Children’s Mental Health in Texas: A State of the State Report

Children’s Hospital Association of Texas (CHAT)
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FORWARD

Children’s Hospital Association of Texas (CHAT) is a non-profit association whose mission is to ensure that Texas Children have access to effective, high quality, comprehensive and appropriately funded health care. CHAT members include Children’s Medical Center – Dallas, CHRISTUS Santa Rose Children’s Hospital – San Antonio, Cook Children’s Medical Center – Fort Worth, Covenant Children’s Hospital – Lubbock, Driscoll Children’s Hospital – Corpus Christi and Texas Children’s Hospital – Houston.

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EXECUTIVE SUMMARY

Children’s Mental Health Services in Texas: A State of the State Report

Research has indicated that 1 in 5 children in the United States has a diagnosable mental or addictive disorder associated with at least minor functional impairment; for 1 in 20 children, this impairment is severe.1 Despite this and other evidence of the need to provide services for children’s mental health, the Texas Department of State Health Services has recognized that Texas families and children are not receiving adequate mental health care.2 This report provides an overview of the state’s system of mental health service delivery for children and identifies the following key issues:

Limitations of public and private insurance
There are approximately 1.4 million children without health insurance in Texas today.3 Mental health services available to these children are limited, and those that are available are disproportionately crisis services.4 In addition, public insurance plans like Medicaid and CHIP do not fully meet the level of need and do not necessarily guarantee access to mental health care. Even children who are covered by private insurance plans cannot always access mental health care as these plans typically do not provide equal coverage for mental health and medical services.

Inadequate state-level funding
While the population of Texas has grown rapidly in recent years, funding for mental health services has not kept pace with this growth. In FY 2003, Texas ranked 47th among the 50 states and District of Columbia in terms of per capita mental health expenditures.5 The consequences of inadequate funding include a decline in the number of children served by state and local agencies and increased reliance on de facto providers such as public schools and the juvenile justice system. In addition, low funding levels have compelled state agencies to focus their limited funding on crisis treatment. Texas is, according to many stakeholders, expending the majority of its money and energy on crisis management rather than maximizing the impact of funds by targeting early intervention.6

Increasing need for services
Demographic trends furnish evidence of a growing need for public services in Texas. The development of mental health disorders among children has been linked to a variety of socioeconomic and other risk factors, including poverty, child abuse, and substance abuse.7 There is substantial evidence that such risk factors are becoming increasingly prevalent among Texas’ children. Moreover, the increasing prevalence and severity of mental disorders among youth in contact with the juvenile justice system provides further evidence of the need for more adequate mental health services.

Deficiencies in system capacity and coordination
Gaining access to mental health services in the public system has become increasingly difficult due to strained capacity and insufficient coordination among agencies. There is a documented state-wide shortage of child psychiatrists, and access to inpatient and residential care is problematic as demonstrated by lengthy waitlists and disparities in access to care among different regions of the state. Additionally, fragmented funding streams and the lack of financial
support for coordinating mechanisms have left many families unable to navigate a complex public system.

**Inadequate community-based care**

Funding and coordination challenges present a formidable threat to community-based services for children with mental health needs. Although there appears to be a consensus among advocates and providers that community-based care is the most effective way to treat children’s mental health needs, the emphasis on community-based initiatives has arguably diminished due to funding decreases.8

**Lack of prevention and early intervention services**

There is a growing consensus among advocates, scholars, and providers that more should be done to develop a system of promotion, prevention, and intervention services for mental health concerns in very young children.9 According to children’s mental health experts, the only way to leverage the scarce money available is to maximize funding on the front end through early childhood and school-based intervention programs. By identifying behavioral health concerns early, children and families might be spared from having to enter the system when their condition is more severe and less manageable.

**Limited intervention programs for substance abuse**

A complicating factor in any analysis of children’s mental health is the intersection of substance abuse and mental illness. Substance abuse often co-occurs with mental health disorders among children and adolescents, but treatment options for children with co-occurring disorders are limited. As a result, the juvenile justice system has become in many cases the de facto provider of mental health and substance abuse treatment.

**Recommendations**

To address the challenges facing children’s mental health care in Texas, this report makes the following recommendations:

- Increase state money to support community-based services;
- Support parity legislation;
- Improve identification efforts and treatment for the birth to five population;
- Reduce barriers to Medicaid/CHIP enrollment and continued coverage;
- Increase oversight and coordination of children’s mental health services.

**Conclusion**

The continuum of care for children with mental health needs in Texas is broken. Several promising initiatives exist, but there are infrastructural and funding challenges that get in the way of families trying to access care. Given the numerous changes that have affected the children’s mental health enterprise, perhaps the most helpful question to ask is not “what does the future hold?” but “what should the future hold?” Texas’ children should be able to access a continuum of mental health services that address the promotion, prevention, and availability of care. While it undoubtedly takes money to make any health care system work, targeting funding to programs
that will most effectively use these funds is equally, if not more, important. The state’s resources should be used to support existing efforts that have been proven through academic research to have real, positive effects on children’s health outcomes. Moreover, future funding should focus on promising initiatives and services that will improve children’s mental health while reducing costs in the long run. Creating a healthier future for Texas’ children should be at the top of lawmakers’ list of priorities; that these services could save money is an added benefit that all residents of Texas will appreciate.


4 Telephone interview by Becky Pastner with Eddie Greenfield, Director, Waco Center for Youth, Waco, Texas, March 23, 2006.


6 Telephone interview by Jennifer Deegan with Betsy Schwartz, Executive Director, Mental Health Association in Houston, Houston, Texas, February 13, 2006; interview by Becky Pastner with Erin Espinosa, Federal Programs Specialist and Vonzo Tolbert, Director, Strategic Planning Division, Texas Juvenile Probation Commission and Tracy Levins, Ph.D., Children and Prisoner Representative, Texas Youth Commission, Austin, Texas, February 14, 2006; and telephone interview by Jennifer Deegan with Richard Poe, Manager for Federal Policy and State Programs, IDEA Coordination Division, Texas Education Agency, Austin, Texas, February 13, 2006.

7 Presentation by the Mayor’s Mental Health Task Force Monitoring Committee to the Health and Human Services Subcommittee of the Austin City Council, Austin, Texas, January 31, 2006.

8 Interview by Becky Pastner with Steven Shon, MD, Medical Director of Behavioral Health, Texas Department of State Health Services, Austin, Texas, February 14, 2006.

INTRODUCTION

Historically, the provision of children’s mental health services has been limited in Texas. While the need for a more comprehensive focus on children’s mental health had been evident to advocates and mental health providers for many years, there were no specific appropriations for these services until 1990. In response to reports detailing system fragmentation, provider shortages, disparities between rural and urban areas, and an overall lack of community-based services, the legislature established the Texas Children’s Mental Health Plan in 1991 and approved the first state dollars targeted specifically for children’s mental health. These appropriations were renewed and expanded modestly over the next few years. Beginning with the 75th Legislature in 1997, however, there were no new appropriations for these services, signaling a decline in commitment to their provision. By 2003, the government’s focus had shifted to the mental health needs of the adult population. As a result, children’s mental health services have been largely neglected, and many of the same barriers to care recognized in 1990 remain pertinent today.

This report provides a descriptive analysis of the current structure of the state’s mental health service delivery system as it pertains to children and briefly summarizes the impact of recent legislation on system organization and access to care. Interviews were conducted with mental health providers and individuals involved in mental health advocacy in and around the major metropolitan areas of Texas as well as staff at state and local agencies in Austin. Through these interviews, the following key issues in the provision of quality care for Texas’ children have been identified:

- Limitations of public and private insurance;
- Inadequate state-level funding;
- Increasing need for services;
- Deficiencies in system capacity and coordination;
- Inadequate community-based care;
- Lack of prevention and early intervention services;
- Limited intervention programs for substance abuse.

Following a discussion of the aforementioned challenges, several promising state initiatives in mental health service delivery are highlighted, and preliminary recommendations are offered based on the findings of this report.
Chapter 1

Background

Prevalence
According to a 2001 report of the Surgeon General, approximately 1 in 5 children in the United States has a diagnosable mental or addictive disorder associated with at least minor functional impairment; for 1 in 20 children, this impairment is severe. Using 2004 U.S. Census Bureau projections, this translates to more than 1.2 million Texas children with a diagnosable mental disorder. However, fewer than 116,000 children were eligible to receive services in 2002 as part of the priority population defined by the Texas Department of Mental Health and Mental Retardation in 2002.

