El Paso Behavioral Health Assessment

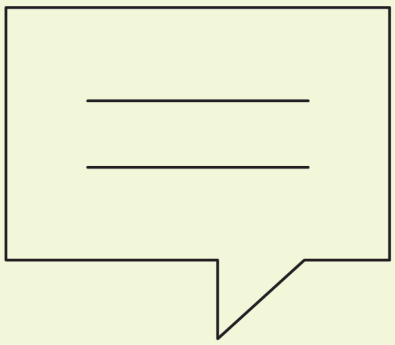
FINAL REPORT APRIL 2021

MEADOWS
MENTAL HEALTH
POLICY INSTITUTE

Contents

Acknowledgements

The Meadows Mental Health Policy Institute is grateful to the Paso del Norte Health Foundation for its financial support of this work. We are especially grateful to the members of the System Assessment Implementation Group, who gave their time and expertise throughout the duration of this engagement. We are also grateful to the more than 100 people we interviewed either individually or in groups who helped inform our findings and recommendations.



Executive Summary

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In May 2020, the Paso del Norte Health Foundation engaged the Meadows Mental Health Policy Institute (Meadows Institute) to assess the community's behavioral health system and evaluate the El Paso Behavioral Health Consortium project. The goal of this work was to inform the community's efforts to improve behavioral health services for its residents and to assess local capacity to meet the needs of residents with behavioral health conditions. We (the Meadows Institute) were asked to provide an update to the 2014 El Paso Community Behavioral Health System Assessment and to specifically address the following three domains:

- Overall access to behavioral health services,
- Strategy development for high-risk children and youth (not including the child welfare system), and
- Crisis system improvement analysis.

To conduct this assessment, we relied on extensive quantitative and qualitative data. In addition to the data analysis on prevalence and utilization described in this report (See Appendix Thirteen), we interviewed more than 100 community members. (See Appendix Three for a list of interviewees and Appendix Four for the interview questionnaire.) These included stakeholders from the criminal justice and health systems; mental health and substance use disorder providers; local independent school districts; philanthropic organizations; several divisions within the Texas Tech University Health Sciences Center El Paso and University of Texas at El Paso; people with lived experience of mental illness and substance use disorder; the court system; the juvenile justice system; specialty providers; and national, state, county, and city elected and appointed officials. In every case, we found people to be forthcoming about gaps and opportunities to improve behavioral health care in the El Paso community. As the full report details, we have constantly sought feedback and guidance throughout the assessment, primarily but not exclusively through meetings with the El Paso System Assessment Implementation Group. (See Appendix Two for a list of members.) That feedback has been enormously helpful.

In this Executive Summary, we highlight key findings and recommendations. We presented a summary of draft findings and recommendations to the El Paso System Assessment Implementation Group members on November 19, 2020, and formally submitted the summary on November 30, 2020. A draft report was submitted in December 2020. This final assessment integrates community feedback we have received to date.

Organization of the Report and Key Recommendations in Summary Form

This Executive Summary provides a succinct overview of our key findings and recommendations. We begin first by describing the guiding principles that inform our work and the attributes of the ideal behavioral health system.

Following the discussion of guiding principles, we describe the important contextual factors shaping the future of behavioral health care in the El Paso community as well as the progress achieved since the 2014 El Paso community behavioral health system assessment (2014 assessment) was conducted.[1] We then discuss data related to accessing services, followed by findings and recommendations for high-risk children and youth, crisis services, and adult intensive and special populations. Finally, we conclude with a section of findings and recommendations related to the El Paso Behavioral Health Consortium and a brief discussion on the existing capacity and future potential of community data sharing, for which we envision the El Paso Behavioral Health Consortium would play a significant role.

Guiding Principles and the Ideal Behavioral Health System

The guiding principle for our work in the El Paso community and throughout Texas is that the traditional approach of treating the mind and body separately has led to inadequate and often inappropriate care for people with mental illnesses and substance use disorders; an overuse of jails, emergency departments, and hospital beds; and treatment of adults with serious mental illnesses and children and youth with serious emotional disturbances that stands in sharp contrast to the integrated care provided to people with complex physical health needs. Care for mental illness and substance use disorder should be the same as care for physical illness unless clinical needs or public safety warrants a specialty approach, with integration of care the norm and not simply a goal.

There are several principles that flow from this guiding principle:

- Identification and treatment of mental illness and substance use disorder should occur at the earliest stage in the illness, just as with any other physical illness. Additionally, treatments should be provided, whenever possible, in the general health care system, from the initial response to a crisis using outpatient and inpatient care, with specialty care reserved for those whose needs cannot be addressed by the general health care system. In practice, this means that traditional reliance on law enforcement response to behavioral health crises should be shifted, to the degree possible, to the medically facing response used for all other health crises.

[1] TriWest Group. (2014, February). El Paso community behavioral health system assessment: Final summary of findings and recommendations. https://www.texasstateofmind.org/wp-content/uploads/2016/02/3-El-Paso-Community-Behavioral-Health-Assesssment-MMHPI.pdf

- It is particularly important to identify and provide treatment for children, youth, and families at the earliest possible point because untreated mental illnesses, emotional disturbances, and substance use disorders can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.
- Many people with diagnoses of mental illnesses and substance use disorders have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses such as depression or substance dependence that can compromise care. Given this, emergency assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and treat both physical and mental health conditions, including medically supervised detoxification and medication-assisted treatment needs. Cross-system efficiencies that target navigation and coordination of treatment need to incorporate trauma-informed responses, beginning in the least restrictive settings, and include capabilities to identify acute physical and behavioral health needs at each entry point. When more intensive treatment is necessary, coordination should be person-centered, with the transferring systems – not the person – assuming responsibility for communicating details about the crisis and coordinating transitions between levels of care. Lastly, communities should prioritize the expansion and evolution of existing intensive community-based services to reduce the need for hospitalizations, incarceration, and crisis services, with the ultimate goal of improving health, well-being, and quality of life for those in need.
- We use the term "behavioral health" to include mental illness and substance use disorders, both separately and as co-occurring health care needs. It is important that mental health and substance use disorder services are integrated into an ideal behavioral health system. Specific substance use disorders treatment protocols such as medically supervised detoxification and medication-assisted treatment need to be developed within the broader context of integrated physical and behavioral health care. Although this assessment did not include an in-depth analysis of service capacity, gaps, and needs for substance use disorder services, we did consider substance use disorder services as part of the overall El Paso County behavioral health care system. We provide prevalence data for substance use as a subset of mental health data, where appropriate.

No community in Texas or the nation has a system that seamlessly incorporates all of these principles. In many instances, behavioral health care delivery is fragmented and segregated from the health care system. Too often, the behavioral health system in the El Paso community, as in much of Texas, looks like the system depicted in the current behavioral health system diagram in the following figure, when it should look as much as possible like the system depicted in the second – and ideal – behavioral health system diagram.

Figure 1: The Current Behavioral Health Care System

Figure 2: The Ideal El Paso Behavioral Health Care System

With these principles and framework as a backdrop, our core findings and recommendations are informed by the following:

- First, there are important contextual factors that shape the environment in the El Paso community and have had significant impact on individual and community health. These contextual factors include the following:
  - Social determinants of health, the most significant of which is poverty;
  - The Walmart mass shooting tragedy, which stimulated a community response to behavioral health issues, has had a continuing traumatic impact on many individuals and the community as a whole;
  - The coronavirus disease 2019 (COVID-19) pandemic, which we predict will have long-lasting effects on behavioral health, with suicides and deaths from substance use expected to increase as a result of social isolation, unemployment, and related factors; and, simultaneously, the lasting impact of COVID-19 on the provider system such as the emergence of telehealth as a preferred treatment tool;
  - Political leadership (essential to any system transformation and a significant strength in the El Paso community), with local, state, and national leadership engaged to support in the behavioral health work in the community; and
  - The demographic and cultural make-up of the community, particularly El Paso County's largely Hispanic or Latino population, which have important ramifications for attitudes toward and access to treatment. These issues are discussed in detail in the section on access to services.
- Second, the El Paso community has made significant strides since the original El Paso community behavioral health system assessment in 2014. That assessment outlined 10 findings and recommendations for the community to work toward to improve its behavioral health system. We found positive achievement in each of the 10 areas. These include:
  - The creation of multiple collaborative leadership councils (in response to the recommendation that the community develop a data-driven, quality improvement-based system of care collaborative);
  - Increased focus and collaboration (in response to the recommendation to plan new efforts for earlier interventions for children);
  - An extensive and successful series of interventions and programs (in response to the recommendation to prioritize crisis response and early intervention, particularly with children);
  - The development of multiple, focused efforts to address negative perceptions, bias, and discrimination of persons with mental illness (in response to the recommendation to continue the community's stigma reduction efforts);
  - The success of the Paso del Norte health information exchange in developing multiple relationships to use integrated information for improved assessment and care (in

response to a recommendation to use data-driven, cross-agency projects to share data for individual and population health outcomes);
- Expansion of treatment options for veterans and greater awareness of issues associated with being a "tri-border" community (in response to a recommendation to develop cross-system opportunities for veterans and identify and resolve issues stemming from the county's "tri-border" location);
- Emergence Health Network's development of a walk-in crisis center (known as EHN's Crisis & Emergency Services) and extended observation unit (in response to a recommendation to create a full-service psychiatric emergency service);
- Expanded efforts to address children and youth in crisis and develop additional crisis and early response initiatives (in response to a recommendation to develop a crisis continuum for children, youth, and families within the broader crisis system);
- Adoption of a Crisis Intervention Team (in response to a recommendation to prioritize the development of a Crisis Intervention Team); and
- The use of an integrated care model in multiple clinics and sites across the community (in response to a recommendation to actively develop earlier access to behavioral health assessments and care in routine settings in which children receive care).

While there are still multiple ways the community can build on and extend these gains (and these are detailed in this report), the community leaders took the 2014 assessment to heart and have made significant advances in each of the areas identified for action in that assessment. It is also clear that community leaders have a deep commitment to continued development of a data-driven, integrated care system in which most behavioral health care for children and adults occurs in the primary care system. Because of this prior work, El Paso has a robust array of services, engaged leaders, and is well positioned to take concrete next steps to further support and expand its behavioral health services for residents.

Third, we have made numerous findings and recommendations for each of the three deliverables that were the substantive focus of this assessment: (1) overall access to and use of behavioral health services; (2) strategy development for high-risk children and youth; and (3) crisis system improvement analysis.

Access to and use of behavioral health services. In assessing access to services, we considered three primary issues:
- Prevalence,
- Demographic characteristics of the population, and
- Service capacity.

Our quantitative analyses of prevalence and service capacity can be found in full detail as Appendix Thirteen, *Quantitative Data Summary: El Paso County, Behavioral Health System*

Assessment – Updated Final Report, *April 2021 (Quantitative Data Summary)*. In the *Quantitative Data Summary*, we highlight several important facts:

- Of the 160,000 children and youth in El Paso County (ages 6–17), 90,000 (or 56%) live in poverty, an exacerbating factor for emotional disorders. Of the 60,000 children and youth with a mental health condition (Table 5), approximately 3,000 had a documented substance use disorder (Table 13 and Figure 11). We also estimated that at least 50,000 (or 83%) of those with a mental health condition have mild to moderate conditions that can be treated in primary care settings (Table 5).
- Of the 610,000 adults in El Paso County, 260,000 (or 43%) live in poverty. We estimated that 140,000 individuals have a mental health condition, 115,000 (or 82%) of whom can be treated in primary care (Table 5). We further estimated that approximately 40,000 adults have a substance use disorder, with 15,000 adults having a comorbid psychiatric and SUD condition (Table 7 and Figure 7).
- There are strategies outlined in the report such as the Child Psychiatry Access Network program, which can bring psychiatric consultation to primary care settings, facilitating the integration of care for those who do not require specialty care.
- We also documented the smaller subsets of people with specific diagnostic needs that may require specialized treatments (depression, posttraumatic stress disorder) and the smaller subsets of people with severe needs. Among the subgroups of children and youth with more intense needs, there are approximately 30 youth between the ages of 12 and 17 who first develop a psychosis each year and 800 at high risk of having to live out of home because of the severity of their needs, many of whom only access needed services when they become involved in the child welfare or juvenile justice system (Table 5). Among adults, there are an additional 80 adults who will first develop a psychosis each year and 500 more with very severe symptoms trapped in cycles of super-utilization and poverty that put them at very high risk for use of hospitals, emergency rooms, and the jail (Table 6).

The demographic make-up of the El Paso County community is also critical in considering access to care. Approximately 80% of the El Paso County adult population is Hispanic or Latino (the term we use for this population; see discussion in the report on terminology) and 87% of children and youth (age 6–17) in the county are Hispanic or Latino. Although the prevalence of mental illnesses, emotional disorders, and substance use disorders among Hispanic or Latinos is not significantly different from that of the population at large, some factors do manifest themselves differently in some respects and have an impact on attitudes toward and access to care. These include the following:

- Stigma, as noted above, has been a major focus of community leadership. In general, Hispanic or Latino populations have higher rates of perceived stigma and lower rates of behavioral health service use over time, which suggests that the continued focus on stigma in the El Paso community is particularly important.

- Hispanics or Latinos overall also have significantly higher uninsured rates (29%) compared to whites (13%) and are more likely to lack a "usual source of care" (a specific health provider where the person would ordinarily go to address illness).
- Medical mistrust because of historical discrimination may also play a role in the decisions of many Hispanics or Latinos regarding whether to use health care, even when it is available. This situation is made worse by an insufficient supply of Hispanic or Latino health providers overall and behavioral health providers in particular.
- Cultural and linguistic competence and the representation of providers in the workforce whose demographics match those of the broader community can play a role in decisions to seek health care as well, and the El Paso community has taken steps to attempt to address these issues that we document.
- Finally, all these issues are particularly complicated for undocumented immigrants who face additional barriers to care, including fear of deportation, separation from families, histories of trauma, and related issues if they seek essential health care.

Each of these issues individually can worsen access to services; however, in combination, they can result in significant numbers of people deciding to forego care that could improve their behavioral health, as well as the behavioral health status of the community. The El Paso community is uniquely situated to address many of these issues because of a willingness to acknowledge their importance and ongoing community efforts to intentionally address them.

In the section on access to and use of behavioral health services, we focus on two issues. The first is integrated care, an important strategy in implementing the El Paso community's commitment to intervening as early as possible in care settings best equipped to address physical and behavioral health needs together. As an example of best practices in the community, we applaud and urge the expansion of Project Vida's work. Project Vida is a federally qualified health center that has six clinics that are fully integrated with mental and behavioral health services and use state-of-the-art screening tools for depression, anxiety, and other disorders. The Child Psychiatry Access Network, created by the Texas Legislature, also provides a tool that can build on the El Paso community's foundation for providing integrated care to children. Additionally, University Medical Center has expanded its integrated care footprint by embedding Emergence Health Network behavioral health workers into four community primary care clinics. Finally, the creation of a Collaborative Care Model, a systematic and integrated approach to behavioral health care, will pay dividends and is discussed in detail in this report. This care model can help address access issues among the Hispanic or Latino population, which research suggests is more willing than other populations to consider primary care an appropriate setting for child behavioral health problems.

Finally, in considering access to services, we analyzed the use of emergency departments and inpatient hospitalization beds for psychiatric care. As noted, most of that data can be found in

our updated *Quantitative Data Summary* report in Appendix Thirteen. Two points are worth noting here. First, unlike many communities in which we have conducted assessments, there was not a clamor for "more beds" in El Paso. However, there are issues with bed access, for example, with COVID-19 related bed closures at El Paso Psychiatric Center. Among people who were hospitalized in a psychiatric bed after visiting an El Paso County emergency department, 70% were hospitalized locally. This might indicate a need for additional local capacity to meet local needs; however, a substantial portion of people admitted to inpatient psychiatric beds from El Paso emergency departments were not El Paso residents and may have sought care outside of El Paso for other reasons. With the 2019 opening of Rio Vista Behavioral Health, which provides inpatient psychiatric services, it is likely that El Paso County has sufficient local bed capacity to meet the demand for inpatient psychiatric care.

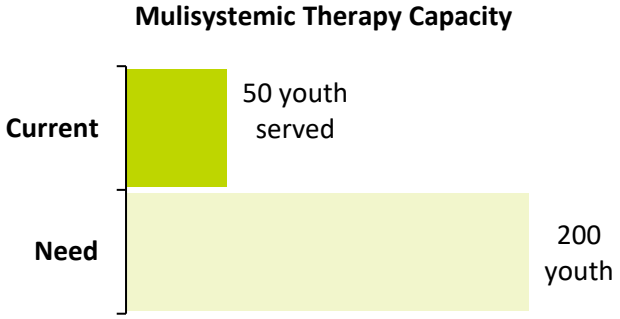
Behavioral health strategy development for high-risk children and youth. Our assessment focused specifically on high-risk children and youth in school and juvenile justice settings; we defined high-risk children and youth as those with intensive mental health and substance use disorder needs who are involved with, or at risk of becoming involved with, the juvenile justice system. We organized our work to align with the components of the ideal children's behavioral health system, illustrated in the following figure and explained in more detail in the report.

Figure 3: The Ideal Children's Behavioral Health System

In school settings, students with untreated behavioral health conditions are more likely to have higher rates of school absences and school behavioral incidents, and lower rates of timely course completion and graduation. At the same time, some of these children and youth find themselves in or on a path to the juvenile justice system.

School districts in El Paso County currently do not have a consistent way of identifying students who need intensive services and supports. We recommend adoption of the Multi-Tiered System of Supports model, which has been endorsed by the Texas Education Agency's Long-Range Plan (details on the Multi-Tiered System of Supports model and the Texas Education Agency's Long-Range Plan are described in the behavioral health strategy development for high-risk children and youth section of the report). This tiered approach adopts universal prevention strategies for all students (Tier 1), targeted supports for a smaller group of students experiencing or at risk of a behavioral health issue (Tier 2), and specialized and individualized supports for a small group of students with complex needs (Tier 3) that Tiers 1 and 2 cannot address. In the report, we provide examples of partnerships in educational and service systems that can be used as a foundation for adopting Multi-tiered System of Supports. In our view, formal adoption and implementation over time of the Multi-Tiered System of Supports framework is the best way to transform how the El Paso County school system identifies student need and targets strategies to meet that need.

For children and youth who are involved with the **juvenile justice system**, we recommend expansion of an approach that is already being implemented in El Paso County. The El Paso Juvenile Probation Department uses a standardized assessment tool to assess need and effectively divert children and youth into treatment. For the highest need youth referred to the juvenile justice system, Multisystemic Therapy is a well-established evidence-based intervention for youth with more severe behavioral problems related to willful misconduct and delinquency. Fortunately, El Paso is one of only three communities in Texas that has providers who are licensed to offer Multisystemic Therapy. We urge the community to expand this service, though we recognize that established eligibility criteria are narrow and have an impact on access to this treatment. While capacity exists, the El Paso Juvenile Probation Department in partnership with Emergence Health Network is only able to serve 50 youth a year and our



prevalence data suggests a need for the capacity to serve about 200 youth per year in Multisystemic Therapy.[2]

Beyond school and juvenile justice system settings, Emergence Health Network has expanded services to children and youth with intensive behavioral health needs. However, there are important service gaps, including a particular need to develop additional intensive, evidence-based outpatient services, for which need currently exceeds capacity.

In summary, we found a strong commitment to intervention at the earliest possible point to prevent children and youth from requiring intensive services; a strong Multisystemic Therapy program that is rare in Texas, although could be expanded; and a need to adopt a framework (ideally the Multi-Tiered System of Supports model) for creating a tiered approach to identifying and serving children in school settings. At the same time, there are many partnerships in place that can serve as a foundation for accomplishing these goals.

Crisis system improvement analysis. We found that the El Paso community has developed a robust crisis response system that creates a foundation for an integrated, medically facing crisis response to people at risk of entering the criminal justice system. There are five identified points of formal entry into crisis care, each employing an assessment protocol to determine the necessary level of intervention, based on acuity of need. These entry points include:

1. Emergence Health Network's 24/7 crisis hotline,
2. 911,
3. Emergency departments,
4. Emergence Health Network's Crisis & Emergency Services, and
5. Private psychiatric hospitals.

There are also other ways to access crisis services that we identify in this report, including the U.S. Department of Veterans Affairs crisis hotline for veterans.

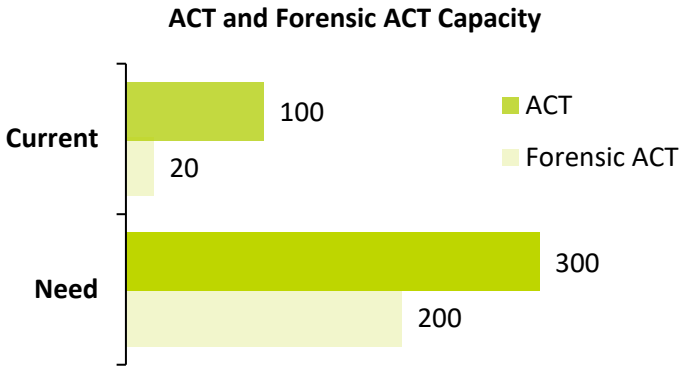
Another component of the El Paso community's crisis response is a Crisis Intervention Team that was created through a partnership between Emergence Health Network, the City of El Paso, El Paso County, and University Medical Center, and funded by the City of El Paso and the

[2] We calculated the average number of families who used MST in states that fund MST participation (North Carolina and Louisiana). We examined the number of families served by MST in each state divided by (a) the total population of the state; and, (b) the total population ages 12-17 in each state. We then averaged these multipliers across states to generate two estimates of MST need (one using the total population overall, and another using the total youth population ages 12-17). After applying these multipliers to the total population in El Paso County and the total number of youth 12-17 in El Paso County, we estimate that between 175 and 235 children and youth in El Paso County could benefit from MST. Given that Emergence Health Network already serves about 50 youth per year, an additional 125 to 190 youth could benefit from MST services each year.

Texas Health and Human Services Health Grant Program for Justice-Involved Individuals (SB 292). To encourage coordinated community planning, the SB 292 grant requires participation of a community collaborative defined as a county, a local mental health authority, and county hospital district. This component is the subject of a separate assessment we conducted that was sponsored by Emergence Health Network.

We make several recommendations designed to improve what we believe is a very good crisis system. These include:

- Begin a community dialog with the goal of transforming 911 response to mental health emergencies by shifting the primary locus of response from police to a multi-disciplinary approach that relies on a team comprised of a specially trained community paramedic, licensed mental health professional, and law enforcement officer that can address the health and mental health issues often present in a mental health emergency, while providing linkages to same day services such as prescription medication and housing;
- Educating the community and providers regarding the crisis services that are available, given that there is a lack of knowledge about these services;
- Creating crisis respite to address the lack of a short-term crisis response, particularly for children and youth, using Medicaid managed care financing provisions as the funding mechanism;
- Creating and integrating a medical stability protocol with El Paso Fire Department/ emergency medical services and El Paso Police Department. Hospital partners, law enforcement, and emergency medical services must work together to create the criteria necessary for a patient to be cleared in the field to be transported directly to an inpatient psychiatric facility, bypassing the emergency department;
- Finding a way to create medical clearance in the Emergence Health Network extended observation unit so that people do not have to be transported to another facility (often an emergency room) for medical clearance, then transported back to the extended observation unit; and
- Expanding the capacity of Assertive Community Treatment and Forensic Assertive Community Treatment, both evidence-based interventions that can reduce reliance on hospital beds and emergency departments (ACT) and jail bookings (FACT), and committing to operating those services at the highest level of fidelity standards. Currently, we estimate the need for Assertive Community Treatment to be 300 adults a year, whereas annual capacity can only serve 100 adults. For Forensic Assertive Community Treatment, current capacity is 20, with an estimated need of 200.



We also make several recommendations specific to people who are involved with the criminal justice system (with a focus on creating better linkages to services upon discharge from jail) and for veterans (with an emphasis on better coordination of care between the Department of Veterans Affairs, and community and specialty/inpatient organizations with competency in military culture). Again, existing collaborations in the community provide a solid foundation for these improvements.

Finally, we found opportunities for **community collaboration and data sharing.** Over the course of this assessment, we received input about the El Paso Behavioral Health Consortium and its role, as well as the roles of the various leadership councils and forums that have been (and will continue to be) critical to sustaining and expanding improvements to the El Paso community system of care.

We recommend that as conditions and contexts change, the El Paso Behavioral Health Consortium consider reassessing the structure of engagement and employing dedicated administrative staff. Steps toward this end have already been taken during a March meeting of the System Assessment Implantation Group members. Although our initial draft report suggested a structured survey of members, the final report focuses on the community feedback and discussions that occurred between the draft and final report.

Since 2014, the Paso del Norte health information exchange has succeeded in developing the infrastructure for collecting and sharing data across partner agencies to improve individual health outcomes. More than most communities, El Paso providers and policymakers have a

well-developed interest in expanding data sharing[3,4] and data integration.[5,6] However, while El Paso has advanced further on this issue than many communities, there are still perceived obstacles to expanding data sharing and the data currently being shared are limited in that many private practices and behavioral health care providers do not participate. As such, we offer recommendations to improve community data sharing.

Conclusion. We discuss myriad issues within the body of this report. This executive summary is designed to (a) provide the framework from which we conducted our assessment; (b) note the progress that has been made in the El Paso community since the original 2014 assessment; (c) highlight key findings and recommendations in access to behavioral health services, behavioral health strategy development for high-risk children and youth, and crisis response; and (d) comment on defining the future role of the El Paso Behavioral Health Consortium and community data sharing.

We appreciate the assistance and cooperation of the more than 100 individuals who provided information to us, and we are particularly grateful to the members of the System Assessment Implementation Group for engaging in an iterative process that improved both our assessment and our overall understanding of the El Paso community behavioral health system.

[3] Data sharing permits data sharing partners to integrate information for various purposes including continuity of care, program evaluation, and policy making. Given that many persons with mental illnesses and complex health needs find themselves in multiple treatment and social service systems, data sharing is essential to understanding service utilization, cost, and access issues.
[4] About Data Sharing. (n.d.). Actionable Intelligence for Social Policy. Retrieved January 21, 2021, from https://www.aisp.upenn.edu/about-data-sharing/
[5] Data integration is a more complex type of data sharing that involves record linkage, which refers to the joining or merging of data based on common data fields.
[6] About Data Sharing. (n.d.). Actionable Intelligence for Social Policy.

Overview and Background, Contextual Issues, and Access to and Use of Behavioral Health Services

Overview and Background of Assessment

In May 2020, the Paso del Norte Health Foundation (PdNHF) engaged the Meadows Mental Health Policy Institute (Meadows Institute) to assess the community's behavioral health system and evaluate the El Paso Behavioral Health Consortium project. The goal of this work was to inform the community's efforts to improve behavioral health services for its residents and to assess local capacity to meet the needs of residents with mental health conditions. We (the Meadows Institute) were asked to provide an update to the 2014 El Paso Community Behavioral Health System Assessment and to specifically address the following three domains:

- Overall access to behavioral health services,
- Strategy development for high-risk children and youth (not including the child welfare system), and
- Crisis system improvement analysis.

The contract we executed with PdNHF established deadlines for various deliverables and undertook an iterative process to ensure multiple points of community engagement and feedback on the content of the final report, as outlined below:

- July 2020 – submit a revised work plan and host a community kick-off event.
- October 2020 – submit an initial quantitative data summary report.
- November 2020 – submit a summary of draft findings and recommendations.
- December 2020 – submit a draft final report.
- End of April 2021 – submit a final report.

As part of this assessment, we committed to an iterative process to provide El Paso community stakeholders with multiple opportunities to offer feedback on our findings and recommendations. As part of this process, we hosted monthly meetings, beginning in May 2020, with the System Assessment Implementation Group (SAIG), which is composed of 12 local stakeholders who represent various organizations, including hospitals and other health care providers such as the local mental health authority and a federally qualified health center, city and county officials, local nonprofits, higher education, and philanthropy. We also met every two weeks with Enrique Mata, PdNHF Senior Program Officer, to provide an update on our progress. In addition, we have presented to several community groups, as summarized below:

- August 6, 2020 – Gary Blau, Executive Director, The Hackett Center for Mental Health, presented to the El Paso Behavioral Health Consortium executive committee.
- September 8, 2020 – Victoria Walsh, Assistant Director of Child and Family Policy, and Tegan Henke, Senior Director of Program Implementation for Child and Family Policy, presented to the Family Leadership Council.
- September 16, 2020 – Kyle Mitchell, Vice President of Adult and Veterans Policy, presented to the Justice Leadership Council.

- October 14, 2020 – Melissa Rowan, Executive Vice President for Policy Implementation, and John Petrila, Senior Executive Vice President of Policy, presented at the 6th Annual El Paso Behavioral Health Consortium Progress Summit.

Guiding Principles and the Ideal System of Care

The guiding principle for our work in the El Paso community and throughout Texas is that the traditional approach of treating the mind and body separately has led to inadequate and often inappropriate care for people with mental illnesses and substance use disorders; an overuse of jails, emergency departments, and hospital beds; and treatment of adults with serious mental illnesses and children and youth with serious emotional disturbances that stands in sharp contrast to the integrated care provided to people with complex physical health needs. Care for mental illness and substance use disorder should be the same as care for physical illness unless clinical needs or public safety warrants a specialty approach, with integration of care the norm and not simply a goal. For more details on transforming mental health care please see the publication, "*A Unified Vision for Transforming Mental Health & Substance Use Care.*"[7]

There are several principles that flow from this guiding principle:

- Identification and treatment of mental illness and substance use disorder should occur at the earliest stage in the illness, just as with any other physical illness. Additionally, treatments should be provided, whenever possible, in the general health care system, from the initial response to a crisis using outpatient and inpatient care, with specialty care reserved for those whose needs cannot be addressed by the general health care system. In practice, this means that traditional reliance on law enforcement response to behavioral health crises should be shifted, to the degree possible, to the medically-facing response used for all other health crises.
- It is particularly important to identify and provide treatment for children, youth, and families at the earliest possible point because untreated mental illnesses, emotional disturbances, and substance use disorders can have cascading effects on the child or youth's health, school performance, and other measures that, if left unaddressed, are associated with greater risks of entry into the juvenile justice and adult criminal justice systems.
- Many people with diagnoses of mental illnesses and substance use disorders have complex physical health needs and, conversely, many people with complex physical health needs suffer from mental illnesses such as depression or substance dependence that can compromise care. Given this, emergency assessment and hospitalization of people with mental illness diagnoses should occur, whenever possible, in settings that can assess and

[7] A Unified Vision for Transforming Mental Health & Substance Use Care. (2020, December 16). MMHPI. https://mmhpi.org/topics/announcements/unified-vision-launch/

treat both physical and mental health conditions, including medically supervised detoxification and medication-assisted treatment needs. Cross-system efficiencies that target navigation and coordination of treatment need to incorporate trauma-informed responses, beginning in the least restrictive settings, and include capabilities to identify acute physical and behavioral health needs at each entry point. When more intensive treatment is necessary, coordination should be person-centered, with the transferring systems – not the person – assuming responsibility for communicating details about the crisis and coordinating transitions between levels of care. Lastly, communities should prioritize the expansion and evolution of existing intensive community-based services to reduce the need for hospitalizations, incarceration, and crisis services, with the ultimate goal of improving health, well-being, and quality of life for those in need.

- We use the term "behavioral health" to include mental illness and substance use disorders, both separately and as co-occurring health care needs. It is important that mental health and substance use disorder services are integrated into an ideal behavioral health system. Specific substance use disorders treatment protocols such as medically supervised detoxification and medication-assisted treatment need to be developed within the broader context of integrated physical and behavioral health care. Although this assessment did not include an in-depth analysis of service capacity, gaps, and needs for substance use disorder services, we did consider substance use disorder services as part of the overall El Paso County behavioral health care system. We provide prevalence data for substance use as a subset of mental health data, where appropriate.

No community in Texas or the nation has a system that seamlessly incorporates all of these principles. In many instances, behavioral health care delivery is fragmented and segregated from the health care system. Too often, the behavioral health system in the El Paso community, as in much of Texas, looks like the system depicted in the current behavioral health system diagram in the following figure, when it should look as much as possible like the system depicted in the second – and ideal – behavioral health system diagram.

Figure 4: The Current Mental Health Care System

Figure 5: The Ideal El Paso Behavioral Health Care System

There are also important contextual factors that shape the El Paso community system – some local (the Walmart mass shooting tragedy) and some national (COVID-19). We discuss those factors in the next section of our report.

Contextual Issues Affecting Behavioral Health Care in the El Paso Community

There are important contextual factors that shape the environment in the El Paso community and have had significant impact on individual and community health. These contextual factors include the following:

- The Walmart mass shooting tragedy, which stimulated a community response to behavioral health issues, has had a continuing traumatic impact on many individuals and the community as a whole;
- The coronavirus disease 2019 (COVID-19) pandemic, which we predict will have long-lasting effects on behavioral health, with suicides and deaths from substance use expected to increase as a result of social isolation, unemployment, and related factors; and, simultaneously, the lasting impact of COVID-19 on the provider system such as the emergence of telehealth as a preferred treatment tool;
- Emerging changes in payment mechanisms, particularly to the Delivery System Reform Incentive Payments, though their ultimate shape is unknown (these changes and their implications need to be at the forefront of efforts at transforming the El Paso community behavioral health systems);
- Political leadership (essential to any system transformation and a significant strength in the El Paso community), with local, state, and national leadership engaged to support in the behavioral health work in the community; and
- The demographic and cultural make-up of the community, particularly El Paso County's largely Hispanic or Latino population, which have important ramifications for attitudes toward and access to treatment. These issues are discussed in detail in the section on access to services.

August 3, 2019 Walmart Mass Shooting Tragedy

The August 3, 2019 Walmart mass shooting tragedy (Walmart tragedy) was an unprecedented act of domestic terrorism that had a profound impact on the El Paso community at the time and continues to reverberate through the community more than a year later. Dr. Marcelo Rodriguez-Chevres, a psychiatrist and the chief medical officer for Emergence Health Network (EHN), said, "It's not only the people that were direct victims or the ones close to them. As you've probably gathered, it affects the whole community."[8] The initial and ongoing community

[8] Borunda, D., & Montes, A. (2020, July 30). Physical, emotional damage could last lifetime for survivors of El Paso Walmart shooting. *El Paso Times*. https://www.elpasotimes.com/in-depth/news/local/el-paso/2020/07/29/el-paso-mass-shooting-victims-physical-emotional-damage-last-lifetime/2116282001/

response to the Walmart tragedy highlights the many strengths of El Paso, especially the collaborations that were quickly put into action. For example, EHN was in the command center as soon as it was safe, meeting first responders as they left the Walmart. EHN counselors remained embedded with the El Paso Police Department for 48 hours following the tragedy, providing whatever support the officers and other first responders needed.

The community's needs for support quickly emerged, with calls to the EHN crisis line tripling in the days following the tragedy.[9] Data we requested from providers about their services and discussions we had with key informants about the community response revealed how community behavioral health providers mobilized in response to this tragedy. El Paso Child Guidance Center provided 589 hours of services to 495 individuals affected by the tragedy, including child and adolescent psychiatric services and individual and family psychotherapy, plus more, at eight outreach events. The University of Texas at El Paso provided 1,000 people with support groups, debriefing sessions, and outreach events. During this difficult time, EHN created the Emergence Community Resource Center to provide counseling and support to victims and families. The Steven A. Cohen Military Family Clinic at Endeavors provided therapy and support to 230 veterans, active military, and their families. Texas Tech University Health Sciences Center provided psychiatric and medication services to twelve people. Family Services of El Paso provided individual counseling and supported 1,440 people through six debriefing sessions per day for 20 days.[10]

An important long-term support has grown from the Walmart tragedy. In December 2019, United Way of El Paso opened the El Paso United Family Resiliency Center in partnership with El Paso County and the City of El Paso, with funding from the American Red Cross and the Office of the Texas Governor.[11] The center provides referrals, support groups, non-traditional therapies, and education and messaging to people affected by the tragedy. Christina Lamour, Vice-President of Community Impact for the United Way of El Paso County, said in a news story: "We are of the mindset that the entire El Paso community was affected one way or another whether they were present at the site or not. If the need is tied to Aug. 3 in some way, we can serve them."[12]

Impact of COVID-19

The El Paso community understands that the impact of the Walmart tragedy will linger for years, if not generations. Moreover, the COVID-19 pandemic has made it more difficult for the community to heal from the mass shooting tragedy. El Paso County Judge Ricardo Samaniego

[9] Borunda, D., & Montes, A. (2020, July 30).
[10] El Paso community providers and Meadows Institute (personal communication).
[11] Borunda, D., & Montes, A. (2020, July 30).
[12] Borunda, D., & Montes, A. (2020, July 30).

said in an April 2020 interview: "We still have a heavy heart due to the third of August, this tragedy. We know how hard it is on our community. We were called to unite. And now we're called to be individuals in this battle."[13]

On March 13, 2020, Texas Governor Greg Abbott issued a disaster declaration for COVID-19 and Texas entered an era unprecedented in our lifetimes. Although policymakers and providers have, by necessity, focused on the spread of the virus and its impact on inpatient facilities, our work during COVID-19, and what we learned about the impact of catastrophic events in the aftermath of Hurricane Harvey, suggests that the virus has had a significant negative impact on mental health in several critical ways and that those effects will multiply over time. We have observed a cascading set of effects that include the virus itself, the social isolation of mitigation efforts, the accompanying economic shutdown, accelerating unemployment, and an increase in suicide and substance use overdose deaths associated with rising unemployment. We also anticipate other significant effects such as increases in depression and post-traumatic stress disorders that will occur months after the current situation eases.[14,15]

Our research, based on prior research conducted in the United States and internationally during times of severe economic dislocation, found that reduced per capita gross domestic product (GDP) and associated rises in unemployment are directly associated with increases in suicide.[16,17] Increases in unemployment rates are also associated with increased rates of SUD and overdose deaths. For every person who dies from suicide, many more experience suicidal thoughts and even more experience mental illnesses and SUD associated with suicide, especially depression.[18] In terms of COVID-19's impact on Texas, our model projects that each

[13] Borunda, D., & Montes, A. (2020, July 30).
[14] Meadows Mental Health Policy Institute. (2020). Projected COVID-19 MHSUD Impacts, Volume 1: Effects of COVID-Induced Economic Recession (COVID Recession) (Volume 1). https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf
[15] Meadows Mental Health Policy Institute. (2017, November 30). Hurricane / Tropical Storm Harvey impact on child and youth mental health.
[16] Reeves, A., McKee, M., Chang, S-S., Stuckler, D., Gunnell, D., & Basu, S. (2012, November 24). Increase in state suicide rates in the USA during economic recession. *The Lancet, 380*(9856). https://doi.org/10.1016/S0140-6736(12)61910-2
[17] Frasquilho, D., Matos, M. G., Salonna, F., Guerreiro, D., Storti, C. C., Gaspar, T., & Caldas-de-Almeida, J. M. (2016, February 3). Mental health outcomes in times of economic recession: A systematic literature review. *BMC Public Health, 16*, 115. https://doi.org/10.1186/s12889-016-2720-y
A few credible sources challenge the conclusion that unemployment is the causal factor. See, for example, Harper, S., & Bruckner, T. (2017, July). Did the Great Recession increase suicides in the USA? Evidence from an interrupted time-series analysis. *Annals of Epidemiology, 27*(7), 409–414. https://doi.org/10.1016/j.annepidem.2017.05.017
[18] Han, B., et al. (2017). National trends in the prevalence of suicidal ideation and behavioral among young adults and receipt of mental health care among suicidal young adults. *Journal of the American Academy of Child & Adolescent Psychiatry, 57*(1), 20- 27. DOI: https://doi.org/10.1016/j.jaac.2017.10.013
A comparison of these reported ideation rates to completed suicides demonstrates that suicidal ideation occurs at a rate that is between 30 and 240 times that of completed suicides.

percentage point increase in the unemployment rate may result in 60 additional lives lost to suicide each year. As a result, we project that for every five-percentage point increase in unemployment in Texas during the COVID-19 recession across a year, an additional 725 Texans could die each year from suicide (300) and drug overdose (425).[19] A second report updated our original report with state-level projections.[20] Subsequent reports have been issued in partnership with the Cohen Veterans Network, specifically on veteran suicide and SUD.[21]

According to the Texas Department of State Health Services (DSHS) COVID-19 data dashboard, as of early April 2021, El Paso County ranks fifth in the number of fatalities from COVID-19 out of the 254 Texas counties.[22] El Paso County residents also face some of the worst unemployment rates in history. According to the May 2020 Labor Market Review released by Workforce Solutions Borderplex, El Paso County had a 14.8% unemployment rate in April 2020, which was slightly higher than the statewide unemployment rate of 13%.[23] The unemployment rate for the county has come down significantly since then (8.3% in February 2021), but remains more than double from the same time last year (3.8% in February 2020).[24] Because of these dual hardships, we anticipate an increase in the need for behavioral health services nationally and statewide, including in El Paso. Specifically, when we apply our analysis to the El Paso community, we estimate that there may be an additional 17 completed suicides, 30 drug overdoses, and 2,000 new cases of SUD. Our white paper series also includes an analysis of the potential impact that universal access to collaborative care models for depression and medication-based treatment for opioid use disorders could have as potential strategies to mitigate against these COVID-19-related deaths from suicide and drug overdose.[25]

[19] Meadows Mental Health Policy Institute. (2020). *Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession) (Volume 1)*.
[20] Meadows Mental Health Policy Institute. (2020). *Projected COVID-19 MHSUD impacts, volume 1 (appendix): Effects of COVID-induced economic recession (COVID recession) on each U.S. state*. https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts-StateAppendix.pdf
[21] Meadows Mental Health Policy Institute. (2020). *Projected COVID-19 MHSUD impacts, volume 2: Effects of COVID-induced economic recession (COVID recession) on veteran suicide and substance use disorder (SUD).* https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpactsVeterans.pdf
[22] Texas Health and Human Services. (n.d.). *Texas COVID-19 data.* https://dshs.texas.gov/coronavirus/AdditionalData.aspx
[23] Workforce Solutions Borderplex. (2020, May 22). *May labor market review, volume 6, issue 8*. https://borderplexjobs.com/files/documents61.pdf
[24] Workforce Solutions Borderplex. (2021, April 12). *February labor market review*. https://www.borderplexjobs.com/files/documents208.pdf
[25] Meadows Mental Health Policy Institute. (2020). *Projected COVID-19 MHSUD impacts, volume 3: Modeling the effects of collaborative care and medication-assisted treatment to prevent COVID-related suicide and overdose deaths*. https://www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDPrevention.pdf

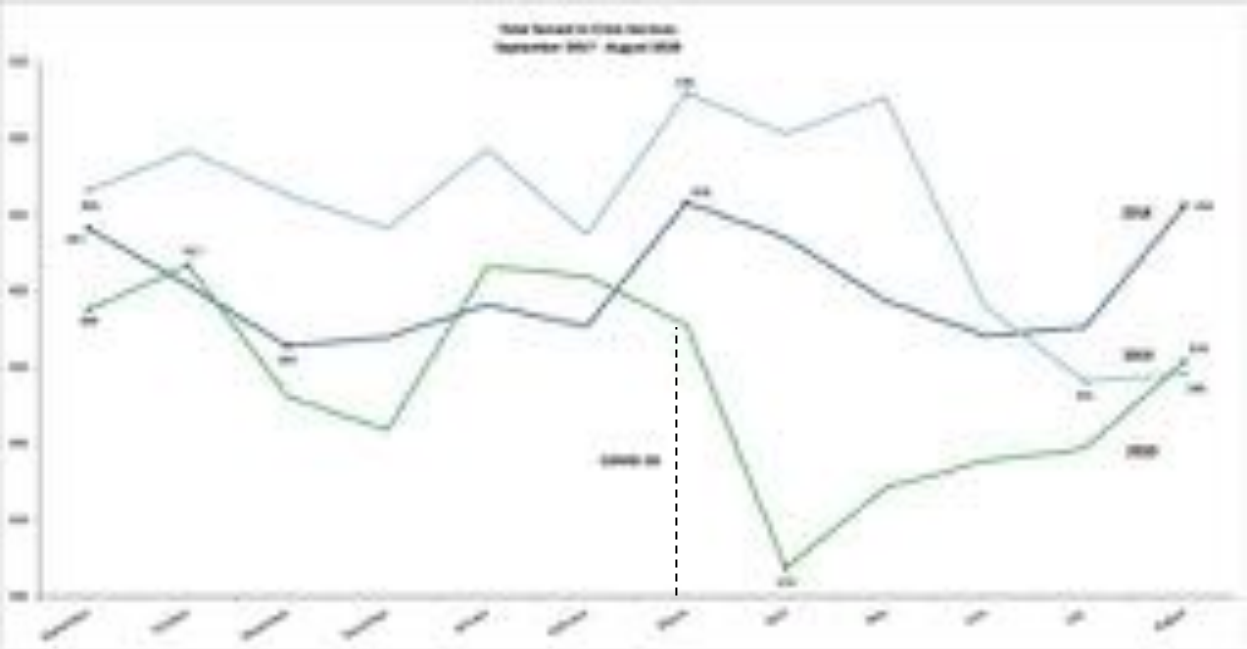
Impact of COVID on El Paso Service Utilization

Crisis Services

The COVID-19 pandemic has altered the utilization of health care services throughout the nation, particularly for some medical specialties and sub-specialties. The impact of the pandemic on EHN's crisis services is illustrated in Figure 6, which shows the variation in crisis service utilization between September 2017 (beginning of fiscal year 2018) and August of 2020 (end of fiscal year 2020). Over fiscal years 2018, 2019, and the first half of fiscal year 2020 (pre-COVID-19), crisis services utilization ranged from 309 individuals per month (December 2019) to a high of 530 served in March 2019.

Each year, use of crisis services declines every November and December and tends to peak in the spring (March – May). However, the trajectory for January to August 2020 was substantially different from the two prior years. In 2020, use of crisis services peaked in January and February, with more than 400 people served per month, and suddenly dropped off in April (219 people served) because of the COVID-19 pandemic. Service utilization increased slightly in each subsequent month and as of August 2020, the volume of crisis services clients had resumed levels seen in previous years.

Figure 6: Total Number Clients Served through Crisis Services, Emergence Health Network (Sept. 2017 – Aug. 2020)[26]



[26] Emergence Health Network (personal communication, 2020, October 30).

Telehealth

As a result of the COVID-19 pandemic, regulations of service delivery and reimbursement for telehealth services have been loosened to broaden access to behavioral health services delivered via telehealth.[27] This allowed for increased use of telehealth services across the El Paso community and has enhanced our understanding of telehealth's potential to deliver needed care. The effects of the COVID-19 pandemic and the resulting social distancing and stay-at-home orders have necessitated a significant shift to telehealth services to overcome barriers to receiving behavioral health care.[28,29] Behavioral health providers in the El Paso community and across the country have been compelled to offer online and telephonic services to avoid treatment disruption, maintain access and capacity, and remain in business. This kind of rapid adaptation has been important to sustain service delivery during the pandemic. As more behavioral health providers and organizations add innovative telehealth approaches to their practices, there is a growing need to review, evaluate, and identify best practices in telehealth care so that when social distancing is no longer necessary, behavioral health providers, program administrators, and policymakers have a framework to guide future treatment options. These considerations will also be highly relevant for employers, regulators, and payers as they consider how best to integrate and reimburse telehealth services in a post-COVID-19 environment.

Local providers we engaged for this assessment reported both benefits and challenges associated with the increased use of telehealth in their practices. Local providers reported that the use of telehealth has drastically reduced their no-show rates, but they also reported some barriers with the shift to telehealth. For example, telehealth services can be difficult when providing play therapy services to young children who have a short attention span. Furthermore, some clients do not have telehealth coverage through their insurance plan, or if they do, they do not have access to technology or struggle to understand how to use it. Finally, some providers reported that not being able to see some of their clients reduced their ability to fully assess how they are doing.

1115 Transformation Waiver: Delivery System Reform Incentive Payments (DSRIP)

In December 2011, the Centers for Medicare and Medicaid Services (CMS) approved Texas' 1115 Transformation Waiver. Waiver funds support two objectives: (1) uncompensated care payments were designed to help offset the costs of uncompensated care; and (2) DSRIP, which "are incentive payments to hospitals and other providers that develop programs or strategies

[27] CMS. (2020, March 17). Medicare Telemedicine Health Care Provider Fact Sheet. https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet
[28] Birk, S. (2020). Behavioral healthcare now and post COVID-19: Integrating telemental health services. Healthcare Executive, 35(4), 18-24.
[29] O'Brien, M., & McNicholas, F. (2020, May 21). The use of telepsychiatry during COVID-19 and beyond. Irish Journal of Psychological Medicine, 1-6. https://doi.org/10.1017/ipm.2020.54

to enhance access to health care, increase the quality of care, the cost-effectiveness of care provided, and the health of the patients and families served."[30]

According to the Texas Health and Human Services Commission (HHSC), "DSRIP is locally driven, based on community needs, and as an incentive payment program, offers flexibility to: (1) innovate to deliver better care and improve health outcomes; and (2) deliver services not traditionally billable to insurance but that can improve health. Major DSRIP focus areas include:

- Behavioral health;
- Primary care;
- Patient navigation, care coordination, and care transitions, especially for complex populations;
- Chronic care management; and
- Health promotion and disease prevention."[31]

The impact of DSRIP – and possible changes to it – on behavioral health systems throughout the state cannot be overstated. DSRIP has been a major financial force in closing gaps in care and launching innovative solutions to what had been long-standing community problems. From a federal government perspective, the DSRIP program was never intended to be a long-term financial opportunity for states and their provider communities. Its goal was to transform the health care delivery system and improve health outcomes.

In May 2016, Texas and CMS agreed to an extension of the waiver. Then, in December 2017, CMS approved a five-year renewal to September 2022. Both the extension and the renewal continued the uncompensated care pool and the DSRIP program pool. From October 2013 to September 2017, providers in Texas received over $15 billion in DSRIP funds and served 11.7 million people.[32]

Under the waiver, payment eligibility requires participation in one of the state's 20 regional healthcare partnerships (RHPs). RHP participants include governmental entities providing public funds known as intergovernmental transfers (IGTs); Medicaid providers, including hospitals and physician groups; local community mental health authorities; public health departments; and other stakeholders. RHP 15, comprised of El Paso County and Hudspeth County, includes the following providers: University Medical Center of El Paso, City of El Paso's Department of

[30] Texas Health and Human Services. (n.d.). *Waiver overview and background resources*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources
[31] Texas Health and Human Services Commission. (2019, September 30). *Draft Delivery System Reform Incentive Payment (DSRIP) transition plan*. https://hhs.texas.gov/sites/default/files/documents/laws-regulations/policies-rules/1115-waiver/waiver-renewal/draft-dsrip-transition-plan-cms.pdf
[32] Texas Health and Human Services Commission. (2019, September 30).

Health, the El Paso Children's Hospital, Emergence Health Network (EHN), Las Palmas Medical Center, Providence Memorial Hospital, Sierra Providence East Medical Center, Texas Tech University Health Science Center El Paso, and the El Paso County Medical Society.

Each RHP has one anchoring entity, which "acts as a primary point of contact for HHSC in the region and is responsible for seeking regional stakeholder engagement and coordinating development of a regional plan."[33] The University Medical Center of El Paso anchors RHP 15 and its responsibilities include facilitating learning opportunities for regional DSRIP providers and providing technical assistance related to DSRIP reporting requirements specific to the providers' achievement metrics. In the DSRIP program, each provider selects their own achievement measures, as determined by HHSC and CMS guidelines. The anchor has no authority to mandate a provider to select a specific achievement goal.

Regional DSRIP Behavioral Health Funding

In the first phase of the waiver (2011–2017), providers reported on projects, including outcome measures. RHP 15 projects ranged from expanding access to dental care for low-income children and pregnant women to establishing a diabetes clinical information system. Given the project-focused nature of the waiver during that period, we can determine the DSRIP payments providers received for behavioral health initiatives. RHP 15 behavioral health-related projects included establishing a tele-psychiatric consultation in an emergency department and creating a nursing psychiatric liaison service for patients admitted with medical conditions that also had a behavioral health diagnosis. In phase one of the waiver, El Paso County providers received $123,194,707 for behavioral health-related projects.

Table 1: Regional Healthcare Partnership 15 Behavioral Health Payments Earned

Regional Healthcare Partnership 15	Payments Earned[34]
Emergence Health Network	$92,911,613[35]
Other RHP 15 behavioral health-related projects	$30,283,094[36]
Total	$123,194,707

[33] Texas Health and Human Services. (n.d.). *Waiver overview and background resources*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-overview-background-resources

[34] Texas Health and Human Services. (n.d.). RHP summary information: Total payments to date for DY1-DY10 (Excel) (1/21/21). https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information.

[35] EHN staff report receiving $93,615,285.32, a slight discrepancy between HHSC and EHN internal figures.

[36] Other RHP 15 behavioral health related projects for 2011–2017.

A "significant transition occurred"[37] during phase two of the waiver (2017–2021), with funding shifting to system-wide activities intended to achieve provider-selected outcome measure bundles. Under phase two, the waiver shifted from project "clients" (e.g., an integrated care clinic serving 225 people) to "all patients in the provider system measured for health care quality achievement."[38] In the all-patients methodology, larger provider system changes are measured, such as follow up after hospitalization for mental illness or care planning for dual diagnoses across all patients in the providers' system of care.

Total Regional DSRIP Funding

Through the 1115 transformation waiver's lifespan (from 2011 through 2021), the DSRIP value to the two counties in RHP 15 is over $1.1 billion. Of that, the region has already earned over $937 million. According to HHSC data, to date, EHN has received $92,911,613. According to EHN, for fiscal year (FY) 2019, DSRIP funds represented 16% of their overall budget.

Table 2: RHP 15 Total DSRIP Valuation and Payments (2021)[39]

Provider Name	**Total DY1-10 Valuation** (excludes withdrawn)	**Total DY1-10 Payments to Date** (includes withdrawn)
City of El Paso Department of Health	$68,455,766	$55,469,828
Texas Tech University Health Sciences Center EL Paso	$130,460,824	$102,475,739
Las Palmas Medical Center	$191,157,251	$145,165,076
Emergence Health Network	$127,942,437	$92,911,613
Providence Memorial Hospital	$73,286,274	$60,489,541
University Medical Center of El Paso	$540,792,468	$434,174,466
Sierra Providence East Medical Center	$61,156,881	$43,469,950
El Paso Children's Hospital	$4,684,581	$3,472,300
Total	**$1,197,936,483**	**$937,628,513**

[37] Texas Health and Human Services Commission. (2019, September 30).
[38] Texas Health and Human Services. (n.d.). *Health information technology (health IT) strategic plan: Draft DSRIP revised transition plan – Submitted to CMS (4/13/2020).* https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/waiver-renewal
[39] Texas Health and Human Services. (n.d.*). RHP summary information: Total payments to date for DY1-DY10 (Excel) (1/21/21)*. https://hhs.texas.gov/laws-regulations/policies-rules/waivers/medicaid-1115-waiver/rhp-summary-information

Post DSRIP

The current waiver is set to expire in September 2022 with the current funding pool ending in September 2021. In October 2019, HHSC submitted a draft DSRIP transition plan[40] to CMS, describing how the state will further develop its delivery system reform efforts without DSRIP funding. On January 15, 2021, CMS approved a ten-year waiver extension but did not extend DSRIP. Rather, the waiver extension included the creation of a Public Health Providers Charity Care Pool (PHP-CCP) and the Directed Payment Program for Behavioral Health Services, along with other hospital and physician payment programs, as shown in Table 3 on the next page. The PHP-CCP is available for publicly owned community mental health centers, local behavioral health authorities, local mental health authorities, local health departments, and public health districts. This program is designed to defray the cost of uncompensated care. The Directed Payment Program for Behavioral Health is designed for publicly operated community mental health centers and will be implemented through the state's Medicaid managed care program. We do not have the anticipated value of these programs for El Paso County at this time, but in general, providers participating in DSRIP expressed positive views about the potential impact of the new waiver programs on financial sustainability over the next ten years.

On April 16, 2021, CMS notified HHSC that the approval issued on January 15, 2021 was rescinded. HHSC must follow the normal public notice process and then may resubmit the waiver for approval. It is unclear at this time whether CMS will approve the terms of the waiver that was approved in January after the public notice process is completed. Given this significant change in the waiver process, there is no clear understanding if new funding will be available to providers. The DSRIP funding is interwoven throughout the county's system of care and the impact of eliminating DSRIP funding will be significant for both providers and the community they serve.

[40] Texas Health and Human Services Commission. (2019, September 30).

Table 3: Proposed Supplemental and Directed-Payment Programs and Providers[41]

Pools/Programs	Providers Who Benefit from Programs
Existing Programs	
Uncompensated Care Program	Hospitals, Physician Practice Groups, Ambulance Groups, Public Dental Providers
Quality Incentive Payment Program	Nursing Facilities (Public and Private)
Programs Phasing Out	
Delivery System Reform Incentive Payment	Hospitals, Physician Practice Groups, Local Mental Health and Local Health Departments
Network Access Improvement Program	Publicly Owned Academic Health Science Centers and Hospitals
New or Expanding Programs	
Public Health Providers – Charity Care Pool	Public Community Mental Health Centers and Local Health Departments
Comprehensive Hospital Increased Reimbursement	Hospitals
Ambulance Average Commercial Reimbursement	Ambulance Providers
Texas Incentive for Physicians and Professional Services	Physician Practice Groups
Behavioral Health Services	Community Mental Health Centers
Rural Access to Primary and Preventative Services	Rural Health Clinics

[41] *1115 Waiver Extension*. (2021). Texas Health and Human Services. https://www.tha.org/Portals/0/files/Issues/waiver/1115_Waiver_Extension_Presentation_1-19-2021.pdf?ver=2021-01-20-160815-530

Political Leadership

We appreciate the nine El Paso community political leaders, representing city, county, state, and national levels of government, who volunteered their time to participate in this assessment and provide their candid thoughts on the local behavioral health care system. Their interests ranged from services for children and veterans to culturally appropriate resources for the Hispanic or Latino population. Common concerns they identified included the high percentage of people without insurance, which has been exacerbated by COVID-19-induced job loss, and the law enforcement response to people with mental illness. These leaders are not only knowledgeable about the local system, but also committed to working together to implement recommendations and advocating for the El Paso community's needs. The Walmart mass shooting tragedy pressure-tested the system, helped identify gaps, and showed what can be accomplished when the community works together.

Community Progress – 2014 to 2020

In 2014, TriWest Group completed an assessment of the El Paso community behavioral health system (2014 assessment). That assessment outlined 10 findings and recommendations for the community to work toward to improve its behavioral health system. PdNHF committed to use this assessment to measure progress, celebrate success, and acknowledge opportunities for improving the behavioral health system. We have used the 2014 assessment's recommendations as a guide for our review of the current system. Below, we discuss the El Paso community's progress and successes related to many of the 2014 assessment findings and recommendations. Later in this report, we further expand upon additional findings, recommendations, and opportunities for improvement.

El Paso Behavioral Health Consortium

2014 Recommendation #1: *El Paso County needs to develop a formal, functional, data-driven, quality improvement-based System of Care Collaborative to represent all key partners in the El Paso mental health and substance use services delivery system.*[42]

Success to Date

The El Paso Behavioral Health Consortium (Consortium) was created in 2012 to examine the El Paso community behavioral health system in preparation for future service needs and funding trends.[43] The Consortium envisions an accessible, person-centered behavioral health system of care in the El Paso region. Its actions were informed by TriWest Group's 2014 assessment, which outlined several specific recommendations that the community has since successfully implemented. For example, the Consortium created a structure for collaboration, which

[42] All references to 2014 recommendations have been shortened.
[43] Paso del Norte Health Foundation. (n.d.*). Health priorities, initiatives & programs: El Paso Behavioral Health Consortium*. https://pdnhf.org/what_we_do/initiatives/el-paso-behavioral-health-consortium

included the establishment of three leadership councils that meet regularly and are dedicated to a specific population, policy, and program goals – the Justice Leadership Council, the Family Leadership Council, and the Integration Leadership Council. Each council is chaired by an executive committee member who represents the council at the executive committee quarterly meetings. Each council and the executive committee have diverse membership representing a spectrum of providers, law enforcement entities, schools, local elected officials, nonprofits, and many more, and each has established goals, objectives, and strategic plans. Additionally, these councils have created workgroups to address specific topics. The Family Leadership Council workgroups have been critical to moving the work of the committee forward. Of note, Family Leadership Council workgroups contributed to successfully securing funding to support its work toward its goals and objectives, which provides sustainability to its efforts.

In 2017, PdNHF engaged the Meadows Institute to conduct a deeper analysis of the structure and functioning of the Consortium and its councils. That work resulted in our report, *El Paso Behavioral Health Consortium Assessment: Final Report and Recommendations*[44] (2017 El Paso Behavioral Health Consortium assessment). In our experience working with behavioral health collaboratives across the state, we have found that maintaining momentum over the course of years can be challenging and, as such, we expand on opportunities the Consortium may consider adopting (see the section on Opportunities for the El Paso Behavioral Health Consortium).

Early Intervention for Children and Youth

2014 Recommendation #2: *Plan new efforts to promote earlier intervention and multi-agency service coordination using new Medicaid options under the current YES Waiver and STARKids benefit currently under design to develop crisis supports, in home services, family-focused care, and other needed supports.*

Success to Date

STAR Kids, a Texas Medicaid managed care program for children and adults ages 20 years and younger who have disabilities,[45] was implemented on November 1, 2016, by Amerigroup[46] and Superior,[47] two managed care organizations operating in the El Paso service delivery area. The

[44] Meadows Mental Health Policy Institute. (2017, March 23). *El Paso Behavioral Health Consortium assessment (final report and recommendations)*. http://www.healthypasodelnorte.org/content/sites/pasodelnorte/Behavioral_Health_/El_Paso_BHC_Assessment_FINAL_REPORT.pdf

[45] Texas Health and Human Services. (n.d.). *STAR Kids*. https://hhs.texas.gov/services/health/medicaid-chip/medicaid-chip-members/star-kids

[46] Amerigroup Insurance Company. (n.d.). Provider directory/ directorio de proveedores El Paso service area. https://www.myamerigroup.com/tx/txep_starkids_referraldirectory.pdf

[47] Superior Health Plan. (2020, September). Provider directory / directorio de proveedores, STAR Kids, El Paso service delivery area.

Youth Empowerment Services (YES) Waiver, a 1915(c) Medicaid program that helps children and youth with serious mental, emotional, and behavioral difficulties,[48] has also been implemented and is managed by EHN, which has 50 slots available. In 2019, EHN reports 44 children and youth received YES Waiver services, which offers nontraditional and specialized therapy.

In addition, El Paso providers and stakeholders have increased their attention on child and family services at the systems level. The Consortium's Family Leadership Council works with child, youth, and family health organizations; other child-serving agencies; and natural support systems to transform El Paso County into a model community for child, youth, and family behavioral health services and support. This group consistently brings together providers of child, youth, and family services across systems to focus on meeting the needs of children, youth, and families.

In addition to the Family Leadership Council's efforts, the El Paso community has also improved collaborations for early access to services for children, youth, and families, some of which are listed here:

- Through generous support by PdNHF, the West Texas Trauma-Informed Care Consortium (WTTICC) is composed of a group of organizations in West Texas working together to provide information and resources for trauma-informed care. Led by the El Paso Child Guidance Center, WTTICC is made up of a variety of professionals and organizations in West Texas that work with children, including mental health clinicians, school personnel, medical/nursing professionals, occupational/physical therapists, law enforcement, and juvenile justice professionals. The consortium meets quarterly to network, share information, coordinate trainings, and guide trauma-informed communications.
- Through increased collaboration among members of the Family Leadership Council, El Paso Center for Children was awarded a grant from the U.S. Department of Health and Human Services Administration Children's Bureau (also referred to as the "Strong Families Initiative") and is working collaboratively with other child-serving organizations to implement services funded by this grant.
- Paso del Norte Children's Development Center is leading a Help Me Grow collaborative workgroup, with support from the Texas Department of Health and Human Services. The group will work to improve connection, coordination, and continuity of care for families with children ages zero to three.

https://www.superiorhealthplan.com/content/dam/centene/Superior/Medicaid/PDFs/412106_SHPD_STARKIDS_El Paso_EPSKKF-0920_WEB.pdf

[48] Texas Health and Human Services. (n.d.). *YES waiver*. https://hhs.texas.gov/services/mental-health-substance-use/childrens-mental-health/yes-waiver

- The Rise Up Region 10 Task Force, one of the workgroups under the Family Leadership Council, was developed through the Prevention Resource Center in Region 10, with support from Aliviane and the Texas Department of State Health Services. This task force convened in March 2017 to tackle prescription medication misuse.

Behavioral Health Service Capacity for Children and Adults
2014 Recommendation #3: *Prioritize development efforts to (1) stabilize crisis situations and (2) build broader capacity to intervene earlier, particularly with children.*

Success to Date
Behavioral health services for children and adults have increased across the El Paso community through EHN, STAR Kids, the Texas Child Health Access Through Telemedicine program, and other community providers such as the Hospitals of Providence, which opened an inpatient geriatric behavior health unit, and Rio Vista Behavioral Health Hospital, which also recently opened as serves both children and adults. In addition, Aliviane built the capacity to intervene earlier through an array of substance use disorder services, including prevention services such as skills building, education programs, and outreach services.

Senate Bill (SB) 11 (86th Regular Session, 2019) established the Texas Child Mental Health Care Consortium to foster collaboration on pediatric mental health care among medical schools in Texas.[49] As described in SB 11, the Texas Child Mental Health Care Consortium is responsible for overseeing five key initiatives, including the Texas Child Health Access Through Telemedicine (TCHATT), which is being implemented by Texas Tech University Health Sciences Center at El Paso. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth with urgent mental health needs whom school personnel have identified as high-risk. Urgent assessments and short-term stabilization care are available through TCHATT, increasing community-wide urgent care capacity. TCHATT also requires linkages for follow-up care to specialty outpatient mental health providers. As of August 2020, the Texas Tech University Health Sciences Center at El Paso hub has begun implementing TCHATT in the following districts in El Paso County: Anthony Independent School District (ISD), Canutillo ISD, Clint ISD, El Paso ISD, San Elizario ISD, and Socorro ISD. The Texas Child Mental Health Care Consortium is also overseeing the Child Psychiatry Access Network (CPAN), which we discuss in more detail in the section, Behavioral Health Care in Routine Settings in Which Children Receive Care. The Family Leadership Council has a workgroup that is focused on CPAN and TCHATT implementation and coordination.

[49] Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

As shown in Table 4, despite the slight decline in the prevalence of SED and SED in children and youth living in poverty,[50] the total number of children and youth served by EHN increased by 76% between 2014 and 2019. Nearly all El Paso resident children and youth were treated in local psychiatric beds. Although there was no substantial change in the need for LMHA services between 2018 and 2019 (see Table 4), EHN's service provision data suggest that the number of adults it served increased substantially (more than 150%) between 2014 and 2019. During the same time frame (2014 to 2019), the number of adults who occupied beds at the El Paso Psychiatric Center (the state psychiatric hospital) declined from 70 to 64. The number of psychiatric beds dedicated for adult patients declined slightly (six fewer adult beds), as did the number of adult patients who occupied those beds.[51] Nearly all El Paso resident children and youth were treated in local psychiatric beds.

Table 4: Changes in Number of El Paso County Children, Youth, and Adults Served by Emergence Health Network (2014–2019)[52]

Clients Served – Children and Youth	2014[53]	2018[54]	2019[55]	% Change[56]
Prevalence of SED in Children and Youth Living in Poverty[57]	**10,000**	**8,000**	**8,000**	**–20%**
Total Served	1,596	1,862	2,815	+76%
% of Total Need	16%	23%	35%	+19%
Clients Served – Adults	**2014[58]**	**2018[59]**	**2019[60]**	**% Change**
Prevalence of SMI in Adults Living in Poverty	—	**15,000**	**15,000**	—
Total Served	4,048	4,067	10,425	158%
% of Total Need	—	27%	70%	—

[50] When adjusted for the changing population size over time, this represents a 1% decline in the rate of SED in children and youth living in poverty.
[51] TriWest Group. (2014, February).
[52] Table modified to display pertinent data. See Appendix Thirteen for full table.
[53] TriWest Group. (2014, February).
[54] Texas Health and Human Services Commission. (2019, February).
[55] Texas Health and Human Services Commission. (2020, January).
[56] This reflects the rate of change in service utilization from 2014 to 2019.
[57] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey.
[58] TriWest Group. (2014, February).
[59] Texas Health and Human Services Commission. (2019, February).
[60] Texas Health and Human Services Commission. (2020, January).

Stigma

2014 Recommendation #4: *Continue current stigma reduction efforts, as these local efforts are best practices nationally and in Texas and they can be leveraged to maximize the utility of other efforts.*

Success to Date

Since 2014, the El Paso community has implemented several programs such as PdNHF's Think.Change initiative, with the goal of reducing stigma associated with mental illness.[61] This initiative has united disparate community collaboratives to work together and has harnessed the diverse expertise of the local nonprofit community to fund a variety of programs to reach across multiple populations, some of which are listed here:[62]

- The City of El Paso Housing Authority for Think.Change Housing;
- Comision de Salud Fronteriza Mexico-Estados Unidos, which strengthens mental health care and reduces stigma associated with mental illness in Ciudad Juárez;
- The County of El Paso, which has created and implemented an education and contact-based trauma-informed care model to reduce mental health stigma among professionals;
- Emergence Health Network's Project Emerge, which provides Mental Health First Aid trainings for at least 1,000 individuals in El Paso County, hosts a Mental Health First Aid instructor summit, and expanded Mental Health First Aid training to areas in Hudspeth County; and the Mental Health Learning Library training courses, which allow residents to learn about mental illness and understand that managing and recovering from mental illness is possible; [63]
- Family Service of El Paso, Inc. partnered with NAMI El Paso to establish People Empower El Paso;
- Programa de Parentalidad Positiva en Ciudad Juarez, which is a trauma- and resiliency-informed approach for reducing mental health stigma and building organizational and system capacity to empower youth and families;
- Techo Comunitario, A.C., which offers the Triple P – Positive Parenting Program: Change the Stigma to Ask for Help in Parenting and Continue Building Healthy Communities;
- The Regents of New Mexico State University, who foster community partnerships and education to reduce mental illness stigma in Otero County; and
- The University of Texas at El Paso, which promotes mental and emotional well-being in the Paso del Norte region by creating a backbone organization that will help lead priority area programs for mental health and emotional well-being.

[61] Paso del Norte Health Foundation. (n.d.). Think.Change. https://pdnhf.org/what_we_do/initiatives/think-change
[62] Paso del Norte Health Foundation. (n.d.). Awarded grants. https://pdnhf.org/grant_center/grants
[63] Emergence Health Network. (n.d.). *Mental health*. https://emergencehealthnetwork.org/mental-health/

Additionally, in 2013 PdNHF commissioned the *Mental Illness Stigma Reduction Situational Analysis* report,[64] which analyzed varying perspectives and provided data-driven answers about mental illness and stigma, its cause and consequences, and potential solutions for the Paso del Norte region, including Doña Ana, Luna, and Otero counties in New Mexico; El Paso and Hudspeth counties in Texas; and Ciudad Juarez in the state of Chihuahua, Mexico.

Finally, and most recently, in response to the COVID-19 pandemic, the National Alliance on Mental Health (NAMI) El Paso has successfully transitioned its educational courses online, making these helpful resources accessible during a time of increased stress.[65]

Data Analytic Capacity: Paso del Norte Health Information Exchange
2014 Recommendation #5: *Use focused, data-driven, cross-agency quality improvement projects to develop capacity to share data to improve individual and population health outcomes.*

Success to Date
The Paso del Norte Health Information Exchange (PHIX) has succeeded in developing the infrastructure for data collection and sharing across partner agencies to improve individual health outcomes. PHIX was founded in 2011 and is funded jointly by the PdNHF, Texas Tech University, and providers who use PHIX data. The goal of PHIX at its inception was to facilitate the transfer of health-related information between providers so that they better understand patients' needs for improved treatment planning and care coordination.

PHIX currently partners with EHN, The Hospitals of Providence Memorial Campus, Texas Tech University Medical Center at El Paso and Texas Tech psychiatrists, the U.S. Department of Veterans Affairs (VA), the El Paso Police Department's Crisis Intervention Team, local federally qualified health care providers, laboratories (e.g., Quest Diagnostics), and other large area hospitals. Partners use PHIX data to verify and review patients' medical histories, current and prior diagnoses across providers, and laboratory test results (including COVID-19), and to improve follow-up practices and linkages to care. All providers access shared data through the same portal, with a small number of organizations receiving customized alerts (e.g., when one of their patients has been admitted to or discharged from an emergency department). A major gap exists for behavioral health care data from specialty providers, and we expand on opportunities the PHIX may consider adopting (see the section on Community Data Sharing).

[64] Behavioral Assessment, Inc. (2013). *Mental illness stigma reduction situational analysis (executive summary)*. https://pdnhf.s3.amazonaws.com/documents/files/000/000/025/original/2013_MISRI_Situational_Analysis_Exec_Summary.pdf?1450740750
[65] NAMI El Paso. (n.d.). *Education and support*. https://namiep.org/education-and-support

Cross-System Development Opportunities

2014 Recommendation #6: *There is a broader range of cross-system development opportunities that should be considered in any implementation efforts, including (1) the needs of active duty military service members, veterans, and their families; (2) cross-border issues related to the El Paso community's unique status as a "tri-border" community that spans the US/Mexican and Texas/New Mexican borders; and (3) the needs of those with co-occurring mental health and substance use disorders that particularly challenge trans-organizational care delivery.*

Success to Date

The El Paso community has considered and made progress on cross-system development opportunities since the 2014 assessment. For example, community organizations have responded to the needs of active-duty military service members, veterans, and their families. EHN opened the Veteran One-Stop Center in 2016; The Steven A. Cohen Military Family Clinic at Endeavors opened in 2017 (serving active-duty service members, veterans, and their families); the VA expanded its physical space and the services it provides in El Paso, opening its first stand-alone mental health clinic in January 2020 and its newest outpatient clinic on the west side of El Paso in August 2020. Endeavors is also a member of the Family Leadership Council, resulting in strengthened partnerships and collaboration around services provided to veterans and their families.

Stakeholders we interviewed acknowledged that individuals who receive services in El Paso often live or work in Mexico or New Mexico. This "tri-border" status also creates some challenges such as favorable laws in New Mexico that can reduce retention of qualified professionals in Texas. Stakeholders were aware of the service providers in border areas; however, it was not clear if efforts were being made to increase collaboration with providers in Mexico or New Mexico.

Expand Adult Acute and Crisis Capacity

2014 Recommendation #7: *El Paso Psychiatric Center should contract existing first floor "intake space" to become a full-service psychiatric emergency service that provides a basic emergency and diversion function as a front-end to El Paso Psychiatric Center and other psychiatric inpatient programs in the county, and also serves as the core for a system-wide crisis triage and diversion system for both acute and forensic cases.*

Success to Date

Although the El Paso community has not yet implemented a psychiatric emergency services unit, specifically, EHN has developed a walk-in crisis center (known as EHN's Crisis & Emergency Services) and extended observation unit (EOU). These services provide alternatives to emergency department usage, inpatient hospitalization, and, even more importantly, diversion

from potential incarceration. Individuals can access EOU services voluntarily by being evaluated by EOU staff, through an Emergency Detention Order (EDO), or by police/emergency medical services drop-off. An assessment and medical screening are completed prior to admission. However, full medical clearance is not available and if the onsite medical personnel cannot rule out acute medical treatment needs, the person must be transported to University Medical Center for a complete medical clearance evaluation. We address filling this gap in our section regarding Crisis System Improvement Analysis Findings and Recommendations. Additionally, the EOU service is not available for children and youth.

In 2019, the El Paso Police Department and EHN crisis services partnered to develop and implement a Crisis Intervention Team (CIT), creating an additional opportunity for more efficient and appropriate crisis system navigation. Other programs may also have an impact on crisis service use, including Multisystemic Therapy (MST) for youth, Coordinated Specialty Care (CSC) for first episode psychosis treatment, Forensic Assertive Community Treatment (FACT), opioid treatment programming, assisted outpatient treatment, transition of care unit, partial hospitalization program, intensive outpatient program, Veterans One-Stop Center, and home and community-based services.

Crisis Services for Children and Youth

2014 Recommendation #8: *Develop a crisis continuum for children, youth, and families – coordinated with the broader crisis system – that centers on a non-forensic mobile crisis team supported by a continuum of community-based and residential service components.*

Success to Date

As noted in Table 4, above, the total number of children and youth served by EHN increased by 76% between 2014 and 2019, with most of this growth occurring in complex services (an increase of 500%). Since 2014, EHN has increased its crisis services with the following:

- A crisis hotline, which is available 24 hours a day, seven days a week and answers calls for the national suicide prevention hotline, and now also takes COVID-19 calls through collaboration with the Federal Emergency Management Agency and Texas Health and Human Services Commission (HHSC). The crisis line also receives calls from local and state police and local hospital systems;
- A walk-in crisis center;
- A Crisis Intervention Team, which started in February 2019 and is dispatched by 911;
- A mobile crisis outreach team, which has a specialized training for all staff on how to respond to children and youth;

In addition, other providers have added services for children and youth in crisis:

- El Paso Behavioral Health offers inpatient treatment for youth and has a partial hospitalization program and intensive outpatient program.
- Rio Vista offers inpatient treatment for youth and has a partial hospitalization program and intensive outpatient program.

Law Enforcement Readiness to Respond to Behavioral Health Crises
2014 Recommendation #9: *Alongside developments in the health system, prioritize the identification of community resources to support ongoing certification training for correctional officers, recertification training for peace officers, and adoption of the Crisis Intervention Team model within El Paso County and the City of El Paso.*

Success to Date
EHN and the El Paso Police Department implemented a CIT unit in 2019. Officers for the CIT unit began responding to calls in December 2018 and the fully staffed team, including an EHN clinician, was launched in February 2019. The primary purpose of the CIT unit is to deescalate, intervene, divert, and provide connections to services for people in crisis. EHN has engaged the Meadows Institute separately for a longitudinal analysis of the CIT program. This evaluation started in September 2019 and a final report is projected for completion in Spring 2021.

Behavioral Health Care in Routine Settings in Which Children Receive Care
2014 Recommendation #10: *Actively develop earlier access to behavioral health assessments and care in the settings in which children naturally receive help – schools and the family doctor*.

Success to Date
Senate Bill (SB) 11 (86th Regular Session, 2019) established the Texas Child Mental Health Care Consortium to foster collaboration on pediatric mental health care among medical schools in Texas.[66] As described in SB 11, the Texas Child Mental Health Care Consortium is responsible for overseeing five key initiatives, including the Texas Child Health Access Through Telemedicine (TCHATT), which is being implemented by Texas Tech University Health Sciences Center at El Paso. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth with urgent mental health needs whom school personnel have identified as high-risk. Urgent assessments and short-term stabilization care are available through TCHATT, increasing community-wide urgent care capacity. TCHATT also requires linkages for follow-up care to specialty outpatient mental health providers. As of August 2020, the Texas Tech University Health Sciences Center at El Paso hub has begun implementing TCHATT in the following districts in El Paso County: Anthony Independent School District (ISD), Canutillo ISD, Clint ISD, El Paso ISD, San Elizario ISD, and Socorro ISD.

[66] Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

The Texas Child Mental Health Care Consortium is also overseeing the Child Psychiatry Access Network (CPAN). The CPAN program supports pediatric primary care providers by offering them no-cost psychiatric consultation for patients with a presenting or suspected mental health concern. El Paso County pediatricians and other primary care providers can access child psychiatric and mental health consultation services through the CPAN hub at the Texas Tech University Health Sciences Center at El Paso. When pediatricians and primary care providers identify behavioral health needs in their patients, they can access their CPAN hub's referral network to refer these patients to community services and supports to address the behavioral health needs they identified. Specialty mental health providers in El Paso County – including El Paso Child Guidance Center, Aliviane, and Emergence Health Network – have already partnered with Texas Tech University Health Sciences Center at El Paso to coordinate services and ensure they are included on the CPAN referral list.

Access to and Use of Behavioral Health Services

As noted elsewhere in this report, multiple factors, including composition of the population, insurance status, access to a primary care doctor, and perceived stigma have an impact on "access to care". In utilizing quantitative data to assess access to and use of behavioral health services in the El Paso community, we considered several issues, including:

- Prevalence,
- Demographic characteristics of the population, and
- Service capacity.

In analyzing these issues, we used archival data sources such as the Texas Health Care Information Collection (THCIC), which is a data repository of inpatient, outpatient, and related data generated by hospitals throughout Texas. We also used data from other sources, including community mental health providers, Emergence Health Network (EHN), the El Paso Juvenile Probation Department (EPJPD), and the Texas Education Agency's (TEA) Public Education Information Management System. We also engaged local organizations to share their data to assess the capacity and array of services. We received data from El Paso Center for Children, El Paso Child Guidance Center, Project Vida, Family Services of El Paso, The Steven A. Cohen Military Family Clinic at Endeavors, The University of Texas at El Paso Counseling and Psychological Services, Texas Tech University Health Sciences Center at El Paso, the YWCA, the National Alliance on Mental Illness El Paso, and Aliviane. We also incorporated information from prior reports, including the 2014 El Paso community behavioral health system assessment conducted by TriWest Group, the 2017 El Paso Behavioral Health Consortium Assessment led by the Meadows Institute, and the Meadows Institute's current longitudinal analysis of the El Paso CIT unit.

We used quantitative data to evaluate service use. These data describe the burden of mental illness and substance use disorders in El Paso County as well as general service delivery and hospital and emergency department utilization information between 2016 and 2019. We also compared updated behavioral health need and service utilization data to the 2014 El Paso Community Behavioral Health System Assessment [67] and the 2017 El Paso Behavioral Health Consortium Assessment[68] to assess changes in demand or provision of behavioral health services over time.

We explain source data and methodology techniques in detail in the appendices of our updated *Quantitative Data Summary*, in Appendix Thirteen.[69] Note that the quantitative data are presented in detail in the *Quantitative Data Summary*; we highlight them here to emphasize that a relatively small number of people require the most intensive services and that a focus on prevention and early intervention can reduce reliance on the crisis and criminal justice systems.

Prevalence

To understand how many people in a community might require behavioral health care, it is important to first look at the prevalence of mental illness and emotional disorders in the community.

As shown in Table 5 below, the most common mental illness among children and youth in El Paso County in 2019 was depression, with an estimated 10,000 children and youth experiencing this condition. The next most common conditions were anxiety and self-injury/self-harming behaviors, which were experienced by about 8,000 children and youth each, followed by conduct disorder (a type of behavioral disorder characterized by antisocial behavior such that a child or youth may disregard basic social standards and rules)[70] and post-traumatic stress disorder (a condition triggered by acute or chronic exposure to traumatic or terrifying events),[71] which affected 4,000 and 3,000 children and youth, respectively. According to the most recent data available from the Centers for Disease Control and Prevention, less than ten children and

[67] TriWest Group. (2014, February). *El Paso community behavioral health system assessment: Final summary of findings and recommendations*. www.healthypasodelnorte.org/content/sites/pasodelnorte/Behavioral_Health_/El_Paso_Community_BH_Assesssment_-_Final_Report_2014_03_12.pdf

[68] Meadows Mental Health Policy Institute. (2017, March 23). *El Paso community behavioral health consortium assessment: Final report and recommendations.* www.healthypasodelnorte.org/content/sites/pasodelnorte/Behavioral_Health_/El_Paso_BHC_Assessment_FINAL_REPORT.pdf

[69] Meadows Mental Health Policy Institute. (2020, October). *Quantitative data summary: El Paso County, final report*.

[70] Stanford Children's Health. (n.d.). *Conduct disorder in children*. www.stanfordchildrens.org/en/topic/default?id=conduct-disorder-90-P02560

[71] Mayo Clinic. (n.d.). *Post-traumatic stress disorder (PTSD)*. www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967

youth completed suicide in El Paso County in 2019.[72] Note that there is more discussion of information from this table in the section on high-risk children and youth.

Table 5: Twelve-Month Prevalence of Mental Health Disorders and Related Conditions Among El Paso County Children and Youth (2019)[73]

Mental Health Condition – Children and Youth	Age Range	Prevalence[74]
Total Population	**6–17**	**160,000**
Population in Poverty[75]	6–17	90,000
All Mental Health Conditions (Mild, Moderate, and Severe)[76]	**6–17**	**60,000**
Mild	6–17	35,000
Moderate	6–17	15,000
Serious Emotional Disturbance (SED)[77]	6–17	10,000
SED in Poverty	6–17	8,000
At Risk for Out-of-Home/Out-of-School Placement[78]	6–17	800
Specific Disorders – Youth		
Depression	12–17	10,000
Bipolar Disorder	12–17	2,000
Post-Traumatic Stress Disorder	12–17	3,000
Schizophrenia[79]	10–17	100

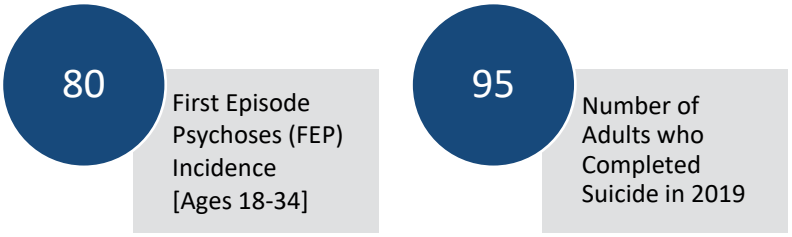
[72] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2018 on CDC WONDER Online Database, released in 2020. Data are from the Multiple Cause of Death Files, 1999–2018, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10.html. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."
[73] Unless otherwise referenced, prevalence estimates were estimated using data from Kessler, R. C., et al. (2012a).
[74] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[75] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[76] Kessler, R. C., et al. (2012a) and Kessler, R. C., et al. (2012b).
[77] Holzer, C., Nguyen, H., & Holzer, J. (2019). *Texas county-level estimates of the prevalence of severe mental health need in 2019*. Meadows Mental Health Policy Institute. See Appendix One for additional information.
[78] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.
[79] Frejstrup Maibing, C., Pedersen, C., Benros, M., Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin,* 41*(4),* 963–970.

Mental Health Condition – Children and Youth	Age Range	Prevalence[74]
First Episode Psychosis (FEP) – New Cases per Year[80]	12–17	30
Obsessive-Compulsive Disorder[81]	6–17	3,000
Eating Disorders[82]	12–17	700
Self-Injury/Harming Behaviors[83]	12–17	8,000
Conduct Disorder[84]	12–17	4,000
Number of Deaths by Suicide[85]	0–17	<10
Specific Disorders		
All Anxiety Disorders[86]	13-17	8,000
Population with 1 or 2 Adverse Childhood Experiences (ACEs)[87]	0–17	85,000
Population with 3 or More ACEs	0–17	25,000

Table 6, below, summarizes 2019 data on El Paso County adults. There were about 610,000 adults living in El Paso County in 2019. Slightly less than one quarter of adults in the region (about 140,000) had any mental health need. Most adults living with mental health conditions had conditions that were mild to moderate in severity (115,000), which could be treated in

[80] Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.
[81] Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.
[82] Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. This study included anorexia nervosa and bulimia nervosa only.
[83] Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(11). https://doi.org/10.1186/1753-2000-6-10
[84] Kessler, R. C., et al. (2012a).
[85] Centers for Disease Control and Prevention. (2020).
[86] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012c). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184.
[87] Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Child Trends. www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

primary care settings, ideally with psychiatric consultation.[88,89] The rest (about 25,000) had serious mental illnesses (SMI), more than half of whom (15,000) were living in poverty.



Based on 2019 data, most mental health needs for adults (as with children and youth) included major depression (45,000 adults) and post-traumatic stress disorder (20,000 adults). Bipolar disorder and schizophrenia affected about 3,000 adults each. The number of anticipated cases of first episode psychosis (FEP) among adults (80) was larger than those anticipated for youth (30). According to the Centers for Disease Control and Prevention, 95 El Paso County adults completed suicide in 2019 —five more than the completed suicides in 2018.

Table 6: Twelve-Month Prevalence of Mental Health Disorders for Adults in El Paso County (2019)[90]

Mental Health Condition – Adults	El Paso County
Total Adult Population	**610,000**
Population in Poverty[91]	260,000
All Mental Health Needs (Mild, Moderate, and Severe)[92]	**140,000**
Mild	60,000
Moderate	55,000
Serious Mental Illness (SMI) [93]	25,000
SMI in Poverty	15,000

[88] Integrated care combines primary health care and mental health care in one setting.
[89] Meadows Mental Health Policy Institute experts estimated that the proportion of the adult population with mental health needs who are best treated in integrated primary care settings is approximately equal to the proportion with mild or moderate mental health conditions. Although some portion of people with serious mental illness (e.g., people with major depression) can be effectively treated in integrated primary care, a proportion of people with moderate mental illness need care at specialty settings. These are offsetting factors and approximately cancel each other.
[90] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[91] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[92] Kessler, R. C., et al. (2005).
[93] Holzer, C., Nguyen, H., & Holzer, J. (2019).

Mental Health Condition – Adults	El Paso County
Complex Needs without Forensic Need (ACT)[94]	300
Complex Needs with Forensic Need (FACT)[95]	200
Specific Diagnoses	
Major Depression[96]	45,000
Bipolar I Disorder[97]	3,000
Post-Traumatic Stress Disorder[98]	20,000
Schizophrenia[99]	3,000
First Episode Psychoses (FEP) Incidence – New Cases per Year (Ages 18–34)[100]	80
Number of Adults who Completed Suicide[101]	95

Table 7: Prevalence of Substance Use Disorders (SUD) Among El Paso County Adults (2019)[102,103]

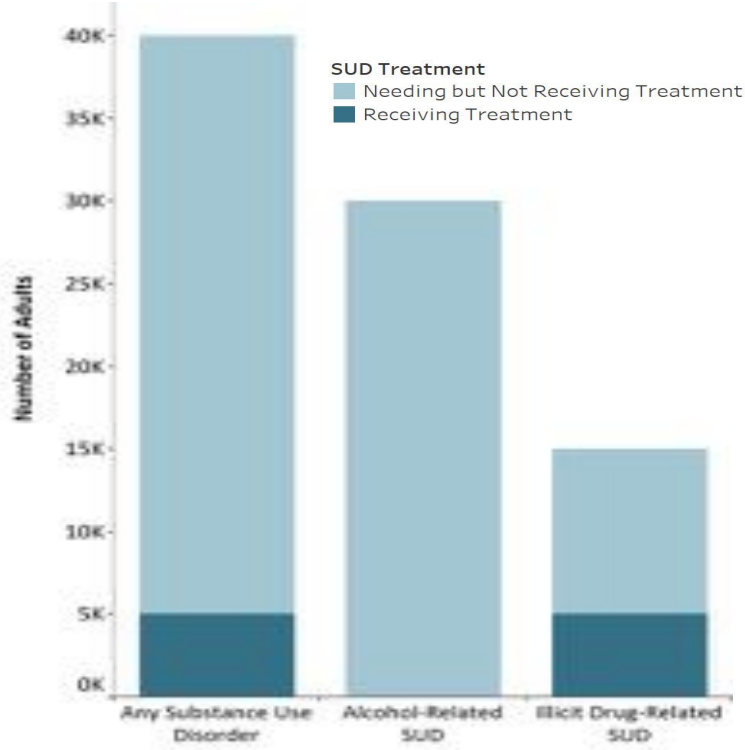
Population	El Paso
Total Population	**610,000**
Total Population in Poverty	260,000
Any Substance Use Disorder	**40,000**
SUD in Poverty[104]	15,000

[94] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*(12), 1803–1806.
[95] Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205–208.
[96] Holzer, C., Nguyen, H., & Holzer, J. (2019).
[97] Holzer, C., Nguyen, H., & Holzer, J. (2019).
[98] Kessler, R. C., et al. (2005).
[99] Simeone, J. C., Ward, A. J., Rotella, P., Collins, J. & Windisch, R. (2015). An evaluation of variation in published estimates of schizophrenia prevalence from 1990–2013: A systematic literature review. *BMC Psychiatry*; *15*:193.
[100] Simon, G. E., Coleman, K. J., Yarborough, B. J. H., Operskalski, B., Stewart, C., Hunkeler, E. M., Lynch, F., Carrell, D., & Beck, A. (2017). First presentation with psychotic symptoms in a population-based sample. *Psychiatric Services, 68*(5): 456–461.
[101] Centers for Disease Control and Prevention. (2020).
[102] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[103] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[104] National Survey on Drug Use and Health (2018-2019), American Community Survey (2019), and Texas Demographic Center (2018).

