El Paso Community Behavioral Health System Assessment

Final Summary of Findings and Recommendations

February 2014
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Executive Summary

Approach and Methods. The El Paso Community Behavioral Health Consortium (BH Consortium) contracted with TriWest Group to identify what must take place for El Paso County to achieve the finest behavioral health system in the country. This extensive task included, but was not limited to, review and assessment of El Paso’s entire behavioral health continuum, focused evaluation of the El Paso Psychiatric Center, establishing a community baseline of need and capacity, and assessing development opportunities, challenges, and funding sources. In developing these findings, TriWest interviewed over 50 system leaders, clinicians and stakeholders, analyzed data on needs and local resources, and reviewed both national and international best and promising practices.

Vision of the Ideal Behavioral Health System for El Paso County. The model we recommend to guide development of El Paso system is the Comprehensive, Continuous, Integrated System of Care (CCISC) framework. This model envisions behavioral health and other related service delivery systems (including criminal justice, law enforcement, veterans services, juvenile justice, child welfare, schools, homeless providers, health systems) to be organized at every level (policy, program, procedure, and practice) – within whatever resources are available – to be customer-driven and focused on meeting the needs of the individuals and families needing services. The primary vehicle for meeting those needs is to organize every level of the system – from the partnership across payers and system leaders at the top, across the systems that must collaborate to deliver care, and ultimately at the point of interaction between an individual person served, their family, and their providers – around the establishment of a welcoming, empowered, and helpful partnership. Such organization results in a system of care that is welcoming, recovery- and resiliency-oriented, integrated, trauma-informed, and culturally competent, and organized from a population health perspective to most effectively meet the needs of individuals and families with complex, co-occurring conditions of all types (mental health, substance abuse, medical, cognitive, housing, legal, parenting, etc.) and help them to make progress to achieve the happiest, most hopeful, and productive lives they possibly can.

Within this customer-driven framework, the system of care includes:

- **Local control of the system of care through a System of Care Collaborative:** The system must be led by a functional, ongoing, empowered collaborative structure trusted to represent all key partners in the El Paso mental health and substance abuse services delivery system in an ongoing planning and system coordination role. This is a best practice best exemplified currently in Texas in Tarrant County, but nationally in places such as Milwaukee, WI (child and family system) and Miami, FL (adult system).

- **A data-driven quality improvement infrastructure:** The System of Care Collaborative must have the capacity to drive innovation and quality improvement using data on
population health, costs, and the customer experience of care. This requires dedicated staffing and organized data-sharing to promote population health across all partners.

- **A system organized to be integrated and able to respond to priority populations within existing resources:** No system has sufficient resources, so it must be able to integrate care and prioritize development to respond to priority needs (not just crises).

- **Multi-payer coordination:** Systems of care can only address population health goals (e.g., controlling global costs and promoting the health of the broader community) when state, local, and private payers coordinate. There needs to be a shared structure in which all local parties with responsibility and resources come together to make decisions about how to most effectively leverage local health resources.

- **The system must be focused on prevention and early intervention, delivering care as early on as concerns are identified:** Waiting until needs reach a crisis or result in contact with law enforcement is not sufficient. The system must respond to crises effectively and support law enforcement, but its primary focus should be on meeting needs early in routine care settings: primary care, pediatric, school, and community settings.

- **Development of a comprehensive system of care with the levels described in the table below.**

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**Crisis Response System**

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<td>A continuum of crisis residential, transport, respite, therapeutic foster care, emergency shelter, crisis follow-up and stabilization</td>
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**Adequate Medical Care in Restrictive Settings**

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<td>Systemic justice diversion / outpatient competency restoration (OCR) / reentry</td>
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<td>Juvenile detention, residential settings</td>
<td>Adult detention center, forensic, homeless</td>
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**Primary Findings and Recommendations: Systemic Needs, Gaps and Opportunities**

**Finding 1:** Fragmentation and a lack of substantive programmatic collaboration remains the biggest challenge confronting the El Paso community behavioral health system. While important steps have been taken to establish new collaborative structures (e.g., the BH Consortium, Brain Trust Committee, Regional Health Partnership 15), there is no countywide structure (dedicated leadership, staffing, and organization) functioning to coordinate cross-agency collaboration and cross-funder planning. **Recommendation 1: El Paso County must 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 abuse services delivery system, with subunits focused on specific populations: (1) criminal justice; (2) a crisis collaborative; and (3) a structure for collaboration across child and family-serving agencies. The System of Care Collaborative (and each subunit) should identify one to three quality improvement projects to focus their work and provide a framework for development.

**Finding 2:** There is too little system-level attention on child and family services – much less than on the overall system – and current forward momentum regarding health planning offers
the chance to try again. Fragmentation is just as (or more) severe across child and family service providers in El Paso and there is substantially less system-level planning effort focused on the needs of children and families. Inertia for positive system change seems to have ebbed, but there is opportunity to try again by linking new efforts to the emerging system planning process currently underway. **Recommendation 2: Begin now to 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. The planning process should include all child and family providers in El Paso County, as well as all major funders of services. In particular, family-focused interventions, whether in-home, outpatient or peer-driven, represent a critical service modality for children and families that is largely missing from El Paso’s systems of care. School-based and school-linked care should also be included in the plan.

**Finding 3: A dramatic lack of capacity exists in El Paso County for both adult and child behavioral health services.** The bottom line is that need greatly exceeds service capacity at every level of the system, especially crisis care, prescribers, culturally-competent care, and intensive community-based services to provide ongoing care for those most in need, as well as the supported housing, supported employment, and peer supports needed to foster true recovery over time.

Over 165,000 adults need care each year for mental health or substance use disorders, with 40,000 suffering severe needs. Of the 31,500 of those adults in poverty, less than 15,000 receive formal behavioral health care.

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<th>Adults in Need</th>
<th>Population</th>
<th>Estimated Need</th>
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<tbody>
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<td>All Behavioral Health Disorders</td>
<td>557,250</td>
<td>166,339</td>
</tr>
<tr>
<td>Serious Mental Health &amp; Substance Use Disorders</td>
<td>557,250</td>
<td>40,679</td>
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</table>

<table>
<thead>
<tr>
<th>Adults &lt; 200% Federal Poverty Level</th>
<th>Population</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Serious Mental Health &amp; Substance Use Disorders</td>
<td>328,778</td>
<td>31,563</td>
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<tr>
<th>Annual Provider Capacity</th>
<th>Hospital</th>
<th>Residential</th>
<th>Crisis</th>
<th>Outpatient / Community</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Served Annually</td>
<td>992(^1)</td>
<td>887</td>
<td>3,753</td>
<td>6,676</td>
<td>1,178</td>
</tr>
</tbody>
</table>

More than 44,000 children and adolescents need care each year for mental health or substance use disorders, with 18,000 suffering severe emotional disturbances. Of the 13,000 of those children and adolescents in poverty, less than 5,000 receive formal behavioral health care.

\(^1\) This includes only adults seen at EPPC; data on the number of people seen by UBH and Peak was not provided.
### Children and Adolescents in Need

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<tr>
<th>Population</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Behavioral Health Disorders</td>
<td>243,397</td>
</tr>
<tr>
<td>Severe Emotional Disturbance – ages 0-11</td>
<td>162,346</td>
</tr>
<tr>
<td>Severe Emotional Disturbance – ages 12-17</td>
<td>81,051</td>
</tr>
<tr>
<td>Substance Use Disorders – ages 12-17</td>
<td>81,051</td>
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</table>

### Providers

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<th>Outpatient / Community</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>143²</td>
<td>138</td>
<td>906</td>
<td>2,575</td>
</tr>
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</table>

**Recommendation 3:** Prioritize development efforts to (1) stabilize crisis situations and (2) build broader capacity to intervene earlier, particularly with children, in order to break the repeating cycle of dependency on crisis, law enforcement, criminal justice, juvenile justice, and child welfare services and build preventive capacity over time in federally qualified health centers and UMC clinics, primary care and pediatric practices, schools, and local communities.

**Finding 4:** Stigma is a major barrier to care that impedes access and compounds the consequences of mental health and substance use disorders in the lives of people suffering from them. **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. The next step developmentally for El Paso is to broaden these efforts across all levels of the community, with a particular emphasis on engaging natural helpers – schools, the faith community, the business community, and the broader array of community service organizations – to maximize the collective impact of these activities.

**Finding 5.** Data analytic capacity exists and is growing, but is limited by system fragmentation, impeding data sharing across organizations in support of planning at the system level. **Recommendation 5:** Through the System Partnership, use focused, data-driven, cross-agency quality improvement projects to develop capacity to share data to improve individual and population health outcomes. For example, as primary care integration begins to be addressed for adults with serious mental illness, it should be possible to work to reduce the prevalence and morbidity of co-occurring chronic illness across hospitals and physical health settings. Other potential opportunities could focus on: adults with co-occurring mental health and substance use disorders, people involved in or returning from the criminal justice system to

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² This includes only children and adolescents seen at EPPC; data on the number of people seen by UBH and Peak was not provided.
link them with outpatient providers, and earlier intervention in the community behavioral health system to divert use of the juvenile justice and child welfare systems.

Finding and Recommendation 6: There is a broader range of cross-system development opportunities that must 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.

Clinical System Findings and Recommendations Prioritized for Near Term Action

While the overall system requires improvement at every level, the following four areas of development are recommended as near term priorities for focused development effort over the next 12 months.

Finding 7: State operation of the El Paso Psychiatric Center (EPPC) offers the most cost-effective option for expanding adult acute and crisis capacity in accord with local priorities and inclusive of locally operated services co-located at EPPC. The Department of State Health Services (DSHS) has expressed a willingness and flexibility to partner with the local community to support the development of EPPC programming, including the option of contracting with a local hospital provider to operate the program. It would be more cost effective for EPPC to continue as a state facility. Recommendation 7: EPPC should contract existing first floor “intake space” to become a full service Psychiatric Emergency Service (PES) that provides not just a basic emergency and diversion function as a front-end to EPPC and other psychiatric inpatient programs in the county, but also the core for a system-wide crisis triage and diversion system for both acute and forensic cases. Over time it would offer multiple functions at a single site, including psychiatric emergency response, crisis triage, coordinated medical clearance with UMC, integrated detox capacity on site, coordination of access to inpatient psychiatric and detox resources across the community (including the new extended observation unit), an anchor for mobile crisis response, a primary site for forensic drop-off and jail diversion, robust linkages to outpatient competency restoration (OCR) diversion, strong ties to intensive outpatient mental health hospital diversion programs, robust linkages to intensive outpatient SUD resources, and broader linkages to the full system of mental health and substance abuse services in the community for less acute needs. Examples of model programs in Texas include the Restoration Center in Bexar County and John Peter Smith Hospital in Tarrant County.

Finding 8: Crisis services for children and families are also lacking, and require development of a focused sub-system within the broader crisis response system focused on their distinct needs.
Recommendation 8: Develop a crisis continuum for children 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 components. The ideal crisis continuum centers on a dedicated on-call mobile team – separate from but supported by law enforcement-to serve children, youth and their families in crisis across systems (mental health, substance abuse, schools, child welfare, and juvenile justice). The team must be integrated within a broader crisis system that includes at least one high quality, respected children’s hospital program anchoring an array of brief out-of-home options for children and youth in crisis (with some available up to 30 days), including inpatient care for truly complex cases, crisis residential, respite, therapeutic foster care, and emergency shelter options.

Finding 9: Despite a strong commitment by local law enforcement leadership to robust behavioral health liaisons and mental health training for peace officers, there continue to be significant gaps in the readiness of law enforcement and correctional officers to respond to behavioral health crises. 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.

Finding 10: Access to behavioral health care in routine settings in which child health concerns generally present – pediatric practices, primary care clinics, and schools – is dramatically lacking. Recommendation 10: Actively develop earlier access to behavioral health assessments and care in the settings in which children naturally seek help – schools and the family doctor. Families must be empowered to access care on their own terms to support healthy development and help their children realize their full potential.

Conclusion
While the people of El Paso County experience behavioral needs as severe as any community in Texas or the nation, and the community’s behavioral health systems suffer from multiple gaps, El Paso also enjoys many strong providers, and every provider we met with demonstrated a commitment to improving practice, promoting evidence-based care, and innovating to respond to the community needs they perceive. While the community currently lacks a systemic approach to meeting these pervasive and often complex needs, hopeful movement towards such a systemic partnership has begun, anchored by the BH Consortium and the leadership of the Paso del Norte Health Foundation. There is a sound base and forward momentum in every area of recommendation we have offered. If the behavioral health leadership of El Paso County is prepared to take the next steps down the road to develop the finest behavioral health system in the nation.
Approach and Methods

The El Paso Community Behavioral Health Consortium (BH Consortium) contracted with TriWest Group to identify what must take place for El Paso County to achieve the finest behavioral health system in the country. The TriWest team developed the following summary of challenges and recommendations based on interviews with over 50 leaders, clinicians and key stakeholders across the El Paso behavioral health system (see Appendix One for a list of people interviewed), analysis of local data (see Appendix Two for a summary of data reviewed), and a review of national best practices (see Appendix Three for additional information on all of the practices referenced in the main body of the report and additional detail on the framework in which we recommend considering best practices, including cultural and linguistic factors). A glossary of other key terms used is available in Appendix Four. The assessment included:

- Review of El Paso’s entire behavioral health continuum, from advocacy through acute care to recovery, including: inpatient, outpatient, health promotion services and the cultural and linguistic appropriateness of services,
- A focused evaluation of the El Paso Psychiatric Center,
- Assessment of the current behavioral health delivery system and relevant available data to establish a community baseline, including indicators, needs, services, and gaps,
- An overview of existing local, state, national, and international models of evidence-based practices in all areas,
- Assessment of opportunities and challenges posed by integrated health care and current system changes, including the 1115 Waiver, Senate Bill 58, 2013-15 biennium expansion of behavioral funding (including the YES Waiver), the Affordable Care Act, Mental Health Parity, the Balanced Incentives Payment Program, Money Follows the Person initiatives, the Mental Health Code Project, and other changes, and
- An evaluation of current funding sources focused on future service needs and funding trends.