The Structure of Children’s Mental Health Services
The provision of mental health services to children is affected by a variety of factors that are driven by innovations in mental health care as well as the structure of state systems that organize service delivery. In recent years, an emphasis on community-based care, including the Systems of Care approach, has emerged nationally. Systems of Care and other community-based initiatives are widely viewed as the most effective ways to treat children with mental and addictive disorders. In Texas, numerous entities are responsible for coordinating these and other mechanisms of mental health service delivery for children.

Defining Community-Based Care
The concept of community-based care for children with mental health needs is multi-faceted. In its broadest sense, “community-based” refers to a plan of care that emphasizes the role of family in a child’s treatment, and requires close partnership between providers and families. As its name implies, community-based also means that treatment for children takes place in their homes and their schools—in their local communities—rather than in residential or inpatient facilities away from their home environment. Adhering closely to the community-based philosophy of care, “Systems of Care” refers to initiatives that offer a range of community-based services and serve as a vehicle for comprehensive planning at the community level. Systems of Care initiatives have taken root across the nation in various forms.

Agencies Involved with Children’s Mental Health Service Delivery
In 2003, the 78th Legislature passed House Bill 2292, dramatically altering the structure of state health and human service agencies under the direction of the Texas Health and Human Services Commission (HHSC). As part of this reorganization, twelve agencies were consolidated into five. Four of these include programs that directly address children’s mental health. In addition
to the agencies overseen by HHSC, both public schools and the juvenile justice system play a crucial role in service provision to children with mental health disorders.

Health and Human Services Commission

The Health and Human Services Commission subsumed the responsibilities of the former HHSC and provides oversight for the other four agencies and departments. Additionally, the Commission administers both Medicaid and the Children’s Health Insurance Program (CHIP), public insurance programs that provide low-income children with coverage for both medical and mental health services. In FY 2005, Medicaid and CHIP insured more than 2 million children in the state.¹⁵

HHSC also oversees two programs designed to improve interagency coordination and increase access to community-based care: The Texas Integrated Funding Initiative (TIFI) and Community Resource Coordination Groups (CRCGs). TIFI operates four pilot communities demonstrating a Systems of Care approach for children with serious emotional disturbances. If TIFI and Systems of Care are considered the community-wide, macro-level mechanism for implementing community-based services for children, then CRCGs are the mechanism for creating individual child and family service planning. CRCGS, available in every Texas county, use interagency staffing teams to address a child’s particular needs.¹⁶

Department of State Health Services

Four departments, including the Texas Department of Mental Health and Mental Retardation and the Texas Council on Alcohol and Drug Abuse, were consolidated in 2004 to create the Department of State Health Services (DSHS). Within this agency, the Division of Mental Health and Substance Abuse Services oversees local mental health authorities and state hospitals. DSHS contracts for children’s community-based mental health services with 41 Community Mental Health Centers serving 247 Texas counties. The remaining seven counties are served by the Dallas Area NorthSTAR Authority (DANSA), a managed care organization. Residential and inpatient services are provided through the state hospitals and through the Waco Center for Youth, Texas’ only state-owned residential treatment center serving adolescents.

Department of Family and Protective Services

The Department of Family and Protective Services (DFPS), formerly the Department of Protective and Regulatory Services contains two divisions providing mental health services to children: Child Protective Services (CPS) and Prevention and Early Intervention (PEI). CPS provides services to children both in foster care and in their own homes, and PEI manages community programs designed to prevent child abuse and neglect. Additionally, PEI operates the Services to At-Risk Youth (STAR) Program, which contracts for some mental health services for at-risk youth who meet its eligibility requirements.

Department of Assistive and Rehabilitative Services

The Early Childhood Intervention Division (ECI) operates under the oversight of the Department of Assistive and Rehabilitative Services (formerly the Texas Rehabilitative Commission, Commission for the Blind, Commission for the Deaf and Hard of Hearing, and the Interagency Council on Early Childhood Intervention). Through ECI, children under the age of three with disabilities or developmental delays may receive mental health services.
Independent School Districts

Public schools throughout the state provide numerous services to children with mental health needs. In fact, it has been estimated that 70 percent of children with mental health needs are served by providers within the education sector. Because the array of available services varies by school district, it is difficult to make generalizations about service provision, and statistics are available only for the estimated 36,000 children in special education services diagnosed with severe emotional disturbance (SED). Among schoolchildren with mental health disorders, special education services are available only to those diagnosed with SED, but the Communities in Schools (CIS) program provides counseling to many children with less serious diagnoses. In addition, some school districts have secured outside funding to develop programs that meet the mental health needs of their student population.

Texas Juvenile Probation Commission

Approximately 4 percent of the nation’s children who access treatment for mental health disorders do so through the juvenile justice system. In Texas, this system is divided into two state-level components. The first, the Texas Juvenile Probation Commission (TJPC), funds and oversees local probation boards, which may provide mental health services to juvenile offenders, depending on available funding and court orders. In addition, TJPC operates the Special Needs Diversionary Program (funded by the 77th Legislature) to provide treatment to juvenile offenders with serious mental impairment. TJPC served 764 juveniles in this program in FY 2002. Apart from the Special Needs Diversionary Program, which serves a limited population, TJPC has no funding specifically designated for the provision of mental health services. Nevertheless, an estimated 47.5 percent of juvenile offenders referred to TJPC in 2002 reported at least one mental health or addictive disorder.

Texas Youth Commission

The Texas Youth Commission (TYC), the institutional component of the state’s juvenile justice system, provides more intensive inpatient treatment to court-committed juvenile offenders with mental health needs. TYC has reported a growing number of juveniles with mental health disorders in its custody and has also noted an overall increase in the severity of disorders in recent years. In FY 1997, approximately 29 percent of youths committed to TYC had a diagnosed mental health disorder; by 2004, this number had grown to almost 45 percent. To meet the needs of this population, TYC provides intensive services at the Corsicana Stabilization Unit as well as residential treatment at the Corsicana Residential Treatment Center and the Crockett State School.

Recent Legislation

House Bill 2292

The passage of House Bill 2292 in 2003 resulted in the reorganization and consolidation of health and human service agencies in an attempt to increase accountability and reduce the number of agencies responsible for health services. In addition to agency consolidation, a new focus on disease management for mental health was initiated to target service delivery in a more cost-effective manner based on standardized diagnoses and evidence-based treatment. HB 2292 also reduced funding for state mental health services by approximately 3.5 percent, though these services were certainly not the only ones to undergo cuts.
While the majority of providers, advocates, and agency directors agree that the motivation to integrate mental health and substance abuse services is laudable, they also recognize that consolidation has had a number of negative effects, including a declining emphasis on children’s mental health needs. Some have expressed frustration that reorganization alone cannot improve service delivery without additional funding and a well-defined mission. The transition, compounded by lower levels of funding, has resulted in confusion and reduced access to children’s mental health services. This may be evidenced by the recent experiences of non-profit agencies that have noted increases in the number of children seeking care at their organizations who formerly received state-funded services.

The negative impact of agency consolidation on children in the public system has been exacerbated by the lack of any one constituency or group advocating for children’s services. One consequence of this change has been less certainty that state money for children’s mental health services is actually finding its way to this population.

In addition to agency consolidation, HB 2292 also enacted changes to the mental health component, eligibility rules, and renewal periods for CHIP. The net result has been a 42 percent decline in CHIP enrollment between September 2003 and April 2006, a change that has affected more than 200,000 Texas children. When combined with these and other cuts, integration has been largely unable to achieve the goals of improved access to and quality of care. Juvenile justice agencies, which were not affected by the 2003 legislation, have been able to effectively demonstrate a need for increased funding, while per capita mental health expenditures by DSHS have declined since 2003. As a result of these funding changes, some mental health services that could be provided more appropriately by the public health system have been relegated to correctional facilities.

**Senate Bill 6**

In 2005, the Texas Senate passed Senate Bill 6 with the intention of improving medical and behavioral health outcomes for children in state foster care. Among other provisions, SB 6 calls for the establishment of a medical home for children in foster care and the creation of an electronic medical passport to ensure greater continuity of care for children in state custody. Furthermore, SB 6 will require the state to contract with a private health organization to provide medical and behavioral health services to children in foster care. Most stakeholders agree that it is still too early to tell what the ultimate effects of this legislation will be, but some have predicted a combination of positive and negative effects on the provision of mental health services to children in the foster care system.