Population	El Paso
Comorbid Psychiatric and Substance Use Disorders[105]	15,000
Needing but not Receiving Treatment for SUD	35,000
Alcohol-Related SUD	**30,000**
Needing but not Receiving Treatment for Alcohol-Related SUD[106]	30,000
Illicit Drug-Related SUD	**15,000**
Needing but not Receiving Treatment for Illicit Drug-Related SUD[107]	10,000
Number of Drug-Related Deaths in 2019[108]	**96**
Number of Alcohol-Induced Deaths in 2019[109]	**114**

[105] SAMHSA's 2019 report, *Behavioral Health Trends in the United States*, the 2017–2018 NSDUH AMI rates for Texas.
[106] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[107] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[108] Centers for Disease Control and Prevention. (2021).
[109] Centers for Disease Control and Prevention. (2021).

Figure 7: Estimated Substance Use Disorders Among Adults in El Paso County (2019)[110]



Although the overall size of a population in need can be daunting, our prevalence analysis also showed that relatively few people require the most intensive services. Fortunately, there are evidence-based interventions that can have a significant impact on these cohorts. For example, we estimated that in El Paso County, about 300 adults could benefit from ACT, two thirds of whom may benefit from FACT because of their involvement in the criminal justice system. Investment in these programs and using evidence-based tools could have a significant impact by providing the type of intensive services that people with the most serious mental illnesses and emotional disorders require without involving them in the criminal justice or medical systems. There is extended discussion of ACT and FACT in the section on the crisis system.

Demographic Characteristics of the Population

Addressing the issues that affect access to services requires an understanding of the population characteristics in a particular community and the relationship between those characteristics and access to services. This is particularly true in El Paso County, with its predominantly Hispanic or Latino population.

Mental illness affects people of all races, ethnicities, and socio-economic backgrounds. In fact, most racial/ethnic groups have similar prevalence rates, with about 20% experiencing a mental

[110] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

health condition.[111] However, it is also true that there are disparities in access to treatment and minority populations often experience poor mental health outcomes for various reasons, including exposure to significant risk factors, underreporting, limited access to services, cultural stigma, lack of culturally-tailored interventions, and issues with the quality of treatment.[112] Concerns about disparities are certainly true in the Hispanic or Latino population as barriers to care result in increased risk for more severe and persistent mental health conditions.[113]

Because of the large population of Hispanic or Latino residents in El Paso County, our report seeks to contextualize the unique mental health needs of this population, particularly as it affects access to services. It is important to recognize the diversity of culture and life experiences within the Hispanic or Latino population, which, as defined by the U.S. Census Bureau, refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.[114] Recent research and terminology has used Latino, Latina, Latinx, Chicano, and Hispanic to describe these individuals. After consulting with experts from the National Latino Behavioral Health Association, we chose Hispanic or Latino for this report. The Hispanic or Latino population in the U.S. is far from monolithic. Collectively, those who identify themselves as Hispanic or Latino have immigrated or have ancestry from more than 20 countries and territories, speak more than six different languages, and fall all along the socioeconomic spectrum.[115] These individuals are heterogenous and their identity, culture, needs, and experiences differ vastly. For these reasons, we determined that it would be important to provide an overall context to better understand mental health disparities and the impact they have on the population seeking or needing treatment.[116]

Table 8 and Table 9, below, outline the demographics and prevalence of mental health needs of El Paso County residents. These tables show that the population of El Paso County is predominantly Hispanic or Latino, evenly split between male and female youth, with more than half of children and youth living below 200% of the federal poverty level. This is particularly important because research suggests that poverty is generally associated with a higher burden of mental illness, with childhood exposure to poverty – and the length of this exposure – being

[111] American Psychiatric Association. (2017). *Mental health disparities: Diverse populations*. https://www.psychiatry.org/psychiatrists/cultural-competency/education/mental-health-facts
[112] American Psychiatric Association. (2017).
[113] McGuire, T., & Miranda, J. (2008). Racial and ethnic disparities in mental health care: Evidence and policy implications. *Health Affairs, 27*(2), 393–403. https://doi.org/doi: 10.1377/hlthaff.27.2.393
[114] U.S. Census Bureau. (n.d.). *QuickFacts: El Paso County, Texas*. https://www.census.gov/quickfacts/fact/table/elpasocountytexas/RHI725219#RHI725219
[115] Aragones, A. (2014). *Characterization of the Hispanic or Latino population in health research: A systematic review*. https://doi.org/10.1007/s10903-013-9773-0
[116] Fortuna, L. (n.d.). *Working with Latino patients*. https://www.psychiatry.org/psychiatrists/cultural-competency/education/best-practice-highlights/working-with-latino-patients.

strongly associated with poorer mental health outcomes.[117] Comparatively, non-Hispanic whites represented 8% of the total population but only 6% of the population in poverty. Hispanic youth represented 87% of the population and 92% of the population in poverty.

Table 8: Demographics of Children and Youth in El Paso County (2019)[118]

Population	Total Population	Total Population with SED	Total in Poverty[119]	Total Population with SED in Poverty
Children and Youth (6–17)	160,000	10,000	90,000	8,000
Age				
Ages 6–11	75,000	6,000	45,000	4,000
Ages 12–17	80,000	6,000	45,000	4,000
Sex				
Male	80,000	6,000	45,000	4,000
Female	75,000	6,000	45,000	4,000
Race/Ethnicity				
Non-Hispanic White	15,000	900	5,000	500
Black or African American	3,000	200	700	60
Asian American	1,000	100	300	30
Native American	400	30	300	30
Multiple Races	2,000	200	1,000	90
Hispanic or Latino	140,000	10,000	85,000	8,000

Adult demographics are similar to child and youth demographics in that most of the population is Hispanic or Latino, representing 80% of the total population, as depicted in Table 9. The poverty distribution is largely equal across age groups, with adults ages 65 and older slightly over-represented among the population in poverty. Females were also slightly more likely than males to be in poverty, as were Hispanic or Latino adults (81% of the total population and 89%

[117] Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics, 139*(1). https://doi.org/10.1542/peds.2015-1175
[118] All Texas population estimates were rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts.
[119] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.

of the population in poverty). Of adults in El Paso County, 75% were U.S born, 29% spoke English as their primary language at home, and one fourth were uninsured.[120]

Table 9: Demographics of Adults in El Paso County (2019)[121]

El Paso County	Population	Population with SMI	Adults in Poverty[122]	Adults with SMI in Poverty
Adult Population 18 and Older	610,000	25,000	260,000	15,000
Age				
18–20	40,000	700	20,000	500
21–24	60,000	2,000	25,000	1,000
25–34	120,000	7,000	55,000	5,000
35–44	110,000	7,000	45,000	5,000
45–54	95,000	5,000	35,000	3,000
55–64	85,000	3,000	35,000	2,000
65 and Older	100,000	2,000	45,000	1,000
Sex				
Male	290,000	10,000	110,000	6,000
Female	310,000	15,000	150,000	10,000
Race/Ethnicity				
Non-Hispanic White	85,000	4,000	20,000	2,000
Black or African American	20,000	1,000	5,000	400
Asian American	8,000	200	2,000	70
Native American	2,000	100	800	80
Multiple Races	4,000	200	1,000	100
Hispanic or Latino	490,000	20,000	230,000	15,000

[120] United States Census Bureau. (2020). *QuickFacts: El Paso County, Texas.* www.census.gov/quickfacts/elpasocountytexas

[121] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

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

According to the 2018 National Survey on Drug Use and Health, approximately 33% of U.S. Hispanic or Latino adults with mental illness receive treatment each year, compared to the national average of 43%; however, Hispanic or Latino communities show similar susceptibility to mental illness as the general population.[123] Members of Hispanics or Latino communities living in the U.S. have significantly higher scores on measures of mental health needs (depression) compared to their non-Hispanic white counterparts, and U.S.-born Hispanics or Latinos demonstrate greater mental health symptom severity than do immigrant Hispanics or Latinos.[124] Disparities in access and utilization of mental health services exist for many minority populations, including many Hispanics or Latino populations, who are less likely to utilize mental health services, including prescription medications, and are more likely to discontinue treatment prematurely.[125] The continued failure to address the significant unmet mental health needs among Hispanics or Latinos will result in an increased burden on many Hispanic or Latino families and communities and to the United States overall.[126]

Because the El Paso community is predominantly Hispanic or Latino, the following section focuses on cultural factors that can affect decisions to address mental illness (e.g., seeking help, disclosing personal information). To inform this section of the assessment, we engaged experts from the National Latino Behavioral Health Association to review this content and provide input to ensure that our analysis and recommendations were culturally appropriate and responsive. We used their input to inform our discussion of several barriers to accessing mental health care for the Hispanic or Latino population, including stigma and a lack of health insurance coverage, and guide our exploration of other contributing factors to consider, including medical mistrust, cultural and linguistic competency, and the specific needs of the undocumented population.

Barriers to Access to Care

Stigma

Stigma toward mental illness is a complex construct that affects people's desire to seek mental health care and engage in treatment. There are several constructs of mental illness stigma, including self-stigma, perceived stigmatization, stigma tolerance, indifference to stigma, desired

[123] Substance Abuse and Mental Health Services Administration. (n.d.). *2018 NSDUH detailed tables*. https://www.samhsa.gov/data/report/2018-nsduh-detailed-tables

[124] Alegría, M., Canino, G., Shrout, P. E., Woo, M., Duan, N., Vila, D. &, Meng, X-L. (2008, April). Prevalence of mental illness in immigrant and non-immigrant U.S. Latino groups. *American Journal of Psychiatry, 165*(3):359–369. https://ajp.psychiatryonline.org/doi/full/10.1176/appi.ajp.2007.07040704

[125] Cabassa, L. J., Zayas, L. H., & Hansen, M. C. (2006). Latino adults' access to mental health care: A review of epidemiological studies. *Administration and Policy in Mental Health and Mental Health Services Research,33*, 316–330.

[126] López, S. R. (2002). Mental health care for Latinos: A research agenda to improve the accessibility and quality of mental health care for Latinos. *Psychiatric Services, 53*(12), 1569–1573.

social distance, and stigma toward treatment and antidepressant medications.[127] Certain groups, including ethnic minorities, are disproportionately affected by the effects of stigma.[128] Among many Hispanics or Latinos, stigma has been found to be negatively associated with the desire to engage in mental health care, manage depression symptoms, disclose mental illness to family and friends, and adhere to antidepressant medication regimens.[129] In general, individuals from the Hispanic or Latino population have higher rates of perceived stigma and lower lifetime prevalence rates of behavioral health service use.[130] This results in delays and gaps in opportunities to discuss mental wellness, recognize early signs and symptoms associated with mental health conditions, and reduce access to needed services.

Stigma has been shown to have a negative impact on access to services. Some people in the Hispanic or Latino community fear that people may think "me estoy volviendo loco" ("I'm going crazy"), or that they will be shamed for talking opening or publicly about their mental health challenges. Hispanic or Latino parents are also less likely to seek treatment for their children if they feel high levels of stigma regarding mental health services, as these parents may be more concerned about being ostracized by friends, families, and co-workers.[131] Hispanic or Latino parents are more likely to seek health care services for their child if they believe their children's problems are the result of biological issues, rather than to seek help for problems related to social, personality, or familial difficulties.[132]

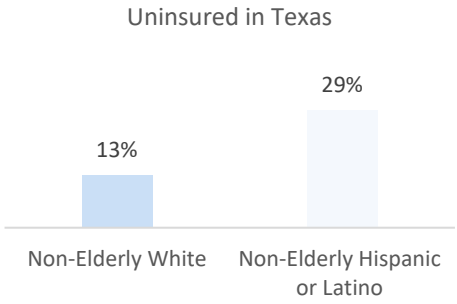
It is important to emphasize that Hispanic or Latino families experience the full range of psychosocial stressors that all families, irrespective of ethnicity or culture, experience. However, stress from acculturation – the process when immigrants begin to adapt and develop new, hybrid cultures after arriving in the United States – may affect Hispanic or Latino families in unique ways that make coping more difficult because the usual cultural and social supports

[127] Eghaneya, B. H., & Murphy, E. R. (2020). Measuring mental illness stigma among Hispanics: A systemic review. *Stigma and Health, 5*(3), 351–363. https://doi.org/10.1037/sah0000207
[128] Wong, E. C., Collins, R. L., Cerully, J., Seelam, R., & Roth, B. (2017). Racial and ethnic differences in mental illness stigma and discrimination among Californians experiencing mental health challenges. *Rand Health Quarterly, 6*(2), 6.
[129] Eghaneya, B. H., & Murphy, E. R. (2020).
[130] Benuto, L. T., Gonzalez, F., Reinosa-Segovia, F., & Duckworth, M. (2019, December). Mental health literacy, stigma, and behavioral health service use: The case of Latinx and non-Latinx Whites. *Journal of Racial and Ethnic Health Disparities, 6*(6):1122–1130. doi: 10.1007/s40615-019-00614-8
[131] Jimenez, D. E., Bartels, S. J., Cardenas, V., & Alegría, M. (2013). Stigmatizing attitudes toward mental illness among racial/ethnic older adults in primary care: Stigma in older adults. *International Journal of Geriatric Psychiatry, 28*(10), 1061–1068. https://doi.org/10.1002/gps.3928
[132] Yeh, M., McCabe, K., Hough, R. L., Lau, A., Fakhry, F., & Garland, A. (2005). Why bother with beliefs? Examining relationships between race/ethnicity, parental beliefs about causes of child problems, and mental health service use. *Journal of Consulting and Clinical Psychology, 73*(5), 800–807. https://doi.org/10.1037/0022-006X.73.5.800

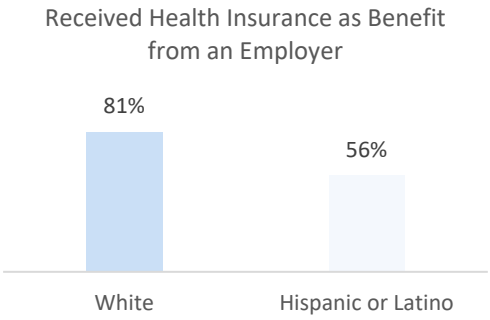
(e.g., extended family) that were available in their country of origin may not be readily available in their adopted country.[133]

Lack of Health Insurance Coverage and Lack of a Usual Source of Care

Another major barrier to accessing mental health treatment is the disparity in health insurance coverage for the Hispanic or Latino population. According to the Kaiser Family Foundation, in Texas, 29% of non-elderly Hispanics or Latinos were uninsured, compared to 13% of non-elderly whites in Texas;[134] in the U.S., 19% of non-elderly Hispanics or Latinos are uninsured.[135] Two key barriers to health care access are (1) not having health insurance coverage and (2) not having a usual source of care. A usual source of care is the specific health care provider, health clinic, health center, or other place where a person would usually go if they were sick or in need of advice about their health. Health insurance reduces the out-of-pocket costs of health care and has been shown to be the single most important predictor of utilization. Similarly, having a usual source of care reduces non-financial barriers to obtaining care, facilitates access to health care services, and increases the frequency of contacts with health care providers.[136]



Members of the Hispanic or Latino community are less likely than non-Hispanic or Latino whites to receive health insurance as a benefit from an employer, which is the most common source of health insurance coverage for working-age adults and their children in the United States; Hispanic or Latino workers are less likely to work for an employer that offers health insurance than their white counterparts (56% versus 81%).[137] Research shows that those who are uninsured often delay or go without needed care, which can lead to worse health outcomes over the long term and may ultimately result in conditions that are more



[133] Cervantes, R. C., Fisher, D. G., Padilla, A. M., & Napper, L. E. (2016). The Hispanic Stress Inventory Version 2: Improving the assessment of acculturation stress. *Psychological Assessment, 28*(5), 509.
[134] Kaiser Family Foundation. (2018). *Uninsured rates for the nonelderly by race/ethnicity*. https://www.kff.org/uninsured/state-indicator/rate-by-raceethnicity/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[135] Kaiser Family Foundation. (2018).
[136] Escarce, J. J., & Kapur, K. (2006). Access to and quality of health care. In M. Tienda & F. Mitchell (Eds), *Hispanics and the future of America* (consensus study report). The National Academies Press. https://www.ncbi.nlm.nih.gov/books/NBK19910/
[137] Escarce, J., & Kapur, K. (2006).

complicated and expensive to treat.[138] Familiarity with a particular provider may also make people more comfortable in seeking care, make it easier to schedule appointments at convenient times, and reduce uncertainty about the costs or other inconveniences involved in obtaining care.[139]

Additional Contributing Factors

Medical Mistrust

In addition to stigma and a lack of health insurance coverage, medical mistrust can affect access to mental health care for the Hispanic or Latino population. Medical mistrust as a result of historical discrimination may also play a role in the decisions of many Hispanic or Latinos regarding whether or not to use health care, even when it is available.[140] Research on medical mistrust indicates that mistrust originates from a patient's negative experiences in one aspect of the health care system, which then leads to a general mistrust of health care overall.[141]

One consistent predictor of trust for medical providers among the Hispanic or Latino population is health insurance coverage status.[142] A lack of health insurance coverage usually results in a lack of a usual source of care and more variability of providers at emergency departments or community clinics. This lack of continuity of care impedes the development of a trusting and meaningful relationship between patients and providers, which then exacerbates medical mistrust.[143]

Cultural and Linguistic Competence and Representation

Cultural and linguistic competence is the term used to describe a provider's ability to understand the role that culture and language play in the treatment of mental health conditions, including the set of skills or processes that enable mental health professionals to provide services that are culturally appropriate for the diverse populations that they serve. This includes knowledge of how culture influences attitudes, expressions of distress, and help seeking practices.[144] Showing respect for patients' cultural beliefs and attitudes is an important component of cultural competency, especially when the patients' views differ from their

[138] Escarce, J., & Kapur, K. (2006).
[139] Escarce, J., & Kapur, K. (2006).
[140] López-Cevallos, D. F., Harvey, S. H., & Warren, J. T. (2014, February 27). Medical mistrust, perceived discrimination, and satisfaction with health care among young-adult rural Latinos. *The Journal of Rural Health, 30*(4). https://doi.org/10.1111/jrh.12063
[141] LaVeist, T. A., Isaac, L. A., & Williams, K. P. (2009, September). Mistrust of health care organizations is associated with underutilization of health services. *Health Services Research, 44*(6):2093–105. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2796316/
[142] Boyas, J., & Valera, P. A. (2011). Determinants of trust in medical personnel. *Hispanic Health Care International, 9*(3), 144–152.
[143] Boyas, J., & Valera, P. A. (2011).
[144] Bhui, K., Warfa, N., & Bhugra, D. (2007). Cultural competence in mental health care: A review of model evaluations. *BMC Health Services Research, 7*(15). https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1800843/

providers' views. Cultural competence includes working toward a common goal to increase the capabilities of staff to provide culturally appropriate care to patients. If a provider does not demonstrate cultural competence, communication can be affected and mistrust can develop, creating a barrier to care and contributing to negative outcomes.[145] Cultural and linguistic competence and the representation of providers in the workforce whose demographics match those of the broader community can play a role in decisions to seek health care as well, and the El Paso community has taken steps to attempt to address these issues that we document.

Providers should practice cultural humility along with cultural competence. Cultural humility is defined as the ability to maintain an interpersonal stance that is oriented toward others rather than toward oneself, particularly in relation to key aspects of the other person's cultural identity.[146] This construct can be used to understand and develop a process-oriented approach to cultural competence. Cultural humility includes a lifelong commitment to self-evaluation and self-critique, a desire to correct power imbalances, and an aspiration to develop partnerships with people and groups who advocate for others.[147,148] The U.S. Department of Health and Human Services Office of Minority Health (OMH) released the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care* in 2000. The CLAS standards establish a blueprint that health care organizations can use to provide culturally competent services that respect individuals and respond to their health needs and preferences.[149] Although OMH originally released the CLAS standards in 2000 and later updated them in 2013, nationally representative data are still lacking on perceived cultural competence in health care settings and the importance of providers' cultural competence to patients.[150]

Language is also a barrier in seeking and delivering appropriate treatment among some members of the Hispanic or Latino populations; language proficiency is especially important in psychiatric care because determination of psychiatric diagnoses significantly depends on verbal

[145] Saha, S., Beach, M. C., & Cooper, L. (2008, November). Patient centeredness, cultural competence and healthcare quality. *Journal of the National Medical Association, 100*(11), 1275–1285. https://doi.org/doi: 10.1016/s0027-9684(15)31505-4
[146] Hook, J. N., Davis, D. E., Owen, J., Worthington Jr., E. L., & Utsey, S. O. (2013). Cultural humility: Measuring openness to culturally diverse clients. *Journal of Counseling Psychology, 60*(3):353–366. doi:10.1037/a0032595
[147] Jones, N. A., & Bullock, J. (2012, September). *The two or more races population: 2010*. U.S. Census Bureau. http://www.census.gov/prod/cen2010/briefs/c2010br-13.pdf
[148] Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility versus cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Health Care for the Poor and Undeserved, 9*, 117–125.
[149] Terlizzi, E. M., Connor, E. M., Zelaya, C. E., Ji, A. M.,& Bakos, A. D. (2019, October 8). Reported importance and access to health care providers who understand or share cultural characteristics with their patients among adults, by race and ethnicity. *National Health Statistics Reports, 130*. https://www.cdc.gov/nchs/data/nhsr/nhsr130-508.pdf
[150] Terlizzi, E. M., Connor, E. M., Zelaya, C. E., Ji, A. M.,& Bakos, A. D. (2019, October 8).

communication between patients and professionals.[151] There is a clear association between limited language proficiency and underutilization of psychiatric services.[152] A major factor for people who have limited proficiency in English is access to providers who speak their native languages. Language fluency, above and beyond cultural factors, is therefore a significant barrier for people with limited English proficiency to seek treatment, placing them at greater risk for poor mental and physical health outcomes.[153]

Undocumented Populations

Immigrants within the Hispanic or Latino population also face health disparities. According to the United States Census Bureau, the immigrant population includes naturalized citizens and legal immigrants such as lawful permanent residents; refugees, or visa holders; and undocumented immigrants. It is estimated that approximately 67,000 undocumented immigrants in Texas reside in El Paso County, 18% of whom are 24 years of age or younger.[154] Ninety-five percent (95%) of undocumented immigrants in El Paso County have immigrated from Mexico and Central America and 62% are uninsured.[155,156] Furthermore, undocumented Mexican immigrants are at a higher risk for mental health disorders, particularly depression and anxiety disorders. One factor contributing to this risk is the experience of post-migration living difficulties,[157] which can include discrimination, stigmatization, marginalization, isolation, fear of deportation, exploitability, victimization, living in unsafe neighborhoods, and socioeconomic disadvantage.[158] Undocumented immigrants to the United States are often faced with multiple stressors and contextual challenges, which may increase risk for mental health disorders.[159]

Undocumented immigrants face additional barriers to accessing quality mental health treatment. They are more likely to be uninsured since they have limited options for affordable health coverage. The Personal Responsibility Work Opportunity Reform Act of 1996 restricted

[151] Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015, May). Language barriers and access to psychiatric care: A systematic review. *Psychiatric Services, 66*(8):798–805. https://doi.org/10.1176/appi.ps.201400351
[152] Ohtani, A., Suzuki, T., Takeuchi, H., & Uchida, H. (2015, May).
[153] Patel, S., Firmender, W. M., & Snowden, L. R. (2013). Qualitative evaluation of mental health services for clients with limited English proficiency. *International Journal of Mental Health Systems, 7*(27). https://doi.org/doi: 10.1186/1752-4458-7-27
[154] Migration Policy Institute. (n.d.). *Profile of the unauthorized population: El Paso County, TX*. Retrieved September 17, 2020, from https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/48141
[155] Migration Policy Institute. (n.d.). *Profile of the unauthorized population: El Paso County, TX*. Retrieved October 28, 2020, from https://www.migrationpolicy.org/data/unauthorized-immigrant-population/county/48141
[156] Migration Policy Institute. (n.d.).
[157] Garcini, L. M., Galvan, T., & Klonoff, E. (2017). Mental disorders among undocumented Mexican immigrants in high-risk neighborhoods: Prevalence, comorbidity, and vulnerabilities. *Journal of Consulting and Clinical Psychology, 85(*10), 927–936. https://doi.org/doi: 10.1037/ccp0000237
[158] Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016). Mental health of undocumented immigrant adults in the United States: A systematic review of methodology and findings. *Journal of Immigrant & Refugee Studies, 14*:1–25.
[159] Garcini, L. M., Murray, K. E., Zhou, A., Klonoff, E. A., Myers, M. G., & Elder, J. P. (2016).

eligibility for federal public benefits, including Medicaid, for both undocumented and lawfully present immigrants, resulting in less access to services.[160]

In addition to having higher uninsured rates, undocumented immigrants may be reluctant to seek care because they believe health care providers will report them or their families to immigration authorities. They may fear that if they are reported, they will be considered a "public charge" by immigration authorities, which generally prevents them from obtaining lawful permanent residency or citizenship.[161] An undocumented immigrant is considered a "public charge" if they rely on government assistance for basic necessities for more than 12 months.[162]

Finally, immigrants are often in a "mixed-status" family, which includes individual members with different immigration statuses, including U.S. citizens. To protect other family members from the potential for deportation, family members of undocumented immigrants are less likely to obtain health coverage or access services, even if they qualify for federally funded health care programs such as Medicaid or Medicare. For example, assuming all family members have the same immigration status has likely resulted in children (who are U.S. citizens) of immigrant parents being disproportionately uninsured than children with parents who were born in the United States.[163,164]

Service Capacity

Access to care depends on service capacity, and service capacity requires matching the best possible care to need. While this may seem axiomatic, our knowledge of "what works" best for people with mental illnesses and serious emotional disorders has improved significantly in the last two decades, and we increasingly understand that most people with mental illnesses and serious emotional disorders can and should be treated in primary and integrated care settings. We discuss service capacity below, with reference, as appropriate, to the demographic characteristics of El Paso County's population. Other capacity issues (for example, Assertive

[160] For a helpful summary of the immigrant eligibility restrictions under the Personal Responsibility Work Opportunity Reform Act that still apply today, see *Overview of Immigrant Eligibility for Federal Programs*, National Immigration Law Center, available at: http://www.nilc.org/table_ovrw_fedprogs.html.
[161] U.S. Citizenship and Immigration Services. (n.d.). *Public charge fact sheet*. Department of Homeland Security. https://www.uscis.gov/news/public-charge-fact-sheet
[162] U.S. Citizenship and Immigration Services. (n.d.).
[163] Kaiser Family Foundation. (2013, March 4). *Key facts on health coverage for low-income immigrants today and under the Affordable Care Act*. https://www.kff.org/racial-equity-and-health-policy/fact-sheet/key-facts-on-health-coverage-for-low/
Kenney, G. M., Haley, J. M., Anderson, N., & Lynch, V. (2015, May 1). Children eligible for Medicaid or CHIP: Who remains uninsured, and why? *Academic Pediatrics, 15*(3), S36–S43. http://www.academicpedsjnl.net/article/S1876-2859(15)00010-8/abstract
[164] Kenney, G. M., Haley, J. M., Anderson, N., & Lynch, V. (2015, May 1).

Community Treatment) are discussed in this report's sections on the crisis system and children and youth; we highlight key issues of general importance here.

Integrated Primary Care

Integrated care occurs when mental health and general medical care providers work together to address both the physical and behavioral health needs of their patients. Integrated primary care settings can help detect behavioral health needs earlier and successfully treat routine and even some moderately severe needs related to behavior, anxiety, and depression. Integrating behavioral health within all primary care settings is an essential strategy for increasing access to behavioral health services, treating those with most mild to moderate conditions, and coordinating referrals for those in need of specialty and more intensive care.

Furthermore, pediatric care, where the family doctor provides ongoing, routine care for children, youth, and their caregivers, is the front line for health care delivery and the place where families are most likely to receive care. 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 are optimally provided. Integrated primary and behavioral health care provide the opportunity for early detection and treatment of mental health concerns. Studies have found that the use of an integrated primary care model improved outcomes for children and youth and was feasible in a variety of settings.[165,166,167] Furthermore, fully scaled statewide integrated care programs have shown that about two thirds of children and youth with behavioral health needs could be served in an integrated primary care model.[168]

Finding: There are some good examples of integrated primary and behavioral health care in El Paso County, and their scope and reach should be expanded. Project Vida, a federally qualified health center (FQHC) in El Paso County, has six clinics that are fully integrated with mental and behavioral health services and satellite clinics in rural areas of El Paso County. Providers screen patients in primary care by using the Patient Health Questionnaire (PHQ-9) for depression, the Overall Anxiety Severity and Impairment Scale (OASIS) for anxiety, the Generalized Anxiety Disorder 7-item (GAD-7) to screen youth for anxiety, and screening tools with pictures for

[165] Asarnow, J. R., Jaycox, L. H., Dunan, N., LabBorde, A. P., Rea, M. M., Murray, P., et al. (2005, January 19). Effectiveness of a quality improvement intervention for adolescent depression in primary care clinics: A randomized controlled trial. *JAMA, 293*(3): 311-319. https://jamanetwork.com/journals/jama/fullarticle/200194

[166] Richardson, L. P., Ludman, E., McCauley, E., Lindembaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014, August 27). Collaborative care for adolescents with depression in primary care: a randomized clinical trial. *JAMA, 312*(8): 809-816. https://jamanetwork.com/article.aspx?doi=10.1001/jama.2014.9259

[167] Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski, S. (2014, April). Collaborative care outcomes for pediatric behavioral health problems: a cluster randomized trial. *Pediatrics, 133*(4): 2981-2992. https://pubmed.ncbi.nlm.nih.gov/24664093/

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

patients who are illiterate. Project Vida conducts screenings every time a patient comes in for services and uses previous screenings to determine progress in patients' outcomes. Furthermore, Project Vida uses required risk assessments to assess if patients are at high risk and need to be qualified for inpatient treatment services. One of the providers at Project Vista also works at Rio Vista, a private inpatient provider in El Paso County, which further enhances continuity of care for their patients. Project Vida also provides integrated care for populations experiencing homelessness, including conducting outreach and utilizing mobile units that go to shelters.

Screening Tools	Patient Health Questionnaire (PHQ-9) for depression
	Overall Anxiety Severity and Impairment Scale (OASIS) for anxiety
	Generalized Anxiety Disorder 7-item (GAD-7) to screen youth for anxiety, and screening tools with pictures for patients who are illiterate

EHN operates two integrated primary medical care clinics that are staffed with multi-specialty providers and a behavioral health consultant who provides integrated behavioral health and primary care. Additionally, EHN has partnered with University Medical Center (UMC) to co-locate behavioral health workers in four of UMC's primary care clinics. EHN's recent Certified Community Behavioral Health Center accreditation could potentially leverage alternative payment options through Medicaid managed care organizations.

Primary care physicians at Centro San Vicente, another FQHC in El Paso County, treat mild to moderate mental and behavioral health needs of their patients and refer people with higher needs to mental health providers within the FQHC. Project Vida also provides integrated care for populations experiencing homelessness, including conducting outreach and utilizing mobile units that go to shelters.

The Child Psychiatry Access Network (CPAN) is another example of integrated primary care being implemented in El Paso County. As described in Senate Bill (SB) 11, the Texas Child

Mental Health Care Consortium is responsible for overseeing five key initiatives, one of which is CPAN. The CPAN program supports pediatric primary care providers by providing them with no-cost psychiatric consultations for patients with a presenting or suspected mental health concern. A similar program established in Massachusetts currently supports over 95% of the pediatric primary care providers in the state and suggests that two thirds of behavioral health care could be provided in pediatric settings with the right integration supports.[169] Through CPAN, pediatricians and other primary care providers can access child psychiatric and mental health consultation services through regional "hubs" supported by Texas medical schools. The hub that includes El Paso County is located at the Texas Tech University Health Sciences Center at El Paso.

In 2020, El Paso County had 67 licensed psychiatrists.[170] This indicates that one psychiatrist is available per 11,500 El Paso County residents.[171] Of these, only 18 reported a specialization in child and adolescent psychiatry, pediatric psychiatry, or developmental-behavioral pediatrics to the Texas Medical Board. Given the population size of children and youth ages 6 to 17 in El Paso County in 2020,[172] we estimate that there is 11.11 child and adolescent psychiatrist in El Paso County per 100,000 child and adolescent residents. CPAN will help address the shortage of child psychiatrists in El Paso County and across Texas. Access to child and adolescent psychiatrists is a national challenge, particularly outside of major urban hubs. According to an article published in the journal of the American Academy of Pediatrics, nationally, there were 9.75 child psychiatrists for every 100,000 children ages 0 to 19 in 2016, which is slightly below the distribution of child psychiatrists in El Paso County.[173]

Although there are some promising examples of integrated primary care in El Paso County, there are opportunities to expand these services to reach more children and youth.

Recommendation: El Paso County providers can learn from and build on the examples at Project Vida, Centro San Vicente, and Emergence Health Network, and also implement new opportunities. There are a range of strategies and supports providers can implement to move toward integrated care. There are standardized instruments to help primary care providers screen their patients to identify mental health needs, such as the PHQ-9 for depression, the

[169] Straus, J. H., & Sarvet, B. (2014).
[170] Registry data on all actively practicing physicians in the state of Texas were abstracted from the Texas Medical Board Open Records Self-Service Portal on March 30, 2020. orssp.tmb.state.tx.us/
[171] Many of the licensed psychiatrists with practice addresses in El Paso are affiliated with local universities and may have limited clinical appointments. Therefore, our providers-to-population ratio for all providers, and psychiatrists in particular, is likely an overestimation of the number of providers available to serve the El Paso population.
[172] Texas Demographic Center. (2018).
[173] McBain, R. K., Kofner, A., Stein, B. D., Cantor, J. H., Vogt, W. B., & Yu, H. (2019). Growth and distribution of child psychiatrists in the United States: 2007-2016. *American Academy of Pediatrics, 144*(6). https://doi.org/10.1542/peds.2019-1576

GAD-7 to screen youth for anxiety, and the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5) for trauma. If potential mental health concerns are identified through these instruments, providers can refer patients to specialty providers in the community.

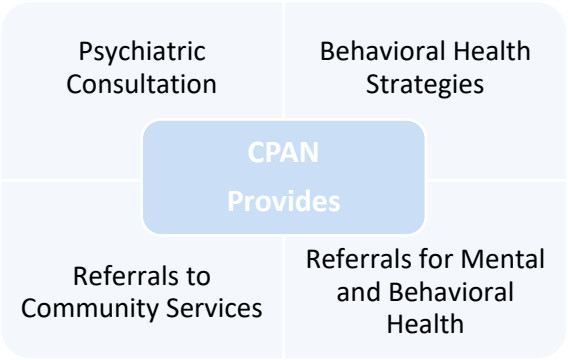
Along with increasing the practice of screening children and youth for mental health, it is also important to establish supports for new mothers. As of July 1, 2018, Medicaid and the Children's Health Insurance Program (CHIP) began covering postpartum depression screenings and a child's physician can be paid for one exam per eligible child over a 12-month period.[174] This practice recognizes that in a pediatric primary care setting, the health and mental health of caregivers is equally important to the health and mental health of 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 support the healthy development of the child.

In addition, the American Academy of Pediatrics recently published recommendations on mental health competencies for pediatric primary care providers to help support the integration of mental health care in primary care settings.[175] Within these recommendations, the American Academy of Pediatrics Task Force on Mental Health created an algorithm illustrating where mental health assessment and management can be incorporated within the pediatric practice workflow. These recommendations could be used as a framework for clinical settings that are considering the implementation of integrated care into their practice.

Providers should also explore financing options for integrated care. Health and Behavior Assessment and Intervention[176] services are designed to help providers identify the psychological, behavioral, emotional, cognitive, and social needs of a child or youth with an underlying physical illness or injury. Providers can advocate with commercial insurers and payers for appropriate payment to primary care providers and mental health specialists for the mental health services they provide and use appropriate coding and billing practices to support mental health services.[177] The Medicaid benefit is for children and youth who are 20 years of age and younger when the services are provided. Services need to be provided by a licensed practitioner of the healing arts who is co-located in the same office or building complex as the

[174] Doolittle, D. (2018, July 10). *Postpartum depression screening now covered by Texas Medicaid*. Texas Medical Association. https://www.texmed.org/TexasMedicineDetail.aspx?id=48072
[175] Foy, J. M., Green, C. M., Earls, M. F., AAP Committee on Psychosocial Aspects of Child and Family Health, Mental Health Leadership Work Group. (2019). Mental health competencies for pediatric practice. *Pediatrics, 144*(5), e20192757. https://pediatrics.aappublications.org/content/pediatrics/144/5/e20192757.full.pdf
[176] Texas Medicaid and Healthcare Partnership. (2020, June 16). *Texas Medicaid provider procedures manual*. http://www.tmhp.com/resources/provider-manuals/tmppm
[177] Foy, J. M., Green, C. M., Earls, M. F., AAP Committee on Psychosocial Aspects of Child and Family Health, Mental Health Leadership Work Group. (2019). Mental Health Competencies for Pediatric Practice. Pediatrics, 144(5), e20192757. https://pediatrics.aappublications.org/content/pediatrics/144/5/e20192757.full.pdf

physician, physician's assistant, nurse practitioner, or clinical nurse specialist who is treating the patient.[178] Health and Behavior Assessment and Intervention services help promote physical and behavioral health integration, and identify the psychological, behavioral, emotional, cognitive, and social factors that are important to prevent, treat, or manage physical health symptoms. Health and Behavior Assessment and Intervention services can include the child or youth's family if the family members directly participate in the overall care of the client. Additional information on the eligibility criteria and procedures codes that can be billed for Health and Behavior Assessment and Intervention services can be found in the Texas Medicaid Provider Procedures Manual.[179]



Finally, with the recent launch of CPAN in El Paso County, pediatric primary care providers and mental health leaders in the county can collaborate, maximizing the opportunities the initiative offers. Pediatric primary care providers currently can enroll in the CPAN program through Texas Tech University Health Sciences Center at El Paso. When mental health needs are identified, pediatric primary care providers can access the CPAN hub's referral network for psychiatric consultation, behavioral health strategies, and referrals to community services and supports to address the mental and behavioral health needs they identify in their patients. Specialty outpatient services providers play a critical role in CPAN as referral sources for conditions that cannot be managed in primary care. The Texas Tech University Health Sciences Center at El Paso CPAN referral network enables pediatricians and primary care providers to be better equipped to refer their patients to community services and supports that specifically address the behavioral health needs of children and youth.

Finding and Recommendation: Research has shown that, compared to non-Hispanics or Latinos, individuals in the Hispanic or Latino population believe primary care providers should treat child mental health problems, and that these parents are more willing to allow their child to receive medications or visit a therapist if recommended by a primary care provider.[180] This supports suggestions that Hispanic or Latino adults are more likely to seek advice about mental health from a primary care provider rather than from a

[178] Texas Medicaid and Healthcare Partnership. (2020, June 16).
[179] Texas Medicaid and Healthcare Partnership. (2020, June 16).
[180] Brown, J. D., Wissow, L. S., Zachary, C., & Cook, B. L. (2007). Receiving advice about child mental health from a primary care provider: African American and Hispanic parent attitudes. *Medical Care, 45*(11), 1076–1082. https://doi.org/10.1097/MLR.0b013e31812da7fd

specialist.[181,182,183] **Given these findings, primary care may be a good setting for mental health interventions for the Hispanic or Latino population, especially through use of the Collaborative Care Model. In addition, providers should hire and train staff to address cultural competence and linguistic needs.**

One systematic approach to treating mental health conditions in primary care settings is the Collaborative Care Model (CoCM), a best practice integrated care model. CoCM is an evidence-based approach[184] to deliver mental health services effectively and efficiently in primary care settings with a care team lead by the primary care provider (PCP) and includes a behavioral health care manager and consulting psychiatrist, as demonstrated in Figure 8. By embedding mental health services into medical practices, CoCM can significantly expand access to mental health assessment and treatment for people who are experiencing mental health concerns, which will lead to improved health outcomes and reduced costs to the overall health system. CoCM is the only evidence-based procedure for integrated care that is currently reimbursable in primary care, covered by Medicare since 2017 and by nearly all commercial and many Medicaid payers.[185] Additionally, it is the only model with strong evidence of cost-savings.[186,187,188]

[181] Cook, B. L., Zuvekas, S. H., Carson, N., Wayne, G. F., Vesper, A., & McGuire, T. G. (2014). Assessing racial/ethnic disparities in treatment across episodes of mental health care. *Health Services Research, 49*(1), 206–229. https://doi.org/10.1111/1475-6773.12095

[182] Brown, J. D., Wissow, L. S., Zachary, C., & Cook, B. L. (2007).

[183] Miranda, J., & Cooper, L. A. (2004). Disparities in care for depression among primary care patients. *Journal of General Internal Medicine, 19*(2), 120–126. https://doi.org/10.1111/j.1525-1497.2004.30272.x

[184] Centers for Medicare & Medicaid Services. (2019, May). Behavioral health integration services. https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/BehavioralHealthIntegration.pdf

[185] American Psychiatric Association. (2019). Coverage for psychiatric Collaborative Care Management (CoCM) codes. file:///C:/Users/bwils/Downloads/CoCM-Payers-June-2019.pdf

[186] Unützer, J., Harbin, H., Schoenbaum, M., & Druss, B. (2013, May). The Collaborative Care Model: An approach for integrating physical and mental health care in Medicaid health homes. Center for Health Care Strategies, Inc. https://www.chcs.org/resource/the-collaborative-care-model-an-approach-for-integrating-physical-and-mental-health-care-in-medicaid-health-homes/

[187] Press, M. J., Howe, R., Schoenbaum, M., Cavanaugh, S., Marshall, A., Baldwin, L., & Conway, P. H. (2017). Medicare payment for behavioral health integration. *New England Journal of Medicine, 376*(5), 405–407. https://doi.org/10.1056/NEJMp1614134

[188] Davenport, S., Matthews, K., Melek, S. P., Norris, D., & Weaver, A. (2018, February 12). *Potential economic impact of integrated medical-behavioral healthcare: Updated projections for 2017*. Milliman. file:///C:/Users/bwils/Downloads/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf

Figure 8: Infographic of Collaborative Care Model[189]

By incorporating CoCM into mental health services, physicians and mental health service providers can intervene early and provide assessment and treatment, which will save lives and reduce overall costs. Primary care practices, in particular, are well positioned to detect postpartum depression in their patients while providing timely care. To support routine mental health screening and treatment, influential entities in El Paso County could help promote CoCM while working with providers and health plans to develop integration strategy guidance for providers. Additionally, providers should hire and train staff to address cultural competence and linguistic needs for their Hispanic or Latino patients.

Primary care providers increase their effectiveness when they are cognizant of the role of race and ethnicity when they discuss mental health problems and deliver mental health services.[190] Cultural perceptions associated with mental health – such as addressing stigma and collaborating with primary care providers – should be considered when developing and administering interventions for the very diverse Hispanic or Latino populations. Furthermore, increasing efforts to provide education about mental illnesses, mental health providers, and other issues relating to mental health can help reduce stigma. When this information can be provided in a reassuring manner by a culturally credible and easily accessible provider, it is

[189] Workplace Mental Health—Infographic: The Collaborative Care Model. (n.d.). Center for Workplace Mental Health. Retrieved February 9, 2021, from http://workplacementalhealth.org/Employer-Resources/Infographic-Collaborative-Care-Model

[190] Brown, J. D., Wissow, L. S., Zachary, C., & Cook, B. L. (2007).

more likely that stigma will be reduced and the person seeking care will follow up with services.[191]

Integrated Substance Use Disorder Treatment and Recovery Support

We use the term "behavioral health" to include mental illness and substance use disorders (SUD), both separately and when referring to co-occurring health care needs. It is important that mental health and SUD services are integrated in an ideal behavioral health care system. Specific SUD treatment protocols such as medically supervised detoxification need to be developed within the broader context of integrated physical and behavioral health care. Local providers, including EHN, Homeward Bound Trinity, and Aliviane offer a comprehensive range of SUD treatment and recovery support services.

Finding: Our assessment did not reveal any formal collaborations or workgroups that specifically focused on substance use disorder treatment and recovery support services. However, we did find formal collaborations focused on substance use prevention. El Paso Advocates for Prevention Coalition is a community-based education and awareness program. The Prevention Resource Center Region 10 is a prevention system supported by the Health and Human Services Commission. PdNHF supports two prevention efforts: A Smoke-Free Paso del Norte and Shift+, which focus on underage and binge drinking. We learned during our stakeholder interviews that the Family Leadership Council has been discussing initiatives that would focus on SUD treatment and services.

Recommendation: The El Paso Behavioral Health Consortium should explore how existing collaborations and work groups can incorporate a focus on substance use disorder treatment and recovery support services. A SUD-focused group should work toward integrating SUD into mental health and primary care, adopting emerging best practices (especially with medically-assisted treatment for opioid use), improving the effectiveness of current interventions, analyzing needs compared to service capacity, and developing a community-wide funding strategy. Additionally, we recommend the El Paso community consider conducting an extended, more in-depth assessment of the SUD treatment and recovery support system in El Paso County.

Mental Health Literacy and Stigma

Limited cultural sensitivity, health illiteracy, and a shortage of Hispanic or Latino health care providers are the main barriers to accessing health services for many members of the Hispanic or Latino community. Even for those with access to health care services, underutilization of

[191] Mishra, S. I., Lucksted, A., Gioia, D., Barnet, B., & Baquet, C. R. (2009). Needs and preferences for receiving mental health information in an African American focus group sample. *Community Mental Health Journal, 45*(2), 117–126. https://doi.org/10.1007/s10597-008-9157-4

preventive care is still a challenge.[192] Providers need to increase their knowledge and skills to ensure they are aware of and utilizing the most up-to-date treatments available. As physicians and providers increase their understanding of the Hispanic or Latino culture, work to raise awareness about the importance of "caring for every person's mental health," and enhance their understanding of symptoms and disorders, they improve the chances of reducing mental health disparities in the Hispanic or Latino population.

Finding and Recommendations: Increased expressions of concerns about stigma are associated with clinically significant reductions in service utilization rates in the Hispanic or Latino population.[193] Potential ways to remove the barrier of stigma include:

- *Encouraging family involvement* – Include the ongoing work of peer support specialists and trained navigators (promotors) with lived experience to help keep people connected to services. The Hispanic or Latino population tends to have strong family networks. Utilizing peer support specialist to engage with and support families can help alleviate the stigma of mental illness and provide support and encouragement for people to engage in treatment.
- *Educating about the physiologic roots of mental illness* – A lack of information and understanding contributes to stigma, which leads to the avoidance of issues and treatment. Providing details about diagnoses, discussing treatment options, and answering questions is an effective way to reduce stigma and help the Hispanic or Latino community overcome their fear of discussing mental illness.

Hospital Capacity

As our updated *Quantitative Data Summary* report indicated, we believe it is likely that El Paso has sufficient local inpatient beds to meet the demand for behavioral healthcare (see the section in that report titled, *El Paso County Psychiatric Hospitalization*). Table 10 contrasts daily capacity and utilization of psychiatric beds in El Paso County in 2019. The table presents an overview of per-day average psychiatric bed utilization for each hospital that had an inpatient bed capacity reported to the Texas Hospital Association. The table shows that psychiatric beds were available on all days that Rio Vista Behavioral Health was open and on most days at the El Paso Psychiatric Center. Conversely, El Paso Behavioral Health System commonly functioned at or near capacity.

[192] Velasco-Mondragon, E., Jimenez, A., Palladino-Davis, A.G. et al. Hispanic health in the USA: a scoping review of the literature. Public Health Rev 37, 31 (2016). https://doi.org/10.1186/s40985-016-0043-2

[193] Interian, A., Ang, A., Gara, M. A., Link, B. G., Rodriguez, M. A., & Vega, W.A. (2010, April). Stigma and depression treatment utilization among Latinos: Utility of four stigma measures. *Psychiatric Services, 61*(4):373–379. https://ps.psychiatryonline.org/doi/10.1176/ps.2010.61.4.373?url_ver=Z39.88-2003&rfr_id=ori:rid:crossref.org&rfr_dat=cr_pub%3dpubmed

Table 10: Average Daily Psychiatric Utilization and Capacity – El Paso County (2019)[194]

All Ages Utilization	El Paso Psychiatric Center	El Paso Behavioral Health System	Rio Vista Behavioral Health
Average Daily Utilization	48	148	24
Utilization as a Percentage of Capacity	65%	91%	20%
Percentage of Days with 25% of Beds Open	67%	7%	100%

In addition, depicted in Table 11, El Paso County inpatient psychiatric services providers are currently able to meet most residents' needs; few El Paso County residents (84 of 6,423 total admissions with a primary psychiatric diagnosis, or less than 2%) were admitted to beds outside the county.

Table 11: El Paso County Psychiatric Bed Admissions for Primary Psychiatric and Substance Use Disorders (SUD), Including Co-Occurring Behavioral Health Conditions (2019)[195,196]

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
All Admissions to El Paso County Beds	**6,339**	**2,354**	**173**	**160**
El Paso Psychiatric Center	641	0	< 6	—
Providence Memorial Hospital	184	14	< 6	< 6
El Paso Behavioral Health System	4,894	2,293	161	151

[194] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.
[195] In addition to the 6,339 admissions with a primary psychiatric diagnosis and the 173 admissions with a primary SUD diagnosis, 123 admissions had a primary "other" diagnosis. These "other" diagnoses, although not psychiatric diagnoses, were those that are often the result of, or contribute to, psychiatric symptoms. These include diagnoses such as Alzheimer's disease, open physical wounds, and carbon monoxide poisoning.
[196] Data were obtained from the THCIC (January – December 2019) discharge records.

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
Rio Vista Behavioral Hospital	620	47	< 10	< 10
Admissions to Non-El Paso County Beds	**84**	**10**	**< 10**	**< 6**
All Admissions	**6,423**	**2,364**	**179**	**163**

In 2019, most inpatient psychiatric beds were used by residents and they were rarely transported to other regions for inpatient behavioral health care. In 2019 Rio Vista Behavioral Health opened, which is currently an 80-bed in-patient acute care behavioral health hospital with 20 beds designated for each of their four programs with the capability to expand or condense their program when the need arises. The hospital, regarding child and adolescent capacity, utilizes between 25 – 30 beds on average at any given time. Rio Vista leadership reports that an additional 40 beds will be added during construction. With their opening in the community, there does not appear to be a shortage of local psychiatric beds to meet the needs of El Paso County residents, particularly children. In addition to the local behavioral health hospitals, El Paso residents have access to Peak Behavioral Health located in Santa Teresa, New Mexico. Bed capacity at Peak includes 88 acute inpatient beds as well as 31 residential treatment beds. Peak leadership noted that while Texas resident admissions vary, recently a little below 15% of census was due to this population. And, of special note, due to Texas Medicaid coverage issues, Texas children are not sent to Peak's residential treatment program. Therefore, in reflecting on this abundant capacity, this suggests that El Paso currently has an adequate quantity of inpatient psychiatric beds to serve its population.

The Impact of El Paso Psychiatric Center Inpatient Bed Closures on Patient Care and Psychiatric Fellowships/Residencies

Historically, the state hospital in El Paso County, El Paso Psychiatric Center, has had eight beds available for children and youth with significant mental health issues and who need inpatient treatment. In addition to providing treatment for children and youth with the most complex needs, the facility has also provided training opportunities for child psychiatric fellows and general psychiatric residents completing their medical school education at the Texas Tech University Health Sciences Center at El Paso. In March 2020, there was a COVID-19 outbreak at the El Paso Psychiatric Center. To contain the outbreak and minimize exposure, the El Paso

Psychiatric Center closed its unit for children and youth, allowing adult patients to be treated in individual rooms.

Residency programs have shown to be an effective tool for retaining medical students once they complete their training. According to an Association of American Medical Colleges' 2010–2019 survey that examined the retention of physicians in the state of their residency training, by state, 55.5% of the physicians who completed residency training from 2010 through 2019 were practicing in the state of their residency training. While rates varied across states, Texas's retention rate of 66.6% was above the overall average.[197]

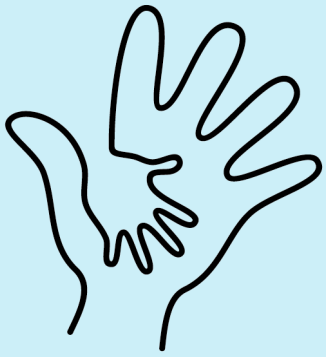
Finding: The closure of the El Paso Psychiatric Center's beds for children and youth has had an impact on both patient care and the center's ability to train psychiatric fellows and medical residents from the Texas Tech University Health Sciences Center at El Paso. Although few children and youth need the intensity of treatment provided by a state psychiatric facility, some do. These children and youth must now be admitted to the Austin State Hospital or another state facility. The closure of the El Paso Psychiatric Center's inpatient treatment services for children and youth also affected the rotation of medical residents and fellows who serve children and youth since child and adolescent psychiatry medical residents and fellows from the Texas Tech University Health Sciences Center at El Paso are unable to complete their rotations with this unit. If psychiatry residents and fellows are unable to complete rotations at the state hospital, the ability to train and retain child and adolescent psychiatrists in El Paso County will be diminished, which could lead to reduced provider capacity and decreased access to services for children and youth.

Recommendation: Other inpatient treatment facilities – Rio Vista and El Paso Behavioral Health – should work with Texas Tech University Health Sciences Center at El Paso to add child and adolescent psychiatry residents and fellows at their hospitals. These inpatient treatment facilities should accommodate all child and adolescent psychiatry residents and fellows at their hospitals, including the residents and fellows who were unable to complete rotations last year due to the closure of El Paso Psychiatric Center's beds for children and youth. This will allow Texas Tech University Health Sciences Center at El Paso child and adolescent psychiatry residents and fellows to continue participation in rotations in El Paso County and hopefully retain much needed child and adolescent psychiatrists. Furthermore, having medical residents and fellows rotate at multiple inpatient treatment facilities will increase access to services and enhance collaboration among providers.

[197] Association of American Medical Colleges. (2020). *Table C6. Physician retention in state of residency training, by state*. https://www.aamc.org/data-reports/students-residents/interactive-data/report-residents/2020/table-c6-physician-retention-state-residency-training-state

Summary

We have focused on prevalence, population characteristics, and service capacity in key domains because those issues are essential to understanding access to services. However, these issues manifest themselves in other ways as well, including in the other two major areas of our assessment: children and youth's mental health and the crisis services system. We next turn to children and youth's mental health, with a focus on high-risk children and youth.



Behavioral Health Strategy Development for High-Risk Children and Youth

Behavioral Health Strategy Development for High-Risk Children and Youth

An Ideal System of Care for Pediatric Behavioral Health

Half of all mental health conditions manifest by age 14 and 75% by age 24,[198] and yet individuals often do not receive care until symptoms have been present for years and needs become acute.[199] This demonstrates that we are missing an opportunity to intervene at a time when services can have the most impact. Moreover, no community in Texas or the nation currently has services and supports that make up a comprehensive continuum of care. Today, most care is delivered – when it is delivered – in primary care settings by providers without adequate supports to detect and treat emerging concerns. These same providers often struggle to connect patients with more complex needs to appropriate specialty providers, who may be in short supply, do not accept certain types of insurance, are located far away, or are not accepting new patients. Because of the challenges in accessing treatment in the current system, many opportunities to respond early are missed. These missed opportunities often result in an exacerbation of conditions. As a result, historically too many children and youth have received their first mental health treatment in a juvenile justice facility or an emergency department. We highlight strategies below to buffer against this in El Paso County.

To better address mental illness that often begins in adolescence, we need to rethink the way health systems are organized so they can provide care to children, youth and families sooner and more effectively. The Meadows Institute developed the Mental Health Systems Framework for Children and Youth (framework) to illustrate the components that make up a comprehensive continuum of care for children and youth. The five overall components are described in Figure 9 on the next page. These components include strategies to support needs ranging from mild to moderate, intensive, and crisis.

As we summarize the framework, please keep in mind that no community in Texas or anywhere in the nation currently offers this full range of care. Although examples of the best practices described below are increasingly available in communities across the nation, most mental health care today is delivered without the coordinated array of supports required to detect and treat such health needs early and effectively.

[198] 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. https://doi.org/10.1001/archpsyc.62.6.593

[199] 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.

Figure 9: The Ideal Children's Behavioral Health System

Framework Components

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

moderate conditions in primary care, and creating referral pathways for those in need of more specialized and intensive care.[200] The majority of El Paso County children and youth suffering from mild-to-moderate anxiety, depression, attention issues, and other behavior challenges each year (about 50,000 of 60,000 total children and youth with mental health conditions in El Paso County) could have their needs adequately addressed in such settings if detected early and treated with adequate supports to the primary care provider (such as the Child Psychiatry Access Network – or CPAN – a program that was launched in May 2020), particularly if the clinical setting offers collaborative care (which pays for a behavioral health specialist in the primary care office, either in person or through telehealth).[201,202,203,204]

- **Specialty Outpatient Care** (Component 2) is the level of the system that most people tend to think of when imagining mental health care: a mental health (other behavioral health) specialist such as a psychiatrist, psychologist, social worker, therapist, counselor, or nurse practitioner providing care in a clinic or office. However, research shows that such care is only needed for children and youth with moderate-to-severe needs in a well-functioning system that routinely provides adequate primary care supports to the family doctor. Specialty care is essential for both assessing more complex conditions and providing ongoing care for conditions like bipolar disorder, posttraumatic stress, severe depression, and other more complex disorders that require specialized interventions beyond the capacity of integrated primary care. This level of care includes the typical example of a clinician in an office as well as more novel approaches using telehealth such as the new Texas Child Health Access Through Telemedicine (TCHATT) program for underserved Texas schools that launched in May 2020. We estimate that less than one quarter of children and youth with mental health conditions (about 10,000 of the 60,000 total children and youth with mental health conditions in El Paso County) need specialty outpatient care each year.
- **Specialty Rehabilitative Care** (Component 3) includes the broad range of evidence-based services necessary to address more severe conditions that result in functional impairments such as early onset psychosis and severe behavioral impairment that too often, if untreated, can lead to severe problems at home or school and even involvement in the juvenile justice system. Such care needs to address both the underlying clinical needs and the associated severe functional impairment in multiple life domains. Each year, about 6,000 children and

[200] Straus, J. H., & Sarvet, B. (2014).
[201] We estimate that about two out of three children and youth with mental health needs have conditions that can be successfully managed in an integrated primary care setting. This translates to around 40,0000 children and youth in El Paso County.
[202] Shippee, N. D., Mattson, A., Brennan, R., Huxsahl, J., Billings, M. L., & Williams, M. D. (2018). Effectiveness in regular practice of collaborative care for depression among adolescents: A retrospective cohort study. *Psychiatric Services, 69*(5), 536–541. https://doi.org/10.1176/appi.ps.201700298
[203] Kolko, D. J., Campo, J., Kilbourne, A. M., Hart, J., Sakolsky, D., & Wisniewski S. (2014).
[204] Richardson, L. P., Ludman, E., McCauley, E., Lindenbaum, J., Larison, C., Zhou, C., Clarke, G., Brent, D., & Katon, W. (2014).

youth in El Paso County suffer from these more severe and often chronic needs and impairments that require specialty rehabilitative care. This includes intensive home and community-based services for the approximately 800 children and youth with the most severe needs and who face the greatest risk for out-of-home or out-of-school placement each year.

- **Crisis Care** (Component 4) is essential to effectively respond to the acute needs of children, youth, and their families that can flare up at any level of care. Crisis services are not intended as substitutes for routine, ongoing care. However, even with optimal levels of the right kinds of prevention, primary care, specialty, rehabilitation, and intensive services, any health condition can become acute at times and require urgent intervention to respond to crises that can jeopardize a child or youth's safety and functioning. Crisis care ideally includes mobile teams that respond to urgent needs outside the routine delivery of care and offers a continuum of time-limited out-of-home placement options ranging from crisis respite to acute inpatient to residential care. In addition to preventing a potentially dangerous escalation of a mental health condition, crisis services also create connections between the crisis care continuum and ongoing care.

Readers should be mindful that this description of an ideal system serves as a benchmark for assessing current services and envisioning future improvements. A key premise of this 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 placed on a path for healthy development.

The Current Behavioral Health System in El Paso County for Children and Youth with Intensive Behavioral Health Needs

For this assessment, we are focusing on and providing a deeper analysis of children and youth with **intensive behavioral health needs**. These children and youth suffer from severe needs, termed serious emotional disturbances (SED), and are at risk for involvement with the juvenile justice system or out-of-home or out-of-school placement.

Figure 10 and Table 12 provide prevalence estimates of various mental health conditions and substance use disorders among children and youth in El Paso County in 2019. As shown in Figure 10, there were about 60,000 children and youth in El Paso County with any mental health needs in 2019. Among children and youth with any mental health condition, more than half (about 35,000) had mild conditions, whereas about 15,000 had moderate conditions and another 10,000 had mental health needs that caused substantial impairment and are considered an SED. Nearly eighty percent (80%; 8,000) of the children and youth with an SED were living in poverty (Table 12). The most severe conditions (conditions causing so much impairment that the child or youth is at risk for out-of-home or out-of-school placement or involvement in the child welfare or juvenile justice systems) affected about 800 children and youth in the region (Table 12). These children and youth would benefit from intensive

wraparound care that could be provided at the local mental health authority through Youth Empowerment Services (YES) Waiver services.[205] In 2018–2019, there were approximately 3,000 youth in El Paso County with substance use disorders. One third (1,000) were living in poverty and one third (1,000) had co-occurring psychiatric and substance use disorders (Table 13). Very few youth received needed treatment for substance use disorders (Figure 11).

Figure 10: Distribution of Mental Health Needs Among El Paso County Children and Youth (2019)[206]

Table 12: Twelve-Month Prevalence of Mental Health Disorders and Related Conditions Among El Paso County Children and Youth (2019)[207]

Mental Health Condition – Children and Youth	Age Range	Prevalence[208]
Total Population	**6–17**	**160,000**
Population in Poverty[209]	6–17	90,000
All Mental Health Conditions (Mild, Moderate, and Severe)[210]	**6–17**	**60,000**
Mild	6–17	35,000
Moderate	6–17	15,000
Serious Emotional Disturbance (SED)[211]	6–17	10,000
SED in Poverty	6–17	8,000
At Risk for Out-of-Home/Out-of-School Placement[212]	6–17	800
Specific Disorders – Youth		

[205] The Youth Empowerment Services (YES) Waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional, and behavioral difficulties.
[206] Kessler, R. C., et al. (2012a). Prevalence, persistence, and sociodemographic correlates of DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69(4), 372–380, and Kessler, R. C., et al. (2012b). Severity of 12-Month DSM-IV disorders in the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry*, 69(4), 381–389.
[207] Unless otherwise referenced, prevalence estimates were estimated using data from Kessler, R. C., et al. (2012a).
[208] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[209] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[210] Kessler, R. C., et al. (2012a) and Kessler, R. C., et al. (2012b).
[211] Holzer, C., Nguyen, H., & Holzer, J. (2019). *Texas county-level estimates of the prevalence of severe mental health need in 2019*. Meadows Mental Health Policy Institute.
[212] MMHPI estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.

Mental Health Condition – Children and Youth	Age Range	Prevalence[208]
Depression	12–17	10,000
Bipolar Disorder	12–17	2,000
Post-Traumatic Stress Disorder	12–17	3,000
Schizophrenia[213]	10–17	100
First Episode Psychosis (FEP) – New Cases per Year[214]	12–17	30
Obsessive-Compulsive Disorder[215]	6–17	3,000
Eating Disorders[216]	12–17	700
Self-Injury/Harming Behaviors[217]	12–17	8,000
Conduct Disorder[218]	12–17	4,000
Number of Deaths by Suicide[219]	0–17	<10
Specific Disorders		
All Anxiety Disorders[220]	13-17	8,000
Population with 1 or 2 Adverse Childhood Experiences (ACEs)[221]	0–17	85,000
Population with 3 or More ACEs	0–17	25,000

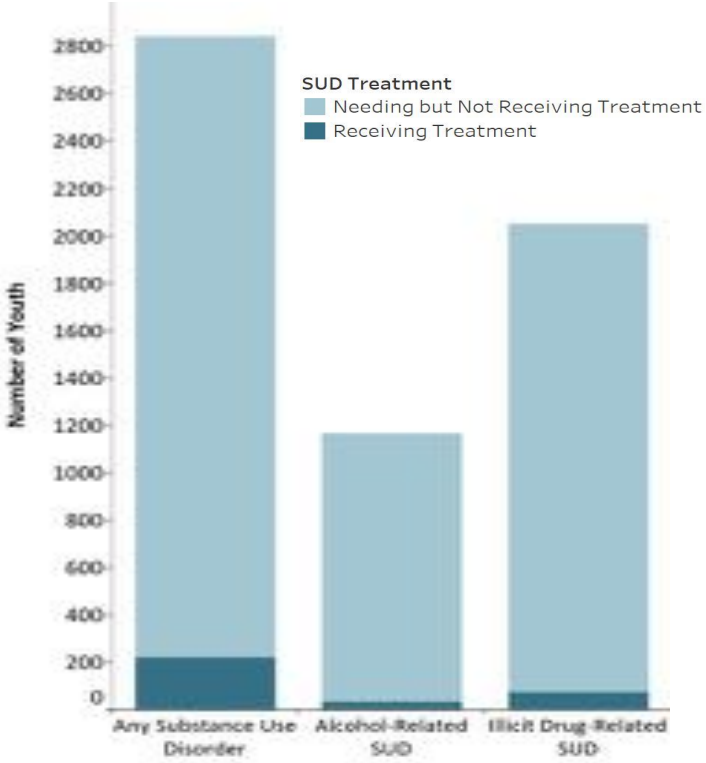
[213] Frejstrup Maibing, C., Pedersen, C., Benros, M., Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin,* 41*(4),* 963–970.
[214] Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.
[215] Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.
[216] Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. This study included anorexia nervosa and bulimia nervosa only.
[217] Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(11). https://doi.org/10.1186/1753-2000-6-10
[218] Kessler, R. C., et al. (2012a).
[219] Centers for Disease Control and Prevention. (2020).
[220] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012c). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184.
[221] Sacks, V., Murphey, D., & Moore, K. (2014). *Adverse childhood experiences: National and state-level prevalence (research brief No. 2014–28)*. Child Trends. www.childtrends.org/wp-content/uploads/2014/07/Brief-adverse-childhood-experiences_FINAL.pdf

Table 13: Prevalence of Substance Use Disorders (SUD) Among El Paso County Youth (2019)[222,223]

Population	El Paso Youth Ages 12–17
Total Population	**80,000**
Total Population in Poverty	45,000
Any Substance Use Disorder	**3,000**
SUD in Poverty[224]	1,000
Needing but not Receiving Treatment for SUD	3,000
Comorbid Psychiatric and SUD[225]	**1,000**
Alcohol-Related SUD	**1,000**
Needing but not Receiving Treatment for Alcohol-Related SUD	1,000
Illicit Drug-Related SUD	**2,000**
Needing but not Receiving Treatment for Illicit Drug-Related SUD	2,000
Number of Alcohol and Drug-Related Deaths in 2019[226]	**< 10**

[222] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[223] All SUD prevalence rates were rounded to reflect uncertainty in the Texas Demographic Center estimates.
[224] The percentage of youth in poverty with an SUD is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2018–2019. The percentage was applied to the estimated number of youth in poverty in Texas according to the American Community Survey 2019 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates.
[225] The prevalence of comorbid major depression and substance use disorders among youth ages 12–17 was based on the intersection between the national prevalence rate of major depressive episodes (MDE) and SUD, as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2018–2019 National Survey on Drug Use and Health (NSDUH) sub-state rates of MDE for Texas.
[226] Centers for Disease Control and Prevention. (2021).

Figure 11: Substance Use Disorders Among El Paso County Children and Youth (2019)[227,228]



In many cases, children and youth are involved with multiple systems simultaneously, particularly if they have more serious needs or are at risk of out-of-home or out-of-school placement. Each system is governed by its own set of policies, rules and regulations, funding limitations, and information-sharing processes — all of which complicate efforts to deliver coordinated and effective care across systems. Furthermore, these systems need to address a child or youth's changing developmental needs and levels of acuity of need over time and throughout the course of care while aligning safety concerns and the restrictiveness of the setting (e.g., incarceration, other secure and non-secure out-of-home placements, or community-based options) with the needs of children, youth, and families.

Strategy Development for High-Risk Children and Youth Findings and Recommendations

In the following sections on schools, intensive outpatient for children and youth, and juvenile justice, we provide findings and recommendations for children and youth with intensive mental health needs, including those who are at risk for out-of-home or out-of-school placement. To do this we will start by examining the strengths, challenges, and opportunities within El Paso County's school systems. We then examine the intensive community-based services available in

[227] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[228] All SUD prevalence rates were rounded to reflect uncertainty in the Texas Demographic Center estimates.

El Paso County for children and youth with intensive needs as well as opportunities to strengthen these services. Finally, we examine the strengths, challenges, and opportunities within El Paso County's juvenile justice system for meeting the needs of youth with mental health needs who are involved with that system. We examine the crisis system in the next section of this assessment as a whole – for children, youth, and adults.

In addition to pediatric primary care providers, schools and juvenile justice services providers play important roles in identifying behavioral health challenges and facilitating connections to mental health interventions and treatment. For nearly every student, schools can help support healthy development and improve academic performance by implementing strategies to improve the social and emotional wellness of their students and linking those in need to care.[229] Some schools are also able to provide space for service providers on campus, greatly improving access to services for many students and their families.

Additionally, although relatively few children and youth from a given community are involved in the juvenile justice system at any one time, those who are have an array of needs and vulnerabilities, including mental health needs, which often require communities to link these children and youth to needed services. Often, access to this care is essential to support the ultimate success of the child and youth.

Finally, because schools and the juvenile justice system play such integral roles in identifying and addressing the behavioral health needs of children and youth, we often infer that they are a segment of the behavioral health care delivery system, when, in fact, they are not. In the Mental Health Systems Framework for Children and Youth (framework), behavioral health services are integrated within these systems and then are well-coordinated with the broader health system.

School Findings and Recommendations

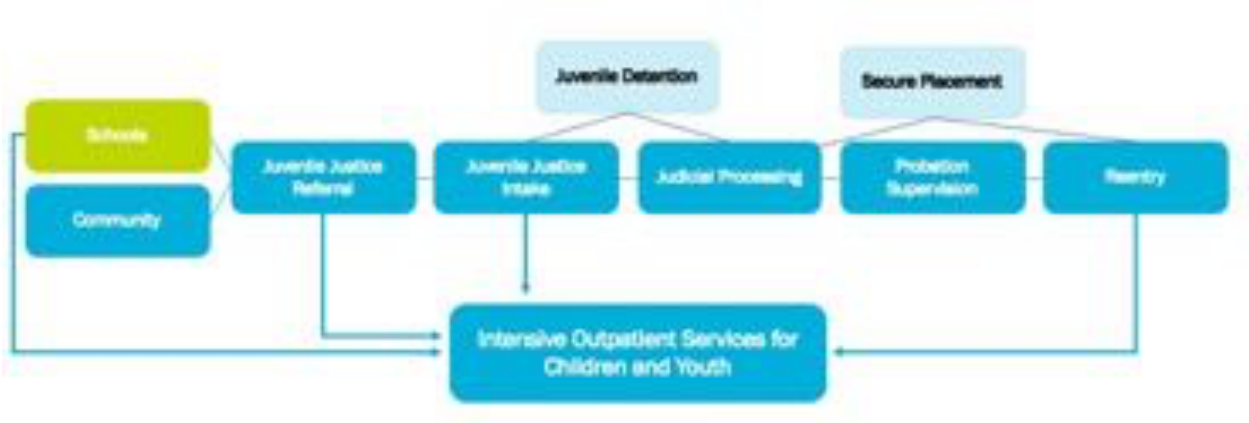
The primary purpose of school is to help students learn, and academic goals are more difficult to achieve when the behavioral health needs of students and staff are not addressed. Children and youth with untreated mental health conditions are more likely to have higher rates of school absence and reduced rates of timely course completion and graduation.[230] Student

[229] Meadows Mental Health Policy Institute. (2019, November 1). *Mental and behavioral health roadmap and toolkit for schools*. https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf
[230] Blackorby, J., & Cameto, R. (2004). Changes in school engagement and academic performance of students with disabilities. In J. Blackorby, M. Wagner, R. Cameto, E. Davies, P. Levine, L. Newman, C. Marder, & C. Sumi (Eds.), *Engagement, academics, social adjustment, and independence: The achievements of elementary and middle school students with disabilities.* Special Education Elementary Longitudinal Study Office of Special Education, U.S. Department of Special Education, Special education elementary longitudinal study. Menlo Park, CA: SRI International.

behavioral health concerns not only affect the student experiencing the concern, they also have an impact on the people that surround them since students with unaddressed behavioral health symptoms may disrupt the learning environment for other students.[231] Furthermore, children and youth with the most severe conditions are at risk for out-of-home or out-of-school placement, or involvement in the child welfare system. It is estimated that around 800 El Paso County children and youth between the ages of 6 and 17 years are at risk for out-of-home / out-of-school placement.[232]

Figure 12, below, depicts how children and youth with intensive behavioral health needs come into contact with – and move through – various systems, with a specific focus on the juvenile justice system. Although this graphic depicts how children and youth come into contact and move through systems, this process is not always linear. Children and youth with intensive behavioral health needs are often connected to services and systems in various capacities. This image, which was based on the Crisis Intervention Mapping Model from Policy Research Associates,[233] will appear throughout this report, changing in color to demonstrate which area of the image we are currently discussing. In this instance, we are discussing schools, highlighted in green.

Figure 12: The Critical Intervention Mapping Model[234]



[231] 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? *Early Childhood Research Quarterly,* 36, 506–520. https://www.sciencedirect.com/science/article/pii/S0885200616300205?via=ihub

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

[233] National Center for Youth Opportunity and Justice. (n.d.). *Adolescents, mental health and juvenile justice: A prevalence study*. http://ncyoj.policyresearchinc.org/projects/1/adolescents-mental-health-and-juvenile-justice-a-prevalence-study/

[234] Policy Research Associates, Inc. (n.d.). Critical Intervention Mapping for Juvenile Justice. The National Center for Youth Opportunity. Retrieved October 27, 2020, from https://ncyoj.policyresearchinc.org/img/resources/NCYOJ_CIM_Flyer-298639.pdf

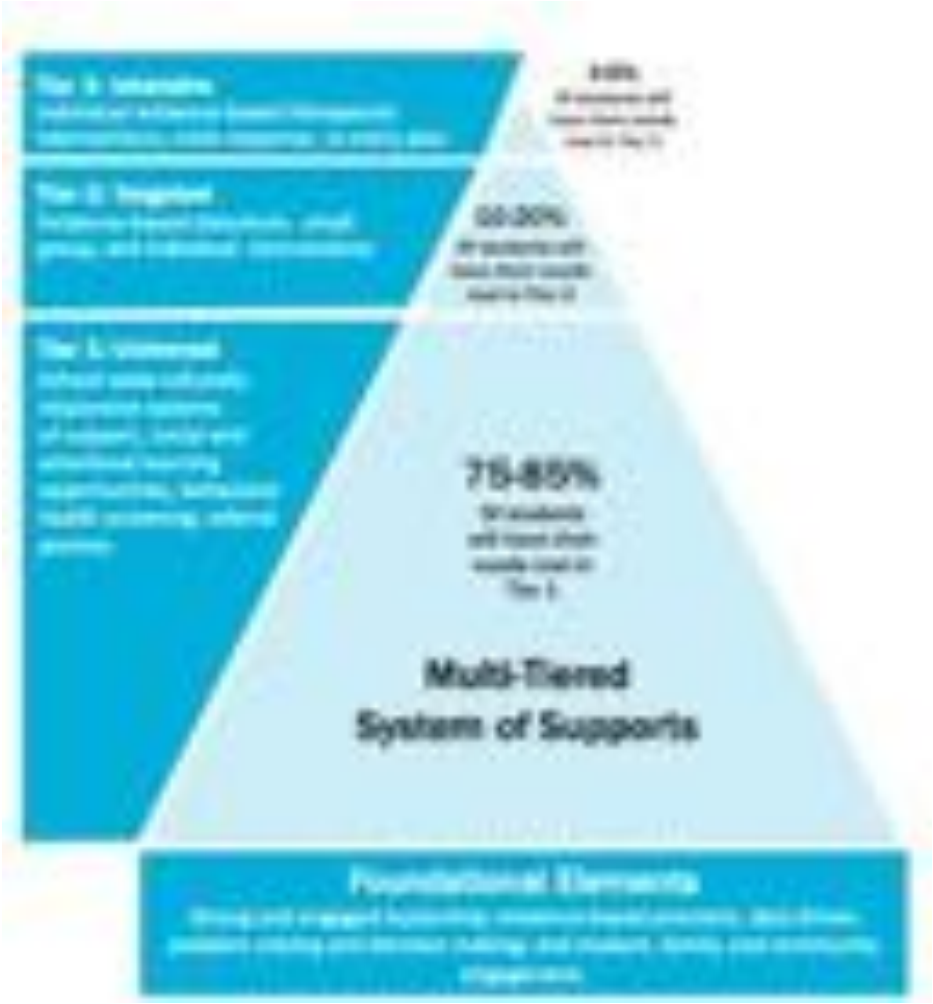
Finding: School districts in El Paso County have begun to adopt elements of the Multi-tiered Systems of Support framework, including forming community partnerships. Local school districts engaged for this project are taking critical steps in response to the 2014 assessment to increase the behavioral health supports within their schools. While this includes partnerships with community providers to offer mental and behavioral health services to students, no school district is implementing a comprehensive framework to address mental and behavioral health. We also noted inconsistencies across campuses within school districts regarding the availability of behavioral health services for students.

To empower students, the Texas Education Agency (TEA) Long-Range Plan[235] recommends financial incentives for school districts that establish integrated and data-driven academic and non-academic Multi-tiered Systems of Support (MTSS) model on every campus. This model seeks to identify and connect all students with appropriate support services, including supports for behavioral health and intrapersonal and interpersonal effectiveness (see Figure 13 on the next page). The TEA Safe and Healthy Schools Task Force identifies MTSS as the guiding framework for districts to use when implementing a school behavioral health system and included the Interconnected Systems Framework (ISF) as a recommended tool for school districts. In addition, the Substance Abuse and Mental Health Services Administration and the Centers for Medicare and Medicaid Services released a joint informational bulletin on July 1, 2019[236] that provides guidance to states and school districts on how to address mental health and substance use needs in schools.

[235] Texas Education Agency. (n.d.). 86th Texas Legislature enacts many LRP recommendations. Retrieved from https://tea.texas.gov/About_TEA/Leadership/State_Board_of_Education/LRP/86th_Texas_Legislature_enacts_many_LRP_recommendations

[236] McCance-Katz, E & Lynch, C. (2019, July 1). *Guidance to states and school systems on addressing mental health and substance use issues in schools*. Substance Abuse and Mental Health Services Administration, Centers for Medicare and Medicaid Services, and Center for Medicaid and CHIP Services. https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/cib20190701.pdf

Figure 13: Multi-Tiered Systems of Support Framework



MTSS brings together two long-established, research-supported school practices – Response to Intervention and Positive Behavioral Interventions and Supports (PBIS) – and links both to students' academic needs. Response to Intervention aims to provide the behavioral support identified within the PBIS framework. The MTSS framework includes universal promotion strategies for all students (Tier 1), targeted services and supports for a smaller group of students experiencing or at risk of experiencing a mental and behavioral health challenge (Tier 2), and specialized and individualized services for the small number of students with complex mental and behavioral health needs that Tier 1 or Tier 2 programs cannot adequately meet

(Tier 3).[237] For a more in-depth discussion of MTSS and examples of Tier 1, 2, and 3 interventions, please see our *Mental and Behavioral Health Roadmap and Toolkit for Schools.*[238] MTSS Tier 3 intensive services and supports address the academic, social, emotional, and behavioral development of students (special and general education) who need intensive interventions to succeed. These intensive services and supports serve a relatively small number of students with more complex mental and behavioral health needs that universal supports (Tier 1) or targeted supports (Tier 2) cannot adequately meet. Tier 3 supports and interventions (a) align with the student's needs, (b) use a comprehensive approach to understand and intervene with behaviors, and (c) include multiple interventions to address different areas of the student's life. Tier 3 services are also often delivered in conjunction with community partners such as local mental health authorities or community providers.

School districts in El Paso County should formalize a method to identify students who need intensive mental and behavioral health services and supports. Implementing the MTSS framework would provide a structure for identifying and connecting these students to services. In an MTSS framework, decisions about the system of supports are made by gathering and interpreting data and using this data to make changes to student instruction and interventions, establishing tiers of support, and providing an overall evaluation of the MTSS framework to ensure that services are available to support students across all three tiers.[239]

The school districts that participated in this assessment shared various examples of partnerships they have with community providers to deliver intensive services and supports (Tier 3) and partnerships with community providers have increased since 2014; however, additional partnerships are needed. These partnerships provide an integral component of Tier 3 services in an MTSS framework. A few examples of partnerships for mental and behavioral services are included below:

- **Canutillo Independent School District (ISD)** is partnering with Aliviane, Texas Tech University Health Sciences Center at El Paso, Project Vida, Rio Vista, El Paso Child Guidance Center, El Paso Center for Children, and National Alliance on Mental Illness of El Paso, among others.
- **El Paso County ISD** is partnering with Aliviane, Texas Tech University Health Sciences Center at El Paso, Project Vida, El Paso Child Guidance Center, and Big Brother and Big Sister, and has developed a memorandum of understanding (MOU) with Emergence Health Network.

[237] American Institutes for Research. (2017, September). *Mental health needs of children and youth: The benefits of having schools assess available programs and services*. https://www.air.org/sites/default/files/downloads/report/Mental-Health-Needs-Assessment-Brief-September-2017.pdf
[238] Meadows Mental Health Policy Institute. (2018, November). *Mental and behavioral health roadmap and toolkit for schools*. https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf
[239] Metcalf, Terri, M.Ed., J.D. (n.d.). What's Your Plan? Accurate Decision Making within a Multitier System of Supports: Critical Areas in Tier 1. *RTI Action Network*.

- **Socorro ISD** is partnering with Aliviane, Texas Tech University Health Sciences Center at El Paso, National Alliance on Mental Illness of El Paso, and Project Vida.
- **Ysleta ISD** is partnering with Aliviane and the psychiatry department and student clinic at Texas Tech University Health Sciences Center at El Paso and the El Paso Child Guidance Center.

Furthermore, school districts shared with us that they are meeting monthly as a cohesive group in the county. The El Paso Area Directors of Guidance comprises the directors of guidance for the districts in Education Service Center (ESC) Region 19 and they meet as a group to share community resources and partnerships. This collaboration has taken place for over 20 years. Higher education partners participate in these meetings and local agencies are invited to provide updates. These meetings provide a natural setting for community partners to collaborate with schools. Districts can use these meetings to invite community partners to share an overview of their services. It then becomes a natural forum to develop MOUs, which can be used across districts in the county.

Despite the increase in partnerships and collaboration among El Paso County school districts, there is still a need for intensive services and supports (Tier 3). In our assessment process, we retrieved data from the TEA and requested data directly from the school districts. Our analysis of these data demonstrated the importance of organizing efforts around the three tiers of support identified in MTSS.[240] In a fully functioning MTSS framework, 3–5% of students will need intensive services and supports (Tier 3).[241] Although El Paso ISDs do not identify children as "intensive or high risk," based on this estimate, we calculated the number of students who may require Tier 3 services and supports for each district, as shown in Table 14 below.

[240] A full list of the provider organizations that we examined can be found in Appendix Three.
[241] Edutopia. (2014, September 11). *Developing a Multi-Tiered System of Supports*. https://www.edutopia.org/practice/improving-learning-all-students-multi-tiered-approach

Table 14: El Paso Independent School District Data (2019 – 2020 School Year)

School District Discipline Data				
District	**Students Enrolled in 2019–2020 School Year**[242]	**3–5% of Total Enrollment Potentially Needing Individual Counseling (Tier 3)**[243]	**Actual Referrals to Individual Counseling (Tier 3)**[244]	**Discipline Population, 2019–2020 School Year**
Canutillo ISD	6,585	197 – 328	105	2,995
Ysleta ISD	42,276	1,300 – 2,167	491	2,913
Socorro ISD	50,040	1,854 – 3,090	358	3,094
El Paso ISD	58,884	1,854 – 3,090	358	2,995

Although the scope of this report only included an assessment of intensive and crisis services, a comprehensive, fully functioning MTSS model that is implemented to fidelity would provide services at the appropriate levels for all students. The data above indicate that not enough students are receiving individual counseling (Tier 3) or there is a problem with data collection and not all students are being represented in these data. We also acknowledge that 2019–2020 school year data may be affected by COVID-19.

Recommendation: By adopting the Multi-tiered Systems of Support framework, school districts in El Paso County can develop an organizational structure that aligns with this framework to better identify and support students who need intensive mental and behavioral health services and supports. School districts are responsible for providing schools with the necessary support to implement intensive services and supports (Tier 3) in an MTSS framework to fidelity. Strategies that support schools and school districts include developing school leadership teams, creating professional development for all levels of staff, and ensuring data are collected and reviewed to determine which type of support is needed for students. Furthermore, districts can adjust policies, procedures, manuals, teaming structures, and guidance lessons to align with the MTSS framework.[245] The Texas Education Agency (TEA) defines the MTSS framework as integrating assessment and intervention within a schoolwide, multilevel prevention system to maximize student achievement and reduce behavior

[242] These data were retrieved from the Public Education Information Management System (PEIMS). Submission of PEIMS data to the Texas Education Agency (TEA) is required of all school districts. https://rptsvr1.tea.texas.gov/adhocrpt/Disciplinary_Data_Products/Download_District_Summaries.html
[243] Edutopia. (2014, September 11).
[244] These data were reported by the districts to the Meadows Institute.
[245] Bureau of Exceptional Education and Student Services. (2014, March 27). *A blueprint for Tier 3 implementation: A results-driven system for supporting students with serious behavior problems*. http://www.fldoe.org/core/fileparse.php/7690/urlt/Tier3Blueprint.pdf

problems.[246] TEA also recognizes that many schools across Texas are currently using Response to Intervention frameworks and is recommending that districts shift to an MTSS framework to decrease referrals for behavioral health concerns.[247]

Implementation of the three tiers of supports and interventions requires support from district and school personnel as well as formal and informal partnerships with community providers. In Appendix Five: Implementing MTSS: A Considerations for District and School Leadership, we provide information and strategies for successfully implementing Tier 1, Tier 2, and Tier 3 services. Furthermore, our *Mental and Behavioral Health Roadmap and Toolkit for Schools*[248] provides information on all three tiers and additional guidance for building a robust framework.

Implementing all three tiers of the MTSS framework to fidelity will ensure more students receive preventative support, put less stress on crisis response, and decrease the need for more intensive services. In an effective framework, all decision makers in the district are empowered to work together to solve problems in a collaborative manner with open lines of communication. School districts can also utilize MTSS fidelity implementation rubrics to track their progress toward implementing this model to fidelity.[249,250] Below, we provide district level recommendations for implementing an MTSS framework:

- Districts facilitate each schools' efforts with financial support, joint problem solving, and long-term systems change.
- District level MTSS trainers communicate and collaborate regularly, share data, design professional development, and establish integrated policies and practices.
- A district leadership team should be formed and represent key stakeholders, including district and school administrators, support personnel, and teachers.
- Team-based trainings with follow-up events are offered to support ongoing implementation over at least two years.
- Awareness-level training is available to introduce elements of MTSS to family members and the broader community.[251]

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[246] Bailey, T. R. (n.d.). *Overview of implementation of Multi-tiered Systems of Support (MTSS)*. American Institutes for Research. https://tea.texas.gov/sites/default/files/2-21-18%20Multi-Tiered%20Systems%20of%20Supprt.pdf
[247] Bailey, T. R. (n.d.).
[248] Meadows Mental Health Policy Institute. (2018, November).
[249] Center on Response to Intervention. (2014). Multi-Tiered System of Support Fidelity of Implementation Rubric. https://www.gadoe.org/Curriculum-Instruction-and-Assessment/Special-Education-Services/Documents/MTSS/MTSS_Fidelity_Rubric.pdf
[250] CMS-Arizona Department of Education. (n.d.). MTSS Implementation Rubric. Arizona Department of Education. https://cms.azed.gov/home/GetDocumentFile?id=56f5c458aadebe1f54acc6a7
[251] Rachel Freeman, Dawn Miller, & Lori Newcomer. (2015, March). Integration of Academic and Behavioral MTSS at the District Level using Implementation Science. Learning Disabilities: A Contemporary Journal. http://www.morningsideacademy.org/wp-content/uploads/2015/10/LDCJ-3-15-web.pdf#page=66

- The district leadership team should work with its ESC to create a comprehensive plan to address the emotional wellness and behavioral health needs of students and families. This framework can guide efforts and provide the foundation for measuring progress and success.
- The district should provide direction and assistance with financing and other resources to support strategies as possible and appropriate, including federal, state, and local funding streams and grants as well as private sources such as foundations. Our *Mental and Behavioral Health Roadmap and Toolkit for Schools*[252] describes various sources of funding that districts can consider.

Recommendation: Continue to expand and formalize data-driven intensive services and supports (Tier 3) through partnerships with community providers. Continuing to establish and formalize partnerships with community providers will increase services and supports for students with complex mental and behavioral health needs. The Family Leadership Council and El Paso Area Directors of Guidance monthly meeting offers an opportunity for school districts in El Paso County to establish a connection with community providers. We recommend that districts establish a set of MOUs with community providers and other community partners to establish effective partnerships. MOUs help formalize partnerships between school districts and community organizations, as they outline the purpose of the agreement between the parties, the allocation of funds and resources, the duration of the agreement, and the roles and responsibilities of the parties as well as liability releases, insurance, and indemnifications.[253] The Center for School Mental Health provides a template for an MOU in its resources, *School Mental Health Teaming Playbook: Best Practices and Tips from the Field*.[254] The school districts we reviewed recognized that not all of their partnerships had MOUs in place. Furthermore, the effectiveness of any MTSS framework is contingent upon the evidence-based practices in each of the tiers. School districts and their community partners should carefully consider the evidence-based practices they choose.