This final report summarizes the major findings and recommendations from that assessment.

Vision of the Ideal Behavioral Health System for El Paso County

The model we recommend to guide development of El Paso system is the Comprehensive, Continuous, Integrated System of Care (CCISC) framework, which is described in more detail in Appendix Three. This model envisions behavioral health and other related service delivery systems (including criminal justice, law enforcement, veterans services, juvenile justice, child welfare, schools, homeless providers, health systems) to be organized at every level (policy, program, procedure, and practice) – within whatever resources are available – to be customer-driven and focused on meeting the needs of the individuals and families needing services. The primary vehicle for meeting those needs is to organize every level of the system – from the partnership across payers and system leaders at the top, across the systems that must
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Within this customer-driven framework, the system of care includes:

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- **Development of a comprehensive system of care with the levels described in the table below.** Some levels of care (such as stigma prevention) extend across the developmental continuum. Others, such as crisis supports, have a different focus for children and families (non-forensic cross-agency mobile crisis) than for adults (law enforcement crisis intervention team supported by adult mobile crisis). Additionally, there should not be a rigid barrier between child/family and adults systems, as adolescents, youth
in transition to adulthood, and young adults often need services and support across both the adult and child arrays.

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### Primary Findings and Recommendations: Systemic Needs, Gaps and Opportunities

**Finding 1: Fragmentation and a lack of substantive programmatic collaboration.**

Fragmentation of services across discrete service providers supported largely by separate silos of funding streams is a central system gap in nearly every community in the nation\(^3\) and a particular challenge in Texas.\(^4\) System leaders in El Paso agreed that important steps have been taken in the community to address fragmentation through improved collaboration, most notably the establishment of collaborative bodies such as the El Paso Community Behavioral Health Consortium (BH Consortium), the Brain Trust Committee, collaborative development by Regional Health Partnership 15 of DSRIP\(^5\)-funded projects such as the extended observation unit, and reorganization of the leadership of key providers to increase collaboration and effectiveness. However, the need to move forward and develop a more meaningful cross-agency collaboration across discrete provider agencies remains the biggest challenge confronting the El Paso community behavioral health system. In addition, a reported history of distrust and division within the community goes back decades and, while most leaders are

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\(^5\) This refers to the Delivery System Reform Incentive Payment, a component of the Texas Health Care Transformation and Quality Improvement Program (authorized under a federal 1115 transformation waiver). This waiver allows the state to expand Medicaid managed care while preserving federal hospital funding previously received as upper payment limit (UPL) payments. Under the waiver, two funding pools replace the UPL payment methodology: (1) the Uncompensated Care Pool helps offset the costs to hospitals for treating people who are uninsured and (2) the Delivery System Reform Incentive Pool (DSRIP) funds programs and strategies that enhance access to health care, quality of care, and cost-effectiveness. Payments will be based on performance outcomes and not simply on delivering a service. Eligibility for DSRIP payments requires participation in a regional health care partnership (RHP). Texas has designated 20 RHPs and has identified an “anchor entity” for each to coordinate efforts to develop and implement regional plans. Each partnership is comprised of participating entities that can provide public funds known as intergovernmental transfers (IGT). LMHAs use state general revenue funding as IGT and will be eligible for the DSRIP federal funding. For more information, see the November, 2012 Hogg Foundation Report referenced previously.
optimistic about the possibility of increased collaboration, significant and legitimate skepticism of the potential for real and meaningful collaboration remains. Respondents voiced caution that the simple addition of funding into the community would not be helpful without an accompanying framework that incentivizes and provides structure for cross-system collaboration.

This is not just a functional gap across agencies. It is also an organizational gap in that there is currently no countywide structure (dedicated leadership, staffing, and organization) functioning to coordinate cross-agency collaboration within El Paso County. There is no single person or entity responsible for coordinating planning across behavioral health services funded by El Paso County, including the jail, juvenile justice, community corrections, the hospital district, and the broader human service array. There is also no collaborative process through which El Paso County can coordinate its behavioral health activities with its critical system partners, including other human service agencies; state agencies such as the Department of Family and Protective Services (DFPS), the Texas Juvenile Justice Department (TJJD), and the Department of Aging and Disability Services (DADS); schools; Medicaid STAR / STARPlus / STARHealth networks; Veterans Administration and Department of Defense funded care; private behavioral health providers, homeless services agencies, advocates, consumers, and families. The absence of active collaboration was such that key goals of this study (for example, documenting gaps and opportunities for individuals with developmental disabilities) were impeded due to an inability to access local stakeholders and data on this subpopulation despite repeated assistance by BH Consortium members.

Such a structure is a best practice (Tarrant County provides perhaps the best example of which we are aware in Texas) and critical to assess county needs and develop plans to address them. While Emergence Health Network (EHN) has stepped forward to develop needed data analytic and reporting capacity that can support the broader community in such efforts, unless this capacity is seen as functioning on behalf of the community as a whole (rather than simply EHN), its role will continue to be limited. Similarly, University Medical Center of El Paso (UMC) has pulled together substantial analytic capability and what could become a core element of a system-wide health planning process through the 1115 Waiver DSRIP Regional Health Partnership (RHP) and its associated learning collaborative, but this process is also limited by a perception that it excludes critical system partners (e.g., federally qualified health centers).

These findings echo those of the recently completed Community Health Assessment for El Paso County,\(^6\) which identified improvements in mental health and wellness and reductions in substance abuse as two of its five top priorities for the next five years. Specific emphases within

each focus area centered on the need for systemic efforts to improve referrals to care (focused on information dissemination and leveraging of the 2-1-1 system), culturally-focused stigma reduction, networking and relationship building across mental health and substance abuse providers to improve system capacity through improved coordination and reduced duplication of effort, and a combination of law enforcement and prevention to reduce the negative impacts of substance abuse. The report also prioritized “Collaboration and the Care Community” at the top of its goals and emphasized the roles of the Paso del Norte Health Foundation and the RHP as keys to “an unprecedented opportunity to significantly improve residents’ overall health” (page vi).

**Recommendation 1: El Paso County must develop a formal, functional, data-driven, quality improvement-based System of Care Collaborative.** A functioning, ongoing, empowered collaborative structure needs to be developed that is trusted to represent all key partners in the El Paso mental health and substance abuse services delivery system. It seems clear that the Paso del Norte Health Foundation is the only entity currently trusted by stakeholders to convene such a structure, but the structure must be formally empowered by its members to function in an elevated, ongoing planning and system coordination role. The current membership of the BH Consortium involves most of the major provider systems, and its membership has expanded during the course of this assessment to include county probation and schools. However, other major system components are not represented, most notably Aliviane (the leading substance abuse provider agency in the community), FQHCs, juvenile probation, DADS, and DFPS. The Brain Trust does involve many (but not all) of these additional parties, and could potentially partner with the BH Consortium in the development of a more representative structure. System-level planning functions currently carried out by EHN and UMC (via the RFP framework) could also be aligned with the partnership oversight process and become more influential. Please see Appendix Three for a detailed discussion of the importance of system-wide, data-driven, quality improvement functions within health systems.

In addition to the needed overarching partnership structure, sub-units focused on specific populations within El Paso County are also needed, most notably: (1) a structure for coordination between criminal justice, mental health, and substance abuse resources (perhaps building on the Interfacility Transfer Task Force); (2) crisis collaborative meetings to manage both challenging cases and the system as a whole (the El Paso Psychiatric Center currently has a regular meeting with EHN, but this is mostly a reactive meeting to deal with complaints, rather than a meeting that establishes and manages a working partnership); and (3) a structure for collaboration across child and family-serving agencies.

Related to this, we also recommend that the System of Care Collaborative (and each of its population-specific subunits) identify one to three meaningful quality improvement (QI) projects to focus both the work of the Partnership and to provide a positive, forward-looking
framework within which to develop Partnership data analytic, planning, prioritization, decision-making, implementation, and QI-based monitoring activities.

**Finding 2: There is too little system-level attention on child and family services – much less than on the overall system** – and current forward momentum regarding health planning offers the chance to try again. While our initial finding centered on the fragmentation of the overall system, fragmentation is just as (or more) severe across child and family service providers and there is substantially less system-level planning effort focused on the needs of children and families. At the system level through the Mental Health Consortium, prior to the inclusion of a school representative, child providers were not represented (other than EHN, which is a comprehensive provider, but primarily serves adults), and many critical partners (additional school districts, DFPS, juvenile probation) have yet to become involved. Additionally, for a variety of reasons beyond the scope of this assessment to tease out, past efforts to develop a coordinated children’s system of care through the Border Children’s Mental Health Collaborative were less successful than originally envisioned in their broad aims (though El Paso County continues to be an important provider of child and other behavioral health services). Inertia for positive system change seems to have ebbed. However, the analysis under Finding 1 regarding the health planning momentum of the Paso del Norte Health Foundation and RHP 15 offers the chance to try again. Perhaps most importantly, the Paso del Norte Health Foundation is widely viewed as a neutral convener and “honest broker,” an essential role in the promotion of collaboration that did not previously exist.

In addition, two sets of more focused efforts may offer opportunities to build trust and collaboration through mutual effort:

- **A cross-system inter-agency training model**, building on current training resources (such as the impressive range of training currently offered within the juvenile probation system or training in specific clinical models like trauma-informed care through smaller providers such as the El Paso Child Guidance Center) offers the possibility to build a local training hub in which resources (both funding and technical/training) from multiple allied systems are pooled, supplemented, and made available across systems.

- **Cross-system interventions** can also be a support. In particular, efforts involving the juvenile justice and mental health/behavioral health systems are another largely missing component of the local system of care that, if more robust, could keep youth out of juvenile justice settings (diversion) and increase the likelihood of their success after leaving incarceration to return to the community (transition). On the front end, collaborations incorporating screening and assessment for youth coming in contact with the juvenile justice system can allow them to access needed treatment. During transitions, models such as Washington State’s Family Integrated Transitions (FIT) build a bridge to support transitions from secure facilities to the community by linking the
youth and family to ongoing family and community-based treatment while they are still in residence.

**Recommendation 2:** Through the child-focused collaborative planning process described under Recommendation 1, begin now to 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. The State of Texas made a substantial investment in expanding children’s mental health services for those most in need through the expansion of the YES Waiver, a home- and community-based services waiver within the state’s Medicaid program. Funding for this program was increased by nearly $70 million statewide, and participation was expanded to any community demonstrating readiness (Harris County initiated participation this fiscal year). Just as importantly, Tarrant County (which began implementation last fiscal year) has emerged as a model for successful use of these financing options to expand access to intensive mental health services for children.

We recommend that El Paso County begin a deliberate planning process to develop a systemic system improvement plan focused on expanding crisis supports, in home services, family-focused care, and other needed supports with an implementation target of September 2014, to coincide with the shift of the Medicaid targeted case management and rehabilitation benefits from EHN to local STAR programs. The planning process should include all child and family providers in El Paso County (and potentially adjoining counties), as well as all major funders of child and family services, including STAR and STARHealth managed care organizations (MCOs), DFPS (focused on DFPS-funded residential and other care, in addition to the STARHealth program they oversee), El Paso County, juvenile probation, RHP 15, and UMC.

In addition to prioritizing the development of evidence-based service coordination models such as Wraparound (based on fidelity to the National Wraparound Initiative standards) and intensive family-based interventions provided in the home and community (such as MST and FFT), there should also be a broader shift to family-focused treatment (such as family therapy) and supports (such as family and youth peer support). Family-focused interventions, whether in-home, outpatient or peer-driven, represent a critical service modality for children and families that is largely missing from El Paso’s systems of care. Because children and youth exist within a family and have limited control of their environment, involving the family in treatment is vital; individual therapies with children too often only have limited utility. School-based and school-linked supports should also be included in the plan.

**Finding 3:** A dramatic lack of capacity exists in El Paso County for both adult and child behavioral health services. The bottom line is that need greatly exceeds service capacity at every level of the system, especially crisis care, prescribers, culturally-competent care, and
intensive community-based services to provide ongoing care for those most in need, as well as the supported housing, supported employment, and peer supports needed to foster true recovery over time.

The epidemiological analysis of need conducted for this assessment was limited to a high level application of the most current national prevalence studies. We did not conduct a quantitative need analysis that took into account the specific demographic make-up of the El Paso community. Our quantitative analysis of system capacity focused on data voluntarily provided by leading system partners. Many key system partners were unable to provide such data (either due to a lack of capacity or a lack of resources available to carry out and/or provide the analysis), but the result was sufficient to starkly illustrate a key system gap: an overall and marked lack of capacity.