Coordination of care is a commendable goal, as the foster care system can be a “nightmare of complexity.” There is general support for the creation of a medical passport to avoid unnecessary duplication of care and to ensure that providers know each child’s medication history. As children are relocated within the foster care system, resources are too often spent “starting over again.” Additionally, the use of evidence-based medication protocols is viewed as a means to avoid the overmedication of children in foster care, a concern that has been expressed by some providers.
There is also concern, however, that the outsourcing and privatization of services will prove challenging, and some medical providers have had mixed experiences with the transition to managed care. Still, it is too early to identify the precise consequences of this legislation.
Chapter 2

Key Challenges and Issues

The Texas Department of State Health Services has recognized that Texas’ families and children are not receiving adequate mental health care.\textsuperscript{40} In light of the current state of affairs, the following challenges and issues have been identified as key contributors to ineffective mental health service delivery at both the state and community levels.

Insurance

Insurance status can be a systemic barrier for families seeking children’s mental health services. Clearly, the lack of insurance coverage is a hindrance to obtaining care, but problems also exist with both public and private insurance that effectively prohibit children from accessing needed services.

The Uninsured

There are approximately 1.4 million children without health insurance in Texas today.\textsuperscript{41} Mental health services available to these children are limited, and those that are available are disproportionately crisis services, since state money is primarily earmarked for uninsured children with the most severe conditions.\textsuperscript{42} As explained earlier, due to the large numbers of children waiting to enter this system, lengthy waiting lists are a frequent problem.

Despite the limitations on treatment options for uninsured children, there are programs to serve children without insurance in Texas. Children in the school system or those who enter the juvenile justice or CPS system are not denied treatment because of uninsured status. In fact, there are documented cases of parents charging their children with crimes or relinquishing custody precisely because they cannot afford adequate mental health services for their children. In 2002, 244 children were relinquished as a last resort to access mental healthcare. Strikingly, it is not only uninsured children who end up in this situation. Some of the 244 families had private insurance that would not cover the needed treatments.\textsuperscript{43} Similarly, Medicaid will cover an uninsured child or adolescent who is court-committed to a residential facility (determined an independent child), but voluntary admissions require a payor. This perverse incentive leads parents to commit their children to treatment through the court system.\textsuperscript{44} In the Austin area, the Children’s Partnership, a local Systems of Care site, serves children regardless of ability to pay. If a child has Medicaid or CHIP, then reimbursement will be sought, however the ability or inability to pay does not determine whether or not a child will receive services.\textsuperscript{45}

Uninsured children are at a disadvantage when it comes to accessing mental health services, but enrollment in the public or private insurance systems does not guarantee adequate coverage.

Public Health Insurance

In Texas, low-income children receive public health insurance coverage through one of two programs: Medicaid or CHIP. Medicaid is available to children who are Texas residents, whose families own assets below an established level, and meet Medicaid income requirements.\textsuperscript{46} CHIP is designed for children whose families earn too much money or have too many assets to qualify for Medicaid, but cannot afford private insurance.\textsuperscript{47} While the vast majority of children...
on Medicaid and CHIP are enrolled on the basis of income, these programs are also available to children based on non-income criteria, namely disabled children and foster children.48

When it comes to receiving care for mental health needs, public insurance plans like Medicaid and CHIP fall short of the state’s level of need. Reimbursement rates for Medicaid and CHIP are extremely low; for example, a 30-minute visit with a psychiatrist receives a $41 reimbursement from Medicaid.49 As noted earlier, because of these low rates, few providers are willing to accept Medicaid patients thereby preventing thousands of children from accessing mental health services in their area. Children’s mental health experts express a near unanimous dismay with the lack of Medicaid providers in Texas, emphasizing that both rural and urban areas are affected by the unwillingness of providers to accept Medicaid because of their low reimbursement rates.

Even if Medicaid and CHIP providers exist in a community, there is evidence to suggest that Medicaid and CHIP recipients aren’t always taking advantage of the mental healthcare potentially available to them. One way to measure this is to look at penetration rates—the percentage of enrollees who used mental health services—and comparing this to the overall prevalence of mental health needs in the population. Estimates for Texas Medicaid penetration rates are extremely low, ranging from two to eight percent depending on the number of services and enrollees included in the calculation.50 Reasons for these low penetration rates might be stigma regarding mental illness,51 lack of knowledge about available resources, or simply a shortage of mental health providers who accept public insurance. Furthermore, the 90-day waiting period to join CHIP, as well as frequent re-application requirements for both CHIP and Medicaid prevent eligible children from receiving immediate and continuous coverage.52

Another aspect of the public insurance system is a growing reliance on managed care. In 2003, more than a decade after Texas began experimenting with and eventually expanding Medicaid managed care programs,53 a section of HB 2292 directed HHSC to provide all Medicaid services through managed care programs that proved to be the most cost-effective as determined by a mandated study by the Commission.54 Managed care differs from the traditional fee-for-service arrangements by providing a network of health care providers that coordinate care in return for a specific payment per person. Despite the fact that managed care was expanded in an attempt to improve access, quality and continuity of care,55 critics of managed care claim that the system limits providers from offering a wide range of services for children’s mental health.56

Private Health Insurance

Children whose families can afford to purchase private insurance, or receive coverage through their employer, have more access to mental health services than uninsured or publicly insured children. However, private insurance presents its own set of barriers that make accessing mental health services difficult.

One such problem is the issue of parity. Health insurance typically doesn’t cover mental health benefits to the same extent as physical health benefits. With the exception of some voluntary corporate parity programs, employer-sponsored health insurance plans do not necessarily provide a sufficient level of mental health coverage for employees and their families. Caps on mental health visits and psychotropic medication as well as higher deductibles and co-payments for mental health (versus physical health) visits have often created a system in which sufficient mental healthcare is out of reach for children who have private insurance, forcing these families
into the public system. Inequality between the two systems has motivated advocates to push for parity legislation in Texas and nationwide to varying levels of success. The benefits of parity were substantiated by a recent study in the New England Journal of Medicine showing that the implementation of parity in insurance benefits for mental health care can improve insurance protection without increasing total costs.

A second concern with private insurance is carve-outs. Most private insurance companies offer their mental health benefits through a separate provider; mental health benefits are “carved out” and given to another company to administer. This arrangement often involves major differences between the primary insurance provider and the carve-outs, including co-pay amounts, accepted network providers and formularies. Despite initial support among many mental health experts in Texas, and some positive findings among researchers analyzing the effects of carve-outs, critics claim that such an arrangement may not promote the integration of behavioral and physical health, and often results in consumers muddling through an inconsistent, fragmented and confusing system to get the care their child needs.

**Funding**

**Appropriations for Mental Health Services**

The population of Texas has grown rapidly in recent years, increasing by almost 35 percent between 1990 and 2005. Funding for mental health services, however, has not kept pace with this growth. In FY 2003, Texas ranked 47th among the 50 states and District of Columbia in terms of per capita mental health expenditures. Because these expenditures are not confined to a single agency in Texas, and overlaps exist among children accessing care through state agencies and public insurance programs, it is difficult to assign a precise dollar amount to children’s mental health expenditures. However, the Mental Health Association in Texas has documented a decline in the number of children served between 2002 and 2004. While an estimated 31,303 children received services through DSHS in 2003, this number decreased by 28 percent to 22,499 in 2004.

The consequences of low funding levels are serious for children with mental health disorders. Research has found that states with higher per capita mental health expenditures also rank higher in overall measures of child well-being. While there are likely a number of explanations for the positive correlation between per capita mental health expenditures and child well-being, access to services is an important one. Access to care, however, is admittedly problematic for Texas families and children. According to DSHS, only about 25 percent of children in its priority population were served in 2001, and this percentage is likely to have been even smaller in recent years, given population growth and the aforementioned decrease in the number of children served. The reduction in CHIP enrollment has likely affected access to mental health services as well. Overall, low levels of funding have made it more difficult for Texas’ children and families to obtain mental health care.

**Funding Priorities**

A common complaint voiced by providers, state agencies, and advocates alike is that a paucity of state-level funding has led to the concentration of funds on inpatient care, to the detriment of community-based and outpatient services. More intensive services will always be needed, but effective spending on early identification, prevention, and outpatient or community-based
services can minimize the need for more expensive crisis treatment later on. In comparisons with other states, Texas spends a greater percentage of mental health funds on inpatient rather than on community-based services. The state is, according to many stakeholders, expending the majority of its money and energy on crisis management rather than maximizing the impact of funds by targeting early intervention.