Consistent collection and monitoring of data is needed to ensure school districts make decisions based on student outcomes and determine the appropriate tier of services and partnerships needed to address identified needs. Tier 3 assessments combine the information gathered in lower tiers with a more focused student-level assessment to determine if the current service matches the student's identified need and is being implemented to fidelity. These assessments are holistic and address both behavioral and academic needs. School districts should use these data to inform the partnerships they have developed and formalized with community providers for intensive services and supports (Tier 3). Data-driven problem

[252] Meadows Mental Health Policy Institute. (2018, November).
[253] Center for School Mental Health. (n.d.). *School mental health teaming playbook*. from https://nepbis.org/wp-content/uploads/NEPBIS_Leadership_Forum/2019/E2.-School-Mental-Health-Teaming-Playbook.pdf
[254] Center for School Mental Health. (n.d.).

solving and decision making are foundational elements of the MTSS framework for identifying which students need Tier 3 services as well as tracking outcomes. Furthermore, data-driven Tier 3 services will result in improved outcomes (e.g., improved academic performance and social skills and reduced suspensions, expulsions, and problem behaviors). Research studies indicate that schools implementing MTSS to fidelity can have up to 30% fewer suspension incidents and behavior referrals than schools that do not offer MTSS.[255]

Community and school leaders should actively engage with Texas Tech University Health Sciences Center at El Paso to work to expand Texas Child Health Access Through Telemedicine (TCHATT) services in all districts and schools in El Paso County. Senate Bill (SB) 11 (86th Regular Session, 2019) established the Texas Child Mental Health Care Consortium to foster collaboration on pediatric mental health care among medical schools in Texas.[256] As described in SB 11, the Texas Child Mental Health Care Consortium is responsible for overseeing five key initiatives, one of which is TCHATT, which is operated by Texas Tech University Health Sciences Center at El Paso. TCHATT is a statewide program that gives schools access to mental health providers via telemedicine and telehealth to help children and youth who have urgent mental health needs and have been identified by school personnel as high-risk. Urgent assessments and short-term stabilization care, which are available through TCHATT, increase community-wide urgent care capacity. TCHATT also requires linkages for follow-up care to specialty outpatient mental health providers. Although TCHATT is offered statewide, it will not be provided in every Texas ISD or in every school in the ISDs served by the program because of limited funding allocations to the regional "hubs" supported by Texas medical schools.

In early August 2020, the Texas Tech University Health Sciences Center at El Paso hub began to implement TCHATT in the following districts in El Paso County: Anthony ISD, Canutillo ISD, Clint ISD, El Paso ISD, San Elizario ISD, and Socorro ISD. Texas Tech University Health Sciences Center at El Paso is also implementing TCHATT in San Felipe Del Rio CISD in Val Verde County.

In addition to TCHATT, the 86th Legislature initiated and expanded multiple opportunities to help sustain and increase access to services and supports that include mental health promotion and prevention. SB 11 created a new School Safety Allotment (Allotment), which is administered through the TEA. School districts can use Allotment funds to create supportive school environments and prevent mental and behavioral health concerns from emerging. This can be done through school partnerships with community-based organizations.

[255] Scott, T. M., Gage, N. A., Hirn, R. G., Shearer Lingo, A., & Burt, J. (2019, May). An examination of the association between MTSS implementation fidelity measures and student outcomes: *Preventing School Failure: Alternative Education for Children and Youth, 6*3(4), 308–316. DOI: 10.1080/1045988X.2019.1605971
[256] Senator Jane Nelson filed Senate Bill (SB) 10, which ultimately passed as a component of Senator Larry Taylor's SB 11.

Beyond these initiatives, House Bill (HB) 19, effective December 1, 2019, put a non-physician mental health professional at each of the 20 regional ESCs throughout the state to focus on social and emotional well-being by supporting school personnel and facilitating their training in mental health and trauma-informed care. This legislation requires the local mental health authority, Emergence Health Network (EHN), to hire a licensed professional counselor (LPC), who will be housed at the Region 19 ESC. This legislation outlines that this person will act as a resource for school districts by:[257]

- Helping personnel gain awareness and a better understanding of mental health and co-occurring mental health and substance use disorders;
- Assisting personnel to implement mental health and substance use disorder initiatives and programs;
- Ensuring personnel are aware of a list of best practice-based programs and research-based practices;
- Ensuring personnel are aware of other public and private mental health and substance use disorder programs and resources available, including local mental health authority programs;
- Facilitating monthly Mental Health First Aid training;
- Facilitating monthly training on the effects of grief and trauma and providing support to children with intellectual and developmental disabilities who suffer from grief and trauma; and
- Facilitating monthly prevention and intervention training programs on coping with pressures to use alcohol, cigarettes, and illegal drugs, and misuse prescription drugs.

As of April 2021, EHN and Region 19 ESC have filled this position with the hire of an LPC. EHN and Region 19 ESC can maximize this position by developing an MOU to jointly identify ways in which this new staff member can best support the schools in the county. Our *Mental and Behavioral Health Roadmap and Toolkit for Schools* can be used as a resource on research-driven, evidence-based practices and practical guidance to help EHN and Region 19 ESC jointly support their schools and address student mental and behavioral health needs to improve educational and life outcomes for students.[258] We recommend that school districts engage the LPC hired by EHN and Region 19 ESC to support the mental and behavioral health services provided in their schools. School districts can also connect with local service providers to coordinate assessment and treatment, particularly for students who require more intensive services.

[257] 86(R) House Bill (HB) 19 – Enrolled Version (2019). https://capitol.texas.gov/tlodocs/86R/billtext/pdf/HB00019F.pdf#navpanes=0
[258] Meadows Mental Health Policy Institute. (2018, November).

Schools and COVID-19

The COVID-19 pandemic has thrust schools into uncharted territory, forced them to close in mid-March 2020, and necessitated the implementation of distance learning, using online technology platforms. This rapid shift to virtual classrooms hindered the connection between students and the teachers and school staff who support them. Difficulties with accessing technology and broadband services only complicated matters. In the broader community, widespread social isolation and the pandemic-related economic crisis made it challenging for schools to deliver many social services, including mental and physical health supports.

School districts in El Paso County are reopening at different times and students and families have differing school plans during this uncertain time. The COVID-19 pandemic and lockdown has brought about a sense of fear and anxiety around the globe. This phenomenon has led to short-term as well as long-term psychosocial and mental health implications for children and youth.[259]

Although we did not specifically explore the potential short- and long-term impacts of the COVID-19 pandemic in El Paso County, recent literature suggests that the negative effects of social isolation and increased family stress can lead to increases in depression and anxiety among students, particularly in communities of color. As a result, attention should be focused on meeting the social and emotional need of students as they return to school, including a focus on grief and loss.[260]

Intensive Community-Based Services for Children and Youth Findings and Recommendations

Intensive community-based services are a critical component of the children's behavioral health continuum of care. These services can address a child or youth's behavioral health needs before they reach a point of crisis or their mental health deteriorates to a point where they require inpatient hospitalization. Used in this way, intensive community-based services prevent the need for more restrictive levels of care. Intensive community-based services also provide the level of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental trajectory within their home and community after a mental health crisis has occurred. When children and youth are discharged from an inpatient treatment program, the goal is to establish support for them and their family to ensure a successful transition back to their home, school, and community. Treatment and support services are

[259] Singh, S., Roy, D., Sinha, K., Parveen, S., Sharma, G., & Joshi, G. (2020). Impact of COVID-19 and lockdown on mental health of children and adolescents: A narrative review with recommendations. *Psychiatry Research, 293*, 113429. https://doi.org/10.1016/j.psychres.2020.113429

[260] *The Immediate and Lasting Impacts of COVID-19 on Children – Alliance for Health Policy*. (2020, August 4). https://www.allhealthpolicy.org/the-immediate-and-lasting-impacts-of-covid-19-on-children/

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

Figure 14: The Critical Intervention Mapping Model[261]

Finding: Children and youth with the highest needs lack access to intensive, community-based services. As noted elsewhere, we estimate that approximately 10,000 children and youth in El Paso County have a serious emotional disturbance (SED) and 800 have mental health conditions that place them at risk of out-of-home or out-of-school placement.[262,263] Of the 10,000 children and youth with SED, we estimate that 6,000 will need access to rehabilitative or intensive services to effectively treat their mental health needs, with 800 needing the most intensive treatments in order to remain in the community. Children and youth with SED, especially those at risk of being removed from their community, would benefit from intensive community-based services to improve their emotional and behavioral functioning, and keep them in their home,

[261] Policy Research Associates, Inc. (n.d.). *Critical intervention mapping for juvenile justice*. The National Center for Youth Opportunity

[262] All Texas prevalence estimates were rounded to reflect uncertainty in the underlying American Community Survey. Because of this rounding process, row or column totals may not equal the sum of their rounded counterparts. Estimates between 1 and 5 were rounded to "<6," and values between 5 and 9 were rounded to "<10."

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

school, and community. [264,265] The rest of this section will provide an overview of the delivery of intensive community-based services in El Paso County, including areas of strength and opportunities to enhance intensive community-based service offerings in the community.

In El Paso County, there is a shortage of providers who offer intensive community-based services. Both EHN and El Paso Child Guidance Center offer intensive community-based practices. However, as outlined on Table 15, below, there is more need across the county (800 as noted above) than what the current capacity can serve. In fiscal year 2019, EHN served 110 children and youth combined in its Youth Empowerment Services (YES) Waiver (44),[266] Multisystemic Therapy (MST) (50)[267] and Coordinated Specialty Care (CSC) programs (16). EHN delivers MST in partnership with the El Paso County Juvenile Probation Department (EPJPD). In addition, El Paso Child Guidance Center provided 37 children with Parent-Child Interaction Therapy (PCIT). This leaves a critical gap in care for children and youth with the highest needs which could result in an overreliance on the crisis system and hospitalization, and youth being unnecessarily placed out of their homes and community.

Table 15: Number of Children and Youth Receiving Intensive Evidence-Based Practices[268]

Fiscal Year 2019 Provider Data				
Provider	**Parent-Child Interaction Therapy (PCIT)**	**Multisystemic Therapy (MST)[269]**	**YES Waiver**	**Coordinated Specialty Care**
Emergence Health Network	N/A	50	44	16
El Paso Child Guidance Center	37	N/A	N/A	N/A
Total Receiving Intensive Evidence-Based Practices	147			

[264] The Meadows Institute estimates that one in 10 children with mental health needs require mental health rehabilitation or intensive care to adequately manage their conditions.
[265] The Meadows Institute estimates that 10% of children and youth with SED are most at risk for school failure and involvement in the juvenile justice system. These youth need intensive family- and community-based services.
[266] For more information on the Levels of Care offered by EHN, please see Appendix Six of this report.
[267] El Paso Juvenile Probation Department. (2019). *Probation Data* [Unpublished Data Set].
[268] Intensive evidence-based practices are those that demonstrate improvement among children and youth who are at risk of out-of-home or out-of-school placement due to their mental health condition.
[269] EHN delivers MST in partnership with El Paso Juvenile Probation Department (EPJPD).

In Texas, intensive community-based services are most often provided through Medicaid-funded services like Targeted Case Management (TCM), Mental Health Rehabilitative Services (MHRS), or the YES waiver. While these are useful vehicles for providing intensive community-based services, the Health and Human Services Commission (HHSC) places parameters around who can receive these services, who can deliver these services, and how they can be delivered. In addition, Medicaid does not provide full reimbursement for the evidence-based practices that are most effective for children and youth with the most intensive needs. Instead, providers must bill for discrete services like counseling or skills training. While many intensive evidence-based practices include these discrete services, they also include additional services that are not able to be directly reimbursed. As a result, the cost to deliver intensive evidence-based practices is not fully funded. Therefore, many providers seek alternative funding to deliver practices like MST, Functional Family Therapy (FFT), and PCIT. The parameters placed by HHSC on Medicaid funded-services, combined with the challenges securing funding for other intensive community-based services, result in a shortage of intensive community-based services available across communities, including El Paso County.

As noted above, Medicaid-funded TCM and MHRS are the most common way intensive community-based services are provided and funded. These services are unique in that they provide the flexibility and resources needed to support a range of individual needs, many of which cannot be addressed through traditionally reimbursable office-based clinical services. However, TCM and MHRS can only be delivered by providers credentialed through HHSC. In addition, credentialed providers must use specific interventions approved by HHSC. Combined, these requirements limit the number of providers who may deliver TCM and MHRS as well as the types of interventions they are able to provide. EHN and El Paso Child Guidance Center are credentialed to provide TCM and MHRS. EHN includes these services in its intensive programs. El Paso Child Guidance Center became credentialed in March 2021 and is in the beginning stages of providing services. In our review, we found that Amerigroup also contracts with Amanecer Health Systems (associated with Atlantis Health Services) and La Familia del Paso for these services. Based on our prevalence estimates, even with the expected additional capacity after El Paso Child Guidance Center's program is fully operational, the need for rehabilitative or intensive services will still exceed the community's capacity.

Targeted Case Management (TCM) is a care coordination service that connects children and youth to necessary services, encompassing both routine case management and intensive case management. Routine case management is most frequently delivered to children and youth with mild to moderate needs, while intensive case management is delivered to children and youth with more serious mental health needs. The care coordination model that HHSC requires for intensive case management is called "wraparound service coordination." For the relatively small subset of children, youth, and their families with complex conditions and multi-agency involvement whose needs cannot be adequately met through discrete services, wraparound

care coordination is necessary to help pinpoint critical needs and determine the best approaches for meeting those needs.[270] Although wraparound is not a treatment modality, it is an essential care coordination process that aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process. The wraparound approach also places an emphasis on integrating children and youth into the community and building a family's social support network, which results in plans that are more effective and more relevant to the child, youth, and family.

Mental Health Rehabilitative Services (MHRS) are intended to help children, youth, or caregivers improve or acquire the skills needed to function as independently as possible in the community. MHRS includes certain crisis services, medication training and support, and skills training and development. HHSC has approved five curriculums for credentialed providers to use when delivering skills training and development services. These curriculums address trauma (Seeking Safety), parenting skills (Nurturing Parenting), coping and social skills (Aggression Replacement Training, Barkley's Defiant Child/Teen), and needs of youth transitioning to adulthood (Preparing Adolescents for Young Adulthood).

Further, children and youth covered through private insurance face additional barriers to receiving Medicaid-funded intensive community-based services. Private insurance plans do not include TCM and MHRS in their benefit plans and, therefore, do not pay providers to deliver these services. TCM and MHRS are still offered by EHN to families who have private insurance through a sliding scale based on income. It is important to extend access beyond the publicly funded system to children and youth whose families' income is too high to qualify for public benefits.[271] Children and youth who are on their parent's insurance and do not qualify for publicly funded services also experience debilitating mental health conditions that impair functioning across multiple life domains and require specialized treatment and evidence-based rehabilitation services. As such, both public and private insurance types should support access to evidence-based practices.

As noted earlier, in addition to TCM and MHRS, many communities rely on other funding streams to deliver intensive community-based services. In El Paso County, El Paso Child Guidance Center offers PCIT, an intensive intervention for children ages three to six years and their caregivers. In addition, EHN offers Multisystemic Therapy for youth who are involved in

[270] Currently, the Texas Medicaid program requires wraparound service coordination for all children and youth receiving intensive home and community-based services. Although the principles of wraparound should inform all intensive treatment, the evidence suggests that a wraparound facilitator and formal wraparound plan is only needed when the needs are so complex that a given type of care (e.g., CSC, FFT, or MST) is not sufficient.
[271] Although children and youth covered through private insurance do not qualify for TCM and MHRS, the YES waiver has exceptions on income limits that allow children and youth with private insurance to enroll in the YES waiver.

the juvenile justice system, and their caregivers. This is discussed in more detail in the juvenile justice section of this report.

A lack of sufficient intensive community-based services that allow children and youth to thrive at home and in their communities could lead to an overreliance on more restrictive placements, such as psychiatric hospitals and residential facilities. Providers reported sufficient capacity in the community to meet the inpatient treatment needs of children and youth. However, many providers reported a critical gap in services that help children and youth transition home after a stay in an inpatient or residential setting, including both service coordination and intensive step-down services. This further supports the need to increase the community's capacity to provide intensive community-based services.

Recommendation: Develop capacity for intensive community-based evidence-based practices that both fall within and go beyond the services funded by the Health and Human Services Commission through Medicaid managed care organizations. As noted above, EHN is the largest provider of Medicaid-funded intensive community-based services in El Paso County. While EHN is a strong provider of these services, the estimated need across the county is greater than what the current capacity can serve. To improve access to intensive community-based services, we recommend other providers in the community explore becoming credentialed Medicaid TCM and MHRS providers. Although the addition of El Paso Child Guidance Center as a credentialed Medicaid managed care comprehensive provider of TCM and MHRS will improve access, additional capacity is needed to meet the estimated need since the center would only have capacity to serve approximately 20 children or youth in intensive levels of care.

One strategy for El Paso County to expand the use of evidence-based practices would be to take advantage of Texas Senate Bill (SB) 1177 (86th Regular Session, 2019), which gives Medicaid managed care organizations the option to support the delivery of intensive evidence-based practices in lieu of other mental health services such as hospitalization for children and youth.[272] The evidence-based practices that the Medicaid Managed Care Advisory Committee allows can be used in lieu of other mental health services and hospitalization. Implementation of this initiative, which will be administered by HHSC, includes two phases: Phase 1 targets services in lieu of inpatient hospitalization and Phase 2 targets services in lieu of outpatient services. Phase 1 is scheduled to be available on September 1, 2021, pending CMS approval to HHSC, and includes the following services:

- Coordinated Specialty Care,
- Crisis outreach/outpatient team,

[272] Senate Bill 1177, 86th Texas Legislature, Regular Session (2019). https://capitol.texas.gov/Search/DocViewer.aspx?ID=86RSB011775B&QueryText=%22SB+1177%22&DocType=B

- Crisis respite,
- Crisis stabilization units/extended observation units,
- Partial hospitalization, and
- Intensive outpatient programs.

Outpatient services for Phase 2 are currently being evaluated for cost effectiveness. HHSC plans to add approved services that have known positive outcomes for children and youth to managed care contracts no later than September 2022. One evidence-based practice still under consideration is Multisystemic Therapy (MST). This intervention has been proven highly effective for youth with intensive needs, especially those who are involved in the juvenile justice system. The section that follows discusses the effectiveness of MST in more depth.

Expanding the use of intensive evidence-based practices (EBPs) such as MST, FFT, PCIT, and others (see Appendix Seven: Mental Health Best Practices for Children, Youth, and Families, for a full list) can help meet the needs of the estimated one percent (1%) of children and youth (one in ten children and youth with intensive needs) who require time-limited, intensive mental health services. Supporting providers to specialize in the delivery of intensive EBPs needed across the community can help close the gap between the number of children and youth who need these services and those who receive them. One way to support the expansion of intensive EBPs is to explore alternative payment arrangements for certain EBPs. For example, El Paso Child Guidance Center can currently bill Medicaid for delivering PCIT under counseling services; however, this does not fully cover the cost of providing this service. To fully cover the treatment, the center is exploring options with some Medicaid managed care organizations that offer alternative payment arrangements for providers who deliver EBPs, given that the services have proven positive outcomes. Once approved for reimbursement, El Paso Child Guidance Center could reallocate funds to increase capacity for PCIT or offer additional intensive services to help meet the critical need for intensive services in the community.

In addition, we estimate that a small number of older youth with intensive needs will experience a first episode of psychosis. For youth first experiencing psychosis, the best evidence-based intervention is Coordinated Specialty Care (CSC). This intervention involves an average of two years of intensive outpatient treatment that includes effective medication, education, and skill-building for the youth and their family and encourages them to maintain school enrollment and continue (or regain) a healthy developmental track. CSC also provides support to the youth's school or work setting to develop accommodations tailored to the youth's symptoms that promote success. There are currently 23 local mental health authorities throughout Texas that provide this service, including EHN. We project El Paso County will have 30 new cases of first episode psychosis each year and while this may be a small number, the impact of psychosis is significant. This comparatively small number of new cases would make it possible to intervene with these cases, assuming there is appropriate capacity to identify and

treat individuals experiencing a first episode psychosis. EHN served 16 youth between the ages of 12–17, in their CSC program (LOC-Early Onset) in 2019.[273]

Sometimes a child or youth's needs are so complex that the treatment providers and child-serving agencies involved in their life (e.g., child welfare, special education, juvenile justice) are unable to identify the best treatment option for the child or youth and family. For children and youth involved in the juvenile justice system who exhibit severe externalizing symptoms (e.g., classroom disruption, angry outbursts, defiance) related to untreated or inadequately treated depression or anxiety disorders (perhaps related to trauma), a three- to seven-month regimen of FFT or MST would offer the most effective treatment and achieve the best outcomes. Additional information on MST is included in the section on the juvenile justice system in this report.

Finding: Unfortunately, the future of early psychosis programs – and their ability to help the nearly 100,000 young people who experience psychosis every year[274] including the estimated 30 new cases in El Paso – is at risk because current reimbursement models do not sustainably support the provision of Coordinated Specialty Care services. The key to expanding CSC is to standardize reimbursement that funds all essential elements of this evidenced-based model. Some current fee schedules are typically based on assumptions that individual practitioners provide office-based services, which is not the case with many CSC services. CSC is a multi-disciplinary team-based intensive intervention that requires higher staff-to-patient caseload ratios and incurs costs associated with coordination, oversight of the team, training, supervision, and certification. CSC programs also have non-billable, indirect, and overhead costs that cannot be directly billed under some traditional reimbursement models, including costs for non-face-to-face professional services, collateral contacts, travel associated with community-based services, daily team meetings, outreach, telephone calls, and documentation. Fortunately, Medicaid and Mental Health Block Grants in multiple states are funding all essential services for low-income and uninsured populations but that is not enough and does not provide a sustainable financing mechanism for the future.

The current reimbursement methodology for Medicaid and commercial insurance – using multiple billing codes – pays for each service individually under the existing fee schedule for an individual practitioner/clinic model. Although this option does allow flexibility for the provision of some office-based services, the current reimbursement rates are set using office-based assumptions that all services are being provided face-to-face, which excludes essential elements of the CSC evidence-based model that are noted above. As a result, the traditional fee

[273] Emergence Health Network (personal communication, 2020).
[274] Heinssen, R. K., Goldstein, A. B., & Azrin, S. T. (2014, April 14). *Evidence-based treatments for first episode psychosis: Components of coordinated specialty care.* National Institute of Mental Health. Retrieved from: https://www.nimh.nih.gov/health/topics/schizophrenia/raise/nimh-white-paper-csc-for-fep_147096.pdf

schedule does not reimburse adequately for the CSC model. This, in effect, under-compensates the model that provides the most efficient and cost-effective interventions for a condition that can be quite costly to treat.

Recommendation: Emergence Health Network should explore new reimbursement strategies in the 1115 waiver renewal, along with recommendations in our *Coordinated Specialty Care—Payment Strategies* document, to determine the best path forward in creating more sustainable funding for Coordinated Specialty Care. The Meadows Institute, along with multiple national partners, published payment strategies for CSC on January 10, 2020. This document provides a reimbursement strategy to fund the CSC program sustainably and adequately over time, which would also allow for expansion to additional individuals experiencing the first episode of psychosis. The strategy identified includes a monthly case rate for delivery of the full CSC model.[275]

Starting September 1, 2021, pending CMS approval to HHSC, Medicaid managed care organizations will have an approved list of programs that can be provided in-lieu of inpatient hospitalization which includes CSC. This allows and encourages managed care organizations to reimburse for evidence-based practices that intervene early and reduce long term health care costs. We understand the complexities in negotiating new rate strategies with Medicaid managed care plans. However, Senate Bill 1177 and HHSC's adoption of CSC as an in-lieu of service, along with the new payment programs, have laid new groundwork to support EHN in its efforts to receive fair compensation for this invaluable service.

On January 15, 2021, CMS approved a ten-year waiver extension but on April 16, 2021, CMS rescinded approval. Rather than DSRIP, the extension included the creation of a Public Health Providers Charity Care Pool (PHP-CCP) and the creation of the Directed Payment Program for Behavioral Health Services. These payment programs appeared promising for adequately funding CSC but given the most recent CMS decision, it is impossible to know what waiver options may be available in the future.

Juvenile Justice Findings and Recommendations

In Texas, the juvenile justice system has jurisdiction over children and youth who are at least 10 years old, but not yet 17, at the time they commit a delinquent act. Even when it is necessary to incarcerate children and youth, the juvenile justice system is designed to be protective, not punitive, prioritizing treatment and rehabilitation. Because the juvenile justice system is one place where children and youth access behavioral health services, and because a significant portion of children and youth involved in juvenile justice have a behavioral health need, there is

[275] This document can be found here: *Coordinated Specialty Care—Payment Strategies*. (2020, January 10). MMHPI. https://mmhpi.org/topics/policy-research/coordinated-specialty-care-payment-strategies/

value in understanding system barriers and initiating the development of a framework to meet the complex behavioral health needs of children and youth in the juvenile justice system as part of any systems improvement effort.

This section will explore the service delivery system that is available to children and youth with behavioral health needs through the juvenile justice system. While children and youths' interaction with police, schools, and crisis systems are outside the scope of this section, we will note cross-cutting themes from other sections of the larger assessment. The findings are organized into sections that align with the critical intervention mapping model in Figure 15 below, which shows how youth enter and move through the juvenile justice system in El Paso County.

Figure 15: The Critical Intervention Mapping Model[276]

Initial Contact and Referral

The El Paso County Juvenile Probation Department (EPJPD) is the agency charged with supervising children and youth referred to the juvenile justice system. EPJPD is a leader among probation departments across Texas in almost every measure of performance, particularly in the use of alternatives to incarceration and evidence-based practices, diversion of children and youth from juvenile justice system involvement, cross-system collaboration, and trauma-informed care. In fiscal year (FY) 2019, 1,508 children and youth were referred to EPJPD. Of those referred, 86% were Latino, nine percent (9%) were white, and five percent (5%) were African American or Black.[277] Latino and white children and youth who were referred to the juvenile justice system were represented proportionately to the general population, but African American/Black children and youth were disproportionately referred, making up only two percent (2%) of El Paso County's six to 17 year-old population, while representing five percent

[276] Policy Research Associates, Inc. (n.d.).
[277] El Paso Juvenile Probation Department. (2019). *Probation data* [Unpublished data set].

(5%) of juvenile justice referrals.[278] The majority of referrals came from local law enforcement (51%), school resource officers (24%), and juvenile probation and courts (22%).[279]

Behavioral Health Identification and Risk Assessment

Most children and youth in the juvenile justice system have behavioral health issues or needs. These unmet needs often result in children and youth engaging in behaviors that result in them receiving a referral to the juvenile justice system. Studies estimate 70–90% of children and youth in the juvenile justice system have experienced trauma.[280] EPJPD reports 833 (55%) children and youth who were referred in FY 2019 had a behavioral health need. Nationally, it is estimated that children and youth in the juvenile justice system have a higher prevalence of behavioral health needs than the general population, with an estimated 65% of children and youth with at least one diagnosable condition.[281] For some children and youth involved with the juvenile justice system, behavioral health was the main factor that gave rise to the offending behavior. Others had a behavioral health need that was unrelated to the reason for referral or was identified for the first time when the child or youth entered the juvenile justice system.

EPJPD uses a standardized tool, the Positive Achievement Change Tool, to assess risk and need. The utility of this tool is high because protocols are in place that match care recommended in assessment findings. Additionally, all children and youth are pre-screened for behavioral health needs using the Massachusetts Youth Screening Instrument-2 (MAYSI-2) within 48 hours of intake.[282] The MAYSI-2 is a brief, 52-question self-report screening tool with several subscales and is designed to help juvenile justice facilities flag youth who may need a lengthier mental health assessment to ensure they receive adequate care.[283] Results from the Positive Achievement Change Tool and MAYSI-2 – combined with self-reported information collected from caregivers and children and youth regarding mental health needs, diagnosis, and prior treatment – are taken into account at key decision points in the juvenile justice system. Judges, attorneys, and probation staff are cross trained to ensure the administration of and results from these tools are used in a systematic way to drive service planning and match children and youth to appropriate services. Psychosocial assessments are only administered post-

[278] Estimates were calculated using prevalence data from the American Community Service (2018) and the El Paso Juvenile Probation Department (2019). *Probation data* [Unpublished data set].
[279] El Paso Juvenile Probation Department. (2019). *Probation data* [Unpublished data set]
[280] Maschi T. (2006). Unraveling the link between trauma and male delinquency: The cumulative versus differential risk perspectives. *Social Work, 51*(1): 59–70; Abram, K. M., Teplin, L. A., Charles, D. R., Longworth, S. L., McClelland, G. M., & Dulcan, M. K. (2004). Posttraumatic stress disorder and trauma in youth in juvenile detention. *Archives of General Psychiatry, 61*: 403–410.
[281] Shufelt, J.S., & Cocozza. J.C. (2006). *Youth with mental health disorders in the juvenile justice system: Results from a multi-state, multi-system prevalence study*. National Center for Mental Health and Juvenile Justice.
[282] National Youth Screening & Assessment Partners. (n.d.). *MAYSI-2.* http://nysap.us/maysi2/index.html
[283] County of El Paso. (n.d.). *Interlocal agreement with R.E. Thomason General Hospital*. http://www.epcounty.com/meetings/commcourt/2009-01-26/18.pdf

adjudication for children and youth with the highest needs who are on the most intensive level of probation supervision. For those who receive an assessment, the protocol includes a clinical interview and the administration of valid and reliable psychometric tools to aid in the formulation of diagnostic impressions and treatment recommendations.

Diversion and Deferred Prosecution

Almost half (48%) of the children and youth referred to EPJPD were diverted from formal involvement in the system.[284] Children and youth who are diverted have a lower recidivism rate than those who are given another disposition, including probation or out-of-home placement. In fact, El Paso County has the lowest recidivism rate for diverted children and youth in Texas, according to Texas Juvenile Justice Department (TJJD) estimates.[285] This indicates that children and youth who reach the front door of the juvenile justice system are then diverted from further involvement by being connected to services that sufficiently address their externalizing behaviors.

Children and youth who are not diverted may be placed in deferred prosecution, meaning the case will be dismissed if the child or youth completes the supervision requirements. At this stage, some children and youth with mental health needs are referred to the EMPOWER program, which is administered in partnership with the University of Texas at El Paso Center for Law to divert children and youth with serious mental illnesses from the juvenile justice system. EMPOWER links program participants to services such as education regarding mental illnesses and manifestations of those illnesses that are more appropriate for their successful rehabilitation than probation supervision. Youth who are identified as having mental health needs may also receive restoration services through Chapter 55 Proceedings. This involves the youth receiving court ordered EHN services.

Probation and Treatment Programs

Adjudication is a finding by the juvenile court that the child or youth has committed the act for which they are charged. Children and youth who are adjudicated to community-based probation supervision benefit from several evidence-based and empirically supported programs offered by EPJPD, including parenting support services, high-fidelity mentoring, trauma-focused multigenerational sex offender treatment, the Serious Habitual Offender Comprehensive Action Program, a restorative justice program embedded in local neighborhoods, and graduated levels of supervised probation services.

In FY 2019, the EPJPD Juvenile Drug Court program partnered with Aliviane (a local substance use treatment provider) to serve 42 children and youth and their families. The program uses

[284] El Paso Juvenile Probation Department. (2019). Probation Data [Unpublished Data Set].
[285] Marquez, M. (2020, October 6). *Key Informant Interview with El Paso County Juvenile Justice Center* [Personal communication].

the Positive Achievement Change Tool to identify substance use and criminogenic needs among children and youth and guide efforts to decrease future offending and substance use through coordination of substance use disorder treatment, intensive supervision, and drug testing services. Aliviane clinicians participate in weekly staffing and court hearings with the drug court team. These clinicians provide individual, family, and group counseling and parenting education sessions to the referred children and youth and their families, utilizing culturally sensitive, evidence-based strategies. The El Paso County Juvenile Drug Court has received international recognition for its success, and staff have been asked to train other judges on how to set up juvenile drug courts around the world.

EPJPD also has a Mental Health Specialty Court that partners with Pinnacle Social Services, which also served 42 children and youth and their families in FY 2019. Through community involvement and intensive services provided by a treatment team, these specialty courts have successfully diverted children and youth with mental illnesses and substance use disorders away from a juvenile justice residential treatment placement and kept them with their families.

For the highest need youth referred to the juvenile justice system, Multisystemic Therapy (MST) is a well-established evidence-based intervention for youth with more severe behavioral problems related to willful misconduct and delinquency. MST keeps youth living at home while engaging schools, friends, and community members in the treatment process.[286,287] El Paso County is one of only three communities in Texas that has licensed MST providers offering this service. The service provides comprehensive outreach to address variables such as family, school, and peer groups. MST therapists are also available to youth and their families 24 hours a day, seven days a week. In FY 2019, EPJPD, in partnership with EHN, served 50 children and youth with MST.[288] Only youth on intensive "Level 4" probation, and who do not have a severe mental health diagnosis as the primary reason for referral, are eligible to receive MST services. MST is the only home-based family support program offered to youth on probation and EHN is the only provider of these services in El Paso County.

Most children and youth with behavioral health needs who are not accepted into one of the intensive programs or specialty courts default into what EPJPD refers to as "Level 3 probation," or basic community supervision. These are the children and youth who may have behavioral health needs but do not have access to a continuum of structured treatment services or

[286] 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.
[287] 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). Lawrence.
[288] El Paso Juvenile Probation Department. (2019). *Probation Data* [Unpublished Data Set]

supports. Although EPJPD does not fund or broker many behavioral health services or specialized programs for this population, the department is required by TJJD standards to connect these children and youth to outside services within three to six months. EPJPD reports that it is having difficulties in accessing timely services from the public mental health system for this population.

County Detention

Of the 1,508 El Paso County children and youth referred to juvenile probation in FY 2019, 601 came through the detention facility. Detention is primarily used to hold children and youth charged with delinquent acts pretrial until they can be released to a parent or guardian. The amount of time they are kept in detention varies based on the offense, needs, and circumstances, with 25% of detentions in El Paso County occurring for one day or less and 44% of detentions occurring for less than one week.[289] Youth who remain in detention past 10 days typically have more serious offenses, a history of juvenile justice involvement, unstable living situations, and significant behavioral health needs. The detention center in El Paso County has a capacity of 62 beds. In preparation for future legislation that will increase the demand for space at county-run facilities, the department has been adopting strategies to decrease its reliance on detention facilities. The legislation, known as "Raise the Age," changes the current state law that automatically charges 17-year-old offenders as adults. This legislation will automatically try people who are 18 years old and younger as juveniles. Texas is one of only three states that has not yet raised the age of criminal jurisdiction.

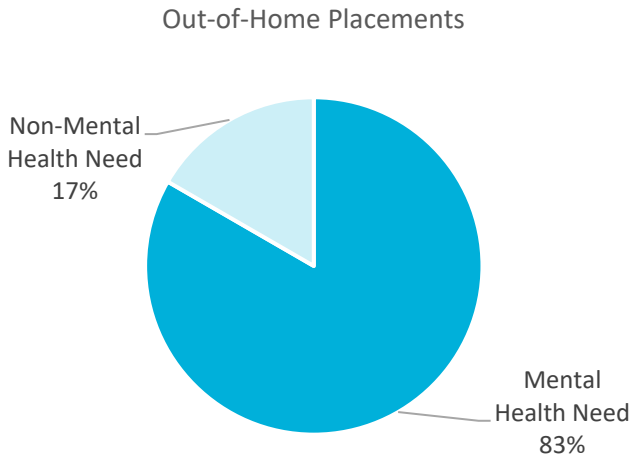
Although it is expected that "Raise the Age" legislation will not pass in in the 87th legislative session, the juvenile probation department's work to reduce its reliance on secure detention enabled it to respond rapidly to keep children, youth, and staff safe during COVID-19. El Paso County's juvenile detention facility was one of the first facilities in the state to report a case of COVID-19 among its detained population. EPJPD was assertive in releasing detainees from the detention facility, using electronic monitoring and other tools to ensure public safety. The department immediately coordinated with police in March 2020 to reduce referrals of misdemeanants, nonviolent offenders, and probation violators. The detained population reached a low of 18 children and youth in July 2020 but climbed back steadily as soon as the protocols were lifted. EPJPD may re-initiate these protocols to reduce the population and lower the risk of exposure to COVID-19.

Secure Residential Placement and Reentry

EPJPD is committed to minimizing the use of out-of-home placement and has been a leader in the state in reducing the use of juvenile state prisons and county juvenile detention facilities. Only 11 youth were referred to TJJD juvenile prisons in 2019. Most youth who require

[289] El Paso Juvenile Probation Department. (2019). *Probation data* [Unpublished data set]

residential treatment are placed close to home at the EPJPD-operated Samuel F. Santana Challenge Academy (Challenge Academy), a secure treatment facility for both males and females ages 14 to 17. The facility held 81 youth in FY 2019, including youth with mental health needs and substance use disorders (SUD), and females with complex trauma-related issues. In addition to the Challenge Academy, EPJPD contracts with 13 additional residential providers, most of which are located outside of El Paso County. Because EPJPD prioritizes these placements only for youth who pose a public safety risk or need intensive services that are not available locally, it was able to send only 33 youth to these contracted placements in FY 2019.[290] Of the 114 youth who were sent to out-of-home placements, 95 (or 83%) were identified as having a mental health need.[291]



Youth who are detained in the department's secure facilities (county detention and Challenge Academy) have access to an array of mental health supports on site or via telehealth through a partnership with the Texas Tech Health Science Center at El Paso. They also have access to an in-house clinical department staffed by licensed professional counselors (LPCs) and licensed clinical social workers (LCSWs). These high-quality child psychiatry and clinical services are only provided to youth who are in the facility and services stop upon release; they are not available to most of the youth in the juvenile justice system who are diverted, deferred, or on probation and not placed in a facility. Providers reported a critical gap in services to help transition youth with mental health needs back home after being released from a secure facility.

Trauma-Informed Care

EPJPD considers itself a trauma-informed organization. All staff are trained in Motivational Interviewing (MI), an evidence-based approach used to increase a person's motivation to make positive changes in their life. Annual employee evaluations include a fidelity check on MI skills and staff receive booster trainings every year. The department's clinical teams use trauma-informed service delivery methods and practices, including Trust Based Relational Intervention, Trauma-Informed Cognitive Behavioral Therapy, and Eye Movement Desensitization and Reprocessing. The department employs a clinical team of LCSWs and LPCs to deliver services to

[290] El Paso Juvenile Probation Department. (2019). Probation Data [Unpublished Data Set]
[291] El Paso Juvenile Probation Department. (2019). Probation Data [Unpublished Data Set]

incarcerated or detained youth, and these licensed professionals make themselves available for consultation with probation officers who need support for youth being supervised in the community, as needed. The juvenile justice workforce has knowledge of adolescent development, child trauma, and adolescent behavioral health conditions, and staff are trained to understand how these issues may affect youth-staff interactions. Additionally, the department has enacted policies and procedures to minimize the use of seclusion and restraint, practices which can cause or trigger past trauma.

Cross-System Collaboration

Juvenile justice system leaders participate in most of the important collaboratives that work on youth issues in El Paso County. EPJPD has a good reputation as a collaborative, trauma-focused organization with quality programming, high standards, and effective follow-through. EPJPD has formal linkages with public mental health agencies and strong collaborations with schools, nonprofits, law enforcement, and the courts. EPJPD staff are represented on the local Rise Up Task Force, which focuses on substance use issues, and the Family Leadership Council's Trauma and Resiliency work group. EPJPD staff are also sought out as leaders in the state and have been invited to serve on statewide and national coalitions and workgroups on topics including brain science and adolescent development, dual status youth with child protective services (CPS) crossover, diversion, juvenile shackling, "Raise the Age" preparation, court improvement, and juvenile detention alternatives.

Finding: The El Paso Juvenile Probation Department was able to divert significant numbers of children and youth from juvenile justice system involvement and detention by coordinating with police to reduce referrals of children and youth for probation violations, misdemeanors, and nonviolent offenses. This was accomplished both in preparation for "Raise the Age" legislation and to minimize the number of youth in detention in an effort to reduce the spread of COVID-19. These youth were held accountable in the community and their behaviors were addressed with less expensive community-based diversion strategies.

Recommendation: Sustain the progress made to reduce the use of detention for probation violations, misdemeanors, and nonviolent offenses and reinvest the savings in the expansion of community-based behavioral health programs. EPJPD is committed to minimizing the use of out-of-home placement and has been a leader in the state in reducing the use of state prisons and county detention facilities. By sustaining the systemic changes made during the COVID-19 pandemic, the department's cost savings can be reinvested in the expansion of programs in the community, which are typically less expensive than residential facilities and have better outcomes.

Finding: The El Paso Juvenile Probation Department has partnered with Emergence Health Network for the last seven years to operate a successful Multisystemic Therapy program for

youth with intensive needs; unfortunately, the program does not have the capacity to adequately serve all who could benefit from it. In FY 2019, EPJPD, in partnership with EHN, served 50 children and youth with MST.[292] Only youth on intensive "Level 4" probation, and who do not have a severe mental health diagnosis as the primary reason for referral, are eligible to receive MST services. Even with that narrow and limited eligibility criteria, EHN and EPJPD reported that youth who were eligible to receive MST services and were referred to the program had a two-month wait for services. This leaves a critical gap in care for youth with the most acute mental health needs, as well as those with a mental health need who are referred to probation at a lower level of supervision and could benefit from services before moving deeper into the juvenile justice system.

Recommendation: Utilize a data-driven approach to select and expand upon services such as Multisystemic Therapy that have proven successful for children and youth with intensive needs who are involved in the juvenile justice system. EPJPD maintains an impressive performance measurement analytics system that uses an interactive data dashboard to track referrals to the department, the disposition of those referrals, and outcomes for each of its in-house and contracted programs. EPJPD data demonstrate that MST has been one of its most effective programs over the last few years and could benefit even more youth if the eligibility criteria and staffing capacity were both expanded.

The current EPJPD MST program that is provided through EHN costs approximately $7,800 per youth, a cost savings of $64,050 per youth compared to a secure residential facility.[293] EHN has one active MST team that serves an average of 11 youth at any given time, with an average of 6.69 cases per therapist. MST requires teams to comply with stringent fidelity standards regarding team structure, training, certification, and the delivery of services. Outcome reports from 2019 show the current EHN team operated at 100% adherence to required program practices in 2019, with an 85% average adherence score per therapist. Of the 43-youth discharged from EHN's MST team in 2019, 82% were living at home, 82% were in school or working, and 85% had no new arrests. The average length of stay in the MST program was 117 days, with 77% completing treatment.[294] Analysis of outcomes data over four years demonstrate that on average, 88% of youth in MST stayed living at home, 91% continued with their studies or obtained employment and 93% showed no rearrests during participation in MST. This is particularly significant, as no other models have shown these types of outcomes for high-risk youth.[295]

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[292] Emergence Health Network. (2019). *MST PIDR summary report* [Unpublished data set].
[293] Legislative Budget Board. (2017). Criminal and Juvenile Justice Uniform Cost Report. https://www.lbb.state.tx.us/Documents/Publications/Policy_Report/4911_Criminal_Juvenile_Uniform_Cost_Jan_2019.pdf.
[294] Emergence Health Network. (2019). *MST PIDR summary report* [Unpublished data set].
[295] Emergence Health Network. (2019). Emergence Health Network Multisystemic Therapy (MST) Community Report.

The developers of MST have created specialized supplements to meet the needs of specific sub-groups of youth. These supplemental programs include MST–Psychiatric (MST-P) and MST–Contingency Management (MST-CM). We recommend that MST eligibility be extended to youth who have moderate behavioral health needs before they enter the highest level of intensive probation supervision; therefore, we recommend considering adding another MST team with the MST-P or MST-CM adaptation. The demand in the community indicates that at least one additional MST team is required to fully meet all the needs of EPJPD. By adding another MST team (which would consist of four licensed professionals), an additional 40 youth could receive MST services each year, with a cost of around $312,000. By calculating the cost savings of reduced recidivism, EPJPD may be able to appeal to El Paso County decision makers for additional funds for the program. The department may also be able to reinvest funds saved from reductions in the use of detention beds to add an additional MST team.

Finding: Although El Paso Juvenile Probation Department provides several evidence-based programs for children and youth with *intensive* behavioral health needs, gaps exist in services for children and youth with needs that do not reach that level of acuity. EPJPD reported a 38% recidivism rate (576 of 1,508 youth) in 2019, meaning it received another referral for the same child/youth within the same year. Of those children and youth who were re-referred to the system, 74% were screened as having a mental health need, compared to 55% of first-time referrals.[296] A lack of services for children and youth who present with mild to moderate needs contributes to this recidivism rate as children and youth with intensive needs are more frequently referred to evidence-based programs.

Recommendation: Increase the county's capacity to provide community-based services to children and youth with mild to moderate behavioral health needs who are involved in the juvenile justice system by formally partnering with additional providers beyond the local mental health authority. EPJPD could enhance its ability to serve children and youth with various levels of mental health needs by establishing a referral pathway and MOUs with additional community-based providers. EHN offers some community-based services, including Texas Resiliency and Recovery Services along with Level of Care 4 and YES Waiver. However, there are other providers in the community beyond the local mental health authority that can offer quality mental and behavioral health services for this population, as described below:

- Project Vida offers substance use disorder education and recovery.
- Aliviane (already an EPJPD partner through the Juvenile Drug Specialty Court) also offers prevention, intervention, treatment, and recovery services for children and youth with mental health and substance use disorder needs.

[296] Emergence Health Network. (2019). *MST PIDR summary report* [Unpublished data set].

- El Paso Child Guidance Center offers evidence-based clinical interventions, including Eye Movement Desensitization and Reprocessing, Parent Child Interaction Therapy (PCIT), and Trauma-Focused Cognitive Behavioral Therapy (TF-CBT).
- El Paso Center for Children provides individual and group counseling and youth skills training.
- The Steven A. Cohen Military Family Clinic at Endeavors provides mental health services for children and youth from military families.

El Paso community organizers could elevate the work of neighborhood-based, grassroots organizations in the communities they serve and guided by people with life experience in the criminal justice system by creating an inventory of current service offerings outside of traditional mainstream providers. Using this inventory, EPJPD can extend its continuum of supports with local programs that are culturally and linguistically responsive and community led. The programs listed below are just a few alternatives to incarceration that may be well-suited for the El Paso community and fill identified gaps in the current service array:

- Culturally rooted, healing-centered models that use an indigenous health framework such as those pioneered by the National Compadres Network, including La Cultural Cura healing *circulos,* the *El Joven Noble* Rites of Passage program for boys, and the *Xinachtli* curriculum for girls.
- Credible Messenger Mentoring for Justice-Involved Youth Model applies a restorative justice approach that is based on relationships between peers and paraprofessionals with life experience in the criminal justice system (Credible Messengers) and justice-involved youth.
- Brief Strategic Family Therapy is a problem-focused, family-based approach to eliminating substance use disorder risk factors. It targets problem behaviors in children and youth ages six to 17 years, strengthens family functioning, and can be used with Hispanic or Latino families. At an average cost of $3,200 per family, Brief Strategic Family Therapy is a cost-effective, evidenced-based treatment model that has been rated as "Well Supported" by the Title IV-E Prevention Services Clearinghouse, which could open additional funding mechanisms to support the program.

Finding: Despite the finding that the El Paso County juvenile justice system has made significant progress in becoming trauma-informed, the juvenile courts in El Paso still practice the potentially harmful act of shackling youth in court. Local system stakeholders reported that the El Paso County juvenile justice system used shackling, although this practice is currently suspended while court hearings are virtual because of COVID-19 precautions. Indiscriminate juvenile shackling is the practice of forcing children and youth to wear chains around their wrists and ankles when appearing in court, regardless of their referral reason, level of risk, or criminal history. Although the state prohibits the use of indiscriminate shackling of adults in courtrooms, this practice is still widespread for children in Texas, including El Paso.

Children and youth with behavioral health needs are particularly vulnerable to negative impacts from shackling in court, which can exacerbate symptoms of mental health disorders, compromise daily functioning, undermine trust in adults, precipitate reactive behaviors that can lead to further disciplinary action, trigger memories of past abuse, and deepen depression.[297,298]

Recommendation: In an effort to fully achieve the department's goal of becoming a trauma-informed system, eliminate the use of shackling in the juvenile courts. Dallas, Tarrant, Williamson, and Travis counties have successfully implemented restrictions on shackling children and youth in courtrooms without needing additional courtroom personnel. Shackling can be reserved for narrow situations such as when the child or youth presents a substantial risk of flight, physical harm, or imminent threat to self or others. El Paso County should join other large cities such as New York, Chicago, and Miami and the 25 states that have taken steps to limit the use of restraints on children and youth as they have been shown to potentially re-traumatize youth who often have had multiple adverse childhood experiences.[299]

Finding: El Paso County children and youth with severe behavioral health needs often enter the juvenile justice system in order to access treatment, as demonstrated by data provided by the El Paso Juvenile Probation Department, which shows that at least 55% of all juvenile referrals have a behavioral health need. EPJPD has developed a robust array of evidence-based interventions that reduce recidivism and protect public safety, but as one system leader put it: *"We tend to bring kids into the system for services—and this is not unique to El Paso. We create these intensive programs for mental health, drugs, gangs…and now we feel compelled to adjudicate. We use the programs because we have them. If the services existed elsewhere that would be better."* This was reinforced by another provider, who shared: *"Sometimes these services only become available when the kid comes into our justice system. It really shouldn't be that way. They shouldn't have to get into trouble to get help."*

Recommendation: Implement strategies to reduce reliance on the juvenile justice system as a place to treat children and youth with severe behavioral health needs. Diversion is prioritized as a juvenile probation department value, and our review of department documents and data revealed that this philosophy clearly drives policy and procedural decisions. While it is not at the juvenile probation department's discretion to determine who is diverted, it can make recommendations to the court. Data show higher success for children and youth who were

[297] National Center for Mental Health and Juvenile Justice. (2015, December 11). *Policy statement on indiscriminate shackling of juveniles in court*. http://www.modelsforchange.net/publications/791
[298] McLaurin, K. (2012). Children in chains: Indiscriminate shackling of juveniles. *Washington University Journal of Law & Policy, 38*.
[299] Texas Appleseed. (n.d.). *A trauma-informed court doesn't shackle kids*. https://www.texasappleseed.org/sites/default/files/Trauma-InformedCourt.pdf

diverted than for those who are deeper in the system. The El Paso community can build on the success of the EPJPD's diversion efforts by ensuring schools, law enforcement, and other system stakeholders build a collaborative system to avoid the unnecessary involvement of children and youth in the juvenile justice system.

One potential strategy to serve children and youth with intensive behavioral health needs, including those involved with the juvenile justice system, is through the "system of care" (SOC) approach.[300] This approach offers a comprehensive array of community-based services and supports that are coordinated across systems; individualized; delivered in the appropriate, least restrictive setting; culturally and linguistically competent; and based on full partnerships with families and young people. The SOC approach is focused on children and youth with intensive needs and has demonstrated positive results across the county. The ability to develop and implement this framework would be greatly enhanced by applying for a "system of care" grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). Applicants need to be a government agency, such as EPJPD, and a community can apply for as much as $1 million per year for four years. Although there is a match requirement, much if not all of this match can be obtained by diverting children and youth from higher levels of care and reinvesting those dollars into community-based services such as those described in this section. A local group comprising members of the Family Leadership Council has been meeting to discuss the possibility of an El Paso County application for 2021, and we highly recommend that government officials, partner agencies, philanthropy, and other key constituency groups support this effort. Areas of a cross-system collaborative's focus could include:

- Developing alternatives that divert children and youth from the unnecessary use of higher levels of care (e.g., residential treatment, hospitalization, formal court processing in child welfare and juvenile justice),
- Addressing risks and needs outside the court system entirely and involving children and youth in diversion opportunities only as long as necessary, and
- Engaging child-serving systems other than the juvenile justice, including schools and child welfare, to address matters that do not affect public safety.[301]

Conclusion

The findings and considerations outlined above should be considered when strengthening practices for children and youth with intensive mental health needs who are involved with – or at risk of becoming involved with – the juvenile justice system. It is important to consider these

[300] Substance Abuse and Mental Health Services Administration. (2020, January). The Comprehensive Community Mental Health Services for Children with Serious Emotional Disturbance Program: 2017 report to Congress. https://store.samhsa.gov/product/The-Comprehensive-Community-Mental-Health-Services-for-Children-with-Serious-Emotional-Disturbances-Program-2017-Report-to-Congress/PEP20-01-02-001

[301] Teigen, A., & Brown, S. (2018, January). *Principles of effective juvenile justice policy*. North Country Library Institution. https://www.ncsl.org/Portals/1/HTML_LargeReports/Principles_JJ.htm

strengths, challenges, and opportunities within the community, educational system, and juvenile justice system.

The following section of this assessment examines the crisis system and current crisis intervention approaches for children, youth, and adults in El Paso County.

Crisis System Improvement Analysis and Intensive Adult Services and Special Populations

Crisis System Improvement Analysis

The Texas Administrative Code defines "crisis" as a situation in which (a) a person presents an immediate danger to self or others, (b) a person's mental or physical health is at risk of serious deterioration, or (c) a person believes that they present an immediate danger to self or others or that their mental or physical health is at risk of serious deterioration.[302] Common examples of a mental health crisis include (1) thoughts or plans to commit suicide; (2) a person's existing mental health disorder deteriorates, creating severe symptoms; (3) someone whose current functioning restricts their ability to go school or work, maintain healthy relationships, or successfully engage in activities of daily living; or (4) major changes in mood that affect functioning.

From a system intervention perspective, individual crises exist on a spectrum, with some crises requiring immediate intervention in a safe and secure place such as an emergency room, while others are best resolved and treated in a community-based setting such as a school, office, via telehealth, or in a home environment. Both ends of the crisis spectrum require a significant response; however, the challenge lies in ensuring treatment occurs in the most appropriate setting.

Crisis Continuum Within the Ideal System of Care

Strong behavioral health service systems include a crisis response and ongoing care management structure that provides support for children, youth, and adults who are affected by a single traumatic event as well as those struggling with complex mental health challenges.[303] Crisis service providers work closely with an individual and their family to address behaviors that put the individual or others at risk of harm. For many people, crisis services act as the front door to mental health treatment, making the availability of a continuum of quality crisis services extremely important.[304]

The ideal crisis continuum is based on the fundamental principle that people have the greatest opportunity for healthy development when they maintain their ties to community and family while receiving help. The Substance Abuse and Mental Health Services Administration

[302] Texas Administrative Code, Title 25, Part 1, Chapter 416, Subchapter a, Rule §416.3 (2014). https://texreg.sos.state.tx.us/public/readtac$ext.TacPage?sl=R&app=9&p_dir=&p_rloc=&p_tloc=&p_ploc=&pg=1&p_tac=&ti=25&pt=1&ch=416&rl=3

[303] Pires, S. A. (2010). *Building a system of care: A primer (2nd edition).* National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development.

[304] Burns, B. J., Hoagwood, K., & Mrazek, P. J. (1999). Effective treatment for mental disorders in children and adolescents. *Clinical Child and Family Psychology Review, 2*(4), 199–254.

(SAMHSA) practice guidelines provide an overview of the ideal continuum of crisis services and outline essential values for crisis services.[305] These values and guidelines emphasize:

- Rapid response,
- Safety,
- Crisis triage,
- Active engagement of the person in crisis, and
- Reliance on natural supports.

It is also essential that the crisis system be integrated into the broader continuum of emergency medical response. Traditionally, communities across the United States (including El Paso) have primarily relied on law enforcement for the initial response to mental health emergencies, although those same communities do not take this approach in responding to other health emergencies as part of 911 calls (like emergency child births or heart attacks). When police do respond, too often they have been forced to choose one of three generally inappropriate, and too often tragic, responses: 1) book the person into jail, 2) transport them to a hospital emergency department, or 3) leave them in the community with no linkage to needed supports or treatments. There have been significant improvements to the criminal justice system's response to people with mental illnesses in the last two decades, including advanced crisis intervention training for law enforcement, laws and initiatives requiring better screening for and treatment of mental illness in jails, the creation of processes to release people with mental illnesses from jails on personal bond, specialty treatment courts, treatment-oriented probation, and the use of sequential intercept mapping (SIM) as a planning tool.[306]

However, these improvements have occurred primarily within the criminal justice system. For example, as SIM developed, the goal was to divert people with mental illnesses from jail, but the process often failed to include the health systems that can play a major role in resolving a mental health emergency, particularly hospital emergency departments. This is an important omission, because people with mental illnesses often stay much longer in hospital emergency departments than people with other illnesses and linking people to care from an emergency department is often as difficult as linking people to care from a jail.[307,308] These same issues were well-documented in El Paso during our assessment, just as they are in every other

[305] Substance Abuse and Mental Health Services Administration. (2009). Practice guidelines: Core elements in responding to mental health crises. Office of Consumer Affairs, Center for Mental Health Services. https://store.samhsa.gov/shin/content/SMA09-4427/SMA09-4427.pdf
[306] Munetz, M., Griffin, P. (2006). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. https://pubmed.ncbi.nlm.nih.gov/16603751/
[307] Ngo, S., Shahsahebi, M., et al. (2018). Evaluating the effectiveness of community and hospital medical record integration on management of behavioral health in the emergency department. *Journal of Behavioral Health Services & Research*, *45*(4), 651–658.
[308] Nordstrom, K., et al. (2019). Boarding of mentally ill patients in emergency departments: American Psychiatric Association resource document. *Western Journal of Emergency Medicine*, *20*(5), 690.

community across the country. While El Paso has implemented Crisis Intervention Teams (CIT), this is still fundamentally a law enforcement driven response. While CITs have some level of mental health training, their primary skill set remains law enforcement, and they do not have the capacity, nor should they be asked to assess mental health conditions in the field and make triage decisions.

The need to refocus the default response to mental health emergencies from a primarily law enforcement response has assumed new urgency with the COVID-19 pandemic[309,310,311] and calls to redesign policing more broadly.[312] There are now renewed efforts to provide law enforcement agencies with models to shift their role as "default first responders to numerous social issues that they are neither trained nor equipped to properly handle,"[313] to more effective responses that provide access to needed medical care and resources rather than criminalizing behaviors related to mental illnesses and other health and social needs.

While these national and state efforts aim to improve mental health crisis response,[314] they generally center only on the mental health sector rather than health systems more broadly while ignoring the justice system. For example, response models such as 988 and mobile crisis outreach team (MCOT) are designed to respond outside of the 911 system used for general health emergencies. In El Paso, the current MCOT brings a crisis worker into the community to provide face-to-face assessment and intervention and linkage to appropriate community treatment consistent with state requirements.[315] MCOTs may be dispatched to a person's home, place of work, community setting, hospital, or school for assessment and connection to care. Services are coordinated with community organizations and designed to reduce inpatient hospitalizations and intervention with law enforcement. However, MCOTs operate on a parallel

[309] Meadows Mental Health Policy Institute. (2020, April 28). Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession). http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpacts.pdf
[310] Meadows Mental Health Policy Institute. (2020, June 15). Projected COVID-19 MHSUD impacts, volume 2: Effects of COVID-induced economic recession (COVID recession) on veteran suicide and substance use disorder (SUD). http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDImpactsVeterans.pdf
[311] Meadows Mental Health Policy Institute. (2020, August 6). Projected COVID-19 MHSUD impacts, volume 3: Modeling the effects of collaborative care and medication-assisted treatment to prevent COVID-related suicide and overdose deaths. http://mmhpi.org/wp-content/uploads/2020/09/COVID-MHSUDPrevention.pdf
[312] For an example, see: Policing Project. (2020). *Reimagining public safety.* NYU School of Law. https://www.policingproject.org/rps-landing
[313] Neusteter, R. S., et al. ((2019). Gatekeepers: The role of police in ending mass incarceration. Vera Institute of Justice. https://www.vera.org/downloads/publications/gatekeepers-police-and-mass-incarceration.pdf
[314] Substance Abuse and Mental Health Services Administration. (2020). *National guideline for behavioral health crisis care: Best practice toolkit*. https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf
[315] Texas Health & Human Services Commission. (2020, April 2020). *Information item V – crisis service standards*. https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/community-mh-contracts/info-item-v.pdf

track to police response in El Paso and nearly every other Texas community, leaving law enforcement to provide the primary response to all other mental health emergencies dispatched through 911.

There is emerging evidence MCOT expansion can be used to reduce police involvement in subsets of 911 calls to deliver much needed care to people in situations which do not pose a risk to their non-police civilian response teams.[316] However, while such programs can reduce the role of police response, they cannot eliminate it given the subset of calls that involve use or suspected use of a weapon or other risk to public safety that fall outside MCOT response parameters. Although people with mental illness have comparable rates of violence to the public, specific mental illnesses such as psychosis are at much higher risk for violence against others.[317] In addition, members of the public often perceive threats to public safety that do not actually exist, but that 911 dispatch cannot rule out. As a result, law enforcement remains an essential element of mental health emergency response because it is not possible in all circumstances to know in advance which mental health emergencies may pose a public safety risk or otherwise be inappropriate for civilian response teams. In fact, the most tragic outcomes may occur during calls in which a civilian-only response occurs first but is not enough, and law enforcement comes in only after the initial non-police response has encountered a weapon.[318]

So, communities seeking reform face a core dilemma: An emergency response that eliminates police is insufficient to respond to public safety, while a response that relies on police is insufficient to respond to mental and broader health care needs. What is needed is a response that can assure public safety, ensure rapid identification and assessment of acute mental health and broader health care needs (including substance use), and provide access to needed assessment, treatment, and broader resources (such as housing). Multi-disciplinary response teams (MDRT) can provide such a response and have become the model for our work in Texas.

The Texas MDRT model provides an integrated, health-driven approach based on best-practice responses to medical emergencies proven effective for other emergency 911 responses to

[316] For more information, see: Eugene Police Department. (n.d.). *CAHOOTS.* https://www.eugene-or.gov/4508/CAHOOTS

[317] Meadows Mental Health Policy Institute. (2019, November). Mental illness and violence: Current knowledge and best practices. https://mmhpi.org/wp-content/uploads/2018/11/Mental-Illness-and-Violence-November-2019-FINAL.pdf

[318] Consider: 1. Herrera, I. (2020, August 26). *Man, 31, killed in deputy-involved shooting on far west side, Bexar County sheriff says*. KSAT.COM. https://www.ksat.com/news/local/2020/08/26/watch-live-sky-12-over-scene-of-officer-involved-shooting-on-far-west-side/; 2. Sellars, F. S., Shepherd, K., Witte, G., Ewing, M., & Berman, M. (2020, October 27). *Protests grip Philadelphia, leaving officers injured and stores damaged, after police kill a black man*. The Washington Post. https://www.washingtonpost.com/nation/2020/10/27/philadelphia-police-shooting-walter-wallace/; and, 3. Avanier, E. (2020, September 2). *Body cam: Knife-wielding woman killed after stabbing Jacksonville officer.* News4Jax https://www.news4jax.com/news/local/2020/09/01/body-cam-knife-wielding-woman-killed-after-stabbing-jacksonville-officer/

people with chronic illnesses. MDRT is based on a community paramedicine approach that brings together paramedics, licensed mental health professionals, and specialized law enforcement officers within an integrated team with unique potential to transform the response to mental health emergencies through the 911 system from one that relies on either law enforcement or civilians, to one that can address mental health and broader health care and social needs while assuring public safety.[319] The Texas MDRT model provides a comprehensive response that recognizes that people with emergency mental health needs often have multiple needs, and those needs are best met outside of a jail or hospital emergency department, even when the exceed the capacity of mental health crisis systems.

The Meadows Institute is working in multiple communities across Texas to assist in the transformation of emergency response systems that are overly reliant on either police or specialty mental health response. We have developed a specialized MDRT framework for that work that addresses the public safety, mental health, and broader health and resource needs (including substance use and homelessness) that often presented in a single emergency response call. We are working with local stakeholders in communities that are diverse in population and ethnic and racial makeup, including the cities of Abilene and El Paso, Galveston, Lubbock, and Travis (Austin) and Bexar (San Antonio) counties.

Dallas has implemented a MDRT program known as RIGHT Care (the Rapid Integrated Group Healthcare Team). RIGHT Care is an integrated, health-driven approach based on best-practice responses to medical emergencies proven effective for other emergency 911 responses to people with chronic illnesses. RIGHT Care, like MDRT generally, is based on the community paramedicine approach described above and relies on carefully chosen multi-disciplinary teams of a paramedic, a licensed master's level mental health professional with at least five years' experience in providing mental health emergency care, and a tenured law enforcement officer with advanced crisis and mental health peace officer training. The team and its characteristics are described in more detail below.

The RIGHT Care model also includes a different approach to the 911 call center (Figure 16), something that will be critically important in any MDRT effort and particularly as integration of 911 with 988 becomes a priority. When someone calls 911 and reports a mental health emergency, the absence of clinical triage in the call center plays a role in dispatching law enforcement as the first response. As RIGHT Care was implemented in Dallas, the 911 call center added a mental health clinician who can manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs. This allows the

[319] U.S. Department of Health and Human Services, Health Resources and Services Administration. (2012). *Community paramedicine evaluation tools.* https://www.hrsa.gov/sites/default/files/ruralhealth/pdf/paramedicevaltool.pdf

911 call center to decide to dispatch the RIGHT Care team as the appropriate response. The team provides a health-driven medical response first and foremost while assuring public safety, as is necessary within the 911 emergency response system.

Figure 16: Traditional 911 Response Model Compared to RIGHT Care Model, as Implemented in Dallas, Texas

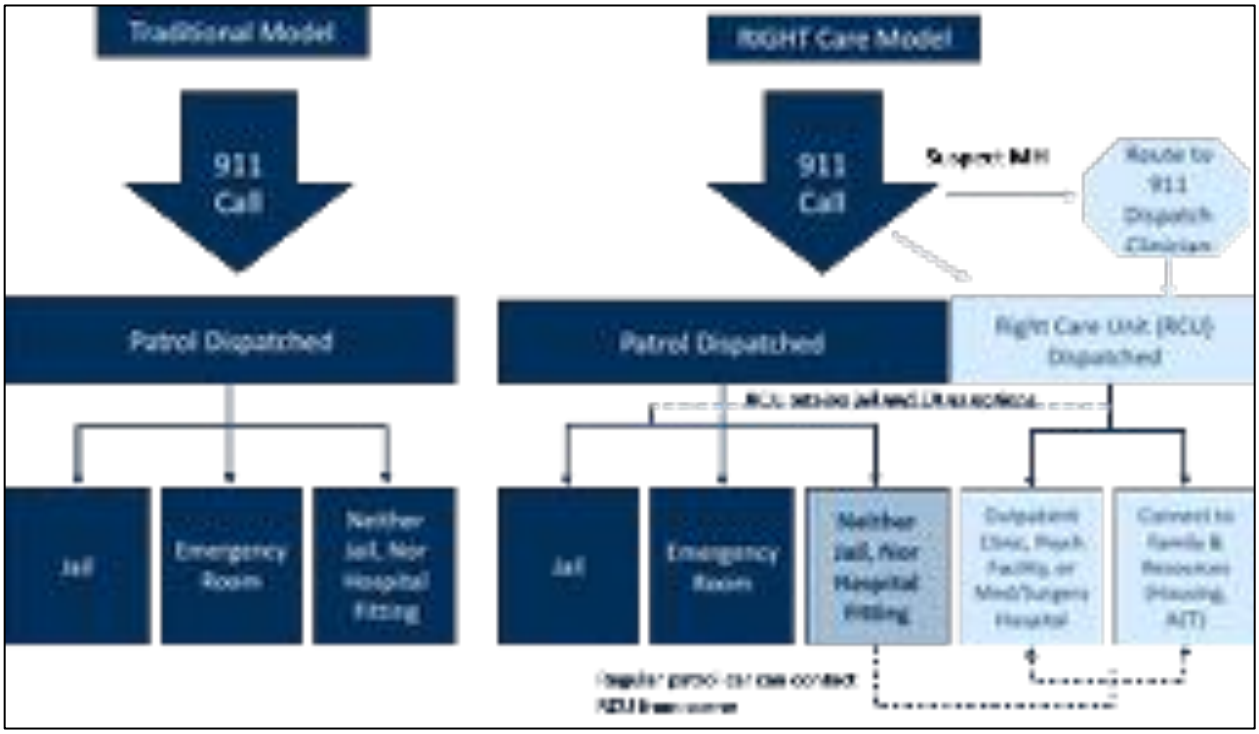
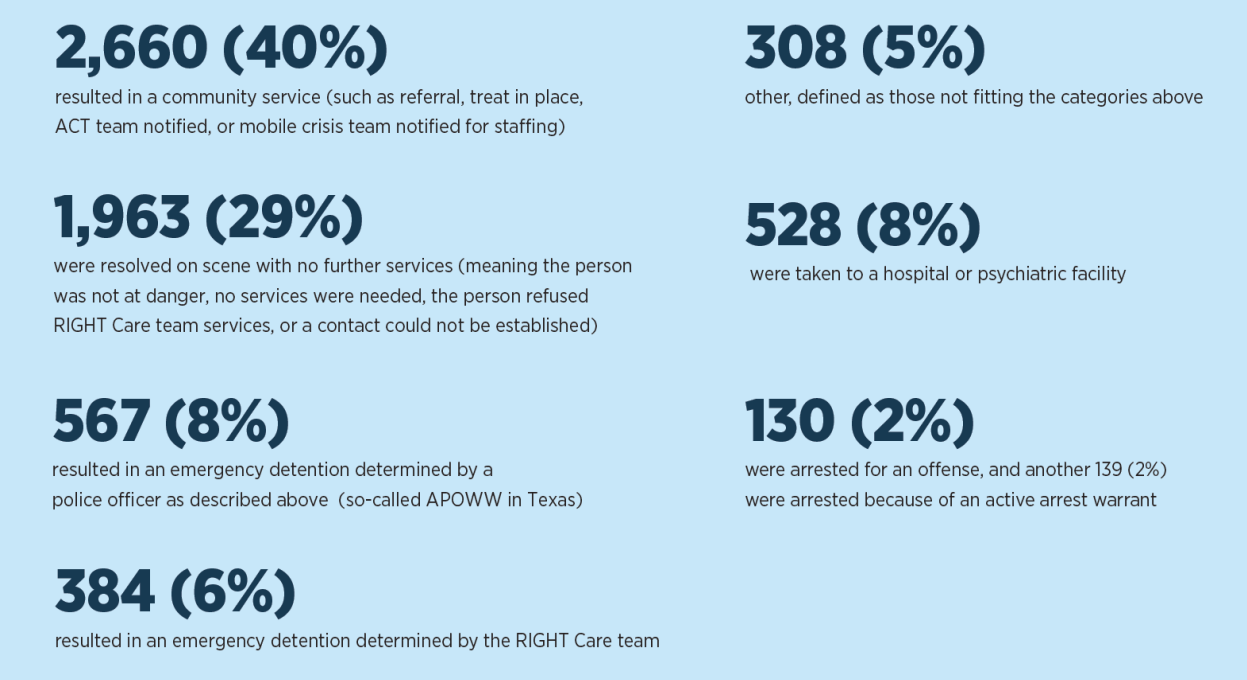


Figure 17 below shows the Meadows Institute's analysis of the last available metrics report of June 7, 2020, showing the cumulative program metrics from program start date of January 29, 2018, to June 7, 2020, for the pilot in the South-Central Division of the Dallas police department. During this period there were 6,679 total responses by the RIGHT Care team. Of those responses:

Figure 17:South-Central Dallas Division RIGHT Care Team Cumulative Program Metrics (January 2018 – June 2020)



In this section of the report, we focus on El Paso's current and potential crisis and emergency response continuum, and we define the critical elements of that continuum below in Table 16. However, and as emphasized above, it is important to remember that the ideal crisis continuum exists within a broader system of care that identifies and responds to the behavioral health needs of the individual in the community. Without the availability of community-based behavioral health services that address needs ranging from mild to severe, the crisis end of the services spectrum becomes the default point of entry for care. In the ideal system, most people would have their behavioral health needs identified prior to reaching a point of crisis. Developing a strong community-based services continuum that people can access prior to being in crisis is critical to preventing crises and maximizing efficient use of the available crisis services. When meaningful community-based alternatives to inpatient treatment are absent, many people in crisis have nowhere to turn but to the most restrictive, disruptive, and expensive care.

No community in Texas or the nation currently offers all these services as part of their crisis services continuum. Planners need to prioritize which services are most beneficial to their communities and focus on effectively implementing those services.

Table 16: Continuum of Crisis Services in an Ideal System[320]

Continuum of Crisis Services in an Ideal System	
Program or Service	**Description & Services Provided**
24/7 Crisis Hotline	These hotlines provide direct services delivered through a free telephone line that is answered 24 hours a day, 7 days a week (24/7) by licensed and trained staff. A 24/7 crisis hotline provides immediate support, appropriate referrals, and linkages to a mobile crisis team or emergency medical services (EMS) response, if appropriate.
Mental Health Integration with 911 Response	When someone calls 911 and reports a mental health emergency, the call center plays a role in dispatching law enforcement as the first response includes a mental health clinician who can manage calls with clinical expertise and effectively assess the presence of an emergency related to mental health needs.
Multi-Disciplinary Response Teams (MDRT)	Based on the community paramedicine model, MDRTs include a paramedic, a licensed master's level mental health professional with at least five years' experience in providing mental health emergency care, and a tenured law enforcement officer with advanced crisis and mental health peace officer training. They are the first line of response to mental health emergencies and need access to same day medication prescription, linkages to a housing provider, and access to community hospital beds.

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

Continuum of Crisis Services in an Ideal System	
Program or Service	**Description & Services Provided**
Mobile Crisis Outreach Team (MCOT)	MCOTs provide a rapid response to crisis calls in the community by mental health specialists who provide outreach, de-escalate crises, and make determinations for needed treatment. Mobile outreach is a key service that can help with onsite assessment, rapid medication when a psychiatric prescriber is available by telephone or tele-medicine (using mobile devices), and transportation of people who are agreeable to go to a crisis respite program, crisis residence, or a peer-operated crisis program. In most communities in Texas (and across the nation), crisis outreach services are either not sufficiently available after business hours or are hindered by inadequate geographic coverage (e.g., there may be one crisis team located at a single site in a large metropolitan or geographic area). Other communities may have multiple outreach programs that are not connected to each other, resulting in limited coordination. An effective system of care will have multiple crisis sites, including mobile outreach and communication protocols among crisis teams that allow coordination and critical information sharing. This helps promote efficiency, care coordination, and sharing of after-hours coverage.
Crisis Transportation	A crisis system should include transportation services that are provided in a safe and timely manner when crisis services are needed. Depending on the circumstance, this service is provided by mobile crisis teams, EMS, or local law enforcement.
Peer Crisis Services	Peer crisis services include peer-led interventions and support that are provided in a calming, home-like environment during a crisis, operated by individuals with life experience of mental illness. These services are intended to last less than 24 hours but can last several days.
Walk-in Crisis Center	These centers are physical walk-in locations in which crisis assessments and triage are conducted by medical staff (including prescribers). Crisis urgent care centers, which may or may not be based in a hospital, provide immediate walk-in crisis services, including assessment, medication administration, and support services.

Continuum of Crisis Services in an Ideal System	
Program or Service	**Description & Services Provided**
Crisis Telehealth Services	Crisis telehealth services provide access to emergency psychiatry services at crisis facilities and other settings, allowing highly trained staff to provide interventions over the phone without the cost of the person in crisis needing to be on site continuously, or when services would otherwise be unavailable. Crisis telehealth services include assessment, crisis de-escalation, and prescribing services.
Crisis Respite	Crisis respite offers opportunities to provide a safe environment to resolve crises and help people engage in services. Depending on the needs of the individual, the acuity of the crisis, and the resources of the program, many people can use these services as an alternative to inpatient care. Providing respite for an individual or a child/family prevents further escalation of relational stressor and decompensation, thereby avoiding a crisis that could result in hospitalization or incarceration.
Short-Term Crisis Residential	Short-term crisis residential services provide urgent care treatment in a safe environment for people who are experiencing acute crisis symptoms. These units are used as a step-down out of an extended observation unit for people who need more time for stabilization and are not ready to return to the community. They may also be used for people who are at risk for decompensation such as someone who has become homeless and requires placement. Short-term crisis residential services include 24-hour supervision, prompt assessments, medication administration, individual/group treatment, meetings with family and other supports, and referrals to community treatment.
Extended Observation Unit (EOU) / Crisis Stabilization Unit	Extended observation units (EOU) play a significant role in allowing people in crisis to be stabilized in the community rather than at an inpatient facility or a hospital emergency department. In addition, EOUs are secure facilities with the capacity to accept involuntary and voluntary patients who are experiencing a psychiatric crisis. This feature provides law enforcement officers an alternative to taking people in crisis to jail or a hospital. An EOU is not appropriate for people with high medical needs, who need to be restrained or secluded, or who are actively violent; however, almost all other psychiatric crises can be managed in an EOU. An EOU provides intensive treatment in a safe environment for people who have significant thoughts of suicide or significantly compromised ability to cope in the

Continuum of Crisis Services in an Ideal System	
Program or Service	**Description & Services Provided**
	community. EOU services include prompt assessments, medication administration, meetings with extended family and other supports, and referrals to appropriate services.
Psychiatric Emergency Centers	Also referred to as psychiatric emergency services, the essential functions of a psychiatric emergency center include immediate access to assessment, treatment, and stabilization for people with the most severe and emergent psychiatric symptoms. Services include assessment, treatment, stabilization services, and immediate access to emergency medical care.
Hospital Emergency Departments	Similar to a psychiatric emergency center, hospital emergency departments include immediate access to assessment, treatment, stabilization, and admission/referral to inpatient care for people experiencing the most severe and emergent psychiatric symptoms. Services include assessment, treatment, stabilization services, immediate access to emergency medical care, referral, and admission to inpatient psychiatric care.
Inpatient Services	Inpatient treatment services are reserved for people with mental illnesses who are a danger to themselves or others or who have a psychosis or compromised ability to cope in the community and cannot be safely treated in another level of care. Inpatient services include treatment, assessments, medication administration and management, meetings with extended family and others, transition planning, and referrals to appropriate community services.

Crisis Services Available in El Paso County

In El Paso County, multiple behavioral health providers, along with local emergency response, operate programs as part of the continuum of crisis services. Although Emergence Health Network (EHN) is the primary provider of community-based mental health crisis response services for the general population, there are many other organizations involved in the community's response to mental health crises. In Table 17, below, we provide the full continuum of services and note who provides the services. The table also shows the gaps in services that would be available in an ideal system.

Table 17: Continuum of Crisis Services in an Ideal System; Services Available in El Paso County[321]

Continuum of Crisis Services in an Ideal System					
Program or Service	**EHN**		**Other Providers**		
	Children & Youth	**Adults**	**Provider(s):**	**Children & Youth**	**Adults**
24/7 Crisis Hotline	√	√			
Other Specialized Hotlines			El Paso Center for Children	√	
			Center Against Sexual and Family Violence	√	√
			NAMI El Paso	√	√
			Medicaid managed care organizations	√	√
Mental Health Integration with 911 Response	Not Available				
Multi-Disciplinary Response Teams (MDRT)	Not Available				
Crisis Intervention Team (CIT)	√	√	El Paso Police Department	√	√
Mobile Crisis Outreach Team (MCOT)	√	√			
Crisis Transportation	√	√	El Paso Police Department	√	√
			EMS	√	√
Peer Crisis Services	Not Available				
Walk-In Crisis Center	√	√			
Crisis Telehealth Services	√	√			
Crisis Respite	Not Available				
Short-Term Crisis Residential		√			

[321] El Paso community providers (personal communication 2020)

Continuum of Crisis Services in an Ideal System					
Program or Service	**EHN**		**Other Providers**		
	Children & Youth	**Adults**	**Provider(s):**	**Children & Youth**	**Adults**
Extended Observation Unit (EOU) / Crisis Stabilization Unit		√			
Psychiatric Emergency Centers	Not Available				
Hospital Emergency Departments			Del Sol Medical Center	√	√
			El Paso Children's Hospital	√	
			El Paso Specialty Hospital	√	√
			Foundation Surgical Hospital of El Paso	√	√
			Las Palmas Medical Center	√	√
			The Hospitals of Providence, Memorial Campus	√	√
			The Hospitals of Providence, Sierra Campus	√	√
			The Hospitals of Providence, East Campus	√	√
			The Hospitals of Providence, Transmountain Campus	√	√
Inpatient Services			El Paso Behavioral Health	√	√
			The Hospitals of Providence Memorial Campus		√ *(65 and older)*

Continuum of Crisis Services in an Ideal System					
Program or Service	EHN		Other Providers		
	Children & Youth	Adults	Provider(s):	Children & Youth	Adults
			Rio Vista	√	√
			Peak Behavioral Health	√	√
			El Paso Psychiatric Center*		√

**At the time this report was released, El Paso Psychiatric Center closed its child and adolescent unit because of COVID-19 protocols and a date to reopen had not been set.*

Financing Crisis Services

Financial support for most crisis services (which are provided by EHN) comes from multiple funding streams, including the State of Texas, federal funds, 1115 waiver, the City of El Paso, El Paso County, earned income (e.g., billing Medicaid and other insurances for services delivered), and other sources (e.g., grants, foundations, private funds). The Health and Human Services Commission (HHSC) has appropriated state general revenue and federal block grant funds for EHN's provision of behavioral health crisis services in El Paso County; EHN is also required to secure local "match" funds to support crisis services.

Key partners in the El Paso community have successfully collaborated to leverage local match funds to access state grants. EHN, the City of El Paso, El Paso County, and University Medical Center received funding from the City of El Paso and the Texas Health and Human Services Commission Health Grant Program for Justice Involved Individuals (Senate Bill 292) to develop a Crisis Intervention Team program in 2018. We discuss this program in detail later in this section. There are other funding opportunities from federal and state government as well as philanthropy and research organizations that require this collaborative approach. The El Paso community is well positioned to use its existing planning and collaborative structures to explore all options for re-allocating existing funding or accessing additional funding to expand crisis services.

Entry into the Crisis System

People can access crisis services in El Paso County through various entry points; however, the path to each service will vary based on how crisis services are initiated and through which entry point the person enters. In El Paso County, there are five points of entry:

1. EHN's 24/7 crisis hotline,
2. 911,
3. Emergency departments,

4. EHN's Crisis & Emergency Services, and
5. Private Psychiatric Hospitals.

Staff at each entry point utilize an assessment protocol to determine the level of intervention necessary, based on the person's acuity of need. In every instance, efforts are made to resolve the crisis. If that is not possible, staff initiate a more intensive intervention. If staff are unable to resolve the crisis through less intensive means, they facilitate access to inpatient care. Below, we review the process for accessing crisis services through each of the five entry points.

Figure 18: Entry Point #1 – EHN 24/7 Crisis Hotline

The EHN 24/7 crisis hotline is the most common access point for crisis services. EHN crisis hotline staff answer calls placed to the hotline, along with calls for EHN's Assertive Community Treatment (ACT) and Forensic Assertive Community Treatment (FACT) programs and jail clinics as well as calls that are placed into National Suicide Prevention Lifeline by El Paso County residents. EHN staffs the 24/7 crisis hotline itself and staff are cross trained to answer various types of calls for multiple populations, including calls related to children, youth, and adults. If a person calls the EHN 24/7 crisis hotline, EHN hotline staff will try to resolve the crisis over the phone and connect that person to follow-up care. Some crisis calls can be resolved over the phone. In these instances, outcomes range from resolving the person's needs over the phone, connecting them to community resources, or scheduling an initial intake appointment when follow-up care is needed.

Although the hotline is intended for responding to psychiatric crisis situations, EHN reports that 92%[322] of calls made to the crisis line were not related to crises, but rather involved people who were seeking community resource information or had routine outpatient needs. This pattern of usage signals that the community is ill-informed of the purpose of this service, which had led to a misuse of a valuable community resource.

If the call is urgent and the crisis cannot be resolved over the phone, as is the case in 8%[323] of total calls to the crisis line, EHN crisis hotline staff can dispatch EHN's mobile crisis outreach team (MCOT). The MCOT comprises of clinical professionals from EHN who provide assessment to people in psychiatric crisis to determine if psychiatric hospitalization is appropriate. EHN's MCOT clinicians can respond anywhere in the community, including private homes, emergency departments, and other public spaces. MCOT may resolve crises and, at the point of intervention, provide referrals to community agencies for outpatient services. MCOT may also refer adults to an extended observation unit (EOU). The EOU is only allowed to admit individuals who are 18 years and older. Finally, MCOT can also facilitate admission for a child, youth, or adult to inpatient treatment by completing an assessment and deeming the individual appropriate for inpatient psychiatric hospitalization. EHN's MCOT team is currently not responding in person because of COVID-19 and is providing telehealth assessment at emergency departments instead.

EHN reported that of the assessments completed by MCOT in fiscal year 2019, the majority took place in emergency departments. Specifically, 86% of child and youth assessments and 88% of adult assessments were conducted in emergency departments.[324] EHN's ACT and FACT programs have their own crisis response protocols for program participants. When ACT and FACT clients call the EHN crisis hotline, hotline staff refer them to EHN ACT and FACT 24-hour on-call staff. Team clinicians, who are expected to be first responders for their program recipients, then respond to their clients in the community and provide crisis intervention. EHN's ACT and FACT programs are only available to adults.

The EHN 24/7 crisis hotline can also refer people in crisis to EHN's walk-in crisis center, EHN's Crisis & Emergency Services, if they can voluntarily and safely arrive on their own or be brought in by a family member or other supportive person. This option is only utilized if the person is determined not to be an imminent risk to themselves or others. The dispositions that occur after the individual arrives at Crisis & Emergency Services are described further in our discussion of the fourth entry point to crisis services.

[322] Emergence Health Network (personal communication, 2020).
[323] Emergence Health Network (personal communication, 2020).
[324] Emergence Health Network (personal communication, 2020).

If EHN 24/7 crisis hotline staff determine that a person is at risk of attempting suicide or meets Crisis Intervention Team (CIT) criteria, they will transfer the caller to 911, which will either dispatch law enforcement or, when available and appropriate, a CIT unit. Officers on the scene of a psychiatric crisis may also request a CIT unit join them to help manage the situation, provide jail diversion, or link the person to resources. Additional details on dispositions that occur with CIT are described further in our discussion of the second entry point.

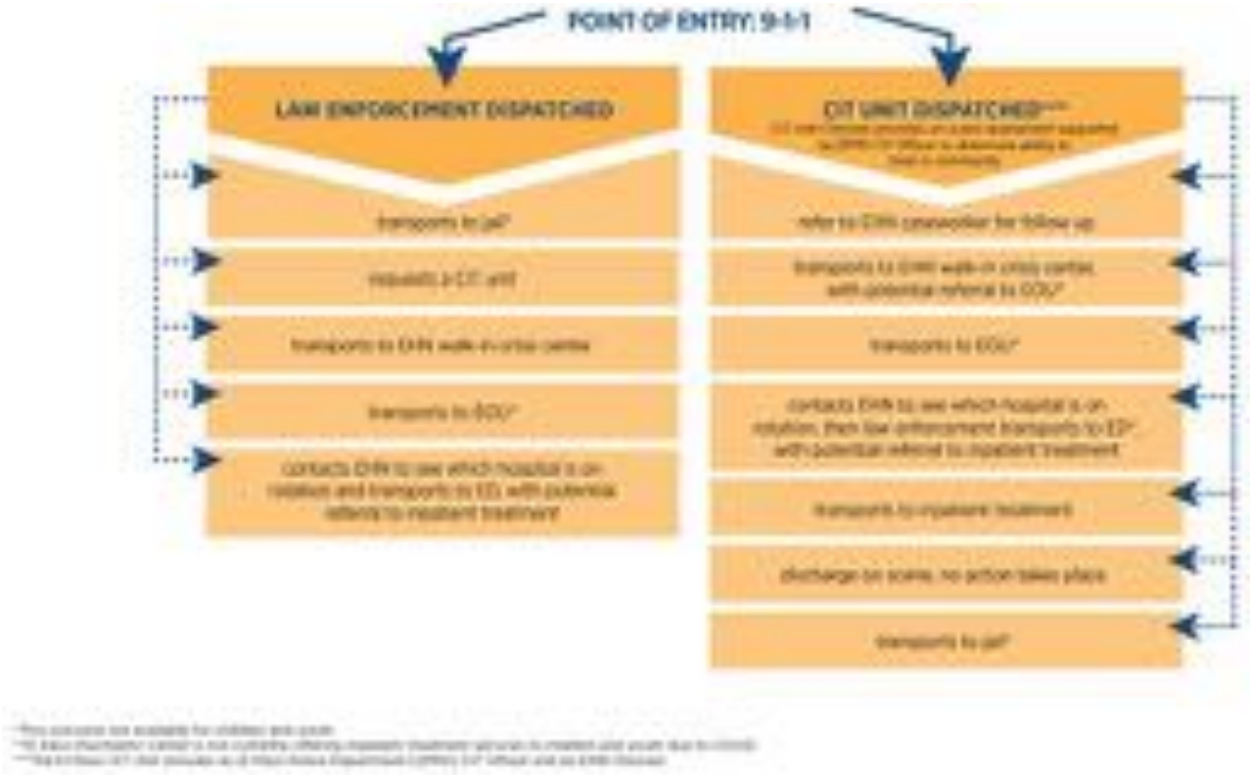
Crisis Connection Points

Other specialized hotlines are available in the community, including hotlines operated by the Center for Children, Family and Youth Success (formerly STAR); Center Against Sexual and Family Violence; and Medicaid managed care organization hotlines. These specialized hotlines serve a defined population and refer to the general crisis mental health system in the community. Additional information on these hotlines is summarized below.

- The El Paso Center for Children (EPCC) offers the Family and Youth Success Program (FAYS, formerly STAR), which includes a 24-hour hotline for families with urgent needs. FAYS is a prevention and early intervention program provided by the Texas Department of Family and Protective Services. EPCC receives calls for people needing emergency shelter placement and housing, but primarily its focus is on de-escalating issues related to family conflict and domestic violence, which are among the most common reasons people seek out and are referred to EPCC for counseling.
- Medicaid managed care organizations are required to have toll-free emergency and crisis behavioral health services hotlines available throughout their service areas that are staffed by trained personnel, 24 hours a day, 7 days a week (24/7). Crisis hotline staff need to include or have access to qualified behavioral health services professionals to assess behavioral health emergencies. Emergency and crisis behavioral health services may be arranged through mobile crisis teams.
- People may also access crisis services in El Paso County through Crisis Text Line, which provides free, 24/7 mental health support via text message. This text line can connect people to crisis services in El Paso County. Although this is another entry point into the crisis system, it only offers mental health support in English.
- The VA's crisis hotline is another resource for veterans in crisis. Accessible 24 hours a day, veterans can call the hotline and speak with a licensed independent practitioner. The hotline also acts as an entry point into the mental health system. In addition to crisis telehealth services, hotline providers coordinate with the veteran's local Department of Veterans Affairs facility to follow up with the veteran within 24 hours. If the veteran calls the crisis hotline and is considered a risk for suicide, the provider can also initiate a welfare check with local law enforcement.
- Another El Paso County organization that provides support for people in crisis is the El Paso Child Guidance Center, which offers Critical Incident Stress Management, an intervention that helps people who have been through traumatic events.