The tables below summarize the annual need for adult behavioral health services in El Paso County and the available services for which data was provided. The estimated number of people with the most severe disorders is highlighted, including the proportion estimated to live in poverty. For services, the number of people served each year is provided (unless otherwise noted). Note the dramatic gap between the over 31,500 adults estimated to have severe needs each year and the less than 15,000 people we were able to document as served across settings (many of which are likely duplicate counts).

<table>
<thead>
<tr>
<th>All Adults</th>
<th>Population</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
<td>557,250</td>
<td>64,084</td>
</tr>
<tr>
<td>Mild-Moderate Mental Health &amp; Substance Use Disorders</td>
<td>557,250</td>
<td>125,660</td>
</tr>
<tr>
<td>Serious Mental Health &amp; Substance Use Disorders</td>
<td>557,250</td>
<td>40,679</td>
</tr>
<tr>
<td>All Behavioral Health Disorders</td>
<td>557,250</td>
<td>166,339</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Adults &lt; 200% Federal Poverty Level</th>
<th>Population</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Use Disorders</td>
<td>328,778</td>
<td>37,809</td>
</tr>
<tr>
<td>Mild-Moderate Mental Health &amp; Substance Use Disorders</td>
<td>328,778</td>
<td>97,976</td>
</tr>
<tr>
<td>Serious Mental Health &amp; Substance Use Disorders</td>
<td>328,778</td>
<td>31,563</td>
</tr>
<tr>
<td>All Behavioral Health Disorders</td>
<td>328,778</td>
<td>129,538</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>Hospital</th>
<th>Residential</th>
<th>Crisis</th>
<th>Outpatient / Community</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Paso Psychiatric Center</td>
<td>932</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>70 adult</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
UBH | n/a |  
---|---|---
Beds | 141 adult |  
Peak Behavioral Health | n/a |  
Beds | 32 adult |  

**Outpatient/Community Providers**

Emergence Health Network | 350 | 3,753 | 3,269 |  
Aliviane, Inc. | 537 | 1,008 | 1,178 |  
El Paso Center for Children | | 427 |  

**Veteran and Active Duty Military Services**

William Beaumont Medical Center | 60 | 1,200 |  

**Federally Qualified Health Centers**

Centro San Vicente | | 273 |  
Project Vida Health Center | | 300 |  
Centro de Salud Familiar Le Fe, Inc. | | 199 |  

**Total Served Annually** | **992**<sup>7</sup> | **887** | **3,753** | **6,676** | **1,178** |  

The next set of tables below summarize the **annual need for child behavioral health services** in El Paso County and the **available services** for which data was provided. The estimated number of children and adolescents with the most severe disorders is highlighted, including the proportion estimated to live in poverty. For services, the number of people served each year is provided (unless otherwise noted). Note the similar gap between the over 13,000 children and adolescents estimated to have severe needs each year and the less than 5,000 that we were able to document as served across settings (many of which are likely duplicate counts).

<table>
<thead>
<tr>
<th>All Children/Adolescents</th>
<th>All Children/Adolescents</th>
<th>Estimated Need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe Emotional Disturbance - ages 0-11</td>
<td>162,346</td>
<td>11,527</td>
</tr>
<tr>
<td>Severe Emotional Disturbance - ages 12-17</td>
<td>81,051</td>
<td>6,484</td>
</tr>
<tr>
<td>Substance Use Disorders - ages 12-17</td>
<td>81,051</td>
<td>6,565</td>
</tr>
</tbody>
</table>

<sup>7</sup> This includes only adults seen at EPPC; data on the number of people seen by UBH and Peak was not provided.
<table>
<thead>
<tr>
<th>Substance Use Disorders - ages 18-24</th>
<th>84,869</th>
<th>16,210</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children/Adolescents &lt; 200% Federal Poverty Level</td>
<td>Population</td>
<td>Estimated Need</td>
</tr>
<tr>
<td>Severe Emotional Disturbance ages 0-11 &lt;200% FPL</td>
<td>95,784</td>
<td>8,812</td>
</tr>
<tr>
<td>Severe Emotional Disturbance ages 12-17 &lt;200% FPL</td>
<td>47,820</td>
<td>4,399</td>
</tr>
<tr>
<td><strong>Total children/adolescents&lt; 200% FPL with SED</strong></td>
<td><strong>143,604</strong></td>
<td><strong>13,212</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Providers</th>
<th>Hospital</th>
<th>Residential</th>
<th>Crisis</th>
<th>Outpatient / Community</th>
<th>Substance Abuse</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Inpatient Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>El Paso Psychiatric Center</td>
<td>143</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>7</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UBH</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>12 (ages 12-17)</td>
<td>12 (ages 5-11)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Peak Behavioral Health</td>
<td>n/a</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Beds</td>
<td>22</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient/Community Providers</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergence Health Network</td>
<td></td>
<td></td>
<td></td>
<td>691</td>
<td></td>
</tr>
<tr>
<td>Aliviane, Inc.</td>
<td></td>
<td>4</td>
<td></td>
<td>882</td>
<td>652</td>
</tr>
<tr>
<td>El Paso Center for Children</td>
<td>134</td>
<td>906</td>
<td></td>
<td>1,002</td>
<td></td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>143</strong></td>
<td><strong>138</strong></td>
<td><strong>906</strong></td>
<td><strong>2,575</strong></td>
<td><strong>652</strong></td>
</tr>
</tbody>
</table>

In sum, need greatly exceeds service capacity. This is seen at every level of the system. While much of the attention at a system level has focused on the need for intensive services (for example, crisis supports, extended observation, inpatient capacity) and prescribers (psychiatrists, primary care physicians, nurse practitioners), multiple additional needs were identified across our analysis, including:

- **Culturally-competent care.** While many providers emphasized capacity to provide services in Spanish, only a few notable exceptions emphasized specific efforts to provide

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8 This includes only children and adolescents seen at EPPC; data on the number of people seen by UBH and Peak was not provided.
services in a culturally congruent manner responsive to major cultural groups represented in El Paso (specifically, various Latino populations and military culture). There seems to be a lack of systemic emphasis on culturally competent care. This need was summarized well in the 2013 Mental Health Stigma Reduction Situational Analysis\(^9\) (page 2 of the executive summary) and applies as well to behavioral health services as to stigma reduction efforts: *Increasing cultural competence makes for better regional mental health and emotional well-being for all residents. When planning or implementing stigma reduction efforts, culturally appropriate interventions must take into account multiple and complex world views, cultural beliefs, languages and immigration policy challenges. Increase the use of culturally and linguistically appropriate (CLAS) cultural standards in all stigma reduction strategies. Military culture also has a strong influence along the border and must be considered in any stigma reduction effort.*

- **Intensive service capacity.** Most of the emphasis in this area fell on the disconnect between justice settings and mental health service capacity. While strong collaboration was noted between law enforcement (both the sheriff and the El Paso Police Department) with EHN and between county courts and both the services they manage and Drug Court connections to Aliviane, there was a notable lack of intensive outpatient, housing, and residential options. Intensive, community-based outpatient options in particular, including Assertive Community Treatment (ACT) for adults and services such as Multisystemic Therapy (MST) for adolescents, were particularly lacking. On the positive side, EHN is using DSRIP funds to develop an MST team and also operates a single ACT team with capacity for approximately 90 individuals that served 106 people in the past year. As a point of comparison, Denver County in Colorado, a smaller county in terms of population, operates multiple ACT teams and fewer intensive community treatment teams with capacity to treat over 750 adults at one time.

- **Supported Housing and Supported Employment.** These are two critical evidence-based models of care that are dramatically under-developed in El Paso County (EHN provided supported housing to 86 adults in the last year and supported employment to 42). Dallas County, while only three times larger in population, has capacity to provide over 1,200 people with supported housing. Dallas and Bexar Counties both operate best practice comprehensive homeless programs (The Bridge in Dallas and Haven for Hope in Bexar). These supports are among the keys to helping individuals recover and move out of more debilitating housing and income situations.

- **Peer Support.** Another critical level of care to help individuals recover is peer support. The state of Texas, led by the work of the Hogg Foundation for Mental Health as well as efforts through the Department of State Health Services (DSHS) to develop recovery-
oriented systems of care for substance abuse treatment, learning communities to promote peer support and recovery through Via Hope, and self-directed care pilots in the NorthSTAR region, has advanced this important service substantially in recent years. However, EHN reported no delivery of peer support in the past year and best practices developed with federal grants in the substance abuse arena by El Paso Alliance, Inc., have been challenging to sustain.

While we have highlighted the gaps above, it should be kept in mind that every level of care we reviewed is inadequate in terms of capacity. Even promising programs, such as the strong array of substance abuse treatment aligned with El Paso County’s successful drug and re-entry courts, address only a portion of need.

Recommendation 3: Prioritize development efforts to (1) stabilize crisis situations and (2) build broader capacity to intervene earlier, particularly with children, in order to break the repeating cycle of dependency on crisis, law enforcement, criminal justice, juvenile justice, and child welfare services and build preventive capacity over time in federally qualified health centers and UMC clinics, primary care and pediatric practices, schools, and local communities. The broad array of gaps requires a structure for prioritization and organization of current resources (as described in Recommendation 1), as well as prioritization of limited development resources. We recommend that these efforts focus on two areas: breaking the repeating cycle of dependency on crisis, law enforcement, and criminal justice services and building preventative capacity over time in FQHCs and UMC clinics, primary care and pediatric practices, schools, and local communities to care for children and adults before untreated needs drive El Paso children into conflict with the law and parents and caregivers into desperate measures to seek help (including the continued need for many parents to relinquish custody of their children in order to access intensive services through the child welfare system). Both parts of this focus are essential, as the system will never get ahead of the cycle of dependence on acute and legal settings until the broader care system is able to build capacity for earlier intervention.

- **Breaking the cycle of dependency** involves a combination of setting up systems to systematically divert children and their families from juvenile justice settings, helping them reenter treatment outside the justice system, building crisis capacity in local communities to stabilize out-of-control situations as often as possible without using a jail or hospital, and directly linking people in emergency rooms and hospitals to care in outpatient settings. Breaking the cycle also requires coordinated screening and assessment systems to assess for treatable mental health and substance abuse needs at every entry point of the justice system, divert every person who does not pose a safety risk to the community, and provide treatment to every person with substantial need that can reduce current and future dependency.
• **Building preventive capacity** involves a combination of changes that will take longer: making access to preventative and necessary mental health and substance abuse care available in all primary care and pediatric clinics and offices, addressing the long-term shortage of prescribers trained to treat mental health care for children (both child psychiatrists and pediatricians) by using proven approaches to expand access through an interdisciplinary array professionals (advance practice nurses, physician assistants, and mental health professionals) and telemedicine, and changing how the symptoms of mental health are addressed in schools by using effective discipline approaches and linking children whose needs manifest during the school-day with the right medical resources. Preventive capacity for adults looks the same, and begins by treating children early so they never end up in court and detention settings. It also involves organizing El Paso’s public resources more effectively across community treatment settings to provide necessary medical treatment for mental health and addictive disorders within current resources.

Such prioritization is especially critical because these decisions cannot be made at the state level in a state as large and diverse as Texas. By way of example, despite a 26% increase in DSHS community mental health funding for the 2014-15 biennium (an 18% funding increase for adults, 25% for crisis, and 58% for children), DSHS projects serving only 6.1% more adults and 2.7% more children. Despite funding flexibility under Rider 78 to use 10% of the quarterly allocation of General Revenue funds for local mental health authorities (LMHAs) for performance-based incentive payments, DSHS has largely focused on requiring more of the same process measures it has historically used. Additionally, Senate Bill 7 clarified that LMHAs are permitted to provide services to individuals with mental health conditions other than schizophrenia, bipolar disorder and major depression, however it provided no guidance or structure to help LMHAs prioritize how best to use this flexibility, nor additional resources to augment services already stretched too thinly to meet the needs under those three sets of diagnoses. The bottom line is that local communities must come together and prioritize both (1) investment of new resources and (2) direction of current resources. The gaps are too large to address simply through system expansion, despite the unprecedented increases in resources provided by the 83rd Legislature to DSHS and through the 1115 DSRIP projects. The community must make decisions about how to use current flexibility in the system (albeit limited) to prioritize service delivery in accord with local priorities to improve the health of the overall population (rather than only the required targets within a given funding stream).

**Finding 4: Stigma is a major barrier to care.** Two recent systematic community analyses – the July 2013 Community Health Assessment and the 2013 Mental Health Stigma Reduction Situational Analysis underscored the myriad ways in which stigma impedes access to care and compounds the consequences of mental health and substance use disorders in the lives of people suffering from them. These findings were echoed in our conversations with El Paso
system leaders, as they consistently point to stigma as a key, limiting factor in access to care, especially among Latino communities.

**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. El Paso County, thanks to the leadership of the Paso del Norte Health Foundation and key community partners, including EHN, Family Services of El Paso, and Centro de Salud Familiar La Fe, is implementing a comprehensive, data-driven stigma reduction effort as well conceived and resourced as any similar effort we are familiar with across Texas or nationally. As other efforts are prioritized, this effort should be maintained and leveraged to maximize the utility of other efforts.

**Finding 5. Data analytic capacity exists and is growing, but is limited by system fragmentation.** We identified many promising trends regarding data-driven quality improvement. EHN has made a substantial investment in developing its quality improvement data analytic capacity and was the most complete and detailed BH Consortium member in response to our data queries (though we were appreciative of the efforts of all BH Consortium and other community members that participated). The Community Health Assessment demonstrated impressive capacity to convene stakeholders and leverage the capacity of the RHP data analysis to set community priorities. In addition, individual providers are building capacity, such as EPPC’s recent upgrade of its Netsmart electronic health record (EHR).