This trend has had at least two detrimental effects on the provision of mental health services to children. First, because state funding for community-based services and coordination mechanisms is limited, there has been a tendency to rely on schools and the juvenile justice system as de facto providers of mental health services. Schools, however, lack the resources to adequately deal with the mental health needs of students and often fail to identify children with mental health disorders until behavioral problems and poor performance become problematic. Additionally, the documented increase in mental health disorders among children and adolescents in the juvenile justice system may be directly linked to inadequate community-based services, leading some to describe this trend as the “criminalization of mental health disorders.”

In 2006, the research division of TJPC conducted a cross-system data analysis and found that the number of youth in the juvenile justice system who had received mental health services from the local Mental Health and Mental Retardation (MHMR) centers had decreased by 15 percent between 2001 and 2004, while the number served by juvenile probation departments had increased by 258 percent.

Furthermore, inpatient treatment facilities have been overwhelmed by the number of children in need of crisis services, and even children in crisis are not always able to access care. Waco Center for Youth reports being over capacity almost every day, with waitlists of up to six months. This increasing pressure on inpatient facilities for children and adolescents can be attributed in part to a lack of outpatient and community-based treatment programs that identify and treat children before their problems become severe. The overall lack of early intervention services allows the condition of some children with mental health disorders to deteriorate to the point of crisis, at which point inpatient care may be the only viable option. Further complicating this situation, children in non-crisis situations, who might be treated more appropriately in outpatient settings were they available, end up competing for these limited inpatient resources. In short, evidence that inpatient capacity is strained may, in fact, indicate a deficiency of community-based intervention alternatives.

Need for Services

Indicators of the substantive and growing need for children’s mental health services are both demographic and socioeconomic. The population of Texas has undergone dramatic changes over the past several decades, and public health services must adapt to address current and future demands. Moreover, renewed focus on children’s mental health is imperative given the documented increase in the number of children exposed to risk factors for developing mental disorders.

Population Growth

The 2000 census results revealed that Texas, the second fastest growing state in the U.S., had grown more rapidly and become more diverse than demographers had previously anticipated. In 2000, 57 percent of Texans under the age of 18 were Hispanic, and household composition showed marked changes as the proportion of married-couple households decreased between
1990 and 2000. As state demographers have noted, age, ethnicity, and family structure are often correlated with income levels and other socioeconomic factors that affect the demand for services. Given these correlations, the trends described above “provide the impetus for substantial change in Texas.”

Socioeconomic and Other Risk Factors

The development of mental health disorders among children has been linked to a variety of socioeconomic and other risk factors, including poverty, child abuse, and substance abuse. There is substantial evidence that such risk factors are becoming increasingly prevalent in Texas. Approximately 1.3 million (21.3 percent) of the state’s children live in poverty, a modest increase from 20.7 percent in 2000 and more than four percentage points above the national average. Additionally, many families with incomes that did not fall below Federal Poverty Guidelines in 2005 experienced “significant economic distress,” with the cost of basic expenses requiring income levels between 1.5 and 2 times the poverty line.

The number of children in foster care in Texas has increased dramatically in recent years, and this trend is expected to continue. In FY 2005, more than 32,000 children were in foster care (a 93 percent increase since 1994). In the same year, more than 61,000 Texas children were confirmed victims of abuse or neglect. Because abuse, neglect, relationship difficulties, and exposure to trauma are recognized risk factors for developing a mental illness, many of these children will likely require publicly funded mental health services.

Mental health disorders and substance abuse are often co-occurring in both children and adults. According to DSHS, while adolescent use of tobacco and alcohol has declined steadily in recent years, illicit drug use has not followed the same trend. Thirty-two percent of secondary students reported using illicit drugs in 2004, up from 22 percent in 1992.

Prevalence of Mental Disorders in Juvenile Justice System

The increasing prevalence of mental disorders among youth in contact with the juvenile justice system provides further evidence of the need for more adequate mental health services. For many of these children and adolescents, early intervention “could have potentially eliminated or reduced the frequency or intensity of their delinquent behaviors.” In the past decade, there has been a documented increase in the number of youths committed to TYC with mental health problems, from 27 percent in 1995 to 45 percent in 2004. As noted earlier, the severity of these problems has increased as well, and 36 percent of juvenile offenders in 2004 were diagnosed with a severe mental disorder. While mental health services are available in the TYC system, this is not necessarily the case with TJPC. Of the 12,737 youths with a mental health disorder on probation or paroled in 2001, only about 31 percent received care through MHMR or the juvenile justice system.

Relinquishment to State Custody

Perhaps the most distressing indication of the inadequacy of mental health services for children can be found in CPS statistics. In 2002, the Texas Department of Protective and Regulatory Services (now DFPS) documented that 244 children were relinquished to state custody because their families had no other means of accessing mental health care.
Deficiencies in System Capacity and Coordination

Gaining access to mental health services in the public system has become increasingly difficult due to strained capacity and insufficient coordination among agencies. While the lack of a clear definition of children’s mental health makes it difficult to determine system capacity with great precision, a dearth of children’s mental health providers in many areas of the state and lengthy waitlists for both inpatient and outpatient services provide clear indicators of system inadequacy.

Capacity

The capacity of the public system to provide both inpatient and outpatient services to children with mental health needs has been strained in recent years as evidenced by the declining number of total children served and the low percentage of eligible children who ultimately receive services. Even for children who are covered by Medicaid or CHIP, an overall provider shortage renders access to care problematic. In 2005, a total of 190 child psychiatrists served 35 of 254 Texas counties, and only seven of these counties were located west of the I-35 corridor.

Inpatient capacity is also limited. The Waco Center for Youth has a total of 77 inpatient beds, and there is no public residential treatment facility for children under the age of 13. Additionally, only four of nine state hospitals have beds allocated for children (41 total inpatient beds), and five of nine provide a total of 198 beds for adolescents. The Hospitals Section of DSHS emphasizes that the number of beds allocated for children and adolescents in state hospitals is determined by the expressed community need for this service. Nevertheless, vast areas of the state have little or no access to inpatient care for youth. Dallas County has no emergency psychiatric hospital for children, a situation that has recently forced young children to share an emergency psychiatric ward with adults at Parkland Memorial Hospital, the city’s only public hospital.

Waitlists

An overwhelming number of providers in both the public and private systems complain of extensive waitlists at every level of care. Providers, agencies, and advocates agree that there are simply not enough resources to serve the growing number of children seeking mental health services in the public system. The Waco Center for Youth has an average of 70 children on its waitlist at any given time, and it can take five to six months to receive residential treatment. In fact, many families simply give up because the wait is so lengthy. Waitlists are more difficult to document for community mental health centers, and capacity varies in different areas of the state. While there is no documented waitlist at Austin Travis County MHMR, children may wait weeks before receiving an initial assessment. Providers and non-profit agencies in Travis County report that many of the children they refer may wait anywhere from one to six months to receive services from the local MHMR.

Due to the statewide shortage of psychiatrists, even children with private insurance may wait months and travel long distances to receive psychiatric care. One child psychiatrist in Bexar County points to 6-12 week waiting periods, even for children with private insurance. For children with public insurance, access to psychiatry is even more limited. According to HHSC data, only 38 percent of psychiatrists in Texas had one or more paid Medicaid claims in FY 2005. Additionally, many families must travel to metropolitan areas on a weekly basis to access care for their children.
Non-profit providers such as Child Guidance Centers have also documented year-round waitlists and an increasing demand for mental health services. Waitlists in Austin may be a month or more, while those in San Antonio are somewhat shorter, averaging three to four weeks.96

**Coordination**

Despite the reorganization of HHSC in 2004, a lack of coordination among agencies providing mental health services to children is a common complaint, and there are a variety of reasons for fragmentation. First, funding streams are not integrated at the state level and tend to be inflexible. Second, mental health services offered by schools and local probation departments vary by county, as do coordination mechanisms between local mental health authorities and these de facto providers. While CRCGs are charged with helping families that require interagency coordination to navigate the public system, local budget allowances and staff participation and support for these groups have decreased. The result has been a documented decline in the number of initial individual service plans for children and adolescents who are served by CRCGs.97 Additionally, the Texas Integrated Funding Initiative has not been expanded since its inception in 1999, despite documentation that the Systems of Care approach is more cost-effective than inpatient treatment.98 Finally, in managed care systems, mental health carve-outs often prevent families from receiving mental health and medical services in the same location, making care coordination difficult even for those with insurance coverage.99