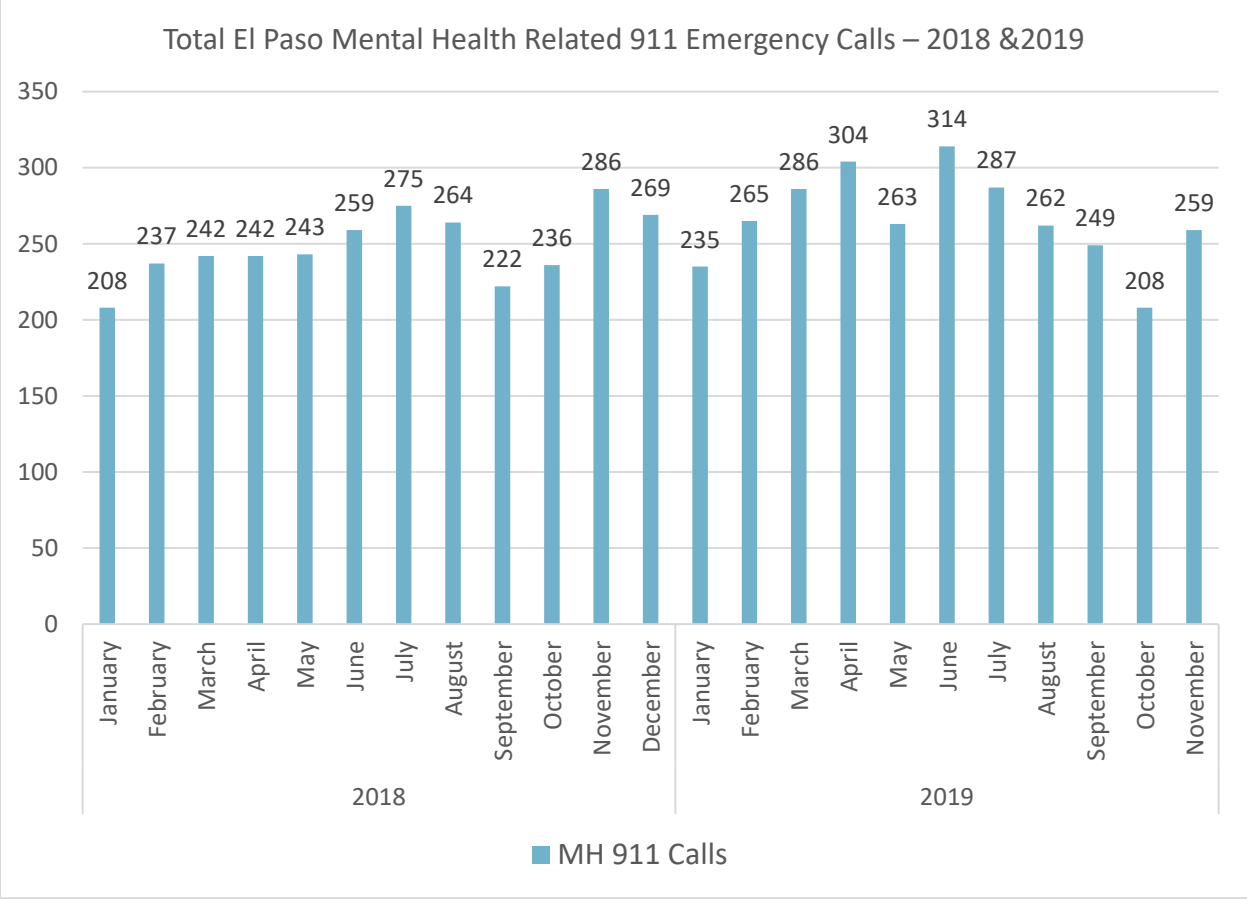
- NAMI El Paso does not have a dedicated crisis hotline, but it does provide guidance to people who place crisis calls to the agency by connecting them back to the EHN crisis line, educating them about requesting a CIT officer if they need 911 assistance, or assisting families in obtaining an emergency detention order. However, the national NAMI does have a HelpLine that can be reached Monday through Friday, 10 am – 6 pm, ET, 1-800-950-NAMI (6264) or info@nami.org.

Figure 19: Entry Point #2 – 911



As is the case in most communities, 911 receives many behavioral health crises calls. On average, El Paso County 911 receives 257 mental health related emergency calls per month. The following figure displays the total number of behavioral health calls per month in 2018 and the first 11 months of 2019.

Figure 20: Total El Paso Mental Health Related 911 Emergency Calls (2018 & 2019)[325]



El Paso County 911 will either dispatch traditional law enforcement or, when available and appropriate, a CIT unit (a CIT unit includes an officer trained to be part of a Crisis Intervention Team). Officers on the scene of a call may also request a CIT unit to join them to assist with scene management, jail diversion, or linkage to resources.

When law enforcement is dispatched, the following dispositions can occur:

- Transporting the individual to jail if they are an adult and have committed an offense;
- Requesting a CIT unit if the individual meets CIT criteria and a unit is available;
- Transporting the individual to EHN's Crisis & Emergency Services (EHN's walk-in crisis center), which may make a referral to the EOU for adults;
- Transporting the adult directly to the EOU if the person is in acute need of intervention and does not need medical attention; or
- Contacting EHN to see which hospital is on rotation and transporting the individual to the emergency department, which could potentially result in a referral to inpatient treatment.

[325] Tong, L., PCO_EDO Cases with address and Geo Code. (personal communication, 2020, March 17)

EHN, the City of El Paso, El Paso County, and University Medical Center received funding from the City of El Paso and the Texas Health and Human Services Health Grant Program for Justice Involved Individuals (SB 292) to develop a Crisis Intervention Team in 2018. While EHN and the El Paso Police Department oversee the operations of the team, to receive grant funds SB 292 required the participation of a community collaborative defined as a county, a local mental health authority, and a county hospital district. Officers on the CIT unit began responding to calls in December 2018 and the fully staffed team was launched in February 2019. The CIT unit consists of specialized officers with the El Paso Police Department and an EHN clinician who co-respond to mental health related 911 calls. The primary purpose of the CIT unit is to de-escalate and intervene in behavioral health crises and divert people in crisis from the criminal justice system and connect them to treatment. When the CIT unit is dispatched, an EHN clinician provides an assessment on site to determine if the person in crisis could be treated in the community or needs to be referred to inpatient treatment. When CIT is dispatched, the following dispositions can occur:

- If the individual is enrolled in EHN services and the CIT has access to their medical records, they will refer the individual to their EHN caseworker for follow-up care;
- Transporting the individual to EHN's Crisis & Emergency Services (EHN's walk-in crisis center);
- Transporting adults directly to the EOU if they are in acute need of intervention and do not need medical attention;
- Contacting EHN to see which hospital is on rotation and transporting the individual to the emergency department, which could potentially result in a referral to inpatient treatment;
- Transporting the individual directly to inpatient treatment at either the state hospital (El Paso Psychiatric Center) or a private hospital (Rio Vista and El Paso Behavioral Health);
- Transporting the individual to outpatient services;
- De-escalating the crisis in person; or
- Transporting the individual to jail if they are an adult and have committed an offense or are identified as having active warrants.

Not all City of El Paso Police Department officers have received advanced CIT training. CIT responses for children and youth are limited to de-escalation and referrals. The El Paso County's Sheriff's office does not currently have a CIT team; however, all of the sheriff deputies have received advanced mental health training.

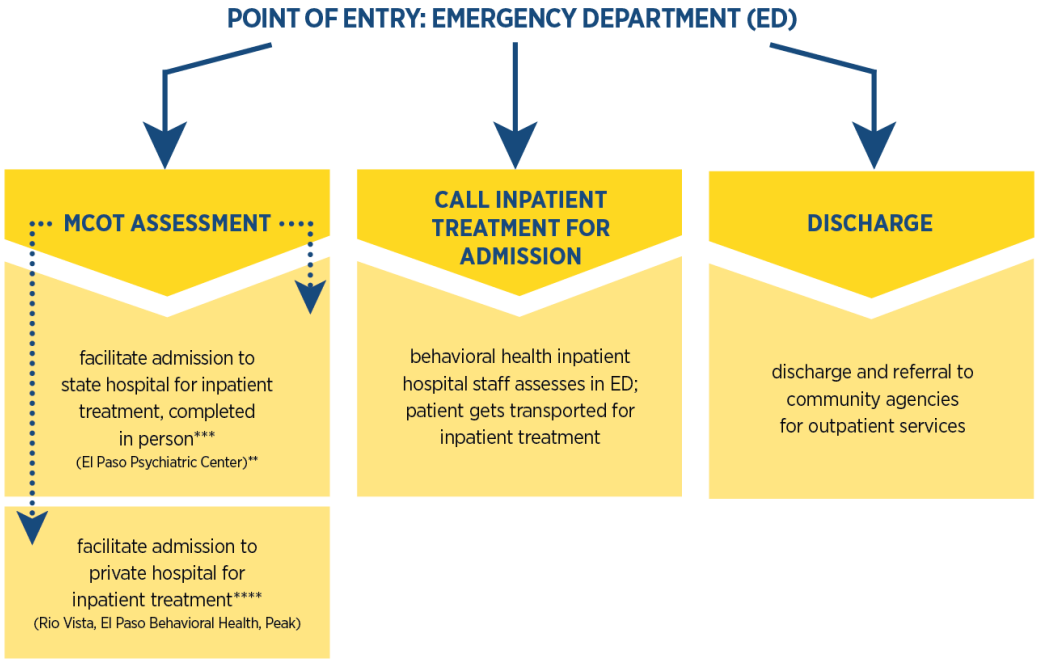
We contracted with EHN to complete a longitudinal analysis of its CIT program. This evaluation analyzes the impact of the CIT program related to the following areas:

- Reductions in criminal justice involvement for people with mental illnesses,
- Increases in service utilization,
- Costs of incarceration and involuntary detention,

- Officer resources,
- Encounter trends, and
- Connections to community treatment.

In addition to those analyses, we will complete a community dashboard to display baseline data from this study, which can be compared with ongoing trends. The CIT evaluation began in September 2019. To date, progress reports have been issued to describe progress with the evaluation and dashboard, share data, and offer findings and recommendations for action.[326] The final report, *Emergence Health Network Crisis Intervention Team Evaluation: Final Report*, will be issued in Spring 2021 with full findings and recommendations.

Figure 21: Entry Point #3 – Emergency Department



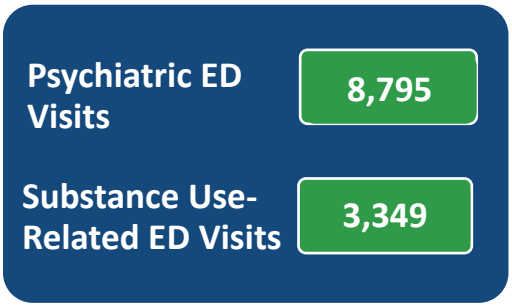
**El Paso Psychiatric Center is not currently offering inpatient treatment services to children and youth due to COVID.
***MCOT assessments are being completed via telehealth during COVID
****Admission by private hospitals may be directly accessed through walk-in by patient.

Even in a community with an ideal service array of integrated primary care, specialty care, and rehabilitation capacity, the emergency department will play an important role in helping with behavioral health crises. In systems without the full array of outpatient services, the emergency

[326] The Meadows Institute. (2020) Emergence Health Network Crisis Intervention Team Evaluation: First quarterly report; The Meadows Institute. (2020). Emergence Health Network Crisis Intervention Team Evaluation: Second quarterly report.

department takes on the less ideal and more frequent role of acting as the entry point to care for people with untreated behavioral health conditions.

Figure 22: Emergency Department (ED) Visits All Ages (2019)



Across El Paso County emergency departments in 2019, there were a total of 8,795 visits for primary and secondary psychiatric diagnoses and 3,349 visits for primary and secondary substance use disorder (SUD) diagnoses. As Table 18 shows, Del Sol Medical Center, The Hospitals of Providence East Campus, University Medical Center of El Paso, and Las Palmas Medical Center were the most frequently utilized emergency departments for psychiatric visits (representing 5,630 of 8,795 total psychiatric emergency department visits, or 64%). Del Sol Medical Center was more frequently utilized for emergency department visits related to SUD diagnoses (714 of 3,349 visits, or 21%), based on data from 2019. Aside from Legent Hospital (formerly Foundations Surgical Hospital), which had only 13 psychiatric and SUD emergency department visits (only two were SUD-related), El Paso Children's Hospital had the fewest psychiatric and SUD-related emergency department visits. Because of this small number of total visits, Legent Hospital was included in the total count but not as a separate breakout in Table 18. Across all emergency departments, there were nearly three times as many emergency department visits for primary or secondary psychiatric conditions than there were for substance use-related conditions.

Table 18: Emergency Department Visits for Total Primary and Secondary Psychiatric and Substance Use Disorders – All Ages (2019)[327]

Hospital	Psychiatric Visits	SUD-Related Visits
Del Sol Medical Center	1,619	714
University Medical Center of El Paso	1,484	635
The Hospitals of Providence East Campus	1,333	412
Las Palmas Medical Center	1,194	456
The Hospitals of Providence Transmountain Campus	923	354
The Hospitals of Providence Memorial Campus	795	298

[327] Data were obtained from the Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records. Legent Hospital (formerly Foundations Surgical Hospital), which had only 13 psychiatric and SUD ED visits (only two were SUD-related), is not shown but was included in the total.

Hospital	Psychiatric Visits	SUD-Related Visits
The Hospitals of Providence Sierra Campus	458	245
The Hospitals of Providence Northeast Campus	456	142
The Hospitals of Providence Horizon Campus	279	65
El Paso Children's Hospital	241	26
All Emergency Department Visits	**8,795**	**3,349**

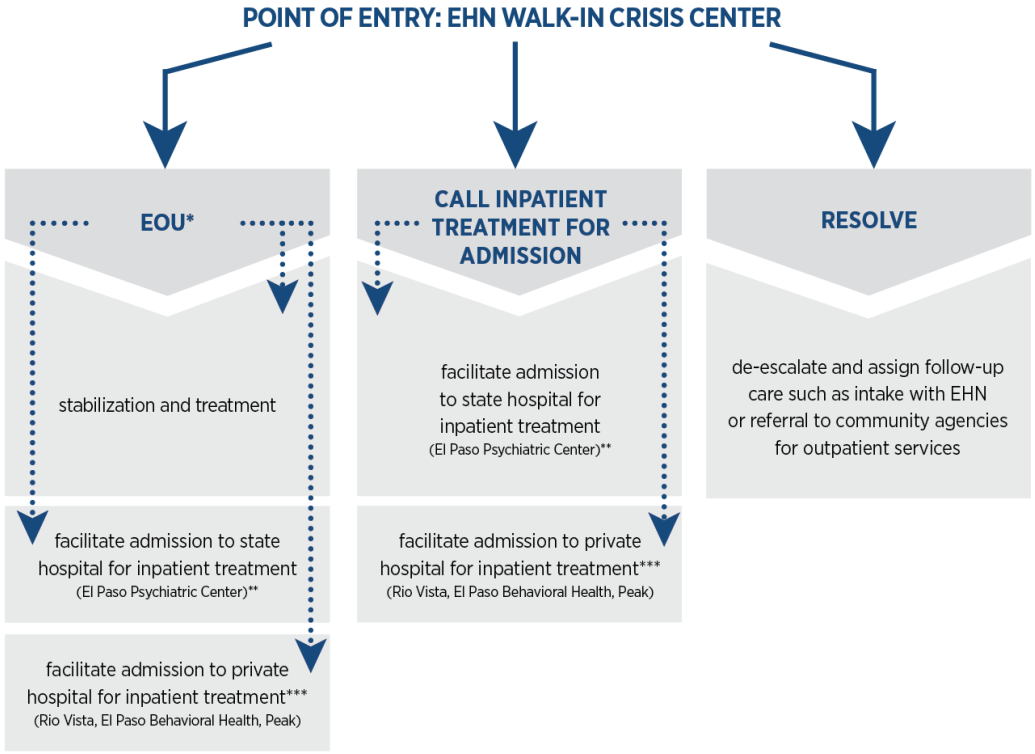
When a person experiencing a psychiatric crisis enters a general acute care hospital emergency department, they need to be "medically cleared" before they are transferred to a behavioral health facility for psychiatric treatment. That is, the person's primary diagnosis cannot be a physical health condition that requires acute medical attention. If a person does present with an acute physical emergency as a primary presenting diagnosis, they are admitted to a medical unit in the general hospital for treatment until the physical condition can be stabilized, at which time the person is evaluated for psychiatric hospitalization. However, when a person does not require immediate medical care for an acute physical emergency, the emergency department staff contact EHN or inpatient psychiatric hospitals to request a psychological assessment for admission. When EHN is called, its Mobile Crisis Outreach Team (MCOT) can come to the emergency department to conduct a crisis assessment to determine the level of intervention needed. Before the COVID-19 pandemic, these assessments were completed in person; however, they now must be completed via telehealth. If inpatient hospitalization criteria are met, MCOT staff can facilitate admission to the state hospital (El Paso Psychiatric Center) or private hospitals (Rio Vista, El Paso Behavioral Health, and Peak Behavioral Health)[328] for inpatient treatment or a partial hospitalization program. El Paso Psychiatric Center is not currently offering inpatient treatment services to children and youth because of COVID-19; therefore, children and youth are referred to Rio Vista, El Paso Behavioral Health, and Peak Behavioral Health.

When inpatient psychiatric hospitals are contacted by the general acute care emergency departments, they conduct an emergency crisis assessment in the emergency department to determine whether inpatient admission criteria are met. According to stakeholders we interviewed, for the most part, private inpatient hospitals usually conduct assessment for people with private insurance because EHN is required to assess and approve all

[328] In addition to local capacity, the El Paso community also has access to 88 inpatient beds at Peak Behavioral Health located in Las Cruces, New Mexico.

hospitalizations for people with Medicaid or those who are uninsured. If the emergency crisis assessment indicates that a person meets criteria for inpatient psychiatric treatment, that person is transported to an inpatient treatment facility.

Figure 23: Entry Point #4 – EHN's Crisis & Emergency Services



*This outcome not available for children and youth
**El Paso Psychiatric Center is not currently offering inpatient treatment services to children and youth due to COVID.
***Admission by private hospitals may be directly accessed through walk-in by patient.

People can voluntarily access crisis services through EHN's Crisis & Emergency Services. This resource is available to children, youth, and adults. EHN's walk-in crisis center, EHN's Crisis & Emergency Services, can refer adults to the EOU if the individual is acutely in need of intervention and is not in need of medical attention. Once in the EOU, EHN may facilitate admission to the state hospital (El Paso Psychiatric Center) or private hospitals (Rio Vista, El Paso Behavioral Health, and Peak Behavioral Health) for inpatient treatment, if criteria are met. If the person's needs are acute, EHN staff can also bypass the EOU and directly facilitate admission to the El Paso Psychiatric Center, Rio Vista, El Paso Behavioral Health, or Peak Behavioral Health for inpatient treatment. At this time, EHN's walk-in crisis center is unable to provide medical clearance, outside of routine vitals, prior to admission to inpatient treatment. If the EHN onsite nurse reports acute physical health concerns, EHN has to transport the individual to an emergency department to receive a full medical evaluation before they are admitted to an inpatient psychiatric facility.

Veterans in the Crisis System

The primary source of crisis support for veterans in El Paso County is the U.S. Department of Veterans Affairs (VA). Mental health clinics in the El Paso VA Health Care System purposely reserve appointment slots for same-day access to mental health care for veterans in crisis or in urgent need of care. VA clinics also have crisis procedures in place that allow veterans to meet with providers they have previously seen. If necessary, these clinics can implement contingency plans to coordinate quicker access to another clinic provider. Because of the COVID-19 pandemic's forced reduction in the number of face-to-face appointments, the VA has applied the same procedures for reserving appointment times in the telehealth schedule that allow veterans to have same-day access to providers.

The VA's crisis hotline is another resource for veterans in crisis. Accessible 24 hours a day, veterans can call the hotline and speak with a licensed independent practitioner. The hotline also acts as an entry point into the mental health system. In addition to providing crisis telehealth services, hotline providers coordinate with the veteran's local VA facility to follow up with the veteran within 24 hours. If a veteran calls the crisis hotline and is considered suicidal, the provider can also initiate a welfare check with local law enforcement.

Outside of the VA, EHN's Veterans One-Stop Center and The Steven A. Cohen Military Family Clinic at Endeavors have contingency plans for providing immediate support to stabilize veterans in crisis and then referring them to an appropriate facility or emergency room for follow-up and continued care, if necessary. Unfortunately, there is no concerted effort among mental health organizations that serve veterans to create a predictable, uniform pipeline for veterans in crisis. We received input that staff at different organizations do not know other organizations well enough to consistently make appropriate referrals for services. We requested data to help determine the number of referrals for services, including the destinated organization(s) and satisfactory completion of care, but data were not made available for this report.

Crisis System Improvement Analysis Findings and Recommendations

El Paso County has a particularly strong crisis system for children, youth, and adults. However, like all counties and regions, the crisis system in El Paso County has challenges and opportunities for growth that could move the community closer to the ideal crisis system previously described.

In this section, we highlight key findings and recommendations for the areas of the crisis system we have analyzed. This information was informed by extensive input from locally based providers, research on national best practice, and our analysis of quantitative data from available sources.

Navigating the Crisis System

Finding: El Paso County's system focuses on crisis response but has not yet begun to redesign the broader 911 system response to mental health emergencies to center on a health-driven, rather than a public safety-driven, response. El Paso has not embedded mental health clinicians into its 911 call center, nor has it begun to redesign police response to focus instead on a partnership with community paramedics and integrated mental health specialists. Few communities in Texas have yet done this, but El Paso has the building blocks to begin to do so, should local leader decide to take on this additional capacity.

Recommendation: Begin a community dialog on the potential to reform 911 response to better leverage El Paso's mental health crisis response system and shift the primary locus of response from police to health providers (paramedics and mental health specialists). The Meadows Institute is working with the Pew Charitable Trusts to help well-positioned communities such as El Paso begin such dialog and fund program start up, if there is sufficient community support. The SB 292 funding stream is available to support such programs, and El Paso will have a chance to review its SB 292 funding priorities in the late summer and early fall of 2021.

Finding: El Paso County has a robust crisis system; however, providers and individuals are unsure how to access the crisis system and which services are available. Since TriWest's 2014 assessment of El Paso County's crisis services system, there has been remarkable improvement in the crisis service array, including, but not limited to, launching a CIT unit to serve El Paso residents experiencing a mental health crisis. One issue that remains, however, is that providers and community members are not aware of all the crisis services available and how to best navigate the crisis system in El Paso County.

Often people enter the crisis system through more intensive entry points such as emergency departments or law enforcement, rather than entering through less intensive, system-efficient points available through EHN such as its 24/7 crisis hotline or its walk-in crisis center (known as EHN's Crisis & Emergency Services). This confusion can also result in people delaying access to services, which can result in an exacerbation of symptoms and overuse of the most intensive treatments (like inpatient hospitalization). The goal of a crisis system is to connect people to services long before inpatient hospitalization is needed.

Recommendation: Crisis system providers should work together to educate El Paso County residents about the crisis services that are available in the community and how to access the crisis system. EHN should collaborate with hospital emergency departments and inpatient treatment providers on ways they can work together to educate specialty providers and the public more effectively about the crisis services and supports that are available for individuals in El Paso County. EHN can conduct presentations with schools, juvenile and criminal justice

organizations, and specialty mental health providers to increase awareness of the 24/7 crisis hotline, including how and when to use it. El Paso County stakeholders can also utilize the crisis process map developed in this assessment to further educate the community on how to navigate the El Paso County crisis system. Furthermore, crisis services providers can share this information with providers and stakeholders across systems through the El Paso Behavioral Health Consortium, Family Leadership Council, Justice Leadership Council, and Integrated Leadership Council.

Crisis Respite

Finding: There are no available out-of-home, short-term crisis stabilization environments that could serve as an alternative to hospitalization for children and youth in crisis. Although EHN operates an EOU that is frequently used as an alternative to inpatient hospitalization for adults, there is no alternative to hospitalization for children and youth in crisis. Crisis respite, whether facility-based or home-based, provides temporary relief for caregivers; a safe environment to resolve crises; and an opportunity to engage children, youth, and their families in services. Further, depending on the severity of the crisis and the needs of the child or youth, crisis respite can serve as a safe alternative to inpatient hospitalization. Services that may be provided in a crisis respite setting include crisis planning for the family and child/youth, therapy, and skills training. The goal is to strengthen the ability of children, youth, and their families to prevent future crises and to better manage them if they do occur. Stakeholders report that a now-closed crisis respite facility in the community was a helpful alternative in the past, and our interviews revealed widespread interest in making this service available in the community again.

Recommendation: Medicaid managed care providers should explore the provisions of Senate Bill (SB) 1177 to add crisis respite to the community's array of crisis services. During Texas legislative session 86(R) the Texas Legislature passed SB 1177. Through SB 1177,[329] intensive evidence-based practices with known positive outcomes became available to children and youth who are eligible for Medicaid managed care programs. The evidence-based practices would be used in lieu of other mental health services and could serve as alternatives to residential and inpatient care. The law requires the Health and Human Services Commission (HHSC) to update Medicaid managed care contracts with language allowing managed care organizations to offer evidenced-based services in lieu of more restrictive services; as part of that process, the State Medicaid Managed Care Advisory Committee is charged with approving the services that are included as "in lieu of" services. Phase 1 of implementation takes effect September 1, 2021 and will include crisis respite as an allowable service. Providers who contract with Medicaid managed care organizations should explore the feasibility of amending

[329] Senate Bill 1177, Texas Senate (2019). https://capitol.texas.gov/Search/DocViewer.aspx?ID=86RSB011775B&QueryText=%22SB+1177%22&DocType=B

their contracts to include reimbursement for crisis respite in lieu of inpatient hospitalization. Community-level planning around crisis respite will also be necessary to ensure families and providers are able to access the service when needed and, more importantly, to ensure its effective integration into the existing crisis framework so there is clear coordination from intake to discharge and beyond.

Medical Stability Protocol – Inpatient Psychiatric Hospital Admission

Finding: Individuals needing inpatient psychiatric treatment are required to go to emergency departments or receive medical clearance from emergency medical services in the field before they can be transported to an inpatient psychiatric hospital. Currently in El Paso County, most people who need inpatient psychiatric hospitalization can only receive inpatient treatment at a private psychiatric hospital. Therefore, they must be transported by a law enforcement officer to an emergency department or remain in the field until emergency medical services (EMS) arrives, wait to receive a medical clearance, and then be transported again to an inpatient psychiatric hospital. This process is not only traumatizing and time consuming for both the patient and the officer, but it also obstructs emergency departments with people who may be medically stable and have non-emergent needs.

Recommendation: Create and integrate a medical stability protocol with the El Paso Fire Department/emergency medical services, and the El Paso Police Department. The best crisis response to a person with mental illness who is at risk of becoming involved with the justice system is a multidisciplinary team comprised of specially trained law enforcement (to secure the scene and assure public safety), a paramedic (to assess the medical conditions that often accompany serious mental illness), and a licensed mental health professional (to address mental health issues and assure linkage to community treatment). However, as an important interim step, communities can employ a "medical stability protocol". A medical stability protocol, as has been modeled in Bexar County, allows law enforcement to determine whether the person in crisis needs emergency medical services response/medical attention or can be transported directly to an inpatient psychiatric hospital. To create the protocol, hospital partners, law enforcement, and EMS need to work together to create language that is understandable to law enforcement and clearly communicates the criteria necessary for a person to be medically cleared in the field and transported directly to an inpatient psychiatric facility, bypassing the emergency department. Currently in Bexar County, a dedicated dispatch relays questions to law enforcement officers to assist in making that decision.[330]

This broadened practice of determining medical clearance in the field helps reduce front-end crisis wait times in that people needing emergency services are triaged by a dispatch center that accepts calls 24/7. Bexar County initiated a law enforcement navigation system in October

[330] Sarah Hogan, Southwest Texas Crisis Collaborative Division Director (personal communication, October 2020).

2017 to divert people experiencing a mental health crisis from emergency departments and triage them to appropriate treatment. People in crisis and law enforcement officers often had to wait for hours in Bexar County emergency departments for referrals to more appropriate facilities. With the Bexar County protocol, navigation occurs through MEDCOM, originally a dispatch center accepting calls 24/7 for all trauma patients in the region. Data show that the program has been successful in diverting people away from waiting holds at the emergency departments and into psychiatric facilities.[331]

Medical Stability Protocol – Extended Observation Unit

Finding: Emergence Health Network currently operates an extended observation unit without the ability to provide medical clearance onsite. Within the crisis system, the extended observation unit (EOU) plays a significant role in allowing people in crisis to be stabilized in the community rather than at an inpatient facility or a hospital emergency department. A critical issue that is often a source of frustration for law enforcement is transporting people in crisis to an EOU only to find that they require medical clearance to be admitted.

Medical clearance is essential to assess and treat medical conditions (which are not always apparent to non-medical staff); however, this practice often results in law enforcement waiting for long periods of time at emergency departments for a person to be "medically cleared" before they can be transported to the designated facility. At the EHN's Crisis & Emergency Services, before admission to the EOU is approved, a patient must be medically cleared. However, the assessment to do so is currently limited; an onsite nurse completes routine vitals and a medical screening but cannot provide a full medical evaluation if there are any concerns about acute physical needs. For all patients, even those that present with symptoms that appear to be primarily psychiatric in origin, a medical evaluation needs to take place to determine if any acutely serious underlying physical illness exists, since admission to a psychiatric facility without medical capacity would be unsafe or inappropriate. Because of limited assessment capacity available at EHN, people experiencing psychiatric crises must be transported to an emergency department to receive full medical clearance, which defeats the purpose of diversion and system efficiency that the EOU provides. The establishment of training and clear protocols, and ensuring that all stakeholders understand and follow them, would be important components of a successful EOU.[332]

Recommendation: Emergence Health Network should embed medical clearance personnel within the extended observation unit and establish a medical clearance protocol. The protocol could involve having a physician at EHN's Crisis & Emergency Services (EHN's walk-in

[331] Meadows Mental Health Policy Institute. (2018, November). San Antonio State Hospital redesign: Stakeholder engagement report and SWOT analysis.

[332] For resource information on behavioral health emergency assessment see Zun, L. S., Chepenik, L. G., & Mallory, M. N. S. (2013). *Behavioral emergencies for the emergency physician*. Cambridge University Press.

crisis center) provide medical clearance, co-locating a paramedic, or having a community-based primary care physician conduct an exam to provide medical clearance. This latter approach has been utilized in some locations where either the community mental health center or local mental health authority has established a primary care clinic or has an arrangement with a federally qualified health center to offer medical clearance in emergency.

Prior to the start of the COVID-19 pandemic, EHN leadership partnered with a local hospital system to create a business plan to place a nurse practitioner in the EHN's Crisis & Emergency Services unit. At the time of this assessment, the health system indicated it will have to re-visit its potential contribution for funding this capacity at EHN later in the fiscal year as its financial priorities have been re-focused to pandemic-related needs.

Standardized Community-Wide Assessment Protocols and Training

Finding: Assessments for inpatient psychiatric hospital admissions are often conducted by multiple assessors from different organizations. According to stakeholders we interviewed, people in psychiatric crisis often endure multiple admission assessments prior to being accepted to an inpatient psychiatric facility. Each organization has unique protocols, assessments, and training. Not only does this process create a delay in the system and extend time in the emergency department for the person waiting for treatment, it also does not follow trauma-informed and person-centered practices.

Recommendation: Organizations providing admission assessments should move to a common standardized assessment tool as well as consolidated and collaborative training among providers. Pooling resources and collaborative efforts among current assessment providers will create a single accepted assessment among providers. Developing and concurrently disseminating one training for all assessment providers will ensure standardized learning and administration of the tool chosen. Operationally, a standardized, system-wide recognized assessment allows the opportunity for multiple organizations to provide this service and, therefore, creates system efficiencies, dissolves bottlenecks as well as duplication of services as the initial assessment will be acknowledged as accurate across admitting and funding community partners. Most importantly, this practice will allow for better treatment of the individual, more efficient use of community resources, more timely response, and collaborative treatment decisions among providers.

Crisis System Financing

Finding: The El Paso community developed an effective collaboration that secured new funding to expand crisis services. EHN, the City of El Paso, El Paso County, and University Medical Center received funding from the City of El Paso and the Texas Health and Human Services Commission Health Grant Program for Justice Involved Individuals (Senate Bill 292) to

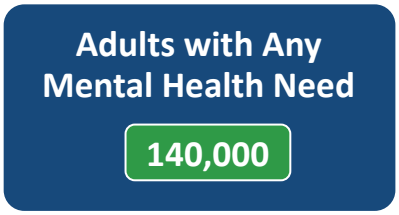
develop a Crisis Intervention Team (CIT) program in 2018. This grant required local match funds to access the state grant funds. This model will likely be used for future grant opportunities.

Recommendation: The El Paso community should build upon the successful Senate Bill (SB) 292 collaboration to find and access additional funding for crisis services, or reallocate existing funding, as appropriate. Community planning should begin now to develop funding priorities for the expected renewal of SB 292 and other state grant programs. Planning can also include re-allocation of existing funding as new best practices are identified that can improve outcomes. This would permit El Paso County to build on the foundation established by the initial use of SB 292 funding to create a CIT program in 2018.

Intensive Adult Services and Special Populations

Although the focus of our report was on overall access to services, strategy development for high-risk children and youth, and the crisis system, our research and analysis led to additional findings and recommendations related to intensive adult services and special populations, including veterans and people involved with the criminal justice system.

Intensive Adult Outpatient Services Findings and Recommendations



Overall, there were about 610,000 adults living in El Paso County in 2019 and slightly less than one quarter of adults in the region (about 140,000) had any mental health condition. Most adults living with mental health conditions had conditions that were mild to moderate in severity (115,000), which could be treated in primary care settings ideally with psychiatric consultation available[333,334]. The rest (about 25,000) had serious mental illnesses (SMI), more than half of whom (15,000) were living in poverty (Figure 24). Most people with SMI would benefit from treatment in a specialized behavioral health setting, such as treatment provided in local mental health authority community clinics.

[333] Integrated care combines primary health care and mental health care in one setting.
[334] Meadows Mental Health Policy Institute experts estimated that the proportion of the adult population with mental health needs who are best treated in integrated primary care settings is approximately equal to the proportion with mild or moderate severity. Although some portion of people with serious mental illness (e.g., people with major depression) can be effectively treated in integrated primary care, a proportion of people with moderate mental illness need care at specialty settings. These offsetting factors approximately cancel each other.

Figure 24: Distribution of Mental Health Needs Among El Paso County Adults (2019)[335]

We reviewed a full range of programmatic options centered on the primary objective to assess the current crisis system structure in El Paso County to inform recommendations to reduce the unnecessary use of the jail, emergency departments, and inpatient hospitalization by people with severe mental illnesses.

As in most communities, El Paso County's local mental health authority, Emergence Health Network (EHN), provides intensive services to people with complex needs who routinely cycle between jails, emergency rooms, and inpatient care and are most in need of intensive, community-based wraparound services. These services include Assertive Community Treatment (ACT) and Forensic ACT (FACT), Coordinated Specialty Care (CSC) for first episode psychosis treatment, and Permanent Supportive Housing services. While these services can be found in local mental health authorities across the state, it should be noted that EHN excels at this level of care. The leadership of these teams have extensive knowledge about and dedication to the populations they serve. Additionally, the leadership of EHN provides rigorous ongoing surveillance of the changing community mental health landscape to respond to community needs and gaps and stay on the cutting edge of clinical intervention.

Below, we provide background information, findings, and recommendations on the evolution and expansion of the existing services at EHN. EHN's teams are currently providing exemplary work and our recommendations represent their readiness and exceptional ability to evolve their services to the next level of excellence.

Change in Service Provision for Adults Between 2014 and 2019

The increase in the El Paso County adult population, combined with a slight decline in the poverty rate, have implications for the public behavioral health care system. Although there was no substantial change in the need for LMHA services between 2018 and 2019 (see Table 19), EHN's service provision data suggest that the number of adults it served increased substantially (more than 150%) between 2014 and 2019.

[335] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of Gen Psychiatry, 62*(6), 617–627.

Assertive Community Treatment Services

We took a particularly close look at the functioning of EHN's ACT team.[336] The purpose of an ACT team is for people who need high-acuity services to be referred for intensive outpatient treatment. EHN's ACT team serves people who have serious and complex behavioral health needs and often find themselves cycling between hospitals, emergency services, and the criminal justice system. According to local stakeholders and EHN's ACT team, one strength of the ACT program is that it receives an estimated 80% of its referrals from external sources, which is chiefly attributed to the work of the EHN hospital liaison and strong relationships with the crisis services and the CIT police unit. Additionally, as an example of assertive outreach, the team's clinical director consistently reviews EHN's utilization management department for cases of people who qualified for ACT but requested fewer and less intensive services, recognizing that people who with the highest need often require assertive outreach and engagement before they agree to participate in the full array of ACT services. Fortunately, state-mandated criteria for services were clarified in 2017 to allow pre-enrollment outreach to help teams better prioritize care for people most in need of services.[337]

To be financially sustainable, ACT teams need to target people who are receiving care that is more expensive than ACT to justify the intensity and cost of this treatment. Research shows that high fidelity ACT teams can yield significant cost savings in hospital and emergency room use, but only among high utilizers of these services. High-fidelity ACT achieves its cost savings by stabilizing repeat episodes of psychosis and acute symptoms, which reduces the costs associated with repeated use of inpatient care, emergency services, and the criminal justice system, with one study finding a reduction in 32 days of hospitalization per year.[338] At an approximate cost of $12,500 per person per year, ACT expenditures can be recovered by reducing hospitalization by 13 days in a year or incarceration by 130 jail days in a year. Recovery-oriented ACT was associated with cost savings in annual hospital use for people with recent high utilization of services.[339]

These interventions need to be managed so people are stepped down assertively to lower levels of care as soon as they are stabilized to the point where they can reliably engage in less

[336] The Assertive Community Treatment (ACT) team provides the highest level of community-based care to people with serious mental illness, who are vulnerable to homelessness, hospitalization, and criminal justice system involvement.
[337] Miller, J., & Strickland, R. (March 15, 2017). Assertive Community Treatment Fidelity Tool: Using the Tool of Measurement of Assertive Community Treatment as an alternative to the Dartmouth Assertive Community Treatment Scale [Memorandum]. Texas Health and Human Services Commission.
[338] Morrissey, J. P., Domino, M. E., & Cuddeback, G. S. (2013). Assessing the effectiveness of recovery-oriented ACT in reducing state psychiatric hospital use. *Psychiatric Services, 64*(4), 303-311. For a review see Bond, G. R., McGrew, J. H., & Fekete, D. M. (1995). Assertive outreach for frequent users of psychiatric hospitals: A meta-analysis. *The Journal of Mental Health Administration, 22*(1), 4-16.
[339] Morrissey, J. P., Domino, M. E., & Cuddeback, G. S. (2013).

intensive interventions. These interventions should include clear protocols that are shared with system partners and address when to step people down to lower levels of care in order to free up limited ACT capacity for people with high needs. Protocols should also ensure coordination with system partners who serve people receiving ACT services to avoid premature transitions to lower levels of care. To accomplish this, the team should realign its work so that it adheres to current ACT fidelity standards to ensure that the highest quality of services is delivered.

Forensic Assertive Community Treatment Services

Forensic ACT (FACT), a derivative of ACT, has been shown by research to reduce jail recidivism rates for people with serious mental illnesses and high risk for criminal justice recidivism who frequently cycle through the criminal justice system, emergency departments, and hospital services. Best practices for FACT are based on best practice ACT principles (Tool for Measurement of Assertive Community Treatment), but the FACT team also includes a forensic specialist, and all staff are specially trained to focus on factors that increase a person's risk for recidivism (called "criminogenic risk").

Although FACT studies are sparse and methodologically limited, the soundest experiment found that FACT reduced jail bookings and hospitalizations over a two-year follow-up period.[340] While the evidence for FACT is sparser and therefore more tentative at this point, results of a rigorous randomized controlled trial conducted in California showed that at both 12 and 24 months, FACT clients had more outpatient contacts, significantly fewer jail bookings, and fewer hospital days than treatment as usual clients.[341] FACT can apply principles from the risk-need-responsivity (RNR) model, which has a well-developed research literature.[342,343]

Finally, ACT and FACT teams are often used as vehicles for other evidence-based programs in the field. In keeping with this movement, FACT teams can primarily be vehicles for the RNR model (i.e., targeting high-risk cases, focusing on risk factors for recidivism, and doing so in a manner responsive to learning styles/symptoms). RNR is considered the "premier model for guiding offender assessment and treatment" and has become the basis for many interventions in the criminal justice/mental illness field.[344]

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[340] Morrissey, J., & Louison, A. (2013). *Forensic Assertive Community Treatment: Updating the evidence*. http://www.prainc.com/wp-content/uploads/2015/10/slides-forensic-assertive-community-treatment-updating-the-evidence.pdf.

[341] Cusack, K. J., et al. (2010). Criminal justice involvement, behavioral health service use, and costs of Forensic Assertive Community Treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363.

[342] Washington State Institute for Public Policy. (2016). *Benefit-cost results: Risk, need, and responsivity for moderate-high-risk offenders*. http://www.wsipp.wa.gov/BenefitCost/Program/157.

[343] Andrews, D. A. (2012). The risk-need-responsivity model of correctional assessment and treatment. In Dvoskin, J. A., Skeem, J. L., Novaco, R. W., & Douglas K. S. (Eds.), *Using social science to reduce violent offending* (pp. 127-156). Oxford University Press.

[344] Andrews, D. A., & Bonta, J. (2011). The risk-need-responsivity (RNR) model: Does adding the good lives model contribute to effective crime prevention? *Criminal Justice and Behavior, 38*(7), 735–755.

Currently, people who are involved in the criminal justice system receive the same treatment as those who are not involved in this system, which is not best practice for forensic services. Without a specialized forensic component, the FACT program participants are likely to experience reincarceration since ACT has not been shown to be effective in reducing arrests and jail time.[345] In summary, there is compelling evidence that ACT and RNR-infused FACT will have sizable effects on utilization rates for the population of interest. EHN serves 20 individuals with its current FACT capacity, which is a fraction of the need in the El Paso community.

Finding: Currently, both the Assertive Community Treatment and Forensic Assertive Community Treatment programs lack capacity to meet community need. One of the recommendation in our 2017 assessment report for the El Paso Behavioral Health Consortium was for the consortium's Justice Leadership Council to "serve as a forum that supports creative approaches to identifying various means of enhancing the availability of ACT, FACT, and other intensive services in El Paso County."[346] As shown in Table 19, the provision of ACT and FACT services nearly doubled between 2014 and 2019, with 123 adults served in 2019 compared to 64 adults served in 2014. This indicates that there was progress in expanding access to ACT and FACT services, but these programs continued to reach only a small portion of the estimated 500 El Paso County adults with complex mental health needs.

Table 19: Changes in Number of El Paso County Adults Served by Emergence Health Network (2014–2019)

Clients Served – Adults	2014[347]	2018[348]	2019[349]	% Change[350]
Prevalence of SMI in Adults Living in Poverty	**—**	**15,000**	**15,000**	**No Change**
Crisis Services	1,555	1,663	2,068	+33%
Crisis Follow-Up	136	228	412	+203%
Medication Management Only	21	0	0	–100%
Medications and Therapy	56	903	1,304	+2,229%
Medications and Case Management	2,152	1,101	1,422	–34%

[345] Beach, C., Dykema, L., Appelbaum, P., Deng, L., Leckman-Westin, E., Manuel, J., McReynolds, L., & Finnerty, M. (2013). Forensic and non-forensic clients in assertive community treatment: A longitudinal study. *Psychiatric Services, 64*(5), pp.437–444.
[346] Meadows Mental Health Policy Institute. (2017, March 23). p. viii.
[347] TriWest Group. (2014, February).
[348] Texas Health and Human Services Commission. (2019, February).
[349] Texas Health and Human Services Commission. (2020, January).
[350] This reflects the rate of change in service utilization from 2014 to 2019.

Clients Served – Adults	2014[347]	2018[348]	2019[349]	% Change[350]
ACT / FACT	64	86	123	+92%
Total Served[351]	**4,048**	**4,067**	**10,425**	**+158%**
% of Total Need	**—**	**27%**	**70%**	**+159%**
% Paid by Medicaid	76%	59%	28%	–48%

EHN reports that it is considered an urban ACT with a potential capacity of up to 100 people. Although EHN is working toward that capacity, it reports that because of consistent staff turnover, ACT caseloads have been ranging between 80 and 85 individuals per month on average.

Recommendation: Expand the capacity of both Assertive Community Treatment and Forensic Assertive Community Treatment teams at Emergence Health Network. The most serious cases of serious mental illness cause a level of impairment that leads to frequent use of crisis resources such as hospitals, emergency rooms, and jails. Often, these people can benefit from intensive outpatient services such as ACT.[352,353] We estimate that in El Paso County, about 500 adults could benefit from ACT or FACT services. Specifically, we estimate that 300 adults could benefit from ACT and about 200 adults could benefit from FACT because of their involvement in the criminal justice system. In 2019, EHN served 123 people in both programs.

As discussed earlier, people with the highest amount of emergency department and inpatient hospitalization utilization need to be identified and engaged in these services to prevent hospitalization and improve their quality of life, which would also decrease stress on an over-burdened crisis system and reduce use of costly health care safety net services such as emergency medical services (EMS) and emergency departments. Table 20, below, outlines the needs of El Paso County adults, including those that could be met by an expansion of EHN's ACT and FACT programs.

[351] The total for 2018 does not sum to 4,067 because two categories were omitted. These include LOC1S, in which 5,057 were served, and FEP care, with 39 people served).
[352] Assertive Community Treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness, 24 hours a day, 7 days a week. ACT is based on the idea that people receive better care when their mental health care providers work together. ACT team members help patients with every aspect of their lives, including medications, therapy, social supports, employment, or housing.
[353] National Alliance on Mental Illness. (n.d.). *Psychosocial treatments*. https://www.nami.org/About-Mental-Illness/Treatments/Psychosocial-Treatments

Table 20: Adults in Need, by Care Setting (FY 2019)

Adults – Community Care Need, by Setting[354]	
Adults with Mental Health Conditions[355]	**140,000**
Need that Can Be Met in Integrated Care[356]	110,000
Need that Requires Specialty Setting[357]	25,000
In Poverty Needing Specialty Care[358]	15,000
Complex Needs without Forensic Need (ACT)[359]	300
Complex Needs with Forensic Need (FACT)[360]	200
Adults with Substance Use Disorders[361]	**40,000**
Need that Can Be Met in Integrated Care[362]	20,000
Need that Requires Specialty Setting[363]	20,000

As can be seen in the prevalence data above, EHN is currently able to only serve 10% (20 people) of the estimated need that could be met by a FACT team. Steps should be taken to expand the staff capacity of the FACT model component that is currently embedded within EHN's ACT team. We recommend adding additional dedicated FACT capacity to the team. Ultimately, to meet the full community need, we recommend a total increase of 180 slots over time. However, with a realistic understanding of the current state of the world and workforce, EHN should set a goal of doubling capacity by increasing FACT staff by hiring two additional case managers who are forensic specialists.

Additionally, adding these positions to the FACT team would enhance the continuity of care for people with behavioral health needs who are incarcerated. These new positions would enable the team to expand its diversion services to the jail by providing people with a psychiatry intake appointment before they are released from jail and then, upon release, transitioning them to a clinic setting to begin services. As part of our Crisis Intervention Team (CIT) evaluation, we

[354] All population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[355] Kessler, R. C., et al. (2012a); Kessler, R. C., et al. (2012b).
[356] Kessler, R. C., et al. (2005).
[357] The remaining individuals with SUD who needed more intensive treatment than what could be provided in an integrated care setting were categorized as needing specialty care.
[358] Holzer, C., Nguyen, H., & Holzer, J. (2019); American Community Survey PUMS. (2019).
[359] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006).
[360] Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008).
[361] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.
[362] Madras, B. K., et al. (2008).
[363] The remaining individuals with SUD who needed more intensive treatment than what could be provided in an integrated care setting were categorized as needing specialty care.

completed a study of people released from the El Paso County Jail who made connections to mental health treatment and subsequently returned to jail within 90 days of release. There was an average of 4,890 people released from jail each quarter, of whom an average of 1,373 (28%) were entered into the EHN system, indicating that they had received some level of service in the past. We determined the proportion of people released from jail who had ever connected with EHN services prior to jail admission to those who re-connected with EHN within 90 days of jail release. On average, 260 of 1,365 people (19%) who were released from jail had re-connected to EHN within 90 days of jail release.

Whenever possible, EHN should complete the intake process while the person remains in jail, with a warm hand-off (including transportation, if needed) to community services. EHN can use staff resources embedded in the jail, telehealth, and other services to complete intakes with people while they are in jail. Where available, EHN can coordinate with case managers from specialty courts, reentry services, or other formal programs who are developing release plans to facilitate a warm hand-off to community-based services. The goal of increasing re-connection to services upon release from jail is to ensure there is no break in services, especially medication.

This team expansion can also provide outreach and engagement more broadly (not everyone leaving the jail will need FACT services), though the dedicated FACT capacity of the team would diminish as the duties of the new positions extend beyond the targeted clientele. Overall, this forensic staff expansion within the ACT team will increase the team's capacity to engage people who are leaving the jail and be more supportive of best practices.

Finding: The Emergence Health Network Assertive Community Treatment and Forensic Assertive Community Treatment teams have not integrated the current state-of-the-art model of fidelity. Best practices in ACT services – including those in Texas – seek to systematically promote consistent outcomes across programs over time through a comprehensive process of interactive, qualitative fidelity monitoring that uses best practice measures. Such an approach is particularly critical because high fidelity implementation of programs like ACT is a predictor of good outcomes[364] and system-wide cost savings.[365] Texas has historically used the Dartmouth Assertive Community Treatment Scale, which was developed in the late 1990s, rather than the current cutting-edge Tool for Measurement of

[364] Teague, G. B., & Monroe-DeVita, M. (in press). Not by outcomes alone: Using peer evaluation to ensure fidelity to evidence-based Assertive Community Treatment (ACT) practice. In J. L. Magnabosco & R. W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods* (2nd ed.). National Association of Social Workers Press.

[365] Latimer, E. (1999). Economic impacts of assertive community treatment: A review of the literature. *Canadian Journal of Psychiatry, 44*, 443–454.

Assertive Community Treatment (TMACT).[366] Although the Texas Health and Human Services Commission endorsed the conversion from the Dartmouth Assertive Community Treatment Scale to the TMACT in March 2017,[367] the decision to move to the state-of-the-art model was left to each individual local mental health authority. At this time, EHN has decided to continue using the Dartmouth scale.

Research has indicated that ACT teams scoring higher on the TMACT yield statistically significant reductions in the use of state psychiatric hospitals, local hospital psychiatric inpatient units, and local crisis stabilization units.[368] A potential solution to reduce the need for inpatient hospitalization would be to increase the capacity of the team and quality of intensive outpatient community treatment by integrating the TMACT fidelity model to further enhance ACT services.

Risk-Needs-Responsivity Model and Criminogenic Risk Assessment

FACT teams also need to closely coordinate services with community supervision and implement risk-need-responsivity principles,[369] which entail assessing and reducing various aspects of criminogenic risk – criminal thinking, substance use, and associating with criminal companions, for example – by matching interventions to each person's specific constellation of risk factors. The primary driver of criminogenic risk is history of involvement with the criminal justice system (e.g., recidivism), but there are multiple factors involved in this risk and the FACT team and its system partners will require training in using the model and incorporating its principles into case identification and management. But this investment should be worthwhile, as research on FACT has shown that incorporating risk-need-responsivity principles into case assignment and care planning can reduce both psychiatric hospitalizations and jail use among people who previously were caught in patterns of frequently cycling through the criminal justice system and local emergency and hospital services.[370]

Recommendation: Emergence Health Network should move to the Tool for Measurement of Assertive Community Treatment for its Assertive Community Treatment team and integrate the risk-needs-responsivity model into the Forensic Assertive Community Treatment team practices. To evolve its already strong and high-fidelity services, EHN should enhance its ACT program fidelity by using the state-of-the-art TMACT. The TMACT is the current standard in the

[366] Monroe-DeVita, M., Teague, G. B., & Moser, L. L. (2011). The TMACT: A new tool for measuring fidelity to assertive community treatment. *Journal of the American Psychiatric Nurses Association, 17(*1), 17–29.
[367] Miller, J., & Strickland, R. (2017, March 15).
[368] Cuddeback, G. S., et al. (2013). Fidelity to recovery-oriented ACT practices and consumer outcomes. *Psychiatric Services, 64*(4), 318–323.
[369] Skeem, J. et al. (2014). Offenders with mental illnesses have criminogenic needs, too: Toward recidivism reduction. *Law and Human Behavior, 38*(3), 212–224.
[370] See, for example: Cusack, K.J. et al. (2010). Criminal justice involvement, behavioral health service use, and costs of forensic assertive community treatment: A randomized trial. *Community Mental Health Journal, 46*(4), 356–363.

field and represents the best-known way to promote high-quality ACT services.[371] Moving to the TMACT standards requires training in this model by an individual trained by the developers of the tool. Additionally, we highly encourage EHN to receive a baseline fidelity review prior to implementing to be followed by a one-year fidelity review to monitor progress and adherence to the model.

Just as matching ACT services to people who repeatedly cycle through restrictive and expensive services can maximize outcomes such as reduced hospital and emergency department use, matching FACT services to people who have a moderate to high criminal risk score can reduce jail use and criminal justice system involvement. FACT also requires tailoring intensive wraparound services and interventions to target criminogenic thinking and actions. The fidelity model that was created by the Meadows Institute and the University of California, Berkeley,[372] combines best practices in risk-need-responsivity principles and ACT to support a model that is practical to implement in real-world settings.

Substance Use Disorder Treatment within the El Paso Crisis System

Access to substance use disorder (SUD) treatment and recovery support is critical to an ideal behavioral health crisis system. Medically supervised detoxification, residential and outpatient treatment, and recovery support services are important components of a functioning crisis system. EHN operates the state-funded outreach, screening, assessment, and referral (OSAR) service that serves as an access point to SUD treatment. EHN also provides medication-assisted treatment for opioid use, outpatient counseling, and a partial hospitalization program. Homeward Bound Trinity provides medication-based treatment for detoxification and residential treatment beds for males through state funding and contracts with EHN for crisis residential and outpatient counseling. Aliviane is the largest provider of SUD treatment, offering a broad range of services, including residential beds for females, outpatient counseling, adolescent treatment, and medication-assisted treatment for opioid use. Aliviane has collaboration agreements with over 100 providers. As part of its OSAR program, EHN has assembled a comprehensive directory of SUD treatment and recovery support providers in El Paso County.

Recommendation: Existing planning and collaboration efforts should ensure that substance use disorder treatment and recovery supports are included in integrated behavioral health and primary care crisis services. EHN's comprehensive directory of services and existing collaborations between community agencies can serve as a starting point for integrating SUD and recovery best practices into the El Paso County crisis services continuum.

[371] The TMACT is currently the standard used in numerous states for statewide ACT implementation (e.g., Delaware, Indiana, North Carolina, Pennsylvania, and Washington).
[372] Meadows Mental Health Policy Institute. (2017). *Smart justice FACT fidelity scoring guide*.

Criminal Justice Findings and Recommendations

Our foundation for criminal justice mental health assessments is grounded in the Sequential Intercept Model (SIM).[373] The SIM is a planning tool that organizes the criminal justice system into six phases, or intercepts, beginning with an individual's first contact with the criminal justice system. The SIM intercepts include (0) community services such as crisis lines, (1) arrest, (2) booking and preliminary arraignment, (3) time spent in the courts and jail, (4) community reentry, and (5) community corrections (services in the community to prevent re-offense). The SIM framework has been used in jurisdictions across the United States and is an excellent tool for organizing diversion planning across the many systems that may have contact with an individual at each of the various intercepts. In fact, the El Paso community uses the SIM to map its specific criminal justice system. See Appendix Nine to refer to the El Paso SIM map.

El Paso community planning and collaboration efforts in criminal justice are based on the SIM. These efforts have included the following:

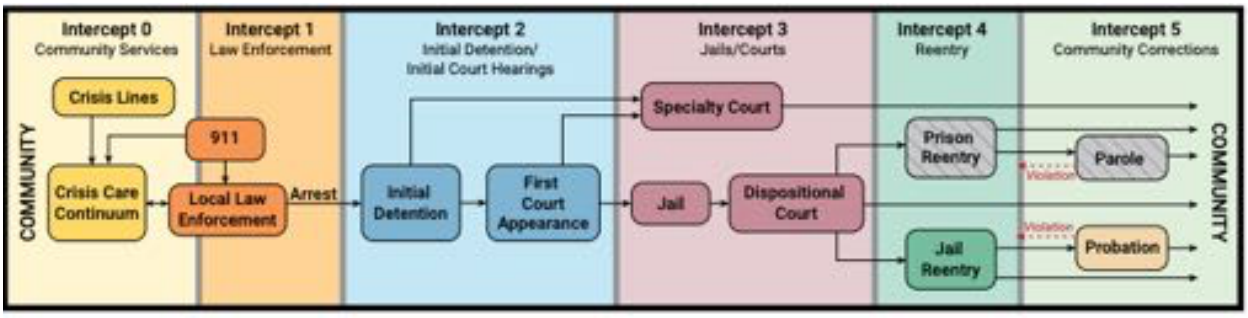
- In-depth SIM mapping efforts, which were supported by federal grants, were conducted in 2014 and 2019.
- The Justice Leadership Council completes annual updates that focus on changes since its previous review.
- The Jail Diversion Committee meets monthly and works primarily on Intercepts 0 through 3.
- A Mental Health Court Committee has worked on Intercepts 2 through 4.
- An emerging Re-entry Committee that focuses on Intercepts 3 through 5 has recently received grant funding for expanded re-entry services.

Recommendation: The Mental Health Court Committee should consider this assessment and the reports from the criminal justice system modernization efforts (described below) to determine what court-based interventions will best serve the El Paso community. If a mental health court is established, we recommend it focus on oversight of the local competency docket, including outpatient restoration. In many jurisdictions, people who are found incompetent to stand trial, but who can receive outpatient competency restoration services, are assigned to dedicated courts or dockets. There is also a promising practice in some Texas jurisdictions to provide judicial oversight for assisted outpatient treatment for people on civil commitments for behavioral health issues. Supporting these people or other individuals with

[373] The Sequential Intercept Model is described in a 2006 paper by Mark Munetz and Patricia Griffin. It has since become a basic planning tool used by communities across the United States. In recent years, the model has been updated to include an Intercept 0, Community Services, to reflect the use of crisis lines and the crisis care continuum, as shown in the model in this report. The 2006 paper can be found here: Muntez, M. R., & Griffin, P. A. (2006, April). Use of the Sequential Intercept Model as an approach to decriminalization of people with serious mental illness. *Psychiatric Services, 57*(4), 544–549. https://www.ncbi.nlm.nih.gov/pubmed/16603751

complex needs may be a better use of resources than a court that serves people post disposition.

Figure 25: Sequential Intercept Model [374]



The El Paso community's experience with the SIM was helpful as the six intercept points are integral to the overall continuum of crisis services that is core to our assessment. We reviewed adults in the El Paso County criminal justice system as a special population within the crisis continuum. The criminal justice portion of our assessment builds upon the existing technical assistance (TA) engagement between the Meadows Institute and El Paso County leadership. This TA engagement is explained below and has supported significant improvements in processing people through Intercepts 2 and 3 and the jail reentry portion of Intercept 4. This TA engagement is ongoing and additional system improvements are in the planning or implementation stages. We were able to focus the criminal justice assessment on connecting people to treatment while they are still incarcerated and upon release to the community and enhancing existing collaborations specific to jail services. We reviewed additional data provided by EHN and conducted interviews with key stakeholders, including the El Paso County Attorney, El Paso County Public Defender's Office, criminal justice administration staff, and jail reentry staff.

Concurrent Criminal Justice System Modernization Efforts

Prior to this system assessment, El Paso County officials contracted with us (the Meadows Institute) in 2019 to provide TA in reviewing efforts to modernize the county's criminal justice pretrial system and identify areas for further improvement. The TA team for the pretrial system review includes Dr. Tony Fabelo, Senior Fellow for Justice Policy, and Jessy Tyler, Senior Director for Justice Research. The TA team is working with El Paso County officials to examine (1) pretrial processing and policies, (2) mental health jail screening and assessment processes and connections to community treatment, and (3) the county's indigent defense system for people who are unable to afford a defense attorney.

[374] Policy Research Associates. (n.d.). *The Sequential Intercept Model advancing community-based solutions for justice-involved people with mental and substance use disorders*. https://www.usf.edu/cbcs/mhlp/tac/documents/mapping/sim-handout-new.pdf

The TA team has produced two reports to date. The *El Paso Pretrial System Assessment – Final Report; Review of Policies and Recidivism Trends and Recommendations to Improve Efficiencies and Outcomes* was released in May 2019.[375] That report highlighted where the El Paso County pretrial system was working well and where improvements were needed, and provided recommendations for improved outcomes, including a review of metrics for tracking system performance. *The Roadmap to Address Challenges for Public Defender Offices to Become Data-Driven Organizations; El Paso Indigent Defense Evaluation as a Case Study, Report One: Qualitative Review* was released in September 2019.[376] That report reviewed comparative metrics of El Paso County and state-wide indigent defense caseloads and costs, identified "core requirements" of the state Fair Defense Act to determine if El Paso County had the metrics in place to ensure compliance with those requirements, identified monitoring strategies and measures of quality standards for the El Paso County Public Defender's Officer, identified areas that needed to be strengthened, and provided recommendations for improvement.

Finding: The monthly jail diversion meeting provides an opportunity for enhancing already strong collaboration through the expanded use of data. Meadows Institute staff have joined three monthly jail diversion meetings. These meetings are chaired by the Public Defender's Office and include key stakeholders who work in the jail, within the justice system, or in the community. The meetings are well organized and attended, having adjusted to virtual meetings in response to the COVID-19 pandemic.

Recommendation: Include available system data to drive the jail diversion meeting agenda and discussions. Jail data dashboards are now available and can provide data on program performance, emerging service needs, population trends, and other performance metrics that can guide the work of this important and effective committee.

Finding: Connection to community services is difficult for people released from the El Paso County Jail. We learned in our stakeholder interviews that people released from jail often wait up to 90 days for community intake appointments. Our earlier findings and recommendations for expanding ACT and FACT found that 19% of the people with a history of receiving services from EHN reconnected to EHN within 90 days of jail release. EHN reported that for these people, on average, intake appointments take place 19.99 days after their initial contact with EHN and appointments with a psychiatrist take place 26.38 days after the intake appointment.[377]

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[375] Meadows Mental Health Policy Institute. (2019). *El Paso pretrial system assessment – final report; review of policies and recidivism trends and recommendations to improve efficiencies and outcomes*.
[376] Meadows Mental Health Policy Institute. (2019). *Roadmap to address challenges for public defender offices to become data-driven organizations; El Paso indigent defense evaluation as a case study, report one: Qualitative review*.
[377] Emergence Health Network (personal communication, provided via AirTable, Wait Times Tab).

Recommendation: There should be a focused effort to provide timely intake appointments – for any needed service – for people released from the El Paso County Jail. The intake process should begin as soon as people who need behavioral health care are identified, with a goal of having no break in services, especially medication. Although EHN is the community provider for many people released from jail, providers of housing-related support services are also important to community engagement and should also begin intake procedures as soon as possible. Providers can use dedicated or shared staff resources, telehealth, and other tools to ensure timely community intake appointments.

Finding: El Paso County's efforts to modernize the criminal justice system have led to improved processes and outcomes in important domains. There have been improvements in screening, assessing, and connecting people in the criminal justice system with needed behavioral health treatment. The collaboration among elected officials, government agencies, and the community has been impressive.

Recommendation: Ongoing work to modernize the El Paso County criminal justice system should continue coordination with the broader behavioral health system of care, specifically the crisis continuum of services. As work continues in the criminal justice system, efforts should be coordinated with existing community planning. There should be a specific effort to identify potential future funding opportunities for improving collaboration between the justice system and behavioral health system.

El Paso County Veterans Findings and Recommendations

Veterans Mental Health

Table 21 on the next page shows that the estimated population of veterans in El Paso County in 2019 was approximately 60,000. Approximately 3,000 veterans in the county lived with serious mental illness (SMI), while approximately 8,000 used illicit drugs. An estimated 2,000 veterans in the county misused psychotherapeutics such as antidepressants and antipsychotics, and an additional 2,000 El Paso County veterans engaged in nonmedical use of pain relievers.

The number of veterans in the region with a serious mental illness accounted for 10% of the 25,000 adults living El Paso County with SMI, as listed in Table 21. Additionally, the rate of veterans with any mental health need was three times greater among female veterans than male veterans (30% versus 14%, respectively). Of the 95 suicide deaths in El Paso County in 2019, around 20 were attributed to veterans. This means that veterans with SMI comprised only about 10% of the adult population in El Paso County in 2019, yet accounted for nearly one-quarter of adult suicides. El Paso County officials will need to consider these critical needs of veterans when planning for community-level care.

Table 21: Prevalence of Mental Health and Substance Use Disorders Among Veterans in El Paso County (2019)[378]

Veteran Behavioral Health Conditions	Male	Female	Total[379]
Total Veteran Population	50,000	8,000	60,000
Behavioral Health Condition	**Total Prevalence**		
Any Mental Illness	7,000	2,000	10,000
Serious Mental Illness	2,000	800	3,000
Major Depression	2,000	900	3,000
Alcohol Use Disorder	2,000	400	3,000
Illicit Drug Use	7,000	1,000	8,000
Nonmedical Use of Psychotherapeutics	2,000	400	2,000
Nonmedical Use of Pain Relievers	1,000	400	2,000
Estimated Veteran Suicide Deaths[380]	20	< 6	< 26

Veterans Access to Care

According to the U.S. Department of Veterans Affairs (VA), almost 60,000 veterans reside in El Paso County,[381] including more than 23,000 veteran households with children.[382] In the 2014 community assessment, TriWest identified a need to build mental health awareness, education, and prevention supports for the military and veteran population in El Paso County. Since then, community organizations have embraced this recommendation and expanded their roles to help serve El Paso's veterans and their families. Emergence Health Network (EHN) opened the Veteran One-Stop Center in 2016, The Steven A. Cohen Military Family Clinic at Endeavors opened in 2017, and the VA opened its newest clinic on the west side of El Paso in August 2020. Additionally, a Combined Arms Needs Assessment completed in March 2020 provided topical survey questions to a small cohort of veterans (1,125 total), family members (241 total), and a

[378] Data were abstracted from the Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). National Survey on Drug Use and Health: 2-Year RDAS (2018 to 2019). rdas.samhsa.gov/#/survey/NSDUH-2017-2018-RD02YR/crosstab/?weight=DASWT_1&run_chisq=false&results_received=true

[379] Veteran prevalence and population estimates were rounded to reflect uncertainty in the Department of Veterans Affairs estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts.

[380] U.S. Department of Veteran Affairs. (2019). *State data appendix*. www.mentalhealth.va.gov/suicide_prevention/data.asp

[381] U.S. Department of Veteran Affairs. (n.d.). *National Center for Veterans Analysis and Statistics*. https://www.va.gov/vetdata/docs/Demographics/New_Vetpop_Model/9L_VetPop2018_County.xlsx

[382] U.S. Department of Veteran Affairs. (n.d.) *Veteran households with children FY15*. https://www.va.gov/vetdata/report.asp

collection of community members, health care providers and others (157 total). The Combined Arms survey covered an array of different topics and included a mental health component that provided insights into the overall needs and barriers for veterans accessing care.

U.S. Department of Veterans Affairs Health Care System in El Paso

The El Paso VA Health Care System is composed of a medical center and community outpatient clinics that are responsible for providing primary care, behavioral health care, and some specialized ambulatory services to veterans in El Paso and surrounding counties. The El Paso VA Medical Center provides primary and behavioral health care, including onsite VA Healthcare System substance use disorder treatment programs and a post-traumatic stress disorder (PTSD) program. The El Paso VA Medical Center is adjacent to the William Beaumont Army Medical Center and is a joint venture site between the Department of Defense (DoD) and the VA. Traditionally, the VA and DoD medical facilities have strict parameters regarding patient eligibility for care – the DoD treats active-duty service members and the VA treats veterans. However, the El Paso VA Health Care System has a unique agreement in place between the DoD and VA that allows William Beaumont Army Medical Center to provide inpatient care for acute medical and surgical emergencies for El Paso's veteran population.

Table 22 displays the number of mental health diagnoses among El Paso veterans in fiscal year (FY) 2015 as well as mental health care utilization among veterans who use Veterans Health Administration services.[383] Out of nearly 30,000 service veterans who used these services, approximately 31% used mental health services, averaging eight visits per veteran. One fourth of all veterans who used Veterans Health Administration services had a confirmed mental illness, and one third had a possible mental illness.

Table 22: El Paso Veteran Affairs Health Care System Mental Health Care Prevalence and Service Utilization (FY 2015)[384]

Mental Illness Among Veterans	El Paso VA Health Care System
Total Number of Veterans Who Used VHA Services	**29,137**
El Paso Area Veterans Who Received VHA Mental Health Services	9,039
Average Number of Mental Health Encounters per Veteran	8
Veterans with Diagnosed Mental Health Condition	**7,412**
Veterans Who Utilized Any VHA Mental Health Services	92%

[383] Northeast Program Evaluation Center (NEPEC). (2016, April). *FY15 annual data sheet on mental health*. https://mihiriyer.shinyapps.io/MentalHealth/
[384] Northeast Program Evaluation Center. (NEPEC). (2016, April).

The El Paso VA Health Care System opened its first stand-alone mental health clinic in January 2020 and has many other community-based outpatient clinics located throughout El Paso County, which has increased access and availability of primary care and mental health services. The El Paso Eastside Community-Based Outpatient Clinic, El Paso Westside Community-Based Outpatient Clinic, and El Paso Northeast Community-Based Outpatient Clinic each offer Primary Care-Mental Health Integration (PC-MHI) services. PC-MHI incorporates mental health staff into primary care teams to screen and provide treatments for depression, anxiety, post-traumatic stress, and substance use without requiring separate mental health consults. The number of PC-MHI teams varies by the size of the clinic and is often limited by available physical space, or the ability to hire and retain licensed staff. As part of the VA's expansion of mental health services at its clinic locations, the newly opened Westside Community-Based Outpatient Clinic will also provide SUD programs.

More than 29,000 veterans in El Paso are enrolled in VA services and of those, more than 9,000 are receiving mental health care at VA facilities.[385] As a prerequisite to receiving services from the VA, veterans must meet eligibility standards and have at least a zero percent (0%) service-connected disability.[386] Although it is critical that veterans gain access to federal health care, the economic impact of service-connected disability payments is also substantial. In El Paso County, there are more than 20,000 veterans with a VA disability rating that collectively received more than $504,695,000 in payments for compensation and pensions in fiscal year 2019.[387] In addition, the VA spent more than $277,833,000 in medical and behavioral health care for veterans in El Paso in fiscal year 2019 alone.

Emergence Health Network Veterans One Stop

Approximately 50% of El Paso County veterans either cannot or choose not to participate in VA services.[388] As one of two community organizations that provide culturally competent veteran mental health programming outside of the VA, the EHN Veterans One-Stop Center plays a critical role in the mental health care of El Paso's veteran population by providing low-barrier access to mental health care and support services. Despite the COVID-19 pandemic's disruption of traditional in-person services, EHN reported that its Veterans One-Stop Center provided

[385] Veterans' Health Administration prevalence and utilization data were obtained from the Northeast Program Evaluation Center (NEPEC). (2016, April). *FY15 annual data sheet on mental health*. hmihiriyer.shinyapps.io/MentalHealth/

[386] A zero percent (0%) service-connected disability rating may be compensable or non-compensable and allows the veteran to access no-cost healthcare and prescription drugs at a VA medical facility for service-connected disabilities, travel allowances for scheduled appointments at VA medical facilities, or VA authorized health care facilities, and the use of commissaries, exchanges, and retail facilities.

[387] U.S. Department of Veterans Affairs. (n.d.) *Summary of expenditures by state for fiscal year 2019*. https://www.va.gov/VETDATA/Expenditures.asp

[388] Veterans' Health Administration prevalence and utilization data were obtained from the Northeast Program Evaluation Center (NEPEC). (2016, April). *FY15 annual data sheet on mental health*. hmihiriyer.shinyapps.io/MentalHealth/

mental health services to more than 154 veterans and referred 150 more to other organizations for specialized mental health services from mid-December 2019 to August 2020.[389]

EHN also houses a veteran-focused program called the Military Veteran Peer Network. The Military Veteran Peer Network coordinator position, which focuses on peer-to-peer support, is funded by the state of Texas through the local mental health authority and supported by the Texas Veterans Commission's Veterans Mental Health Program through training, technical assistance, and connections to a statewide network of peer support for military trauma-affected veterans. The Military Veteran Peer Network coordinator and a cohort of trained volunteer peers serve as a conduit to mental health providers, including outreach to EHN, to engage and identify veterans who need mental health services but have not yet connected with a provider.

The Steven A. Cohen Military Family Clinic at Endeavors

The Steven A. Cohen Military Family Clinic at Endeavors El Paso (Cohen Clinic) opened in 2017 as part of the Cohen Veterans Network's goal to build a network of outpatient mental health clinics for veterans and their families in high-need communities. The Cohen Clinic focuses on improving mental health outcomes for post-9/11 veterans and their families through integrated and evidence-based mental health services. Considering that more than 30,000 active-duty service members are stationed at Fort Bliss,[390] these services provide much needed mental health service capacity. Table 23 below illustrates the demand for service type and the number of unduplicated service members, veterans, and family members that have participated in the Cohen Clinic's mental health services in the past year.

Table 23: Active-Duty Service Members, Veterans, and Family Members Served at The Steven A. Cohen Military Family Clinic at Endeavors (October 2019 – September 2020)[391]

The Steven A. Cohen Military Family Clinic at Endeavors	Total
Number of military-affiliated clients participating in mental health services (unduplicated)	**480**
Adults (18 years of age and older)	400
Children and youth (ages 3 to 17)	80
Top five mental health services provided by type (duplicated clients)	

[389] Information was provided during an interview with Emergence Health Network Veterans One-Stop Center (personal communication, July 17, 2020).
[390] Texas Comptroller of Public Accounts. (n.d.). *Fort Bliss economic impact on the Texas economy, 2019*. https://comptroller.texas.gov/economy/economic-data/military/fort-bliss.php
[391] The Steven A. Cohen Clinic at Endeavors (personal communication, October 23, 2020).

The Steven A. Cohen Military Family Clinic at Endeavors	Total
Individual therapy	465
Biopsychosocial	380
Telehealth – individual therapy	235
Telehealth – family assessment	143
Therapy – couples	134

Veteran Access to Military-Informed Inpatient Treatment Programs

There are several specialty facilities in El Paso County and the surrounding area that recognize the importance of military service and offer custom programming. Rio Vista Behavioral Health has an inpatient military treatment program named S.T.A.R. (Support, Treatment, Action, Recovery), Peak Behavioral Health provides military recovery programming for inpatient care and partial hospitalization, and Mesilla Valley Hospital is a TRICARE-certified facility that provides military-specific treatments and case management for crisis stabilization and dual-diagnosis treatments for mental health and substance use disorders. These organizations have been consistently named as key partners for veteran mental health providers who help veteran clients access inpatient treatment.

Veterans Mental Health Transition to Telehealth in Response to COVID-19

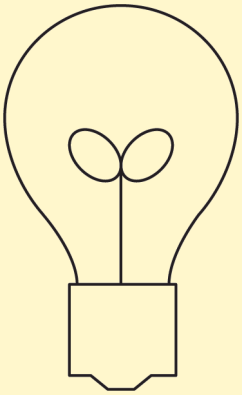
During this assessment, stakeholders shared similar difficulties in transitioning from face-to-face mental health services to telehealth in response to the COVID-19 pandemic. Stigma, as previously discussed in this report, was uniformly mentioned as a barrier to treatment and was further compounded by the lack of privacy many veterans and family members faced while they were quarantined at home. Additionally, many providers had to re-educate their clients regarding the safety of telehealth and make assurances that this technology offered protections in its use for therapy sessions. At the onset of COVID-19, these barriers severely disrupted client access to services, but as the pandemic has continued, veterans and their family members have increasingly accepted telehealth as a viable alternative. The Steven A. Cohen Military Family Clinic at Endeavors experienced one of the more remarkable transitions to telehealth. Prior to the pandemic, the Cohen Clinic provided telehealth to approximately 3% of its clients and ramped up to 100% telehealth services shortly after the start of the quarantine at home. The transition to 100% telehealth utilization resulted in a client attrition rate of 15% in the months following the stay-at-home order but has since been slowly recovering.[392]

Finding: The El Paso community's progress over the past six years in expanding mental health services for veterans and their families has been significant. However, veterans with complex

[392] The Steven A. Cohen Military Family Clinic at Endeavors (personal communication, September 22, 2020).

mental health needs, and their family members, are left to navigate the mental health services of multiple organizations on their own in order to find appropriate care. Moreover, veterans and their family members who can access care need to rely on the expertise of mental health providers to make appropriate referrals for follow-up or specialty care. In addition, referrals to mental health providers who are at capacity and cannot accept new patients, or do not have the services for which the veteran was referred, present additional obstacles to care. We also discovered during stakeholder interviews that mental health providers do not always have familiarity with the capacity of and treatments provided by other mental health organizations and may make an incorrect (though well-intentioned) referral. Another concern is that referrals between organizations are not being effectively tracked and, as a result, inappropriate referrals may be acting as a deterrent to care and contributing to patient attrition.

Recommendation: El Paso County's veterans mental health programs need to improve coordination of care between federal organizations (VA), community service providers (Steven A. Cohen Military Family Clinic at Endeavors, Emergence Health Network), and specialty/inpatient organizations that provide culturally competent services for service members and veterans (Rio Vista, Peak, and Mesilla Valley). Improving coordination can begin with a collaborative project to track, measure, and hold accountable each organization for their mental health services (capacity and available services) and referrals made to external providers.



Community Collaboration and Data Sharing

Community Collaboration and Data Sharing

This section outlines findings and recommendations related to community collaboration and data sharing, with a specific focus on the El Paso Behavioral Health Consortium and the Paso del Norte Health Information Exchange.

Opportunities for the El Paso Behavioral Health Consortium

Maintaining collaborative momentum over the course of years can be challenging. In addition to changes in the local community context and its needs, the policy and financial landscape in Texas has changed dramatically since TriWest Group's 2014 assessment of El Paso County's behavioral health system. The inception of the El Paso Behavioral Health Consortium (Consortium) aligned with several significant legislative and policy developments in Texas, including Senate Bill (SB) 292, which created a funding program enabling counties to develop programs focused on justice-involved individuals; House Bill (HB) 13, which created a matching program enabling counties to devise programs to improve their mental health care systems; and a host of other initiatives. The Texas Legislature has also increased funding significantly, invested in the redesign of the state psychiatric hospital system, and created the Texas Child Mental Health Care Consortium. In addition, the Texas Supreme Court and the Court of Criminal Appeals have created (and the Legislature has funded) a Judicial Commission on Mental Health, which is examining ways to improve judicial response to people with mental illnesses who become involved in the criminal justice system.

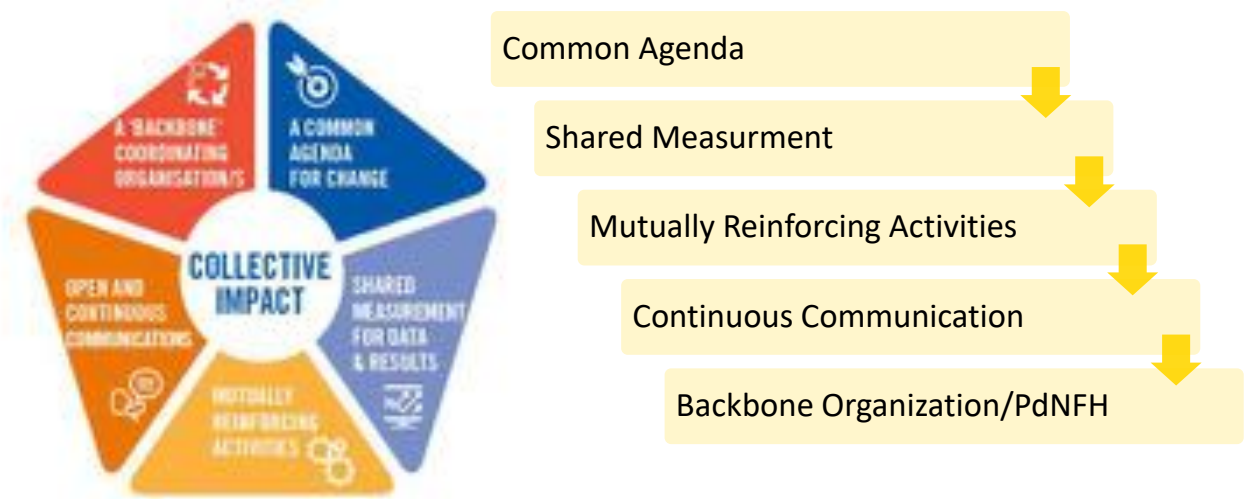
Although the policy landscape has changed significantly, and in nearly all cases for the better, there are financial threats to local initiatives. The Texas 1115 Medicaid waiver program, for example, has supported multiple local initiatives to improve care. However, this waiver's current Delivery System Reform Incentive Payments program is ending, and the financial implications of a replacement program are not yet clear. Also, the anticipated financial losses for state and local government budgets because of the COVID-19 pandemic will also create leaner financial times for the Consortium. As such, the following recommendations focus on continued collaboration in the years ahead.

As previously mentioned, the Consortium was convened in 2012 and used TriWest Group's 2014 assessment findings and recommendations to inform much of its work. After eight years and having the opportunity to use findings and recommendations from this current assessment, it is a good time for members to revisit where they envision the Consortium should be in the next eight years and examine their plans for achieving continued successes in the years ahead. In this section, we provide recommendations for minor changes to the executive committee and leadership council functions to better equip community leaders and stakeholders to create positive changes for the behavioral health system in El Paso County, and to increase

administrative support for the Consortium to help ensure momentum and progress toward its goals.

The Future of the El Paso Behavioral Health Consortium: 2021 – 2025
Finding: Over the course of the past eight years, more structure has been put in place to support the Consortium; however, as previously mentioned, the community context and the needs of its members have changed since then. Collaboration can take many forms and it is ultimately the Consortium's members' decision to determine how to structure their partnership to best achieve their goals. On March 2, 2021, members of the System Assessment Implementation Group discussed the future of the Consortium and identified a few key areas to refine the current structure, with a plan to bring their suggested changes to the three councils for input.

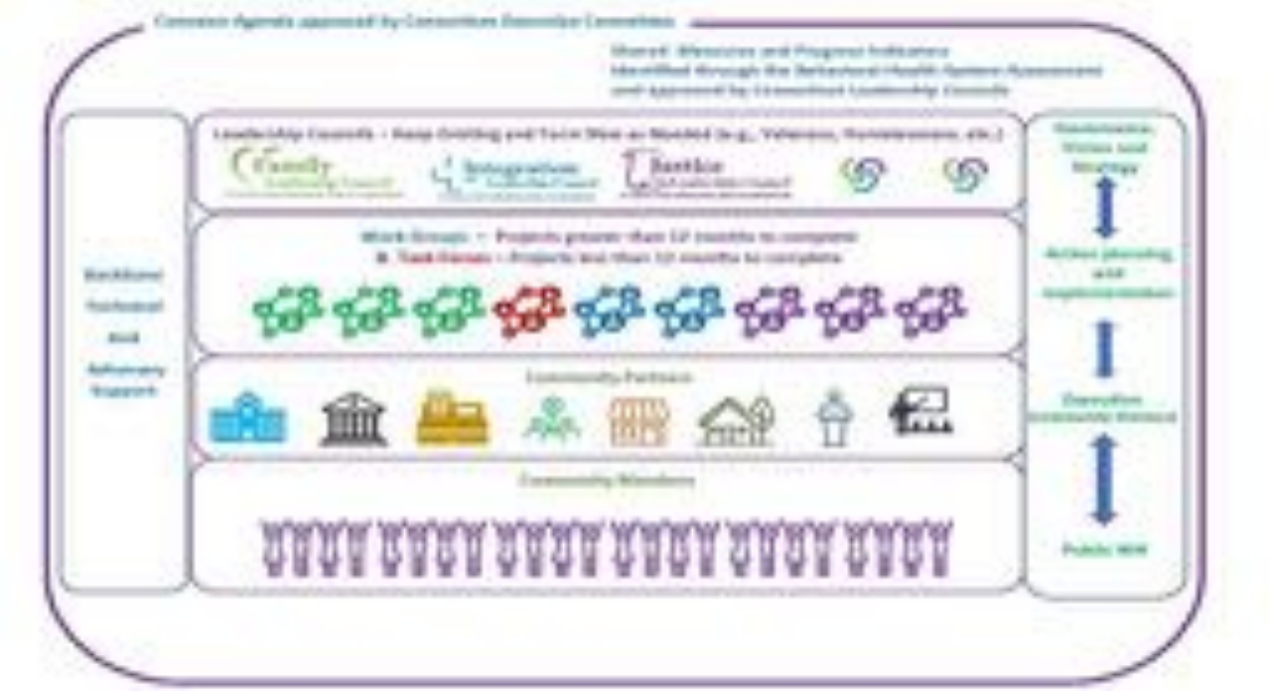
Figure 26: The El Paso Behavioral Health Consortium Structure; A Collective Impact-Informed Approach[393]



The Consortium was founded on and functions through a collective impact approach, which is defined by the National Council of Nonprofits as, "an intentional way of working together and sharing information for the purpose of solving a complex problem."[394] This model has proven its effectiveness for the Consortium and the same model is being proposed going forward.

[393] Presented at the System Assessment Implementation Group meeting, March 2, 2021.
[394] National Council of Nonprofits. (2015, June 15). *Collective Impact*. https://www.councilofnonprofits.org/tools-resources/collective-impact

Figure 27: 2021 – 2025 Structure Proposal[395]



As is currently proposed, the structure will largely remain the same, with leadership councils functioning as a collection of engaged local stakeholders who convene to implement policy and program changes, and PdNHF serving as the backbone organization and convenor of the overall Consortium. However, there are several proposed changes that were identified by System Assessment Implementation Group members, which are presented below.

Recommendation: Minor changes are recommended for the executive committee and leadership council functions to better equip community leaders and stakeholders to create positive changes for the behavioral health system in El Paso County.

Executive Committee Changes (2021 – 2025)
Historically, the executive committee was a group of local funders committed to improving mental and behavioral health in El Paso County. Its function was to bring local decision makers to the table, when needed. This functionality is still required and should remain; however, over time, the perception of the executive committee was that it served a governance role, which has not been useful to the overall functioning of the Consortium or the councils. As such, we propose a few changes to the functioning of the executive committee, including that it no longer serves a governance role for the councils; rather, it should convene as an information sharing body instead of an authority granting body. Councils should oversee their own

[395] Presented at the System Assessment Implementation Group meeting, March 2, 2021.

functioning and define their goals, structure, and membership roles. As currently proposed, the executive committee should:

- Be known as the El Paso Behavioral Health Consortium,
- Provide guidance and support on priority goals and strategies,
- Recognize leadership council progress and governance (e.g., changes in chairs of leadership councils),
- Organize and support advocacy efforts (e.g., confirm a common agenda or a state legislative agenda), and
- Meet twice per year.

Leadership Council Changes (2021 – 2025)

As previously mentioned, leadership councils function as a collection of engaged local stakeholders who convene to implement policy and program changes. Over time, each council has charted its own path and experienced various levels of progress and success. As such, the proposed changes support the autonomy of the councils and reaffirm their ability to oversee their functioning and define their goals, structure, and membership roles. As currently proposed, each council will:

- Provide executive leadership and governance for its work groups and task forces;
- Approve common agendas related to its priority areas;
- Approve strategies, shared measures, and progress indicators and communicate these to its work groups and task forces;
- Develop or assign organization staffing support for its work groups and task forces (e.g., Strong Families, Help Me Grow, CPAN, Workforce); and
- Identify areas in need of policy or practice improvement or advocacy efforts (e.g., organizational policy changes or state level policy change needs).

One area of ongoing improvement would be to ensure appropriate membership for each council. A few gaps were identified, including:

- The Family Leadership Council could benefit from more private organization membership,
- The Integration Leadership Council could benefit from more private physician membership, and
- The Justice Leadership Council could benefit from membership beyond the largely governmental entity organizations currently represented.

Additional Changes (2021 – 2025)

Beyond the functional changes of the executive committee and minor tweaks to the leadership councils, a few additional changes were proposed, including the following.

Recommendation: We recommend that the roles of work groups and tasks forces be defined with more clarity. Work groups would be developed for longer-term projects (longer than 12 months) and task forces for short-term (less than 12 months) projects.

Roles of work groups and task forces should include the following:

- Implementing programs and projects that are consistent with identified behavioral health priorities;
- Engaging with existing community groups or organizations to create positive synergy in addressing a behavioral health area of concern (e.g., El Paso Area Directors of Guidance, Region 19, and School Mental Health Work Group); and
- Communicating and coordinating with funders and technical and advocacy support advisors (e.g., provide documentation for grant report requirements, identify technical support needs, set task timelines).

Meetings would be scheduled based on work group needs. Members would be designated to present progress updates and support requests from the Consortium and the leadership councils.

Recommendation: Ensure that new members who join the Consortium and leadership councils are aware of the Consortium's history, intent, and structure to help them successfully and effectively contribute to the Consortium's success. As the backbone organization, the Paso del Norte Health Foundation (PdNHF) can develop orientation materials and manage the ongoing need to update them as necessary. PdNHF can also offer public relations materials for the Consortium. These functions may best be fulfilled by additional administrative support personnel, which we recommend the Consortium consider.

Recommendation: To provide transparency to the El Paso community and ensure accountability, the Consortium and its members should revisit plans to host a public-facing data dashboard. We recommend that the Consortium revisit the 2017 El Paso Behavioral Health Consortium Assessment conducted by TriWest Group, which provided a review of mental health data dashboards across the country.

Administrative Support

Recommendation: Dedicated administrative support is required to organize the Consortium and its committees, gather data and resources, and track progress toward goals. It can be difficult for community-based groups to make progress without administrative support, given that members all have full-time responsibilities at their organizations. The Consortium has a large and diverse membership with ambitious goals and objectives. With an entirely voluntary membership, a dedicated staff member – or members – would provide needed facilitation support and ongoing data maintenance for the Consortium. Administrative support should be a

steward of the collaborative process[396] and bring stakeholders together, encourage member engagement,[397,398,399,400,401] ensure integrity of the processes,[402] make sure all participants are meaningfully heard and engaged, and be able to synthesize the knowledge of diverse members to create new ideas and understanding.[403]

Any arrangement for administrative support should also facilitate data collection and maintenance, help identify data gaps, and support strategies for data solutions for the Consortium. Currently, a Consortium data dashboard exists, though it is not maintained. This hinders the Consortium's ability to communicate its successes accurately and effectively with the community. In addition, access to the right data helps determine what the community's needs are. As such, administrative support should be able to align the Consortium's goals and objectives with meaningful data that would help members understand the community's needs as well as track progress toward meeting those needs. This work would likely involve data agreements and conversations with the local health information exchange, the Paso del Norte Health Information Exchange.

Community Data Sharing

We used statewide and local data to inform our analyses and recommendations. El Paso County providers' willingness to share data was impressive; more than most communities, El Paso providers and policymakers have a well-developed interest in expanding data sharing[404,405] and data integration.[406,407] This local interest in data sharing and integration coincides with a

[396] Chrislip, D., & Larson, C. E. (1994). *Collaborative leadership: How citizens and civic leaders can make a difference*. Wiley. https://www.wiley.com/en-us/Collaborative+Leadership%3A+How+Citizens+and+Civic+Leaders+Can+Make+a+Difference-p-9780787900038
[397] Chrislip, D., & Larson, C. E. (1994).
[398] Ozawa, P. (1993, March). Improving citizen participation in environmental decision-making: The use of transformative mediator techniques. *Environment and Planning C, 11*, 103–117.
[399] Pine, B. A., Warsh, R., & Maluccio, A. N. (1998). Participatory management in a public child welfare agency. *Administration in Social Work, 22*(1), 19–32. https://doi.org/10.1300/J147v22n01_02
[400] Reilly, T. (2001). Collaboration in action: An uncertain process. *Administration in Social Work, 25*(1), 53–74. https://doi.org/10.1300/J147v25n01_06
[401] Susskind, L., & Cruikshank, J. (1987). Breaking the impasse: Consensual approaches to resolving public disputes.
[402] Ansell, C., & Gash, A. (2007).
[403] Lasker, R. D., & Weiss, E. S. (2003). Broadening participation in community problem solving: A multidisciplinary model to support collaborative practice and research. *Journal of Urban Health, 80*(1), 14–47. https://doi.org/10.1093/jurban/jtg014
[404] Data sharing permits data sharing partners to integrate information for various purposes including continuity of care, program evaluation, and policy making. Given that many persons with mental illnesses and complex health needs find themselves in multiple treatment and social service systems, data sharing is essential to understanding service utilization, cost, and access issues.
[405] About Data Sharing. (n.d.). Actionable Intelligence for Social Policy. Retrieved January 21, 2021, from https://www.aisp.upenn.edu/about-data-sharing/
[406] Data integration is a more complex type of data sharing that involves record linkage, which refers to the joining or merging of data based on common data fields.
[407] About Data Sharing. (n.d.). Actionable Intelligence for Social Policy.

national movement to better understand and improve policy and program outcomes through data collaboration. Over the years, the field of community data sharing and integration has received considerable attention because of increased recognition that "good policy is evidence-based."[408] Although data sharing can be challenging, it can be undertaken as an iterative process that could become more complex over time, depending on the needs of the community.