Yet, despite these system improvements, the ability to share data across organizations appears to be non-existent at the system level. No organization we met with demonstrated any knowledge of the service capacity or data capabilities of their partners, even when organizations worked closely together. Even basic data sharing between criminal justice and mental health was lacking, despite the existence of robust liaison relationships at the staff level. Furthermore, while we did not examine this closely, reports in our key informant interviews regarding local efforts to promote individual case-level data sharing via a health information exchange (HIE) noted that behavioral health data had been specifically excluded from the HIE development efforts because of perceptions that this would complicate development.

**Recommendation 5: Through the System Partnership, use focused, data-driven, cross-agency quality improvement projects to develop capacity to share data to improve individual and population health outcomes.** The system has emerging capacity and opportunities abound to leverage this capacity to support quality improvement efforts for specific populations.

For example, as primary care integration begins to be addressed for adults with serious mental illness, it should be possible to work to reduce the prevalence and morbidity of co-occurring chronic illness, which studies consistently show to be overrepresented in that population.
People with serious mental illness (SMI) die on average 25 years younger than the rest of the population nationally on average (at age 53 of largely preventable causes)\(^\text{10}\) and over four years sooner in Texas (age 49.5 on average).\(^\text{11}\) Focusing on adults with SMI, the factors underlying this trend, as described in the National Association of State Mental Health Program Directors (NASMHPD) study (as well as other sources\(^\text{12}\)), are largely preventable conditions:

- Rates of respiratory disease are five times higher;
- Rates of diabetes, cardiovascular disease, and infectious diseases are 3.4 times higher;
- Rates of lung cancer are three times higher; and
- Rates of stroke among people under age 50 are two times higher.

Data sharing across agencies will be necessary if behavioral interventions in outpatient settings (both EHN and medical providers such as the federally qualified health centers and the UMC outpatient clinics) are to be linked to potential cost-savings in inpatient settings.

Other potential opportunities for data sharing that should be considered include efforts to:

- Identify shared cases and coordinate service delivery for adults with co-occurring mental health and substance use disorders who are being served by both EHN and Aliviane;
- Proactively identify people involved in the criminal justice system who are currently in care with outpatient providers (e.g., EHN and Aliviane) and divert them to providers’ outpatient teams rather than tertiary care settings;
- Support re-entry for people leaving correctional settings (adult detention, juvenile detention, TJJD facilities, Texas Department of Criminal Justice facilities) to connect them to care settings; and
- Promote earlier intervention in the community behavioral health system to divert use of the juvenile justice system (for example, through EHN’s new MST team) by measuring the effects of such efforts in potentially reducing demand (and potentially reducing use) of juvenile justice resources (and the potential reduction of the disproportionate involvement of youth of color in such settings).

As noted earlier, the opportunities are myriad, and the examples just cited are illustrative. The point of the recommendation is to use quality improvement projects to develop data sharing capacity at the system level. In addition, we recommend that the decision to delay inclusion of


\(^{12}\) Thorpe, K.E., Ogden, L.L., Galactionova, K. April, 2010. Chronic conditions account for rise in Medicare spending from 1987 to 2006. Health Affairs. Vol. 29 No. 4.
behavioral health data in the developing HIE be revisited in light of the data on the human and financial costs of behavioral health co-morbidities cited above.

Finding 6: There is a broader range of cross-system development opportunities that must be considered in any implementation efforts. The cross-cutting priority of needing to improve the cultural competency of El Paso County behavioral health systems was noted previously. Similarly, other needs were evident that will require cross-system effort to address. Three more stand out in particular:

- Related to the need to address military culture, there is also a need to build awareness, education, and prevention supports for active duty military service members, veterans, and their families,
- There is a need to address 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
- The need to develop capacity across the continuum to deliver integrated mental health and substance use disorder services as between 50% and 60% of adults with serious mental illness also have some level of co-occurring substance use disorders (SUD).\(^\text{13}\)

In particular, the needs of active duty military service members, veterans, and their families are increasingly well documented. There is also increasing awareness among Texans of the debt owed to active duty and returning warriors, and the responsibility of the state and local communities to work alongside and in coordination with services through the Department of Defense and the Veterans Administration to meet the needs not being met by the federal government. There are nearly 1.6 million veterans residing in Texas, ranking just behind California,\(^\text{14}\) and El Paso County is home to many given its proximity to Fort Bliss. Texas is also home to 186,000 uninsured veterans and family members, the most of any state. Nationally, 22 veterans take their own lives each day, up from 20 per day in 1999.\(^\text{15}\) Among Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) veterans, one-third of those previously deployed had post-traumatic stress disorder (PTSD), major depression, traumatic-brain injury (TBI), or a combination of these conditions.\(^\text{16}\) In terms of stigma, nearly two-thirds of active duty service members strongly agreed that they would

\(^{13}\) For the lower range: Buckley, P.F. et al. (2009). Psychiatric comorbidities and schizophrenia. *Schizophrenia Bulletin, 35*(2), 383-402. Experts such as Dr. Ken Minkoff estimate the proportion to be 60%.

\(^{14}\) [http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf](http://governor.state.tx.us/files/twic/Veterans_in_Texas.pdf)


“seen as weak” (65%) or treated differently by unit leadership (63%) if they received mental health care.\textsuperscript{17}

**Clinical System Findings and Recommendations Prioritized for Near Term Action**

In addition to the systemic findings and recommendations offered above, our team has also identified several recommendations pertinent to specific clinical subcomponents of the broader system. Note that these recommendations are secondary to the systemic recommendations above, in particular Recommendation 1 regarding the need for a System of Care Collaborative. In our view, these system-level challenges are the primary limiting factor currently impeding greater progress at the system level and must be addressed, or implementing the additional recommendations will likely not produce desired results and may, in fact, set back progress further as limited resources run the risk of being sub-optimally invested in the face of critical needs.

While the overall system requires improvement at every level, the following four areas of development are recommended as near term priorities for focused development effort over the next 12 months.

**Finding 7:** State operation of the El Paso Psychiatric Center (EPPC) offers the most cost-effective option for expanding adult acute and crisis capacity in accord with local priorities and inclusive of locally operated services co-located at EPPC. DSHS has expressed a willingness and flexibility to partner with the local community to support the development of EPPC programming, including the option of contracting with a local hospital provider to operate the program.

From a financial perspective, on balance it seems clear that it would be more cost effective for EPPC to continue as a state facility. In particular, the operating budget that could potentially be contracted out to a locally operated entity does not include major cost centers, including employee benefits, capital costs, critical direct operating expenses (such as information technology and the electronic health record), and indirect costs such as legal and human resources. In addition, DSHS has granted EPPC flexibility to adapt programming to meet local needs, so the benefit of local control is unclear. The best use of DSHS flexibility in the operation of EPPC is to leverage EPPC resources to maximize development of necessary locally operated programs to address priority community needs.

Recommendation 6: EPPC should contract existing first floor “intake space” to become a full service Psychiatric Emergency Service (PES) that provides not just a basic emergency and diversion function as a front-end to EPPC and other psychiatric inpatient programs in the county, but also the core for a system-wide crisis triage and diversion system for both acute and forensic cases. The January 2013 Ad Hoc Committee on Psychiatric Emergency Services in El Paso, informed by January 2012 recommendations by Dr. Avrim Fishkind, recommended the establishment of a comprehensive psychiatric emergency service on the first floor of EPPC. This is also the recommendation of the TriWest team, and these recommendations have been reviewed by EPPC and DSHS leadership and generally discussed as sufficiently feasible to serve as a basis of continued discussion and program development.

This program should go beyond a basic emergency and diversion function as a front-end to EPPC and other psychiatric inpatient programs in the county, and be developed to become the core for a system-wide crisis triage and diversion system for both acute and forensic cases. The programmatic and facility capacity of EPPC is a key system strength, and the proximity to the medical resources of the University Medical Center (UMC) make it the optimal site. In a community as geographically large as El Paso, this program will have to develop robust linkages with other emergency room, hospital, and crisis providers across the community (including the new extended observation beds located at 1600 Montana Avenue). While there is a rationale for building this locus at other sites (such as 1600 Montana), any location in the county would need to coordinate with other sites, and the combined resources of EPPC and UMC at the Alameda Avenue site are superior to other options.

The best practice model that should be developed over time would offer multiple functions at a single site, including psychiatric emergency response, crisis triage, coordinated medical clearance with UMC, integrated detox capacity on site, coordination of access to inpatient psychiatric and detox resources across the community (including the new extended observation unit), an anchor for mobile crisis response, a primary site for forensic drop-off and jail diversion, robust linkages to outpatient competency restoration (OCR) diversion, robust linkages to intensive outpatient mental health hospital diversion programs (including Assertive Community Treatment), strong ties to intensive outpatient SUD resources, and broader linkages to the full system of mental health and substance abuse services in the community for diversion of cases with less acute needs. Examples of model programs in Texas include the Restoration Center in Bexar County and John Peter Smith Hospital in Tarrant County.

This unit should welcome adults and children (integrated with the specialized primary crisis system for children recommended below), as well as individuals with co-occurring mental health/substance use disorders (MH/SUD), including those who may require detox interventions integrated into crisis stabilization, including those who may require detox interventions integrated into crisis stabilization. The primary barrier to developing this capacity
is the lack of a structure for fostering collaboration across silos, particularly EPPC, UMC, EHN, Aliviane, county probation, and the broader network of community providers, including federally qualified health centers.

As part of this primary recommendation, we also recommend consideration of the following clinical improvement opportunities within the expanded crisis triage system anchored by EPPC:

- **Develop cross-program coverage staffing plans for medical staff and residents.** EPPC medical staff and residents should be organized to provide psychiatric back-up coverage across all programs located at EPPC, including mobile crisis, PES, and inpatient units.

- **Development of clearer and more practical medical clearance guidelines, as well as guidelines to facilitate access for individuals with mental health crisis and active substance use.** This will require collaboration between the EPPC Medical Director, residency faculty, the EHN Medical Director, UMC, and Aliviane. The TriWest team has access to examples of best practice guidelines from other facilities nationally that we could provide upon request.

- **Close the EPPC Child Inpatient Unit, and develop best practice child inpatient capacity over time at another community facility.** This unit has been underused for a decade and multiple efforts to increase utilization have failed for a variety of reasons, none of which addressable by EPPC or any single actor within the system. Furthermore, even if fully utilized, the basic design of the unit (seven total child and adolescent beds) is inefficient and unable to leverage any economies of scale. These resources (both physical and staff) would be better used to both (1) support development of additional adult acute capacity and resources to support the comprehensive Psychiatric Emergency Service and (2) redeploy to augment other child and adolescent inpatient capacity in the community better situated to function as a robust center for child and adolescent acute care. It would be ideal for El Paso County to have child and adolescent inpatient capacity physically integrated within its children’s hospital so that the overall health of El Paso children with acute needs requiring inpatient care can be addressed in a single, state-of-the-art facility. However, physical and programmatic constraints (not the least of which is a severe lack of child psychiatric providers) will likely require a concerted effort over multiple years to realize such a vision. In the meantime, UBH and Peak are the leading child psychiatric acute care providers in the community and seem to be the natural candidates for development of an alternative program. Concerns about Peak centered largely on its location across the state line in New Mexico, but EHN representatives assured our team that there is no legal barrier to such access. Concerns were also expressed regarding the willingness and capacity of UBH to develop a program accountable not just to UBH priorities, but also to the broader needs of the community. In particular, the need to maintain (and strengthen over time) the child residency training program currently based at EPPC is essential, to the point that the EPPC child unit cannot close until the residency program is assured of continuity (and preferably...
expansion) at a new facility without a gap in training capacity. The need for additional child psychiatric providers in the community is too severe.

- **Establish additional adult programming in the previous child unit space, either an additional adult inpatient unit or expanded step-down residential rehabilitation capability (potentially under contract with a co-located community provider) for high need adult consumers, including high-risk individuals who no longer need acute psychiatric care, but are in need of forensic competency restoration.** Current capacity pressures for adult beds and increased acuity (including increased incidents of patient to patient and patient to staff aggression) result in a need for more acute treatment capacity than currently available, as well as back up of individuals who need step-down care. It was beyond the scope of the current project to analyze case-based data with sufficient granularity to determine which of the above two options would be most effective for the system, but this analysis should be a primary focus of the community-based planning efforts recommended above. Also, as these beds are shifted to adult use within the current 74 bed state hospital allocation, there will need to be focused effort to ensure that there is not an adverse impact on EHN due to changes in payer mix for the former child beds.

- **Continue to improve the recovery-oriented, trauma-informed, co-occurring capability of all EPPC services.** EPPC, like other services in El Paso, is working to improve its ability to work effectively with individuals who have complex needs. There is a well-organized quality improvement program at EPPC to address these issues that has made some good initial progress, but there is continued opportunity for further development of more organized rehabilitative services on the units to address skills related to co-occurring SUD, trauma, and health needs.