**Underserved Areas**

Disparities in the availability of mental health services exist throughout the state, but they cannot be neatly classified as a “rural-urban divide.” While it is true that children in rural areas have limited access to mental health services, providers are careful to point out that children in urban areas face their own set of unique challenges. In 2005, only 2.6 percent of Texas’ 190 child psychiatrists were practicing in five of the state’s 177 rural counties.100 Additionally, travel required to access care is often prohibitive, particularly in West Texas and the Panhandle.101 In contrast, the overall need for services can be greater in urban settings, making access to treatment more competitive in large cities. Furthermore, service levels have not caught up to demand in many rapidly growing counties.102

Research has identified substantial ethnic disparities in the United States concerning access to and attitudes about mental health care.103 Limited system capacity in areas near the Texas-Mexico border suggests that Texas is not immune to this national trend. In 2005, 42 child psychiatrists were practicing in the 43 border counties, and 34 of these were located in Bexar County.104 Linguistic and cultural diversity in this area of the state provides an additional challenge to the provision of mental health services, and many agencies report difficulty finding bilingual providers. Crisis care is also difficult to access for families in the Rio Grande Valley, as no state hospital beds south of Bexar County are allocated for children or adolescents.105

**Limitations on Community-Based Services**

The funding and coordination challenges mentioned earlier in this report present a formidable threat to community-based services for children with mental health needs. Although there appears to be a consensus among advocates and providers that community-based care is the most effective way to treat children’s mental health needs, and the will to coordinate services seems to exist, the lack of funding has eliminated the ability to fully coordinate services.
The emphasis on community-based initiatives has arguably diminished due to funding decreases. Some claim that the emphasis on community-based, integrated initiatives has been replaced with a more entrenched, “silo” perspective among agencies. Others point out that success rates of community-based services, both Systems of Care and CRCGs, vary depending on the geographic area. While the Travis County initiatives are considered a success story, other CRCGs and Systems of Care approaches in Texas have suffered due to lack of attention and resources. In contrast with other states, Texas has not linked Systems of Care approaches to a formal funding system.

A second perspective on this issue contends that decreased funding has led to more innovation, out of sheer desperation to provide services among agencies with limited resources.

Need for Prevention and Early Intervention

Research has demonstrated that somewhere between nine and fifteen percent of children between birth and age five have diagnosable mental disorders. Often left untreated, these children frequently go on to develop mental illness later in life. Evidence of early childhood behavioral issues was highlighted in a 2005 study by Dr. Walter Gilliam that found overall expulsion rates for children in preschool settings for challenging behavior to be three times the rate of all children in grades K-12. Gilliam’s findings have caused concern beyond the field of early childhood advocates, since children who exhibit this type of challenging behavior are likely to drop out of school, be arrested, and suffer other obstacles throughout their adult lives.

To address this problem, there is a growing consensus among advocates, scholars, and providers that more should be done to develop a system of promotion, prevention, and intervention services for mental health concerns in very young children. However, instead of focusing on prevention and early intervention, the mental health service delivery system is dealing with the squeakiest wheels after they’ve become a problem.

From an economic perspective, preventative services such as home visitation by nurses for high-risk (low income and unmarried) mothers have been shown to result in cost savings in the criminal justice and child welfare system. In addition, quality preschool programs that address both cognitive and social-emotional development of young children results in reduced costs down the road. A recent RAND study on quality preschool programs demonstrates future economic cost savings.

In keeping with the trend toward prevention, there is a growing movement to involve parents more closely with their child’s development through the Parents as Teachers (PAT) program. Begun in 1981 in Missouri, PAT programs have emerged nationwide. Texas PAT, like other programs around the country, provides parents with education and support to understand and identify emotional and behavioral problems early on in their child’s development. Although the available research indicates the importance of parenting skills on the mental health of the child, research on PAT programs seems to indicate that while positive overall, the effectiveness of this particular program varies with the intensity and frequency of home visits, level of engagement and demographic profile of the parents, and qualities of parent educators.

According to children’s mental health experts, the only way to leverage the scarce money available is to maximize funding on the front end through early childhood (birth to three), pre-
school (three to five), and school-based intervention programs. By identifying behavioral health concerns early in schools, many children and families might be spared from having to enter the system when their condition is more severe and possibly less manageable. Furthermore, identifying and receiving services in the school setting is less stigmatizing for children and their family. Since ages zero to six are the most developmentally sensitive time period in a child’s life, evidence suggests that more preventative services should be targeted to this age group. In calling for an increase in preventative services, however, it is necessary to define exactly what prevention means so that money is used effectively.

Substance Abuse
A complicating factor in any analysis of children’s mental health is the intersection of substance abuse and mental illness. As discussed earlier in this report, substance abuse often co-occurs with mental health disorders among children and adolescents. Although this report focuses on children with co-occurring mental illness and substance abuse, the occurrence of these disorders among parents and family members must also be considered in terms of the impact on a child’s mental health. Just as substance abuse can exacerbate mental illness in children, family members who abuse drugs and alcohol and/or have mental illness can create the conditions for children’s mental illness. A visit to a central Texas school district revealed that among students diagnosed with depression, their biggest personal challenges were family concerns regarding drug and alcohol use, extreme poverty, and parents with mental illness.

Unfortunately, treatment options for children with both substance abuse and mental health issues are limited, as many services treat only one of the conditions. For uninsured children with substance abuse problems in addition to mental illness, the juvenile justice system often becomes their de facto provider of mental health and substance abuse treatment. Due to an insufficient number of private facilities, even children with private insurance face an uphill battle when it comes to accessing services to address both their mental health and substance abuse needs. The current mental health service structure does not seem to consider the importance of substance abuse as a facet of physical and mental health. As the director of a local mental health authority expressed, there is a need to look at the child as a whole, and substance use comprises part of this picture. By disconnecting conditions from each other, the mental health service system has lost sight of looking at the whole child.
Chapter 3

Promising Initiatives

To address the myriad challenges facing the children’s mental health system in Texas, several initiatives have been developed by advocates, providers, and scholars in the field.

**Systems of Care**

As discussed earlier in this report, the Systems of Care approach to children’s mental health is based on the idea that in order to address children’s mental health needs effectively, multiple systems must work together. The core values of Systems of Care include: child-centered, family-focused and family-driven, community-based, and culturally competent and responsive. Advocates of such an approach emphasize the need for a holistic perspective of treatment and call for increased communication between agencies that address different aspects of mental health.

Because of the multi-level coordination of the approach, it has been argued that Systems of Care is extremely expensive to maintain. However, an opposing view maintains that when compared to the costs of residential placement, community-based care proves to be more cost-effective. Despite documentation of substantial cost savings in certain Texas Systems of Care sites, due to a lack of funding, the Systems of Care approach has not yet made great strides in the state.

**SAMHSA Grants**

Considered the best possible funding source for community-based programs, federal SAMHSA grants have transformed the way communities can provide comprehensive, wraparound care to children with mental health needs. The Substance Abuse and Mental Health Services Administration, or SAMHSA, provides funding for local community initiatives to implement a Systems of Care service delivery approach to integrate community services and also incorporate an individual service plan for children and youth with severe emotional disturbances and their families. In FY 2005/2006, SAMHSA awarded nearly $6.5 million in discretionary funds dedicated specifically to children’s programs in Texas. The grants were awarded to four sites in Texas: Fort Worth ($2 million), El Paso ($2 million), and Harris County ($1 million) to fund their Systems of Care initiatives. Travis County was the first site to be awarded a SAMSHA grant to start its Systems of Care initiative, and now this program is fully sustained locally through the Travis County Children’s Partnership, discussed earlier in this report.

Although all four SAMHSA-funded sites are charged with implementing the same Systems of Care approach, in practice each site has its own unique characteristics and arrangements. For example, the Travis County Children’s Partnership system is administered through the county health and human services agency, with the local community mental health center serving as the managing service organization and providing oversight to the partnership. Fort Worth partners with a local school district with strong coordination with local public health operations. El Paso is closely tied to the county juvenile court system, while Harris County, the newest of the SAMHSA-funded sites, is more directly linked to the county child protective services agency.
Community Resource Coordination Groups

Another promising initiative to address children’s mental health more effectively is the movement to support innovative practices of Community Resource Coordination Groups. In general, CRCGs are interagency groups who collaborate to develop individual plans of care for children with complex needs requiring the coordinated participation of several different agencies. However, there is no specific model for CRCGs in Texas, leaving room for local customization of how CRCGs will function in a particular community. Because CRCGs are not funded by the legislature, it is up to the local CRCG to address funding issues and service gaps in the community. Several successful CRCGs have hired full-time or part-time coordinators to assist in facilitating the coordination of services. However, overall budget constraints within the health and human service system has resulted in the challenge of sustaining some of these coordinator positions. While promising, the emphasis on these types of collaborative programs has diminished due to lack of funding.