In El Paso County, the Paso del Norte Health Information Exchange (PHIX) is a particularly important resource. PHIX receives and analyzes data from all major El Paso County hospital systems. However, most behavioral health providers we interviewed had little or no knowledge of PHIX, which means that the most developed venue for data sharing in El Paso County lacks basic data on behavioral health care service use. In addition, stakeholders are interested in expanding data sharing to include metrics related to the social determinants of health such as housing, transportation, and food access. Whether greater data sharing and integration is expanded through PHIX or another platform, there is an opportunity to utilize and eventually expand the existing resources, knowledge, and enthusiasm for data sharing in the El Paso community.

Although El Paso County has made more progress on this issue than many communities, community members still perceive that there are obstacles to expanding data sharing. For example, many stakeholders' first concern is, *"what does the law allow me to share?"* This concern is particularly acute for providers of substance use disorder (SUD) services, who encounter an additional layer of legal constraints through 42 CFR Part 2.[409,410,411] At the same time, federal standards on data sharing have been relaxed to eliminate obstacles to care during the COVID-19 pandemic, and legal barriers to data sharing are not as significant as many providers believe. Working through the actual legal framework will be an essential part of expanding data sharing going forward.

Finding: During our assessment, various El Paso County organizations made local behavioral health data available to our team members to inform our report. However, these data were often siloed within individual organizations and not readily available to other organizations or the public. Data that are available to the public (for example, on the Consortium

[408] Gibbs, L., Nelson, A. H., Dalton, E., Cantor, J., Shipp, S., & Jenkins, D. (2017). IDS Governance: Setting Up for Ethical and Effective Ese. Actionable Intelligence for Social Policy. https://www.aisp.upenn.edu/wp-content/uploads/2016/07/Governance.pdf
[409] CFR 42, Part 2 regulations serves to protect patient records created by federally assisted programs for the treatment of substance use disorders.
[410] U.S. Department of Health & Human Services. (2020, July 13). *Fact sheet: SAMHSA 42 CFR Part 2 Revised Rule*. https://www.hhs.gov/about/news/2020/07/13/fact-sheet-samhsa-42-cfr-part-2-revised-rule.html
[411] U.S. Department of Health & Human Services. (2017, January 18). *Confidentiality of substance use disorder patient records*. https://www.govinfo.gov/content/pkg/FR-2017-01-18/pdf/2017-00719.pdf

dashboard) are not actively maintained. The El Paso community has an opportunity to leverage its existing data collaborations, infrastructure, and local expertise to expand its use of data in decision making. The community should make it a priority to explore whether PHIX is the appropriate venue for expanded data sharing.

Over the years, expanded data sharing and integration has become a tool to better inform decision making in an increasingly constrained public resource environment. This is even more true today because of the COVID-19 pandemic, in which public health and health care resources have become even more limited while needs have increased exponentially.

The driving question for any data sharing collaborative is, "*why do you want to share information?*'' There are many reasons to share data, some of which are listed below. The collaborative's driving reason to share data will inform the structure of other elements of the initiative including governance, legal framework, privacy and security, cost, and more. It is critical that stakeholders ask themselves why they want to share information and come to a consensus before sharing it. A few reasons to share data include:

- To identify a geographic area of greatest impact,
- To evaluate program outcomes,
- To improve services at the point of intervention,
- To assure treatment compliance, and
- To conduct research.

After determining why to share information, the collaborative will be better positioned to navigate the legal and regulatory constraints to develop a legal framework for sharing data. This next phase will involve questions such as the following:

- What type of information do you want to share (for example, protected health information or aggregated, de-identified information)?
- Who do you want to share it with?
- Who decides if you will share it (this is the issue of governance)?

These are a few preliminary steps and questions that stakeholders should consider when beginning a data sharing or integration endeavor. For greater detail and step-by-step toolkits for developing a data sharing and integration collaborative, we recommend resources from the Actionable Intelligence for Social Policy (AISP) organization at the University of Pennsylvania. AISP is a leader in helping state and local governments collaborate and responsibly share data to improve lives.[412]

[412] Actionable Intelligence for Social Policy. (n.d.). About us. https://www.aisp.upenn.edu/about-us/

- For an introduction to data sharing and integration, see: Introduction to Data Sharing & Integration (2020).[413]
- On issues related to governance, see: IDS[414] Governance: Setting Up for Ethical and Effective Use (2017).[415]
- For case studies from other communities, see: AISP Resource Library.[416]

The Legal Environment

The collaborative's purpose and goals for sharing data will inform the legal framework by which it pursues data sharing. However, it should first consider discrete federal and Texas state statutes and regulations. Pertinent laws that largely concern patient consent to disclose information for the purposes of behavioral health data sharing include the Health Information Portability and Accountability Act (HIPAA), Federal Regulations Governing the Confidentiality of Alcohol and Substance Abuse Treatment Records (42 CFR Part 2), Federal Education Rights and Privacy Act (FERPA), the Homeless Management Information System (HMIS), and the Privacy Act (1974).

We briefly cover a few important and high-level points about HIPAA and 42 CFR Part 2 as well as a few recent federal regulatory changes because of the COVID-19 pandemic. We encourage El Paso County stakeholders to review federal law and Texas state restrictions in more detail, depending on the goals of the data sharing collaborative.

- On issues of legality, see: Legal Issus for IDS Use: Finding a Way Forward (2017).[417]

HIPAA

The following information is from the *Legal Issues for IDS Use: Finding a Way Forward* (2017).

- *HIPAA establishes a minimum standard for protecting protected health information. If a state law provides more protection, then the state law applies. This will often be the case when mental health records are involved.*
- *HIPAA only applies to "covered entities," defined as a "health plan" (e.g., insurance companies, Medicaid agencies, Medicare); "health providers," such as hospitals and licensed health professionals; and "health care clearinghouses," which are entities that standardize*

[413] Hawn, N. A., Jenkins, D., Zanti, S., Katz, M., Burnett, T., Culhane, D., & Barghaus, K. (2020). *Introduction to data sharing & integration*. Actionable Intelligence for Social Policy, University of Pennsylvania. https://www.aisp.upenn.edu/wp-content/uploads/2020/06/AISP-Intro-.pdf

[414] IDS refers to integrated data systems.

[415] Gibbs, L., Nelson, A. H., Dalton, E., Cantor, J., Shipp, S., & Jenkins, D. (2017).

[416] Actionable Intelligence for Social Policy. (n.d.). *AISP: Resource library*. https://www.aisp.upenn.edu/resource-library/

[417] Petrila, J., Cohn, B., Pritchett, W., Stiles, P., Stodden, V., Vagle, J., & Humowiecki, M. (n.d.). *Legal issues for IDS use: Finding a way forward*. Actionable Intelligence for Social Policy, University of Pennsylvania. https://www.aisp.upenn.edu/resource-article/legal-issues-for-ids-use-finding-a-way-forward/

health information for functions such as billing. HIPAA does not apply to courts and other entities that may produce or hold health-related information.

- *A question always worth considering is whether it is essential to use information that identifies individuals for the functions of the integrated data system (IDS), or whether de-identified information will suffice (or be the only type of information that is politically possible to use in an IDS). HIPAA provides specific information on the "de-identification" of protected health information. In addition, HIPAA provides for creation of a "limited data set" (similar but not identical to a "de-identified data set") as an alternative to the use of protected health information.*

42 CFR Part 2

This following information is from the *Legal Issues for IDS Use: Finding a Way Forward* (2017).

- *Despite the stringent nature of the regulations, they do provide for the use of covered information for research without the individual's consent if the director of the federally assisted program finds certain conditions are met.*
- *As with FERPA, there is crossover with HIPAA in some circumstances (42 CFR).*[418]
- *Many state laws on SUDs track (or in some cases may exceed) protections in 42 CFR. In thinking about an IDS, it will be important to look at state law as well as the federal regulations.*

Recent Federal Changes

In response to the changing landscape of providing care during the COVID-19 pandemic, there have been changes at the federal level related to 42 CFR Part 2.

42 CFR Part 2: CARES Act (2020)

''Once a patient gives prior written consent, the contents of a record may be used or disclosed by a covered entity, business associate, or a [Part 2 program] for purposes of treatment, payment, and health care operations as permitted by the HIPAA regulations."[419] This change more closely aligns 42 CFR Part 2 with HIPAA.

Recommendation: The El Paso Behavioral Health Consortium should create a data sharing and integration committee or work group connected to an existing Consortium leadership council and comprise of interested and engaged stakeholders who are dedicated to exploring how expanded data sharing and integration can achieve local behavioral health goals. A data sharing and integration endeavor can be complicated. However, the potential benefits of using data for decision making will become increasingly necessary as communities work with tighter

[418] Kamoie, B., & Borzi, P. (2001). Behavioral health issue brief series: A crosswalk between the final HIPAA privacy rule and existing federal substance abuse confidentiality requirements. The George Washington University School of Public Health and Services.

[419] CARES Act, no. H.R. 748, H.R. 748 – 96 (2020). https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf

budgets, increasingly restricted public resources, and increased demand for services as a result of the COVID-19 pandemic. We recommend reviewing the documents we referenced previously to begin exploring steps to expand data sharing and integration in the El Paso community. This data should ultimately be made available publicly on an accessible community dashboard.

Paso del Norte Health Information Exchange

The Paso del Norte Health Information Exchange (PHIX) was founded in 2011 and is funded jointly by the Paso del Norte Health Foundation, Texas Tech University El Paso, and providers who use PHIX data. The goal of PHIX at its inception was to facilitate the transfer of health-related information between providers so that they better understand patients' needs and, as a result, improve treatment planning and care coordination.

PHIX currently partners with Emergence Health Network (EHN), The Hospitals of Providence Memorial Campus, Texas Tech University Health Sciences Center El Paso and Texas Tech psychiatrists, the Department of Veterans Affairs, the El Paso Police Department's Crisis Intervention Team, federally qualified health care providers, laboratories (e.g., Quest Diagnostics), and large area hospitals. Partners use PHIX data to verify and review patients' medical histories, current and prior diagnoses across providers, and laboratory test results (including COVID-19) and to improve follow-up practices and linkages to care. All providers access shared data through the same portal, with a small number of organizations receiving customized alerts (e.g., when one of their patients has been admitted to or discharged from an emergency department).

Despite the breadth of PHIX participation, which includes all major area hospitals but no free-standing psychiatric hospitals as partners, only a small number of private practices participate in PHIX. The primary barriers to data sharing include the cost of a PHIX subscription,[420] the need for cyber liability insurance, the perceived risk of a data breach, or an underlying agenda surrounding the use of data. In 2020, PHIX's board of directors established a committee to assess how data analyses could be conducted so that all partners are assured that their data will not be used to publicly release negative information about their practices. In addition, many private practices and non-profit organizations have incompatible electronic health record data storage systems, and some providers may lack an electronic health record altogether. Finally, as a part of the initial enrollment process, each partner works with PHIX to develop a series of legal, financial, and technical agreements that specify the terms of these agreements and how protected health information can and cannot be used and shared by PHIX and other

[420] The up-front cost of PHIX membership is $20,000, plus ongoing membership fees. PHIX realizes that this cost is not feasible for scaling to small practices and offers a package that costs $100 up front and $25 per month for practices with fewer than five physicians.

partners. These agreements – particularly the legal and financial agreements – have been barriers to broadening PHIX's partnerships.

One factor that hinders the utility of PHIX is its limited infrastructure for sharing aggregated data with external, non-partner agencies and the community at large. PHIX does not have an existing community-facing dashboard, and data requested by external, non-partner organizations must be routed to each partner agency for approval before data may be provided. These data sharing restrictions have been established to maintain patient confidentiality, but they concurrently limit the capacity for data analysis for quality improvement purposes to PHIX staff.

The partnership between PHIX and EHN has great potential, but it is limited by regulations that require EHN – as a SUD provider – to allow its clients to "opt-in" to data sharing with PHIX. This requires clients to actively consent to having their data shared, which many do not. All other PHIX partners have an "opt-out" process, meaning that clients have to proactively refuse to have their data shared. Less than one percent (1%) of clients refuse to have their data shared with PHIX.

Finding: PHIX has succeeded in developing the infrastructure for data collection and sharing across partner agencies to improve individual health outcomes. However, the data being shared are limited in that many private practices do not participate, and data are missing for many Emergence Health Network clients. Partner agencies' limited access to aggregated data also limits the data's utility for system planning and outcomes tracking (e.g., population health) purposes.

Recommendations: Based on our current knowledge of PHIX operations, we recommend the following:

- Continue to include more independent primary care practices. Currently, an estimated five percent (5%) of independent health care providers participate in PHIX, largely because of the prohibitive cost associated with buy-in. This limits the scope of information included in the PHIX database to a small number of larger practices.
- If feasible, expand PHIX to the 911 call center operators at the El Paso Police Department, the El Paso County Sheriff's Office, and mental health/drug courts. This would allow the identification of individuals who are cycling through various systems of care and may need additional support.
- Expand the use of near real-time notifications (when possible) to identify individuals who need referrals and linkages to care. The existing infrastructure has the potential to greatly improve linkages to care and health outcomes at the individual level, but it appears to be used by only a small number of partner agencies.

Appendix One: El Paso Behavioral Health Assessment Summary of Findings and Recommendations

Access to Behavioral Health Services Findings and Recommendations	Consortium Assignment Considerations[421]
Integrated Primary Care Findings and Recommendations	
Finding: There are some good examples of integrated primary and behavioral health care in El Paso County, and their scope and reach should be expanded.	
Recommendation: El Paso County providers can learn from and build on the examples at Project Vida, Centro San Vicente, and Emergence Health Network, and also implement new opportunities.	Integrated Leadership Council (ILC) Goal 3
Finding: Research has shown that, compared to non-Hispanics or Latinos, individuals in the Hispanic or Latino population believe primary care providers should treat child mental health problems, and that these parents are more willing to allow their child to receive medications or visit a therapist if recommended by a primary care provider. This supports suggestions that Hispanic or Latino adults are more likely to seek advice about mental health from a primary care provider rather than from a specialist.	
Recommendation: Given these findings, primary care may be a good setting for mental health interventions for the Hispanic or Latino population, especially through use of the Collaborative Care Model. In addition, providers should hire and train staff to address cultural competence and linguistic needs.	ILC Goal 1
Integrated Substance Use Disorder Treatment and Recovery Support Findings and Recommendations	
Finding: Our assessment did not reveal any formal collaborations or workgroups that specifically focused on substance use disorder treatment and recovery support services. However, we did find formal collaborations focused on substance use prevention.	
Recommendation: The El Paso Behavioral Health Consortium should explore how existing collaborations and work groups can incorporate a focus on substance use disorder treatment and recovery support services.	ILC Goal 4
Mental Health Literacy and Stigma Findings and Recommendations	
Finding: Increased expressions of concerns about stigma are associated with clinically significant reductions in service utilization rates in the Hispanic or Latino population.	

[421] Goals refer to the current El Paso Behavioral Health leadership council goals action plan (through 2020), which can be found here, http://www.healthypasodelnorte.org/tiles/index/display?alias=EPBHConsortium

Access to Behavioral Health Services Findings and Recommendations	Consortium Assignment Considerations[421]
Recommendation: • *Encouraging family involvement* – Include the ongoing work of peer support specialists and trained navigators (promotors) with lived experience to help keep people connected to services. The Hispanic or Latino population tends to have strong family networks. Utilizing peer support specialist to engage with and support families can help alleviate the stigma of mental illness and provide support and encouragement for people to engage in treatment. • *Educating about the physiologic roots of mental illness* – A lack of information and understanding contributes to stigma, which leads to the avoidance of issues and treatment. Providing details about diagnoses, discussing treatment options, and answering questions is an effective way to reduce stigma and help the Hispanic or Latino community overcome their fear of discussing mental illness.	ILC Currently, no council action plans address the unique needs of the majority Hispanic or Latino residents in the El Paso community.
Hospital Capacity Finding and Recommendations	
Finding: The closure of the El Paso Psychiatric Center's beds for children and youth has had an impact on both patient care and the center's ability to train psychiatric fellows and medical residents from the Texas Tech University Health Sciences Center at El Paso.	
Recommendation: Other inpatient treatment facilities – Rio Vista and El Paso Behavioral Health – should work with Texas Tech University Health Sciences Center at El Paso to add child and adolescent psychiatry residents and fellows at their hospitals.	ILC Goal 5

Behavioral Health Strategy Development for High-Risk Children and Youth Findings and Recommendations	Consortium Assignment Considerations
School Findings and Recommendations	
Finding: School districts in El Paso County have begun to adopt elements of the Multi-tiered Systems of Support framework, including forming community partnerships.	
Recommendation: By adopting the Multi-tiered Systems of Support framework, school districts in El Paso County can develop an organizational structure that aligns with this framework to better identify and support students who need intensive mental and behavioral health services and supports.	Family Leadership Council (FLC) Goal 2

Behavioral Health Strategy Development for High-Risk Children and Youth Findings and Recommendations	Consortium Assignment Considerations
Recommendation: Continue to expand and formalize data-driven intensive services and supports (Tier 3) through partnerships with community providers.	FLC Goal 2
Intensive Community-Based Services for Children and Youth Findings and Recommendations	
Finding: Children and youth with the highest needs lack access to intensive, community-based services.	
Recommendation: Develop capacity for intensive community-based evidence-based practices that both fall within and go beyond the services funded by the Health and Human Services Commission through Medicaid managed care organizations.	ILC & FLC Goal 4 (ILC) and Goal 3 (FLC)
Finding: Unfortunately, the future of early psychosis programs – and their ability to help the nearly 100,000 young people who experience psychosis every year including the estimated 30 new cases in El Paso – is at risk because current reimbursement models do not sustainably support the provision of Coordinated Specialty Care services.	
Recommendation: Emergence Health Network should explore new reimbursement strategies in the 1115 waiver renewal, along with recommendations in our *Coordinated Specialty Care—Payment Strategies* document, to determine the best path forward in creating more sustainable funding for Coordinated Specialty Care.	Emergence Health Network specific
Juvenile Justice Findings and Recommendations	
Finding: The El Paso Juvenile Probation Department was able to divert significant numbers of children and youth from juvenile justice system involvement and detention by coordinating with police to reduce referrals of children and youth for probation violations, misdemeanors, and nonviolent offenses.	
Recommendation: Sustain the progress made to reduce the use of detention for probation violations, misdemeanors, and nonviolent offenses and reinvest the savings in the expansion of community-based behavioral health programs.	Justice Leadership Council (JLC) & FLC Currently, no council action plans specifically consider juvenile justice. We recommend the creation of a cross-

Behavioral Health Strategy Development for High-Risk Children and Youth Findings and Recommendations	Consortium Assignment Considerations
	cutting group composed of JLC and FLC members to address all juvenile justice recommendations.
Finding: The El Paso Juvenile Probation Department has partnered with Emergence Health Network for the last seven years to operate a successful Multisystemic Therapy program for youth with intensive needs; unfortunately, the program does not have the capacity to adequately serve all who could benefit from it.	
Recommendation: Utilize a data-driven approach to select and expand upon services such as Multisystemic Therapy that have proven successful for children and youth with intensive needs who are involved in the juvenile justice system.	JLC & FLC See above
Finding: Although El Paso Juvenile Probation Department provides several evidence-based programs for children and youth with *intensive* behavioral health needs, gaps exist in services for children and youth with needs that do not reach that level of acuity.	
Recommendation: Increase the county's capacity to provide community-based services to children and youth with mild to moderate behavioral health needs who are involved in the juvenile justice system by formally partnering with additional providers beyond the local mental health authority.	JLC & FLC See above
Finding: Despite the finding that the El Paso County juvenile justice system has made significant progress in becoming trauma-informed, the juvenile courts in El Paso still practice the potentially harmful act of shackling youth in court.	
Recommendation: In an effort to fully achieve the department's goal of becoming a trauma-informed system, eliminate the use of shackling in the juvenile courts.	JLC & FLC See above
Finding: El Paso County children and youth with severe behavioral health needs often enter the juvenile justice system in order to access treatment, as demonstrated by data provided by the El Paso Juvenile Probation Department, which shows that at least 55% of all juvenile referrals have a behavioral health need.	

Behavioral Health Strategy Development for High-Risk Children and Youth Findings and Recommendations	Consortium Assignment Considerations
Recommendation: Implement strategies to reduce reliance on the juvenile justice system as a place to treat children and youth with severe behavioral health needs.	JLC & FLC See above

Crisis System Improvement Analysis Findings and Recommendations	Consortium Assignment Considerations
Navigating the Crisis System Findings and Recommendations	
Finding: El Paso County's system focuses on crisis response but has not yet begun to redesign the broader 911 system response to mental health emergencies to center on a health-driven, rather than a public safety-driven, response.	
Recommendation: Begin a community dialog on the potential to reform 911 response to better leverage El Paso's mental health crisis response system and shift the primary locus of response from police to health providers (paramedics and mental health specialists).	Consortium-wide and JLC and ILC as lead
Finding: El Paso County has a robust crisis system; however, providers and individuals are unsure how to access the crisis system and which services are available.	
Recommendation: Crisis system providers should work together to educate El Paso County residents about the crisis services that are available in the community and how to access the crisis system.	Consortium-wide
Crisis Respite Findings and Recommendations	
Finding: There are no available out-of-home, short-term crisis stabilization environments that could serve as an alternative to hospitalization for children and youth in crisis.	
Recommendation: Medicaid managed care providers should explore the provisions of Senate Bill (SB) 1177 to add crisis respite to the community's array of crisis services.	FLC Goal 3
Medical Stability Protocol – Inpatient Psychiatric Hospital Admission Findings and Recommendations	
Finding: Individuals needing inpatient psychiatric treatment are required to go to emergency departments or receive medical clearance from emergency medical services in the field before they can be transported to an inpatient psychiatric hospital.	

Crisis System Improvement Analysis Findings and Recommendations	Consortium Assignment Considerations
Recommendation: Create and integrate a medical stability protocol with the El Paso Fire Department/emergency medical services, and the El Paso Police Department.	JLC Goals 1 & 2
Medical Stability Protocol – Extended Observation Unit Findings and Recommendations	
Finding: Emergence Health Network currently operates an extended observation unit without the ability to provide medical clearance onsite.	
Recommendation: Emergence Health Network should embed medical clearance personnel within the extended observation unit and establish a medical clearance protocol.	Emergence Health Network specific
Standardized Community-Wide Assessment Protocols and Training Findings and Recommendations	
Finding: Assessments for inpatient psychiatric hospital admissions are often conducted by multiple assessors from different organizations.	
Recommendation: Organizations providing admission assessments should move to a common standardized assessment tool as well as consolidated and collaborative training among providers.	ILC Goal 2
Crisis System Financing Findings and Recommendations	
Finding: The El Paso community developed an effective collaboration that secured new funding to expand crisis services.	
Recommendation: The El Paso community should build upon the successful Senate Bill (SB) 292 collaboration to find and access additional funding for crisis services, or reallocate existing funding, as appropriate.	Consortium-wide, JLC as lead Goals 1 and 2

Intensive Adult Services and Special Populations Findings and Recommendations	Consortium Assignment Considerations
Assertive Community Treatment and Forensic Assertive Community Treatment Services Findings and Recommendations	
Finding: Currently, both the Assertive Community Treatment and Forensic Assertive Community Treatment programs lack capacity to meet community need.	

Intensive Adult Services and Special Populations Findings and Recommendations	Consortium Assignment Considerations
Recommendation: Expand the capacity of both Assertive Community Treatment and Forensic Assertive Community Treatment teams at Emergence Health Network.	Emergence Health Network specific
Finding: The Emergence Health Network Assertive Community Treatment and Forensic Assertive Community Treatment teams have not integrated the current state-of-the-art model of fidelity.	
Recommendation: Emergence Health Network should move to the Tool For Measurement of Assertive Community Treatment for its Assertive Community Treatment team and integrate the risk-needs-responsivity model into the Forensic Assertive Community Treatment team practices.	Emergence Health Network specific
Substance Use Disorder Treatment Within the El Paso Crisis System Findings and Recommendations	
Recommendation: Existing planning and collaboration efforts should ensure that substance use disorder treatment and recovery supports are included in integrated behavioral health and primary care crisis services.	ILC Goal 3
Criminal Justice Findings and Recommendations	
Recommendation: The Mental Health Court Committee should consider this assessment and the reports from the criminal justice system modernization efforts to determine what court-based interventions will best serve the El Paso community. If a mental health court is established, we recommend it focus on oversight of the local competency docket, including outpatient restoration.	JLC Goal 5
Finding: The monthly jail diversion meeting provides an opportunity for enhancing already strong collaboration through the expanded use of data.	
Recommendation: Include available system data to drive the jail diversion meeting agenda and discussions.	JLC Goal 3
Finding: Connection to community services is difficult for people released from the El Paso County Jail.	
Recommendation: There should be a focused effort to provide timely intake appointments – for any needed service – for people released from the El Paso County Jail.	JLC Goal 3
Finding: El Paso County's efforts to modernize the criminal justice system have led to improved processes and outcomes in important domains.	

Intensive Adult Services and Special Populations Findings and Recommendations	Consortium Assignment Considerations
Recommendation: Ongoing work to modernize the El Paso County criminal justice system should continue coordination with the broader behavioral health system of care, specifically the crisis continuum of services.	Consortium-wide, JLC as lead
El Paso County Veterans Findings and Recommendations	
Finding: The El Paso community's progress over the past six years in expanding mental health services for veterans and their families has been significant. However, veterans with complex mental health needs, and their family members, are left to navigate the mental health services of multiple organizations on their own in order to find appropriate care.	
Recommendation: El Paso County's veterans mental health programs need to improve coordination of care between federal organizations (VA), community service providers (Steven A. Cohen Military Family Clinic at Endeavors, Emergence Health Network), and specialty/inpatient organizations that provide culturally competent services for service members and veterans (Rio Vista, Peak, and Mesilla Valley).	Currently, no council action plans specifically consider Veterans. We recommend Veteran-serving entities are engaged to ensure coordination of care.

Community Collaboration and Community Data Sharing Findings and Recommendations	Consortium Assignment Considerations
Community Collaboration Findings and Recommendations	
Finding: Over the course of the past eight years, more structure has been put in place to support the Consortium; however, as previously mentioned, the community context and the needs of its members have changed since then.	
Recommendation: Minor changes are recommended for the executive committee and leadership council functions to better equip community leaders and stakeholders to create positive changes for the behavioral health system in El Paso County.	Consortium-wide
Recommendation: We recommend that the roles of work groups and tasks forces be defined with more clarity.	Consortium-wide
Recommendation: Ensure that new members who join the Consortium and leadership councils are aware of the Consortium's history, intent, and	Consortium-wide

Community Collaboration and Community Data Sharing Findings and Recommendations	Consortium Assignment Considerations
Community Collaboration Findings and Recommendations	
structure to help them successfully and effectively contribute to the Consortium's success.	
Recommendation: To provide transparency to the El Paso community and ensure accountability, the Consortium and its members should revisit plans to host a public-facing data dashboard.	Consortium-wide
Recommendation: Dedicated administrative support is required to organize the Consortium and its committees, gather data and resources, and track progress toward goals.	Consortium-wide
Community Data Sharing Findings and Recommendations	
Finding: During our assessment, various El Paso County organizations made local behavioral health data available to our team members to inform our report. However, these data were often siloed within individual organizations and not readily available to other organizations or the public. Data that are available to the public (for example, on the Consortium dashboard) are not actively maintained. The El Paso community has an opportunity to leverage its existing data collaborations, infrastructure, and local expertise to expand its use of data in decision making. The community should make it a priority to explore whether PHIX is the appropriate venue for expanded data sharing.	
Recommendation: The El Paso Behavioral Health Consortium should create a data sharing and integration committee or work group connected to an existing Consortium leadership council and comprise of interested and engaged stakeholders who are dedicated to exploring how expanded data sharing and integration can achieve local behavioral health goals.	Consortium-wide
Finding: PHIX has succeeded in developing the infrastructure for data collection and sharing across partner agencies to improve individual health outcomes. However, the data being shared are limited in that many private practices do not participate, and data are missing for many Emergence Health Network clients. Partner agencies' limited access to aggregated data also limits the data's utility for system planning and outcomes tracking (e.g., population health) purposes.	
Recommendations: • *Continue to include more independent primary care practices*. Currently, an estimated five percent (5%) of independent health care providers participate in PHIX, largely because of the prohibitive cost associated with buy-in. This limits the scope of information included in the PHIX database to a small number of larger practices.	PHIX specific

Community Collaboration and Community Data Sharing Findings and Recommendations	Consortium Assignment Considerations
Community Collaboration Findings and Recommendations	
• *If feasible, expand PHIX to the 911 call center operators at the El Paso Police Department, the El Paso County Sheriff's Office, and mental health/drug courts.* This would allow the identification of individuals who are cycling through various systems of care and may need additional support. • *Expand the use of near real-time notifications (when possible) to identify individuals who need referrals and linkages to care.* The existing infrastructure has the potential to greatly improve linkages to care and health outcomes at the individual level, but it appears to be used by only a small number of partner agencies.	

Appendix Two: El Paso System Assessment Implementation Group Members

Name	Organization and Title
Rob Anderson	The Hospitals of Providence - Sierra Campus Chief Executive Officer (CEO)
Joel Bishop	County of El Paso – Executive Director Justice and Community Services
Sharon Butterworth	PdNHF Board – Mental Health Advocate
Kristi Daugherty	Emergence Health Network – CEO
Nicole Ferrini	City of El Paso – Director Community Development
Cathy Gaytan	El Paso Child Guidance Center – Executive Director
Dr. Sarah Martin	Texas Tech Health Sciences Center El Paso – Chief Child Psychiatry
Enrique Mata	Paso del Norte Health Foundation – Senior Program Officer
Nellie Mendoza	NAMI El Paso – Director of Programs
Bill Schlesinger	Project Vida – CEO
Dr. John Wiebe	UTEP – Provost
Ruben Vogt	University Medical Center El Paso – Director of Government Relations
Tracy Yellen	Paso del Norte Health Foundation – CEO

Appendix Three: Key Informant Interviewees

Elected Officials

Name	Title	Organization
Alexsandra Annello	City Representative, District 2	City of El Paso
David Stout	Commissioner, Precinct 2	County of El Paso
César Blanco	State Representative, District 76	Texas House of Representatives
Art Fierro	State Representative, District 79	Texas House of Representatives
Mary González	State Representative, District 75	Texas House of Representatives
Joe Moody	State Representative, District 78	Texas House of Representatives
Lina Ortega	State Representative, District 77	Texas House of Representatives
José Rodríguez	State Senator, District 29	Texas Senate
Congresswoman Veronica Escobar	U.S. Congresswoman, District 16	U.S. House of Representatives

Local Mental Health Authority – Emergence Health Network

Name	Title	Organization
Jennifer Banks	PHP/IOP Program Director	Emergence Health Network
Anna Basler-White	Chief of Diversion	Emergence Health Network
Tara Blunk	Crisis Clinic Manager	Emergence Health Network
Kellie Burns-Franco	Program Manager of Veteran Services	Emergence Health Network
April Celest Corral	Recovery and Community Integration Director	Emergence Health Network
Brad Cherry	Program Director TCOOMMI	Emergence Health Network
Kristi Daugherty	Chief Executive Officer	Emergence Health Network
Crystal L. Davis	Chief Clinical Officer	Emergence Health Network
Melissa French	Chief of Collaborative Care	Emergence Health Network
Janet Ibarra	MST Program Manager	Emergence Health Network
Amanda Muñoz	Supervisor of Coordinated Specialty Care	Emergence Health Network

Name	Title	Organization
Veronica Muro	Coordinated Specialty Care Therapist	Emergence Health Network
Veronica Noriega	Housing and Homeless Manager	Emergence Health Network
Rhonda M. Russ	Crisis Intervention Team Director	Emergence Health Network
Victor S. Talavera	Chief of Crisis and Emergency Services	Emergence Health Network

Health Care and Behavioral Health Care Providers

Name	Title	Organization
Ivonne Tapia	Chief Executive Officer	Aliviane
Jean R. Joseph-Vanderpool	Chief Medical Officer	Atlantis Health Services
Celina Beltran	Chief Medical Officer	Centro San Vicente
Lisa Hernandez	Therapist	Centro San Vicente
Christina Paz	Chief Executive Officer	Centro San Vicente
Phuong Cardoza	Chief Executive Officer	El Paso Behavioral Health System
Beth Senger	Chief Executive Officer	El Paso Center for Children
Cathy Gaytan	Executive Director	El Paso Child Guidance Center
Zulema C. Carrillo	Superintendent	El Paso Psychiatric Center
Richard Salcido	Executive Director	Family Service of El Paso
Douglas W. Denton	Executive Director	Homeward Bound, Inc.
Rob J. Anderson	Chief Executive Officer	The Hospitals of Providence
Linda Lawson	Chief of Nursing	The Hospitals of Providence
R. David Shimp	Chief Executive Officer	Las Palmas Del Sol Medical Center
Sandy Emanual	Chief Executive Officer	Peak Behavioral Health
Rachel Quintanilla	Chief Behavioral Health Officer	Project Vida Health Center
Bill Schlesinger	Chief Executive Officer	Project Vida Health Center

Name	Title	Organization
Marie Alvarez	Chief Executive Officer	Rio Vista Behavioral Health
Karla Silva	Director of Admissions	Rio Vista Behavioral Health
Ruben Vogt	Director of Government Relations	University Medical Center El Paso

Coalitions/Nonprofit Organizations/Private

Name	Title	Organization
Jon Barela	Chief Executive Officer	The Borderplex Alliance
Lisa Saucedo	Chief Executive Officer	CASA of El Paso
Sandra Nevarez Garcia	Executive Director	Center Against Sexual & Family Violence
Nellie Mendoza	Director of Programs	NAMI of El Paso
Emily Hartmann	Executive Director	Paso del Norte Health Information Exchange
Sylivia Acosta	Chief Executive Officer	YWCA El Paso del Norte Region

Government

Name	Title	Organization
Nicole Ferrini	Chief Resilience Officer	City of El Paso

Higher Education

Name	Title	Organization
William Serrata	President	El Paso Community College
Carla Alvarado	Child & Adolescent Psychiatry	Texas Tech University Health Science Center – El Paso
Edward A. Michelson	Professor and Chairman, Department of Emergency Medicine	Texas Tech University Health Science Center – El Paso, Paul L. Foster School of Medicine
Peter M. Thompson	Professor and Chairman Hunt Family Endowed Chair in Psychiatry	Texas Tech University Health Science Center – El Paso

Name	Title	Organization
Sarah Martin	Chief Child Psychiatry	Texas Tech University Health Science Center – El Paso
Jennifer Eno Louden	Associate Professor	The University of Texas at El Paso
Hyejin Jung	Associate Professor	The University of Texas at El Paso
Leslie Robbins	Dean of School of Nursing	The University of Texas at El Paso
Brian Sneed	Clinical Psychologist and Director of Counseling Center	The University of Texas at El Paso

Philanthropy

Name	Title	Organization
Joyce Wilson	Chair, Emergence Health Network Board of Trustees	Retired, CEO, Workforce Solutions Borderplex
Alfonso V. Velarde	Chief Executive Officer	Paso del Norte Children's Development Center
Gilda Gil	Chief Operations Officer and Chair of CRCG	Paso del Norte Children's Development Center
Stacey Hunt Spier	Board Member	Paso del Norte Community Foundation
Sharon Butterworth	Community Advocate	Paso del Norte Health Foundation and The Meadows Institute board member
Ruben Guerra	Chair	Paso del Norte Health Foundation
Michael Kelly	Vice President of Programs	Paso del Norte Health Foundation
Enrique Mata	Senior Program Officer	Paso del Norte Health Foundation
Jana Renner	Program Manager	Paso del Norte Health Foundation
Tracy Yellen	Chief Executive Officer	Paso del Norte Health Foundation

Veterans

Name	Title	Organization
Monique Rodriguez	El Paso Regional Manager	Combined Arms
Connie Ponce	Chief of Mental Health	El Paso VA Health Care System

Name	Title	Organization
Benjamin Miranda	Director, Operational Impact and Business Development	Endeavors/Steven A. Cohen Military and Family Clinic at Endeavors

Criminal Justice/Emergency Responders

Name	Title	Organization
Greg Allen	Chief of Police	City of El Paso
Peter Pacillas	Assistant Chief Uniform Police Services Bureau II	City of El Paso
Kathleen Anderson	Assistant County Attorney	County of El Paso
Joanne Bernal	El Paso County Attorney	County of El Paso
Joel Bishop	Executive Director, Justice Support and Community Service	County of El Paso
William R. “Bill” Cox	Deputy Public Defender (Interim Chief Public Defender at time of interview)	County of El Paso
Beatrice Fierro	Program Manager, Reentry Support Services	County of El Paso
Amanda Frizzelle	Assistant County Attorney, Trial Team Chief, Mental Health Division	County of El Paso
Donnie McGilbra	Assistant County Attorney	County of El Paso
Magdalena Morales-Aina	Director, Community Supervision and Corrections Department	County of El Paso
Alexandra Ruiz	Public Defender’s Office, Chief Social Worker	County of El Paso
Edythe M. Payán	Deputy Public Defender	County of El Paso
Sheriff Richard Wiles	El Paso County Sheriff	County of El Paso

Juvenile Justice

Name	Title	Organization
Laura Christopherson	Assistant County Attorney, Senior Division Chief, Criminal/Juvenile Division	County of El Paso
Emily Dawson	Assistant County Attorney, Trial Team Chief, Juvenile Prosecution Unit	County of El Paso
Elizabeth Hutchins	Juvenile Justice Analyst	County of El Paso
Leobardo Landero	Director of Information Systems & Record, Juvenile Probation Department	County of El Paso
Marc Marquez	Deputy Chief of Operations, Juvenile Probation Department	County of El Paso
Roger Martinez	Chief of Juvenile Probation, Juvenile Probation Department	County of El Paso
Rosie Medina	Director of Special Programs, Juvenile Justice Center, Juvenile Probation Department	County of El Paso
Gerardo Prieto	Software Developer Intermediate, Juvenile Probation Department	County of El Paso
Kim Shumate	Director of Clinical Services, Juvenile Justice Center, Juvenile Probation Department	County of El Paso

School Districts/School-based

Name	Title	Organization
Nicole Morales	District Lead Counselor	Canutillo ISD
Monica Reyes	Student Support Services	Canutillo ISD
Manuel Castruita	Director of Counseling and Advising	El Paso ISD
Olivia Narvaez	Social Worker	El Paso ISD
Mario Carmona	Director of Employee Benefits	Socorro ISD

Name	Title	Organization
Tammi Mackeben	Director of School Counseling	Socorro ISD
Kelly Moreno	Clinic Manager RN	Socorro ISD
Catherine Kennedy	Associate Superintendent of Middle Schools	Ysleta ISD

Community Member

Name	Title
Wendell Holder	Community advocate
Holly Krasfur	Community advocate
Holly Mata	Community advocate
Mike Wendt	Community advocate
Steve Yellen	Community advocate

Appendix Four: Key Informant Interview Questionnaire

1) What are your goals for this assessment?

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

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

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

5) How has the COVID-19 pandemic impacted the delivery of mental health services, both in the short-term and long-term need for mental health services in the El Paso region?

6) What other general comments would you like to offer?

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

Appendix Five: Implementing Multi-Tiered System of Supports (MTSS): Considerations for District and School Leadership

MTSS is an evidence-based framework for teaching and learning that effectively integrates systems that monitor and respond to the academic, social-emotional, and behavioral needs of all students.

Overarching goals:

- To improve learning outcomes for all students;
- To use systems that monitor and track student progress toward specific academic and behavioral goals;
- To implement effective and appropriate disciplinary practices that ensure equitable outcomes; and
- To use data-driven systems to support student growth, teacher alignment, and ongoing school improvement.

Implementation of the three tiers of supports and interventions requires support from district and school personnel, as well as formal and informal partnership with community providers. In the following table, we provide information and strategies for successfully implementing Tier 1, Tier 2, and Tier 3 services.

Considerations for MTSS Implementation		
Tier 1: Universal	**Tier 2: Targeted**	**Tier 3: Intensive**
Superintendent and Senior Leadership		
• Articulate expectations for all staff to support the implementation of the initiative. • Fold MTSS into current initiatives already outlined in the district strategic plan. • Provide funding in support of professional development, leadership development, and data collection and use. • Identify key leadership within departments such as Behavioral Health/Special Education and Curriculum & Instruction to lead initiative. • Direct Business Analytics/Data Research team to develop and adopt systems for data collection and distribution for multiple audiences. • Direct a district-identified team to support school roll out of MTSS framework to all schools, beginning with elementary/pre-K through high school. • Identify central office staff to provide data access, procedural safeguards, and forms to support community- or faith-based organizations' roles.	• Identify key leadership to create professional development plan for implementation of evidenced-based practices throughout schools • Provide forms, templates and timelines to schools that outline how to organize teams, set drop-dead dates for data collection and why timelines for assessing fidelity of plan implementation are important • Offer professional development opportunities for staff to learn Tier II practices in support of behavioral intervention • Offer professional development opportunities for staff to learn evidence based, Tier II academic interventions • Fund intervention curricula and professional learning for academics	• Use Special Education leadership and Behavioral Health staff to teach into function of behavior • Provide onsite support to analyze and diagnose behavioral and academic challenges individual schools are faced with • Coordinate with district 504 staff and special education staff to support generalized major behavior challenges

Considerations for MTSS Implementation		
Tier 1: Universal	**Tier 2: Targeted**	**Tier 3: Intensive**
Superintendent and Senior Leadership		
• Create or reassign project manager to a multi-year implementation timeline, with decision-making ability and accountability. • Initiate district-driven professional development plan in support of trauma-informed, evidence-based practices that focus on the whole child (e.g., social/emotional learning, academics and behavior) • Facilitate district support of building staff to ensure fidelity of implementation and sustainability. • Ensure data accessibility for all Tiers, with common data points for Tier I and sharing capacity for schools, district leadership, and community- or faith-based organizations. • Provide documentation to schools that outline the purpose and how to use systems for support (e.g., data collection, professional learning community format, data base access and tools). • Develop benchmark assessments to use district-wide. • Initiate community outreach, utilizing communications department when possible to inform the community about the initiative and its importance.		

Considerations for MTSS Implementation		
Tier 1: Universal	**Tier 2: Targeted**	**Tier 3: Intensive**
Principal and School Leadership		
• Identify Trauma-Informed Team to lead work. • Develop system to monitor and track behavioral data/office referrals. • Teach staff why behavioral interventions and addressing the need to belong are necessary to shift the school climate and culture regarding discipline. • Lead implementation of PBIS, trauma-informed practices, introduction to ACEs, and family outreach. • Identify key staff to lead initiative. • Provide professional development and time for staff to learn about the functions of behavior. • Develop family outreach and engagement work to align behavioral and academic expectations with families. • Identify benchmark data points that will determine implementation needs and share with staff. • Create calendar for implementation benchmarks/targets/progress monitoring.	• Utilize special education teachers to help with implementing Tier II behavioral plans that are monitored by classroom teachers; provide classroom teachers with feedback and support. • Develop consistent Tier II plans that can be adjusted to meet the students' needs. • Provide professional development on the functions of behavior to staff. • Provide ongoing, responsive support to staff who are implementing academic and behavioral plans. • Use behavioral data tracking systems to identify how best to meet the needs of students identified in Tier II. • Use Trauma-Informed Team to decide how best to support students with challenging behavior. • Identify specific Tier II strategies in support of student behavioral intervention that align with PBIS systems.	• Provide onsite counseling services to students and their families who request help. • Provide CBT/DBT when possible. • Provide CBITS if and when possible.
• Maintain high expectations. • Lead with a culturally responsive lens. • Collect tiered fidelity data on implementation across grade levels and classrooms. • Assign counselor or school psychologist the task of developing a school-wide wraparound team. • Identify and staff a "reset counselor" or other highly trained staff to intervene and support teachers who have students with Tier II and III behavior.	• Set aside funding to pay for substitute teachers or develop plans to give teachers breaks from classroom teaching to participate in progress monitoring meetings.	

Considerations for MTSS Implementation		
Tier 1: Universal	**Tier 2: Targeted**	**Tier 3: Intensive**
Educator		
• Implement trauma-informed classroom management strategies. • Develop predictable learning space. • Remain curious about behavior. • Foster, develop, and grow healthy, committed relationships with *all* students. • Adopt behavioral data-tracking systems for discussions about students' strengths and needs. • Actively participate in professional development that addresses student behavior. • Deliver core content using statewide standards and align curriculum horizontally and vertically. • Consistently provide culturally responsive teaching, inclusive of all students.	• Collect ongoing assessment data in support of student learning. • Provide small group instruction to students in need of additional support, for whom Tier I core instruction is not sufficiently meeting their needs. • Manage behavior plans and communicate regularly with family, guardian, or caregiver. • Collect behavioral data on students receiving behavioral support. • Maintain ongoing parental outreach to share students' positive and challenging behaviors. • Conduct regular check-ins with Trauma-Informed Team in support of any students on behavioral plans.	• Maintain plans for students identified in Tier III as well as ongoing communication with family/guardian, school administration, and counselor. • Coordinate with behavior intervention specialist/administration if immediate support is needed in classroom to intervene with major disruptive behavior. • Collect data and document behavior in preparation for future meetings to address how to support the student and classroom community.
• Behavioral/social-emotional curriculum is regularly scheduled and delivered by the classroom teacher. • Decisions about learning are driven by ongoing formative assessment of academic and behavioral needs. • Align pedagogy with evidence-based practices. • Both formative and summative tools are used to assess and monitor progress. • Provide families with classroom norms developed by students and teacher.		

Considerations for MTSS Implementation		
Tier 1: Universal	**Tier 2: Targeted**	**Tier 3: Intensive**
Families, Guardians, and Caregivers		
• Be involved in developing school-wide expectations. • Collaborate with school to maintain consistency in behavioral expectations for students at school and home. • Know and understand school PBIS expectations for students. • Know and support school homework policies. • Work closely with student's classroom teacher on ways to best support their child.	• Parental support of student; use behavior sheet for daily check-ins as part of intervention support. • Maintain ongoing communication with student's teacher and school administration.	• Attend school meetings to learn about student's academic and social behavior, attempted interventions, and plan for next steps. • Participate in Student Intervention Team process. • Consider attending family counseling in support of student who is struggling behaviorally. • Leave option open to explore special education services, if appropriate.

Appendix Six: Level of Care (LOC) Overview for Child and Adolescent Services

A brief overview of the Texas Resilience and Recovery (TRR) Utilization Management Guidelines is presented below. For a full description, please see *Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services*[422]

Level of Care (LOC)	Population/Purpose	Services
LOC-0: Crisis Services	**Population:** A child or youth experiencing a mental health crisis who is not currently enrolled in services. A Child and Adolescent Needs and Strengths (CANS) assessment is not required. **Purpose:** Brief interventions provided in the community to treat and stabilize a mental health crisis and prevent utilization of more intensive services. **Services authorized for seven days.**	Brief community-based crisis intervention services.
LOC-1: Medication Management	**Population:** Children and youth whose only identified treatment need is medication management. **Purpose:** To maintain stability while developing natural supports and, when possible, transitioning to a community provider. **Monthly Average Utilization:** 0.5 hours	Medication management is the only routine service provided in LOC-1. Additional services include: **Core Services** • Psychiatric diagnostic interview examination • Pharmacological management **Adjunct Services** • Medication training • Routine case management • Parent support group • Family partner support • Family case management

[422] Texas Department of State Health Services. (2016). Texas Resilience and Recovery Utilization Management Guidelines: Child and Adolescent Services. https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-child.pdf

Level of Care (LOC)	Population/Purpose	Services
LOC-2: Targeted Services	**Population:** Children and youth who have an emotional **or** behavioral need with low to no life domain functioning needs. **Purpose:** To improve mood symptoms **or** address behavioral needs. **Monthly Average Utilization:** three hours	All services in LOC-1 are available to children and youth in LOC-2, but they can be delivered at a greater frequency. **Additional Core Services** • Counseling (individual, group, family) **or** skills training & development (individual, group) • Routine case management **Additional Adjunct Services** • Engagement activity • Caregiver skills training & development • Family training & development (individual, group)
LOC-3: Complex Services	**Population:** Children and youth with identified behavioral and emotional needs who exhibit a moderate degree of risk behaviors or impairments in basic life functioning and require multiple service interventions from multiple providers. **Purpose:** To stabilize symptoms and risk behaviors, improve overall functioning, and build strength and resiliency in the child/youth and caregiver so the child/youth can transition to a lower level of care. **Monthly Average Utilization:** five hours	The majority of the services in LOC-3 are the same as in LOC-2. However, services are delivered more frequently, and children and youth can receive both counseling and skills training & development services. **Additional Core Services** • Counseling (individual, group, family) • Skills training & development (individual, group) • Routine case management **Additional Adjunct Services** • Flexible funds • Family partner supports • Community-based respite services • Program-based respite services

Level of Care (LOC)	Population/Purpose	Services
LOC-4: Intensive Family Services (wraparound)	**Population:** Children and youth who have been identified as having behavioral and/or emotional treatment needs and have significant involvement with multiple service systems. These children and youth are likely to be at risk for out-of-home placement and their behavior or mood symptoms may result in or have resulted in juvenile justice involvement, expulsion from school, displacement from home, hospitalization, residential treatment, serious injury to self or others, or death. **Purpose:** To reduce or stabilize symptoms and risk behaviors, improve overall functioning, and build strengths and resiliency in the child/youth and caregiver through a team approach. Caregiver resiliency is fostered by building on strengths and natural supports and linking to community resources using the wraparound planning process. **Average Monthly Utilization:** 7.5 hours	Services from LOC-3 are available to children and youth in LOC-4 at a higher frequency because of a higher level of need. **Additional Core Services** • Intensive case management (wraparound) • Family partner supports • Individual, group, and family counseling **Additional Adjunct Services** Additional services available in LOC-4 include: • Stronger emphasis on family partner services and integrated care • Flexible community supports • Routine case management • Additional adjunct services for transition-age youth Texas Department of State Health Services (DSHS) has identified the National Wraparound Initiative (NWI) model for wraparound for the delivery of intensive case management services. This model requires a treatment team member to provide crisis response 24 hours a day, seven days a week (24/7). In addition, a wraparound team meeting is required within 72 hours of any crisis.

Level of Care (LOC)	Population/Purpose	Services
LOC-YES: Youth Empowerment Services (YES) Waiver	**Population:** Children and youth ages three to 18 years who would need institutional care or whose parents would turn to state custody for care. **Purpose:** To improve clinical and functional outcomes for children and youth, reduce or stabilize symptoms and risk behaviors, improve functioning, and build strengths and resiliency through a team approach and a continuum of flexible community-based services and supports. **Clinical Eligibility:** 365 days	All TRR Medicaid services are available in LOC-YES, as well as services outside of TRR, such as: • Community living supports • Specialized therapies • Respite • Adaptive aids • Transition assistance • Employment services • Family support • Minor home modifications Texas DSHS has identified the NWI model for wraparound for the delivery of intensive case management services. This model requires a treatment team member to provide 24/7 crisis response. In addition, a wraparound team meeting is required within 72 hours of any crisis.
LOC-RTC: Residential Treatment Center (RTC)	**Population:** Children and youth ages five to 17 years who meet RTC eligibility and are admitted to an RTC. **Purpose:** The services in this LOC are intended to meet the needs of youth who are admitted to private RTCs. LOC-RTC is not intended for youth admitted to the Waco Center for Youth or to private RTCs outside of the RTC Project. **Monthly Average Utilization:** two hours	Core Services include: • Family case management • Family partner
LOC-YC: Young Child Services	**Population:** Children three to five with behavioral and/or emotional needs. **Purpose:** The services in this LOC are intended to meet the needs of the young child (ages 3-5) with identified behavioral and/or emotional treatment needs. The young child may also exhibit a moderate degree of life domain functioning impairments that require multiple service interventions. **Monthly Average Utilization:** 3.5 hours	Core Services include: • Routine case management • Counseling • Skills training

Level of Care (LOC)	Population/Purpose	Services
LOC-5: Transitional Services	**Population:** Children and youth who have been discharged from LOC-0 and need continued support to prevent further crisis while they are engaged in appropriate services and supports. **Purpose:** To maintain stability and prevent further crisis events.	This level of care is highly individualized. The level of service intensity and length of stay varies based on individual needs. All services are available at this level.
LOC-CEO: Children Early Onset	**Population:** Youth ages 15 to 17 years who have a diagnosis that includes psychotic features; individuals needs will vary in terms severity and needs. The youth must live in the service areas of the pilot program site. **Purpose:** To stabilize symptoms and maintain stability while the youth develops additional skills to work toward recovery and gain or maintain meaningful educational opportunities or employment.	**Core Services** • Psychiatric diagnostic interview • Pharmacological management • Individual and group skills training & development • Supportive Employment and Education • Supportive housing • Individual and group medication training and support services • Individual psychotherapy • Family counseling • Multiple family psychotherapy • Group counseling • Family partner services • Case management for youth and their family • Family training • Parent support group • Engagement activity • Flexible funds • Flexible community supports • All services within the crisis array

Level of Care (LOC)	Population/Purpose	Services
LOC-TAY: Transition-Age Youth	**Population:** Youth ages 16 to 20 years who may undergo tremendous changes in all life domains. **Purpose:** To provide access to evidence-based assessments, treatment models, and recovery services by strengthening the existing service model for this group of youth/young adults. A transition plan should be developed in collaboration with the youth and their identified supports.	**Core Services** • Psychiatric diagnostic interview examination • Intensive case management • Skills training & development • Peer support • Pharmacological management • Administration of an injection • Medication training & support services • Family counseling • Individual psychotherapy • Group counseling • Supported housing • Supported Employment • Flexible funds **Adjunct Services** • Flexible community supports • Family partner support

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

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of its "Crossing the Quality Chasm"[423] report, which became the first in a series of IOM publications that have underscored the need to fundamentally shift operational priorities and the commitment from health care delivery organizations to ongoing quality improvement. In many ways, the premise of the report is quite simple: the health care industry must move from a traditional "command and control" model to a continuous quality improvement model. These are lessons that the U.S. manufacturing sector had to learn and apply in the 1980s and 1990s, building on the work of pioneers such as Edward Deming and leading to a variety of standards and frameworks now widely used across industry (e.g., ISO 9001:2008[424]).

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

In 2006, the IOM focused its attention on mental health and substance use disorders,[425] documenting severe system-level quality gaps and describing a framework for improving them. The resulting report was explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most mental health/substance use disorder delivery systems in effectively promoting it:

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

[423] Institute of Medicine. (2001). Crossing the quality chasm: A new health system for the 21st Century. The National Academies Press.
[424] For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf
[425] Institute of Medicine. (2006). Improving the quality of health care for mental and substance-use conditions. The National Academies Press.

> *conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.*[426]

The report notes that the challenges facing mental health/substance use disorder systems are, in many ways, more severe than those facing the broader health system because of "a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace."[427] Nonetheless, the IOM recommended clearly that the advised shift from command and control models of quality assurance to customer-oriented quality improvement was both necessary and possible within behavioral health systems; these systems have capacity similar to that of health care systems to produce better outcomes with lower costs.

The implications of the IOM's recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery; it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm report and related report series.[428] The report states the matter in its characteristically direct manner, as quoted below:

> *Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:*
> - If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
> - If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
> - If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
> - If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
> - If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

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[426] Institute of Medicine. (2006). Improving the quality of health care for mental and substance-use conditions. The National Academies Press.
[427] Institute of Medicine. (2006).
[428] Institute of Medicine. (2012). Best care at lower cost: The path to continuously learning health care in America. The National Academies Press.

The point is not that health care can or should function in precisely the same way as all other sectors of people's lives; each is very different from the others, and every industry has room for improvement. Yet if some of the transferable best practices from banking, construction, retailing, automobile manufacturing, flight safety, public utilities, and personal services were adopted as standard best practices in health care, the nation could see patient care in which:

- Records were immediately updated and available for use by patients;
- Treatments were proven reliable at the core and tailored at the margins;
- Patient and family needs and preferences were a central part of the decision process;
- All team members were fully informed in real time about each other's activities;
- Prices and total costs were fully transparent to all participants;
- Payment incentives were structured to reward outcomes and value, not volume;
- Errors were promptly identified and corrected; and
- Results were routinely captured and used for continuous improvement.[429]

Defining Best Practices

There are hundreds of evidence-based practices (EBPs) available for mental health and substance use disorder treatment, and the most definitive listing of these practices was provided by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) through the National Registry for Evidence-Based Programs and Practices (NREPP).[430] While much of the NREPP website was discontinued as of 2018, it has been replaced by the Evidence-Based Practices Resource Center, which now provides information and tools to incorporate evidence-based practices into community or clinical settings rather than a comprehensive listing of EBPs. Other definitive listings of EBPs are provided by the Society of Clinical Child and Adolescent Psychology,[431] Evidence-Based Behavioral Practice,[432] Blueprints for Health Youth Development,[433] and, for child welfare populations, the California Evidence-Based Clearinghouse for Child Welfare.[434] Additionally, with the passage of the Family First Prevention Services Act (FFPSA), the federal Administration of Children and Families (ACF) is also developing and populating a clearinghouse on evidence-based and promising practices.[435]
The terms "evidence-based practice," "evidence-based treatment," or "empirically-supported treatment" are meant to refer to psychological treatments that have undergone scientific

[429] Institute of Medicine. (2012). Best care at lower cost: The path to continuously learning health care in America. The National Academies Press.
[430] The NREPP's database was located at https://www.samhsa.gov/ebp-resource-center
[431] The Society of Clinical Child and Adolescent Psychology's website is located at https://effectivechildtherapy.org/therapies/
[432] The Evidence-Based Behavioral Practice's website is located at https://ebbp.org/
[433] The Blueprints for Health Youth Development's website is located at https://www.blueprintsprograms.org/
[434] The California Evidence-Based Clearinghouse for Child Welfare's website is located at https://www.cebc4cw.org/search/by-topic-area/
[435] The Administration of Children and Families' website is located at https://preventionservices.abtsites.com

evaluation. There are five levels used to evaluate the evidence base for psychosocial treatments for children and adolescents.[436, 437] On the first level are "well-established" treatments that have undergone at least two randomized clinical trials (RCTs) and have been studied by independent teams working at different research settings. The second level includes "probably efficacious" treatments that have strong research support, but treatment may not have been tested by independent teams; or, only one study shows the treatment is much more effective than a well-established treatment; or, if at least two studies show it is better than no treatment. Interventions in the third level are treatments considered "possibly efficacious" in that there may be one study showing that the treatment is better than no treatment, or there may be a number of smaller clinical studies without highly rigorous methodological and procedural controls (e.g., randomization). The fourth level contains treatments considered "experimental" in that they have not been studied carefully, and the fifth level are treatments that have been tested and do not work.

Successful promotion of best practices also requires understanding of the real-world limitations of each specific best practice, so that the understandable stakeholder concerns that emerge can be anticipated and incorporated into the best practice promotion effort. This process is sometimes called "using practice-based evidence" to inform implementation and is a core feature of continuous quality improvement. The reasons for such concerns at the "front line" implementation level are well documented and significant.[438] One major issue is that the literature prioritizes RCTs that address efficacy in controlled research settings, whereas practitioners require research evidence on effectiveness in typical practice settings. This "efficacy-effectiveness gap" was clearly defined in the 1999 U.S. Surgeon General's report on mental health services in America[439] and centers on the much more complex realities that practitioners face in the field. Research that addresses the complexities of typical practice settings (e.g., staffing variability due to vacancies, turnover, inconsistent quality of providers' training, and inconsistent fidelity to existing models) is lacking, and the emphasis on RCTs is not 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

[436] Chambless, D. L. & Hollon, S. D. (1998). Defining empirically supported therapies. Journal of Consulting and Clinical Psychology, 66, 7–18.
[437] Chorpita, B. F., Daleiden, E. L., Ebesutani, C., Young, J., Becker, K. D., Nakamura, B.J. & Starace, N. (2011). Evidence-based treatments for children and adolescents: An updated review of indicators of efficacy and effectiveness. Clinical Psychology: Science and Practice, 18, 154–172.
[438] Waddell, C., & Godderis, R. (2005). Rethinking evidence-based practice for children's mental health. Evidence-Based Mental Health, 8, 60–62.
[439] U.S. Surgeon General. (1999). Mental health: A report of the Surgeon General. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.

individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships.[440] Because of this, practitioners must in many cases extrapolate from the existing research evidence.

One of the biggest concerns about best practices — and one that is certainly highly relevant for a state as diverse as Texas — involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base regarding diversity that often lead providers, people receiving services, and other stakeholders to question the extent to which the research evidence supporting best practices is applicable to their communities and the situations they encounter daily. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across cultures.[441] Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense to implement best practices within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-cultural applications of major best practices.[442] There is also increasing recognition of best practices for refugee and immigrant communities.[443]

It is critical to ground best practice promotion in specific standards for culturally and linguistically appropriate care. The most well-known national standards related to health disparities focus on services for members of underrepresented groups. The National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards)[444] were adopted in 2001 by the U.S. Department of Health and Human Services' Office of Minority Health with the goals of "equitable and effective treatment in a culturally and linguistically appropriate manner" and "as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers" in order "to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans." Updated in 2013, the CLAS Standards

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[440] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52, 1179–1189.
[441] U.S. Surgeon General. (2001). Mental health: Culture, race, and ethnicity: A supplement to Mental health: A report of the Surgeon General. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[442] For more information, see: https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf
[443] American Psychological Association, Presidential Task Force on Immigration. (2012). Crossroads: The psychology of immigration in the new century. http://www.apa.org/topics/immigration/immigration-report.pdf
[444] U.S. Department of Health and Human Services (USDHHS), Office of Minority Health. (2001, March). National Standards for Cultural and Linguistically Appropriate Services in Health Care. https://minorityhealth.hhs.gov/assets/pdf/checked/finalreport.pdf

now include 15 standards addressing the broad themes of culturally competent care, language access, and organizational supports for cultural competence;[445] 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 or Latino, and American Indian groups is also available.[446] Guidance for multicultural applications is available as well.[447]

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

Integrated Primary Care

Integrated primary care (IPC) programs provide the opportunities to improve outcomes and promote a broader culture of medical care that includes physical, emotional, and behavioral health in treatment approaches. Annual well-child visits with primary care providers provide an excellent opportunity for children and youth to access both physical and behavioral health care, especially within comprehensive integrated primary care settings. Collaborative care programs, where primary care providers, care managers, and behavioral health specialists work as a team to provide patient care, can have a positive impact. A 2015 meta-analysis in the *Journal of the American Medical Association (JAMA) Pediatrics* indicated that "the probability was 66% that a randomly selected youth would have a better outcome after receiving integrated medical-behavioral treatment than a randomly selected youth after receiving usual care." [448]

A Meadows Mental Health Policy Institute 2016 report[449] proposed that IBH programs should include the following seven core components:

- Integrated organizational culture,
- Population health management,
- Structured use of a team approach,
- IBH staff competencies,
- Universal screening for the most prevalent primary health and behavioral health conditions,

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[445] U.S. Department of Health and Human Services. (2013). National Standards for Culturally and Linguistically Appropriate Services (CLAS) in health and health care. https://thinkculturalhealth.hhs.gov/assets/pdfs/EnhancedNationalCLASStandards.pdf

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

[447] For more information, see: https://www.cibhs.org/overview/adopting-culturally-competent-practices-accp-project for the overall site and https://www.cibhs.org/sites/main/files/file-attachments/final_summary_matrix.pdf for specific best practices demonstrated in California.

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

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

- Integrated person-centered treatment planning, and
- Systematic use of evidence-based clinical models.

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

Behavioral health integration in primary care settings increases access to behavioral health services for children and youth with mild-to-moderate mental health conditions. About 75% of children and youth with psychiatric disorders can be seen in the pediatrician's office.[450] Importantly, however, there are often significant limitations. Pediatricians typically do not deliver mental health services because of limited time during each patient visit, minimal training and knowledge of behavioral health disorders, concern about prescribing psychotropic medications, gaps in knowledge of local resources, and lack of knowledge about or limited access to behavioral health specialists.[451] 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.[452]

Behavioral health integration in primary care settings also aligns with the concept of the "medical home." According to the American Academy of Pediatrics, the pediatric health home — sometimes called the "pediatric medical home" — refers to "delivery of advanced primary 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."[453] 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.[454] These include the following strategies:[455]

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

[451] American Academy of Child and Adolescent Psychiatry. (2012, June).

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

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

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

[455] American Academy of Child and Adolescent Psychiatry. (2012, June).

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

Examples of Integrated Primary Care Models

Massachusetts Child Psychiatry Access Project (MCPAP) offers one promising approach to integrated care. Established in 2004, MCPAP is a national leader and model that has inspired many other states to create similar programs. It supports over 95% of the pediatric primary care providers in Massachusetts. MCPAP has six regional behavioral health consultation hubs, each with a child psychiatrist, a licensed therapist, and a care coordinator. Each hub also operates a dedicated hotline that can include the following services: timely over-the-phone clinical consultation, expedited face-to-face psychiatric consultation, care coordination for referrals to community behavioral health providers, and ongoing professional education designed for primary care providers. In 2014, following a MCPAP consultation, primary care providers reported managing 67% of the types of problems that they typically would have referred to a child psychiatrist before they enrolled in the program. The MCPAP model was so instrumental in providing accessible behavioral health care for children and youth that it expanded to develop MCPAP for Moms. Created in 2014, MCPAP for Moms is a collaborative model that involves obstetricians, internists, family physicians, and psychiatrists. Its mission is to promote maternal and child health for pregnant and postpartum women for up to one year after delivery to prevent, identify, and manage mental health and substance use disorders.[456]

Seattle Children's Partnership Access Line (PAL) is another leading model of integrating behavioral health care into primary care for children and youth. PAL is a telephone-based mental health consultation system that provides services to Washington and Wyoming. It is available to primary care physicians, nurse practitioners, and physician assistants. Users of this model receive a child mental health care guide and advice from a child psychiatrist that includes a summary of the consult conversation. In addition, the PAL program includes a social worker who can provide a list of local resources tailored to an individual patient and their insurance. If

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

a child needs to be evaluated in person, PAL helps link families to providers in their respective communities. PAL can assist with identifying locations that have telemedicine appointment available. The PAL team also provides educational presentations to primary care providers on aspects of managing behavioral health issues in the primary care setting. Primary care providers reported that in 87% of their consultation calls, they usually received new psychosocial treatment advice. They also reported that children with a history of foster care placements experienced a 132% increase in outpatient mental health visits after the consultation call. Feedback from primary care provider surveys also reported "uniformly positive satisfaction" with PAL.[457] In 2017, following the implementation of PAL, antipsychotic prescriptions for children enrolled in Washington State's Medicaid program decreased by nearly half.[458]

The **Health Care Management** program at Children's Health in Dallas, formerly Children's Medical Center, provides a promising approach to behavioral health care for children and youth. In 2013, Children's Health began an IBH program within its pediatric outpatient clinics. In July 2015, it was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. As of January 2017, the team included 10 licensed master's-level behavioral health clinicians (LPCs, LCSWs, and LMFTs) and two clinical psychologists. The behavioral health team provides consultation and direct treatment to patients who receive primary care in the outpatient clinics. Behavioral health screening tools for monitoring depression are administered and tracked with every well-child visit, starting at age 11. Implementation of these tools has contributed to studies that have shown excellent results, such as more than a 50% reduction in symptoms of depression. One strength of the program is a shared electronic medical record system that offers both primary care and specialty behavioral health providers access to a patient's records, enabling better care coordination. In addition, members of the behavioral health team are co-located with their primary care colleagues in the pediatric clinic setting, increasing accessibility to behavioral health care. The behavioral health team conducts educational presentations for primary care providers on topics such as depression, attention-deficit hyperactivity disorder, and parenting skills. Moreover, the behavioral health team meets internally every two weeks for formal case discussions and treatment planning. Finally, the program uses telemedicine to deliver primary care services to children and youth in local schools to increase access.

The Rees-Jones Center for Foster Care Excellence, located at Children's Health in Dallas, is another Texas-based best practice program. The Rees-Jones Center for Foster Care Excellence

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

[458] 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.

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

School-Based Mental Health Services

Prevention efforts shift as children (ages six to 12) enter school to focus on increasing positive social interactions, decreasing aggression and bullying, and increasing academic motivation. The education and mental health systems in the United States have a long history of providing mental health services to children. With the passage of the Education of All Handicapped Children Act in 1975 (reauthorized in 1990 as the Individuals with Disabilities Act, or IDEA), education systems were given greater responsibility to meet the needs of students with mental and behavioral health concerns.[459] Schools provide a natural setting for mental health services, including prevention.[460, 461] In fact, studies show that for many children and youth, schools seem to be their primary mental health system (one finding showed that for children who receive any type of mental health service, over 70% receive the service from their school).[462] Schoolwide prevention and services that promote behavioral health reduce violence and create a positive school climate that benefits all students.[463]

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

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

[461] Hoover, S., Bracey, J., Lever, N., Lang, J., & Vanderploeg, J. (2018). Healthy students and thriving schools: A comprehensive approach for addressing students' trauma and mental health needs. Child Health and Development Institute of Connecticut. https://www.chdi.org/index.php/publications/reports/impact-reports/health-students-and-thriving-schools

[462] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support

[463] Barrett, S., Eber, L., & Weist, M. (2013).

School-based behavioral health and prevention are best implemented through a public health approach.[464] The public health model could provide a framework that spans the broad range of age groups and challenges seen in public school systems and could support the following recommendations for enhancing school-based mental health services models:

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

Other sources point out emerging trends and practices in school mental health that highlight successful collaboration between schools, communities, and families.[465] As such, several EBPs build on prevention efforts and provide diverse community-based approaches for addressing mental health needs within a school environment. These approaches are summarized below.

Community-Partnered School Behavioral Health (CP-SBH) is a term used for supporting student behavioral health along the full prevention-intervention continuum by bringing together community behavioral health providers with schools and families. These community providers augment existing school resources to provide a more comprehensive array of services (e.g., trauma-informed care, medication management, substance use prevention) within the school building.[466] These partnerships allow schools to expand their behavioral health capacity through enhanced staffing, resources, skills, and knowledge. Comprehensive service provision through CP-SBH can include screening prevention for students identified as at risk for behavioral health problems, and specialized intervention services such as clinical assessment and treatment. CP-SBH programs share several best practice policies and procedures, including establishing and maintaining effective partnerships, integrating community-partnered school behavioral health into multi-tiered systems of support (universal prevention, targeted prevention, individualized intervention and supports, specialized support for substance use and abuse problems), and utilizing empirically supported treatments. In addition, CP-SBH programs also focus on facilitating family-school-community teaming; collecting, analyzing, and utilizing data; and obtaining, sustaining, and leveraging diverse funding streams.[467] Some of the advantages of this approach include improving access to behavioral health services, reducing

[464] Barrett, S., Eber, L., & Weist, M. (2013).
[465] Weist, M. D., & Murray, M. (2007). Advancing school mental health promotion globally. Advances in School Mental Health Promotion, Inaugural Issue, 2-12. http://dx.doi.org/10.1080/1754730X.2008.9715740. as cited in Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support
[466] 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.
[467] Lever, N., Stephan, S., Castle, M., Bernstein, L., Connors, E., Sharma, R., & Blizzard, A. (2015).

the stigma of seeking services, being able to generalize treatment to the child's school environment, and having an impact on attendance and educational outcomes.

Schoolwide initiatives such as **Positive Behavioral Interventions and Supports** (PBIS) have significantly decreased aggressive incidents among students and have increased the comfort and confidence of school staff within the school environment. PBIS is a school-based application of a behaviorally-based systems approach to enhance the capacity of schools, families, and communities to design effective environments that improve the link between research-validated practices and the environments in which teaching and learning occurs. The model includes primary (schoolwide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant – while making desired behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment; (2) comprehensive intervention, and (3) lifestyle enhancement.[468, 469, 470, 471] The value of schoolwide PBIS integrated with mental health services and supports, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent (80%) of students fall into the first tier. For them, schoolwide PBIS creates "a social environment that reinforces positive behavior and discourages unacceptable behaviors."[472] 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"[473] and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can receive intensive services through partnerships between the school, the mental health system, other child-serving agencies, and family. For more information about this approach and its specific interventions, see: https://www.pbis.org/.

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

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[468] Adelman, H. S., & Taylor, L. (1998). Reframing mental health in schools and expanding school reform. Educational Psychologist, 33, 135–152.
[469] 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.
[470] Koegel, L. K., Koegel, R. L. & Dunlap, G. (Eds.). (1996). Positive behavioral support: Including people with difficult behavior in the community. Paul H. Brookes.
[471] Positive Behavior Interventions and Supports website is located at https://www.pbis.org
[472] Bazelon Center. (2006). Way to go: School success for children with mental health care needs. http://www.bazelon.org/wp-content/uploads/2017/01/Way_to_Go.pdf
[473] Bazelon Center. (2006).

additional needs, a team approach to the development and evaluation of alternative interventions, a multi-tiered application of evidence-based instruction determined by identified need, continuous monitoring of the intervention, and parent involvement throughout the process.[474]

- In Colorado, MTSS is a prevention-based framework for improving the outcomes of all students. The essential components of this multi-tiered approach include team-driven shared leadership; data-based problem solving; partnerships with families, schools, and communities; a layered continuum of supports matched to the student's need (from universal to targeted to intensive); and instruction, assessment, and intervention that are evidence-based.[475]
- In California, the MTSS framework has resources and initiatives to address all students' needs. It organizes academic, behavioral, and social and emotional learning into an integrated system of supports for all students. It encompasses Response to Instruction and Intervention and PBIS, and aligns those supports to better serve each student.[476] The model integrates data collection and assessment to inform decisions.

The Interconnected Systems Framework (ISF) helps expand the MTSS framework by including community providers in key roles, such as decision-making, selection and implementation of EBPs, monitoring, and ongoing coaching. ISF brings together Response to Intervention,[477] PBIS, and school mental health services in a framework that enhances all approaches, extends the array of mental health supports for students and families, and meets the need for an overarching framework for implementing evidence-based interventions through collaboration between schools and community providers.[478] ISF addresses limitations of PBIS' insufficient development in targeted prevention and specialized intervention for students with more complicated behavioral health concerns. ISF also targets the lack of structure in the implementation of school mental health services (which contributes to high variability in services and school staff not being aware of these services), the poor use of data, and the general disconnect between mental health and targeted prevention and specialized intervention services.[479]

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[474] Positive Behavioral Interventions and Supports OSEP Technical Assistance Center. (n.d.). Tiered framework. https://www.pbis.org/pbis/tiered-framework
[475] Colorado Department of Education. (n.d.). Multi-Tiered System of Supports (MTSS). https://www.cde.state.co.us/mtss
[476] California Department of Education. (2019, July). Definition of MTSS. https://www.cde.ca.gov/ci/cr/ri/mtsscomprti2.asp
[477] Response to Intervention is an approach that assists in the identification of students with learning and behavioral needs. For more information, see: https://www.cde.ca.gov/ci/cr/ri/
[478] Barrett, S., Eber, L., & Weist, M. (2013). Advancing education effectiveness: Interconnecting school mental health and school-wide positive behavior support. https://www.pbis.org/resource/advancing-education-effectiveness-interconnecting-school-mental-health-and-school-wide-positive-behavior-support
[479] Barrett, S., Eber, L., & Weist, M. (2013).

Restorative Justice is a practice based on an intervention from the criminal justice field that holds people convicted of crimes accountable by having them face the people they have harmed. Within schools, restorative justice programs use a similar process of holding students accountable for their behavior and providing them with opportunities for making amends and repairing relationships. The overall goals of this practice are to help decrease challenging behaviors among students and reduce rates of suspensions.[480]

- One example of a model restorative justice program is Restorative Justice for Oakland Youth (RJOY), created in 2005 to support collaboration in developing restorative practices in schools, the juvenile justice system, and the greater Oakland community. RJOY engages families and communities to positively impact school discipline, racial disparities, and school climate in order to interrupt punitive school discipline and criminal justice policies. This program provides education, training, and technical assistance and, since 2010, has focused on helping schools build capacity for their own restorative justice programs.[481] Outcomes for RJOY include the following: [482]
  - Since the 2011–12 school years, Oakland Unified School District schools that received RJOY training reduced the suspension rate of African American boys by 25%.
  - According to state and local data, RJOY's West Oakland Middle School pilot project eliminated expulsions and reduced suspensions by over 75%.
  - In 2010, the Oakland Unified School District adopted restorative justice as a systemwide alternative to zero-tolerance practices, largely influenced by RJOY.
- The Denver Public Schools Restorative Justice Project also serves as a model example.[483] In the 2007–2008 school year, over 1,000 referrals were made for restorative justice services (unduplicated count of 812 students), with almost 180 of these cases being provided in lieu of suspension or for reduced out-of-school suspension as a result of the referral. Over half (52%) of the cases resulted in a "restorative agreement." Students, parents, and teachers all gave strong endorsement for the restorative justice process, noting its fairness and helpfulness with resolving conflicts as well as its influence on students' improvements in listening skills, empathy, anger control, respect, and appropriate reparative action planning. All participating schools showed reductions in out-of-school suspensions and expulsions compared to the prior year's total.[484]

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

[481] RJOY. (n.d.). About us. Our history. https://rjoyoakland.org/about-us/

[482] Jain, S., Bassey, H., Brown, M., & Kalra, P. (2014). Restorative justice in Oakland schools: An effective strategy to reduce racially disproportionate discipline, suspensions and improve academic outcomes. https://www.ousd.org/cms/lib/CA01001176/Centricity/Domain/134/OUSD-RJ%20Report%20revised%20Final.pdf

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

[484] Baker, M. L. (2008).

Interpersonal Psychotherapy for Adolescents Skills Training (IPT-AST) is a manualized program delivered by mental health clinicians at schools. The program aims to decrease depressive symptoms by helping youth improve their relationships and interpersonal interactions. The psychotherapy group teaches youth communication strategies and interpersonal problem-solving skills that they can apply to their relationships. In order to implement IPT-AST to fidelity, training must be received through the treatment developers. For more information about IPT-AST, see: https://policylab.chop.edu/people/jami-young.

The **Cognitive Behavioral Intervention for Trauma in Schools** (CBITS) program focuses primarily on reducing symptoms of posttraumatic stress disorder, depression, and behavioral problems for children and youth in grades three through eight. CBITS, which was first used in the 2000–2001 school year in the Los Angeles Unified School District, adopts a school-based group and intervention focus. Although primarily directed toward younger children, CBITS has been 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.[485] In order to implement CBITS to fidelity, training and certification must be received through the treatment developers. For more information about CBITS, see: https://cbitsprogram.org/.

Teacher-Child Interaction Therapy (TCIT) is a professional development, train-the-trainer-model designed to strengthen teacher-child relationship skills for children with disruptive behavior or those at risk of developing disruptive behavior. It is a prevention and intervention program. TCIT is implemented in elementary schools or early childcare settings. In order to implement TCIT to fidelity, training and certification must be received through the treatment developers. For more information about TCIT, see: http://www.tcit.org or https://pcit-training.com/teacher-child-interaction-training-training-calendar/.

Promoting Alternative Thinking Strategies (PATHS) is a program designed to reduce aggressive behavior and increase social competencies in children ages four to 12 years. The curriculum is designed to be used by educators to help children with poor classroom behavior and performance. Although primarily focused on the school setting (small groups and classroom), information and activities are also included for use with parents. In order to implement PATHS to fidelity, training and certification must be received through the treatment developers. For more information about PATHS, see: http://www.pathstraining.com/main/.

[485] Treatment and Services Adaption Center (n.d.). Cognitive behavioral intervention for trauma in schools. https://traumaawareschools.org/cbits

Think:Kids is a program that uses a collaborative problem-solving approach with students in a school environment. The program teaches skills related to problem solving, flexibility, and frustration tolerance. Unlike traditional models of discipline, this approach avoids the use of power, control, and motivational procedures; instead, it focuses on building helping relationships and teaching children and youth the skills they need to succeed. Documented outcomes included reductions in time out of the classroom, detentions, suspensions, injuries, teacher stress, and alternative school placement. In order to implement Think:Kids to fidelity, training and certification must be received through the model developers. For more information about Think:Kids, see: http://www.thinkkids.org/train/certification/.

Clinic and Home-Based Interventions

There is growing evidence that in most situations, children and youth can be effectively served in their homes and communities and that community-based treatment programs are often superior to institution-based programs. Studies show that except for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting or repeated sexual offenses), programs in community settings are more effective than those in institutional settings; intensive, community-based, and family-centered interventions are the most promising.[486] Even children and youth with serious emotional disturbances and longstanding difficulties can make and sustain larger gains in functioning when treatment is provided in a family-focused and youth-centered manner within their communities.

The development and dissemination of evidence-based psychosocial interventions for children and youth has rapidly expanded in recent years. The ideal system would have well-established treatment protocols offered in clinics, schools, or homes with the objectives of (1) decreasing problematic symptoms and behaviors, (2) increasing youth and parent skills and coping, and (3) preventing out-of-home placement. This section describes EBPs for specific referral problems. This list is not meant to be exhaustive; rather, it provides examples that can be used as resources. In addition, a host of clinical trials are underway and treatment protocols are being developed that will continually inform and improve the use of EBPs in the months and years to come. The EBPs discussed below fall under the umbrella categories of behavioral therapy or cognitive behavioral therapy in that the focus of intervention is on the cognitions, emotions, or behaviors of the child, youth, caregiver, or teacher, and on the variables that predict these outcomes.

[486] Blau, G. M., Caldwell, B., & Lieberman, R. (eds.) (2014). Residential interventions for children adolescents and families: A best practice guide. Routledge Press.

Disruptive Behaviors

The Incredible Years[487] focuses on reducing disruptive behavior and preventing conduct problems, targeting infants to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and instruction of social skills). This curriculum particularly targets risk factors for conduct disorder and promotes a positive environment for the child both in the home and at school. In order to implement the Incredible Years program to fidelity, training and certification must be received through the treatment developers. For more information about the Incredible Years, see: http://www.incredibleyears.com/.

Positive Parenting Program (Triple P)[488] is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems in their children. Triple P includes five levels of varying intensity (from the dissemination of printed materials to eight- to 10-session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive behavioral, and developmental theories in combination with studies of risk and protective factors for these problems, Triple P aims to increase the knowledge and confidence of parents in dealing with their children's behavioral issues. In order to implement Triple P to fidelity, training and certification must be received through the treatment developers. For more information about Triple P, see: www.triplep.net.

Parent Management Training – The Oregon Model (PMTO) promotes social skills and prevents, reduces, and reverses the development of moderate-to-severe conduct problems in children and youth. PMTO focuses on parent training, classroom behavior management, and peer interventions. In order to implement PMTO to fidelity, training and certification must be received through the treatment developers. For more information about PMTO, see: https://www.generationpmto.org/.

Coping Power Program reduces disruptive behavior in school and home settings. Originally it was developed as a school-based program and has since been adapted to be delivered in outpatient mental health settings. The program is offered to late elementary and middle school students. Its curriculum components focus on skills to enhance emotional awareness, organizational skills, problem solving, goal setting, and social skills. These skills are taught in cognitive behavioral group sessions provided in schools, individual sessions at clinics, and behavioral training groups for parents and guardians. In order to implement the Coping Power

[487] 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.
[488] 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.

Program to fidelity, training and certification must be received through the treatment developers. For more information about the Coping Power Program, see: https://www.copingpower.com.

Problem Solving Skills Training (PSST) reduces oppositional, aggressive, and antisocial behavior in children ages seven to 14 years. The program uses a cognitive behavioral method to teach parents and children more skillful behavior. Children are typically given homework to help them practice implementing these skills. Most sessions are individual, but parents may be brought in to observe and to learn how to assist in reinforcing new skills. In order to implement PSST to fidelity training must be received through the treatment developers. For more information about PSST, see: https://yaleparentingcenter.yale.edu/.

Parent-Child Interaction Therapy (PCIT) has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders.[489, 490, 491] PCIT works by improving parent-child attachment by coaching parents on how to manage their child's behavior. It uses structural play and specific communication skills to help parents implement constructive discipline and limit setting. PCIT teaches parents how to assess their child's immediate behavior and give feedback while an interaction is occurring. In addition, parents learn how to give their children direction toward positive behavior. A therapist guides parents through education and skill-building sessions and oversees practice sessions with the child. PCIT has been adapted for use with Hispanic or Latino and American Indian families. In order to implement PCIT to fidelity, training and certification must be received through the treatment developers at PCIT International. For more information about PCIT, see: http://www.pcit.org/.

Multisystemic Therapy (MST) is a well-established EBP for youth living at home with more severe behavioral problems related to willful misconduct and delinquency , and it has proven outcomes and cost benefits when implemented with fidelity.[492, 493] In addition, the developers are currently working to create 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

[489] 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.
[490] Eyberg, S. M. (2003). Parent-child interaction therapy. In T. H. Ollendick & C. S. Schroeder (Eds.) Encyclopedia of Clinical Child and Pediatric Psychology. Plenum.
[491] 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.
[492] 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.
[493] Schoenwald S. K., Henggeler S. W., Pickrel S. G., & Cunningham, P. B. (1996). Treating seriously troubled youths and families in their contexts: Multisystemic therapy. In M. C. Roberts (Ed.), Model programs in child and family mental health, 317–332. Lawrence.

natural environment at times convenient to the family. MST has low caseloads and varying frequency, duration, and intensity levels. It is based on social-ecological theory that views behavior as best understood in its naturally occurring context and was developed to address major limitations in serving juvenile offenders, focusing on changing the determinants of antisocial behavior in youth.[494] At its core, MST assumes that problems are multi-determined and that to be effective, treatment needs to impact multiple systems, such as a youth's family and peer group. Accordingly, MST is designed to increase family functioning by helping parents improve how they monitor their children, reducing familial conflict, improving communication, and related factors. Additionally, MST interventions focus on increasing the youth's interaction with "prosocial" peers and reducing their association with "deviant" peers, primarily through parental mediation.[495] **MST-Psychiatric** (MST-P) uses a similar approach to MST but is adapted for youth with serious emotional disorders. In order to implement MST and MST-P to fidelity, training and certification must be received through the treatment developers at MST Services. For more information about MST, see: http://www.mstservices.com/.

Multidimensional Family Therapy (MDFT) is a family-based program designed to treat a range of problem behaviors in youth, such as "substance abuse, delinquency, antisocial and aggressive behaviors, school and family problems, and emotional difficulties."[496] MDFT has good support for white, African American, and Hispanic or Latino youth between the ages of 11 and 18 across urban, suburban, and rural settings.[497, 498, 499] Treatment usually lasts four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels: (1) with the youth and parents individually, (2) with the family as an interacting system, and (3) with individuals in the family relative to their interactions with influential social systems (e.g., school, juvenile justice) that affect the youth's development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth's everyday life. MDFT can operate as a standalone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing

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[494] 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.

[495] 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.

[496] For more information see: http://www.mdft.org/MDFT-Program/What-is-MDFT

[497] 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.

[498] 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.

[499] Liddle H. A., Dakof, G. A., Parker K., Diamond G. S., Barrett K., Tejeda, M. (2001). Multidimensional Family Therapy for adolescent drug abuse: Results of a randomized clinical trial. American Journal of Drug and Alcohol Abuse, 27, 651–687.

community-based drug treatment programs, including hospital-based day treatment programs. In order to implement MDFT to fidelity, training and certification must be received through the treatment developers. For more information about MDFT, see: http://www.mdft.org/.

Treatment Foster Care Oregon (TFCO) is a program that provides youth with (1) a consistent reinforcing environment where they are mentored, (2) daily structure, (3) close supervision of their whereabouts, and (4) help to avoid deviant peer associations while providing them with the support and assistance needed to establish prosocial peer relationships. TFCO also has program versions for children and youth ages three to 18 years. In order to implement TFCO to fidelity, training and certification must be received through the treatment developers. For more information about TFCO, see: https://www.tfcoregon.com.

Autism Spectrum Disorders

Applied Behavior Analysis (ABA) has good support for the treatment of autism, particularly in young children.[500, 501, 502, 503, 504, 505] ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for anywhere from two weeks to 11 months. ABA is one of the most widely used approaches with children and youth with autism. The ABA approach teaches social, motor, and verbal behaviors as well as reasoning skills. ABA teaches skills through the use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training for therapists, extensive time spent in ABA therapy (20 to 40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be involved in helping generate these skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit. In order to implement ABA to fidelity, ABA therapists must obtain certification as a Board Certified Behavior Analyst® (BCBA® or BCBA-D). For more information about ABA, see: https://www.bacb.com.

[500] 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.
[501] 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.
[502] McConachie, H. & Diggle, T. (2007). Parent implemented early intervention for young children with autism spectrum disorder: A systematic review. Journal of Evaluation in Clinical Practice, 13(1), 120–129.
[503] 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.
[504] 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.
[505] 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.

Anxiety

Cognitive Behavioral Therapy (CBT) has demonstrated significant and enduring treatment outcomes, and effects lasting for a minimum of one year after treatment.[506] Furthermore, researched CBT interventions showed the greatest amount of diversity among study participants, treatment format, treatment setting, and therapist background. CBT is most frequently provided in individual or group therapy, parent training, or teacher consultation. These protocols involve a *cognitive* component — sessions dedicated to psychoeducation, recognizing the physical signs of anxiety, direct work on cognitive distortions, and instructions on coping skills. These protocols also involve a *behavioral* component, which is referred to as exposure and response prevention. Generally, the younger the child, the more parent training is involved in these protocols. There is typically more emphasis on exposure and response prevention than on cognitions, which can be difficult to assess in young children.

CBT protocols are effective for many different kinds of anxiety disorders (e.g., separation anxiety, phobias, obsessive-compulsive disorder). For these different diagnoses, the focus of the treatment differs, but all of the protocols will gradually and systematically help children approach their fears and decrease their avoidance (e.g., avoiding separation from caregivers in the case of separation anxiety, or avoiding social situations in the case of social anxiety).