- **Develop a more formal oversight mechanism to facilitate flow for patients in transition to OCR and other community services.** Currently, there are a range of struggles and appeals that are occurring between EPPC and EHN for OCR referrals. There is also a lack of close coordination between the broader array of diversion resources at both EHN (including Assertive Community Treatment and other case management capacity) and Aliviane (including intensive outpatient and residential options). There are also concerns about the inability to track follow-up care for high risk consumers in a sufficiently timely manner, which further limits diversion opportunities. This is symptomatic of the overall lack of partnership at the high system level (described above), so that barriers emerge that could otherwise more easily be negotiated in partnership between administrative/medical leadership at these organizations. In the absence of a partnership, staff may at times tend to focus on protecting “risk” in entering OCR, without attention to the larger need for the community to unblock beds. In a better functioning partnership, EPPC (and its crisis services) would “hold the back” of EHN OCR and community services at both EHN and Aliviane so that barriers to entry could be prevented. Instead, referrals across these systems would proceed increasingly
on a basis of mutual trust, while at the same time providing a more responsive safety net for individuals who otherwise are at substantial risk for slipping through the cracks after discharge.

- **Address the needs of the small number of individuals who are backed up in EPPC as long stay patients.** Significant capacity challenges (and costs related to lack of access and lack of documented legal status) are related to a few long stay patients occupying a large percentage of current EPPC beds and a disproportionate share of bed days. A focused community effort, including use of private funding if necessary to address the needs of undocumented individuals without access to other sources of care, is needed to organize access to alternative placements for those individuals. While this group comprises only a small number of people (five or so at any given time), addressing their needs would have a significant impact (analogous to increasing the capacity of the new DSRIP-funded extended observation unit by 50%).

- **Facilitate information sharing.** The current EPPC data system (the DSHS EHR platform) is an impediment to effective data sharing, though the latest Netsmart upgrades may provide the basis for improving its utility within EPPC. As discussed above, we recommend development (as a key function of the nascent local partnership) of a basic data-sharing platform that allows EPPC to share basic data on access and continuity with community partners (including EHN, Aliviane, the West Texas Community Supervision and Corrections Department, and the courts). Such capacity has been developed in other Texas systems (for example, Dallas’s Jail Data Instant Messaging Initiative; Dallas’s joint “Top 100” hot-spotting efforts across NorthSTAR, Parkland, the jail, and The Bridge; and the Austin State Hospital / Austin Travis County Integral Care secure file transfer protocol service and supporting protocols).

**Finding 8: Crisis services for children and families are also lacking and will require an additional focused effort beyond the development of the comprehensive Psychiatric Emergency Service at EPPC.** Crisis services were identified as a critical gap in the children’s system. System leaders interviewed demonstrated broad consensus that El Paso lacks effective child crisis options, with long wait times and gaps in the array of crisis services available.

The service array has significant gaps so children and their families are often referred to and placed within the levels and types of care that are available as opposed to the most appropriate level of care to meet their needs. If one thinks of the community service array like a ladder, El Paso’s ladder is missing several rungs. One of the most notable gaps is in interventions for families (as opposed to individual therapies treating the individual child), especially home-based intensive options like MST or FFT.
The absence of an effective residential option for children in El Paso was noted by leaders in the child welfare system. A residential treatment facility that coordinates with community-based services and emphasizes smooth transitions to and from the community was identified as ideal.

In addition, inpatient psychiatric services, while in actuality more available than in many communities (there is a combined 53 beds between EPPC, UBH and Peak), are generally viewed as lacking and inadequately accessible.

**Recommendation 8:** Develop a crisis continuum for children 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 components. The ideal crisis continuum centers on a dedicated on-call mobile team – separate from but supported by law enforcement-to serve children, youth and their families in crisis across systems (mental health, substance abuse, schools, child welfare, and juvenile justice). The most frequently cited model is the Mobile Urgent Treatment Team first implemented by Wraparound Milwaukee. The team must be integrated within a broader crisis system that includes at least one high quality, respected children’s hospital program anchoring an array of brief out-of-home options for children and youth in crisis (with some available up to 30 days), including inpatient care for truly complex cases, crisis residential, respite, therapeutic foster care, and emergency shelter options.

**Finding 9:** Despite a strong commitment by local law enforcement leadership to robust behavioral health liaisons and mental health training for peace officers, there continue to be significant gaps in the readiness of law enforcement and correctional officers to respond to behavioral health crises. Interviews with Sheriff Wiles and the El Paso Police Department demonstrated a long-standing and impressively knowledgeable commitment to supporting officers of the law and the community in responding to behavioral health emergencies in a manner that is safe and both forensically and medically sound. Major investments have been made in both training peace officers in a core 72 hour training through the Texas Commission on Law Enforcement (TCOLE) and developing liaison relationships with inpatient and outpatient behavioral health providers via mental health liaisons and field officers.

However, two major gaps remain. First, because of the demands on officers for their time (and a lack of resources sufficient to allow officers additional time for training away from their law enforcement duties), there is currently a gap in the area of recertification and training. Relatedly, the more substantive Crisis Intervention Team model currently employed in Harris County, Dallas County, Travis County and Bexar County is not in use.

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Also of concern, correctional officers at the adult detention facility do not receive the core (TCOLE) training. This is a major gap, given the daily requirements of correctional officers to manage the needs of more adults with severe mental illness than do local hospitals (based on a high-level review of tracking records by our team at the detention facility and statewide data on Texas jail and hospital use trends).

**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. For the foreseeable future given Texas statutes, continued resource limitations on the part of the behavioral health system, and the necessary first responder role of law enforcement, El Paso peace officers and correctional officers will routinely respond on a daily basis to a range of behavioral health needs in the community and detention center. Many of these will be routine, and many could also eventually be diverted to the comprehensive Psychiatric Emergency Service recommended previously. However, the health and safety of both peace officers and El Paso residents with severe behavioral health needs will continue to be a heightened risk in the absence of the highest quality training for peace and correctional officers. El Paso County and the City of El Paso are fortunate to have law enforcement leaders with an understanding of these issues and a proactive commitment to maximize the readiness of their officers within their limited resources. As resources are prioritized by the community, additional support to these first responders should be among the top priorities of the community.

**Finding 10:** Access to behavioral health care in routine settings in which child health concerns generally present – pediatric practices, primary care clinics, and schools – is dramatically lacking. Currently, the behavioral system is not well-linked to schools in El Paso. This represents a significant gap in that, after family, schools are generally the most critical support for children and youth. Best practices in school services typically include (1) screening, assessment and referral protocols with local mental health providers (national best practices most often incorporate the CANS, the assessment tool currently required by DSHS for LMHAs like ENH) and (2) comprehensive whole-school environmental interventions such as the Positive Behavioral Interventions and Supports (PBIS) model. Despite newly mandated certification requirements for teachers under Senate Bill 460 to include training in the identification of mental and emotional health needs, the 83rd Legislature did not allocate funds to support the development of either screening / referral systems or expanded school-based / school-linked mental health supports, so it is incumbent on local systems to address this gap.

Similarly, system leaders interviewed for this assessment uniformly noted the difficulty in accessing psychiatric diagnostic and prescription services for children. Long wait times and confusing access protocols compound difficulties for children and families, as well as allied
systems like DFPS, to access the behavioral health system. Relatedly, coordination of other prescriber resources (primary care physicians, nurse practitioners, prescribing psychologists, etc.) did not appear to be a system priority.

**Recommendation 10: Actively develop earlier access to behavioral health assessments and care in the settings in which children naturally seek help – schools and the family doctor.** This recommendation is more of a specific emphasis within the broader system planning envisioned under Recommendation 1. But it is of critical importance and should be prioritized – and resourced – by system leaders.

**Conclusion**

While the people of El Paso County experience behavioral needs as severe as any community in Texas or the nation, and the community’s behavioral health systems suffer from multiple gaps, the TriWest team concluded this assessment with a sense of optimism and hope. Moreover, our hope is not centered on the dramatic increase in funding for services through the 83rd Legislature or the 1115 Waiver DSRIP projects. Simply spending more on something that does not work particularly well is not a sound strategy for success. El Paso enjoys many strong providers and every provider we met with demonstrated a commitment to improving practice, promoting evidence-based care, and innovating to respond to the community needs they perceive. As our findings indicate, the community lacks a systemic approach to meeting the pervasive and often complex needs of the people who live in El Paso County. What gives us hope is movement towards such a systemic partnership, exemplified by the work and expanding membership of the BH Consortium, as well as complementary efforts by the Brain Trust and RHP 15, and anchored by the leadership and commitment of the Paso del Norte Health Foundation. There is a sound base and forward momentum in every area of recommendation we have offered. If the behavioral health leadership of El Paso County is prepared to take the next steps down the road to develop the finest behavioral health system in the nation.
## Appendix One: People Interviewed for the Community Assessment

<table>
<thead>
<tr>
<th>Stakeholders Interviewed</th>
<th>Institutional Affiliation</th>
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<tbody>
<tr>
<td><strong>Individual Stakeholders</strong></td>
<td></td>
</tr>
<tr>
<td>Diana Barajas</td>
<td>Department of Family and Protective Services</td>
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<tr>
<td>Jaime Barceleau</td>
<td>Paso del Norte Children’s Development Center</td>
</tr>
<tr>
<td>Ben Bass</td>
<td>El Paso Alliance, Inc.</td>
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<tr>
<td>Sharon Butterworth</td>
<td>Advocate and Civic Leader</td>
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<tr>
<td>Maria Carrillo</td>
<td>Centro de Salud Familiar La Fe, Inc.</td>
</tr>
<tr>
<td>Zulema Carrillo</td>
<td>El Paso Psychiatric Center</td>
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<tr>
<td>Commander Raymond Chaires</td>
<td>El Paso Police Department, Westside Regional Command</td>
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<tr>
<td>Jacob Cintron</td>
<td>Del Sol Medical Center</td>
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<tr>
<td>Kristi Daugherty</td>
<td>Emergence Health Network</td>
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<tr>
<td>J. Manuel de la Rosa, MD</td>
<td>Texas Tech Health Sciences Center</td>
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<tr>
<td>Michael Escamilla, MD</td>
<td>Texas Tech Health Sciences Center</td>
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<tr>
<td>Hon. Veronica Escobar</td>
<td>El Paso County Judge</td>
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<tr>
<td>Eric Evans</td>
<td>Sierra Providence Health Network</td>
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<tr>
<td>Hon. Eduardo Gamboa</td>
<td>El Paso County, Judge – Statutory Probate Court II</td>
</tr>
<tr>
<td>Danielle Garcia</td>
<td>Aliviane, Inc., Project LAUNCH</td>
</tr>
<tr>
<td>Hon. Patrick Garcia</td>
<td>El Paso County, Judge – 384th District Court</td>
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<tr>
<td>Cathy Gaytan</td>
<td>El Paso Child Guidance Center</td>
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<tr>
<td>Junius Gonzalez, MD</td>
<td>University of Texas at El Paso</td>
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<tr>
<td>Jim and Joan Herendeen</td>
<td>Family Members</td>
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<td>René Hurtado</td>
<td>Emergence Health Network</td>
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<td>Jon Law</td>
<td>Paso del Norte Health Foundation</td>
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<tr>
<td>Col. Dale Levandowski, MD</td>
<td>William Beaumont Army Medical Center, Department of Behavioral Health</td>
</tr>
<tr>
<td>José Luna, Jr., MD, MBA</td>
<td>Centro San Vicente</td>
</tr>
<tr>
<td>Carlos Marquez</td>
<td>El Paso County Department of Mental Health Support Services</td>
</tr>
<tr>
<td>Name</td>
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<tr>
<td>Roger Martinez</td>
<td>El Paso County Juvenile Probation Department</td>
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<tr>
<td>Mario Mendoza</td>
<td>El Paso Alliance, Inc.</td>
</tr>
<tr>
<td>Magdalena Morales-Aina</td>
<td>El Paso County, 384th District Court, West Texas Community Supervision and Corrections</td>
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<tr>
<td>David Morris</td>
<td>University Behavioral Health</td>
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<tr>
<td>Alexander Neill</td>
<td>Attorney, Neill, Strelitz and Associates, P.C.</td>
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<tr>
<td>Rosemary Neill</td>
<td>El Paso County, Family and Community Services</td>
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<tr>
<td>Bruce Parsons</td>
<td>City of El Paso Department of Public Health</td>
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<tr>
<td>Elizabeth Richeson, PhD</td>
<td>Psychologist in Private Practice</td>
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<tr>
<td>Sandy Rioux</td>
<td>El Paso Center for Children</td>
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<tr>
<td>Bill Schlesinger</td>
<td>Project Vida Health Center</td>
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<tr>
<td>Robert Smith, LSSP</td>
<td>Socorro Independent School District</td>
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<tr>
<td>Sherri Terrell, EdD</td>
<td>University of Texas at El Paso, University Counseling Center</td>
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<tr>
<td>Lisa Tomaka</td>
<td>Child Crisis Center</td>
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<tr>
<td>Michael Wendt</td>
<td>Emergence Health Network, Board Chair</td>
</tr>
<tr>
<td>Sheriff Richard Wiles</td>
<td>El Paso County, Sheriff’s Office</td>
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<tr>
<td>James Valenti</td>
<td>University Medical Center of El Paso</td>
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<tr>
<td>John Wiebe, PhD</td>
<td>University of Texas at El Paso</td>
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<tr>
<td>Michael Yeary</td>
<td>El Paso Child Guidance Clinic</td>
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**Group Meetings and Site Visits**

<table>
<thead>
<tr>
<th>Group</th>
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<tr>
<td>Correctional Officers</td>
<td>El Paso County Detention Facility – Downtown</td>
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<tr>
<td>Clinical, Administrative, Quality Improvement, MIS, Crisis / Intake Leadership and Staff</td>
<td>Emergence Health Network</td>
</tr>
<tr>
<td>Medical, Administrative, Quality Improvement, Forensic Leadership and Staff</td>
<td>El Paso Psychiatric Center</td>
</tr>
</tbody>
</table>
Appendix Two: Summary of Data Analytic Methods

Population in Need. Population in need was assessed by applying national and regional epidemiological findings on 12-month prevalence rates to population data for El Paso County. Population and demographic data on El Paso County were drawn from demographic studies conducted by the University of Texas at El Paso\(^{19}\) and the U.S. Census Bureau. Rates from national and regional findings were multiplied by estimates of the adult and child/adolescent populations in El Paso County.

