determined and that, to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children and youth, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and a reduction in association with "deviant" peers, primarily through parental mediation.¹⁴² **MST-Psychiatric (MST-P)** is an approach similar to MST but adapted for teens with serious emotional disorders.

- **Coordinated Specialty Care (CSC)** for first-episode psychosis (FEP) is delivered by a multi-disciplinary team of mental health professionals, including psychiatrists, therapists and substance use disorder counselors, employment specialists, and peer specialists. Early detection is important, as people with psychoses typically do not receive care and treatment until five years after first onset.¹⁴³ Community education activities and the development of strategic partnerships with key entities in the community is critical, and the team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person and it actively engages the family in supporting recovery from early psychosis. Effective treatments, such as medication management, individual therapy, and illnesses management are provided, as well as other less common evidence-based approaches that are known to help people with serious mental illnesses retain or recover a meaningful life in the community, such as Supported Education and Supported Employment. The ultimate goal of CSC is to provide effective treatment and support as early in the illness process as possible so that people can remain on a healthy developmental path. In Kane and colleagues report on the multi-site RAISE study (conducted across 34 clinics in 21 states) in the *American Journal of Psychiatry* in 2016, the authors noted that, especially when receiving CSC within the first 17 months of psychosis onset, participants had better quality of life and were more involved in work and school.¹⁴⁴ CSC was better than care-as-usual at helping people remain on a normal

¹⁴¹ 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.

¹⁴² 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.

¹⁴³ 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.

¹⁴⁴ 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.

developmental path. Researchers have also examined the costs of CSC versus care-as-usual and found that CSC was less expensive per unit of improvement in quality of life.¹⁴⁵ According to the CSC model on which the two RAISE programs are based,¹⁴⁶ teams should, at a minimum, consist of the following:¹⁴⁷

- A team leader or coordinator (PhD or master’s degree), who is responsible for the client’s overall treatment plan and programming as well as the team’s coordination and functioning;
 - A psychiatrist¹⁴⁸ 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.¹⁴⁹ This position should be filled by a person who has experienced serious mental illness and has been able to recover from it or to develop a productive and satisfying life while continuing to receive treatment.
- **Assertive Community Treatment (ACT) for Transition-Age Youth** uses a recovery/resilience orientation that offers community-based, intensive case management, and skills building in various life domains. It also includes medication management and substance abuse services for youth ages 18–21 with severe and

¹⁴⁵ Rosenheck, R., et al. (2016). Cost-effectiveness of comprehensive, integrated care for first episode psychosis in the NIMH RAISE early treatment program. *Schizophrenia Bulletin* (Advance Access, doi: 10.1093/schbul/sbv224)

¹⁴⁶ McNamara, K. et al. (n.d.) *Coordinated specialty care for first episode psychosis, manual I: Outreach and treatment*. Rockville, MD: National Institute of Mental Health. Retrieved on July 30, 2016 from http://www.nimh.nih.gov/health/topics/schizophrenia/raise/csc-for-fep-manual-i-outreach-and-referral_147094.pdf

¹⁴⁷ 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.

¹⁴⁸ Some programs might choose to utilize advanced psychiatric nurse practitioners, but the UTSW Psychosis Center plans to employ psychiatrists in this important role.

¹⁴⁹ Dr. Nev Jones (personal communication, July 6, 2016). For a comprehensive explication of the role of peers in FEP Care programs, see: Jones, N. (2015, September). *Peer involvement and leadership in early intervention in psychosis services: From planning to peer support and evaluation*. Rockville, MD: SAMHSA/CMHS. DOI: 10.13140/RG.2.1.4898.3762

persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. Most ACT services are delivered to the consumer within his or her home and community rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).^{150, 151}

- **The Intensive In-Home and Child and Adolescent Psychiatric Services (IICAPS)** model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or at risk of requiring out-of-home care due to psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide 24-hour/seven-days-a-week emergency crisis response.
- **HOMEBUILDERS** is an intensive family preservation program designed for children and youth from birth to age 17 years, with an imminent risk of out-of-home placement or who are scheduled to reunify with families within a week.¹⁵² 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

¹⁵⁰ Allness, D. J., & Knoedler, W. H. (2003). *A manual for ACT start-up*. Arlington, VA: National Alliance for the Mentally Ill.

¹⁵¹ 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*.

¹⁵² Washington State Department of Social and Health Services. (n.d.). Homebuilders intensive family preservation. Retrieved from <https://www.dshs.wa.gov/node/3303>

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.¹⁵³ HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service, on a flexible schedule.¹⁵⁴

- **Partners with Families & Children: Spokane** (Partners) is a service that relies on referrals from child welfare, law enforcement, or other public health agencies. As such, Partners' main goal is to assist children, youth, and their families in situations of persistent child neglect or those in which briefer interventions are unlikely to be effective.¹⁵⁵ The program is a community-based, family treatment program based on wraparound principles and focused on enhancing parent-child relationships while providing case management, substance abuse and mental health services, parenting resources, and an individualized family care team. These components aim to better assist the whole family in the cessation or prevention of neglect and maltreatment, working toward recovery through the combined efforts of an assigned Family Team Coordinator, a core team (which involves partnerships in community organizations such as schools and Head Start programs), and family team meetings.¹⁵⁶ The Partners approach, then, is designed to emphasize parents at the center of a teamwork-driven mechanism that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.¹⁵⁷