- Social Effectiveness Therapy for Children and Adolescents (SET-C) [507] is an exposure and response prevention protocol for children and youth ages seven to 17 years that targets social phobia. This protocol includes group social skills training, peer generalization sessions, and individual exposure therapy sessions.
- FRIENDS[508] is a family-based, group cognitive-behavioral treatment for children and youth ages seven to 16 years who meet criteria for depression or generalized anxiety disorder, social phobia, or separation anxiety disorder. Although primarily developed for implementation in a group format by trained mental health providers, it can also be delivered in individual session format and implemented by teachers, counselors, and youth workers who have undergone accredited training.
- Coping Cat Parents[509] is a 16-session, cognitive behavioral protocol for children ages seven to 13 years who meet criteria for generalized anxiety disorder, social phobia, or separation anxiety disorder. The protocol involves individual sessions with the child or

[506] Higa-McMillan, C. K., Francis, S. E., Rith-Najarian, L., & Chorpita, B. F. (2015). Evidence-based update: 50 years of research on treatment for children and adolescent anxiety. Journal of Clinical Child & Adolescent Psychology, 45(2), 91–113. http://www.tandfonline.com/doi/full/10.1080/15374416.2015.1046177
[507] Beidel, D. C., Turner, S. M., Sallee, F. R., Ammerman, R. T., Crosby, L. A., et al. (2007). SET-C versus fluoxetine in the treatment of childhood social phobia. Journal of the American Academy of Child and Adolescent Psychiatry, 46, 1622–1632.
[508] Shortt, A. L., Barrett, P. M., & Fox, T. L. (2001). Evaluating the FRIENDS program. Journal of Clinical Child Psychology, 30, 525–535.
[509] For more information about Coping Cat Parents, see: https://www.copingcatparents.com

youth, and parent training sessions. There is an adolescent version of this protocol (C.A.T. Project) for youth ages 14 to 17 years.

- Acceptance and Commitment Therapy (ACT)[510] is considered a "third wave" CBT protocol. This approach differs from traditional CBT in that the aim is not better control of thoughts, emotions, sensations, memories, but rather mindfulness to and acceptance of these private experiences. ACT demonstrates greater changes in psychological flexibility, mindfulness, and valued living as compared to CBT. ACT has been studied in youth with social anxiety, obsessive-compulsive spectrum disorders, and depression. There are a variety of protocols for ACT depending on the setting or target population.

These protocols are most frequently taught in doctoral programs for clinical child psychologists. Continuing education in CBT for already licensed professionals can be obtained through the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (https://beckinstitute.org/certification/),
- The Academy of Cognitive Therapy (https://www.academyofct.org/page/Certification), and
- The National Association of Cognitive-Behavioral Therapists (http://www.nacbt.org/certifications-htm/).

Mood Disorders

CBT[511, 512, 513] has been the most widely researched treatment for **adolescent depression**. There are many individual protocols for CBT for youth. These protocols are most frequently taught in doctoral programs for clinical child psychologists. As noted above, continuing education in CBT for already licensed professionals can be obtained via the following organizations:

- The Beck Institute for Cognitive Behavioral Therapy (https://beckinstitute.org/certification/),
- The Academy of Cognitive Therapy (https://www.academyofct.org/page/Certification), and

[510] Forman, E. M., Herbert, J. D., Moitra, E., Yeomans, P. D., & Geller, P. A. (2007). A randomized controlled effectiveness trial of acceptance and commitment therapy and cognitive therapy for anxiety and depression. Behavior Modification, 31(6), 772–799.
[511] March, J., Silva, S., Petrycki, S., et al. (2004). Fluoxetine, cognitive-behavioral therapy, and their combination for adolescents with depression: Treatment for Adolescents with Depression Study (TADS) randomized controlled trial. Journal of the American Medical Association, 292(7), 807–20.
[512] March, J., Silva, S., Petrycki, S., et al. (2007). The Treatment for Adolescents with Depression Study (TADS): Long-term effectiveness and safety outcomes. Archives of General Psychiatry, 64(10), 1132–1143.
[513] Klein, J., Jacobs, R., & Reinecke, M. (2007). Cognitive-behavioral therapy for adolescent depression: A meta-analytic investigation of changes in effect-size estimates. Journal of the American Academy of Child and Adolescent Psychiatry, 46(11), 1403–1413.

- The National Association of Cognitive-Behavioral Therapists (http://www.nacbt.org/certifications-htm/).

Family Focused Treatment for Adolescents (FFT-A) is a psychosocial treatment for youth with bipolar disorder that consists of 21 sessions (12 weekly, six biweekly, and three monthly) for nine months. Sessions involve the youth with bipolar disorder, their parents, and available siblings. The focus of the first seven to 10 sessions is psychoeducation. Later, the focus is on communication enhancement training and problem-solving skills training. In order to implement FFT to fidelity, training must be received through the treatment developer at **David Miklowitz, PhD, who can be contacted at** dmiklowitz@mednet.ucla.edu.

Multi-Family Psychoeducational Psychotherapy (MF-PEP) is an eight-session (90 minutes per session) group treatment for children ages eight to 12 years old with mood disorders. Sessions begin and end with children and parents together; the bulk of each session is run separately for parents and children. In order to implement MF-PEP to fidelity, training must be received through the treatment developer **Mary A. Fristad, PhD, ABPP, whose background and contact information can be found at this link:** https://wexnermedical.osu.edu/neurological-institute/researchers/mary-fristad-phd-abpp.

Interpersonal Psychotherapy for Adolescents (IPT-A) is a treatment for adolescent depression that focuses on how interpersonal issues are related to the onset or maintenance of depressive symptoms. The treatment addresses emotion regulation, communication, and problem-solving skills. In order to implement IPT-A to fidelity, training must be received through the treatment developer Laura Mufson, PhD, whose background and contact information can be found at this link: https://www.columbiapsychiatry.org/profile/laura-mufson-phd.

Trauma-Related Disorders

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) has strong support for efficacy with children and youth ages three to 18 years and their parents.[514, 515, 516, 517] It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem, and other symptoms related to traumatic experiences. This treatment intervention is

[514] 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.
[515] 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.
[516] 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.
[517] Stein, B., Jaycox, L., Kataoka, S., Wong, M., Tu, W., Elliott, M., & Fink, A. (2003). A mental health intervention for school children exposed to violence: A randomized controlled trail. Journal of the American Medical Association, 290(5), 603–611.

designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies to enhance children and youth's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as intrusive thoughts of the traumatic event, avoidance of reminders of the trauma, emotional numbing, excessive physical arousal/activity, irritability, and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children and youth, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic or Latino children and youth and some of its assessment instruments are available in Spanish.[518] In order to implement TF-CBT to fidelity, training and certification must be received through the treatment developers at the TF-CBT National Therapist Certification Program: https://tfcbt.org/.

Prolonged Exposure Therapy for Adolescents (PE-A) is a treatment that facilitates adolescents' processing of trauma through in vivo and imaginal exposure techniques. PE-A emphasizes psychoeducation and behavioral relaxation training. In order to implement PE-A to fidelity, training and certification must be received through the treatment developers at: https://www.med.upenn.edu/ctsa/pe_certification.html.

Cognitive Processing Therapy is a treatment for trauma that uses cognitive modification, exposure, and behavioral activation techniques. In order to implement cognitive processing therapy to fidelity, training and certification must be received through the treatment developers at: https://cptforptsd.com/achieving-provider-status/.

Suicidal and Self-Injurious Behaviors

Dialectical Behavior Therapy (DBT) is an evidence-based form of cognitive behavioral therapy for people who experience significant trouble managing their emotions, thoughts, and behaviors. DBT is well supported for adults and adolescents (DBT-A),[519, 520, 521] and has moderate support for children (DBT-C) with severe emotion dysregulation. DBT-A includes parents or other caregivers in the skills training group. This inclusion allows parents and caregivers to

[518] 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.
[519] 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.
[520] Rathus, J. H. & Miller, A. L. (2002). Dialectical Behavior Therapy adapted for suicidal youth. Suicide and Life-Threatening Behavior, 32, 146-157.
[521] 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.

coach their adolescents in developing skills and also improve their own skills for interacting with their adolescent. Therapy sessions usually occur twice a week. DBT strategies include both acceptance-oriented (validation) and more change-oriented (problem-solving) approaches. DBT proposes that comprehensive treatment needs to help children and youth develop new skills, address motivational obstacles to implementing these skills, and generalize what they learn to their daily lives. It also needs to keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed through four different modes that support treatment delivery: group skills training, individual psychotherapy, telephone coaching between sessions, and a therapist consultation team meeting. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Eating Disorders

Dialectical Behavior Therapy: Specific adaptations of the original DBT model have been developed for eating disorders. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Family-Based Therapy (FBT or "Maudsley Approach") is an intensive outpatient treatment where parents play an active role in helping their youth restore their weight to normal levels. In order to implement FBT to fidelity, training and certification must be received through the treatment developers at: http://train2treat4ed.com/fbt-for-anorexia-nervosa.

Substance Use Disorder

Multidimensional Family Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mdft.org/.

Multisystemic Therapy: See our summary in the Disruptive Behaviors subsection and, for more details, see: http://www.mstservices.com/.

Dialectical Behavior Therapy: See our summary in the Suicidal and Self-Injurious Behaviors subsection for more details. Specific adaptations of DBT have been developed for substance use disorder. In order to implement DBT to fidelity, training and certification must be received through the treatment developers at Behavioral Tech: https://behavioraltech.org/.

Brief Strategic Family Therapy is a problem-focused, family-based approach to eliminating substance use disorder risk factors. It targets problem behaviors in children and youth ages six to 17 years and strengthens family functioning. Brief Strategic Family Therapy provides families

with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill-building strategies to strengthen family relationships. It targets conduct problems, associations with anti-social peers, early substance use, and problematic family relations; it also has support for use with Hispanic families.[522, 523] In order to implement Brief Strategic Family Therapy to fidelity, training and certification must be received through the treatment developers at: http://www.bsft.org/.

Functional Family Therapy (FFT) is a short-term (approximately 30 hours) family therapy intervention and juvenile diversion program for children and youth ages of 11 and 18 who are at risk of substance use disorder, and their families, targeting a range of behavior problems, including violence, drug use, and conduct disorder as well as family conflict. FFT targets intervention toward multiple areas of family functioning and ecology and features well-developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement.[524] FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout from services. Intervention incorporates community resources for maintaining, generalizing, and supporting family change.[525] In order to implement FFT fidelity, training and certification must be received through the treatment developers at: https://www.fftllc.com/.

Motivational Interviewing (MI) is an evidence-based approach to help people address their ambivalence to change. There are four core principles: express empathy, roll with resistance, develop discrepancy, and support self-efficacy.[526] Multiple disciplines use MI and much of the literature focuses on reducing the use of substances and addressing co-occurring (mental health and substance use) disorders.[527]

Risk of Out-of-Home Placement

Parents play a major role in these empirically-supported treatment protocols. Without a stable caregiver, many of the protocols described above would be difficult to implement effectively.

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[522] 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.
[523] Szapocznik, J., Hervis, O., Schwartz, S. (2003). Therapy manuals for drug addiction. Brief strategic family therapy for adolescent drug use. U.S. Department of Health and Human Services. http://www.nida.nih.gov/pdf/Manual5.pdf
[524] Alexander, J., Barton, C., Gordon, D., Grotpeter, J., Hansson, K., Harrison, R., et al. (1998). Blueprints for violence prevention series, book three: Functional family therapy (FFT). Center for the Study and Prevention of Violence.
[525] 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.
[526] Cole, S., Bogenschutz, M., & Hungerford, D. (2011). Motivational interviewing and psychiatry: Use of addiction treatment, risky drinking and routine practice. Focus: The Journal of Lifelong Learning in Psychiatry, (9)1, 42-54. https://focus.psychiatryonline.org/doi/abs/10.1176/foc.9.1.foc42
[527] Cole, S., Bogenschutz, M., & Hungerford, D. (2011).

Therefore, for children and youth who are at risk for out-of-home placement, the following programs should be considered in addition to the EBPs discussed above.

Wraparound Service Coordination (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals, alongside youth and family partners, for children and youth involved with multiple systems who are at the highest risk for out-of-home placement.[528, 529, 530] Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative, and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the child or youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of children and youth and their family members. Finally, there is an emphasis on integrating children and youth into the community and building the family's social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, who are joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports that are involved with the family, with the family and child/youth ultimately driving the process. The wraparound process involves multiple phases, with responsibility for care coordination increasingly shifting from the wraparound facilitator and the CFT to the family.[531]

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 of psychosis is important since people with psychoses typically do not receive care

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[528] Bruns, E. J., Walker, J. S., Adams, J., Miles, P., Osher, T. W., Rast, J., VanDenBerg, J. D. & National Wraparound Initiative Advisory Group. (2004). Ten principles of the wraparound process. National Wraparound Initiative, Research, and Training Center on Family Support and Children's Mental Health, Portland State University.
[529] Aos, S., Phipps, P., Barnoski, R., & Lieb, R. (2001). The comparative costs and benefits of programs to reduce crime. Washington State Institute for Public Policy.
[530] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H., & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52, 1179–1189.
[531] 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

and treatment until five years after the onset of symptoms.[532] The CSC team provides community education activities and develops strategic partnerships with key entities in the community, which are critical elements of the program. The team also plays a role in detecting emerging psychosis and creating channels through which youth and young adults can be referred for treatment. CSC is individually tailored to the person experiencing early psychosis and it actively engages the family in supporting recovery. CSC provides effective treatments for psychosis, including medication management, individual therapy, and illnesses management as well as other less common evidence-based approaches such as Supported Education and Supported Employment that are known to help people with serious mental illnesses retain or recover a meaningful life in the community. The ultimate goal of CSC is to provide effective treatment and support as early in the illness process as possible so that people can remain on a healthy developmental path. A 2016 study by Kane and colleagues on the multi-site Recovery After an Initial Schizophrenia Episode (RAISE) study (conducted across 34 clinics in 21 states) showed that study participants had a better quality of life and were more involved in work and school, especially when they received CSC within the first 17 months of the onset of psychosis.[533] CSC was better than care as usual at helping people remain on a normal developmental path. Researchers have also compared the costs of CSC to care as usual and found that CSC was less expensive per unit of improvement in quality of life.[534] According to the CSC model on which the two RAISE programs are based,[535] teams should, at a minimum, consist of the following:[536]

- A team leader or coordinator (PhD or master's degree) who is responsible for the client's overall treatment plan and programming as well as the team's coordination and functioning;
- A psychiatrist[537] trained in treatment of early psychosis, who provides medication management, actively monitors and helps ameliorate medication side effects, and coordinates treatment with primary care and other specialty medical providers;

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[532] 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.

[533] 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.

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

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

[536] 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.

[537] Some programs might choose to utilize advanced psychiatric nurse practitioners, but the University of Texas Southwestern (UTSW) Psychosis Center plans to employ psychiatrists in this important role.

- 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.[538] This position should be filled by a person who has experienced serious mental illness and has been able to recover from it or develop a productive and satisfying life while continuing to receive treatment.

Assertive Community Treatment (ACT) for Transition-Age Youth uses a recovery/resilience orientation that offers community-based, intensive case management and skills building in various life domains. It also includes medication management and substance use disorder services for youth ages 18 to 21 with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance use disorder specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. Most ACT services are delivered to the consumer within their home and community rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or assistance. The most recent conceptualizations of ACT include peer specialists as integral team members. ACT is intended to serve individuals with severe and persistent mental illness, significant functional impairments (such as difficulty with maintaining housing or

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

employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).[539, 540, 541]

The **Intensive In-Home and Child and Adolescent Psychiatric Services** (IICAPS) model was developed by Yale University to provide a home-based alternative to inpatient treatment for children and youth returning from out-of-home care or who are at risk of requiring out-of-home care because of psychiatric, emotional, or behavioral difficulties. Services are provided by a clinical team that includes a master's-level clinician and a bachelor's-level mental health counselor. The clinical team is supported by a clinical supervisor and a child and adolescent psychiatrist. IICAPS services are typically delivered for an average of six months. IICAPS staff also provide emergency crisis response 24 hours a day, seven days a week.

HOMEBUILDERS is an intensive family preservation program designed for children and youth from birth to 17 years who are at imminent risk of out-of-home placement or scheduled to reunify with their families within a week. The program uses intensive, onsite intervention aimed at teaching families problem-solving skills that might prevent future crises. HOMEBUILDERS is structured around a quality enhancement system, QUEST, which supports a three-part methodology (delineation of standards, measurement and fidelity of service implementation, and development of quality enhancement plans), offers training for state agencies, and claims a significant success rate (86%) of children and youth who have avoided placement in state-funded foster care and other out-of-home care.[542] HOMEBUILDERS generally intervenes when families are in crisis and provides an average of 40 to 50 hours of direct service on a flexible schedule.[543]

Partners with Families & Children: Spokane (Partners)[544] is a service that relies on referrals from child welfare, law enforcement, or public health agencies. As such, Partners' main goal is to assist children, youth, and their families in situations of persistent child neglect or those in which briefer interventions are unlikely to be effective.[545] The program is a community-based family treatment program based on wraparound principles and focused on enhancing parent-child relationships through case management, substance use disorder and mental health

[539] Allness, D. J., & Knoedler, W. H. (2003). A manual for ACT start-up. National Alliance for the Mentally Ill.
[540] Morse, G., & McKasson, M. (2005). Assertive Community Treatment. In R. E. Drake, M. R. Merrens, & D. W. Lynde (eds.). Evidence-based mental health practice: A textbook. W. W. Norton & Co.
[541] Center for Evidence-Based Practices. (n.d.). Practices: Assertive Community Treatment. Case Western Reserve University. https://www.centerforebp.case.edu/practices/act
[542] Institute of Family Development. (n.d.). Programs: Homebuilders – IFPS. http://www.institutefamily.org/programs_ifps.asp
[543] Institute of Family Development. (n.d.). Training for Practitioners. http://www.institutefamily.org/training_practitioners.asp
[544] Partners with Families & Children. (n.d.). About us. https://partnerswithfamilies.org/about-us
[545] Partners with Families & Children. (n.d.).

services, and parenting resources provided by an individualized family care team. These components aim to better assist the whole family in the cessation or prevention of neglect and maltreatment, working toward recovery through the combined efforts of an assigned family team coordinator, a core team (which involves partnerships with community organizations such as schools and Head Start programs), and family team meetings.[546] Partners' approach is designed to place parents at the center of a teamwork-driven model that creates therapeutic change to address immediate and anticipated problems that might otherwise lead to neglect, abuse, and removal.[547]

Out-of-Home Treatment

Residential treatment is no longer considered the most beneficial way to treat children and youth with significant difficulties. The 1999 Surgeon Generals' Report on Mental Health states, "Residential treatment centers (RTCs) are the second most restrictive form of care (next to inpatient hospitalization) for children and youth with severe mental disorders. In the past, admission to an RTC was justified on the basis of community protection, child protection, and benefits of residential treatment. However, none of these justifications have stood up to research scrutiny. In particular, youth who display seriously violent and aggressive behavior do not appear to improve in such settings, according to limited evidence."[548]

Residential treatment represents a necessary component of the continuum of care for children and youth whose behaviors cannot be managed effectively in a less restrictive setting. However, as residential treatment is among the most restrictive mental health services provided to children and youth, this level of intervention should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors (e.g., fire setting) that may not respond to intensive, nonresidential service approaches.[549] Yet, on a national basis, children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

[546] Partners with Families & Children. (n.d.). About us. https://partnerswithfamilies.org/about-us
[547] Partners with Families & Children. (n.d.).
[548] U.S. Department of Health and Human Services. (1999). Mental Health: A Report of the Surgeon General. U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institutes of Health, National Institute of Mental Health.
[549] Stroul, B. (2007). Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

The Substance Abuse and Mental Health Services Administration (SAMHSA) created the National Building Bridges Initiative (BBI) to identify and promote best practices and policies.[550] BBI is now an independent 501(c)3 organization devoted to developing strong and closely coordinated partnerships and collaborations between families, youth, community- and residential-based treatment and service providers, advocates, and policymakers.[551] Resources, tip-sheets and tools to ensure best practices can be found at: www.buildingbridges4youth.org.[552]

Although it is typically preferable to treat children and youth in their homes and communities, they sometimes need to be placed outside of their homes for their own safety or the safety of others. Safety should be the primary determinant in selecting out-of-home treatment as an option, as the evidence-based community interventions described above allow for even the most intensive treatment services to be delivered in community settings. Whether the child or youth is facing a temporary situation or a crisis or requires longer-term care, the ideal residential intervention should be based on the core values and principles outlined in the BBI Joint Resolution, which focus on the following:

- Family-driven and youth-guided care and engagement,
- Cultural and linguistic competence,
- Clinical excellence and quality standards,
- Accessibility and community involvement,
- Transition planning,
- Workforce development, and
- Evaluation and continuous quality improvement.[553]

When residential treatment is provided, there should be extensive family involvement. Residential (and community-based) services and supports need to be thoroughly integrated and coordinated, and residential treatment and support interventions need to work to maintain, restore, repair, or establish relationships between the child/youth and their family and community. Family involvement is essential throughout the course of residential treatment, especially at admission, in the development of the treatment plan, when milestones are reached, and in discharge planning.

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[550] Stroul, B. (2007). Building bridges between residential and nonresidential services in systems of care: Summary of the special forum held at the 2006 Georgetown University Training Institutes. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
[551] Stroul, B. (2007).
[552] Stroul, B. (2007).
[553] Building Bridges Initiative. (2006). Building bridges between residential and community-based service delivery providers, families and youth: Joint resolution to advance a statement of shared core principles. http://www.buildingbridges4youth.org/sites/default/files/BB-Joint-Resolution.pdf

Treatment foster care is another promising area, particularly Treatment Foster Care Oregon (TFCO). TFCO, formerly Multidimensional Treatment Foster Care, is the most well-known and well-researched intensive foster care model. TFCO has demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who have problems with chronic antisocial behavior, emotional disturbance, and delinquency. TFCO is a well-established EBP that has demonstrated outcomes and cost savings when implemented with fidelity and with research support for its efficacy with Caucasian, African American, and American Indian youth and families.[554,555,556,557] There is an emphasis on teaching interpersonal skills and on participation in positive social activities including sports, hobbies, and other forms of recreation. Placement in foster parent homes typically lasts about six months. Aftercare services remain in place for as long as the parents choose, but typically last about one year. In order to implement TFCO to fidelity, training and certification must be received through the program developers at: https://www.tfcoregon.com/index.php/implementation/.

Keeping Foster and Kin Parents Supported and Trained (KEEP) was developed by the developers of the TFCO model. KEEP is a skills development program for foster parents and kinship parents of children ages zero to five years and youth (KEEP SAFE). The 16-week program is taught in 90-minute group sessions to seven to 10 foster or kinship parents. Facilitators draw from an established protocol manual and tailor each session to address the needs of parents and children.[558] The goal of the program is to teach parents effective parenting skills, including appropriate praise, positive reinforcement, and discipline techniques.[559] Child care and snacks are provided as part of the sessions. A small study of the program funded by the U.S. Department of Health and Human Services Children's Bureau showed fewer placement breakdowns, fewer behavioral and emotional problems, and fewer foster parents dropping out from providing care.[560] A larger randomized study in San Diego showed that biological or adoptive parents who participated in the KEEP program were reunified with their children more frequently. The study also showed fewer disruptions from foster placements. KEEP has been implemented in Oregon, Washington, California, Maryland, New York City, and four regions in Tennessee, as well as in Sweden and Great Britain. In order to implement KEEP to fidelity,

[554] 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.
[555] Hoagwood, K., Burns, B. J., Kiser, L., Ringeisen, H, & Schoenwald, S. K. (2001). Evidence-based practice in child and adolescent mental health services. Psychiatric Services, 52, 1179–1189.
[556] Kazdin, A. E., & Weisz, J. R. (Eds.) (2003). Evidence-based psychotherapies for children and youth. Guilford Press.
[557] 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.
[558] Oregon Social Learning Center. (n.d.). KEEP – based on research conducted at OSLC. http://www.oslc.org/projects/keep/
[559] Child Trends. (n.d). KEEP Program. https://www.childtrends.org/programs/keep-program/
[560] KEEP. (n.d.). Outcomes. https://www.keepfostering.org/outcomes-2/#research

training and certification must be received through the program developers at: https://www.keepfostering.org/.

The Crisis Continuum

Developing a full continuum of crisis response has been shown to keep children and youth safely in their homes, schools, and communities and helps avoid unnecessary placements in hospitals and residential settings.[561] Examples of crisis response includes warm lines; 24 hours a day, seven days a week hotlines; mobile crisis supports; short- to intermediate-term in-home supports; and local out-of-home options such as respite care, 23-hour stabilization/observation beds, and short-term residential interventions.

Often, the first strategy to address a behavioral health crisis is the use of phone support or telehealth support. In these situations, it is important that the service provider has the ability to screen, assess, and triage as well as the capacity to provide ongoing consultation, time-limited follow-up care, and linkages to transportation resources. These activities should be supported by protocols and electronic systems that communicate results to professionals and systems to determine the appropriate level of services.

In some circumstances, it may be necessary to provide a mobile response. A mobile crisis service has the capacity to go into the community to begin the process of assessment and safety and treatment planning. Mobile crisis teams should also have the capacity to provide limited ongoing in-home supports, case management, and direct access to out-of-home crisis supports. For a national example, see Wraparound Milwaukee's Mobile Urgent Treatment Team/MUTT.[562] Mobil crisis service teams should also have the ability to link and coordinate with emergency medical personnel, as needed.

Summary Statement

The focus of this appendix is on the use of evidence-based practices (EBPs) in children's mental health. Its purpose is to help clinicians, agencies, and decision-makers identify what works when treating various mental health conditions and disorders. As demonstrated in this appendix, there are many programs, practices, and techniques that have evidence of effectiveness, and using these EBPs have been shown to improve outcomes. The list of EBPs is always changing as new research is conducted and new data are obtained. Currently, there are a host of clinical trials underway that will continue to add information to this growing field. The good news is that we are getting better at knowing what works. Unfortunately, knowing what works and doing what works are two separate issues. The goal is for practitioners and

[561] Substance Abuse and Mental Health Services Administration. (2014). Crisis services: Effectiveness, cost effectiveness, and funding strategies. HHS Publication No. (SMA)-14-4848.
[562] For more information, see: http://wraparoundmke.com/programs/mutt/

policymakers to have the best available scientific evidence to make informed decisions about what to do and when.

Appendix Eight: The Mental Health System Framework for Children and Youth

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

Some services might be perceived as mental health services, but are not. Because schools, the foster care system, and the juvenile justice system play such integral roles in identifying and addressing the mental health needs of children and youth, we often mistakenly infer that they are a segment of the mental health care delivery system. In the Mental Health Systems Framework for Children and Youth (framework), mental health services are integrated within these systems and then are well-coordinated with the broader health system.

In addition to clarifying the roles of various service providers within the overall mental health care delivery system, it is critical to ensure that children and youth are served at the appropriate level of care. However, current mental health systems in every community in Texas and across the nation are often disjointed and misaligned, lacking the structure for easy navigation by those in need.

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

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

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

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

Component 0: Life in the Community

Component 0 refers to community settings that are potential points of connection to a broad range of child, youth, and family supports that help prevent behavioral health issues or lead to the early detection and minimization of behavioral health needs. Health needs — including diseases affecting the brain, such as mental health disorders, and physical health conditions — occur in the context of life: home, faith communities, childcare providers, schools, foster care, juvenile justice settings, and other places where children, youth, and families spend their time. These places can also be ideal settings for health promotion and disease prevention.

While the education, foster care, and juvenile justice systems are not health care providers, they are well-positioned to substantially mitigate mental health challenges by helping to support those in need with access to mental health services and key educational supports. For example, schools can help foster healthy development by implementing school-wide social and emotional wellness models that are intended to prevent some challenging behaviors while teaching the social and emotional skills that students need to succeed in school.[563] Partnerships between schools and mental health providers and other community resources can help ensure that students receive consistent and sustainable support, which is critical for overall care.

[563] Meadows Mental Health Policy Institute. (2018, November 1). Mental and behavioral health roadmap and toolkit for schools. https://www.texasstateofmind.org/uploads/RoadmapAndToolkitForSchools.pdf.

Likewise, providers within the foster care and juvenile justice systems play an important role in linking children and youth with mental health needs to care.

Component 1: Integrated Primary Care

Pediatric primary care is the front line for health care delivery and the place where families are most likely to obtain clinical care. These settings provide services that are generally affordable, accessible, and easy to identify and navigate. Specialty mental health providers do not have the capacity to screen and treat all children and youth with a mental health disorder, and connections to specialty mental health providers are not always made. Today, about 75% of children and youth with psychiatric disorders are seen in pediatric and other primary care settings.[564] Training and supporting these providers is an effective strategy for expanding access and connecting children and youth to appropriate services and mental health interventions.

Pediatricians and other primary care providers have traditionally had difficulty delivering mental health services because of limited time for each patient visit, minimal training and knowledge of behavioral health disorders, gaps in knowledge of local resources, and limited access to behavioral health specialists. However, a combination of recent policies and funding

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

opportunities, technological advances, and a growing awareness of the connection between physical and mental health has led to numerous advances in the successful integration of mental health care into primary care practices. When pediatricians and other pediatric primary care providers are trained and positioned to help identify and respond to potential mental health concerns, children and youth receive improved mental health care through earlier detection and intervention. Furthermore, when primary care practitioners are trained and supported to respond to mild to moderate mental health needs, overtaxed mental health providers such as child and adolescent psychiatrists can focus on treating the needs of children and youth with more complex and urgent needs. Research shows that in states with fully-scaled statewide integrated care programs and properly trained pediatricians and other primary care providers, about two thirds of children and youth with behavioral health needs can be effectively served in integrated primary care settings.[565] New opportunities for using telehealth and telemedicine can further increase access to mental health care and the overall quality of care.

Drawing from research and national practice models on integrated behavioral health, we identified seven core components of integrated care, any of which could be adopted at the individual practice level to advance care in Nueces County. These core components include:[566]

1. **Integrated organizational culture**, where organizational leaders promote a culture that delivers effective and efficient integrated care in all areas of administrative and clinical practice;
2. **Population health management**, which requires knowing the physical, mental, and social needs of the patient population to deliver interventions across a continuum of care;
3. **Structured use of a team approach**, which includes shared workflows and a health care team that communicates and collaborates in the service of carrying out simultaneous, mutually reinforcing, and coordinated care;
4. **Integrated behavioral health staff competencies**, with each member of the multidisciplinary team having distinctive knowledge and skills to support coordinated care*;*
5. **Universal screening for physical and behavioral health conditions**, which occurs by regularly utilizing behavioral health screening tools to detect and monitor symptoms;
6. **Integrated and person-centered planning**, where each treatment plan incorporates all physical and behavioral health conditions, treatment/recovery goals, and intervention plans, and includes the values, lifestyles, and social contexts of the person obtaining health care; and

[565] Straus, J. H., & Sarvet, B. (2014). Behavioral health care for children: The Massachusetts Child Psychiatry Access Project. Health Affairs, 33(12), 2153–2161.
[566] Meadows Mental Health Policy Institute. (2016, August). Best practices in integrated behavioral health. https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.pdf

7. **Systematic use of evidence-based clinical models**, which includes applying a shared clinical protocol and guidelines that incorporate physical and behavioral health conditions to achieve better outcomes and more cost-effective care. For more information about the core IBH components, see: https://www.texasstateofmind.org/wp-content/uploads/2016/11/Meadows_IBHreport_FINAL_9.8.16.

Component 2: Specialty Outpatient Care

Some conditions (including psychiatric and other illnesses) require tailored interventions provided by specialized providers in outpatient settings. If our framework was fully implemented, only about a quarter of children and youth with mental health conditions would need care in these types of setting, while the majority could be properly cared for through integrated primary care. Anxiety and routine depression can be readily treated in integrated primary care settings, but specialists are needed to treat more complex depression, bipolar disorder, post-traumatic stress disorder, and other conditions that require specialized interventions. Our framework would shift a large portion of the population (those with mild to moderate mental health conditions) from over-burdened specialty outpatient mental health care settings to integrated primary care settings, allowing specialists to focus on children and youth with more severe conditions, and re-allocating scarce resources to serve the children and youth with more intensive needs.

Providers of specialty outpatient mental health care include psychiatrists, psychologists, social workers, nurse practitioners, marriage and family therapists, professional counselors, and chemical dependency counselors in private practice, outpatient clinics, counseling centers, and school-based clinics that offer mental health services. 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 (e.g., cognitive behavioral therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Dialectical Behavior Therapy). Clinics may also provide some rehabilitation services (e.g., skill building – further described in the section on *Component 3: Specialty Rehabilitative Care*). Based on the best current prevalence estimates, about one quarter of the total number of children and youth with mental health needs, or about 6,000 children and youth in Nueces County, need specialty outpatient behavioral health care services each year.[567]

Component 3: Specialty Rehabilitative Care

Some mental health conditions are so complex that they impair functioning across multiple life domains and require evidence-based rehabilitation in addition to specialized treatment of the underlying condition. In the same way that a catastrophic orthopedic injury might require a child to re-learn to walk or carry out other routine activities of life, a severe psychiatric condition that impedes functioning (e.g., a psychosis, untreated depression) may require

[567] We estimate that one out of four children and youth with mental health needs each year (about 6,000) requires specialty outpatient behavioral health care to adequately manage their conditions.

specialty rehabilitative care to treat the underlying condition as well as restore healthy functioning at home, in school, and around the community. Children, youth, and their families with intensive needs require:

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

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

- For older adolescents first experiencing psychosis, the best evidence-based intervention — Coordinated Specialty Care (CSC) — involves about two years of intensive outpatient treatment that combines effective medication, education, and skill-building for the youth and their family, encouraging them to maintain school enrollment and continue on (or regain) a healthy developmental track, as well as providing support to the youth's school or work setting in developing accommodations tailored to the youth's symptoms.
- For children and youth involved in the juvenile justice system who exhibit severe externalizing symptoms (e.g., classroom disruption, angry outbursts, defiance) related to untreated/inadequately treated depression or anxiety disorders (perhaps related to trauma), a three- to seven-month regimen of Functional Family Therapy (FFT) or Multisystemic Therapy (MST) would offer the most effective treatment and achieve the best outcomes.
- For children and youth who are receiving child welfare services, foster care models such as Treatment Foster Care Oregon have demonstrated effectiveness as a cost-effective alternative to group or residential treatment, incarceration, and hospitalization for youth who struggle with chronic antisocial behavior, emotional disturbances, and delinquency.

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

critical needs and determine the best path forward.[568] Although wraparound is not a treatment modality, it is an essential care coordination support for the relatively small subset of children, youth, and families with particularly complex conditions and multi-agency involvement whose needs cannot be adequately met through discrete services.

The framework comprises a continuum of rehabilitation options to match services to the needs of each child, youth, and family, such as home and community-based skill-building and services. In general, these services are provided directly in the child or youth's home and community. The intent of these services is to provide the level, or dose, of clinical intervention and support necessary to successfully return each child or youth to a healthy developmental trajectory within their home and community. Specialty rehabilitative services are provided to children and youth at higher risk for out-of-home placement because of mental health issues, or who have returned or are being discharged home from residential treatment centers or psychiatric hospitals.

Screening is particularly essential during the onset of severe mental illness, especially when a youth or young adult initially displays psychotic symptoms such as hearing voices or experiencing other hallucinations or delusions. Referred to as "first episode psychosis" (or FEP) in medical terms, these symptoms most frequently occur during adolescence and in young adulthood. Many youth go untreated during these years. Services are most effective if they are initiated early in the development of mental health conditions. Treatment and early identification of mental illness for youth ages 15 and older has the potential to radically alter their developmental trajectory and their illnesses, promoting recovery without multiple hospitalizations and loss of education and skills development. Universal screening in integrated care settings, including schools, promotes early detection for children and youth who can then be connected to appropriate services. Those who are identified as having serious or complex conditions would receive the intensive services they need early on, rather than potentially deteriorating because of a lack of appropriate support and intervention in lower levels of care.

Currently, specialty rehabilitative care in Nueces County is limited to the public sector, just as it is throughout Texas and much of the rest of the nation. In Nueces County, these services are available only through the Nueces Center for Mental Health and Intellectual Disabilities (NCMHID). The current system has very limited evidence-based treatment options, particularly for specialty rehabilitation services like Coordinated Specialty Care (CSC), Multisystemic Therapy (MST), and Functional Family Therapy (FFT), which are effective alternatives to more

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

restrictive settings such as hospitals, residential treatment centers, and juvenile justice facilities.

Component 4: Crisis Care

The framework's mental health crisis care continuum includes three distinct service types necessary for an ideal continuum of crisis services:

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

Crisis Intervention Continuum:

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

Although this entire array is difficult to achieve in many communities across Texas, some components exist within the

mental health, child welfare, and juvenile justice systems, though they are often not well coordinated or conceptualized as a single crisis system. This deficiency leads to redundancies that prevent children and youth from getting the right services at the right time.

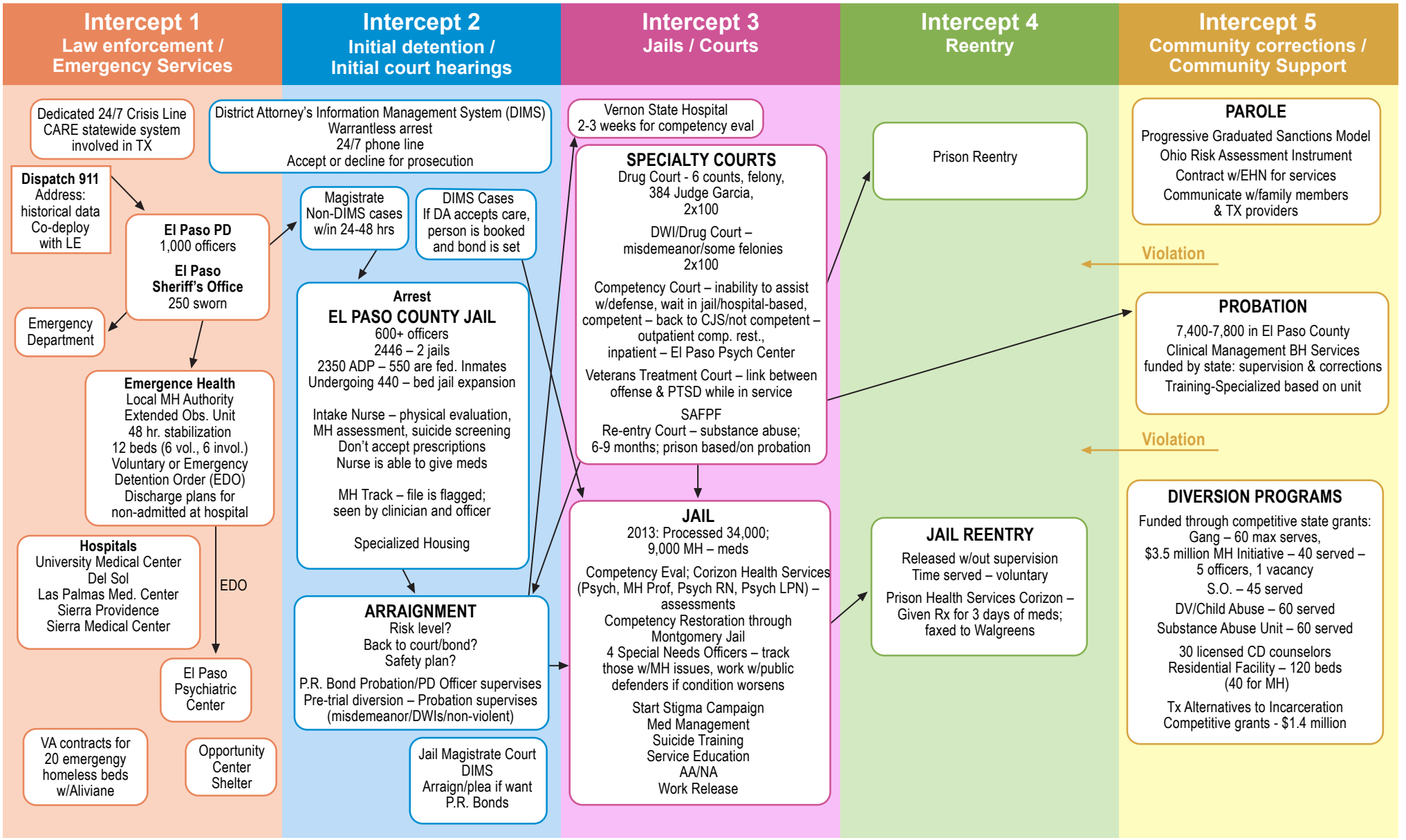
Even when a full continuum of nonresidential crisis options is in place, some children and youth will still need inpatient care for acute and complex needs. As discussed earlier, although inpatient psychiatric care is not a substitute for ongoing, well-coordinated outpatient mental health care, it is an important piece of the crisis care continuum when there are immediate safety concerns. Inpatient psychiatric hospitalizations can be helpful for acute stabilization of children and youth with complex needs, such as high suicide risk or medication adjustments that require close medical monitoring. These hospitalizations should be available when needed, but generally should be brief and supported by the broader crisis array and system. For example, short-term placement in crisis foster or residential care can divert children and youth with less intense needs from inpatient settings as well as provide step-down support as they transition home from these settings. Intensive community-based services and supports can also help children, youth, and their caregivers make the transition back home after a hospitalization.

Residential treatment represents another component of the crisis care continuum for children and youth. It is designed for children and youth whose behavior cannot be managed safely in a less restrictive setting. Residential treatment is one of the most restrictive mental health service settings provided to children and youth. As such, it should be reserved for situations where less restrictive placements are not appropriate, including for children and youth with highly complex needs or dangerous behaviors (e.g., fire setting) who may not respond to intensive, nonresidential service approaches.[569] Across Texas and nationally, children and youth are too often placed in residential treatment because more appropriate, less restrictive community-based services are not available. When they are utilized, residential services should be brief, intensive, family-focused, and as close to home as possible.

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

Appendix Nine: 2014 and 2019 El Paso County, TX Sequential Intercept Maps

September 2014 El Paso County, TX Sequential Intercept Map



Community Resources

Behavioral	Substance Abuse	Housing/Shelter

2019 El Paso County, TX Sequential Intercept Map

Intercept 0
Hospital, Crisis, Community Services

COMMUNITY CRISIS RESPONSE

Certified Community Behavioral Health Clinics **(In Progress)**

Centrally Deployable Mobile Crisis

Crisis Care Response Centers **(In Progress)**

POLICE STRATEGIES

Crisis Intervention Team: EHN and El Paso PD

El Paso PD: CIT 40 Hour Training (TCOLE 1850)

Basic CIT 16 Hour Training (BPOC - TCOLE 3842)

Mental Health Peace Officer (TCOLE 4001)

Crisis Care Principles & Practices **(Needed)**

Homeless Outreach Teams - 1115 Waiver - Salvation Army

Serial Inebriate Programs

Systemwide Mental Assessment Response Teams

COMMUNITY COORDINATION

Justice Leadership Council

Community Dashboard

Intercept 1
Law enforcement / Emergency Services

24/7 Crisis Line CARE statewide system involved in TX

GAP Dispatch 911 Address: historical data Co-deploy CIT training with LE

El Paso PD 758 Officers

El Paso Sheriff's Office

MHFA Certification

Emergency Department

EDO

Emergence Health Local MH Authority Extended Obs. Unit 48 hr. stabilization 10 beds Voluntary or Emergency Detention Order (EDO)

EDO

Hospitals University Medical Center Del Sol Las Palmas Med. Center Sierra Providence Sierra Medical Center

Resources El Paso Psychiatric Center Opportunity Center Shelter VA- 20 emergency homeless beds w/Aliviane

COMMUNITY COORDINATION

Jail Diversion Committee

Intercept 2
Initial detention / Initial court hearings

All arrestees go to:

1. Criminal Justice Coordination Office at Downtown Detention Facility for short risk assessment
2. 24 Hour Jail Magistrate for magistration and to have bond set (if none set).

Judge receives risk assessment. Judge inquires if attorney can be afforded or needs to be appointed.

Arrestees are taken to the DDF Inmate Processing Unit on the second floor.

Criminal Justice Coordination (CJC)

Risk level? Back to court/bond?

Individual is taken to mug shot then to CJC for interview

P.R. Bond CJC supervises
Pre-trial diversion – Probation supervises (misdemeanor/DWIs/non-violent)
MH Bonds
TCOOMMI – Jail Diversion
SAFPF – (Substance abuse Felony Punishment Facility)

Intake and Booking

at EP County Jail

1. University Medical Center (UMC) completes the TCJS required Suicide/Mental Health/IDD Screening Form.
2. Records Officer conducts a CCQ Match through DSHS to identify individuals who have received services through any Texas LMHA.
3. Individuals with mental health track flag placed in the Jail Management System and the Records Officer will notify the Jail Magistrate of the person being in custody.
4. Emergence Health Network will provide mental health screening. Housing recommendation for individuals who do not post bond.

16.22 Assessments - EHN

Intercept 3
Jails / Courts

46B – TCCP Competency Evaluation To State Hospital

SPECIALTY COURTS

1. Drug Court – Felony
2. DUI/Drug/ESTEEM Court Misdemeanor
3. Competency Court – Inpatient
4. Veterans Treatment Court – Link between offense & PTSD while in service
5. Mental Health Court + OCR (Work Group)

Forensic Assertive Community Treatment

JAIL

1. Competency Restoration taking place through Texas State Mental Health Hospitals
2. 95% of Sheriff's Jail supervisors trained in Mental Health First Aid
3. All new Detention Officers trained in Mental Health First Aid
4. Jail Administration and Support Division created to facilitate inmate programs and address special needs. Staffing consists of Officers certified as Mental Health First Aid Instructors, ASK instructors, and Texas Commission on Law Enforcement Certified Instructors.
5. Crisis line available in the cell
6. Blue shirt MH officer support
7. Medication management
8. AA/NA
9. Work Release

Specialty Pods

Jail equipped with Mental Health and Freedom Pods for SUD - provides peer recovery support.

Intercept 4
Reentry

PRISON REENTRY

1. TDJC/RID – Reentry Integration Division
   a. Benefits application and coordination
      i. Healthcare
      ii. Mental Healthcare
      iii. Other services (i.e., housing)

JAIL REENTRY

1. Mental health services coordinates release for inmates on the mental health track who qualify for LMHA services.
2. Mental health services provide mental health track inmates who do not qualify for EHN services with a handout of community resources where possible help to identify links to other community resources.
3. UMC/EHN provides medication prescriptions to CVS upon release.

Intercept 5
Community corrections / Community Support

PAROLE

Progressive Graduated Sanctions Model
Ohio Risk Assessment Instrument
TCOOMMI/TDCJ
Communicate w/family members & TX providers
Specialized Caseloads
CMCN's COC

Violation

PROBATION

Specialized based on unit
Specialized Caseloads
CMCW's
CRTC
SAFPF

Violation

DIVERSION PROGRAMS

Funded through competitive state grants:
Gang – 60 max serves,
$3.5 million MH Initiative –
40 served – 5 officers, 1 vacancy
S.O. – 45 served
DV/Child Abuse – 60 served
Substance Abuse Unit – 60 served
30 licensed CD counselors
Residential Facility – 120 beds (40 for MH)
Tx Alternatives to Incarceration Competitive grants

Appendix Ten: El Paso Local Provider Data

Data presented in this appendix was provided by local El Paso County behavioral health service providers. We requested data from 17 local providers and received data responses from eight. Some reported that they do not provide behavioral health services and, therefore, did not submit data. The data collection timeframes vary; however, we felt this was useful information, especially as it concerns building a shared understanding of community providers' capacity and the types of services they provide. Some providers collapsed their services, which provided less details, while others provided an expanded and more detailed list.

Table A1: Behavioral Health Services Provided by El Paso Center for Children, Inc. (Sept. 2019 – Aug. 2020)

Behavioral Health Services Provided by El Paso Center for Children, Inc. (Sept. 2019 – Aug. 2020)	
Behavioral Health Services for Children and Youth	**Number Served, September 2019 – August 2020**[570]
Number of children and youth (ages 3 to 17) – unduplicated clients served in most recent 12-months of completed data	**846**
Family and youth services	731
Healthy outcomes through prevention and early support program	52
Victims of crime services	63
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	**0**
Family and youth services	0
Healthy outcomes through prevention and early support program	0[571]
Victims of crime services	0
Total capacity for behavioral health services (the total number of children/youth who can be served by agency at any given time)	**329**
Family and youth services	200
Healthy outcomes through prevention and early support program	100[572]
Victims of crime services	29
Behavioral Health Services for Adults (18 years and older)	**Number Served September 2019 – August 2020**[573]
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**789**

[570] September 1, 2019 – August 31, 2020
[571] Last 12 months
[572] No waitlist during the last 12 months
[573] September 2, 2019 – August 31, 2020

Behavioral Health Services Provided by El Paso Center for Children, Inc. (Sept. 2019 – Aug. 2020)	
Family and youth services	695[574]
Healthy outcomes through prevention and early support program	65[575]
Victims of crime services	29
What is the highest number of adults (18+) who were on the waitlist for behavioral health services at any given time?	**0**
Family and youth services	0
Healthy outcomes through prevention and early support program	0[576]
Victims of crime services	0
Total Capacity for behavioral health services (the total number of adults that can be served by your agency at any given time)	**325**
Family and youth services	200[577]
Healthy outcomes through prevention and early support program	100[578]
Victims of crime services	25
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served, 2019**
Family counseling/intake	884[579]
Family session/intake	1,027[580]
Individual counseling/intake	1,512
Individual session/intake	1,610
Individual session (telehealth)	3
Intake	464
Parenting skills training	3,869
Parenting skills training (prison)	68
Youth skills training	284
Victims of crime counseling	220

[574] For every youth, at least one parent was seen in session. We do not have the capacity to run a report filtering for only parents. At time we have one parent and several siblings.
[575] Last 12 months
[576] No waitlist during the last 12 months
[577] Per month
[578] Total capacity for clients
[579] Counseling sessions are modality based with a licensed professional (Counselors)
[580] Sessions are curriculum based with a non-licensed professional (FSS)

Table A2: Behavioral Health Services Provided by University of Texas El Paso Counseling and Psychological Services (2019)

Behavioral Health Services Provided by University of Texas El Paso Counseling and Psychological Services (2019)	
Behavioral Health Services for Children and Youth	**Number Served, 2019**
Number of children and youth (ages 3 to 17) – unduplicated clients served in most recent 12-months of completed data	—
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	—
Total capacity for behavioral health services (the total number of children/youth who can be served by your agency at any given time)	—
Behavioral Health Services for Adults (18+)	**Number Served, 2019**
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**1,454**
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	1,000
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served, 2019**
Couples counseling	16
Group counseling	355
Intake	946
Individual counseling	667
Career counseling	33
Consultation	214
Crisis counseling	687
Assessment consultation	26
Disabilities testing	23
Workshops	78

Table A3: Behavioral Health Services Provided by Aliviane of El Paso (Sept. 2019 – Sept.2020)

Behavioral Health Services Provided by Aliviane of El Paso (Sept. 2019 – Sept. 2020)	
Behavioral Health Services for Children and Youth	**Number Served October 2019 – September 2020**
Number of children and youth (ages 3 to 17) – unduplicated clients served in most recent 12-months of completed data	

Behavioral Health Services Provided by Aliviane of El Paso (Sept. 2019 – Sept. 2020)	
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of children/youth who can be served by your agency at any given time)	126
Behavioral Health Services for Adults (18 years and older)	**Number Served October 2019 – September 2020**
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**—**
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	165
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served October 2019 – September 2020**
Medication-assisted therapy	18
Outpatient clinic	72
Women's residential treatment	68

Table A4: Behavioral Health Services Provided by El Paso Child Guidance Center (2019)

Behavioral Health Services Provided by El Paso Child Guidance Center (2019)	
Behavioral Health Services for Children and Youth	**Number Served, 2019**
Number of children and youth (ages 3 to 17) – unduplicated clients served in most recent 12-months of completed data	**662**
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	140
Total capacity for behavioral health services (the total number of children/youth who can be served by your agency at any given time)	N/A[581]
Behavioral Health Services for Adults (18 years and older)	**Number Served, 2019**
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**144**[582]
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	--[583]
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	--[584]
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served, 2019**
Professional development trainings	1,259[585]
Psychoeducational workshops (professionals)	400[586]
Psychoeducational workshops (parents)	304[587]
Psychoeducational workshops (youth)	50[588]
Psychoeducational groups	149[589]
Navigation	8[590]
Child/adolescent psychiatric services	44
Body-Based Capacitar groups and trainings	39

[581] Waitlist signaled exceed capacity; we are working with a consultant to help project capacity given current staffing profile and are in process of planning for expanding staff to see more clients in both therapy and other services along the MH continuum of care.
[582] Psychotherapy only
[583] Waitlist is not broken out by age
[584] Please see above
[585] Events lasting more than two hours
[586] Two hours or less
[587] Parent/foster parent/caregivers
[588] Homeless youth
[589] Resilience Support Groups
[590] Victim advocate per August 3 response

Behavioral Health Services Provided by El Paso Child Guidance Center (2019)	
Evidence-Based Clinical Interventions	
Eye Movement Desensitization and Reprocessing	
Parent Child Interaction Therapy (PCIT)	
Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)	
Evidence-Informed Group or system interventions	
Reaching Teens	
Capacitar	
Trust-Based Relational Interaction[591]	
Attachment, Regulation, and Competency [592]	

Table A5: Behavioral Health Services Provided by Steven A. Cohen Military Family Clinic at Endeavors (Oct. 2019 – Sept. 2020)[593]

Behavioral Health Services Provided by Steven A. Cohen Military Family Clinic at Endeavors (Oct. 2019 – Sept. 2020)	
Behavioral Health Services for Children and Youth	**Number Served October 2019 – September 2020**
Number of children and youth (ages 3 to 17) unduplicated clients served in most recent 12-months of completed data	**80**
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of children/youth that can be served by your agency at any given time)	100
Behavioral Health Services for Adults (18 years and older)	**Number Served October 2019 – September 2020**
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**400**
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	500
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served, 2019**
Biopsychosocial	380

[591] 2020
[592] 2020 – 2021
[593] October 1, 2019 -September 30, 2020

Behavioral Health Services Provided by Steven A. Cohen Military Family Clinic at Endeavors (Oct. 2019 – Sept. 2020)	
Case management	57
Medication management	39
Telehealth biopsychosocial	73
Telehealth therapy – individual	235
Telehealth couples assessment	9
Telehealth family assessment	143
Telehealth medication management	15
Telehealth therapy – couples	52
Telehealth therapy – family	6
Therapy – couples	134
Therapy – family	6
Therapy – individual	465

Table A6: Behavioral Health Services Provided by Texas Tech University of Health Science Center of El Paso (Sept. 2019 – Sept. 2020)

Behavioral Health Services Provided by Texas Tech University of Health Science Center of El Paso (Sept. 2019 – Sept. 2020)	
Behavioral Health Services for Children and Youth	**Number Served October 2019 – September 2020**
Number of children and youth (ages 3 to 17) – <u>unduplicated</u> clients served in most recent 12-months of completed data	**602**
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	30
Total capacity for behavioral health services (the total number of children/youth who can be served by your agency at any given time)	N/A
Behavioral Health Services for Adults (18 years and older)	**Number Served October 2019 – September 2020**
Number of adults (18 years and older) served – <u>unduplicated</u> clients served in most recent 12-months of complete data	**2,618**
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	N/A
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	70[594]
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served October 2019 – September 2020**
Medication management	3,120
Psychotherapy	100

Table A7: Behavioral Health Services Provided by Family Services of El Paso (Aug. 2019 – July 2020)

Behavioral Health Services Provided by Family Services of El Paso (Aug. 2019 – July 2020)	
Behavioral Health Services for Children and Youth	**Number Served August 2019 – July 2020**
Number of children and youth (ages 3 to 17) <u>unduplicated</u> clients served in most recent 12-months of completed data	**730**
What is the highest number of children/youth (ages 3 to 17) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of children/youth who can be served by your agency at any given time)	33
Behavioral Health Services for Adults (18 years and older)	**Number Served**

[594] 35 to 80 on days that we have clinic

Behavioral Health Services Provided by Family Services of El Paso (Aug. 2019 – July 2020)	
	August 2019 – July 2020
Number of adults (18 years and older) served – unduplicated clients served in most recent 12-months of complete data	**1,716**
What is the highest number of adults (18 years and older) who were on the waitlist for behavioral health services at any given time?	0
Total capacity for behavioral health services (the total number of adults who can be served by your agency at any given time)	77
Please list the behavioral health services you provide and the numbers served, below. ***(These data are not broken down by children, youth, and adults.)***	**Number Served, 2020**
Mental health counseling (individual or family counseling)	2,455[595]

Table A8: Behavioral Health Services Provided by Project Vida Health Center (2019)

Please note: Project Vida provided an extensive amount of data from the HRSA Electronic Handbook. We have only included data related to mental health and substance use disorders.

Behavioral Health Services Provided by Project Vida Health Center (2019)		
Number/Percentage of Patients, by Services	**Number**	**Percent**
Mental health	2,041	15.41%
Substance use disorder	37	0.28%
Total Clinic Visits		
Mental health	11,211	28%
Substance use disorder	353	0.88%
Total Virtual Visits		
Mental health	111	16.30%
Substance use disorder	0	0.0%
Visits Per Patient		
Mental health visits per mental health patient		5.55
Substance use disorder visits per substance use disorder patient		9.54

[595] 2,455 unduplicated individuals received 15,730 counseling units

Appendix Eleven: Level of Care (LOC) Overview for Adults Services

A brief overview of the Texas Resilience and Recovery (TRR) Utilization Management Guidelines is presented below. For a full description, please see *Texas Resilience and Recovery Utilization Management Guidelines: Adult Services*.[596]

Level of Care (LOC)	Population/Purpose	Services
LOC-0: Crisis Services	**Population:** Individuals with acute crisis needs **Purpose:** The services in this level of care are brief interventions provided in the community that ameliorate the crisis situation and prevent utilization of more intensive services. The desired outcome is resolution of the crisis and avoidance of intensive and restrictive intervention or relapse. **Average Utilization:** varies according to need, seven days authorization	**Crisis Services** • Crisis Intervention Services • Psychiatric Diagnostic Interview Examination • Pharmacological Management • Crisis Transportation (event) • Crisis Transportation (dollars) • Safety Monitoring • Day Programs for Acute Needs (when indicated) • Extended Observation • Crisis Residential Treatment • Crisis Stabilization Unit • Crisis Flexible Benefits (event) LOC-0 & LOC-5 • Crisis Flexible Benefits (dollars) LOC-0 & LOC-5 • Respite Services: Community-Based • Respite Services: Program-Based (not in home) • Inpatient Hospital Services • Inpatient Services (psychiatric) • Emergency Room Services (psychiatric) • Crisis Follow-Up & Relapse Prevention • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

[596] Texas Department of State Health Services. (2017). Texas Resilience and Recovery Utilization Management Guidelines: Adult Mental Health Services (p. 38). https://hhs.texas.gov/sites/default/files/documents/doing-business-with-hhs/provider-portal/behavioral-health-provider/um-guidelines/trr-utilization-management-guidelines-adult.pdf

Level of Care (LOC)	Population/Purpose	Services
LOC-1M (Medication Management): Basic Services	**Population:** Individuals appropriate for this level of care are individuals who meet the HHSC definition for priority population. Services in Level of Care (LOC) 1M (Medication Management) are generally intended for adults who have attained and maintained a level of recovery in treatment such that, except for the ongoing need for medications, would be eligible for discharge from services. Individuals appropriate for this level of care are ready to transition out of the public mental health system and would make that transition except for the limited community resources available to allow these individuals to make that transition (i.e., no available physicians in the community, no pharmacological resources available to this individual). **Purpose:** The general focus of this service is to prevent deterioration of the individual's condition, specifically through medication therapy, until such time that they are able to access psychiatric and pharmacological resources in the community. **Monthly Average Utilization: 0**.5 hour / 6 months – 1 hour / 6 months	The hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate. **Core Services** • Pharmacological Management **Adjunct Services** • Psychiatric Diagnostic Interview Examination • Routine Case Management • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-1S (Skills Training): Basic Services	**Population:** Services in this level of care (LOC) are generally intended for individuals who meet the HHSC definition for priority population. Individuals in this level of care present with very little risk of harm and have supports and a level of functioning that does not require higher levels of care. **Purpose:** The general focus of this array of services is to facilitate recovery by reducing or stabilizing symptoms, improve the level of functioning, and/or prevent deterioration of the individual's condition. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. **Monthly Average Utilization:** 1.3 hours / 1 month – 2.25 hours / 1 month	Across the population served at this level of care, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate. **Core Services** • Pharmacological Management • Routine Case Management **Adjunct Services** • Psychiatric Diagnostic Interview Examination • Medication Training & Support Services (individual) • Medication Training & Support Services (group) • Engagement Activity • Skills Training & Development (individual) • Skills Training & Development (group) • Supported Employment • Supported Housing • Cognitive Processing Therapy (Standard Duration – 12 sessions) • Peer Support • Flexible Funds • Flexible Community Supports • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-2: Basic Services including Counseling	**Population:** Services in this level of care (LOC) are intended for individuals with symptoms of major depressive disorder, with or without psychosis (GAF is 50 at intake), who present very little risk of harm, have supports, have a level of functioning that does not require more intensive levels of care, and can benefit from psychotherapy. **Purpose:** The overall focus of services in this level care is to improve level of functioning and/or prevent deterioration of the individual's condition so that the individual is able to continue to work toward identified recovery goals. Natural and/or alternative supports are developed to help the individual move out of the public mental health system. Services are most often provided in outpatient, office-based settings and include psychotherapy services in addition to those offered in LOC-1. **Monthly Average Utilization:** 3.25 hours / 1 month – 5.5 hours / 1 month.	Across the population served at this level of care, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate. **Core Services** • Pharmacological Management • Routine Case Management • Counseling (CBT – individual) Standard Duration – 16 sessions **Adjunct Services** • Counseling (CBT – group) Standard Duration – 16 sessions • Psychiatric Diagnostic Interview Examination • Medication Training & Support Services (individual) • Medication Training & Support Services (group) • Engagement Activity • Skills Training & Development (individual) • Skills Training & Development (group) • Supported Employment • Supported Housing • Peer Support • Cognitive Processing Therapy (Standard Duration – 12 sessions) • Flexible Funds • Flexible Community Supports • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-3: Intensive TRR Services with Team Approach	**Population:** Services in this level of care are generally intended for individuals who enter the system of care with moderate to severe levels of need (or for those whose LOC-R has increased) who require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school). **Purpose:** The general focus of services in this level of care is to support the individual served in his or her recovery through a team approach that engages the individual served as a key partner, stabilize symptoms that interfere with the person's functioning, improve functioning, develop skills in self-advocacy, increase natural supports in the community, and sustain improvements made in more intensive level of care (LOC). **Monthly Average Utilization:** 5.87 hours / 1 month – 20.35 hours / 1 month.	Across the population served at this level of care, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate. **Core Services** • Pharmacological Management • Psychosocial Rehabilitative Services (individual) • Psychosocial Rehabilitative Services (group) • Supported Housing **Adjunct Services** • Psychiatric Diagnostic Interview Examination • Medication Training & Support Services (individual) • Medication Training & Support Services (group) • Engagement Activity • Supported Employment • Cognitive Processing Therapy (Standard Duration– 12 sessions) • Day Programs for Acute Needs • Residential Treatment • Flexible Funds • Flexible Community Supports • Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-EO: Early Onset	**Population:** Individuals in this level of care will have a diagnosis that includes psychotic features and will vary in terms of need and severity. **Purpose:** The purpose of LOC-EO is to provide a specialized treatment approach for those experiencing their first episode of psychosis. **Monthly Average Utilization:** 5.87 hours / 1 month – 20.35 hours / 1 month.	Across the population served in this LOC, some individuals may require more/less intense provision of services or utilize services at a higher/lower rate than others. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate and indicated in the recovery plan. **Core Services** • Psychiatric Diagnostic Interview Examination • Routine Case Management • Psychosocial Rehab (individual) • Psychosocial Rehab (group) • Peer Support • Pharmacological Management • Administration of an injection • Medication Training & Support Services (individual) • Medication Training & Support Services (group) • Family Counseling • Individual Psychotherapy • Group Counseling (other than multiple family) • Supported Housing • Supported Employment • Engagement Activity • Flexible Funds **Adjunct Services** • Flexible Community Supports • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-4: Assertive Community Treatment (ACT)	**Population:** Persons receiving ACT services may have a diagnosis of schizophrenia or another serious mental illness such as bipolar disorder and have experienced multiple psychiatric hospital admissions, either at the state or community level. **Purpose:** The purpose of ACT is to provide a comprehensive program that serves as the fixed point of responsibility for providing treatment, rehabilitation, and support services to identified individuals with severe and persistent mental illnesses **Monthly Average Utilization:** 10 hours / month – 26.65 hours / month.	Across the population served at this level of care (LOC), some individuals may require more/less intense provision of services or utilize services at a higher/lower rate per month. Ideally, the hours of service(s) delivered should include the Core Services and be supplemented with Adjunct Services, when clinically appropriate. **Core Services** • Pharmacological Management • Psychosocial Rehabilitative Services (individual) • Psychosocial Rehabilitative Services (group) • Supported Housing **Adjunct Services** • Psychiatric Diagnostic Interview Examination • Medication Training & Support Services (individual) • Medication Training & Support Services (group) • Engagement Activity • Supported Employment • Cognitive Processing Therapy (Standard Duration – 12 sessions) • Counseling (CBT – individual) Standard Duration – 16 sessions • Counseling (CBT – group) Standard Duration – 16 sessions • Day Programs for Acute Needs • Residential Treatment • Flexible Funds • Flexible Community Supports • Screening, Brief Intervention, and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening, Brief Intervention, and Referral to Treatment (SBIRT) – Screening and Brief Intervention Provided

Level of Care (LOC)	Population/Purpose	Services
LOC-5: Transitional Services	**Population:** adults in need of extended transitional services post-crisis **Purpose:** The major focus for this LOC is to provide flexible services that assist individuals in maintaining stability and preventing further crisis, and engaging the individual into the appropriate LOC or assisting the individual in obtaining appropriate community-based services. This LOC is highly individualized and the level of service intensity and length of stay is expected to vary, dependent on individual need. This LOC is available for up to 90 days. **Average Utilization:** varies according to need, 90 days authorization	LOC-5 is designed to flexibly meet the needs of the individual prior to admission into ongoing services. All services are available in this level of care. Services should reflect the individual's needs. **Core Services** • Routine Case Management • Psychiatric Diagnostic Interview Examination • Pharmacological Management • Medication Training and Support Services (individual, curriculum-based) • Medication Training and Support Services (group, curriculum-based) • Skills Training & Development (individual) • Skills Training & Development (group) • Supported Employment • Supported Housing • Flexible Funds • Flexible Community Supports • Engagement Activity • Screening Brief Intervention and Referral to Treatment (SBIRT) Screening/No Brief Intervention Provided • Screening Brief Intervention and Referral to Treatment (SBIRT) Screening and Brief Intervention Provided **Adjunct Services** • Counseling (Cognitive Processing Therapy) • Counseling (CBT – Individual) Standard duration – 16 sessions • Crisis Intervention Services • Psychiatric Diagnostic Interview Examination • Pharmacological Management • Crisis Transportation (event) • Crisis Transportation (dollars) • Safety Monitoring • Day Programs for Acute Needs (when indicated) • Extended Observation • Crisis Residential Treatment • Crisis Stabilization Unit • Flexible Funds (dollars) • Flexible Community Supports (time) • Respite Services: Community-based • Respite Services: Program-Based (not in-home) • Inpatient Hospital Services • Inpatient Services (psychiatric) • Emergency Room Services (psychiatric) • Crisis Follow-up & Relapse Prevention

Appendix Twelve: Southwest Texas Regional Advisory Council (Bexar County) Medical Stability Protocol and Resources

Medical Director Driven Fire/EMS Medical Stability Evaluation

Patients **MAY NOT** be released for MEDCOM Law Enforcement navigation to a Free Standing Psychiatric Hospital if they have:

1. Lacerations, significant abrasions, wounds or Trauma (need ER eval and Tx)
2. Any history of any ingestion/OD (they must be medically cleared in an ER)
3. Significant intoxications, agitation, delirium, or aggressive behavior such that they cannot walk or participate in a psychiatric interview.
4. Any peg tubes, implanted ports, lines or Medical problems that are not under control *(such as asthma/copd exacerbation, Glucose >400, Hypertension > 200 systolic*)

STRAC MEDCOM

Southwest Texas Regional Advisory Council

Law Enforcement Navigation of Behavioral Health Protocol

CALL EMS **and** FIRE (manpower) for ***EMERGENT*** response if:

- Excited delirium, severe agitation or violent behavior
- Mental status changes or confusion (change from baseline)
- Recent trauma, ingestion or overdose

Call EMS **only** Evaluation for ***URGENT*** response if:

- Officer impression indicates patient needs medical assessment
- Patient complains of medical illness
- Patient requests a medical evaluation

If patient has ***no acute medical issues and is medically stable***, contact MEDCOM for Navigation to the appropriate psychiatric facility by Law Enforcement:

- Provide Patient Name and DOB
- Provide location
- Is the patient combative?
- Is the patient ambulatory, able to perform daily functions?
- Is the patient pregnant? Gestation greater than 20 weeks?
- Any weapons/ammo seized on scene?
- Call MEDCOM (24/7) for navigation to the appropriate psychiatric facility

MEDCOM (24/7): (210) 233-5933

Rev 01/14/19

Appendix Thirteen: Quantitative Data Summary: El Paso County Behavioral Health System Assessment – Updated Final Report, April 2021

Quantitative Data Summary: El Paso County Behavioral Health System Assessment

Updated Final Report

April 2021

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Contents

Executive Summary

Scope of the Need for Behavioral Health Services in El Paso County

In May 2020, Paso del Norte Health Foundation (PdNHF) engaged the Meadows Mental Health Policy Institute (Meadows Institute) to conduct an assessment of the community's behavioral health system and evaluate the El Paso Behavioral Health Consortium project. The goal of this work was to inform the community's efforts to improve behavioral health services for its residents and to assess local capacity to meet the needs of residents with behavioral health conditions. As part of the broader assessment, we (Meadows Institute) have developed this quantitative data summary, which describes the burden of mental illness and substance use disorders in El Paso County as well as general information about service delivery and hospital / emergency department utilization between 2016 and 2019. We also compared updated behavioral health need and service utilization data to the 2014 El Paso Community Behavioral Health System Assessment[1] and the 2017 El Paso Behavioral Health Consortium Assessment[2] to assess changes in demand or provision of behavioral health services over time.

We submitted an initial report on quantitative data in October2020. This final report updates information on hospital utilization patterns and mental health need from 2018 to 2019. The goal of this updated quantitative data summary is to provide a revised description, when possible, of the prevalence of behavioral health conditions and co-occurring substance use disorders (SUD) and mental health conditions in El Paso County and the use of emergency departments and inpatient facilities for behavioral health care in 2019.

In this executive summary, we highlight major findings from the quantitative analysis. Additional detail is provided in the narrative of the report's main body. Please note that *Appendix One: Prevalence Estimation Methodology* and *Appendix Two: El Paso County Hospital Data and Methodology* present detailed discussions of the methodology and data sources used in these analyses, while *Appendix Three: Ancillary Tables* provides supplemental tables.

Core prevalence and utilization data. In 2019, approximately 10,000 El Paso County children and youth had serious emotional disturbances (Table 2), and about 25,000 adults had serious mental illnesses (Table 6). Across all ages, 80% of those with serious emotional disturbances (SED) and more than half of those with serious mental illnesses (SMI) lived in poverty. When

[1] TriWest Group. (2014, February). *El Paso community behavioral health system assessment: Final summary of findings and recommendations*. www.healthypasodelnorte.org/content/sites/pasodelnorte/Behavioral_Health_/El_Paso_Community_BH_Assesssment_-_Final_Report_2014_03_12.pdf

[2] Meadows Mental Health Policy Institute. (2017, March 23). *El Paso community behavioral health consortium assessment: Final report and recommendations.* www.healthypasodelnorte.org/content/sites/pasodelnorte/Behavioral_Health_/El_Paso_BHC_Assessment_FINAL_REPORT.pdf

contrasting counts of people served, by setting, at Emergence Health Network (EHN) – the local mental health authority (LMHA) – to the estimated number of people living in poverty with SED or SMI (Table 2 and Table 6), we found that there was a large gap in care for those who were living in poverty, and just over one third of children and 70% of adults in need received care through the LMHA.

Prevalence and service utilization date. Since our 2014 needs assessments and 2017 behavioral health consortium assessment, the population of children and youth in El Paso County has remained relatively stable, but the adult population has increased by 50,000 – a net population increase. The number of El Paso County residents living in poverty has declined, but roughly half of the county's residents continue to live below the federal poverty level.

This net increase in the population would suggest an increase in the demand for behavioral health services in El Paso County, and our data show small increases in the need for behavioral health services among adults only. During the same time frame, the rate of SED among children and youth living in poverty and the rate of SUD-related needs declined.[3] After adjusting for differences in the population size over time, the portion of adults with SUD, major depression, and SMI increased.

The number of children and youth who were served by EHN increased by 76% between 2014 and 2019 (Table 18). Most of this growth was in crisis service provision (142% increase), complex services (an increase of more than 500%), and young child services, with a nearly four-fold increase in the number of young children served (Table 18). This increase in the number of children and youth who were served indicates that EHN reached a greater proportion of children and youth in need of behavioral health services in 2019 than it did in 2014 (Table 18).

EHN's data suggest that the number of adults it served has remained stable over time, but the type of services it has provided to adults has shifted. For example, the majority of adults (53%) served by EHN in 2014 received medication and case management (Level of Care 3 [LOC 3], based on criteria established by the Texas Health and Human Services Commission), with 2,152 unduplicated adults receiving these services (Table 19). In contrast, EHN most commonly provided crisis services in 2019 (2,068 unduplicated adults served; 19% of all services provided), and the provision of Assertive Community Treatment (ACT) services nearly doubled between 2014 and 2019. This transition to higher levels of care may suggest that EHN served people with more severe or advanced behavioral health conditions in 2019 compared to 2014.

[3] This assessment accounted for the changing population size.

Capacity of El Paso County Hospitals to Serve the Needs of Residents

The largest local inpatient hospital, El Paso Behavioral Health System, often operated at or above reported capacity levels between 2014 and 2019. During the same time frame (2014 to 2019), the number of adults who occupied beds at the El Paso Psychiatric Center (the state psychiatric hospital) declined from 70 to 64 (Figure 14). The number of psychiatric beds dedicated for adult patients declined slightly (six fewer adult beds), as did the number of adult patients who occupied those beds.[4] Nearly all El Paso resident children and youth were treated in local psychiatric beds (see Appendix Three, Table 34).

With the 2019 opening of Rio Vista Behavioral Health (Rio Vista), which provides inpatient psychiatric services, El Paso County does not appear to have a shortage of psychiatric bed capacity. During its first 11 months of operation, Rio Vista experienced a steady increase in the number of occupied beds, with an average of 24 patients filling the 80 available beds. During the same time frame, fewer than one hundred (92) El Paso County residents were admitted to non-local psychiatric beds (Table 34). However, among people who were hospitalized in a psychiatric bed after visiting an El Paso County emergency department, only 70% were hospitalized locally. This might indicate a need for additional local capacity to meet local needs; however, a substantial portion of people admitted to inpatient psychiatric beds from El Paso emergency departments were not El Paso residents and may have sought care outside of El Paso for other reasons. As Rio Vista's operations continue to ramp up, it is likely that El Paso will have sufficient local bed capacity to meet the demand for inpatient psychiatric care.

The primary provider of psychiatric and SUD treatment services in El Paso County is the El Paso Behavioral Health System. This facility provides services to a diverse array of residents and non-residents. In 2019, approximately half (51%) of the people admitted to El Paso Behavioral Health System received Medicaid and one third had commercial insurance (Table 24).[5] Non-local clients admitted to El Paso Behavioral Health System were more likely than local clients to be recipients of Medicaid (70% of non-local resident admissions versus 48% for local residents) and less likely to be covered by commercial insurance (20% of non-local resident admissions versus 37% for local residents; Table 24). Rio Vista's largest proportion of patients had their services covered by other government sources (42%) such as the Department of Veteran's Affairs or LMHA funds, with small proportions reporting their services were covered either by commercial insurance or self-pay (20% and 19%, respectively). Overall, patients who had commercial insurance were more often hospitalized non-locally (Table 23). This variation reflects the wider range of hospital choices available to people who have commercial insurance

[4] TriWest Group. (2014, February).

[5] MMHPI is continuing to revise its classification of payer mix using the THCIC data. As a result, there may be discrepancies between the data reported here and internal hospital classifications.

plans, but it does not necessarily reflect that people with other payer types have reduced access to quality care.

People who were on Medicare or self-paid for services were less likely to receive inpatient care after visiting an emergency department. A comparison of all El Paso County psychiatric emergency department visits (Figure 11) to psychiatric emergency department visits that resulted in inpatient hospitalization (Table 23) in 2019 showed that people who paid out of pocket for services received inpatient care less frequently after visiting an emergency department than did people with commercial insurance.

In summary, it appears that progress has been made in building service capacity to treat the behavioral health needs of El Paso County residents since 2014. Although El Paso Behavioral Health System's inpatient psychiatric program often functions at or near capacity, the addition of Rio Vista Behavioral Health's 80 inpatient beds should provide ample inpatient capacity to serve the needs of El Paso County residents. Given EHN's trajectory of expanded community reach since 2014 (and being on track to serve more El Paso County children, youth, and adults each year), and that it serves approximately half of the county's residents who are in need of behavioral health services (Table 14 and Table 16), additional services – particularly community-based services – may need to be expanded to accommodate increases in demand for behavioral health services.

El Paso County Community Demographics and Prevalence Data

Adults, children, and youth have distinct but overlapping behavioral health needs that are best treated within systems of care. A system of care is a coordinated network of community-based services and supports that is created to meet the challenges faced by adults with serious mental illnesses (SMI) and children and youth at risk for or diagnosed with serious emotional disturbances (SED), and their families.[6] The capacity needed in each system depends on the number of people with behavioral health needs, which changes with the size of each population. For this reason, we begin our preliminary analysis of El Paso County's behavioral health system with a demographic description of the adult, child, and youth population sizes and projected future growth rates for each.

The link between poverty and poor behavioral health outcomes is well established. According to an article published in the Journal of Clinical Psychology, there is a bi-directional association between poverty-related stress and mental health disorders – poverty-related stress is associated with an elevated risk for mental health disorders, and living with severe mental illness increases the likelihood of experiencing poverty.[7] This article also noted that people who live in poverty have higher rates of chronic stress and uncontrollable life events when compared to the general population; common stressors faced by low-income individuals and families include economic strain, family conflict, exposure to violence, frequent moves and transitions, and exposure to discrimination and other traumatic experiences. The exposure to multiple stressors puts people with low incomes at greater risk for mental illness. As such, because people living in poverty often have higher rates of behavioral health needs and are dependent on the publicly funded behavioral health system, we provide additional data on the number of people living in poverty within each group and the number of these people with the most severe forms of mental illness.

We obtained demographic and population data from the U.S. Census Bureau's 2019 American Community Survey. Population growth projections for adults, children, and youth were obtained from the Texas Demographic Center. Figure 1, Figure 2, and Map 1 present data on children and youth; Figure 4, Figure 7, and Map 2 cover adults. Tables in later sections report all ages, except where breakouts are provided by age group.

[6] Whitson, M. L., Kaufman, J. S., & Bernard, S. (2009). Systems of care and the prevention of mental health problems for children and their families: Integrating counseling psychology and public health perspectives. *Prevention in Counseling Psychology: Theory, Research, Practice and Training*, *3*(1), 3–9.

[7] Santiago, C., Kaltman, S., & Miranda, J. (2012). Poverty and mental health: How do low-income adults and children fare in psychotherapy? *Journal of Clinical Psychology*, *69*. https://doi.org/10.1002/jclp.21951

Child and Youth Demographics and Behavioral Health Conditions

Table 1 provides detailed population estimates from 2019, with a demographic breakdown (including age, sex, race, and ethnicity) of children and youth in El Paso County. Because the prevalence of behavioral health care needs for young children is poorly understood, and very few receive any type of treatment, we do not provide population data for children under the age of six. The population of El Paso County in 2019 was predominantly Hispanic or Latino, evenly split between male and female children and youth, with more than half of children and youth living below 200% of the federal poverty level.

Children and youth between the ages of six and 11 made up just under half (47%) of the total population, but accounted for 60% of the number of children and youth under 18 years who were living in poverty (Table 1). Thus, younger children and youth were slightly more likely to live in poverty than were older children and youth in El Paso County. This is particularly important because research suggests that poverty is generally associated with a higher burden of mental illness; length of exposure to poverty and childhood exposure to poverty have been strongly associated with poorer mental health outcomes.[8] Similarly, non-Hispanic White children and youth represented 8% of the total population but only 6% of the population in poverty. Hispanic and Latino children and youth represented 87% of the population and 92% of the population in poverty.

Table 1: Demographics of Children and Youth in El Paso County (2019)[9]

Population	Total Population	Total Population with SED	Total in Poverty[10]	Total Population with SED in Poverty
Children and Youth (6–17)	160,000	10,000	90,000	8,000
Age				
Ages 6–11	75,000	6,000	45,000	4,000
Ages 12–17	80,000	6,000	45,000	4,000
Sex				
Male	80,000	6,000	45,000	4,000
Female	75,000	6,000	45,000	4,000

[8] Hodgkinson, S., Godoy, L., Beers, L. S., & Lewin, A. (2017). Improving mental health access for low-income children and families in the primary care setting. *Pediatrics*, *139*(1). doi.org/10.1542/peds.2015-1175

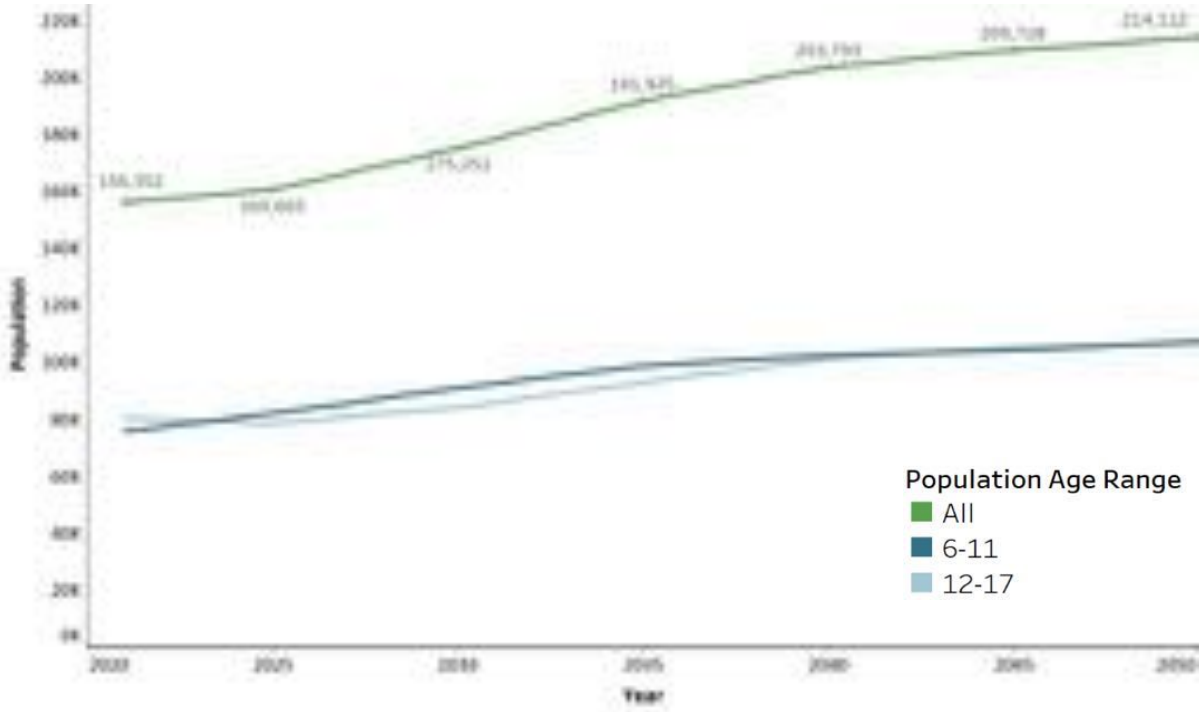
[9] All Texas population estimates were rounded to reflect uncertainty in the underlying American Community Survey estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts.

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

Population	Total Population	Total Population with SED	Total in Poverty[10]	Total Population with SED in Poverty
Race/Ethnicity				
Non-Hispanic White	15,000	900	5,000	500
Black or African American	3,000	200	700	60
Asian American	1,000	100	300	30
Native American	400	30	300	30
Multiple Races	2,000	200	1,000	90
Hispanic or Latino	140,000	10,000	85,000	8,000

Figure 1 shows the projected population change among children and youth in El Paso County. The population of children and youth is expected to *increase* by more than 57,000 children and youth between 2021 and 2050, with the population remaining relatively stable through 2025. This represents a 37% increase by 2050, with a slightly higher increase among children ages six to 11 (42%) compared to youth ages 12 to 17 (37%). Based on these projections, the underlying need for behavioral health services for children and youth in El Paso County should show some growth through 2025 and more linear growth thereafter, especially for younger children.

Figure 1: Estimated Population of Children and Youth in El Paso County (2020–2050)[11]

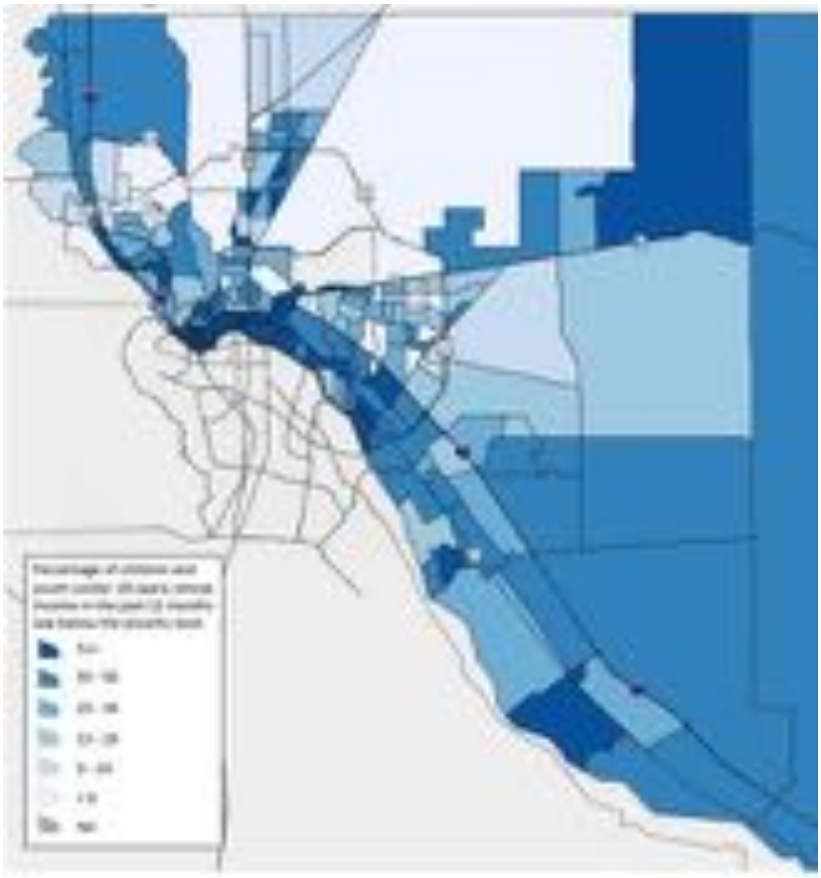


Map 1 and Map 2 show El Paso County census tracts, which are small, relatively permanent statistical subdivisions of a county or equivalent entity.[12] Census tracts are shaded to show which tracts housed the most people living in poverty in 2019, with Map 1 depicting children and youth living in poverty and Map 2 showing adults living in poverty. Darker regions in Map 1 signify a greater proportion of children and youth living in poverty. As this map shows, central El Paso and the lower valley (southeastern) region near the U.S.–Mexico border had tracts with the greatest proportion of children and youth living in poverty, whereas the northwestern region bordering Ciudad Juárez had lower counts of children and youth in poverty. Poverty is an important social determinant of health. Therefore, service locations should be closely matched with locations where children and youth are living in poverty to alleviate transportation barriers and other constraints their families face in accessing care.

[11] Estimated 2019 populations were obtained from the American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018).

[12] United States Census Bureau. (n.d.). *Glossary*. www.census.gov/programs-surveys/geography/about/glossary.html

Map 1: Children and Youth Under Age 18 in Poverty, by Census Tract (2019)[13]



Map 2 shows the distribution of poverty for adults, by census tract, in El Paso County, with darker regions representing a greater proportion of adults living in poverty. The geographic distribution of adults in poverty varied from the distribution of children and youth in poverty in that adults living in poverty were largely concentrated in the central El Paso region, with rates of adults living in poverty decreasing with increased distance from the city's core.

[13] Poverty data were obtained from the U.S. Census Bureau, TIGER/Line with Selected Demographic and Economic Data. www.census.gov/geographies/mapping-files/time-series/geo/tiger-data.html

Map 2: Adults in Poverty, by Census Tract (2019)[14]

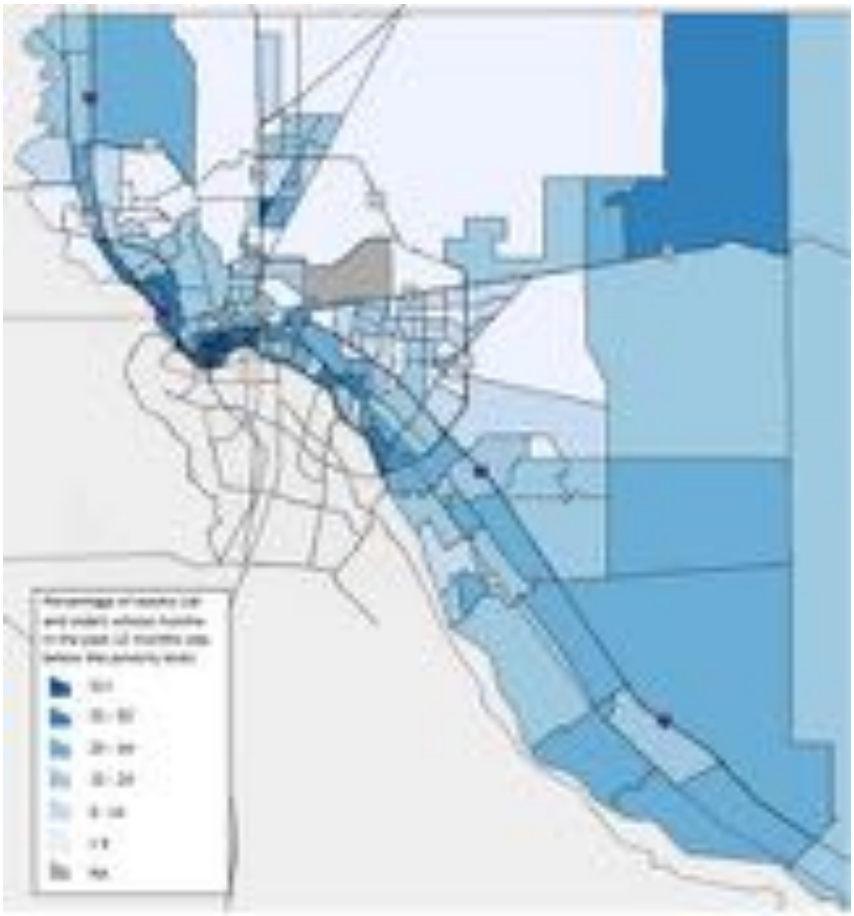


Figure 2 and Table 2 provide prevalence estimates of various mental health conditions and substance use disorders among children and youth in El Paso County in 2019. As shown in Figure 2, there were about 60,000 children and youth in El Paso County with any mental health needs in 2019.