Studies have been conducted separately for adults and children. Estimates of substance use disorders (SUDs) and mild/moderate severity mental health conditions were drawn from a highly regarded multi-national study conducted by Bilj and colleagues.\(^{20}\) Estimates of the prevalence of serious and severe mental illness were drawn from the work of Charles Holzer, who has applied data from several national epidemiological studies, including studies with people from non-White race/ethnicity groups, to demographic data (e.g., poverty, race/ethnicity) to develop more precise estimates of the prevalence of serious mental illness and severe emotional disturbance. In arriving at a total number of adults with behavioral health treatment needs, we used Holzer’s estimates based on the number of people living at less than 200% of the federal poverty level (FPL) and their rates of behavioral health disorders.\(^{21}\)

Epidemiological studies used to estimate the population of children and adolescents in need of services included the following. First, estimates of the prevalence of SUDs in adolescents ages 12-17 and 18-24 were drawn from the National Survey on Drug Use and Health (2009) data. Second, estimates of severe emotional disturbance (SED) for ages 0-5 and 6-11 (separately) were taken from a 1997 National Register report. Unfortunately, epidemiological data on SED were not more recent as of the time of the population in need estimate. However, a recent national epidemiological study of adolescents provided estimates of SED in adolescents ages 12-17.\(^{22}\) Finally, estimates of SED in the under 200% FPL sub-population for each of the three child/adolescent age groups outlined above were also calculated, based on Charles Holzer’s estimates from the 1997 Federal Registry report\(^{23}\) and his application of demographic (poverty) data to those estimates.

\(^{19}\)http://chs.utep.edu/cihre/demographic/el_paso_county_and_city_of_el_paso.php#population


Capacity Assessment. This was carried out in three phases:

- **Phase 1: Establish Service Taxonomy.** To establish a spectrum of adult and child services for the El Paso Behavioral Health Assessment, TriWest Group created a community mental health and substance abuse service taxonomy. This taxonomy reflects an integration of the EHN Service Framework with the Texas Utilization Management Guidelines categories. Provider service and capacity data was applied to this taxonomy in Phase 3 (see the table at the end of this appendix for the TriWest Group Community Service Taxonomy).

- **Phase 2: Survey Community Behavioral Health Providers.** TriWest Group identified and surveyed thirteen (13) community behavioral health providers in the El Paso area. These providers included the following agencies (those that submitted data are in italics).

<table>
<thead>
<tr>
<th>• Emergence Health Network</th>
<th>• Project Vida</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Aliviane</td>
<td>• El Paso Department of Public Health</td>
</tr>
<tr>
<td>• Centro de Salud Familiar La Fe</td>
<td>• Dr. Elizabeth Richeson</td>
</tr>
<tr>
<td>• El Paso Alliance, Inc.</td>
<td>• Dr. John Wiebe</td>
</tr>
<tr>
<td>• El Paso Child Guidance Center</td>
<td>• William Beaumont Army Medical Center (WBAMC)</td>
</tr>
<tr>
<td>• El Paso Center for Children</td>
<td>• Centro San Vicente</td>
</tr>
<tr>
<td>• El Paso Psychiatric Center</td>
<td>• Socorro ISD (Child Only)</td>
</tr>
<tr>
<td>• Providence Memorial Hospital</td>
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</tbody>
</table>

TriWest Group requested that each provider submit existing reports (or complete a survey) that provided quantitative data on the number of people served over a recent 12-month period. Information and data submitted by providers included client inclusion criteria, payee information, the count of clients served, and consumer characteristics associated with mental health and substance use diagnoses.

- **Phase 3: Data Abstraction and Analysis.** Summaries of the number of people served in various programs were abstracted from agency documentation and survey results. In some cases, respondents submitted documentation and/or surveys without detailed quantitative data. A second analysis was conducted, which stratified agency provider services by level of care setting (e.g., Hospital, Residential, Crisis, Outpatient / Community-Based, Substance Abuse) for both adults and children. Providers were identified by provider type (e.g., Inpatient, Outpatient/Community Providers, Veteran and Active Duty Military Services). When detailed program-specific data was unavailable, numbers of people served were estimated, based on the total served by the agency. When agencies had multiple programs that addressed a single service type (within the TriWest Group taxonomy), program data was combined for an overall service total (e.g., Group and Individual counseling data were summed for Counseling – Individual, Family and/or Group).
Assertive Community Treatment Focused Study. A focused study was conducted on assessment data from Assertive Community Treatment clients served through EHN. TriWest compared recommended levels of care, reported hospitalization usage, and authorized levels of care to assess the extent to which the sample of 42 clients included in the EHN data submission were likely to be appropriate for ACT level of care. The primary goal of this study was to assess the capacity of the system to use clinical data to inform quality improvement efforts. This data analysis will be shared with EHN, but will not be publicly released as part of the assessment.

TriWest Group Community Assessment Service Taxonomy

<table>
<thead>
<tr>
<th>Service Taxonomy</th>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>State Hospital Services</strong></td>
<td></td>
<td>PRTF / RTC - long term residential treatment (over 30 days)</td>
</tr>
<tr>
<td>Inpatient Psychiatric Hospital Services</td>
<td><strong>Inpatient Psychiatric Hospital Services</strong></td>
<td></td>
</tr>
<tr>
<td>Inpatient detox services (medically managed)</td>
<td></td>
<td>Psychiatric Emergency Room Services</td>
</tr>
<tr>
<td>Inpatient detox services (medically monitored)</td>
<td></td>
<td>Extended Observation Unit (EOU) Local Emergency Rooms (General)</td>
</tr>
<tr>
<td>Extended Observation Unit (EOU) Local Emergency Rooms (General)</td>
<td></td>
<td>Day Programs for Acute Needs</td>
</tr>
<tr>
<td>Psychiatric Emergency Room Services</td>
<td></td>
<td>Treatment Foster Care</td>
</tr>
<tr>
<td>Residential Treatment - MH / SUD / COD</td>
<td></td>
<td>Children’s Crisis Residential Treatment</td>
</tr>
<tr>
<td>Crisis Stabilization Unit</td>
<td></td>
<td>Crisis Intervention Services</td>
</tr>
<tr>
<td>Crisis Residential Treatment</td>
<td></td>
<td>Crisis Follow-Up and Relapse Prevention</td>
</tr>
<tr>
<td>Crisis triage / law enforcement drop off</td>
<td></td>
<td>Crisis Flexible Benefits</td>
</tr>
<tr>
<td>Crisis Intervention Services</td>
<td></td>
<td>Crisis Transportation</td>
</tr>
<tr>
<td>Crisis Follow-Up and Relapse Prevention</td>
<td></td>
<td>Detention Diversion</td>
</tr>
<tr>
<td>Crisis Flexible Benefits</td>
<td></td>
<td>Law Enforcement Contact</td>
</tr>
<tr>
<td>Crisis Transportation</td>
<td></td>
<td>Youth / Runaway Shelter Services</td>
</tr>
<tr>
<td>Day Programs / Partial Hospital Program for Acute Needs</td>
<td></td>
<td>Publicly Funded Outpatient: Child</td>
</tr>
<tr>
<td>Service Taxonomy</td>
<td>Adult</td>
<td>Child</td>
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<tr>
<td>Outpatient Competency Restoration</td>
<td><strong>Respite Services (Community-Based and Program-Based)</strong></td>
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<tr>
<td>Mental Health Unit in a Jail</td>
<td></td>
<td>Intensive Case Management</td>
</tr>
<tr>
<td>Jail Diversion</td>
<td></td>
<td>Family Case Management</td>
</tr>
<tr>
<td>Law Enforcement Contact</td>
<td></td>
<td>Family Partner Services</td>
</tr>
<tr>
<td>MH/SA Homeless Services</td>
<td></td>
<td>Parent Support Group</td>
</tr>
<tr>
<td>MHSA Funded Outpatient: Adult</td>
<td></td>
<td>Psychiatric Diagnostic Interview Examination</td>
</tr>
<tr>
<td><strong>Respite Services (Community-Based and Program-Based)</strong></td>
<td></td>
<td>Pharmacological Management</td>
</tr>
<tr>
<td>Assertive Community Treatment</td>
<td></td>
<td>Medication Training and Support Services</td>
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<tr>
<td>Supported Housing</td>
<td></td>
<td>Case Management</td>
</tr>
<tr>
<td>Supported Employment</td>
<td></td>
<td>Family Training</td>
</tr>
<tr>
<td>Case Management</td>
<td></td>
<td>Skills Training and Development</td>
</tr>
<tr>
<td>Psychiatric Diagnostic Interview Examination</td>
<td></td>
<td>Cognitive Processing Therapy</td>
</tr>
<tr>
<td>Pharmacological Management</td>
<td></td>
<td>Counseling - Individual, Group, Family</td>
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<tr>
<td>Medication Training and Support Services</td>
<td></td>
<td>Engagement Activity</td>
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<tr>
<td>Skills Training and Development</td>
<td></td>
<td>Flexible Funds and Supports</td>
</tr>
<tr>
<td>Cognitive Processing Therapy</td>
<td></td>
<td>Family and youth peer support</td>
</tr>
<tr>
<td>Counseling (incl. Cognitive Behavioral Therapy)</td>
<td><strong>MHSA Services in Public Schools</strong></td>
<td></td>
</tr>
<tr>
<td>Engagement Activity</td>
<td></td>
<td>FQHC / health clinic based BH services</td>
</tr>
<tr>
<td>Flexible Funds and Supports</td>
<td></td>
<td>Psychiatry / prescriber services in the community - agency</td>
</tr>
<tr>
<td>Peer Support - MH/SUD/COD</td>
<td></td>
<td>Psychiatry / prescriber services in the community - individual practitioner</td>
</tr>
</tbody>
</table>
## Service Taxonomy
*(Bold = Level from the Texas Utilization Management Guidelines)*

<table>
<thead>
<tr>
<th>Adult</th>
<th>Child</th>
</tr>
</thead>
<tbody>
<tr>
<td>FQHC / health clinic based BH services</td>
<td>Outpatient services in agencies (individual, family, group)</td>
</tr>
<tr>
<td>Psychiatry / prescriber services in the community - agency</td>
<td>Outpatient services by individual providers (individual, family, group)</td>
</tr>
<tr>
<td>Psychiatry / prescriber services in the community - individual practitioner</td>
<td>Early childhood MH services (e.g., Project Launch)</td>
</tr>
<tr>
<td>Outpatient services in agencies (individual, family, group)</td>
<td><strong>Advocacy Services</strong></td>
</tr>
<tr>
<td>Outpatient services by individual providers (individual, family, group)</td>
<td><strong>Education/Prevention Services</strong></td>
</tr>
</tbody>
</table>

**Advocacy Services**

**Education/Prevention Services**
Appendix Three: Best Practices Summary

Overarching Framework: Quality Improvement and Health Care

In 2001, the Institutes of Medicine (IOM) fundamentally changed the national dialogue regarding the design of health care systems through the landmark publication of their “Crossing the Quality Chasm”\textsuperscript{24} report, which became the first in a series of subsequent IOM publications that have helped shape our understanding of the need for a fundamental shift in operational priorities and health care delivery organization commitment to ongoing quality improvement. The premise of the report is in many ways 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\textsuperscript{25}).

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

In 2006, the Quality Chasm series focused its attention on mental health (MH) and substance use disorders (SUD),\textsuperscript{26} documenting severe system level quality gaps and describing a framework for improving them. The report was quite explicit in its findings, both in demonstrating the existence of effective treatment and the woeful inadequacy of most MH/SUD delivery systems in effectively promoting it:

\textit{Effective treatments exist and continually improve. However, as with general health care, deficiencies in care delivery prevent many from receiving appropriate treatments. That situation has serious consequences—for people who have the conditions; for their loved ones; for the workplace; for the education, welfare, and justice systems; and for the nation as a whole.}


\textsuperscript{25} For example, see: http://www.iso.org/iso/06_implementation_guidance.pdf.

The report goes on to note that the challenges facing MH/SUD systems are in many ways more severe than those facing the broader health system due to “...a number of distinctive characteristics, such as the greater use of coercion into treatment, separate care delivery systems, a less developed quality measurement infrastructure, and a differently structured marketplace.” (page 2) Nonetheless, the IOM recommended clearly that the advised shift from “command and control” models of quality assurance to customer-oriented quality improvement was not only necessary but possible within behavioral health systems, with similar capacity as in health care to produce better outcomes with lower costs.