The Crisis Continuum and Out-of-Home Treatment Options

Treatment of children and youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states, "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children and youth with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection, and benefits of residential treatment. However, none of these justifications

¹⁵³ Institute of Family Development. (n.d.). Programs: Homebuilders – IFPS. Retrieved from http://www.institutefamily.org/programs_ifps.asp

¹⁵⁴ NREPP SAMHSA's National Registry of Evidence-Based Programs and Practices. (n.d.). HOMEBUILDERS. Retrieved from <http://legacy.nreppadmin.net/ViewIntervention.aspx?id=277>

¹⁵⁵ Substance Abuse and Mental Health Services Administration. (2016, July 8). Partners with Families & Children: Spokane. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=114>

¹⁵⁶ Clearinghouse for Military Family Readiness. (n.d.). Partners with Families and Children: Spokane. Retrieved from <http://www.militaryfamilies.psu.edu/programs/partners-families-and-children-spokane>

¹⁵⁷ Substance Abuse and Mental Health Services Administration. (2016, July 8). Partners with Families & Children: Spokane. Retrieved from <http://nrepp.samhsa.gov/ProgramProfile.aspx?id=114>

have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence.”

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors are not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors (e.g., fire setting) that may not respond to intensive, nonresidential service approaches.¹⁵⁸ Yet, on a national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

Nevertheless, youth do sometimes need to be placed outside of their homes for their own safety or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the situation is temporary, due to a crisis, or for longer term care, the ideal service system should include an array of safe places for children and youth as supported by the following approaches:

- **A family-driven, youth-guided, community-based plan** should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.
- **A full continuum of crisis response**, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial, and behavioral health interventions for youth and their families should include the following:
 - A mobile crisis team for children, youth, and families that has the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports (for a national example, see Wraparound Milwaukee’s Mobile Urgent Treatment Team/MUTT);¹⁵⁹
 - Screening, assessment, triage, ongoing consultation, time-limited follow-up care, and linkages to transportation resources, supported by protocols and electronic

¹⁵⁸ Stroul, B. (2007). Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

¹⁵⁹ For more information, see <http://wraparoundmke.com/programs/mutt/>.

- systems to communicate results across professionals and systems to determine the appropriate level of services;
- Coordination with emergency medical services;
 - Crisis telehealth and phone supports; and
 - An array of crisis placements tailored to the needs and resources of the local system of care, including an array of options such as:
 - In-home respite options;
 - Crisis foster care (placements ranging from a few days up to 30 days),
 - Crisis respite (one to 14 days), and
 - Crisis stabilization (15 to 90 days) with capacity for 1:1 supervision;
 - Acute inpatient care; and
 - Linkages to a full continuum of empirically supported practices.
- **A residential continuum of placement types**, grounded in continued connections and accountability to the home community, is needed. This continuum should offer a focus on specialized programming, including specialized residential programming for youth with gender-identity issues and for gender-responsive services (those intentionally, not superficially, serving female youth and that include a continuum of out-of-home treatment options for young women with behavioral health needs, including histories of sexual maltreatment). It should also provide residential placement options that vary by intensity of service provided, primary clinical needs addressed, and targeted length of stay, emphasizing acute-oriented programs to serve as an inpatient alternative in which children and youth can have behaviors that require longer than a typical acute inpatient stay to be stabilized, complex needs evaluated, and treatment begun while transition planning back to a more natural environment takes place.
 - **Treatment foster care** is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African-American, and American-Indian youth and families.¹⁶⁰ There is an emphasis on teaching interpersonal skills and on

¹⁶⁰ Chamberlain P, Reid J. B. (1991). Using a specialized foster care community treatment model for children and youth leaving the state mental hospital. *Journal of Community Psychology*, 19, 266–276.

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

Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). *Evidence-based psychotherapies for children and youth*. New York: Guilford Press.

participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents want, but typically last about one year.

- **Keeping Foster and Kin Parents Supported and Trained (KEEP)** was developed by the developers of the TFCO model. KEEP is a skills development program for foster parents and kinship parents of children ages 0 to 5 years and youth (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to 7 to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of parents and children.¹⁶¹ The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.¹⁶² Child care and snacks are provided as part of the sessions. A small study of the program funded by the U.S. Department of Health and Human Services Children’s Bureau showed fewer placement breakdowns, fewer behavioral and emotional problems, and greater prevention of foster parents dropping out from providing care.¹⁶³ A larger randomized study in San Diego showed that biological or adoptive parents who participated in the KEEP program were reunified with their children more frequently. The study also showed fewer placement disruptions from foster placements. KEEP has been implemented in Oregon, Washington, California, Maryland, New York City, four regions in Tennessee, and in Sweden and Great Britain.

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

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

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.

¹⁶¹ Oregon Social Learning Center. (n.d.). KEEP Based on Research Conducted at OSLC. Retrieved from <http://www.oslc.org/projects/keep/>

¹⁶² Child Trends. (n.d.). Keep Program. Retrieved from <https://www.childtrends.org/programs/keep-program/>

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