Evidence-Based Treatment

Another trend in children’s mental healthcare is a growing emphasis on evidence-based practices. The evidence-based approach links academic research findings with “real world” treatment practices. By focusing on whether services are clinically effective, evidence-based practices have held the field of children’s mental health to a higher level of scrutiny. Furthermore, the evidence-based model has created a more quantifiable way of discussing what constitutes quality care for children.

Two evidence-based models currently in place in Texas are the Resiliency and Disease Management (RDM) model and the Texas Medication Algorithm Project (TMAP). Both look to research as a guide for creating effective services, and depend heavily on outcome measurements to determine effectiveness and success.

Resiliency and Disease Management

In FY 2004, after a one-year pilot study, the former Texas Department of Mental Health and Mental Retardation implemented evidence-based practices into the statewide service delivery system through an initiative called Resiliency and Disease Management. RDM is an approach to providing mental health services for children with severe emotional disturbance that aims to eliminate or manage symptoms and promote recovery from psychiatric disorders. Other goals of the model focus on how to better measure costs and outcomes of services, as well as clarifying eligibility and management of services. Representing a huge transformation of the mental health system, nearly all aspects of the mental health delivery system, for both children and adults, have changed in order to be in accordance with the goals of RDM.

Through these components, the RDM model seeks to better match services to children’s diagnoses and levels of functioning. By more effectively using the limited funds that are available within the system, RDM is considered a useful and successful model. However, RDM is not without controversy as some find that it limits the options for children and families. Since RDM is based on evidence-based practices, it is inherently limited to current research findings and does not include the universe of effective interventions. Furthermore, due to its relatively short lifespan, it may be too early to determine the impact of resiliency and disease management on the state.
Texas Medication Algorithm Project

Developed in 1996 as a public and academic collaboration, TMAP is an evidence-based program that aims to address medication, education, and documentation in the field of adult and children’s mental health (the term Children’s Medication Algorithm Project, or CMAP, is often used to describe the children’s component of this project). By focusing on research findings to determine the most effective medication and treatment formulas, or algorithms, the project is a “treatment philosophy for the medication management portion of care.”141

The pre-eminence of TMAP as an effective model was demonstrated in 2002 when President Bush used the project as the blueprint for the screening portion of his New Freedom Commission on Mental Health. TMAP is not without its critics, however. The internet is rife with websites dedicated to exposing the program as a conspiracy on the part of pharmaceutical companies to drug children. Driven by groups such as the Citizens Commission on Human Rights, founded by the Church of Scientology,142 these claims seem to have little basis beyond extreme ideological differences with the field of psychiatry as a whole.

While over-medication of children is of real concern within the field of children’s mental health, particularly in the foster care system,143 findings in the mainstream of mental health research shows that when properly applied, medication algorithms can be a vital component in a child’s treatment plan.
Chapter 4

Recommendations

Having explored the pros and cons of the current service delivery system for children’s mental healthcare, what can be done to improve the way things work in Texas? The following recommendations attempt to respond to the most urgent deficiencies described in this report. Beyond merely needing “more money” across the board, these recommendations highlight the particularly promising initiatives that with proper funding, could lead to lower mental healthcare costs in the long run, and better, brighter futures for children and adolescents with mental health needs.

Increase State Funding to Support Development of Community-Based Services

There is little debate over the importance of keeping children in their communities while undergoing treatment for mental health problems. Residential treatment is considered the last resort for many families who have already exhausted the outpatient possibilities in their community. Although some children need lengthier inpatient treatment than others, there is a near consensus on the primacy of community-based services as the best type of treatment.

Integrated Funding and Systems of Care

A critical component of any Systems of Care service for children’s mental health is integrated funding. By divorcing some amounts of money from the funding source and putting it into one pool, funds can be targeted to address the child’s individual needs, not necessarily to support a particular agency’s agenda. As previously described, Texas’ integrated funding program, TIFI, exists in four sites in Texas: Family Connections, a ten-county rural site in north Texas; Tarrant County Mental Health Connection; Harris County Alliance for Children and Families, and Tri-County Mental Health Mental Retardation Services serving two rural and one suburban county in east Texas.

Considering ways to expand TIFI sites, or to implement integrated funding programs as part of existing services, should be a top priority. The Systems of Care approach has become the preferred method to address children’s mental healthcare through state-funded TIFI sites and federally-funded Systems of Care sites. Developing financial strategies to expand Systems of Care across Texas would continue the collaborative momentum that began with the original sites. As with schools, CRCGs, and early intervention programs, an investment in Systems of Care would translate to cost-savings down the road by reducing the number of children who end up in residential treatment and/or the juvenile justice system.

CRCGs

As noted earlier in this report, CRCGs have had varying levels of success due to the lack of a funding structure. While resource-rich communities such as Austin have local resources to support their programs, poorer communities around the state have not been so fortunate. Given the body of evidence on the efficacy and long-term cost-effectiveness of community-based services, it would be wise to look at more fully supporting the CRCG operation through ongoing...
training and technical assistance and offering integrated funding opportunities through TIFI grants.

Schools

The school setting is often the first place that mental health issues are identified. As explained earlier, schools are a de facto provider of mental health services for many Texas children, but insufficient and inconsistent resources across the state fall short of providing children with the mental healthcare they need. As part of SAMHSA’s mental health transformation grant, there is an emphasis on collaboration and information sharing to reduce the inconsistencies among school districts.147

Since identifying and addressing mental health problems in the school setting is extremely complex and time-consuming, more attention must be paid to providing schools with the resources they need to adequately address children’s mental health. There is too high a cost, both financially and socially, in ignoring the problems at their outset and letting behavioral issues transform into severe mental health disorders further down the road.

Support Parity Legislation

Considered the number one issue for mental health advocacy groups in the upcoming 80th legislative session,148 insurance parity for mental health services would greatly increase children’s access to services by ensuring the same coverage for mental disorders as physical disorders. During the 2003 legislative session, Representatives Farabee, Goodman and Davis co-sponsored a parity bill that was left in committee.149 By addressing one of the biggest problems with the current, piecemeal system, a renewed commitment to parity legislation in the 2007 session would be an important first step in increasing families’ access to mental health services. In response to critics who claim that parity is too costly to implement, the New England Journal of Medicine’s recent findings provide compelling evidence to the contrary.

Identification and Treatment for Birth to Five Population

Prevention and early intervention have not been the focus of lawmakers’ attention in the realm of children’s mental health. However, research findings and demographic trends that show children getting younger and younger in the mental health system150 demonstrate the need for more concerted attention to issues of prevention. The Texas Early Childhood Comprehensive Systems Initiative housed in the Health and Human Services Commission is a collaborative program that seeks to strengthen Texas’ system of services for birth through five. Support for and expansion of this type of program would be a wise use of funds and a return on investment for this population in the future.

Reduce Barriers to Medicaid/CHIP Enrollment and Continued Coverage

Texas’ public insurance programs provide the opportunity for eligible children to enjoy a medical home, thereby increasing the likelihood of identifying mental health problems early and improving the chances for effective treatment. However, many children are cut off from receiving needed services because of waiting periods for CHIP and frequent re-application requirements for both CHIP and Medicaid. Despite the legislature’s 2005 approval of funding to restore CHIP benefits and increase enrollment, both CHIP and children’s Medicaid enrollment have seen sharp and unprecedented
drops in the first four months of 2006.\textsuperscript{151} Healthcare advocates and community groups point out that these drops immediately followed the transition to an outsourced benefits enrollment system.\textsuperscript{152}

Once children are enrolled in one of the public insurance programs, priority must be given to keeping them enrolled in the system through outreach and education programs within the community. The recent transition to a new eligibility system requires even more diligence to ensure that eligible children remain enrolled in these insurance programs so families can take advantage of mental health services in a timely and effective way.