The implications of the IOM’s recommended shift from command and control models to continuous quality improvement is not just about improving the quality of care delivery – it is also essential to controlling costs, as documented in one of the latest reports in the Quality Chasm series. The report states the matter in the series’ characteristically direct manner, as quoted below:

*Consider the impact on American services if other industries routinely operated in the same manner as many aspects of health care:*

- If banking were like health care, automated teller machine (ATM) transactions would take not seconds but perhaps days or longer as a result of unavailable or misplaced records.
- If home building were like health care, carpenters, electricians, and plumbers each would work with different blueprints, with very little coordination.
- If shopping were like health care, product prices would not be posted, and the price charged would vary widely within the same store, depending on the source of payment.
- If automobile manufacturing were like health care, warranties for cars that require manufacturers to pay for defects would not exist. As a result, few factories would seek to monitor and improve production line performance and product quality.
- If airline travel were like health care, each pilot would be free to design his or her own preflight safety check, or not to perform one at all.

*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;

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• care delivered was care proven reliable at the core and tailored at the margins;
• patient and family needs and preferences were a central part of the decision process;
• all team members were fully informed in real time about each other’s activities;
• prices and total costs were fully transparent to all participants;
• payment incentives were structured to reward outcomes and value, not volume;
• errors were promptly identified and corrected; and
• results were routinely captured and used for continuous improvement.

An Evidence-Based Approach for Transforming Behavioral Health Systems by Building A Systemic Customer-Oriented Quality Management Culture and Process: Comprehensive, Continuous, Integrated System of Care (CCISC)

Multiple methods have been developed for improving quality management in organizations, building on Deming’s original Plan-Check-Act-Do model, including the ISO 9001:2008 standards for manufacturing noted above, various specific quality planning approaches (e.g., kaizen, lean, six sigma, etc.), and quality frameworks for healthcare more broadly (e.g., the National Committee for Quality Assurance). It was noted above that the challenges in behavioral health systems are specific and in some ways more complex. Fortunately, over the last 15 years a specific model for behavioral health system design and implementation, consistent with the core quality improvement principles of the IOM framework, has been developed and replicated in numerous public behavioral health systems.

The Comprehensive, Continuous, Integrated System of Care (CCISC) model was developed over the past 15 years by ZiaPartners. It is an evidence-based model28 that has been identified by SAMHSA as a “best practice” for system design, and has been used in dozens of local and state systems of care internationally, in over 25 states across the U.S., and in 10 California counties. CCISC is designed to create a framework for systems to engage in this type of vision-driven transformation. It is built on the framework of the IOM Quality Chasm series, which has recommended the need for a customer-oriented quality improvement approach to inform all of health and behavioral health care. Below are the key elements:

1. The system must be built to fulfill the biggest possible vision of meeting the needs and hopes of its customers: both the individuals and families who are seeking help, and the system partners (e.g., criminal justice, child welfare, juvenile justice, homeless services, public health, etc.) that share the responsibility to respond. The emphasis always begins

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with those individuals and families who the system is currently not well designed to serve (people with co-occurring issues, people with cultural diversity, people in complex crisis, etc.).

2. The whole system must be organized into a horizontal and vertical continuous quality improvement partnership, in which all programs are responsible for their own data-driven quality improvement activities targeting the common vision that all programs become person/family-centered, recovery/resiliency-oriented, trauma-informed, complexity capable (that is, organized to routinely integrate services for individuals and families with multiple complex issues and conditions), and culturally/linguistically competent. In addition, all the major processes and subsystems (e.g., crisis response) must be reworked within this quality improvement partnership to be better matched to what people need.

3. The whole process is designed to implement a wide array of best practices and interventions into all the core processes of the system at an adequate level of detail to ensure fidelity and achieve associated outcomes. This is not about simply "funding special programs," but rather about defining what works and making sure, within the systemic continuous quality improvement (CQI) practice improvement/workforce development framework, that what works is routinely provided in all settings.

4. The whole process is data driven. Each CQI component, whether at the program level, the subsystem level, or the overall system level, is driven by commitment to measurable progress toward quantifiable objectives.

5. The whole process is built within existing resources. All systems need more resources, but it is critical to challenge ourselves to use the resources we have as wisely as possible before acquiring more. In most behavioral health systems, as noted by the IOM, poor system design produces inefficient and ineffective results, and then more resources are invested to work around the poorly designed system. The goal of CCISC is to create processes to move beyond that over time.

6. The whole process is built with the assumption that every piece of practice and process improvement needs to be anchored firmly into the supporting operational administrative structure and fiscal/regulatory compliance framework. This includes not only clinical instructions, but also resource and billing instructions, quality and data instructions, paperwork and documentation requirements, and so on. The fiscal/regulatory compliance framework can be the biggest supporter of quality-driven change, if the same rigidity that may hold ineffective processes in place is "re-wired" to hold improved clinical processes in place that are consistent with the overall values and mission of the systems. Many systems think that this cannot occur, and therefore stop trying. CCISC challenges systems to discover
the ways that financial integrity and value-driven practice can be anchored into place simultaneously.

The whole CCISC process begins with a big vision of change and puts in place a series of change processes that proceed in an incremental, stepwise fashion over time. However, because the design of the process is to create organized accountability for change at every level of the system concurrently, thereby increasing the total activation and personal responsibility for improvement by both customers and staff (both front line and managers), even though each part of the system may only take small steps, the whole system starts to make fundamental changes in its approach to doing business. Although a transformation process is by design “continuous improvement” and will involve significant changes over several years, the shift to implementation of a quality-driven framework process can occur in a relatively short time frame (e.g., six to 12 months).

National Best Practices Informing the TriWest Team Recommendations

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

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

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29 The NREPP’s searchable database can be found at: http://www.nrepp.samhsa.gov/.
literature prioritizes randomized clinical trials (RCTs) that address **efficacy** in controlled research settings, whereas practitioners require research evidence on **effectiveness** in typical practice settings. This “efficacy-effectiveness gap” was clearly defined in the 1999 U.S. Surgeon General’s report on mental health services in America\(^{31}\) and centers on the much more complex realities that practitioners face in the field. Toward that end, research that addresses the complexities of typical practice settings (for example, staffing variability due to vacancies, turnover, and differential training) is lacking, and the emphasis on RCTs is not very amenable to exploration of clinically relevant constructs like engagement and therapeutic relationships.\(^{32}\) Related uncertainties about implementing best practices include a lack of clarity about the interactions of development and ecological context with the interventions. While it is generally accepted that development involves continuous and dynamic interactions between individuals and their environments over time, and is inextricably linked to natural contexts, the efficacy research literature is largely silent on these relationships.\(^{33}\) 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 in El Paso County – involves application of practices to individuals and families from diverse cultural and linguistic backgrounds. There are inherent limitations in the research base with regard to 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 on a daily basis. Further, there is wide consensus in the literature that too little research has been carried out to document the differential efficacy of best practices across culture.\(^{34}\) Given that few best practices have documented their results in sufficient detail to determine their effectiveness cross-culturally, it makes sense that best practices be implemented within the context of ongoing evaluation and quality improvement efforts to determine whether they are effective – or more accurately, how they might need to be adapted to be maximally effective – for the local populations being served. The California Institute for Mental Health has compiled an analysis regarding the cross-

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cultural applications of major best practices. There is also increasing recognition of best practices for refugee and immigrant communities.

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

**Major Evidence-Based Practices for Children and Families**

In this section we describe evidence-based practices (EBPs) at three levels – prevention approaches, office and community-based interventions, and out-of-home treatment options. We also try to differentiate approaches by age group, where applicable.

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

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

- **The Incredible Years**\(^{41}\): The Incredible Years program focuses on preventing conduct problems from developing and intervening early in the onset of these behaviors in children, targeting infancy to school-age children. This is accomplished through an interaction of three programs aimed at improving the skills of the child (in the areas of academic and social achievement), parent (to increase communication and nurturing approaches), and teacher (promoting effective classroom management and teaching of social skills). This curriculum particularly targets risk factors for conduct disorder, and promotes a positive environment for the child both in the home and at school.

- **Positive Parenting Program (Triple-P)**\(^{42}\): This program is aimed at teaching parents strategies to prevent emotional, behavioral, and developmental problems. It includes five levels of varying intensity (from the dissemination of printed materials, to 8-10 session parenting programs and more enhanced interventions for families experiencing higher levels of relational stress). Using social learning, cognitive-behavioral, and developmental theory, in combination with studies of risk and protective factors for these problems, Triple-P aims to increase the knowledge and confidence of parents in dealing with their children’s behavioral issues.

Prevention efforts shift as children enter school (ages 6 – 12) to increase positive social interactions, decrease aggression and bullying, and increase academic motivation. School-wide initiatives such as Positive Behavioral Interventions and Supports (PBIS) have significantly decreased aggressive incidents among students and 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 (school-wide), secondary (classroom), and tertiary (individual) systems of support that improve functioning and outcomes (personal, health, social, family, work, and recreation) for all children and youth by making problem behavior less effective, efficient, and relevant, and desired

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behavior more functional. PBIS has three primary features: (1) functional (behavioral) assessment, (2) comprehensive intervention, and (3) lifestyle enhancement.⁴³

The value of school-wide PBIS integrated with mental health, according to the Bazelon Center, lies in its three-tiered approach. Eighty percent of students fall into the first tier. For them, school-wide PBIS creates “a social environment that reinforces positive behavior and discourages unacceptable behaviors.”⁴⁴ A second tier of students benefits from some additional services, often provided in coordination with the mental health system. This, the report notes, makes it “easier to identify students who require early intervention to keep problem behaviors from becoming habitual” and to provide that intervention. Finally, tier-three students, who have the most severe behavioral-support needs, can be provided intensive services through partnerships between the school, the mental health system, other child-serving agencies, and the child’s family.

**Office and Community-Based Interventions**

There is growing evidence that, in most situations, children 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, with the exception of youth with highly complex needs or dangerous behaviors, such as fire setting or repeated sexual offenses, programs in community settings are more effective than those in institutional settings, with intensive, community-based and family-centered interventions the most promising. Even children and adolescents with SEDs 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 adolescents has rapidly developed in recent years. The ideal system would have treatment protocols offered in clinics, schools or homes with the objective of: 1) decreasing problematic symptoms and behaviors, 2) increasing youth’s and parents’ skills and coping and/or 3) preventing out-of-home placement. Core components of some of these interventions should

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

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

- **Parent-Child Interaction Therapy (PCIT)** has strong support as an intervention for use with children ages three to six who are experiencing oppositional disorders or other problems.\(^{45}\) PCIT works by improving the parent-child attachment through coaching parents in behavior management. It uses play and communication skills to help parents implement constructive discipline and limit setting. In order to improve the parent-child attachment through behavior management, the PCIT program uses structural play and specific communication skills to teach parents and children constructive discipline and limit setting. PCIT teaches parents how to assess their child’s immediate behavior and give feedback while the interaction is occurring. In addition, parents learn how to give their child direction towards positive behavior. The therapist guides parents through education and skill building sessions and oversees practicing sessions with the child. PCIT has been adapted for use with Hispanic and Native American families.

- **Early Childhood Mental Health Consultation** in early childhood settings, such as child care centers, emphasizes problem-solving and capacity-building intervention within a collaborative relationship between a professional consultant with mental health expertise and one or more individuals, primarily child care center staff, with other areas of expertise.\(^{46}\) Early childhood mental health consultation aims to build the capacity

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El Paso Community Behavioral Health Assessment

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

- **Applied Behavior Analysis (ABA)** has good support for the treatment of autism in young children in particular.\(^{47}\) ABA can be used in a school or clinic setting and is typically delivered between two and five days per week for two weeks to 11 months. ABA is one of the most widely used approaches with this population. The ABA approach teaches social, motor, and verbal behaviors, as well as reasoning skills. ABA teaches skills through use of behavioral observation and positive reinforcement or prompting to teach each step of a behavior. Generally, ABA involves intensive training of the therapists, extensive time spent in ABA therapy (20-40 hours per week), and weekly supervision by experienced clinical supervisors known as certified behavior analysts. It is preferred that a parent or other caregiver be the source for the generalization of skills outside of school. In the ABA approach, developing and maintaining a structured working relationship between parents and professionals is essential to ensure consistency of training and maximum benefit.

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• **Preschool Post-Traumatic Stress Disorder Treatment** is an approach adapted from trauma-focused cognitive behavioral therapy (TF-CBT – see below) and trauma-focused coping to help young children recover from traumatic events with support from their parents throughout the treatment process.