Among children and youth with any mental health condition, more than half (about 35,000) had mild conditions, whereas about 15,000 had moderate conditions and another 10,000 had mental health needs that caused substantial impairment and are considered an SED. Nearly eighty percent (80%; 8,000) of the children and youth with an SED were living in poverty (Table 2). The most severe conditions (conditions causing so much impairment that the child or youth is at risk for out-of-home or out-of-school placement or involvement in the child welfare or juvenile justice systems) affected about 800 children and

Children and Youth with Any Mental Health Need

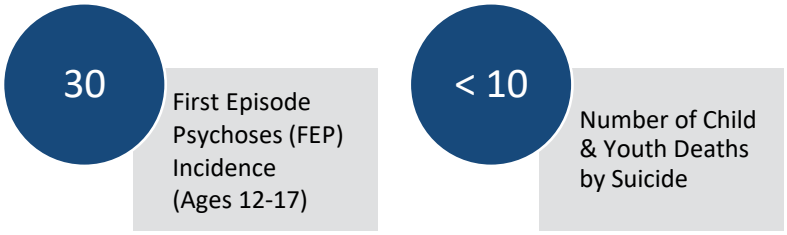
60,000

[14] U.S. Census Bureau, TIGER/Line with Selected Demographic and Economic Data.

youth in the region (Table 2). These children and youth would benefit from intensive wraparound care that could be provided at the local mental health authority through Youth Empowerment Services (YES) Waiver services.[15]

Figure 2: Distribution of Mental Health Needs Among El Paso County Children and Youth (2019)[16]

The most common condition affecting children and youth in El Paso County was depression, which was experience by an estimated 10,000 children and youth in 2019 (Table 2). The second most common conditions experienced among El Paso County children and youth were anxiety and self-injury / self-harming behaviors, which was experienced by 8,000 children and youth. Other common disorders included conduct disorder (a type of behavioral disorder characterized by antisocial behavior such that a child may disregard basic social standards and rules),[17] which affected 4,000 children and youth, and post-traumatic stress disorder (a condition triggered by acute or chronic exposure to traumatic or terrifying events),[18] which affected 3,000 children and youth. According to the most recent data available from the Centers for Disease Control and Prevention, fewer than ten children and youth completed suicide in El Paso County in 2019 (Table 2).[19]



[15] The Youth Empowerment Services (YES) Waiver is a 1915(c) Medicaid program that helps children and youth with serious mental, emotional, and behavioral difficulties.

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

[17] Stanford Children's Health. (n.d.). *Conduct disorder in children.* www.stanfordchildrens.org/en/topic/default?id=conduct-disorder-90-P02560

[18] Mayo Clinic. (n.d.). *Post-traumatic stress disorder (PTSD).* www.mayoclinic.org/diseases-conditions/post-traumatic-stress-disorder/symptoms-causes/syc-20355967

[19] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2019 on CDC WONDER Online Database, released in 2021. Data are from the Multiple Cause of Death Files, 1999–2019, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10.html. In order to meet the CDC's confidentiality restraints, counts of deaths of fewer than 10 were suppressed using values of "<10."

Table 2: Twelve-Month Prevalence of Mental Health Disorders and Related Conditions Among El Paso County Children and Youth (2019)[20]

Mental Health Condition – Children and Youth	Age Range	Prevalence[21]
Total Population	**6–17**	**160,000**
Population in Poverty[22]	6–17	90,000
All Mental Health Conditions (Mild, Moderate, and Severe)[23]	**6–17**	**60,000**
Mild	6–17	35,000
Moderate	6–17	15,000
Serious Emotional Disturbance (SED)[24]	6–17	10,000
SED in Poverty	6–17	8,000
At Risk for Out-of-Home/Out-of-School Placement[25]	6–17	800
Specific Disorders – Youth		
Depression	12–17	10,000
Bipolar Disorder	12–17	2,000
Post-Traumatic Stress Disorder	12–17	3,000
Schizophrenia[26]	10–17	100
First Episode Psychosis (FEP) – New Cases per Year[27]	12–17	30
Obsessive-Compulsive Disorder[28]	6–17	3,000

[20] Unless otherwise referenced, prevalence estimates were estimated using data from Kessler, R. C., et al. (2012a).

[21] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

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

[23] Kessler, R. C., et al. (2012a) and Kessler, R. C., et al. (2012b).

[24] Holzer, C., Nguyen, H., & Holzer, J. (2019). *Texas county-level estimates of the prevalence of severe mental health need in 2019*. Meadows Mental Health Policy Institute. See Appendix One for additional information.

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

[26] Frejstrup Maibing, C., Pedersen, C., Benros, M., Brøbech, P., Dalsgaard, S., & Nordentoft, M. (2015). Risk of schizophrenia increases after all child and adolescent psychiatric disorders: A nationwide study. *Schizophrenia Bulletin,* 41*(4),* 963–970.

[27] Kirkbride, J. B., et al. (2017). The epidemiology of first-episode psychosis in early intervention in psychosis services: Findings from the Social Epidemiology of Psychoses in East Anglia [SEPEA] study. *American Journal of Psychiatry, 174*, 143–153.

[28] Boileau, B. (2011). A review of obsessive-compulsive disorder in children and adolescents. *Dialogues in Clinical Neuroscience, 13*(4), 401–411; Peterson, B., et al. (2001). Prospective, longitudinal study of tic, obsessive-compulsive, and attention-deficit/hyperactivity disorders in an epidemiological sample. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*(6), 685–695; and Douglas, H. M., et al. (1995). Obsessive-

Mental Health Condition – Children and Youth	Age Range	Prevalence[21]
Eating Disorders[29]	12–17	700
Self-Injury/Harming Behaviors[30]	12–17	8,000
Conduct Disorder[31]	12–17	4,000
Number of Deaths by Suicide[32]	0–17	<10
Specific Disorders		
All Anxiety Disorders[33]	13-17	8,000
Population with 1 or 2 Adverse Childhood Experiences (ACEs)[34]	0–17	85,000
Population with 3 or More ACEs	0–17	25,000

The estimated number of children and youth with adverse childhood experiences (ACEs) is also included in Table 2. Experiences of abuse or neglect; having incarcerated parents; and witnessing intimate partner violence, substance misuse, or mental illness within the home are all considered adverse childhood experiences. These types of stressful and traumatic events are correlated with a range of health problems throughout life, including substance use, behavioral health, and physical health conditions.[35] In 2019, about 25,000 children and youth in El Paso County had experienced three or more ACEs and had a much higher risk for health problems, including mental illness, later in life. It is also worth noting that there were relatively few new cases of first episode psychosis (FEP) in 2019 (about 30 cases). This comparatively small number makes intervention possible, assuming appropriate capacity to identify and treat individuals experiencing FEP.

compulsive disorder in a birth cohort of 18-year-olds: Prevalence and predictors. *Journal of the American Academy of Child and Adolescent Psychiatry, 34*(11), 1424–1431.

[29] Swanson, S. A., et al. (2011). Prevalence and correlates of eating disorders in adolescents: Results from the National Comorbidity Survey Replication Adolescent Supplement. *Archives of General Psychiatry, 68*(7), 714–723. This study included anorexia nervosa and bulimia nervosa only.

[30] Muehlenkamp, J. J., et al. (2012). International prevalence of adolescent non-suicidal self-injury and deliberate self-harm. *Child and Adolescent Psychiatry and Mental Health, 6*(11). https://doi.org/10.1186/1753-2000-6-10

[31] Kessler, R. C., et al. (2012a).

[32] Centers for Disease Control and Prevention. (2020).

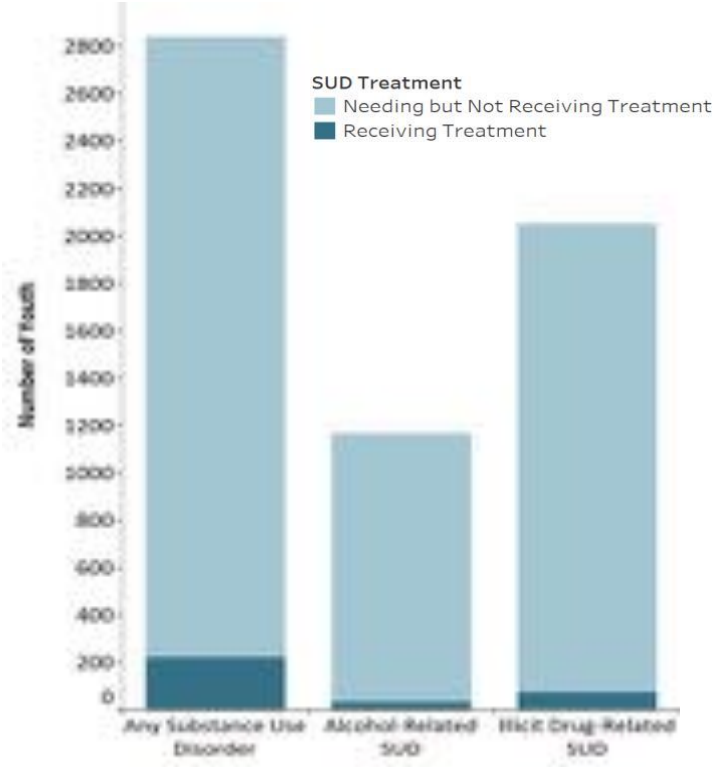
[33] Kessler, D. C., Petukhova, M., Sampson, N. A., Zaslavsky, A. M., & Wittchen, H-U. (2012c). Twelve-month and lifetime prevalence and lifetime morbid risk of anxiety and mood disorders in the United States: Anxiety and mood disorders in the United States. *International Journal of Methods in Psychiatric Research*, *21*(3), 169–184.

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

[35] SAMHSA-HRSA Center for Integrated Health Solutions. (n.d.). *Trauma.* www.integration.samhsa.gov/clinical-practice/trauma-informed

Figure 3 depicts the estimated number of youth with SUD in El Paso County in 2019; these data are numerically displayed in Table 3. In 2018–2019, there were approximately 3,000 youth in El Paso County with substance use disorders. One third (1,000) were living in poverty and one third (1,000) had co-occurring psychiatric and substance use disorders (Table 3). Very few youth received needed treatment for substance use disorders (Figure 3).

Figure 3: Substance Use Disorders Among El Paso County Children and Youth (2019)[36,37]



Despite these relatively low rates of treatment for substance use disorders, fewer than ten children and youth in El Paso County died from alcohol or drug-related causes in 2019.[38,39]

Alcohol and Drug Related Deaths (2019)

< 10

[36] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[37] All SUD prevalence rates were rounded to reflect uncertainty in the Texas Demographic Center estimates.

[38] Death by drug overdose data were obtained from Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2019 on CDC WONDER Online Database. Overdose deaths were classified using underlying cause-of-death ICD-10 codes: X40–44, X60–64, X85, and Y10–Y14. The Public Health Service Act (42 U.S.C. 242m(d)) requires that no data for death or birth counts of 9 or fewer are presented by sub-national geography. Therefore, any demographic groups with fewer than ten deaths were reported as <10. http://wonder.cdc.gov/mcd-icd10.html

[39] The number of alcohol-related deaths were obtained from the Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999–2019 on CDC WONDER Online Database. Alcohol

Table 3: Prevalence of Substance Use Disorders (SUD) Among El Paso County Youth (2019)[40,41]

Population	El Paso Youth Ages 12–17
Total Population	**80,000**
Total Population in Poverty	45,000
Any Substance Use Disorder	**3,000**
SUD in Poverty[42]	1,000
Needing but not Receiving Treatment for SUD	3,000
Comorbid Psychiatric and SUD[43]	**1,000**
Alcohol-Related SUD	**1,000**
Needing but not Receiving Treatment for Alcohol-Related SUD	1,000
Illicit Drug-Related SUD	**2,000**
Needing but not Receiving Treatment for Illicit Drug-Related SUD	2,000
Number of Alcohol and Drug-Related Deaths in 2019[44]	**< 10**

induced deaths were classified using any underlying cause of death and multiple causes of death category, "alcohol-induced causes." http://wonder.cdc.gov/mcd-icd10.html.

[40] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[41] All SUD prevalence rates were rounded to reflect uncertainty in the Texas Demographic Center estimates.

[42] The percentage of youth in poverty with an SUD is based on ABODILAL (Illicit Drug or Alcohol Dependence in Past Year) x Poverty Cross-tabulation, National Survey on Drug Use and Health, 2018–2019. The percentage was applied to the estimated number of youth in poverty in Texas according to the American Community Survey 2019 poverty proportions, applied to the Texas Demographic Center's 2018 population estimates.

[43] The prevalence of comorbid major depression and substance use disorders among youth ages 12–17 was based on the intersection between the national prevalence rate of major depressive episodes (MDE) and SUD, as reported in SAMHSA's 2019 report, *Behavioral Health Trends in the United States: Results from the 2018 National Survey on Drug Use and Health* (HHS Publication No. PEP19-5068, NSDUH Series H-54), and the 2018–2019 National Survey on Drug Use and Health (NSDUH) sub-state rates of MDE for Texas.

[44] Centers for Disease Control and Prevention. (2021).

Change in Behavioral Health Need for Children and Youth Between 2014 and 2019

Based on TriWest Group's 2014 behavioral health needs assessment,[45] the population of children and youth living in poverty in El Paso County has remained relatively stable,[46] with that rate declining slightly from 59% in 2014 to 58% in 2019.[47]

The stability of the child and youth population would suggest that the demand for mental health services among children and youth in El Paso County would at least approximate the 2014 levels. As displayed in Table 4 on the next page, an estimated 40,000 (18%) children and youth were in need of behavioral health services in 2014;[48] in 2019, this number increased to 60,000 (39%). The rate of children and youth with serious emotional disturbances (SED) increased only slightly between 2014 and 2019 (from 7% to 8% of children and youth) after adjusting for the change in population size over time.

There was no change in the prevalence rates of SED from 2018 to 2019. The proportion of children and youth with SED who were living in poverty also declined about 20% between 2014 and 2019. The number of children and youth with SUD-related needs also declined substantially from 7,000 to 3,000 between 2014 and 2019 (8% of children, 3% of youth). Note that these estimates, particularly pertaining to the decline in children and youth with SUD-related needs, were made with several caveats, which are noted in Table 4's footnotes. The noted reductions in SUD-related needs among children and youth between 2014 and 2019 may be fully attributable to changes in the way that SUD prevalence was measured over time, and may not reflect changes in the prevalence of SUD among children and youth in El Paso County.

[45] TriWest Group. (2014, February).

[46] To compare trends over time, we adjusted our estimates for this section only to include 2019 American Community Survey 5-year population estimates for children and youth ages zero to 17 only. As a result, population sizes reported in this section may not be comparable to those reported in the remainder of the data summary. www.census.gov/quickfacts/fact/table/elpasocountytexas/AGE295219#AGE295219.

[47] Caution should be used when comparing these estimates. Although these figures are adjusted for the different population sizes of children and youth in 2014 compared to 2019, different age categories were grouped in 2014 than in 2019. These should be considered as estimates only.

[48] In TriWest Group's 2014 report, mental health and SUD needs were combined into a single "behavioral health need" indicator. To validly compare 2014 and 2019 data, we pooled our estimates of substance use disorders and all mental health needs for 2019.

Table 4: Change in Population Demographics and Need for Behavioral Health Care Among El Paso County Children and Youth (2014–2019)[49,50]

Mental Health Condition – Children and Youth	Ages	El Paso County (2014)[51]	Ages	El Paso County (2019)
Total Children and Youth Population	0–17	**240,000**	0–17	**240,000**
Poverty Rate[52,53]	0–17	59%	6–17	58%
All Behavioral Health Needs (Mild, Moderate, and Severe)[54]	**0–17**	**40,000**	**6–17[55]**	**60,000**
Youth with SUD-Related Needs	12–17	7,000	12–17	3,000
Serious Emotional Disturbances (SED)[56]	0–17	20,000	6–17	10,000
SED in Poverty	0–17	10,000	6–17	8,000

Adult Demographics and Behavioral Health Conditions

On the next page, Table 5 details 2019 population estimates, by demographic group, for adults in El Paso County. Overall, about 610,000 adults lived in the county in 2019. The population was predominantly Hispanic or Latino (80%), with a smaller subset of the population identifying as Non-Hispanic White and smaller counts of Black or African American and other people of color. The population comprised slightly more females than males, and most of the population was in mid-adulthood (i.e., between the ages of 25 and 44). The population of young adults (ages 18 to 24) was similar to the size of the older adult population (65 years and older).

The poverty distribution was largely equal across age groups, with older adults ages 65 and older slightly over-represented among the population in poverty (Table 5). Females were also

[49] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.
[50] Prevalence data from the 2017 report were not included because no information on the age ranges was provided. Therefore, we were unable to assess the suitability of the data for examining changes over time.
[51] TriWest Group. (2014, February).
[52] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level for the region.
[53] These rates are not directly comparable because the American Community Survey used varying methodological approaches to calculate poverty rates in 2014 than it did in 2019. Adjusting for the variable age ranges, the poverty rate declined from 59% in 2014 to 58% in 2019.
[54] These data should be interpreted with caution. The 2014 TriWest group report included children ages 0 to 5, who are unlikely to suffer from mental illness or use substances. This would artificially reduce the need for services.
[55] The Meadows Mental Health Policy Institute currently uses age ranges of 6 to 17 years to estimate most mental health needs and 12 to 17 years to estimate substance use disorder needs among children and youth.
[56] Holzer, C., Nguyen, H., & Holzer, J. (2019).

slightly more likely than males to be in poverty, as were Hispanic or Latino adults (81% of the total population and 89% of the population in poverty). Of adults in El Paso County, 75% were U.S born, 29% spoke English as their primary language at home, and one fourth were uninsured.[57] Although 85% of households had a computer in their home, one fourth of El Paso County adult residents did not have broadband internet. According to Pew Research Center, an estimated 55,000 El Paso County residents were undocumented,[58] with 94% of the undocumented population originating from Mexico.[59]

Table 5: Demographics of Adults in El Paso County (2019)[60]

El Paso County	Population	Population with SMI	Adults in Poverty[61]	Adults with SMI in Poverty
Adult Population 18 and Older	610,000	25,000	260,000	15,000
Age				
18–20	40,000	700	20,000	500
21–24	60,000	2,000	25,000	1,000
25–34	120,000	7,000	55,000	5,000
35–44	110,000	7,000	45,000	5,000
45–54	95,000	5,000	35,000	3,000
55–64	85,000	3,000	35,000	2,000
65 and Older	100,000	2,000	45,000	1,000
Sex				
Male	290,000	10,000	110,000	6,000
Female	310,000	15,000	150,000	10,000
Race/Ethnicity				
Non-Hispanic White	85,000	4,000	20,000	2,000

[57] United States Census Bureau. (2020). *QuickFacts: El Paso County, Texas.* www.census.gov/quickfacts/elpasocountytexas

[58] Pew Research Center. (2019, March 11). *Estimates of unauthorized immigrant population, by metro area, 2016 and 2007*. www.pewresearch.org/hispanic/interactives/unauthorized-immigrants-by-metro-area-table/

[59] Migration Policy Institute analysis of U.S. Census Bureau data from the pooled 2012–2016 American Community Survey and the 2008 Survey of Income and Program Participation. www.migrationpolicy.org/data/unauthorized-immigrant-population/county/48141

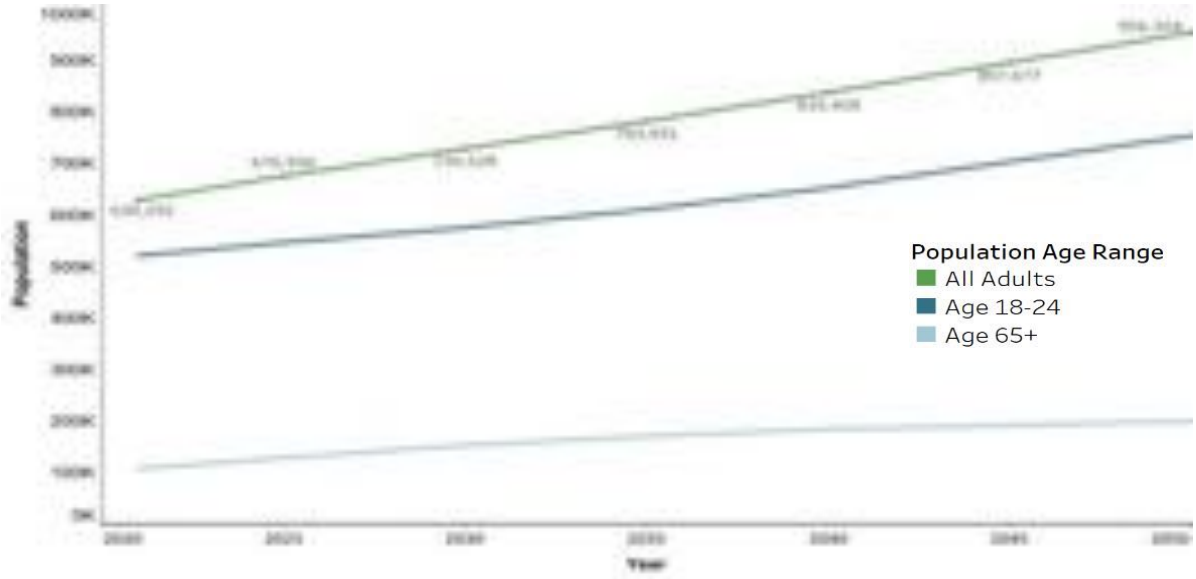
[60] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

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

El Paso County	Population	Population with SMI	Adults in Poverty[61]	Adults with SMI in Poverty
Black or African American	20,000	1,000	5,000	400
Asian American	8,000	200	2,000	70
Native American	2,000	100	800	80
Multiple Races	4,000	200	1,000	100
Hispanic or Latino	490,000	20,000	230,000	15,000

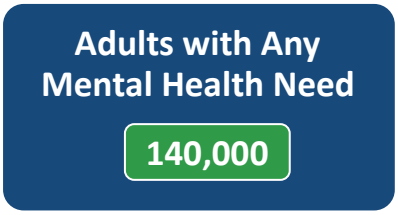
Figure 4 shows the projected population of adults living in El Paso County through 2050. The overall population is expected to increase by 52% by 2050 (from about 630,000 adults in 2021 to 956,000 in 2050), with the older adult population growing faster (86% increase) than other adult populations (52% increase). As a result, the need for behavioral health services for older adults may increase disproportionately to other age groups. Since 2014, the total population of adults has increased by nine percent (9%). If this population growth increases the demand for behavioral health services proportionally, we expect to see an increase in the need for and utilization of behavioral health services.

Figure 4: Estimated Population of Adults in El Paso County – 2021 through 2050[62]



[62] Estimated 2019 population data were obtained from the American Community Survey population estimates. Projected population change was obtained from: Texas Demographic Center (2018).

Above, we described core demographic information. This next section provides an overview of the estimated recent prevalence of specific behavioral health conditions and disorders, and their severity, in El Paso County.



As shown in Table 6, there were about 610,000 adults living in El Paso County in 2019 and slightly less than one quarter of adults in the region (about 140,000) had any mental health condition. The majority of adults living with mental health conditions had conditions that were mild to moderate in severity (82%; 115,000), which could be treated in primary care settings, ideally with psychiatric consultation available (Table 6 and Figure 5).[63,64] The rest (about 25,000) had serious mental illnesses (SMI), more than half of whom (15,000) were living in poverty. Most people with SMI would benefit from treatment in a specialized behavioral health setting, such as treatment provided in local mental health authority community clinics. When not properly treated, SMI can lead to high rates of crisis service utilization, including frequent use of hospitals, emergency rooms, and jails. Often, people with SMI can benefit from intensive outpatient services such as Assertive Community Treatment (ACT).[65,66] As noted in Table 6, below, we estimated that in El Paso County, about 300 adults could benefit from ACT, two thirds of whom may benefit from Forensic ACT (FACT) because of their involvement in the criminal justice system.

[63] Integrated care combines primary health care and behavioral health care in one setting.

[64] Meadows Mental Health Policy Institute experts estimated that the proportion of the adult population with mental health needs who are best treated in integrated primary care settings is approximately equal to the proportion of the adult population with mental health needs that are mild or moderate in severity. Some people with serious mental illnesses (e.g., people with major depression) can be effectively treated in integrated primary care, and some people with moderate mental illnesses need care at specialty settings. These offsetting factors approximately cancel each other.

[65] Assertive Community Treatment (ACT) is a team-based treatment model that provides multidisciplinary, flexible treatment and support to people with mental illness, 24 hours a day, 7 days a week. ACT is based on the idea that people receive better care when their mental health care providers work together. ACT team members help consumers with every aspect of their lives, including medication, therapy, social support, employment, or housing.

[66] National Alliance on Mental Illness. (n.d.). *Psychosocial treatments*. www.nami.org/About-Mental-Illness/Treatments/Psychosocial-Treatments

Figure 5: Distribution of Mental Health Needs Among El Paso County Adults (2019)[67]

Table 6: Twelve-Month Prevalence of Mental Health Disorders for Adults in El Paso County (2019)[68]

Mental Health Condition – Adults	El Paso County
Total Adult Population	**610,000**
Population in Poverty[69]	260,000
All Mental Health Needs (Mild, Moderate, and Severe)[70]	**140,000**
Mild	60,000
Moderate	55,000
Serious Mental Illness (SMI) [71]	25,000
SMI in Poverty	15,000
Complex Needs without Forensic Need (ACT)[72]	300
Complex Needs with Forensic Need (FACT)[73]	200
Specific Diagnoses	
Major Depression[74]	45,000
Bipolar I Disorder[75]	3,000
Post-Traumatic Stress Disorder[76]	20,000

[67] Kessler, R. C., et al. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication. *Archives of Gen Psychiatry, 62*(6), 617–627.

[68] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

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

[70] Kessler, R. C., et al. (2005).

[71] Holzer, C., Nguyen, H., & Holzer, J. (2019). See Appendix One for more information.

[72] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006). How many assertive community treatment teams do we need? *Psychiatric Services, 57*(12), 1803–1806.

[73] Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008). How many forensic assertive community treatment teams do we need? *Psychiatric Services, 59*, 205–208.

[74] Holzer, C., Nguyen, H., & Holzer, J. (2019).

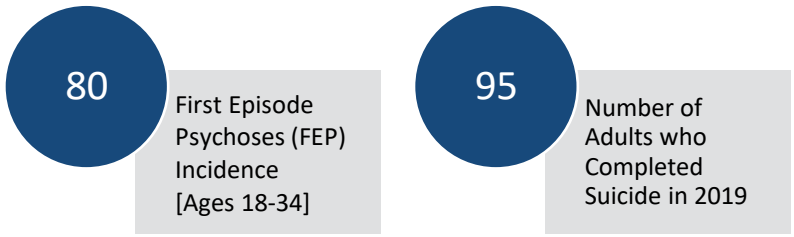
[75] Holzer, C., Nguyen, H., & Holzer, J. (2019).

[76] Kessler, R. C., et al. (2005).

Mental Health Condition – Adults	El Paso County
Schizophrenia[77]	3,000
First Episode Psychoses (FEP) Incidence – New Cases per Year (Ages 18–34)[78]	80
Number of Adults who Completed Suicide[79]	95

Based on 2019 data, most mental health needs for adults (as with children and youth) included major depression (45,000 adults) and post-traumatic stress disorder (20,000 adults). Bipolar disorder and schizophrenia represented approximately 3,000 cases each. There was a comparatively larger number of anticipated cases of first episode psychosis (FEP) among adults (80) compared to youth (30). According to the Centers for Disease Control and Prevention, 95 El Paso County adults completed suicide in 2019 – an increase of five people from 2018.

As shown in Figure 6, below, El Paso County experienced a higher than average increase in the unemployment rate during April 2020 compared to January 2020.[80] We projected that Texas would see an estimated 300 additional suicide deaths attributable to COVID-related unemployment.[81] Based on the unemployment rate in El Paso County, we expect that approximately 17 of those additional deaths will occur in El Paso County if this trend continues. Given the 95 deaths from suicide in El Paso County in 2019, we anticipate that COVID-related deaths from suicide will exceed the expected suicide rate in the county, beginning in 2020. If these increases in COVID-related deaths from suicide are distributed equally across three years, the number of suicide deaths in El Paso during 2020 would exceed 105 deaths.



[77] Simeone, J. C., Ward, A. J., Rotella, P., Collins, J. & Windisch, R. (2015). An evaluation of variation in published estimates of schizophrenia prevalence from 1990–2013: A systematic literature review. *BMC Psychiatry*; *15*:193.

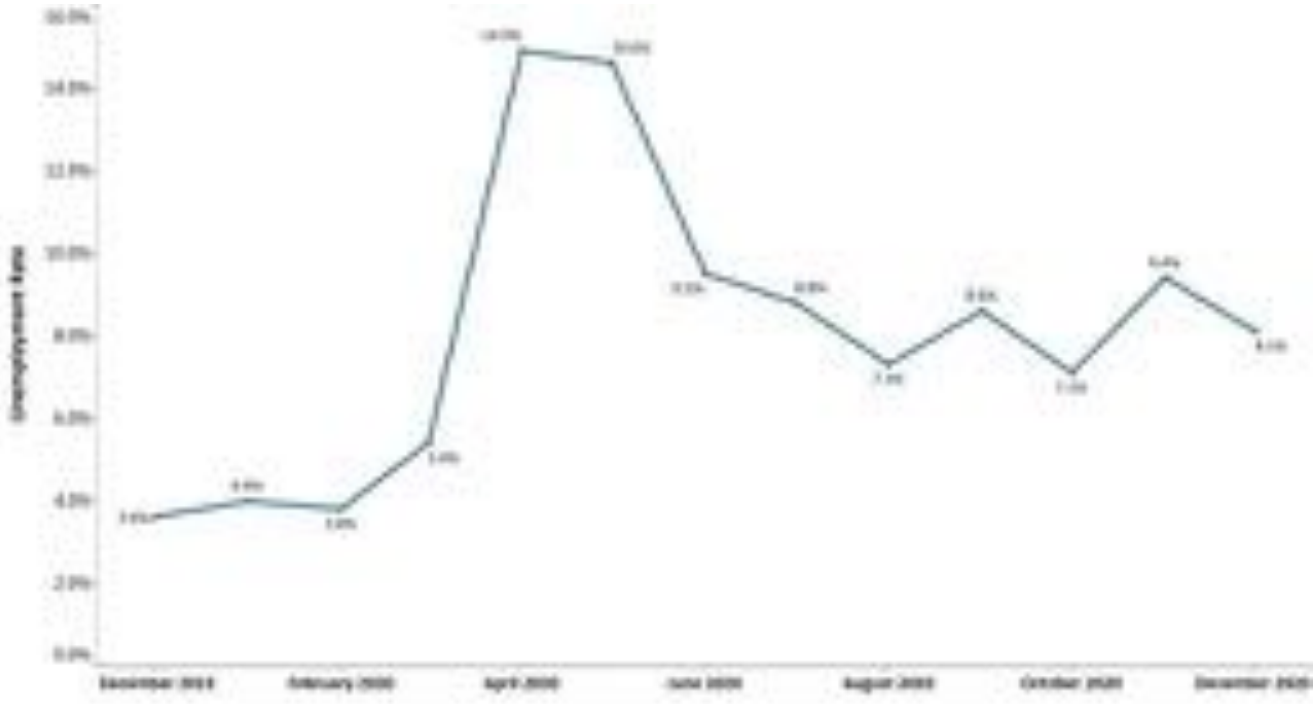
[78] Simon, G. E., Coleman, K. J., Yarborough, B. J. H., Operskalski, B., Stewart, C., Hunkeler, E. M., Lynch, F., Carrell, D., & Beck, A. (2017). First presentation with psychotic symptoms in a population-based sample. *Psychiatric Services, 68*(5): 456–461.

[79] Centers for Disease Control and Prevention. (2020).

[80] Seasonally adjusted unemployment rates were obtained from the Bureau of Labor Statistics. (2020). *Economy at a glance—El Paso, Texas.* www.bls.gov/eag/eag.tx_elpaso_msa.htm#eag_tx_elpaso_msa.f.1

[81] Meadows Mental Health Policy Institute. (2020, April 28). Projected COVID-19 MHSUD impacts, volume 1: Effects of COVID-induced economic recession (COVID recession). www.texasstateofmind.org/uploads/whitepapers/COVID-MHSUDImpacts.pdf

Figure 6: El Paso County Unemployment Rate[82]

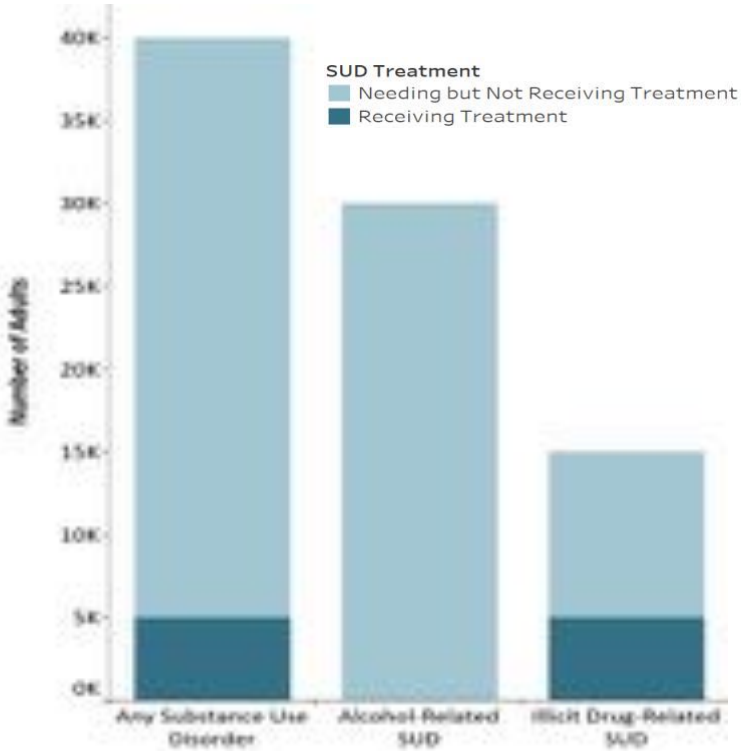


As shown in Figure 7 and Table 7 (on the next page), in 2019, around 40,000 adults in El Paso County had substance use disorders (SUD), more than half of whom (25,000) were people living in poverty. More than half (25,000) of all SUD cases involved co-occurring psychiatric and substance use disorders. In 2019, at least 96 adults died because of drug overdose, and at least 114 adults died of alcohol-related causes. As shown in Figure 7, very few adults who needed SUD treatment received it (approximately 5% of adults who were in need of care received treatment).

Drug-Related Deaths (2019)	96
Alcohol-Related Deaths (2019)	114

[82] Bureau of Labor Statistics. (2021).

Figure 7: Estimated Substance Use Disorders Among Adults in El Paso County (2019)[83]



We also projected the impact of COVID-related unemployment on drug overdose deaths and increases in the prevalence of substance use disorders.[84] Applying our models to local data from El Paso County, we estimate that a prolonged unemployment rate of 10% could result in as many as 30 additional substance-related deaths and 2,000 adults with new SUD diagnoses. Therefore, El Paso County Behavioral System should consider the potential COVID-related increases in addition to the baseline need for sufficient care capacity detailed in this assessment.

Table 7: Prevalence of Substance Use Disorders (SUD) Among El Paso County Adults (2019)[85,86]

Population	El Paso
Total Population	**610,000**
Total Population in Poverty	260,000

[83] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[84] Meadows Mental Health Policy Institute. (2020, April 28).

[85] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[86] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

Population	El Paso
Any Substance Use Disorder	**40,000**
SUD in Poverty[87]	15,000
Comorbid Psychiatric and Substance Use Disorders[88]	15,000
Needing but not Receiving Treatment for SUD	35,000
Alcohol-Related SUD	**30,000**
Needing but not Receiving Treatment for Alcohol-Related SUD[89]	30,000
Illicit Drug-Related SUD	**15,000**
Needing but not Receiving Treatment for Illicit Drug-Related SUD[90]	10,000
Number of Drug-Related Deaths in 2019[91]	**96**
Number of Alcohol-Induced Deaths in 2019[92]	**114**

Change in Behavioral Health Needs for Adults Between 2014 and 2019

Based on TriWest Group's 2014 behavioral health needs assessment,[93] the population of adults in El Paso County has increased by nearly 50,000. The proportion of adults living in poverty in the county declined from nearly sixty percent (59%) in 2014 to less than fifty percent (43%) in 2019. The increase in the adult population would suggest an increase in the demand for behavioral health services in El Paso County. Table 8, below, shows that in 2014, an estimated 170,000 (30%) adults were in need of behavioral health services;[94] in 2018, this number decreased to 140,000 (23% of the total population). The need for behavioral health services continued to decline in 2019, with 140,000 of the 610,000 El Paso resident adults needing behavioral health care – a decline of 7% since 2014.

The number and percentage of adults with SUD-related needs appears to have decreased substantially from 65,000 (12%) to 40,000 (6%) between 2014 and 2019, although because of changes in data sources used in the respective analyses, this apparent decrease should be considered with caution (as in the case with the estimated decline in children and youth

[87] National Survey on Drug Use and Health (2018-2019), American Community Survey (2019), and Texas Demographic Center (2018).

[88] SAMHSA's 2019 report, *Behavioral Health Trends in the United States*, the 2017–2018 NSDUH AMI rates for Texas.

[89] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[90] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[91] Centers for Disease Control and Prevention. (2021).

[92] Centers for Disease Control and Prevention. (2021).

[93] TriWest Group. (2014, February).

[94] In TriWest Group's 2014 report, mental health and substance use disorder needs were combined into a single "behavioral health need" indicator. To validly compare 2014 and 2019 data, we pooled our estimates of substance use disorders and all mental health needs for 2019.

substance use disorders discussed above). It appears that after adjusting for differences in the population size over time, the proportion of adults with SUD declined and the proportion of the population with major depression and SMI increased.

Finally, the suicide rate in El Paso County has been increasing over time, even when adjusting for the county's population growth. In 2014, more than fourteen out of every 100,000 El Paso County resident adults completed suicide. In 2017, the suicide rate per capita dropped to less than twelve adults per 100,000 residents. However, in 2018 and 2019, the rate of suicide exceeded the 2014 rate – 14.9 adults completed suicide per 100,000 adult county residents in 2018, and 15.5 per 100,000 adult county residents in 2019).[95]

Table 8: Change in Population Demographics and Need for Behavioral Health Care Among Adults in El Paso County (2014–2019)[96,97]

Mental Health Condition – Adults	El Paso County (2014)[98]	El Paso County (2017)[99]	El Paso County (2018)	El Paso County (2019)	Change from 2014–2019
Total Adult Population	**560,000**	**580,000**	**600,000**	**610,000**	**+50,000**
Population in Poverty[100]	330,000	300,000	300,000	260,000	-70,000
All Behavioral Health Needs (Mild, Moderate, and Severe)	**170,000**	**—**	**180,000**	**140,000**	**-30,000**
Serious Mental Illness	—	20,000	25,000	25,000	+5,000[101]
Substance Use Disorder (SUD)	65,000	—	40,000	40,000	–25,000
SUD in Poverty	40,000	—	15,000	15,000	–25,000
Major Depression	—	30,000	45,000	45,000	+15,000[102]

[95] Centers for Disease Control and Prevention (2021). Residents are individuals ages one and older. The number of children/youth who completed suicide in 2019 is not reported in order to avoid deductive disclosure.

[96] All Texas prevalence estimates were rounded to reflect uncertainty in the American Community Survey estimates.

[97] The prevalence of many behavioral health conditions in 2017 were not included because no information on the age ranges were provided. Therefore, we were unable to assess the suitability for comparisons over time.

[98] TriWest Group. (2014, February).

[99] The Meadows Mental Health Policy Institute. (2017, March 23).

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

[101] SMI prevalence was not estimated independently of SUD in 2014. Therefore, we compared the 2017 and 2019 prevalence estimates for this indicator.

[102] Major depression prevalence was not estimated in 2014. Therefore, we compared the 2017 and 2019 prevalence estimates for this indicator.

Mental Health Condition – Adults	El Paso County (2014)[98]	El Paso County (2017)[99]	El Paso County (2018)	El Paso County (2019)	Change from 2014–2019
Adults with Complex Needs	—	1,500	500	500	–1,000[103]
Suicide Deaths per 100,000 Population[104]	14.4	11.8	14.9	15.5	+4.5

Veteran's Mental Health

Table 9, below, provides details on the estimated population of veterans in El Paso County in 2019. Of the estimated 60,000 veterans living in El Paso County, approximately 10,000 (17%) lived with any mental illness, while around 8,000 (13%) used illicit drugs. An estimated 2,000 veterans in the county misused psychotherapeutics like antidepressants and antipsychotics, and an additional 2,000 El Paso County veterans used pain relievers non-medically.

Approximately 3,000 veterans in the region had a serious mental illness (SMI), and this rate accounted for ten percent (10%) of the 25,000 adults living with SMI in El Paso County (as listed in Table 6). Additionally, the rate of veterans with any mental health need was three times greater among female veterans than male veterans (30% versus 14%, respectively). Around 20 out of the 95 suicide deaths in El Paso County in 2019 were attributed to veterans. This means that veterans comprised only about ten percent of the adult population in El Paso County in 2019, yet they accounted for nearly one quarter of adult suicides. Therefore, it would be worthwhile to consider the unique needs of the veteran population in El Paso County when planning for community-level care.

Table 9: Prevalence of Mental Health and Substance Use Disorders Among Veterans in El Paso County (2019)[105]

Veteran Behavioral Health Conditions	Male	Female	Total[106]
Total Veteran Population	50,000	8,000	60,000

[103] The number of adults with complex needs was not estimated in 2014. Therefore, we compared the 2017 and 2019 prevalence estimates for this indicator.

[104] Centers for Disease Control and Prevention. (2021).

[105] Data were abstracted from the Substance Abuse and Mental Health Services Administration (SAMHSA)'s restricted online data analysis system (RDAS). National Survey on Drug Use and Health: 2-Year RDAS (2018 to 2019). rdas.samhsa.gov/#/survey/NSDUH-2017-2018-RD02YR/crosstab/?weight=DASWT_1&run_chisq=false&results_received=true

[106] Veteran prevalence and population estimates were rounded to reflect uncertainty in the Department of Veterans Affairs estimates. Because of this rounding, row or column totals may not equal the sum of their rounded counterparts.

Veteran Behavioral Health Conditions	Male	Female	Total[106]
Behavioral Health Condition	**Total Prevalence**		
Any Mental Illness	7,000	2,000	10,000
Serious Mental Illness	2,000	800	3,000
Major Depression	2,000	900	3,000
Alcohol Use Disorder	2,000	400	3,000
Illicit Drug Use	7,000	1,000	8,000
Nonmedical Use of Psychotherapeutics	2,000	400	2,000
Nonmedical Use of Pain Relievers	1,000	400	2,000
Estimated Veteran Suicide Deaths[107]	20	< 6	< 26

The El Paso Veterans Affairs Healthcare (VHA) System serves veterans residing in the El Paso metropolitan area. Table 10**,** below, presents the number of El Paso veterans who utilized VHA mental health service in fiscal year (FY) 2015 as well as the number of veterans who had mental health diagnoses, based on data from the Northeast Program Evaluation Center (NPEC).[108] Out of nearly 30,000 veterans who utilized VHA services, approximately 31% used mental health services, averaging eight visits per veteran. NPEC data showed that one fourth of all VHA users had a confirmed mental illness and one third had a possible mental illness.[109]

Table 10: El Paso Veteran Affairs Health Care System Mental Health Care Prevalence and Service Utilization (FY 2015)[110]

Mental Illness Among Veterans	El Paso VA Health Care System
Total Number of Veterans Who Used VHA Services	**29,137**
El Paso Area Veterans Who Received VHA Mental Health Services	9,039
Average Number of Mental Health Encounters per Veteran	8
Veterans with Diagnosed Mental Health Condition	**7,412**
Veterans Who Utilized Any VHA Mental Health Services	92%

[107] U.S. Department of Veteran Affairs. (2019). *State data appendix*. www.mentalhealth.va.gov/suicide_prevention/data.asp

[108] Northeast Program Evaluation Center (NEPEC). (2016, April). *FY15 annual data sheet on mental health*. https://mihiriyer.shinyapps.io/MentalHealth/

[109] Northeast Program Evaluation Center. (NEPEC). (2016, April).

[110] Northeast Program Evaluation Center. (NEPEC). (2016, April).

Characteristics of Behavioral Health Providers in El Paso County

Table 11 (on the next page) shows the number of licensed psychiatrists, psychologists, chemical dependency counselors, clinical social workers, professional counselors, and psychiatric nurse practitioners who were practicing in El Paso County in 2020. Sixty-seven (67) licensed psychiatrists were practicing in El Paso County in 2020.[111] This indicates that one psychiatrist was available per 11,500 El Paso County residents that year.[112] Out of these 67 psychiatrists, only 18 specialized in child and adolescent psychiatry, pediatric psychiatry, or developmental-behavioral pediatrics, according to reports to the Texas Medical Board. Given the population size of children and youth ages 6 to 17 in El Paso County in 2020,[113] we estimate that there was one child and adolescent psychiatrist in El Paso County per 9,000 child and youth residents.

In 2020, there was a total of 92 licensed psychologists with addresses in El Paso County, indicating that one licensed psychologist was available for every 8,500 El Paso County residents. There were also 148 licensed chemical dependency counselors (1 provider for every 5,000 residents), 652 licensed clinical social workers (1 provider for every 1,500 residents), 462 licensed professional counselors (1 for every 1,200 residents), and 54 psychiatric nurse practitioners (1 for every 14,000 residents). When compared to the number of mental health providers in Texas overall, in 2020, El Paso County had fewer providers per resident, except for licensed professional counselors and psychiatric nurse practitioners. El Paso County's number of licensed professional counselors per resident was equal to the state average in 2020.

[111] Registry data on all actively practicing physicians in the state of Texas were abstracted from the Texas Medical Board Open Records Self-Service Portal on March 30, 2020. orssp.tmb.state.tx.us/

[112] Many of the licensed psychiatrists with practice addresses in El Paso County were affiliated with local universities and may have had limited clinical appointments. Therefore, our providers-to-population ratio for all providers, and psychiatrists in particular, was likely an overestimation of the number of providers available to serve the El Paso County population.

[113] Texas Demographic Center. (2018).

Table 11: Number of Behavioral Health Care Providers in El Paso County (2020)[114,115]

Provider Type	Number of Providers in El Paso County	Number of El Paso County Residents per Provider	Number of Providers in Texas	Number of Texas Residents per Provider
Licensed Psychiatrists	67	11,500	3,112	8,200
Licensed Psychologists	92	8,500	9,248	2,800
Licensed Chemical Dependency Counselors	148	5,000	5,959	4,300
Licensed Clinical Social Workers	652	1,500	24,107	1,100
Licensed Professional Counselors	462	1,200	22,104	1,200
Psychiatric Nurse Practitioners	54	14,000	1,237	21,000

The demographic characteristics of psychiatrists and advanced practice registered nurses in El Paso County are provided Table 12. In 2020, among psychiatrists, most practitioners were male, White, and Non-Hispanic, with just under one third identifying as Hispanic or Latino. The majority of psychiatrists were engaged in direct patient care (72%), but just under one fourth had primarily research and teaching responsibilities. In contrast, for providers with a specialty in child and adolescent psychiatry, most practitioners were female, White, and Non-Hispanic, with even fewer providers (22%) identifying as Hispanic or Latino. One third of child and adolescent psychiatrists were engaged in teaching and research activities, leaving only twelve (12) providers who were dedicated to direct patient care. The demographics for advanced practice registered nurses (APRNs) were similar to child and adolescent psychiatrists. APRNs were predominantly female (74%), White (83%), and non-Hispanic.

The demographic distribution of providers varied substantially from the broader El Paso community. As described above, in 2020, the El Paso County adult population had slightly more

[114] Data on the number of nurses with mailing addresses in El Paso County were obtained through the Texas Board of Nursing. Mailing lists for all registered Texas licensed professional counselors, chemical dependency counselors, and licensed clinical social workers were obtained from the Texas Health and Human Services Commission. Registry data on all actively practicing physicians with practice addresses in El Paso County were abstracted from the Texas Medical Board Open Records Self-Service Portal: orssp.tmb.state.tx.us/. Psychiatrists were classified as practicing in El Paso County if the provider included a practice address located in El Paso County. Several psychiatrists had practice locations at or near area universities and, therefore, may not have had a substantial clinical caseload.

[115] Our list of Texas licensed professional counselors, chemical dependency counselors, and licensed clinical social workers did not include their practice location. Although all providers were licensed to practice in the state of Texas, some providers may reside in El Paso County, but practice in New Mexico.

females than males, and 80% were Hispanic or Latino. Eighty-eight percent (88%) of El Paso County adults who were living in poverty were Hispanic or Latino. This differs significantly from the demographics of the psychiatrists practicing in El Paso County, who were more often male (67%) and non-Hispanic (67%).

A similar pattern emerged for the demographic distribution of child and youth services providers. In 2020, roughly half of the children and youth in El Paso County were male, nearly 9 out of 10 were Hispanic or Latino, and 95% of children and youth living in poverty were Hispanic or Latino. Among child and adolescent psychiatrists, two thirds were female and more than three fourths identified as non-Hispanic. Given that people are substantially more engaged in treatment and communicate more effectively with providers who have similar demographic and cultural backgrounds,[116,117] behavioral health care agencies might consider recruitment strategies that specifically target providers who have experience treating people with various demographic and cultural backgrounds and who have limited English proficiency.[118] Alternatively, health systems might consider offering incentives for providers who are fluent in Spanish to increase access to care for Hispanic or Latino clients and reduce barriers to care for El Paso County residents who do not speak English.[119]

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[116] Traylor, A. H., Schmittdiel, J. A., Uratsu, C. S., Mangione, C. M., & Subramanian, U. (2010). Adherence to cardiovascular disease medications: Does patient-provider race/ethnicity and language concordance matter? *Journal of General Internal Medicine*, *25*(11), 1172–1177.

[117] Jerant, A., Bertakis, K. D., Fenton, J. J., Tancredi, D. J., & Franks, P. (2011). Patient-provider sex and race/ethnicity concordance: A national study of healthcare and outcomes. *Medical Care, 49*(11), 1012–1020. https://journals.lww.com/lww-medicalcare/Abstract/2011/11000/Patient_provider_Sex_and_Race_Ethnicity.9.aspx

[118] The Meadows Mental Health Policy Institute recognizes that a provider's self-identified Hispanic or Latino ethnicity does not indicate that the provider is capable of treating people with limited English proficiency or suggest that the provider has the necessary cultural competency to understand the unique situations that El Paso County families face (e.g., immigration and documentation concerns or family dynamics). Instead, we base this recommendation on the research, which suggests that Hispanic or Latino providers are largely under-represented in practice, and Spanish language proficiency is an important barrier to receiving mental health care for many patients.

[119] Interpreters are commonly used in primary care settings to reduce barriers to care for non-native English speakers. From our Texas Health Care Information Collection (THCIC) database, it is unclear how frequently interpreters are used in El Paso County hospitals. On average, interpreters are recorded in the THCIC database for only one or two patients per quarter. This could indicate that health systems use existing staff members who are fluent in languages other than English to translate information from the provider to the patient. Alternatively, health systems may not record the use of interpreter services in their reports to the state of Texas. Medicaid.gov. (n.d.). *Translation and interpretation services*. www.medicaid.gov/medicaid/financial-management/medicaid-administrative-claiming/translation-and-interpretation-services/index.html

Table 12: Demographic Characteristics of Behavioral Health Providers in El Paso County (2020)[120, 121]

Demographic Characteristic	Psychiatrists N = 67 N(%)	Child / Adolescent Psychiatrists N = 18 N(%)	Advanced Practice Registered Nurses N = 1,020 N(%)
Sex			
Male	45 (67%)	6 (33%)	270 (27%)
Female	22 (33%)	12 (67%)	750 (74%)
Race			
White	43 (64%)	10 (56%)	839 (83%)
Black or African American	2 (3%)	0 (0)	67 (7%)
Asian	7 (10.5)	2 (11%)	5 (1%)
Native American or Alaskan Native	0 (0%)	0 (0%)	24 (2%)
Hawaiian or Pacific Islander	0 (0%)	0 (0%)	0 (0%)
Other	15 (22%)	6 (33%)	85 (8%)
Ethnicity			
Hispanic or Latino	22 (33%)	4 (22%)	375 (37%)
Non-Hispanic	45 (67%)	14 (78%)	645 (63%)
Practice Type[122]			
Direct Patient Care	48 (72%)	12 (67%)	—
Medical Teaching / Faculty	15 (22%)	6 (33%)	—
Administrative Medicine	0 (0%)	0 (0%)	—
Research	0 (0%)	0 (0%)	—
Not in Practice	0 (0%)	0 (0%)	—
Resident / Fellow	4 (6%)	0 (0%)	—

Map 3 shows the practice locations of El Paso County licensed psychiatrists who had practices in El Paso County in 2019. In this map, darker regions signify a greater proportion of the population living poverty, and the markers indicate the number of psychiatrists with practice

[120] Data were obtained from the Texas Board of Nursing, the Texas Health and Human Services Commission, and the Texas Medical Board.

[121] Our list of Texas licensed professional counselors, chemical dependency counselors, and licensed clinical social workers did not include the practice location. Although all providers were licensed to practice in the state of Texas, some providers may reside in El Paso County, but practice in New Mexico.

[122] Practice type was not available for Advanced Practice Registered Nurses.

locations in the census tract. Although El Paso County had pockets of high-poverty areas scattered throughout the city, it is notable that the central El Paso region had a large number of psychiatrists, but nearly all practices were located outside of the high poverty census tracts (dark blue). The southeastern region of El Paso County also had a notable lack of providers available to residents. El Paso County residents who lived in the northwestern region had a greater number of available psychiatrists nearby; however, these providers were located outside of the region's high-poverty census tracts.

Map 3: Locations of Psychiatrists and Area Poverty Levels, by Census Tract (2019)[123]

Map 4, Map 5, and Map 6 (on the following pages) depict the locations of the local mental health authority (LMHA) and federally qualified health center (FQHC) facilities in 2019, according to the level of poverty in each census tract. Map 4 overlays facility locations onto areas of poverty for children, youth, and adults; Map 5 shows the facility locations according to

[123] We only included psychiatrist locations in this map because we were only able to obtain practice locations from the Texas Medical Board.

the adult poverty rate for each census tract; and Map 6 shows facility locations according to the child and youth poverty rate for each census tract.

Although El Paso County had pockets of high-poverty areas scattered throughout the city, the northwestern region of El Paso County had fewer providers available to residents than in the central and southeastern regions. El Paso County residents who lived in the central, northern, and southeastern regions, which had clusters of high-poverty census tracts, had a greater number of available providers nearby; in the southeastern region, these were largely FQHC providers.

Map 4: LMHA and FQHC Facility Locations and Area Poverty Levels, by Census Tract (2019)[124]

In an earlier section of this report, Map 2 showed the locations of adults in poverty, by census tract, and revealed that central El Paso had the highest proportions of adults living in poverty. The northeastern region and parts of the northwestern region had substantially lower counts of adults in poverty, overall. As shown in Map 5, which focuses on the LMHA and FQHC locations

[124] U.S. Census Bureau, TIGER/Line with Selected Demographic and Economic Data.

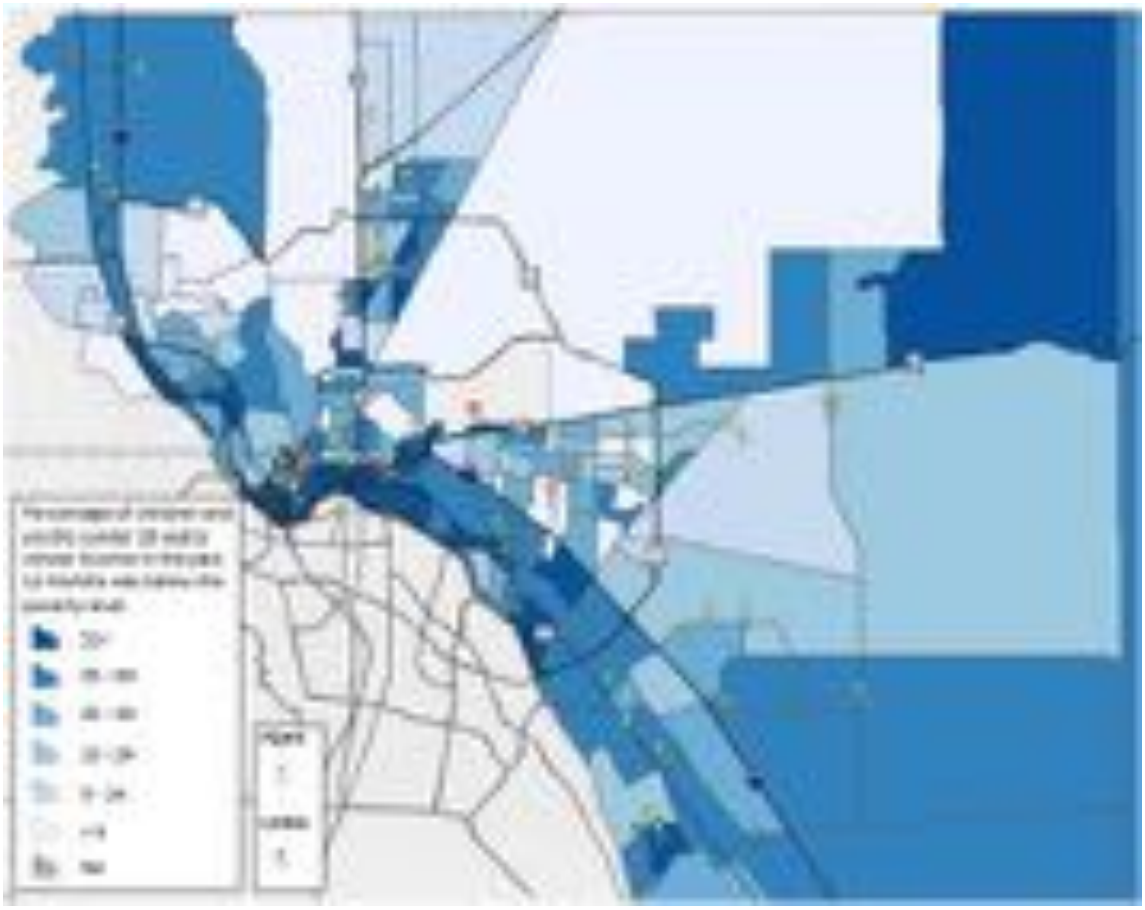
in central El Paso, providers appeared to be concentrated in the census tracts characterized by higher poverty rates. This will likely enhance service availability to adults who are most in need of LMHA and FQHC services.

Map 5: LMHA and FQHC Facility Locations and Adult Poverty Levels, by Census Tract (2019)[125]

In an earlier section of this report, Map 1 showed the locations of children and youth in poverty, by census tract, and revealed that central El Paso and the lower valley (southeastern) region near the U.S.–Mexico border had tracts with the highest percentage of children and youth living in poverty, whereas the northwestern region bordering Ciudad Juárez had lower counts of children and youth in poverty. However, in 2019, LMHA and FQHC providers appeared to be concentrated in the central El Paso region (see Map 4 and Map 5, above), with some located in higher-poverty areas in the northern and lower valley regions. However, the high poverty region in northeastern El Paso County does not appear to have available service providers nearby. Most children and youth in need of services would have access to LMHA and FQHC providers nearby; however, children and youth with mental health needs who live in poverty in remote regions of El Paso County may have difficulty accessing providers (Map 6).

[125] U.S. Census Bureau, TIGER/Line with Selected Demographic and Economic Data.

Map 6: LMHA and FQHC Facility Locations and Child and Youth Poverty Levels, by Census Tract (2019)[126]



Opioid Use in El Paso County[127]

In 2018, nearly 3,000 Texans died from drug overdoses.[128] According to the Centers for Disease Control and Prevention, the age-adjusted drug overdose mortality rate for El Paso County was 10.8 deaths per 100,000 residents in 2018, which was equal to the overall rate for the state of Texas.[129]

Hydrocodone and oxycodone are prescription opioid medications that are used to manage pain. We used the Drug Enforcement Administration's wholesale purchase records from 2006

[126] U.S. Census Bureau, TIGER/Line with Selected Demographic and Economic Data.

[127] Data were obtained from the Drug Enforcement Administration's Automation of Reports and Consolidated Orders System (ARCOS). d2ty8gaf6rmowa.cloudfront.net/dea-pain-pill-database/bulk/arcos_all.tsv.gz. A partial database is maintained by the Washington Post; see www.washingtonpost.com/graphics/2019/investigations/dea-pain-pill-database/#download-resources

[128] Centers for Disease Control and Prevention. (2020).

[129] The age-adjusted drug overdose rate for the state of Texas in 2018 was 11 deaths per 100,000 population.

to 2014 to identify retail locations that could serve as proxies for concentrations of people who used these prescription drugs.

Map 7 shows amount of hydrocodone and oxycodone, in morphine milligram equivalents, that was sold to retailers throughout the county, shaded by census tract, where dark blue represents higher amounts sold and light blue represents smaller amounts sold.

Map 7: Distribution of Hydrocodone and Oxycodone, by El Paso County Pharmacies, 2006–2014

The census tracts with the highest number of distributed opioids were located in the center of the map in the El Paso region, near the U.S.-Mexico border. The map also shows the top 10 opioid purchasing pharmacies, including six Walgreens locations and two Walmarts, geographically distributed throughout the city of El Paso. None of the top opioid retailers were located in west El Paso County, but this area does have multiple small-volume sellers whose sales of opioids aggregated to a high number of opioid medications purchased overall.

Local Mental Health Authority (LMHA) Need and Utilization[130]

The following figures draw from data we received from the Texas Health and Human Services Commission (HHSC) in January 2020. The HHSC provided data on children and adults served by local mental health authorities (LMHAs) in state fiscal year (FY) 2019. In Table 13 and Table 15, we provide estimates of the number of children, youth, and adults who need care, broken out by components of the ideal care setting.

Children and Youth

Table 13 reports the estimated number of El Paso County children and youth who are best served in different care settings. Our estimates, based on 2019 data, suggest that the behavioral health needs of most children and youth in the county can be met in integrated care settings (40,000 out of 60,000 children and youth). In 2019, about one in three children and youth needed care from specialty settings (20,000), including 8,000 with serious emotional disturbances (SED) and living in poverty who could have benefited from care through the LMHA, Emergence Health Network (EHN). Finally, about 6,000 (or 1 in 10) El Paso County children and youth with behavioral health needs required rehabilitation or intensive care, including about 800 with the most intensive needs who were at risk for out-of-home or out-of-school placement and required the most intensive services.

Table 13: El Paso County Children and Youth in Need, by Care Setting (2019)

Children and Youth – Community Care Need, by Setting[131]	
Children and Youth with Mental Health Conditions[132]	**60,000**
Need that Can Be Met in Integrated Care Settings[133]	40,000
Need that Requires Specialty Settings[134]	20,000
In Poverty Needing Specialty Care[135]	8,000
Mental Health Rehabilitation/Intensive Care[136]	6,000
Intensive Service Need (At Risk for Out-of-Home/School Placement)[137]	800
Youth with Substance Use Disorders[138]	**3,000**
Need that Can Be Met in Integrated Care Settings[139]	1,000
Need that Requires Specialty Settings[140]	2,000

[131] All Texas prevalence estimates were rounded to reflect uncertainty in the American Community Survey.

[132] Kessler, R. C., et al. (2012a); Kessler, R. C., et al. (2012b).

[133] We estimated that approximately two out of every three children (64%) with mental health needs have conditions that can be successfully managed in an integrated primary care setting.

Table 14 and Figure 8 provide an overview of the number of children and youth served by EHN, including breakouts for the number served at each level of care (LOC) in 2019. In comparison to the 8,000 children and youth in poverty who needed specialty care for mental health conditions (as reported in Table 13 above), 2,815 unduplicated children and youth received care through EHN – about one third of the total need. The other two thirds of children and youth may have received care in other community–based care settings or may not have received treatment for their mental health conditions.

Table 14: Children and Youth with SED and Living in Poverty Who Received Services from EHN (FY 2019)[141]

LMHA	Children & Youth in Poverty[142]	Children & Youth with SED in Poverty[143]	Children & Youth Served[144]	Percentage in Need Served by EHN	Percentage Medicaid[145]
Emergence Health Network	90,000	8,000	2,815	34%	69%

[133] We estimated that approximately two out of every three children (64%) with mental health needs have conditions that can be successfully managed in an integrated primary care setting.

[134] We estimated that one out of four children with mental health needs require specialty behavioral health care to manage their condition. This estimate is based on Rushton, J., Bruckman, D., & Kelleher, K. (2002). Primary care referral of children with psychosocial problems. *Archives of Pediatrics & Adolescent Medicine, 156*(6), 592–598.

[135] Holzer, C., Nguyen, H., & Holzer, J. (2019). See Appendix one for additional information. Poverty data obtained from the U.S. Census Bureau, American Community Survey 2019 Five-Year Public Use Microdata Sample (PUMS): https://www.census.gov/programs-surveys/acs/data/pums.html

[136] We estimated that one in 10 children with mental health needs require mental health rehabilitation or intensive care to adequately manage their conditions.

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

[138] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[139] Madras, B. K., et al. (2008).

[140] The remaining individuals with SUD who needed more intensive treatment than what could be provided in an integrated care setting were categorized as needing specialty care.

[141] Unduplicated utilization data across levels of care were obtained from Texas Health and Human Services Commission, January 2020, and reflect fiscal year 2019.

[142] "In poverty" refers to the estimated number of people living below 200% of the federal poverty level in the region. All Texas population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

[143] Holzer, C., Nguyen, H., & Holzer, J. (2019); American Community Survey PUMS. (2019).

[144] Data in the "Children and Youth Served in Ongoing Treatment" column are the unduplicated number who were served by EHN across LOCs C1-C4, CY (YES Waiver), and CYC (Young Child Services).

[145] Percentage of children served by the LMHA who were receiving Medicaid during FY 2019. Data were provided by the Texas Health and Human Services Commission (personal communication, February 26, 2020).

Figure 8 provides an overview of the number of children and youth served by EHN, including breakouts for the number served at each level of care (LOC) in FY 2019. In this figure, the deep blue bars represent the number of children and youth who were treated in the lowest levels of care (i.e., outpatient); the light blue lines identify the unduplicated number of children and youth who were treated in rehabilitative care settings; and the light green bar represents the number of children and youth who were treated in crisis care settings (LOC 0). The deep green bars at the bottom of Figure 8 represent the sum of unduplicated children and youth who were treated in outpatient and rehabilitative care settings (Total Non-Crisis Served) and crisis settings (Total Crisis Served).

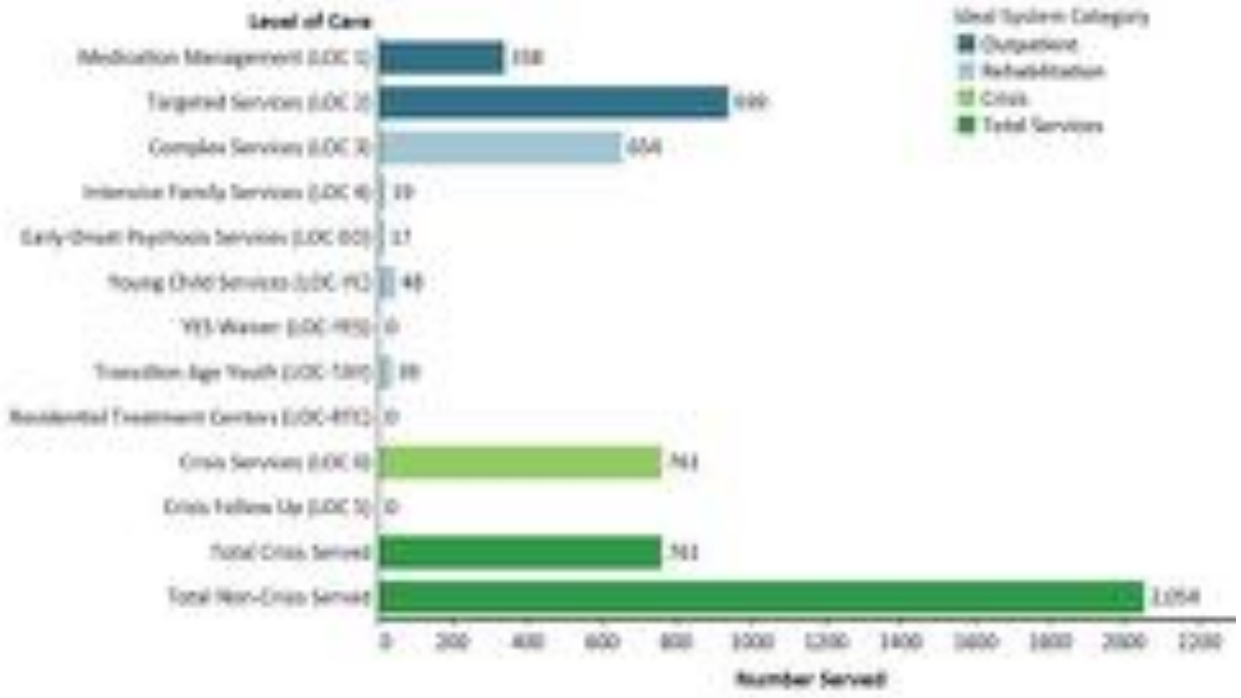
Seventy-three percent (73%) of the 2,815 children and youth served by EHN were served in a non-crisis setting. Additionally, of the approximately 6,000 children and youth needing rehabilitation and intensive services, zero received YES Waiver services,[146] 48 received young child services (LOC-YC), and nineteen received intensive family services (LOC-4) through EHN.

These estimates indicate there may be a large gap in care for children and youth, particularly those with SED, who are living in poverty. The largest need is for rehabilitation and intensive services, but many children and youth with SED also may not be receiving ongoing specialty outpatient care. To close this gap, it will be important to consider the population growth estimates presented earlier in this report – given the anticipated 3% growth rate in the population of children and youth by 2025,[147] the number of children and youth with SED is likely to increase as well.

[146] EHN reports 44 children and youth received YES Waiver services in 2019, indicating a discrepancy between HHSC and EHN internal figures.

[147] 2019 populations were obtained from the American Community Survey. Projected population change was obtained from: Texas Demographic Center (2018). Previously Cited.

Figure 8: Children and Youth Levels of Care Analysis (FY 2019)[148,149,150]



Adults

As shown in Table 15, below, most adult mental health need in El Paso County can be adequately met in an integrated care setting (110,000 adults of the 140,000 with any mental health need). Of the remaining adults who need care in a specialty setting, we estimate that about 15,000 with serious mental illness (SMI) who are living in poverty would benefit from care through EHN. In contrast, 10,425 unduplicated adults received care through the LMHA, representing 70% of estimated need (Table 16). As described earlier in this report, the population of adults in El Paso County is expected to grow by 7% by 2025. The number of adults in need of ongoing specialty care is likely to grow proportionately.

[148] Texas Health and Human Services Commission (2020, February).

[149] EHN reports 44 children and youth received YES Waiver services in 2019, indicating a discrepancy between HHSC and EHN internal figures.

[150] EHN reports 44 children and youth received YES Waiver services in 2019, indicating a discrepancy between HHSC and EHN internal figures.

Table 15: Adults in Need, by Care Setting (FY 2019)

Adults – Community Care Need, by Setting[151]	
Adults with Mental Health Conditions[152]	**140,000**
Need that Can Be Met in Integrated Care[153]	110,000
Need that Requires Specialty Setting[154]	25,000
In Poverty Needing Specialty Care[155]	15,000
Complex Needs without Forensic Need (ACT)[156]	300
Complex Needs with Forensic Need (FACT)[157]	200
Adults with Substance Use Disorders[158]	**40,000**
Need that Can Be Met in Integrated Care[159]	20,000
Need that Requires Specialty Setting[160]	20,000

Table 16: Number of Adults with SMI and Living in Poverty Who Received Services from EHN (FY 2019)[161]

Adults	Emergence Health Network
SMI in Poverty[162,163]	15,000
All LOCs Served	10,425
% in Need Served	70%

[151] All population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

[152] Kessler, R. C., et al. (2012a); Kessler, R. C., et al. (2012b).

[153] Kessler, R. C., et al. (2005).

[154] The remaining individuals with SUD who needed more intensive treatment than what could be provided in an integrated care setting were categorized as needing specialty care.

[155] Holzer, C., Nguyen, H., & Holzer, J. (2019); American Community Survey PUMS. (2019).

[156] Cuddeback, G. S., Morrissey, J. P., & Meyer, P. S. (2006).

[157] Cuddeback, G. S., Morrissey, J. P., & Cusack, K. J. (2008).

[158] 2018–2019 National Survey on Drug Use and Health: Model-Based Prevalence Estimates – Texas.

[159] Madras, B. K., et al. (2008).

[160] The remaining individuals with SUD who needed more intensive treatment than what could be provided in an integrated care setting were categorized as needing specialty care.

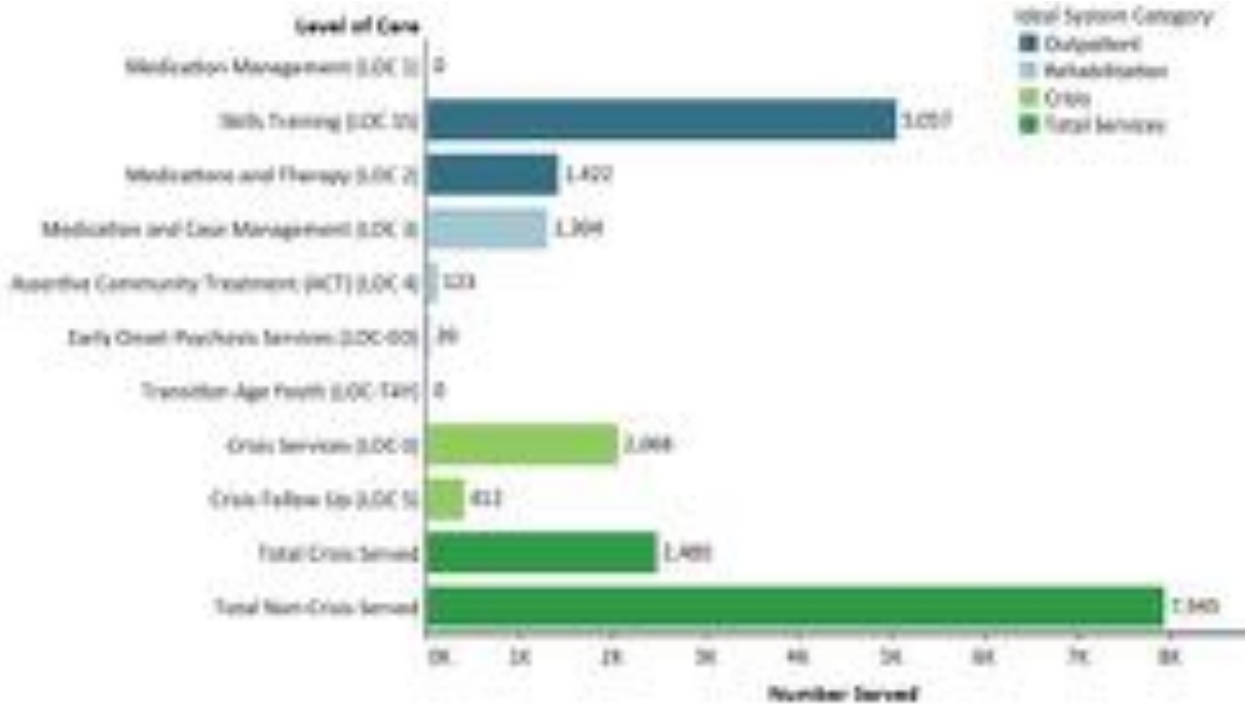
[161] Texas Health and Human Services Commission. (2020, January).

[162] Holzer, C., Nguyen, H., & Holzer, J. (2019); American Community Survey PUMS. (2019).

[163] All population estimates were rounded to reflect uncertainty in the American Community Survey estimates.

Figure 9 displays the number of unduplicated clients served by EHN in FY 2019. The dark green bars at the bottom of Figure 9 represent the sum of unduplicated adults treated in outpatient and rehabilitative care settings (Total Non-Crisis Served) and crisis settings (Total Crisis Served). These data suggest that most clients were served in non-crisis levels of care (7,945 out of 10,425 total unduplicated clients served; bottom deep green bars). The types of care adults received were primarily skills training, medications and therapy (deep blue), and combined medications and case management (indicated in light blue). A small portion of clients received first episode psychosis services (39 clients). EHN also served many clients who were in crisis – this group represented 24% of EHN's total client case load (crisis services clients are presented in light green int Figure 9).

Figure 9: Adult Levels of Care Analysis (FY 2019)[164]



COVID-19 Impact on Crisis Services

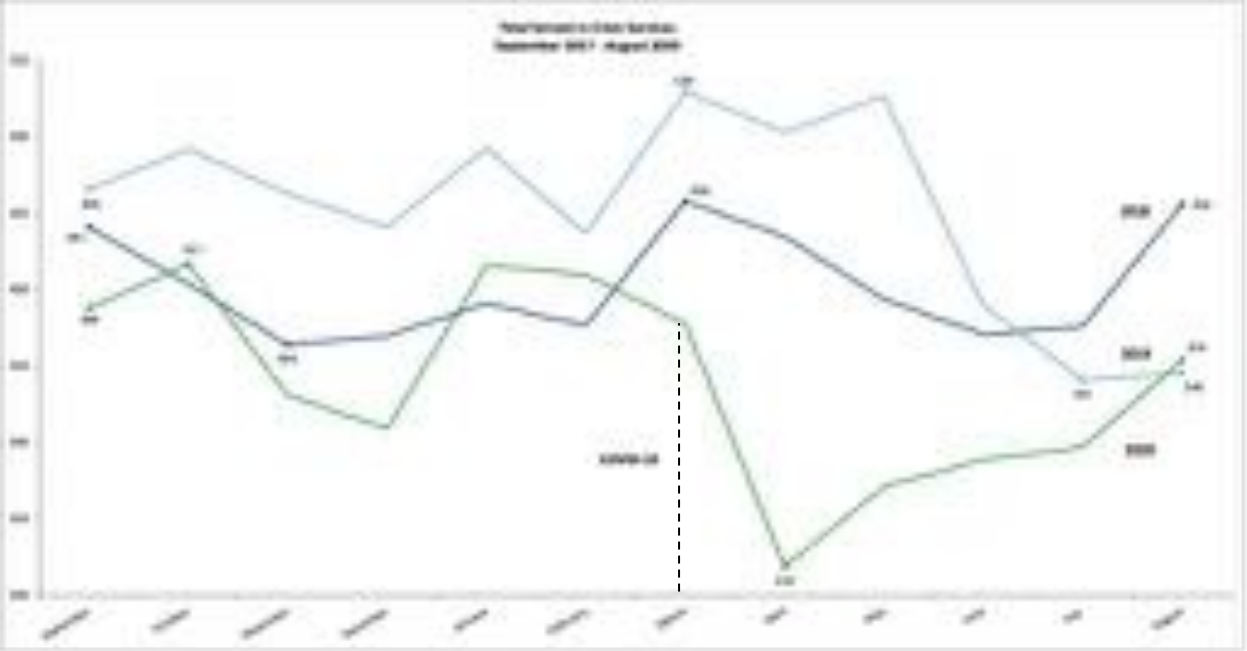
The COVID-19 pandemic has altered the utilization of health care services throughout the nation, particularly for some medical specialties and sub-specialties. The impact of the pandemic on EHN's crisis services is illustrated in Figure 10, which shows the variation in crisis service utilization between September 2017 (beginning of fiscal year 2018) and August of 2020 (end of fiscal year 2020). Over fiscal years 2018, 2019, and the first half of fiscal year 2020 (pre-

[164] Texas Health and Human Services Commission. (2020, February).

COVID-19), crisis services utilization ranged from 309 individuals per month (December 2019) to a high of 530 served in March 2019.

Each year, use of crisis services declines every November and December and tends to peak in the spring (March – May). However, the trajectory for January to August 2020 was substantially different from the two prior years. In 2020, use of crisis services peaked in January and February, with more than 400 people served per month, and suddenly dropped off in April (219 people served) because of the COVID-19 pandemic. Service utilization increased slightly in each subsequent month and as of August 2020, the volume of crisis services clients had resumed levels seen in previous years.

Figure 10: Total Number Clients Served through Crisis Services, Emergence Health Network (Sept. 2017 – Aug. 2020)[165]



Changes in Service Provision for Children and Youth Between 2014 and 2019

Given that there were fewer children and youth living in El Paso County in 2019 than in 2014, we would expect that the demand for behavioral health services would have proportionately declined. Instead, our prevalence data suggest that the number of children and youth with behavioral health needs increased by 20,000 between 2014 and 2019. Table 17, on the next page, shows the changes over time in the number of El Paso County children and youth with SED who were living in poverty.

[165] Emergence Health Network (personal communication, 2020, October 30).

Table 17: Changes in Number of El Paso County Children, Youth, and Adults Served by Emergence Health Network (2014–2019)[166]

Clients Served – Children and Youth	2014[167]	2018[168]	2019[169]	% Change[170]
Prevalence of SED in Children and Youth Living in Poverty[171]	**10,000**	**8,000**	**8,000**	**–20%**
Total Served	1,596	1,862	2,815	+76%
% of Total Need	16%	23%	35%	+19%
Clients Served – Adults	**2014[172]**	**2018[173]**	**2019[174]**	**% Change**
Prevalence of SMI in Adults Living in Poverty	—	**15,000**	**15,000**	—
Total Served	4,048	4,067	10,425	158%
% of Total Need	—	27%	70%	—

Table 18 shows the unduplicated count of clients served by EHN in each level of care.[175] Despite the slight decline in the prevalence of SED (Table 4) and SED in children and youth living in poverty,[176] the total number of children and youth served by EHN increased by 76% between 2014 and 2019. From 2014 to 2019, EHN saw more than double the number of children and youth for crisis services (a 142% increase from 2014; 446 additional children and youth served), complex services (an increase of 500%), and young child services (a nearly four-fold increase in the number of young children served). The rate of children and youth whose EHN care was paid for by Medicaid in 2019 remained stable, with a 3% decline in Medicaid-funded clients in 2019 compared to 2014.

[166] Table modified to display pertinent data. See Appendix Eleven for full table.

[167] TriWest Group. (2014, February).

[168] Texas Health and Human Services Commission. (2019, February).

[169] Texas Health and Human Services Commission. (2020, January).

[170] This reflects the rate of change in service utilization from 2014 to 2019.

[171] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey.

[172] TriWest Group. (2014, February).

[173] Texas Health and Human Services Commission. (2019, February).

[174] Texas Health and Human Services Commission. (2020, January).

[175] Patients were classified according to the highest level of care they received during the fiscal year.

[176] When adjusted for the changing population size over time, this represents a 1% decline in the rate of SED in children and youth living in poverty.

Table 18: Changes in Number of El Paso County Children and Youth Served by Emergence Health Network (2014–2019)

Clients Served – Children and Youth	2014[177]	2017[178]	2018[179]	2019[180]	% Change[181]
Prevalence of SED in Children and Youth Living in Poverty[182]	**10,000**	**15,000**	**8,000**	**8,000**	**–20%**
Crisis Services	315	—	469	761	+142%
Crisis Follow-Up	7	—	0	0	–100%
Medication Management	457	—	198	338	–26%
Targeted Services	645	—	776	939	+46%
Complex Services	109	—	331	654	+500%
YES Waiver	0	—	43	0[183]	0%
Young Child Services	10	—	39	48	380%
Total Served	**1,596**	**1,559**	**1,862**	**2,815**	**+76%**
% of Total Need	**16%**	**10%**	**23%**	**34%**	**+19%**
% Paid by Medicaid	72%	—	73%	69%	–3%

Changes in Service Provision for Adults Between 2014 and 2019

The increase in the El Paso County adult population, combined with a slight decline in the poverty rate, have implications for the public behavioral health care system. Although there was no substantial change in the need for LMHA services between 2018 and 2019 (see Table 19), EHN's service provision data suggest that the number of adults it served increased substantially (more than 150%) between 2014 and 2019.

[177] TriWest Group. (2014, February).

[178] Meadows Mental Health Policy Institute. (2017, March 23).

[179] Texas Health and Human Services Commission. (2019, February).

[180] Texas Health and Human Services Commission. (2020, January).

[181] This reflects the rate of change in service utilization from 2014 to 2019.

[182] All Texas population estimates were rounded to reflect uncertainty in the American Community Survey.

[183] EHN reports 44 children and youth received YES Waiver services in 2019, indicating a discrepancy between HHSC and EHN internal figures.

Table 19: Changes in Number of El Paso County Adults Served by Emergence Health Network (2014–2019)

Clients Served – Adults	2014[184]	2018[185]	2019[186]	% Change[187]
Prevalence of SMI in Adults Living in Poverty	**—**	**15,000**	**15,000**	**No Change**
Crisis Services	1,555	1,663	2,068	+33%
Crisis Follow-Up	136	228	412	+203%
Medication Management Only	21	0	0	–100%
Medications and Therapy	56	903	1,304	+2,229%
Medications and Case Management	2,152	1,101	1,422	–34%
ACT / FACT	64	86	123	+92%
Total Served[188]	**4,048**	**4,067**	**10,425**	**+158%**
% of Total Need	**—**	**27%**	**70%**	**+159%**
% Paid by Medicaid	76%	59%	28%	–48%

In 2014, 2,152 (53%) adults who were served by EHN received medication and case management. In contrast, EHN most commonly provided skills training (5,057 unduplicated adults served in 2019, or about half of EHN clients) and crisis services in 2019 (2,068 unduplicated adults served; 20% of all services provided). The number of adults who received medication and case management services (1,422) in 2019 declined by 34% compared to utilization in 2014. This may suggest that EHN served clients with more severe or advanced behavioral health conditions in 2019 compared to 2014. Notably, a markedly smaller subset of the EHN client population had services paid through Medicaid in 2019, compared to 2014 (48% decrease in Medicaid payer type since 2014).

One of the recommendation in our 2017 assessment report for the El Paso Behavioral Health Consortium was for the consortium's Justice Leadership Council to "serve as a forum that supports creative approaches to identifying various means of enhancing the availability of ACT,

[184] TriWest Group. (2014, February).

[185] Texas Health and Human Services Commission. (2019, February).

[186] Texas Health and Human Services Commission. (2020, January).

[187] This reflects the rate of change in service utilization from 2014 to 2019.

[188] The total for 2018 does not sum to 4,067 because two categories were omitted. These include LOC1S, in which 5,057 were served, and FEP care, with 39 people served).

Forensic ACT (FACT), and other intensive services in El Paso County."[189] As shown in Table 19, the provision of ACT and FACT services nearly doubled between 2014 and 2019, with 123 adults served in 2018 compared to 64 adults served in 2014. This indicates that there was progress in expanding access to ACT and FACT services, but these programs continued to reach only a small portion of the estimated 500 El Paso County adults with complex mental health needs.

The Emergency Department (ED) and Inpatient System[190]

Access to high-quality community-based treatments for mental illness reduces the need for crisis services, including ED and inpatient psychiatric services. We were able to analyze utilization of services data for both of these settings based on discharge records we obtained from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, ED, and outpatient discharge records for hospitals operating throughout Texas. Each discharge record included details on client age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer, and source of admission, among other variables.

We used these THCIC discharge records to analyze psychiatric inpatient and ED utilization in El Paso County, as depicted in the following data tables. Although we obtained data from 2015 through the fourth quarter of calendar year (CY) 2019, the data in the tables are limited to a single full year of data (January to December of 2019), with the exception of the data comparing daily psychiatric and inpatient capacity, which show all utilization going back to October 2015. A description of this source is also included in Appendix Two.

Emergency Department Visits in El Paso County[191]

Even in a community with an ideal array of integrated primary care, specialty care, and rehabilitation capacity, the ED will play an important role in responding to behavioral health crises. Systems without the full array of outpatient services often rely on the ED to take on the less ideal and more frequent role of acting as the entry point to care for people with untreated behavioral health conditions.

This section provides an analysis of ED utilization resulting from primary psychiatric and substance use diagnoses. We also provide the primary payers and estimated payments associated with these visits.[192] This analysis can highlight sub-populations of adults who frequently utilize the ED, indicating a high need among a specific population or a lack of

[189] Meadows Mental Health Policy Institute. (2017, March 23). p. viii.

[190] All inpatient and outpatient data will be updated to reflect calendar year 2019 in the final report.

[191] All tables reflect calendar year 2018 and will be updated to reflect calendar year 2019 for the final report.

[192] Each discharge record includes information on the expected primary source of payment for the visit. We grouped these into five categories: Medicaid, Medicare, Other Governmental Payer, Self-Pay, and Commercial.

capacity to meet the needs of a specific population at lower levels of care. Of particular concern is the group of people who either have Medicaid as their payer, pay for services themselves, rely on charity, or are uninsured. Admission of these people in excessive numbers may reflect poor access to outpatient care for groups served by the public payers.

Because EDs are required to provide treatment, the characteristics of people who seek care at EDs for behavioral health needs serve as good indicators of community members who experience behavioral health crises. We examined the distribution of payer types, ages, and diagnoses for ED patients and contrasted these distributions with those for patients admitted to inpatient psychiatric facilities. This comparison and analysis helped us identify groups of people who experience behavioral health crises who have limited access to inpatient beds.

Eleven (11) EDs reported psychiatric and substance use disorder-related emergency department visits to the THCIC: Del Sol Medical Center, El Paso Children's Hospital, Legent Hospital (formerly Foundations Surgical Hospital of El Paso), Las Palmas Medical Center, six locations of The Hospitals of Providence (e.g., The Hospitals of Providence Memorial Campus, The Hospitals of Providence Sierra Campus, The Hospitals of Providence East Campus, The Hospitals of Providence Horizon Campus, The Hospitals of Providence Transmountain Campus, and The Hospitals of Providence Northeast Campus), and The University Medical Center of El Paso. Legent Hospital reported the fewest psychiatric or substance use disorder (SUD) ED visits (13). Because of this small number of total visits, Legent Hospital was included in the total count but not as a separate breakout in Table 20 on the next page.

As Table 20 shows, Del Sol Medical Center, Sierra Providence East Medical Center, University Medical Center of El Paso, and Las Palmas Medical Center were the most frequently utilized EDs for psychiatric visits, representing 5,630 of 8,795 (64%) total psychiatric ED visits. Del Sol Medical Center was more frequently utilized for ED visits related to SUD diagnoses (714 of 3,349 visits, or 21%), based on data from 2019. Aside from Legent Hospital, El Paso Children's Hospital had the fewest psychiatric and SUD-related ED visits. Across all EDs, there were nearly three times as many ED visits for primary or secondary psychiatric conditions than there were for substance use-related conditions.