**Increase Oversight and Coordination of Children’s Mental Health Services**

There are many reasons behind the fragmentation that exists within Texas’ children’s mental health service delivery system. Of critical importance is the structure of agencies that oversee and coordinate children’s mental health services. There is evidence of a need for HHSC and DSHS to return their focus to children’s mental health—as they have in the past—by creating a single point of coordination, policy development and service integration to provide oversight and coordination of the system as a whole.

While the reorganization that resulted from the passage of HB 2292 had the potential to encourage the integration of physical and mental health, instead the transition has lead to an overall decreased emphasis on children’s mental health. One of the casualties of the agency reorganization was the elimination of the MHMR children’s mental health coordinator position. Critics of this decision claim that removing this position removed any sense of responsibility for children’s mental health and now children get lost in the shuffle. In the absence of someone who is accountable for advocating for children’s mental health services, it appears that adult services may have swallowed up some funds previously earmarked for children’s services.
Chapter 5

Conclusion

The continuum of care for children with mental health needs in Texas is broken. As illustrated in this report, several promising initiatives exist, but there are infrastructural and funding challenges that get in the way of families trying to access care.

Given the numerous changes that have affected the children’s mental health enterprise, perhaps the most helpful question to ask is not “what does the future hold?” but “what should the future hold?” Texas’ children should be able to access a continuum of mental health services that address the promotion, prevention, and availability of care.

While it undoubtedly takes money to make any health care system work, targeting funding to programs that will most effectively use these funds is equally, if not more important. The state’s resources should be used to support existing efforts that have been proven through academic research to have real, positive effects on children’s health outcomes. Moreover, future funding should focus on promising initiatives and services that will improve children’s mental health while reducing costs in the long run. Creating a healthier future for Texas’ children should be at the top of lawmakers’ list of priorities; that these services could save money is an added benefit that all residents of Texas will appreciate.
ENDNOTES


4 Telephone interview by Becky Pastner with Eddie Greenfield, Director, Waco Center for Youth, Waco, Texas, March 23, 2006.


6 Telephone interview by Jennifer Deegan with Betsy Schwartz, Executive Director, Mental Health Association in Houston, Houston, Texas, February 13, 2006; interview by Becky Pastner with Erin Espinosa, Federal Programs Specialist and Vonzo Tolbert, Director, Strategic Planning Division, Texas Juvenile Probation Commission and Tracy Levins, Ph.D., Children and Prisoner Representative, Texas Youth Commission, Austin, Texas, February 14, 2006; and telephone interview by Jennifer Deegan with Richard Poe, Manager for Federal Policy and State Programs, IDEA Coordination Division, Texas Education Agency, Austin, Texas, February 13, 2006.

7 Presentation by the Mayor’s Mental Health Task Force Monitoring Committee to the Health and Human Services Subcommittee of the Austin City Council, Austin, Texas, January 31, 2006.

8 Interview by Becky Pastner with Steven Shon, MD, Medical Director of Behavioral Health, Texas Department of State Health Services, Austin, Texas, February 14, 2006.


11 Interview by Jennifer Deegan and Becky Pastner with Deborah Berndt, Hogg Foundation for Mental Health (former Director of Children’s Services, Texas Department of Mental Health and Mental Retardation), Austin, Texas, January 31, 2006.


16 Correspondence by Becky Pastner with Deborah Berndt, April 21, 2006.


21 Interview by Becky Pastner with Erin Espinosa, Federal Programs Specialist and Vonzo Tolbert, Director, Strategic Planning Division, Texas Juvenile Probation Commission and Tracy Levis, Ph.D., Children and Prisoner Representative, Texas Youth Commission, Austin, Texas, February 14, 2006.


26 Berndt interview; Interview by Becky Pastner with Susan Stone, MD, Mayor’s Mental Health Taskforce Member, Austin, Texas, February 24, 2006; Interview by Becky Pastner with Bill Streusand, MD, Austin, Texas, February 20, 2006; Interview by Becky Pastner with Steven Shon, MD, Medical Director of Behavioral Health, Texas Department of State Health Services, Austin, Texas, February 14, 2006; and Telephone Interview by Jennifer

27 Interview by Jennifer Deegan with Kenny Dudley, Director of State Hospitals, Texas Department of State Health Services, Austin, Texas, February 27, 2006.

28 Berndt interview; Stone interview; and Rogers interview.

29 Interview by Becky Pastner with Michael Hastie, Director of Clinical Services, Austin Child Guidance Center, Austin, Texas, February 27, 2006.

30 Telephone Interview by Becky Pastner with Regenia Hicks, Ph.D., Project Director, National Technical Assistance Center for Child and Family Mental Health and Partnership for Children’s Mental Health, American Institutes for Research (former Director of Children’s Services, Texas Department of Mental Health and Mental Retardation), March 1, 2005; Stone interview; and Berndt interview.

31 Meeting attended by Jennifer Deegan, with Stephen Barnett, MD, Past Chair, TMA Committee on Child and Adolescent Health and Mary Ellen Nudd, Vice President, Lynn Lasky Clark, President and CEO, Denise Brady, Public Policy Director, and Traci Patterson, Communication Director, Mental Health Association in Texas, Austin, Texas, March 7, 2006.


33 MHAT, Turning the Corner (online).

34 Telephone Interview by Jennifer Deegan with Marissa Giggie, MD, San Antonio Child Guidance Center, San Antonio, Texas, February 7, 2006; Berndt interview; and Rogers interview.

35 Telephone Interview by Jennifer Deegan with Lynn Cearley, Clinical Manager, Psychiatry Day Treatment Program, Center for Pediatric Psychiatry at the Children’s Medical Center of Dallas, Dallas, Texas, February 28, 2006.

36 Interview by Jennifer Deegan and Becky Pastner with Denise Brady, Public Policy Director, Mental Health Association in Texas, Monica Thyssen, Children’s Mental Health Policy Specialist, Advocacy, Inc., Marcia Rachofsky, Policy Analyst, Texas Federation of Families for Children's Mental Health, and Tracy Levins, Ph.D., Children and Prisoner Representative, Texas Youth Commission, Austin, Texas, February 10, 2006; Giggie interview; and Berndt interview.

37 Telephone interview by Jennifer Deegan with Karen Hale, Principal, Health Management Associates, (formerly Commissioner of Texas Department of Mental Health and Mental Retardation), Austin, Texas, March 1, 2006.

38 Giggie interview; Hale interview; and Rogers interview.

39 Cearley interview.

40 Texas DSHS, Legislative Appropriations Request (online).

Telephone interview by Becky Pastner with Eddie Greenfield, Director, Waco Center for Youth, Waco, Texas, March 23, 2006.


Correspondence by Jennifer Deegan with Kenny Dudley, April 3, 2006.

Interview by Becky Pastner with Princess Katana, MD, Program Director, Children’s Partnership, Austin, Texas, March 10, 2006.


Dougherty Management Associates, Inc., Children’s Mental Health Benchmarking Project (online); and Email correspondence by Jennifer Deegan with Alan Shafer, Ph.D., Strategic Decision Support Research Team, Texas Health and Human Services Commission, Austin, Texas, April 20, 2006.

Berndt interview.

Rogers interview.


Texas Health and Human Services Commission, Medicaid Managed Care (online).

Cearley interview.


59 Cearley interview.


62 MHAT, *Turning the Corner* (online).


65 MHAT, *Turning the Corner* (online).

66 Dougherty Management, *Children’s Mental Health Benchmarking Project* (online); and MHAT, *Turning the Corner* (online).

67 Telephone interview by Jennifer Deegan with Betsy Schwartz, Executive Director, Mental Health Association in Houston, Houston, Texas, February 13, 2006; Espinosa et al. interview; and Poe interview.

68 Telephone interview by Becky Pastner with Kimberly Hoagwood, Ph.D., Center for the Advancement of Children’s Mental Health at Columbia University (former Research Program Director and State School Psychology Consultant, Texas Education Agency), New York, New York, February 7, 2006; and Espinosa et al. interview.

69 Stone interview; Rogers interview; and Poe interview.

70 Dudley interview; Espinosa et al. interview; and Brady et al. interview


72 Streusand interview; and Shon interview.

73 Greenfield interview.
74 Interview by Jennifer Deegan with Sherri Hammack, Office of Program Coordination for Children and Youth and Judy Willgrem, Office of Early Childhood Coordination, Health and Human Services Commission, Austin, Texas, February 17, 2006; interview by Jennifer Deegan with Kim McPherson, Health Management Associates, Austin, Texas, February 14, 2006; and Dudley interview.


76 Presentation by the Mayor’s Mental Health Task Force Monitoring Committee to the Health and Human Services Subcommittee of the Austin City Council, Austin, Texas, January 31, 2006.


83 Mental Health Association in Texas, Children’s Mental Health Facts (online).

84 Ibid.

85 Texas Department of State Health Services, Highlights of the Supply of Mental Health Professionals in Texas, Publication No. 25-12347 (February 2006), p. 4.

86 Greenfield interview.

87 Dudley interview.

88 Ibid.

90 Greenfield interview.

91 Interview by Becky Pastner with Arturo Hernandez, Director, Child and Family Services Division, Austin Travis County MHMR, Austin, Texas, March 6, 2006.

92 Hastie interview; and Streusand interview.

93 Giggie interview.

94 According to HHSC data, there were 566 unduplicated provider ID’s who identified themselves as psychiatrists and had paid Medicaid FFS/PCCM claims in FY 2005. DSHS data documented 1,298 general psychiatrists and 190 child psychiatrists in Texas in FY 2005 (n = 1,488). Using these figures, approximately 38 percent of psychiatrists in Texas had one or more Medicaid claims in FY 2005. Sources: Shafer email; and Texas DSHS, Highlights of the Supply of Mental Health Professionals, p. 1.

95 Giggie interview; and site visit of Leander ISD attended by Jennifer Deegan with Genie Nyer, Jennifer Folzenlogen, and Lisa Kerber, St. David’s Community Health Foundation, Shandalyn Porter, Project Director for the Safe Schools/Healthy Students Initiative in Leander ISD, Annie Burwell, Executive Director of Intervention Services, Jan Halstead, Executive Director of Special Programs for Leander ISD, Susan Cole, Assistant Principal at Leander High School, and Don McCaul, Vice President of the Leander ISD School Board, Leander, Texas, March 3, 2006.

96 Rogers interview; and Hastie interview.


99 Cearley interview.

100 Texas DSHS, Highlights of the Supply of Mental Health Professionals, p. 4.

101 Greenfield interview.

102 Leander ISD site visit.


104 Texas DSHS, Highlights of the Supply of Mental Health Professionals, p. 4.
Dudley interview.

Shon interview.

Hicks interview.

Berndt interview.

Ibid.

Hastie interview.


Poe interview.


Espinosa et al. interview.
Leander ISD site visit.

Streusand interview.

Hernandez interview.


Stone interview.

Email correspondence by Becky Pastner with Princess Katana, MD, Director, Children’s Partnership, Austin, Texas, April 12, 2006.


Berndt interview.

Hammack and Willgren interview.


Katana interview; and email correspondence by Jennifer Deegan with Sherri Hammack, April 10, 2006.

Hammack and Willgren interview.

Shon interview.

Hoagwood interview.


Ibid.

Hammack and Willgren interview.

Berndt interview.

Hernandez interview.


143 Giggie interview.

144 Katana interview.


146 Berndt interview.

147 Poe interview.

148 Brady et al interview.


150 Hammack and Willgren interview.

151 Texas Health and Human Services Commission, *CHIP Data Tables* (online).

APPENDIX A: Children’s Mental Health Fact Sheet

Prevalence of Mental Health Disorders among Children
Approximately 1 in 5 children in the United States has a diagnosable mental or addictive disorder associated with at least minor functional impairment.¹

For approximately 1 in 20 of these children, this impairment is severe.²

An estimated 1.2 million Texas children have a diagnosable mental disorder.³

Risk Factors for Mental Health Disorders
The development of mental health disorders among children has been linked to poverty, child abuse, exposure to trauma, and substance abuse.⁴

Approximately 1.3 million Texas children (21.3 percent) live in poverty, more than four percentage points higher than the national average.⁵

In 2005, more than 32,000 Texas children were in foster care, a 93 percent increase since 1994.⁶

In 2005 more than 61,000 children were confirmed victims of abuse or neglect.⁷

32 percent of secondary students reported using illicit drugs in 2004, up from 22 percent in 1992.⁸

Decline in Number of Children Receiving State Services
There has been a 42 percent decline in CHIP enrollment between September 2003 and April 2006, which has affected more than 200,000 Texas children.⁹

The Texas Department of State Health Services has documented a decline in per capita mental health expenditures since 2003.¹⁰

The number of children served by the Department of State Health Services has decreased by 28 percent from 31,303 in 2002 to 22,499 in 2004.¹¹

Only about 25 percent of children in the “priority population” received mental health services in 2001.¹²

De Facto Mental Health Service Providers
Approximately 70 percent of the nation’s children with mental disorders receive mental health services in school.¹²

It is estimated that 47.5 percent of juvenile offenders referred to the Texas Juvenile Probation Commission in 2002 had at least one mental or addictive disorder.¹⁴
The percentage of children with mental disorders committed to the Texas Youth Commission has grown from approximately 29 percent in 1997 to almost 45 percent in 2004.\textsuperscript{15}

Approximately 36 percent of youths committed to the Texas Youth Commission in 2004 were diagnosed with a \textit{severe} mental health disorder.\textsuperscript{16}

Between 2001 and 2004, the number of juvenile offenders served by local mental health authorities declined by 15 percent; during the same period, the number served by juvenile probation departments increased by 258 percent.\textsuperscript{17}

**System Capacity**

In 2005, only 35 Texas counties were home to a practicing child psychiatrist, and only seven of these counties were west of the I-35 corridor.\textsuperscript{18}

The Waco Center for Youth, Texas’ only publicly funded residential treatment center for adolescents, has only 77 inpatient beds. On an average day, approximately 70 children are on its waitlist for residential treatment.\textsuperscript{19}

Statewide, there were 41 state hospital beds allocated for children and 198 for adolescents in 2006.\textsuperscript{20}

Approximately 62 percent of psychiatrists in Texas did not file a single Medicaid claim in 2005.\textsuperscript{21}

Approximately 2.6 percent of Texas’ 190 child psychiatrists were practicing in a rural county in 2005. 172 rural counties had no access to a child psychiatrist.\textsuperscript{22}

While 42 child psychiatrists were practicing in the 43 border counties, 34 of these were located in Bexar County.\textsuperscript{23}

There are no state hospital beds for children or adolescents south of Bexar County.\textsuperscript{24}

**Children’s Mental Health Expenditures**

Research shows that states with higher per capita mental health expenditures also rank higher in overall measures of child well-being.\textsuperscript{25}

In comparison with other states, Texas spends a greater percentage of mental health funds on inpatient rather than on community-based services.\textsuperscript{26}

In 2002, 244 children were relinquished to state custody because their families had no other means of accessing mental health care.\textsuperscript{27}


\textsuperscript{2} Ibid
3 Calculated by applying national prevalence estimates to 2004 U.S. Census Bureau projections of the number of individuals in Texas under the age of 18.

4 Presentation by the Mayor’s Mental Health Task Force Monitoring Committee to the Health and Human Services Subcommittee of the Austin City Council, Austin, Texas, January 31, 2006.


7 Ibid.


11 Ibid.


18 Texas Department of State Health Services, *Highlights of the Supply of Mental Health Professionals in Texas*, Publication No. 25-12347 (February 2006) p. 4.

19 Telephone interview by Becky Pastner with Eddie Greenfield, Director, Waco Center for Youth, Waco, Texas, March 23, 2006.

20 Interview by Jennifer Deegan with Kenny Dudley, Director of State Hospitals, Texas Department of State Health Services, Austin, Texas, February 27, 2006.

21 According to HHSC data, there were 566 unduplicated provider ID’s who identified themselves as psychiatrists and had paid Medicaid FFS/PCCM claims in FY2005. DSHS data documented 1,298 general psychiatrists and 190 child psychiatrists in Texas in FY 2005 (n=1,488). Using these figures, approximately 38 percent of psychiatrists in Texas had one or more Medicaid claims in FY2005. Sources: email correspondence by Jennifer Deegan with Alan Shafer, Ph.D., Strategic Decision Support Research Team, Texas Health and Human Services Commission, Austin, Texas, April 20, 2006; and Texas DSHS, *Highlights of the Supply of Mental Health Professionals*, p.1.

22 Texas DSHS, *Highlights of the Supply of Mental Health Professionals*, p.4.

23 Ibid.

24 Dudley Interview.


26 Dougherty Management, *Children’s Mental Health Benchmarking Project*. Online; and MHAT, *Turning the Corner*. Online.