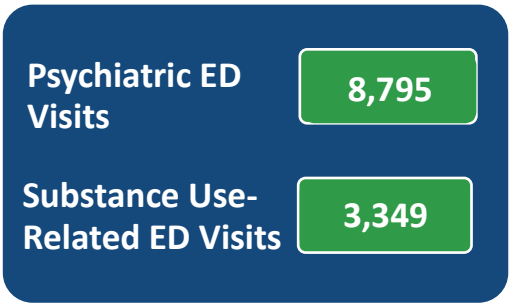


Table 20: Emergency Department Visits for Total Primary and Secondary Psychiatric and Substance Use Disorders – All Ages (2019)[193]

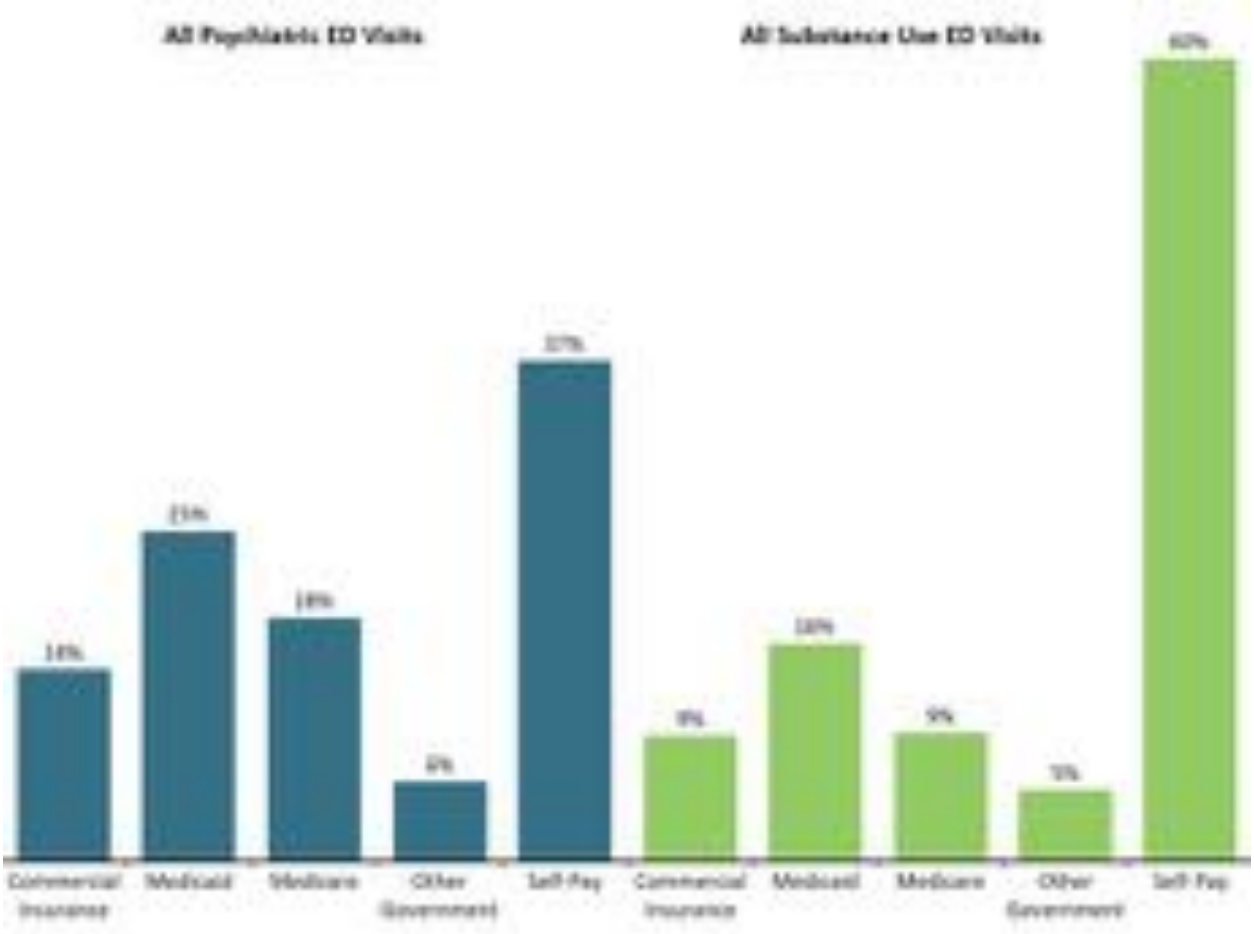
Hospital	Psychiatric Visits	SUD-Related Visits
Del Sol Medical Center	1,619	714
University Medical Center of El Paso	1,484	635
The Hospitals of Providence East Campus	1,333	412
Las Palmas Medical Center	1,194	456
The Hospitals of Providence Transmountain Campus	923	354
The Hospitals of Providence Memorial Hospital	795	298
The Hospitals of Providence Sierra Campus	458	245
The Hospitals of Providence Northeast Campus	456	142
The Hospitals of Providence Horizon Campus	279	65
El Paso Children's Hospital	241	26
All ED Visits	**8,795**	**3,349**

There are some notable differences in the proportion of primary payer types listed for each hospital. Our calculations were based on each discharge record's expected primary payer source as reported by the hospital. In past systems assessments, we encountered some miscoding of payer type on discharge records; therefore, we encourage hospitals to confirm these results. Self-pay was the most common payer type at all hospitals, with the exception of El Paso Children's Hospital and Legent Hospital. Figure 11 shows that, overall, people visiting EDs for SUD issues were more likely to self-pay for services (60%) than people visiting EDs for psychiatric disorders, who were more likely to be funded by a mix of Medicaid (25%), Medicare (18%), and self-pay (37%). This contrast was most apparent at El Paso Children's Hospital, Las Palmas Medical Center, Providence Memorial Hospital, and Sierra Medical Center, where the rate of SUD-related ED visits that were self-funded were nearly double the rate of psychiatric ED visits that were self-funded.

[193] Data were obtained from the Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records. Legent Hospital (formerly Foundations Surgical Hospital), which had only 13 visits psychiatric and SUD ED visits (only two were SUD-related), is not shown but was included in the total.

The rate that commercial insurances were used to pay for psychiatric and SUD ED visits was generally low (less than 15% of visits), with the exception of Legent Hospital.[194] These data, including the reason for visits and type of payer, are presented in Figure 11 below.

Figure 11: Emergency Department Visits for Primary or Secondary Psychiatric and Substance Use Conditions, by Condition and Payer – All Ages (2019)[195]



Suicide-Related ED Visits / Co-Occurring SUD-Related ED Visits

ED visits with primary or secondary diagnoses of suicidal ideation (ICD-10 code R45851) are coded as suicide-related visits. As shown in Figure 12, 890 suicide-related ED visits occurred during calendar year 2019, representing about 10% of all mental health-related ED visits during that time. Most of these visits (674) were for adults between the ages of 18 and 64, followed by youth (209) between the ages of 12 and 17. Older adults had fewer than 10 counts of suicide-related ED visits. There were no suicide-related ED visits for children ages 11 and younger.

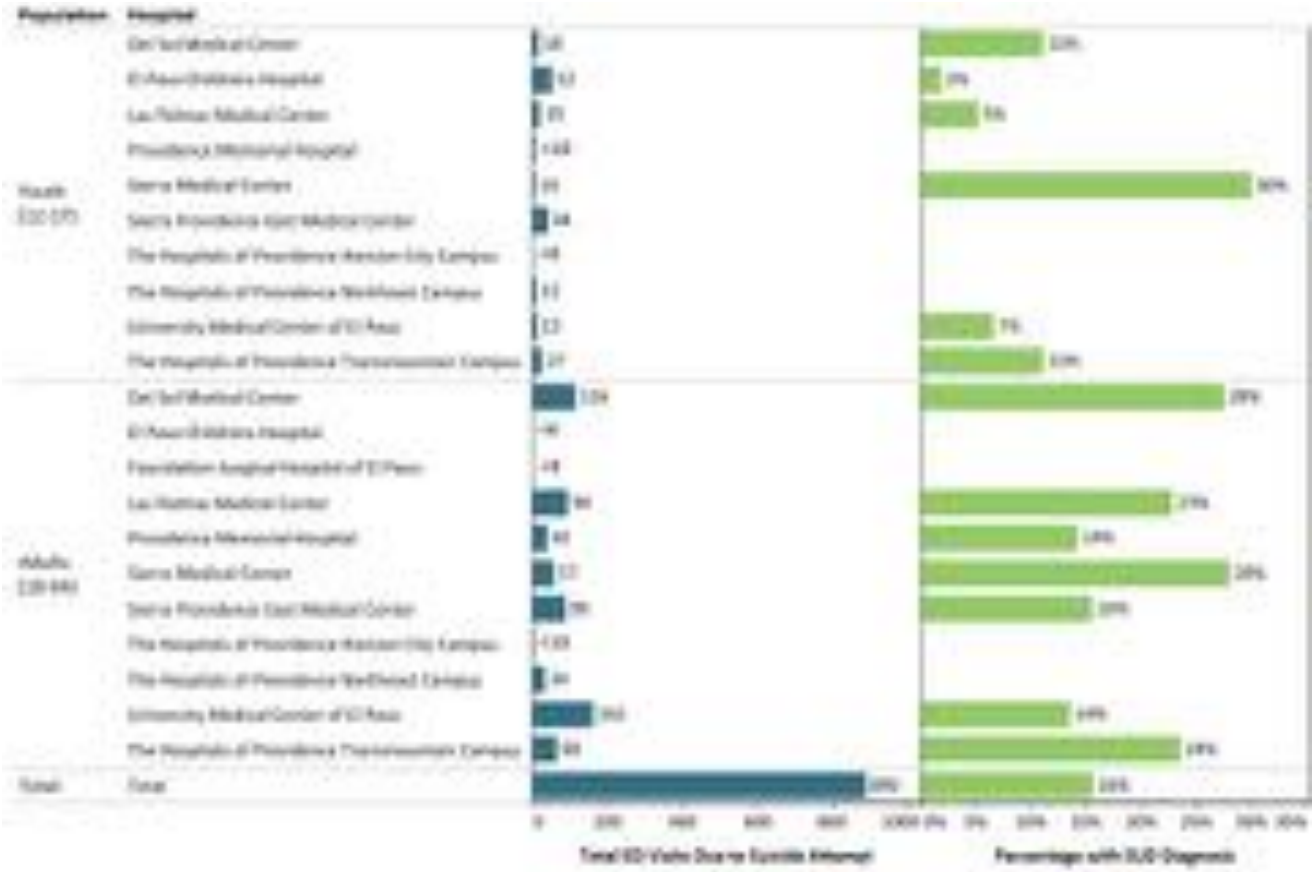
[194] Of Legent Hospital's 13 psychiatric patient visits, 31% were commercially insured.

[195] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

Among adults with suicide-related ED visits, 28% also had a primary or secondary SUD diagnosis (compared to 11% of older adults and 8% of youth). The frequency of suicide-related ED visits for people with substance used disorders suggests a potential gap in care for people who need SUD treatment.

Sierra Providence East Medical Center, Del Sol Medical Center, and University Medical Center of El Paso saw the most adults for suicide-related reasons in 2019. Children and youth with suicide-related concerns were most commonly seen at El Paso Children's Hospital.

Figure 12: Suicide and Substance-Related Emergency Department Visits by Age (2019)[196,197]



Multiple Health Conditions and Emergency Department Visits

Some primary physical health conditions result in ED visits more often when a person has a secondary psychiatric or substance use disorder. Table 21 lists the most common physical

[196] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

[197] The Texas Department of State Health Services requires us to mask patient data such that any hospital with 1–5 visits is reported as <6, and any hospital with 5–9 admissions is reported as <10. The older adult (65 years and older) category was dropped because it had fewer than ten total admissions.

health ED visits among people with secondary behavioral health conditions. Chest pain was the most common primary physical condition among all three groups – people with psychiatric conditions, SUD diagnoses, or co-occurring psychiatric and substance use disorders (COPSD). Chronic and abdominal pain, convulsions and epilepsy, other neurological conditions (e.g., headache and dizziness), and sepsis were also frequently recorded across all groups of patients.

Among people with secondary SUD diagnoses (excluding those with secondary psychiatric diagnoses), alcoholic cirrhosis of the liver, epilepsy, and variations of unspecified pain were in the top 10 primary physical health conditions leading to ED visits. Other common reasons people with secondary psychiatric diagnoses frequented the ED included urinary tract infections, hypertension, upper respiratory infections, and chest pain. For people with secondary COPSD, dehydration and kidney failure were common reason for ED visits.

Many of these comorbid medical conditions such as sepsis, urinary tract infections, and hypertension reflect conditions best treated in integrated primary care or specialty care settings. The high levels of people with behavioral health conditions who visited the ED for these comorbid medical conditions may reflect a lack of access to integrated primary and behavioral health care. The data in Table 21 provide an indication of the potentially avoidable ED visits in El Paso County with the implementation of integrated care.

Table 21: Physical Health ED Visits in El Paso County, by Secondary Psychiatric, SUD, and Co-Occurring Psychiatric and Substance Use Disorder (COPSD) Diagnoses – All Ages (2019)[198]

Primary Physical Diagnoses			
Rank	**Among Patients with a Secondary Psychiatric Diagnoses (Number of Visits)**	**Among Patients with a Secondary SUD Diagnoses (Number of Visits)**	**Among Patients with a COPSD Diagnoses (Number of Visits)**
1	Chest pain (1,175)	Chest pain (187)	Chest pain (56)
2	Urinary tract infection (527)	Alcoholic cirrhosis of liver with ascites (94)	Sepsis (20)
3	Headache (411)	Sepsis (80)	Dehydration (19)
4	Unspecified abdominal pain (274)	Unspecified abdominal pain (73)	Epilepsy, not intractable, without status epilepticus (18)
5	Sepsis (235)	Epilepsy, not intractable, without status epilepticus (64)	Unspecified convulsions (18)

[198] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

Primary Physical Diagnoses			
Rank	**Among Patients with a Secondary Psychiatric Diagnoses (Number of Visits)**	**Among Patients with a Secondary SUD Diagnoses (Number of Visits)**	**Among Patients with a COPSD Diagnoses (Number of Visits)**
6	Dizziness and giddiness (223)	Epigastric pain (58)	Acute kidney failure (17)
7	Primary hypertension (219)	Unspecified convulsions (58)	Chronic pain (17)
8	Chronic pain (216)	Laceration without foreign body of other part of head (56)	Alcoholic cirrhosis of liver with ascites (15)
9	Acute upper respiratory infection (210)	Headache (51)	Abdominal pain (15)
10	Syncope and Collapse (195)	Laceration without foreign body of scalp (50)	Hematemesis (14)

Inpatient Admissions from El Paso County Emergency Departments

Inpatient hospitalization is best provided in a person's local community. Local care improves access for the person's family and support group and helps the person integrate back into the community and engage with community-based services. In the next set of maps and data tables, we focus on admissions from El Paso County emergency departments (EDs) to inpatient psychiatric beds anywhere in Texas, showing how people are separated from their communities to receive inpatient care. We identified these types of admissions by determining, for every psychiatric bed admission, whether a person had been in a El Paso County ED on the same or previous day. Individuals' county of residence did not play a role in this analysis.

There are reasons for large geographic separations between EDs and inpatient facilities, including behavioral health crises that occur during travel and the provision of specialized inpatient behavioral treatment such as competency restoration at a state hospital. Geographic gaps of concern are those that only occur for specific payers (such as sending self-pay patients to distant hospitals) or specific age groups (no youth beds), or because of insufficient local beds in total.

Table 22 shows the number of people sent from these EDs to psychiatric beds across Texas; Table 23 provides payer details. Overall, more than 70% of the estimated 2,521 admissions to psychiatric hospitals from El Paso County EDs (1,767) were sent to local El Paso County beds,

whereas less than one third were sent to inpatient beds in other counties.[199] Many of the people who were admitted to non-local psychiatric beds were not residents of El Paso County. A breakdown of the hospitals that admitted residents of El Paso County EDs is included in Table 22.

Most psychiatric hospitals in other counties that admitted people who were treated at El Paso County EDs were specialized behavioral health facilities or state hospitals. As shown in Table 22, no single facility admitted a substantial number of people from El Paso County EDs, which might occur if a multilocation hospital system sent all behavioral health patients to a single location. Notably, youth ages 12 to 17 were especially likely to be transferred to non-local hospitals; in fact, more youth were admitted to non-local hospitals than were admitted to El Paso County hospitals. Fewer than six older adults (65 years and older) were admitted to non-local hospitals.

Table 22: Admissions to Psychiatric Hospitals from El Paso County Emergency Departments, by Age (2019)[200] [201]

County and Hospital of Admission	Total Admissions	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Older)
Bell County	**< 19**	**< 16**	**< 6**	**—**
Metroplex Hospital	< 6	<6	—	—
Cedar Crest Hospital	13	10	< 6	—
Bexar County	**< 149**	**119**	**24**	**—**
Methodist Specialty & Transplant Hospital	< 10	—	< 10	—
Southwest General Hospital	< 6	—	< 6	—
Laurel Ridge Treatment Center	39	34	< 6	—
Clarity Child Guidance Center	50	47	< 6	—
Nix Behavioral Health Center	< 16	< 10	< 6	—
San Antonio Behavioral Healthcare Hospital	37	32	<6	—

[199] The percentages in this passage are referred to as “les than one third” to prevent un-masking of the THCIC data.

[200] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

[201] The THCIC dataset includes outpatient and inpatient discharges for the state of Texas only. Therefore, any patients who were discharged from a Texas emergency department and admitted to an inpatient facility in New Mexico will not be detected in our analyses.

County and Hospital of Admission	Total Admissions	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Older)
Brazos County – Rock Prairie Behavioral Health	**< 6**	—	**< 6**	—
Cameron County – Palms Behavioral Health	**< 22**	**16**	**< 6**	—
Collin County	**< 30**	**14**	**< 10**	**<6**
Columbia Medical Center – McKinney	< 10	< 6	< 10	<6
Texas Health Presbyterian Hospital-Plano	< 6	< 6	—	—
Texas Health Seay Behavioral Health Center	14	13	< 6	—
Dallas County	**93**	**48**	**45**	—
Children's Medical Center-Dallas	< 6	< 6	—	—
Texas Health Presbyterian Hospital Dallas	< 6	—	< 6	—
Parkland Memorial Hospital	< 10	—	< 10	—
Methodist Richardson Medical Center	< 6	—	< 6	—
UT Southwestern University Hospital – Zale Lipshy Psych	< 6	—	< 6	—
Green Oaks Hospital	31	10	21	—
Hickory Trail Hospital	< 29	19	< 10	—
Dallas Behavioral Healthcare Hospital	18	15	<6	—
Perimeter Behavioral Hospital of Dallas	< 6	< 6	—	—
Denton County	**< 10**	**< 10**	**< 6**	—
University Behavioral Health-Denton	< 10	< 10	—	—
Mayhill Hospital	< 6	—	<6	—
El Paso County	**1,767**	**174**	**1383**	**210**
El Paso Psychiatric Center	< 120	12	102	< 6
Providence Memorial Hospital	132	—	—	132
El Paso Behavioral Health System	1,258	113	1,076	69
Rio Vista Behavioral Health	< 264	49	205	< 10

County and Hospital of Admission	Total Admissions	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Older)
Fort Bend County – Westpark Springs	**11**	**< 10**	**< 6**	**—**
Grayson County – Texoma Medical Center	**< 19**	**<6**	**13**	**—**
Harris County	**187**	**132**	**55**	**—**
Harris County Psychiatric Center	11	<1 0	< 6	—
Houston Methodist Hospital	< 6	—	< 6	—
Cypress Creek Hospital	< 16	10	< 6	—
West Oaks Hospital	< 26	20	< 6	—
Intracare North Hospital	< 17	11	< 6	—
Menninger Clinic	< 6	< 6	—	—
Kingwood Pines Hospital	< 21	15	< 6	—
Behavioral Hospital-Bellaire	29	17	12	—
Houston Behavioral Healthcare Hospital	28	17	11	—
Sun Behavioral Houston	< 43	33	< 10	—
Sacred Oak Medical Center	< 10	—	< 10	—
Hidalgo County – McAllen Medical Center	**< 28**	**22**	**< 6**	**—**
Hunt County – Glen Oaks Hospital	**< 6**	**—**	**< 6**	**—**
Jefferson County – Baptist Hospitals of Southeast Texas	**< 6**	**< 6**	**< 6**	**—**
Lubbock County – Covenant Children's Hospital	**< 6**	**—**	**< 6**	**—**
Midland County – Oceans Behavioral Hospital of the Permian Basin	**< 6**	**< 6**	**—**	**—**
Montgomery County	**13**	**< 10**	**< 6**	**—**
Aspire Hospital	< 6	—	< 6	—
Woodland Springs	< 10	< 10	< 6	—
Nueces County – Bayview Behavioral Hospital	**< 27**	**17**	**< 10**	**—**

County and Hospital of Admission	Total Admissions	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Older)
Potter County – Northwest Texas Hospital	**< 6**	**< 6**	**—**	**—**
Smith County – UT Health East Texas Tyler Regional Hospital	**< 6**	**< 6**	**< 6**	**—**
Tarrant County	**64**	**33**	**31**	**—**
Texas Health Huguley Hospital	< 10	—	< 10	—
Cook Children's Medical Center	<6	< 6	—	—
John Peter Smith Hospital	< 20	< 6	14	—
Texas Health Arlington Memorial Hospital	< 6	< 6	—	—
Millwood Hospital	10	10	—	—
Texas Health Springwood Hospital	< 16	< 10	< 6	—
Mesa Springs	< 10	< 6	< 6	—
Oceans Behavioral Hospital of Fort Worth	< 6	—	< 6	—
Perimeter Behavioral Hospital of Arlington	< 6	< 6	—	—
Taylor County – Oceans Behavioral Hospital Abilene	**< 6**	**< 6**	**—**	**—**
Tom Green County – River Crest Hospital	**< 6**	**< 6**	**< 6**	**—**
Travis County	**< 72**	**49**	**17**	**< 6**
Dell Children's Medical Center	<2 2	16	< 6	—
Austin Lakes Hospital	< 6	—	< 6	—
Austin Oaks Hospital	< 36	26	< 10	—
Cross Creek Hospital	< 26	< 10	< 10	< 6
Wichita County – Red River Hospital	**< 6**	**< 6**	**—**	**—**
Williamson County	**< 24**	**18**	**< 6**	**—**
Rock Springs	< 6	—	< 6	—
Georgetown Behavioral Health Institute	< 24	18	< 6	—

Table 23, below, shows the primary payers associated with psychiatric hospitalizations from El Paso County EDs, with breakouts for local and non-local psychiatric hospitals. The number of people who were admitted to non-local psychiatric beds from any single El Paso ED was relatively small; therefore, the payer mix data should be interpreted with caution.

Table 23: Local and Non-Local Psychiatric Bed Admissions from El Paso Emergency Departments – All Ages, by Payer (2019)[202,203]

El Paso EDs of Origin	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
University Medical Center of El Paso						
to Local Psychiatric Bed	291	29%	5%	9%	27%	30%
to Non-Local Psychiatric Bed	28	18%	18%	4%	11%	50%
Del Sol Medical Center						
to Local Psychiatric Bed	136	33%	3%	10%	18%	36%
to Non-Local Psychiatric Bed	79	27%	5%	3%	18%	51%
Las Palmas Medical Center						
to Local Psychiatric Bed	214	36%	6%	17%	14%	28%
to Non-Local Psychiatric Bed	59	24%	3%	7%	19%	47%
El Paso Children's Hospital						
to Local Psychiatric Bed	55	36%	0%	33%	13%	18%
to Non-Local Psychiatric Bed	40	38%	0%	10%	10%	43%
Sierra Medical Center						
to Local Psychiatric Bed	250	46%	9%	10%	2%	32%
to Non-Local Psychiatric Bed	< 6	25%	0%	0%	25%	50%
Sierra Providence East Medical Center						
to Local Psychiatric Bed	279	36%	8%	10%	5%	42%
to Non-Local Psychiatric Bed	50	28%	4%	2%	10%	58%

[202] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

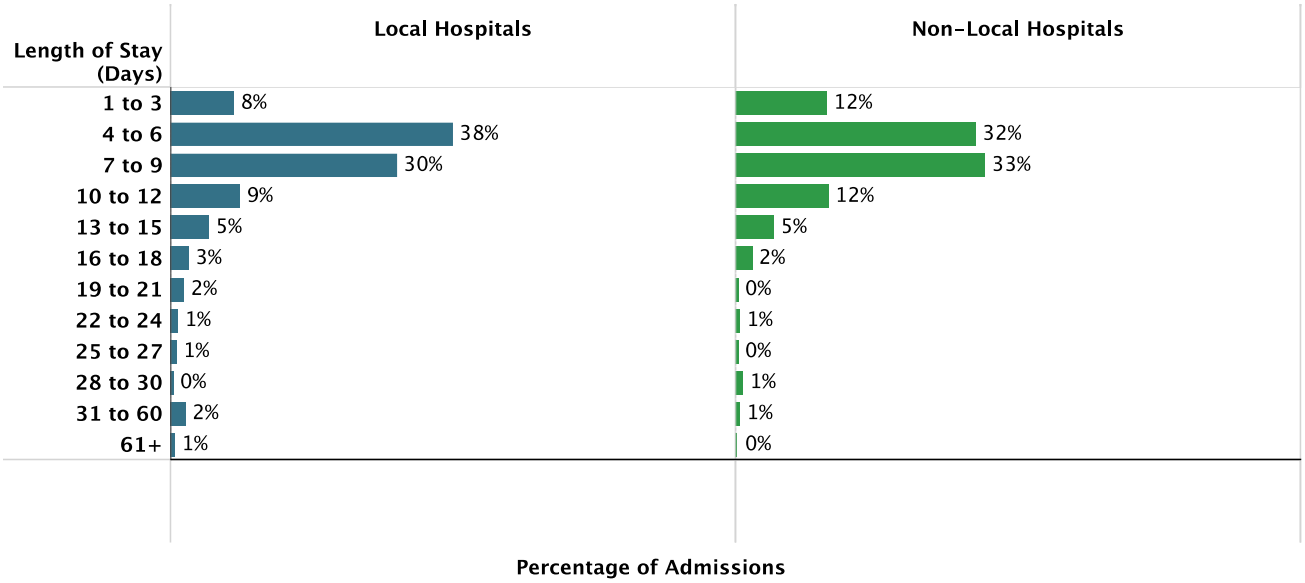
[203] The THCIC dataset includes outpatient and inpatient discharges for the state of Texas only. Therefore, any patients who were discharged from a Texas emergency department and admitted to an inpatient facility in New Mexico will not be detected in our analyses.

Providence Memorial Hospital						
to Local Psychiatric Bed	202	34%	30%	7%	2%	27%
to Non-Local Psychiatric Bed	31	23%	3%	6%	16%	52%
The Hospitals of Providence Transmountain Campus						
to Local Psychiatric Bed	196	34%	10%	14%	1%	42%
to Non-Local Psychiatric Bed	27	30%	0%	0%	7%	63%
The Hospitals of Providence Northeast Campus						
to Local Psychiatric Bed	56	45%	2%	20%	2%	32%
to Non-Local Psychiatric Bed	41	46%	2%	2%	17%	34%
The Hospitals of Providence Horizon City Campus						
to Local Psychiatric Bed	24	50%	0%	4%	4%	42%
to Non-Local Psychiatric Bed	32	34%	0%	0%	19%	47%

A bi-modal distribution in payer type exists for most hospitals, indicating that most patients were funded through commercial insurance or Medicaid. El Paso County ED patients who were funded through commercial insurance were more often sent to non-local psychiatric beds. In contrast, people who were funded through Medicaid or the Children's Health Insurance Program were more often sent to local psychiatric hospitals. This variation reflects the larger range of hospital choices available to people who have commercial insurance, but it does not necessarily reflect reduced access to quality care for people with other payer types.

Our comparison of length of stay for people sent by EDs to local versus non-local inpatient psychiatric facilities revealed notable differences. As shown in Figure 13 on the next page (also see Table 33 in Appendix Three for additional details), people who were sent from El Paso County EDs to psychiatric beds had similar lengths of stay regardless of whether they were placed in a local or non-local bed.

Figure 13: Admissions to Psychiatric Beds from All El Paso County EDs – Length of Stay Details (2019)[204]



In summary, examining the flow of people from local EDs to inpatient psychiatric beds statewide revealed anticipated patterns. These patterns included most people who were sent to local beds and some people who were admitted to non-local hospital beds as a result of idiosyncratic characteristics. However, we did identify at least one potential issue of concern: compared to all ED behavioral health visits, people who were on Medicaid were less likely to be admitted to a psychiatric bed.

Psychiatric Bed Capacity and Utilization

In the previous section, we examined the flow of people from local emergency departments (ED) to inpatient beds. In this section, we analyze inpatient bed use by all El Paso County residents as well as the bed capacity and use of El Paso County inpatient psychiatric beds by residents of all counties. Our analysis focuses on two issues: identifying whether sufficient beds exist locally to serve all the needs of El Paso County residents and assessing the impact that insufficient community-based outpatient services capacity has on bed use. Please see Appendix Two for a description of the sources we used for this analysis.

El Paso County Psychiatric Hospital Utilization

Four hospitals in El Paso County reported inpatient psychiatric utilization: El Paso Behavioral Health System, El Paso Psychiatric Center, Providence Memorial Hospital, and the newly

[204] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

opened Rio Vista Behavioral Health (Rio Vista).[205] When we conduct community assessments, we are often asked whether a community has sufficient inpatient capacity. There is no formula that can simply address this question and answering it depends on multiple factors (e.g., service array, existing capacity). For this assessment, we took a two-pronged approach to address this question.

First, we analyzed the county of residence of people admitted to psychiatric beds in El Paso County. This analysis highlights another facet of bed capacity: many people who reside in distant counties likely use El Paso County psychiatric beds because the county has available beds. In a related analysis, we examined the use of non-El Paso County psychiatric beds by residents of El Paso County. If the flow of people to psychiatric beds outside of the county is substantially greater than the flow to beds inside the county, there may be a lack of local beds.

Then, we compared daily inpatient utilization to the reported staffed bed capacity for each hospital. This approach identifies hospitals that are operating above capacity or under capacity relative to need. Prolonged operation at or above capacity may indicate insufficient capacity to meet need.

Residency of People Admitted to El Paso County Psychiatric Beds

Table 24 lists admissions to each hospital by county of residence (residents of El Paso County compared to all other non-local counties). At each hospital with psychiatric beds (El Paso Behavioral Health System, El Paso Psychiatric Center, Rio Vista, and Providence Memorial Hospital), the majority of admissions were for local residents, with less than 15% of admissions for non-local residents. Because El Paso Psychiatric Center is a state hospital, all patients are classified as self-pay.

Non-local people admitted to El Paso Behavioral Health System were more likely than local patients to be funded by Medicaid (70% of non-local resident admissions versus 48% of local residents) and less likely to have commercially insurance (20% of non-local resident admissions versus 37% of local residents). Regardless of resident county, people admitted to El Paso Behavioral Health System were more likely to be funded through Medicaid or commercial insurance, whereas people admitted to Providence Memorial Hospital were more likely to be funded through Medicare. This difference is likely a result of Providence Memorial Hospital's substantial proportion of older adult patients.

Rio Vista's payer mix was slightly different than the mix at El Paso Behavioral Health System in that the largest proportion of its patients were funded through other government sources, such as the Department of Veteran's Affairs or local mental health authority funds. This was true for

[205] Rio Vista Behavioral Health opened its facility in February of 2019.

local and non-local admissions. The remainder of Rio Vista's patients were funded by commercial insurance (20%), self-pay (19%), or Medicaid (13%). El Paso County resident admissions were more likely to have commercial insurance than non-residents admitted to Rio Vista (23% of residents compared to 6% of non-residents).

Table 24: Admissions to El Paso County Psychiatric Beds by Resident Status and Payer (2019)[206,207]

Hospital	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
El Paso Behavioral Health System						
Total Admissions	**6,032**	**51%**	**1%**	**13%**	**0%**	**34%**
Admissions by El Paso County Residents	5,070	48%	1%	14%	0%	37%
Non-Local Admissions	962	70%	1%	8%	0%	20%
El Paso Psychiatric Center						
Total Admissions	**693**	0%	0%	0%	100%	0%
Admissions by El Paso County Residents	660	0%	0%	0%	100%	0%
Non-Local Admissions	33	0%	0%	0%	100%	0%
Providence Memorial Hospital						
Total Admissions	**305**	**1%**	**95%**	**1%**	**1%**	**1%**
Admissions by El Paso County Residents	273	1%	96%	1%	1%	1%
Non-Local Admissions	32	0%	94%	0%	6%	0%
Rio Vista Behavioral Health						
Total Admissions	**755**	**13%**	**6%**	**42%**	**19%**	**20%**
Admissions by El Paso County Residents	630	13%	4%	40%	19%	23%
Non-Local Admissions	125	11%	14%	54%	15%	6%

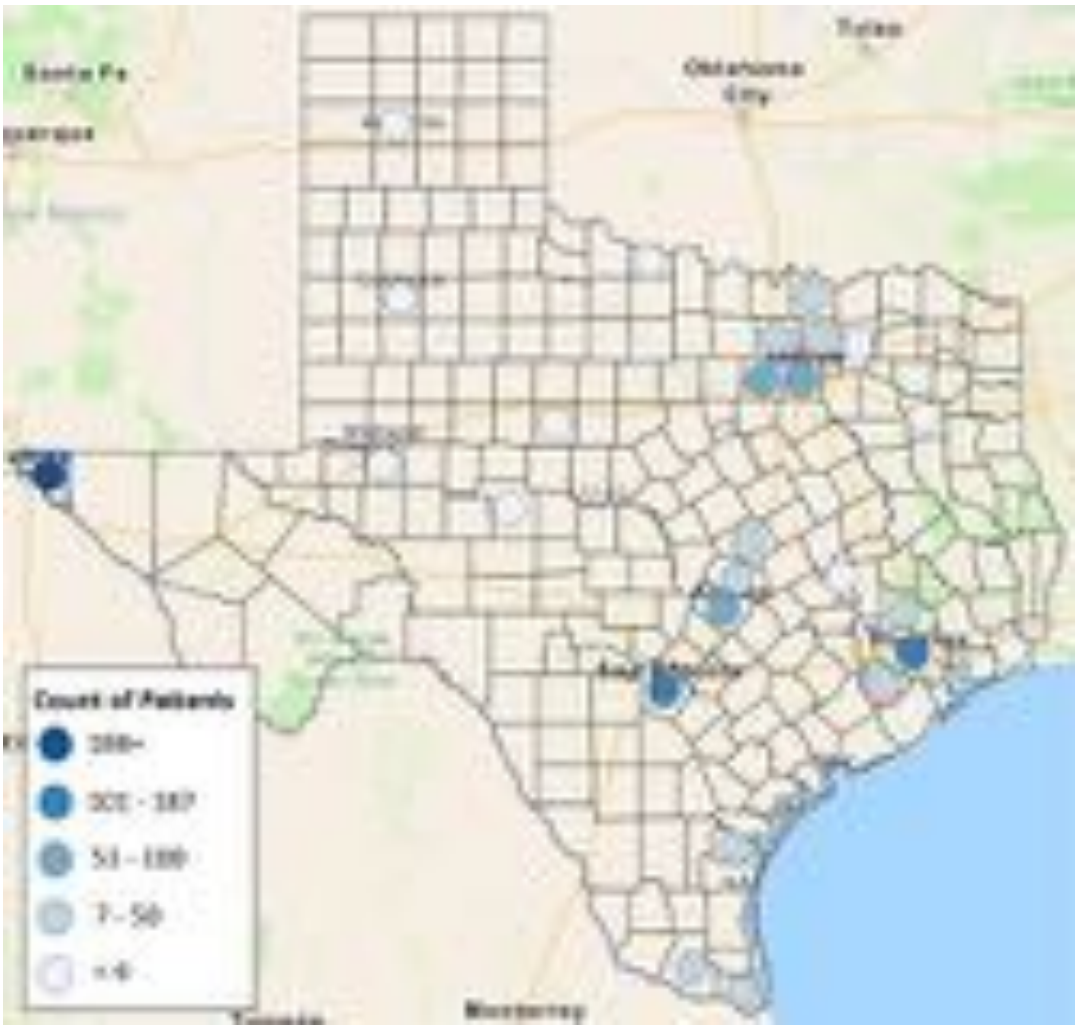
Psychiatric Bed Utilization Among Residents of El Paso County (2019)

This next section shows where residents of El Paso County were admitted to psychiatric beds

[206] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records. Row percentages may not add up to 100% because fewer than 1% of admissions did not have an identified payer.
[207] We are continuing to revise our classification of payer mix using the THCIC data. As a result, there may be discrepancies between the data reported here and internal hospital classifications.

throughout Texas. This analysis can provide additional context for psychiatric bed need in El Paso County. Frequent use of psychiatric beds outside of the region may indicate insufficient local capacity to serve local residents. Additional breakouts showing admissions by primary payer and diagnosis can indicate that certain sub-populations may have a high need that cannot be met locally. Detailed hospital-level admissions are provided in Table 34 in Appendix Three. We obscured counts of fewer than six admissions to prevent patient re-identification, as required by data use agreements governing use and reporting of these data.

Map 8: Admissions to Psychiatric Beds and Location of State Hospitals Among El Paso County Residents (2019)[208,209]



[208] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

[209] The THCIC dataset includes outpatient and inpatient discharges for the state of Texas only. Therefore, any patients who were discharged from a Texas emergency department and admitted to an inpatient facility in New Mexico will not be detected in our analyses.

As depicted in Map 8, above (see associated data in Table 34 of Appendix Three), El Paso residents were admitted to psychiatric beds at several state hospitals throughout Texas. Hospitals that admitted the most El Paso County residents were located in El Paso County: El Paso Behavioral Health System, with 5,070 admissions; El Paso Psychiatric Center, with 664 admissions; Providence Memorial Hospital, with 273 admissions; and Rio Vista Behavioral Health, with 173 admissions. In contrast, Table 24 shows 962 non-local admissions to El Paso Behavioral Health System, 33 non-local resident admissions to El Paso Psychiatric Center, 32 non-local admissions to Providence Memorial Hospital, and 125 non-local resident admissions to Rio Vista Behavioral Health. Many more non-local patients flowed into El Paso County's psychiatric beds than local patients flowed into beds outside of El Paso County.

The largest portion of the 92 admissions to non-local hospitals (Table 34, Appendix Three) went to Rio Grande State Center in Cameron County (21 admissions). Small proportions such as this support the hypothesis that no single age group lacks access to inpatient psychiatric beds in El Paso County.

Overall, few El Paso County residents received care outside of El Paso County. Of those who did, not all of the treatment in non-local hospitals was related to issues with local access to care. For example, people who were admitted to state hospitals often had forensic needs or more complex needs (e.g., comorbid intellectual and psychiatric disabilities) that required a more intensive setting than what community hospitals could offer.

Inpatient Utilization Compared to Bed Capacity

Finally, the following table (Table 25) contrasts daily capacity and utilization of psychiatric beds in El Paso County in 2019. The table presents an overview of the daily average psychiatric bed utilization for each hospital that reported an inpatient bed capacity to the Texas Hospital Association. The table shows that Rio Vista Behavioral Health had available psychiatric beds on all days that it was open and El Paso Psychiatric Center had available beds on most days. Conversely, El Paso Behavioral Health System commonly functioned at or near capacity.

Table 25: Average Daily Psychiatric Utilization and Capacity – El Paso County (2019)[210]

All Ages Utilization	El Paso Psychiatric Center	El Paso Behavioral Health System	Rio Vista Behavioral Health
Average Daily Utilization	48	148	24
Utilization as a Percentage of Capacity	65%	91%	20%

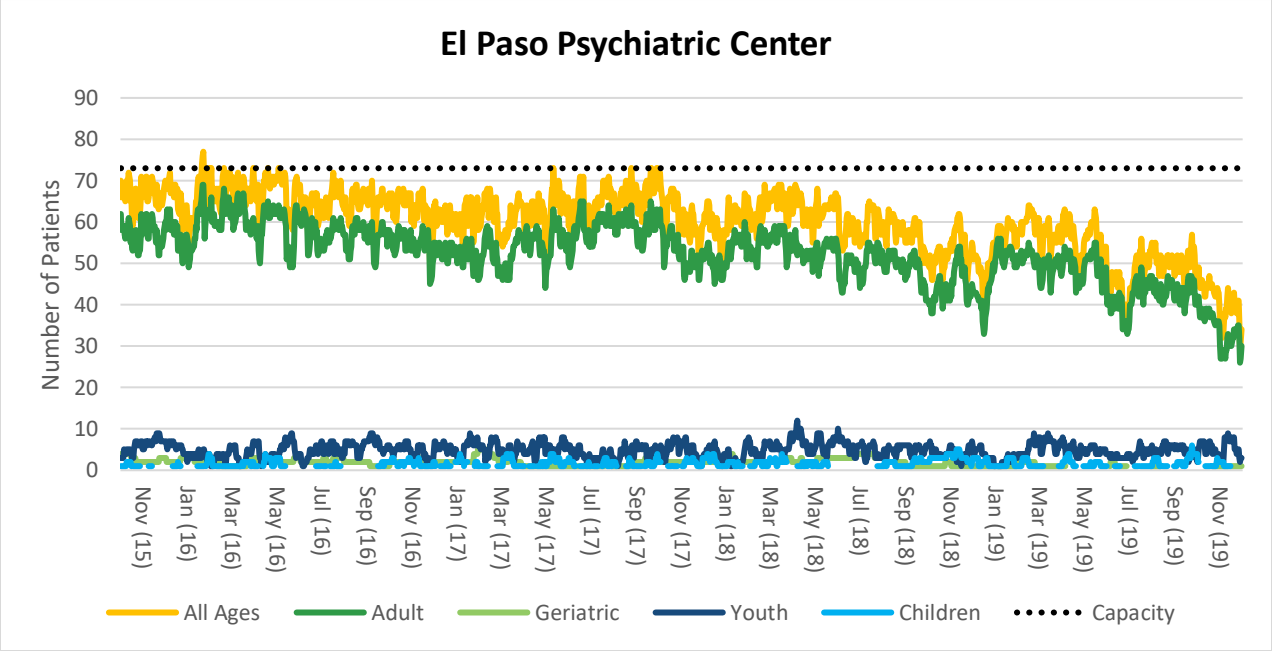
[210] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

All Ages Utilization	El Paso Psychiatric Center	El Paso Behavioral Health System	Rio Vista Behavioral Health
Percentage of Days with 25% of Beds Open	67%	7%	100%

At the El Paso Psychiatric Center, on average, 46 children, youth, and adults (combined) occupied beds each day, compared to 74 available beds. Although more than half of the beds were being occupied (65%, as shown in Table 25), the hospital operated at or near capacity only one time since January 2016. As a result, 25% of its total capacity was available on 67% of days.

The time series charts below present a day-by-day analysis for each hospital between October 2015 and November 2019. Figure 14 reveals that the El Paso Psychiatric Center rarely exceeded its capacity.

Figure 14: El Paso Psychiatric Center Utilization Versus Capacity (2015–2019)[211]

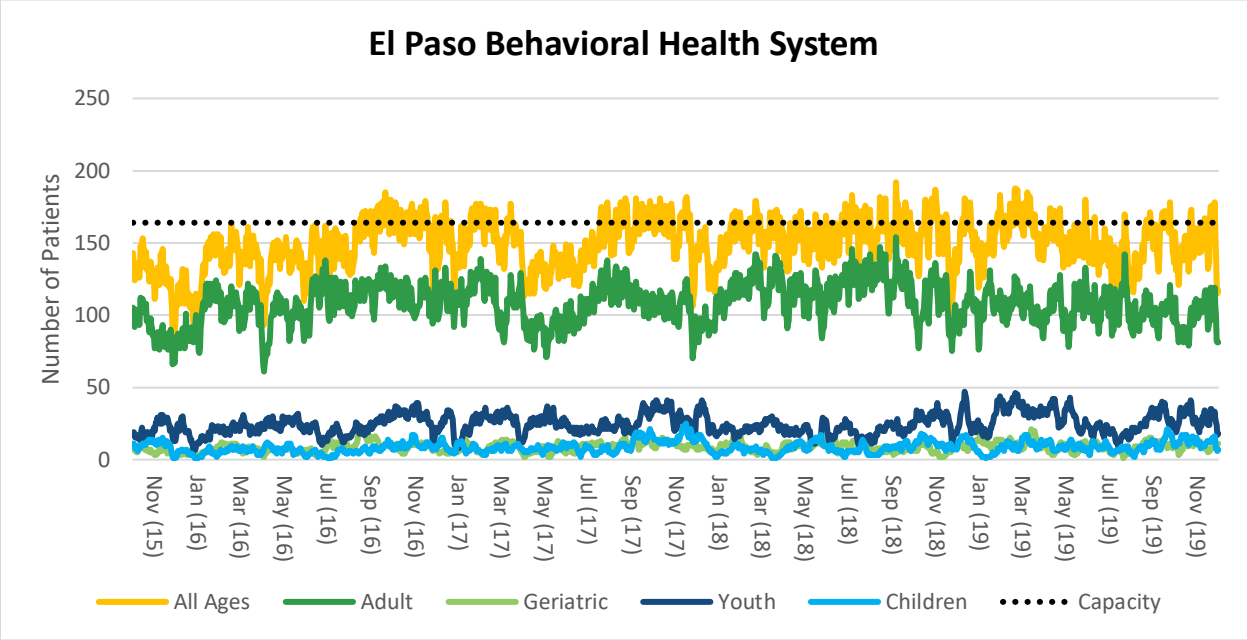


At El Paso Behavioral Health System, on average, 148 children, youth, and adults (combined) occupied beds each day, compared to 163 available beds. Because most of the beds were being occupied (91%, as shown in Table 25), the hospital was often operating above capacity. Figure 15 presents the points throughout the time period when utilization exceeded capacity. The hospital exceeded capacity at multiple times during 2019, resulting in 25% of total beds being

[211] Capacity data were obtained from the Texas Hospital Association (2019). The number of beds occupied each day was calculated using discharge records from the Texas Health Care Information Collection (THCIC; 2015–2019).

available on only 7% of the days (Table 25). Based on data beginning in October of 2015, the time series graph in Figure 15 shows a trend of increased bed utilization over time, with the greatest utilization and concentrations of days operating at capacity occurring from the middle of 2018 to the end of 2019.

Figure 15: El Paso Behavioral Health System Utilization Versus Capacity (2015–2019)[212]



Providence Memorial Hospital (Providence) utilization data are provided in Figure 16. Providence has no listed capacity in the Texas Hospital Association (2019) survey; therefore, capacity data were obtained from local sources. At Providence, nine (9) beds were occupied each day, on average. These data suggest that utilization at Providence Memorial Hospital has remained stable over time, indicating a consistent flow of patients and sufficient bed availability.

[212] Texas Hospital Association (2019) and THCIC (2015 – 2019).

Figure 16: Providence Memorial Hospital Utilization Versus Capacity (2015–2019)[213]

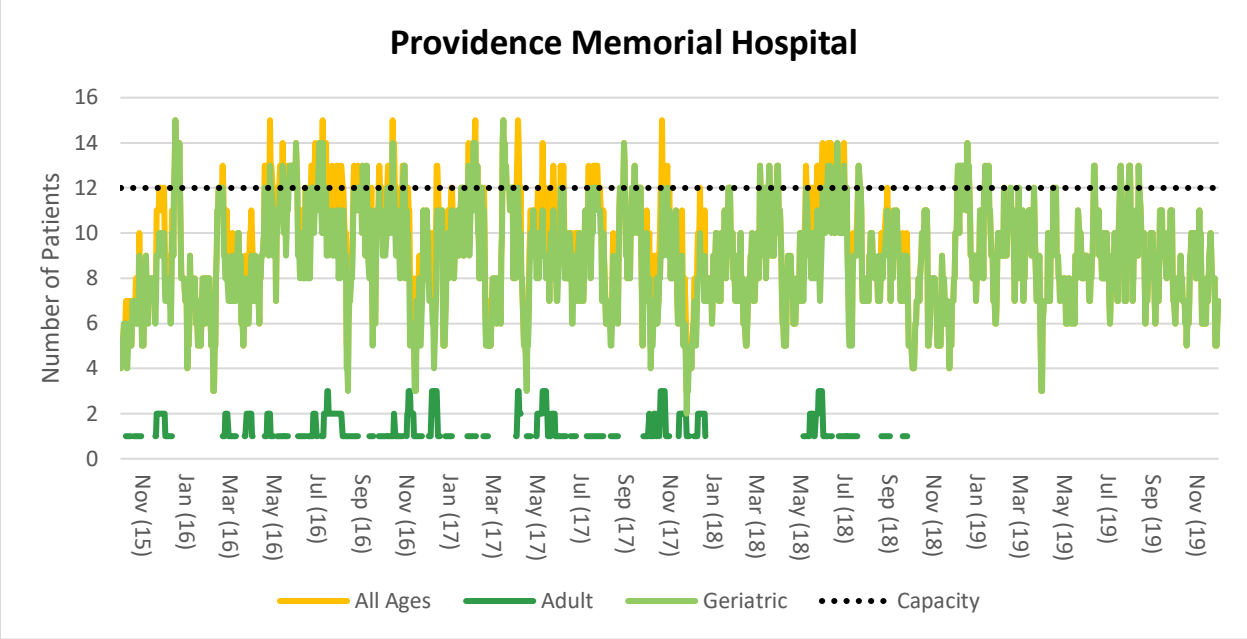
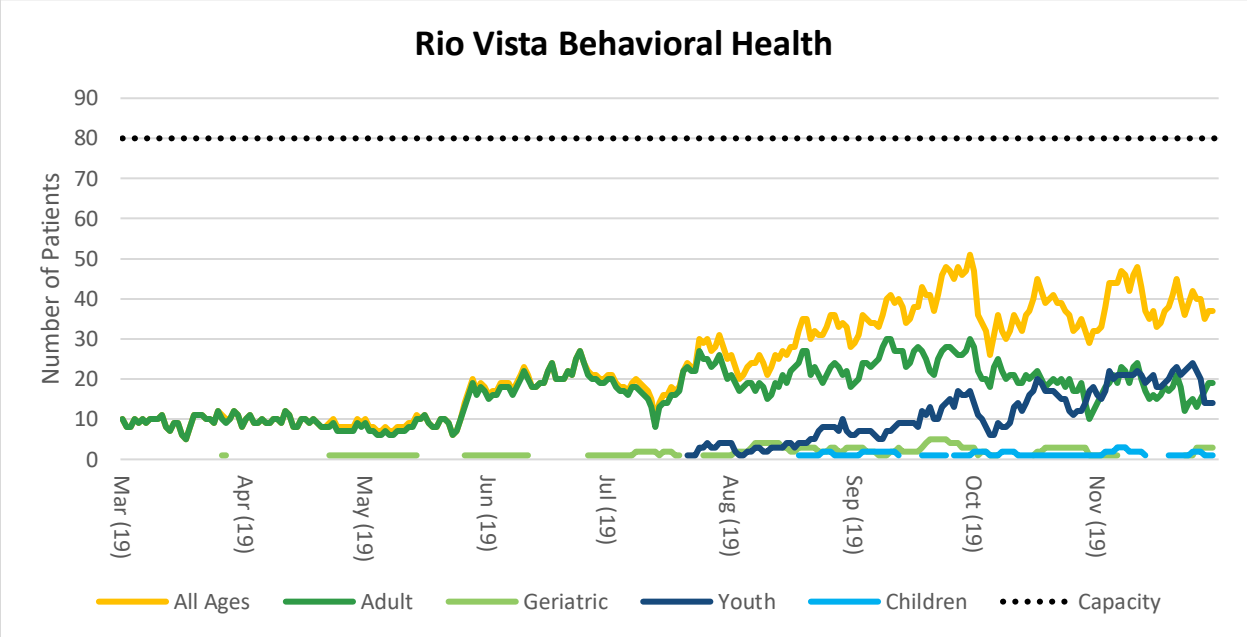


Figure 17: Rio Vista Behavioral Health Utilization Versus Capacity (2019)[214]



[213] Providence Memorial Hospital did not report capacity information to the Texas Hospital Association in 2019; therefore, locally reported capacity numbers were used. The number of beds occupied each day were calculated using discharge records from the THCIC (2015–2019).

Rio Vista Behavioral Health opened in February 2019, with a capacity of 80 beds. On average, 24 patients occupied Rio Vista Behavioral Health's 80 beds during the first eleven months of its operation. The number of occupied beds steadily increased over time, peaking at 51 beds in October 2019. Therefore, beds were available on all days while the facility was open during 2019. With the opening of Rio Vista Behavioral Health, there does not appear to be a shortage of local psychiatric beds to meet the needs of El Paso County residents, particularly children.

Given the expected population growth in El Paso County over time, it would be useful to examine bed utilization for signs of gaps in community-based outpatient services. Poor access to outpatient services, or insufficient capacity in certain types of services, will result in unnecessary use of inpatient services. Several features of inpatient bed use help identify problems with the availability of outpatient services. These features include length of stay, co-occurring psychiatric and substance use disorders, and comorbid behavioral and medical conditions.

Table 26, below, includes a breakdown of patients served in each El Paso County psychiatric facility, by age group, in 2019. Most patients served at El Paso Psychiatric Center were adults (72%), with the remainder largely represented by youth ages 12 to 17 (22%). Providence Memorial Hospital served older adult patients only. El Paso Behavioral Health System served a large number of adults (4,257, or 71% of its total patient volume), along with youth ages 12 to 17 (18%), and smaller numbers of children (6%) and older adult patients (5%). During its first year of admissions, Rio Vista Behavioral Health's patient demographic composition mirrored the other county psychiatric hospitals. Most of its patients were adults (71%) and youth ages 12 to 17 (23%), with a small number of patients over age 65 or under 12 years.

Table 26: Admissions to El Paso psychiatric inpatient beds by age (CY 2019)[215]

Local Hospital	All Ages	Children (6-11 years)	Youth (12-17 years)	Adult (18-64 years)	Older Adult (65+ years)
El Paso Psychiatric Center	693	34	150	502	7
Providence Memorial Hospital	305	0	0	0	305
El Paso Behavioral Health System	6,026	348	1,104	4,257	317
Rio Vista Behavioral Health	755	15	171	536	33

Table 27, below, details the number of child and youth psychiatric inpatient discharges in 2019 for both El Paso County and Texas (statewide). El Paso County discharged two times as many

[215] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

children (6 to 11 years) from psychiatric beds compared to the state average (267 per 100,000 children statewide, compared to 529 per 100,000 in El Paso County). Among youth ages 12 to 17, the rate of El Paso County discharges from psychiatric beds was 14% higher than the state rate (1,503 per 100,000 youth statewide, compared to 1,749 per 100,000 in El Paso County).

Table 27: Number and Rate of Child and Youth Psychiatric Inpatient Discharges for El Paso County, Compared to Texas (2019)[216,217]

Child and Youth Age Group	Location	2019 Encounters	Rate per 100,000
Ages 6 – 11	El Paso	397	529.26
	Texas	6,821	267.20
Ages 12 – 17	El Paso	1,425	1,749.07
	Texas	38,144	1,503.56

Table 28 below describes the number of unduplicated children and youth who were discharged from a psychiatric inpatient facility in 2019 for both El Paso County and Texas (statewide). El Paso County discharged unduplicated children (6-11 years) from psychiatric beds at more than two times the state rate (214 per 100,000 children statewide vs. 443 per 100,000 in El Paso County). Among youth ages 12-17, El Paso discharged 18% more unduplicated youth from inpatient psychiatric beds when compared to the state average (1,144 per 100,000 youth statewide vs. 1,394 per 100,000 in El Paso County).

Table 28: Number and Rate of Unduplicated Child and Youth Psychiatric Inpatient Discharges for El Paso County, Compared to Texas (2019)[218]

Child and Youth Age Group	Location	2019 Unduplicated Patients	Rate per 100,000
Ages 6 – 11	El Paso	332	442.60
	Texas	5,451	213.53
Ages 12 – 17	El Paso	1,136	1,394.34
	Texas	29,032	1,144.39

Figure 18 shows the lengths of stay at the El Paso Psychiatric Center, by age group, in 2019. The distribution indicates that the largest proportion of adult patients stayed for more than 25 days,

[216] The encounters column counts how many patients were discharged from a hospital and not how many are staying at the hospital. If a patient's condition is in severe enough to require staying over a year (for example, with an admission in November 2019 to January 2020), our dataset would not capture that information. The discharge will have occurred in January 2020 and would be reflected in the 2020 dataset, which has not yet been released.

[217] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

[218] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

with smaller numbers of adults ages 18 to 64 having shorter lengths of stay. Children and youth had stays that averaged between four and nine days, and less than 15% stayed for two weeks or more. Our length of stay analysis for the El Paso Psychiatric Center revealed rapid stabilization and discharge for children and youth, but less so for adults.

Figure 18: El Paso Psychiatric Center Length of Stay Details (2019)[219]

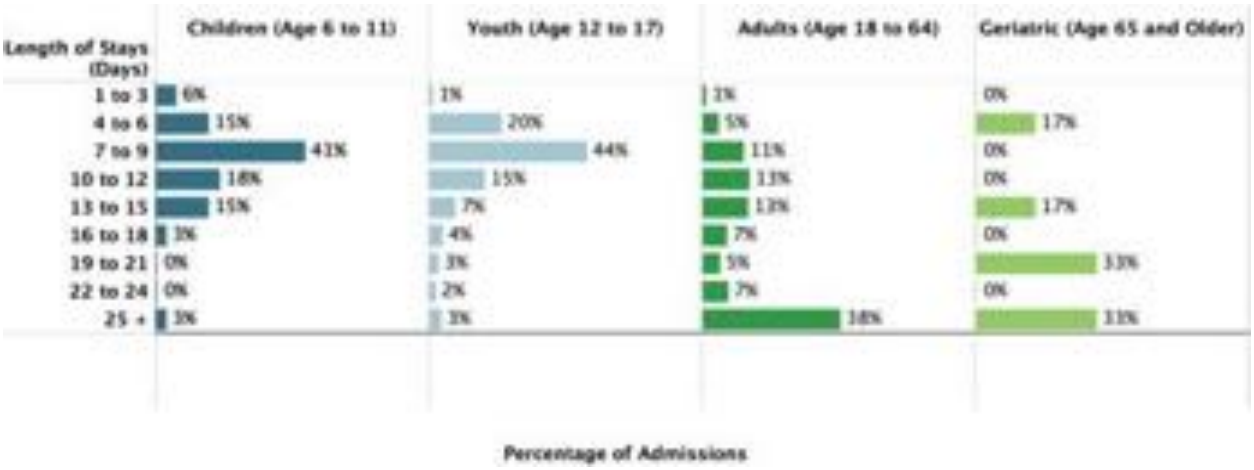
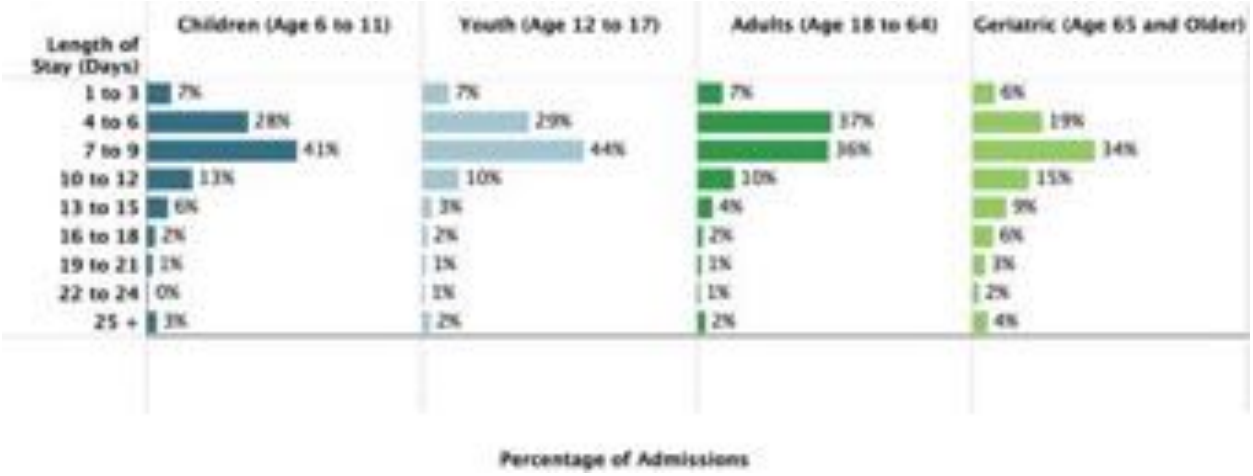


Figure 19 shows the lengths of stay at the El Paso Behavioral Health System, by age group. The graph indicates that most adults, children, and youth stayed for less than nine days. Older adults had slightly longer lengths of stay and about 20% stayed for two weeks or more. Older adults represented most of patients with very long lengths of stay (25 or more days), but only 6% of older adult patients had lengths of stay that were 25 days or longer. The length of stay analysis for El Paso Behavioral Health System revealed rapid stabilization and discharge for most subgroups of patients.

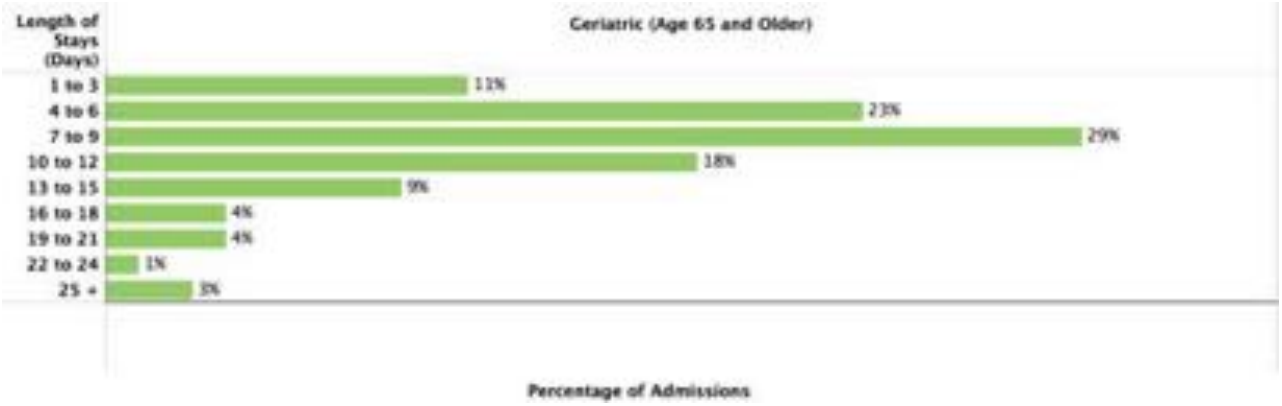
[219] Data were obtained from the THCIC (January – December 2019) discharge records.

Figure 19: El Paso Behavioral Health System Length of Stay Details (2019)[220]



Our analysis of the average length of stay for Providence Memorial Hospital's geriatric inpatient psychiatric unit (Figure 20) revealed that length of stay trends for older adults followed the patterns observed for El Paso Behavioral Health across all age groups. More than half of older adults admitted to Providence Memorial Hospital's geriatric inpatient psychiatric unit stayed between four (4) and nine (9) days.

Figure 20: Providence Memorial Hospital Length of Stay Details (2019)[221]



Older adults at Providence Memorial Hospital and El Paso Behavioral Health were more likely to have lengths of stay that exceeded two weeks (12% of older adults at Providence Memorial Hospital and 15% at El Paso Behavioral Health). The extended length of inpatient stays for older adults may reflect a lack of stepdown services to skilled nursing facilities, forcing older patients to remain hospitalized beyond what is medically necessary. Or it may reflect conditions in older

[220] Data were obtained from the THCIC (January – December 2019) discharge records.

[221] Data were obtained from the THCIC (January – December 2019) discharge records.

populations that are more difficult to stabilize. Chart reviews and analysis of the availability of skilled nursing facilities could help clarify if inpatient bed use in El Paso County hospitals may be reduced for older patients with mental health conditions.

Figure 21, below, shows the lengths of stay, by age group, for people admitted to Rio Vista Behavioral Health. The graph indicates substantial variations in length of stay by age group. Children and youth had lengths of stay patterns similar to those observed for children and youth admitted to El Paso Behavioral Health System. More than half of the children admitted to Rio Vista Behavioral Health stayed between seven (7) and nine (9) days; however, children were just as likely to stay between one and three days as twenty-five (25) days or more (7% of children fell into each category). Two third of youth ages 12 to 17 stayed between seven (7) and twelve (12) days. Adults had shorter lengths of stay, with two third of adult patients staying between four (4) and nine (9) days. Older adults represented very few patients at Rio Vista Behavioral Health in 2019 (33 patients total); however, those patients had highly variable lengths of stay, ranging from one day to more than three weeks.

Figure 21: Rio Vista Behavioral Health Length of Stay Details (2019)

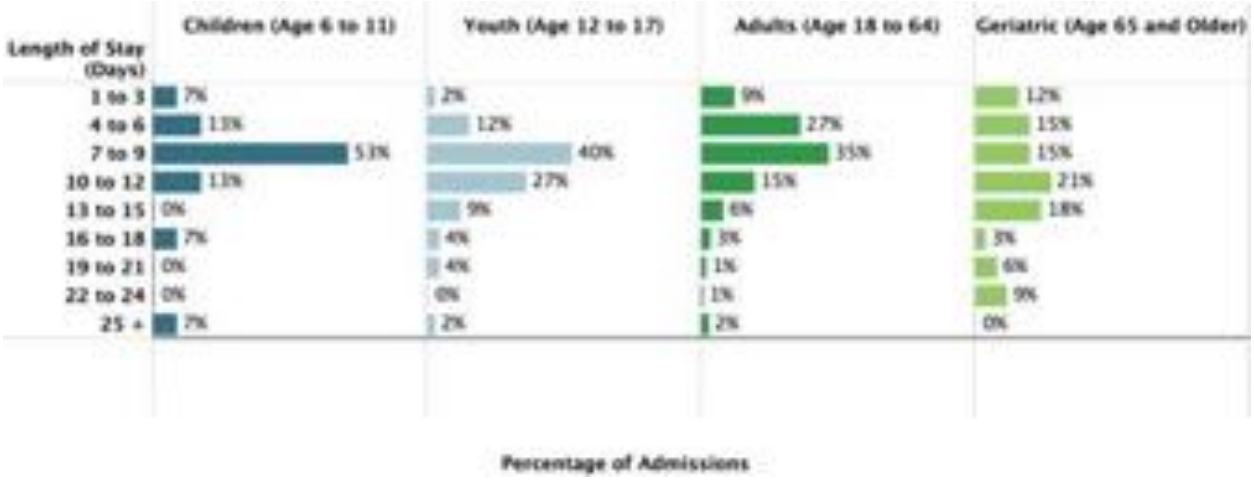


Table 29 through Table 32 report psychiatric bed utilization by El Paso County residents, by diagnoses, including substance use disorders and other co-occurring conditions. As reported in Table 29, 11% of people who were admitted to an El Paso County psychiatric bed were self-funded, 41% were funded through Medicaid, 5% were funded through Medicare, and 29% were funded through commercial insurance. In contrast, among all psychiatric ED visits, as reported in Figure 11, a higher proportion of people were self-funded (37%) and only 15% were funded through commercial insurance. People who were self-funded appeared less likely to receive inpatient care after visiting an ED, whereas people with commercial insurance were more likely to receive care. This pattern implies a lack of access for people who have to pay for ED services

themselves, but it could also indicate that these people require less inpatient care than people with other forms of insurance.

Table 29: Admissions to El Paso County Inpatient Psychiatric Beds, by Payer – All Ages (2019)[222,223]

Hospital	Total Admissions	Medicaid	Medicare	Other Government	Self-Pay	Commercial Insurance
El Paso Behavioral Health System	6,032	51%	1%	13%	0%	34%
El Paso Psychiatric Center	693	0%	0%	0%	100%	0%
Providence Memorial Hospital	305	42%	55%	1%	1%	1%
Rio Vista Behavioral Health	755	13%	6%	42%	19%	20%
Total Admissions to All Hospitals	**7,785**	**41%**	**5%**	**14%**	**11%**	**29%**

Table 30 shows the number admissions from El Paso County EDs to local (El Paso County) and non-local psychiatric beds for primary psychiatric and substance use conditions, and whether co-occurring conditions were present. The table shows that 2,354 out of 6,339 (37%) admissions to local beds and 10 of 84 (12%) admissions to non-local beds were for people with primary psychiatric diagnoses who had co-occurring substance use disorders. Ninety-one percent (91%) of the 179 people who were admitted to psychiatric beds with a primary substance use disorder (including 160 to local beds and fewer than six to non-local beds) had a co-occurring psychiatric disorder.

[222] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

[223] We are continuing to revise our classification of payer mix using the THCIC data. As a result, there may be discrepancies between the data reported here and internal hospital classifications.

Table 30: El Paso County Psychiatric Bed Admissions for Primary Psychiatric and Substance Use Disorders (SUD), Including Co-Occurring Behavioral Health Conditions (2019)[224,225]

Hospital of Admission	Primary Psychiatric Diagnosis		Primary Substance Use Diagnosis	
	Admissions	Admissions with Secondary SUD Diagnoses	Admissions	Admissions with Secondary Psychiatric Diagnoses
All Admissions to El Paso County Beds	**6,339**	**2,354**	**173**	**160**
El Paso Psychiatric Center	641	0	< 6	—
Providence Memorial Hospital	184	14	< 6	< 6
El Paso Behavioral Health System	4,894	2,293	161	151
Rio Vista Behavioral Hospital	620	47	< 10	< 10
Admissions to Non-El Paso County Beds	**84**	**10**	**< 10**	**< 6**
All Admissions	**6,423**	**2,364**	**179**	**163**

Table 31 displays the most common psychiatric diagnoses among El Paso County residents and non-residents who were admitted to psychiatric beds in 2019. Across all admissions to psychiatric beds, the most common psychiatric diagnosis was schizoaffective disorder (bipolar type), followed by major depressive disorder (1,842) and affective disorders (704). However, among those who received care in non-local hospitals, four of the top ten disorders included schizoaffective disorder (most common), schizophrenia (second most common), psychosis (third most common), and paranoid schizophrenia and delusional disorders (seventh most common). Among other factors, this trend could indicate that people served in non-local hospitals had more severe conditions that needed longer-term care from out-of-county state hospitals, or that they had insurance coverage that expanded their treatment options.

[224] In addition to the 6,339 admissions with a primary psychiatric diagnosis and the 173 admissions with a primary SUD diagnosis, 123 admissions had a primary "other" diagnosis. These "other" diagnoses, although not psychiatric diagnoses, were those that are often the result of, or contribute to, psychiatric symptoms. These include diagnoses such as Alzheimer's disease, open physical wounds, and carbon monoxide poisoning.

[225] Data were obtained from the THCIC (January – December 2019) discharge records.

Table 31: Residents of El Paso County, Top 10 Primary Diagnoses Associated with Admissions to Local and Non-Local Psychiatric Beds – All Ages (2019)[226]

Rank	All Admissions to Inpatient Psychiatric Beds N = 6,725	Admissions to El Paso Inpatient Beds N = 6,633	Admissions to Non-Local Inpatient Beds N = 92
	Top Primary Diagnoses (Admissions)	Top Primary Diagnoses (Admissions)	Top Primary Diagnoses (Admissions)
1	Schizoaffective disorder, bipolar type (1,152)	Major depressive disorder, recurrent severe without psychotic features (1,142)	Schizoaffective disorder, bipolar type (16)
2	Major depressive disorder, recurrent severe without psychotic features (1,151)	Schizoaffective disorder, bipolar type (1,136)	Schizophrenia (13)
3	Affective disorder (704)	Affective disorder (704)	Psychosis not due to a substance or known physiological condition (9)
4	Major depressive disorder, recurrent, severe with psychotic symptoms (430)	Major depressive disorder, recurrent, severe with psychotic symptoms (428)	Major depressive disorder, recurrent severe without psychotic features (9)
5	Bipolar disorder, current episode depressed, severe, without psychotic features (305)	Bipolar disorder, current episode depressed, severe, without psychotic features (303)	< 6 admissions per diagnosis: Schizoaffective disorder, depressive type Schizoaffective disorder, unspecified
6	Major depressive disorder, single episode, severe without psychotic features (261)	Major depressive disorder, single episode, severe without psychotic features (261)	Major depressive disorder, single episode Alcohol dependence
7	Psychosis not due to a substance or known physiological condition (239)	Psychosis not due to a substance or known physiological condition (230)	Paranoid schizophrenia Delusional disorders

[226] Data were obtained from the THCIC (January – December 2019) discharge records.

Rank	All Admissions to Inpatient Psychiatric Beds N = 6,725	Admissions to El Paso Inpatient Beds N = 6,633	Admissions to Non-Local Inpatient Beds N = 92
	Top Primary Diagnoses (Admissions)	Top Primary Diagnoses (Admissions)	Top Primary Diagnoses (Admissions)
8	Bipolar disorder, current episode depressed, severe, with psychotic features (212)	Bipolar disorder, current episode depressed, severe, with psychotic features (212)	
9	Unspecified Schizophrenia (205)	Paranoid schizophrenia (192)	
10	Paranoid schizophrenia (194)	Schizophrenia (192)	

Table 32 shows the most common comorbidities related to SUD and physical health conditions among El Paso County residents who received inpatient care for a psychiatric condition. The most common diagnoses among all residents seeking inpatient psychiatric care were related to medication non-compliance; childhood physical or sexual abuse; hypertension; cannabis, nicotine, and alcohol use disorders; general "observation for other suspected diseases," and obesity. Among the 92 El Paso County residents who were admitted to non-local inpatient beds, the most common reason for those admissions was an "unspecified illness" (21 patients).

Table 32: Top 10 Secondary Non-Psychiatric Diagnoses Associated with Admissions to Local and Non-Local Psychiatric Beds Among El Paso County Residents – All Ages (2019)[227]

Rank	All Admissions to Inpatient Psychiatric Beds	Admissions to El Paso Inpatient Beds	Admissions to Non-Local Inpatient Beds
	Top Diagnoses (Admissions)	Top Diagnoses (Admissions)	Top Diagnoses (Admissions)
1	Patient's noncompliance with medication regimen (1,600)	Patient's noncompliance with medication regimen (1,598)	Unspecified Illness (21)

[227] Data were obtained from the THCIC (January – December 2019) discharge records.

Rank	All Admissions to Inpatient Psychiatric Beds	Admissions to El Paso Inpatient Beds	Admissions to Non-Local Inpatient Beds
	Top Diagnoses (Admissions)	Top Diagnoses (Admissions)	Top Diagnoses (Admissions)
2	History of physical and sexual abuse in childhood (1,284)	History of physical and sexual abuse in childhood (1278)	<10 admissions per diagnosis: Nicotine dependence, cigarettes Hypertension Observation for other suspected diseases and conditions ruled out Gastro-esophageal reflux disease History of physical and sexual abuse in childhood
3	Hypertension (1,252)	Hypertension (1243)	
4	Cannabis use disorder (844)	Cannabis use disorder (841)	
5	Observation for other suspected diseases and conditions ruled out (548)	Observation for other suspected diseases and conditions ruled out (540)	
6	Alcohol use disorder (527)	Alcohol use disorder (526)	
7	Obesity (480)	Obesity (478)	<6 admissions per diagnosis: Anemia Nicotine dependence History of adult physical and sexual abuse Cannabis use disorder
8	Asthma (452)	Asthma (450)	
9	Gastro-esophageal reflux disease (448)	Gastro-esophageal reflux disease (442)	
10	Nicotine dependence, cigarettes (431)	Nicotine dependence, cigarettes (422)	

Summary and Conclusions

El Paso County has a growing population and an estimated 15,000 adults with serious mental illness (SMI) living in poverty, many of whom are not receiving adequate treatment. Living with SMI can cause additional financial strain such as lost productivity and wages that can lead to or exacerbate poverty. At the same time, living in poverty may also make it harder to obtain adequate care. It may be difficult or impossible for someone living with SMI to take the time to access care, they may also face difficulties with transportation if care is located far away, or they may not be able to pay for treatment.

Before 2019, efforts to meet the needs of people with SMI in El Paso County had been exacerbated by limited options for inpatient psychiatric care. The opening of Rio Vista Behavioral Health, with a capacity of 80 inpatient beds, has substantially expanded these inpatient care options. El Paso County's primary psychiatric hospital, El Paso Behavioral Health System, frequently operated over capacity, and 25% of its beds were available, on average, on only 7% of days between 2015 and 2019. In 2019, Rio Vista Behavioral Health had a substantial number of beds available on a daily basis, with capacity to serve children, youth, and adults. At Rio Vista Behavioral Health, bed usage did not exceed 51 beds (out of 80 total) on any day in 2019. Most inpatient psychiatric beds in 2019 were used by residents and they were rarely transported to other regions for inpatient behavioral health care. This suggests that El Paso currently has an adequate quantity of inpatient psychiatric beds to serve its population.

Based on the behavioral health conditions of people who use El Paso County's inpatient psychiatric services, it appears that local hospital resources are being used to treat conditions that could otherwise be treated in primary care settings, such as major depression and other mood disorders. Emergence Health Network is currently meeting about half of the community's need for behavioral health services, but the use of inpatient facilities for people with less severe diagnoses could indicate limited options for care within the county. This underscores the need to develop procedures that identify and link people to community-based care, particularly in anticipation of substantial population growth.

As of 2019, few El Paso County residents received inpatient behavioral health care outside of El Paso County. Of those who did seek out-of-county care, not all of the treatment in non-local hospitals was related to issues with local access to care. For example, people who were admitted to state hospitals often had forensic needs or more complex needs (e.g., comorbid intellectual and psychiatric disabilities) that required a more intensive setting than what community hospitals could offer. As a result, many of the inpatient admissions of El Paso County residents in non-local psychiatric facilities were at state hospitals (Table 34).

Finally, given the anticipated growth in El Paso County's population (especially among older adults), the county may also benefit from additional services that are designed to meet the

needs of an expanding older population. These could include addressing issues that lead to health inequities among older adults such as transportation needs, mobility concerns, and isolation. These problems may be amplified given the isolation and collateral effects of the COVID-19 pandemic in the older adult population.[228] Because older adults often have more co-occurring medical conditions, they may benefit from integrated health care settings that can treat commonly co-occurring mental health and physical conditions.

[228] Sepúlveda-Loyola, W., Rodríguez-Sánchez, I., Pérez-Rodríguez, P., Ganz, F., Torralba, R., Oliveira, D. V., & Rodríguez-Mañas, L. (2020). Impact of social isolation due to COVID-19 on health in older people: Mental and physical effects and recommendations. *The Journal of Nutrition, Health & Aging*, *24*, 938–947. https://doi.org/10.1007/s12603-020-1469-2

Appendix One: Prevalence Estimation Methodology

Introduction

To provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding overall prevalence of serious emotional disturbance (SED) and serious mental illness (SMI), we utilize the work of Dr. Charles Holzer.[229] In 2014, we commissioned Dr. Holzer to estimate the prevalence of SMI in Texas counties, using 2012 and earlier data. We believe that Dr. Holzer's original SED and SMI estimates and our adaptation of his data, findings, and methodologies to current Texas populations provide the most practically relevant estimates available. The method, described in detail below, uses statistical formulas that apply national prevalence rates to Texas population and demographic data.

Estimating the prevalence of specific mental illnesses such as bipolar disorder, depression, or schizophrenia in different age groups (e.g., children, youth, adults) is a more complicated endeavor – one requiring us to incorporate the best available national studies of the prevalence of those specific disorders. In cases where these alternative epidemiological sources are used, they are always cited and represent what we judge to be the best available contemporary source.

Holzer and "Horizontal Synthetic Estimation"

Beginning with his work at the University of Florida in the 1970s, Holzer drew connections between established data (drawn largely from census data), demographics, and the careful study of how these factors correlated with various needs among populations. Holzer derived principles about these connections, as presented in the Mental Health Demographic Profile System (MHDPS). This system matched demographic data from the Florida Health Survey with community demographics and known needs for mental health services, creating a model for estimating need in places and situations in which survey data were not available.

The method, which those on the MHDPS team termed "Horizontal Synthetic Estimation," evolved as Holzer refined his work. A crucial step came in the 1980s, following the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) program, the largest psychiatric epidemiological study in the United States at the time. Holzer used ECA findings to develop a series of prevalence estimates for the Texas Department of Mental Health and Retardation, a project which led to several similar projects in Colorado, Ohio, and Washington State. Following the 1990 Census and the 1993 National Comorbidity Survey (NCS), Holzer

[229] Charles E. Holzer III, PhD, was an esteemed psychiatric epidemiologist who has worked and published in behavioral science for forty years.

developed estimates in other states, including Colorado, Wyoming, and Nebraska, among others, and included county-level prevalence estimates.

Holzer's method represented a departure from previous, less-precise methods. He argued that prior approaches mistakenly assumed that local mental health systems served all people with mental health needs. He also criticized indirect methods of estimation, such as those using social indicators (crime levels, poverty, divorce, etc.) with no data on mental illnesses.

Holzer argued that if prevalence estimates and their correlates with demographic characteristics from national epidemiological studies were applied to state and county populations, he could provide more precise estimates of mental health need. He used statistical methods that analyzed survey data from the 2001–2003 Collaborative Psychiatric Epidemiology Surveys to estimate the relationships between seven socio-demographic characteristics (i.e., age, sex, race/ethnicity, marital, education, poverty, housing status) and SED and SMI prevalence rates. He then applied these rates to the most up-to-date, available county- or state-level American Community Survey (ACS)[230] population and demographic data, which include estimates of the number of people who can be categorized by the same seven socio-demographic characteristics.

MMHPI Adaptation of Holzer's Methodology and Data

In 2014, we hired Dr. Holzer to perform a revised county-level estimate throughout Texas, using 2012 three-year ACS data (the most recently available data at the time). Dr. Holzer then licensed the methodology to us for use in estimating prevalence in Texas. From this work, and by using Dr. Holzer's findings, especially his 2012 MMHPI-commissioned Texas estimates, we have developed a new series of 2019 estimates utilizing the 2019 ACS five-year dataset and the 2019 population estimates. These data were the most current at the time of our analysis.

Estimating the Prevalence of Specific Disorders

In estimating the prevalence of specific disorders, we draw on the most recent national prevalence studies conducted by psychiatric epidemiologist Ron Kessler and his colleagues as well as reviews of prevalence studies that target specific disorders. The two primary national studies we use are the National Comorbidity Survey Replication (NCSR)[231] and the National Comorbidity Survey Replication-Adolescent Supplement (NCSR-A).[232] These studies provide

[230] The ACS is an extension of the U.S. Census Bureau. It is an ongoing statistical survey that gathers significant data that, among other things, track shifting demographic data. The use of ACS data helps to align the Holzer estimates with the most up-to-date, local demographic data.

[231] Kessler, R.C., et al. (2005).

[232] Kessler, R.C., et al. (2012b).

national estimates of specific disorders. We then apply these estimates to the Texas populations of the same age groups (all adults ages 18 and older and youth ages 12 to 17).

The national studies do not include all disorders of interest. For example, because of its very low prevalence rate, schizophrenia is not included in the NCSR. In cases of missing diagnoses in the NCSR or NCSR-A, we rely on what we determine to be the best available reviews of epidemiological studies specific to each diagnosis.[233]

[233] See, for example, McGrath, J., et al. (2008). Schizophrenia: A concise overview of incidence, prevalence, and mortality. *Epidemiological Reviews, 30*, 67–76.

Appendix Two: El Paso County Hospital Data and Methodology

We drew our data for emergency department and inpatient psychiatric bed use from the Texas Health Care Information Collection (THCIC). THCIC comprises inpatient, emergency department, and outpatient discharge records for hospitals operating throughout Texas and includes data about Texas residents and non-residents (e.g., New Mexico residents) discharged from Texas hospitals. Each discharge record included details on the client's age, length of stay, county of residence, charges (which reflect the nominal amount billed for each service), primary payer type, and source of admission, among other variables. To analyze the many sources of funding included in records, payer types were grouped into one of five categories for the purposes of this analysis: Medicaid, Medicare, Other Governmental Payer, Self-Pay, and Commercial Insurance.

These THCIC discharge records were used to analyze psychiatric inpatient and emergency department utilization in El Paso County and across Texas, as depicted in the maps and data tables in this report. Although we currently have data from 2015 through the fourth quarter of calendar year 2019, the data in the maps and tables are limited to a single full year of data (January 2019 through December 2019), with the exception of the daily utilization graphs, which report utilization as far back as October 2015. Discharge records were either reported by age group or aggregated across all age groups, as described in the table titles.

Hospital capacity data were obtained from the American Hospital Association's 34rd Annual Survey of Hospitals (for year 2019). We reported the number of beds that are staffed for use by each hospital. However, if the hospital reported in the most recent in-person interviews an alternate number of available beds for 2019, we used that reported capacity in lieu of the American Hospital Association reported capacity.

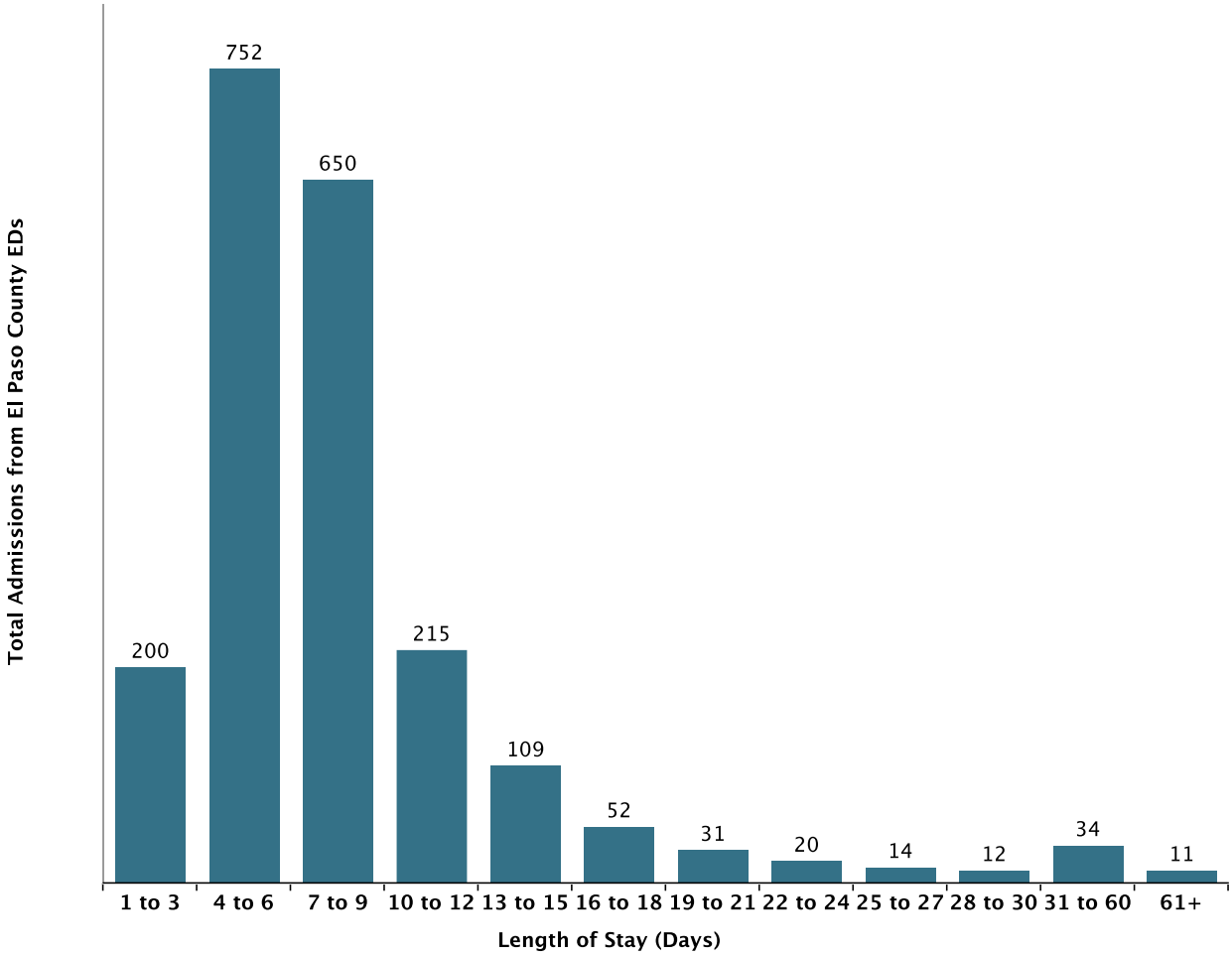
Appendix Three: Ancillary Tables

Table 33: Distribution of Length of Stay for Admissions from El Paso County Emergency Departments (EDs) to Psychiatric Hospital Beds (2019)[234]

Length of Stay in Days	Total Admissions from El Paso County EDs	Percentage Admitted to Local Hospitals	Percentage Admitted to Non-Local Hospitals
1 to 3 Days	200	8%	12%
4 to 6 Days	752	38%	32%
7 to 9 Days	650	30%	33%
10 to 12 Days	215	9%	12%
13 to 15 Days	109	5%	5%
16 to 18 Days	52	3%	2%
19 to 21 Days	31	2%	<1%
22 to 24 Days	20	1%	1%
25 to 27 Days	14	1%	<1%
28 to 30 Days	12	<1%	1%
31 to 60 Days	34	2%	1%
61 Days and Over	11	1%	<1%

[234] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

Figure 22: Data Associated with Table 33 – Length of Stay for Admissions from El Paso County EDs to Psychiatric Hospital Beds, All Hospitals (2019)[235]



[235] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

Table 34: Admissions to Psychiatric Hospital Beds Among El Paso County Residents, by Age (2019)[236]

Name	All Ages	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Over)
Bell County – Scott & White Medical Center Temple	**< 6**	**—**	**< 6**	**—**
Bexar County	**< 10**	**—**	**< 10**	**—**
San Antonio State Hospital	< 6	—	< 6	—
Methodist Specialty & Transplant Hospital	< 6	—	< 6	—
Laurel Ridge Treatment Center	< 6	—	< 6	—
Brazos County - Rock Prairie Behavioral Health	**< 6**	**—**	**—**	**< 6**
Cameron County - Rio Grande State Center	**21**	**—**	**21**	**—**
Cherokee County - Rusk State Hospital	**< 6**	**—**	**< 6**	**—**
Collin County	**< 6**	**—**	**< 6**	**—**
Texas Health Seay Behavioral Health Center	< 6	—	< 6	—
Haven Behavioral Hospital of Frisco	< 6	—	< 6	—
Dallas County	**< 6**	**—**	**< 6**	**—**
Methodist Richardson Medical Center	< 6	—	< 6	—
Dallas Behavioral Healthcare Hospital	< 6	—	< 6	—
Denton County	**< 6**	**—**	**< 6**	**—**
University Behavioral Health-Denton	< 6	—	< 6	—
Carrollton Springs	<6	—	< 6	—
El Paso County	**6,638**	**1,589**	**4,482**	**567**
El Paso Psychiatric Center	664	179	475	<10
Providence Memorial Hospital	273	—	—	273
El Paso Behavioral Health System	5,070	1,237	3,569	264

[236] Texas Health Care Information Collection (THCIC) January 2019 – December 2019 discharge records.

Name	All Ages	Children and Youth (17 and Under)	Adults (18 to 64)	Older Adults (65 and Over)
Rio Vista Behavioral Health	630	173	438	19
Gray County - Pampa Regional Medical Center	**< 6**	**—**	**< 6**	**—**
Grayson County - Texoma Medical Center	**< 6**	**< 6**	**—**	**—**
Harris County - Harris County Psychiatric Center	**< 6**	**< 6**	**< 6**	**—**
Menninger Clinic	**< 6**	**—**	**< 6**	**—**
Kingwood Pines Hospital	< 6	—	—	—
Behavioral Hospital-Bellaire	< 6	—	< 6	—
Howard County - Big Spring State Hospital	**11**	**—**	**< 10**	**< 6**
Lubbock County	**< 6**	**—**	**< 6**	**—**
Covenant Children's Hospital	< 6	—	< 6	—
Sunrise Canyon	< 6	—	< 6	—
Midland County - Oceans Behavioral Hospital of the Permian Basin	**< 6**	**—**	**< 6**	**< 6**
Potter County - Northwest Texas Hospital	**< 6**	**—**	**< 6**	**—**
Tarrant County - Mesa Springs	**< 6**	**< 6**	**< 6**	**—**
Tom Green County - River Crest Hospital	**< 10**	**< 6**	**< 6**	**—**
Travis County - Austin State Hospital	**< 6**	**—**	**< 6**	**—**
Wichita County - North Texas State Hospital	**< 10**	**—**	**< 10**	**< 6**
Wilbarger County - North Texas State Hospital, Vernon	**< 6**	**—**	**< 6**	**—**
Williamson County - Georgetown Behavioral Health Institute	**< 6**	**—**	**< 6**	**—**