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

- **Behavior Therapy** has support for the treatment of attention and hyperactivity disorders; substance abuse; depression; and conduct problems. Typically, behavior therapy features behavior management techniques taught to teachers / parents to aid the child in replacing negative behaviors with more positive ones.\(^{48}\)

- **Brief Strategic Family Therapy (BSFT)** is a problem-focused, family-based approach to the elimination of substance abuse risk factors. It targets problem behaviors in children and adolescents six to 17 years of age, and strengthens their families. BSFT provides families with tools to decrease individual and family risk factors through focused interventions that improve problematic family relations and skill building strategies that strengthen families. It targets conduct problems, associations with anti-social peers, early substance use and problematic family relations.\(^{49}\)

- **Cognitive Behavior Therapy (CBT)** is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.\(^{50}\) It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For children and youth, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder. CBT can be used for anxious and avoidant disorders, depression, substance abuse, disruptive behavior, and ADHD. It can be used with family intervention. Specific pediatric examples include Coping Cat and the Friends Program. CBT works with the individual to understand their behaviors in the context of their

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environment, thoughts and feelings. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

- **Trauma-Focused Cognitive Behavioral Therapy (TF-CBT)** has strong support for efficacy with children and youth aged three to 18 years old, and their parents.\(^5\) It can be provided in individual, family, and group sessions in outpatient settings. TF-CBT addresses anxiety, self-esteem and other symptoms related to traumatic experiences. TF-CBT is a treatment intervention designed to help children, youth, and their parents overcome the negative effects of traumatic life events such as child sexual or physical abuse; traumatic loss of a loved one; domestic, school, or community violence; or exposure to disasters, terrorist attacks, or war trauma. It integrates cognitive and behavioral interventions with traditional child abuse therapies, in order to focus on enhancing children's interpersonal trust and re-empowerment. TF-CBT has been applied to an array of anxiety symptoms as well as: intrusive thoughts of the traumatic event; avoidance of reminders of the trauma; emotional numbing; excessive physical arousal/activity; irritability; and trouble sleeping or concentrating. It also addresses issues commonly experienced by traumatized children, such as poor self-esteem, difficulty trusting others, mood instability, and self-injurious behavior, including substance use. TF-CBT has been adapted for Hispanic/Latino children and some of its assessment instruments are available in Spanish.

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

- **Wraparound Service Coordination** (based on the standards of the National Wraparound Initiative) is an integrated care coordination approach delivered by professionals,


alongside youth and family partners, for children involved with multiple systems and at the highest risk for out-of-home placement.\textsuperscript{52} Wraparound is not a treatment per se. Instead, wraparound facilitation is a care coordination approach that fundamentally changes the way in which individualized care is planned and managed across systems. The wraparound process aims to achieve positive outcomes by providing a structured, creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and more relevant to the child and family. Additionally, wraparound plans are more holistic than traditional care plans in that they address the needs of the youth within the context of the broader family unit and are also designed to address a range of life areas. Through the team-based planning and implementation process, wraparound also aims to develop the problem-solving skills, coping skills and self-efficacy of the young people and family members. Finally, there is an emphasis on integrating the youth into the community and building the family’s social support network. The wraparound process also centers on intensive care coordination by a child and family team (CFT) coordinated by a wraparound facilitator. The family, the youth, and the family support network comprise the core of the CFT members, joined by parent and youth support staff, providers involved in the care of the family, representatives of agencies with which the family is involved, and natural supports chosen by the family. The CFT is the primary point of responsibility for coordinating the many services and supports involved, with the family and youth ultimately driving the process. The wraparound process involves multiple phases over which responsibility for care coordination increasingly shifts from the wraparound facilitator and the CFT to the family (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).

- **Dialectical Behavior Therapy (DBT) Approaches for Adolescents** is well supported for adults, but also has moderate support for helping youth to develop new skills to deal with emotional reaction and to use what they learn in their daily lives.\textsuperscript{53} DBT for youth


often includes parents or other caregivers in the skills-training group so that they can coach the adolescent in skills and so they can improve their own skills when interacting with the youth. Therapy sessions usually occur twice per week. There are four primary sets of DBT strategies, each set including both acceptance-oriented and more change-oriented strategies. Core strategies in DBT are validation (acceptance) and problem-solving (change). Dialectical behavior therapy proposes that comprehensive treatment needs to address four functions. It needs to help consumers develop new skills, address motivational obstacles to skill use, generalize what they learn to their daily lives, and keep therapists motivated and skilled. In standard outpatient DBT, these four functions are addressed primarily through four different modes of treatment: group skills training, individual psychotherapy, telephone coaching between sessions when needed, and a therapist consultation team meeting, respectively. Skills are taught in four modules: mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness.

- **Functional Family Therapy (FFT)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for targeted populations. FFT is a research-based family program for at risk adolescents and their families, targeting youth between the ages of 11 and 18. It has been shown to be effective for the following range of adolescent problems: violence, drug abuse/use, conduct disorder, and family conflict. FFT targets multiple areas of family functioning and ecology for change, and features well developed protocols for training, implementation (i.e., service delivery, supervision, and organizational support), and quality assurance and improvement. FFT focuses on family alliance and involvement in treatment. The initial focus is to motivate the family and prevent dropout. The treatment model is deliberately respectful of individual differences, cultures, and ethnicities, and aims for obtainable change with specific and individualized intervention that focuses on both risk and protective factors. Intervention incorporates community resources for maintaining, generalizing and supporting family change.

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• **Multidimensional Family Therapy (MDFT)** is a family-based program designed to treat substance abusing and delinquent youth. MDFT has good support for Caucasian, African American and Hispanic/Latino youth between the ages of 11 and 18 in urban, suburban and rural settings. Treatment usually lasts between four to six months and can be used alone or with other interventions. MDFT is a multi-component and multilevel intervention system that assesses and intervenes at three levels including: adolescent and parents individually, family as an interacting system, and individuals in the family, relative to their interactions with influential social systems (e.g., school, juvenile justice) that impact the adolescent’s development. MDFT interventions are solution-focused and emphasize immediate and practical outcomes in important functional domains of the youth’s everyday life. MDFT can operate as a stand-alone outpatient intervention in any community-based clinical or prevention facility. It also has been successfully incorporated into existing community-based drug treatment programs, including hospital-based day treatment programs.

• **Multisystemic Therapy (MST)** is a well-established EBP with proven outcomes and cost benefits when implemented with fidelity for youth living at home with more severe behavioral problems related to willful misconduct and delinquency. In addition, the developers are currently working to develop specialized supplements to meet the needs of specific sub-groups of youth. MST is an intensive home-based service model provided to families in their natural environment at times convenient to the family. MST is intensive and comprehensive with low caseloads and varying frequency, duration, and intensity levels. MST is based on social-ecological theory that views behavior as best understood in its naturally occurring context. MST was developed to address major limitations in serving juvenile offenders and focuses on changing the determinants of

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youth anti-social behavior. At its core, MST assumes that problems are multi-determined and that, in order to be effective, treatment needs to impact multiple systems, such as a youth’s family and peer group. Accordingly, MST is designed to increase family functioning through improved parental monitoring of children, reduction of familial conflict, improved communication, and related factors. Additionally, MST interventions focus on increasing the youth’s interaction with “prosocial” peers and a reduction in association with “deviant” peers, primarily through parental mediation. MST-Psychiatric (MST-P) is an approach similar to MST, but adapted for teens with serious emotional disorders.

- **Assertive Community Treatment (ACT) for Transition-Age Youth** uses a recovery/resilience orientation, which offers community-based intensive case management and skills-building in various life domains, as well medication management and substance abuse services for youth ages 18 – 21, with severe and persistent mental illness. More broadly, ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the fields of psychology, social work, rehabilitation, counseling, and occupational therapy. Given the breadth of expertise represented on the multidisciplinary team, ACT provides a range of services to meet individual consumer needs, including (but not limited to) service coordination, crisis intervention, symptom and medication management, psychotherapy, co-occurring disorders treatment, employment services, skills training, peer support, and wellness recovery services. The majority of ACT services are delivered to the consumer within his or her home and community, rather than provided in hospital or outpatient clinic settings, and services are available around the clock. Each team member is familiar with each consumer served by the team and is available when needed for consultation or to provide 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

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housing or employment), and continuous high service needs (such as long-term or multiple acute inpatient admissions or frequent use of crisis services).\textsuperscript{60, 61}

**Out-of-Home Intervention Options**

Treatment of youth in residential facilities is no longer thought to be the most beneficial way to treat those with significant difficulties. The 1999 Surgeon Generals’ Report on Mental Health states: “Residential treatment centers (RTC) are the second most restrictive form of care (next to inpatient hospitalization) for children 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.”

Residential treatment represents a necessary component of the continuum of care for children and adolescent youth whose behavior is not managed effectively in a less restrictive setting. However, residential treatment is among the most restrictive mental health services provided to children and youth and, as such, should be reserved for situations when less restrictive placements are ruled out. For example, specialized residential treatment services are supported for youth with highly complex needs or dangerous behaviors, such as fire setting, that may not respond to intensive, nonresidential service approaches (Stroul, 2007). Yet, on a national basis children and youth are too often placed in residential treatment because more appropriate community-based services are not available.

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

**A family-driven, youth-guided, community-based plan** should follow the child or youth across all levels of care (including out-of-home placements, as applicable) and help him/her return to home as quickly as possible, knitting together an individualized mix from among the following array of services.


A full continuum of crisis response, with mobile supports and short- to intermediate-term, local out-of-home options, including respite, psychosocial and behavioral health interventions for youth and their families should include:

- A mobile crisis team for children and families, with the capacity to provide limited ongoing in-home supports, case management and direct access to out-of-home crisis supports (for a national example, Wraparound Milwaukee’s Mobile Urgent Treatment Team / MUTT\textsuperscript{62} is offered).
- A bio-psychosocial assessment, supported by protocols to communicate assessment results across professionals and to determine the appropriate level of services.
- An array of crisis supports tailored to the needs and resources of the local system of care, including an array of options such as:
  - Crisis foster care (a few days up to 30 days),
  - Crisis group home (up to 14 days),
  - Crisis respite (up to three days),
  - Crisis runaway shelter (15 days),
  - Crisis stabilization (30 – 90 days) with capacity for 1:1 mental health crisis intervention,
  - Crisis supervision (30 – 90 days) to maintain safety in the community,
  - Placement stabilization center, providing out-of-home respite,
  - Acute inpatient care,
  - Consultation, and
  - Linkages to a full continuum of empirically supported practices.

A residential continuum of placement types, grounded in continued connections and accountability to the home community, with a focus on specialized programming, including treatment foster care (Multidimensional Treatment Foster Care 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\textsuperscript{63}), gender-responsive services that go beyond just a willingness to serve female

\textsuperscript{62} For more information, see: http://county.milwaukee.gov/MobileUrgentTreatmen10109.htm. While the MUTT model has not been demonstrated at the level of an EBP, it is widely cited as a best practice and has been the basis of EPSDT settlements in Massachusetts (Rosie D.) and many other positive systems reforms for children’s systems of care nationally.


youth and that include a continuum of out-of-home treatment options for young women with behavioral health needs (including histories of sexual maltreatment) and specialized residential programming for youth with gender-identity issues, and residential placement options that vary by intensity of service provided, primary clinical needs addressed, and targeted length of stay, emphasizing acute-oriented programs to serve as an inpatient alternative, in which children and youth can have behaviors that require longer than a typical acute inpatient stay to be stabilized, complex needs evaluated, and treatment begun while transition planning back to a more natural environment takes place.

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

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

**Best Practices for Adults and Older Adults**

Best practices for adults and older adults with severe needs are emphasized, differentiating between interventions that are well established and those that are promising:

a) **Well established** interventions may be characterized by their support from randomized controlled studies, as well as evidence from real-world care settings. Further, well established interventions are sufficiently documented to allow tracking of fidelity to established standards.

b) **Promising interventions** are supported by methodologically sound studies in either controlled or routine care settings and are sufficiently documented to allow at least limited fidelity tracking.

**Well Established Practices for Adults and Older Adults**

**Assertive Community Treatment (ACT).** ACT is an integrated, self-contained service approach in which a range of treatment, rehabilitation, and support services are directly provided by a multidisciplinary team composed of psychiatrists, nurses, vocational specialists, substance abuse specialists, peer specialists, mental health professionals, and other clinical staff in the


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

The Substance Abuse and Mental Health Services Administration (SAMHSA) also developed an ACT Implementation Kit (often referred to as a “toolkit”) to provide guidance for program implementation. More recent ACT promotion efforts seeking to systematically promote consistent outcomes across programs over time in the states of Washington, Indiana, North Carolina, and elsewhere have focused on supporting ACT service development through a comprehensive process of interactive, qualitative fidelity monitoring of clinical services using best practice measures such as the Tool for Measurement of Assertive Community Treatment (TMACT). This is the current standard in the field and represents the best currently known way to broadly develop high quality teams system wide building on the lessons of best practice implementation science. Such an approach is particularly critical because high fidelity implementation of programs like ACT is a predictor of good outcomes and of system wide cost

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savings.\textsuperscript{68} Rigorous fidelity assessment also provides a basis for needed service delivery enhancements within a continuous quality improvement (CQI) process. In effect, qualitative clinical services monitoring will help ensure fidelity to the ACT model, evaluate whether settlement stipulations are being met, and contribute to a continuous quality improvement process.

ACT is one of the most well-studied service approaches for persons with SPMI, with over 50 published studies demonstrating its success\textsuperscript{69}, 25 of which are randomized clinical trials (RCTs).\textsuperscript{70} Research studies indicate that when compared to treatment as usual (typically standard case management), ACT substantially reduces inpatient psychiatric hospital use and increases housing stability, while moderately improving psychiatric symptoms and subjective quality of life for people with serious mental illnesses.\textsuperscript{71} Studies also show that consumers and their family members find ACT more satisfactory than comparable interventions and that ACT promotes continuity.

This intervention is most appropriate and cost-effective for people who experience the most serious symptoms of mental illness, have the greatest impairments in functioning, and have not benefited from traditional approaches to treatment. It is often used as an alternative to restrictive placements in inpatient or correctional settings.

**Cognitive Behavior Therapy (CBT).** CBT is widely accepted as an evidence-based, cost-effective psychotherapy for many disorders.\textsuperscript{72} It is sometimes applied in group as well as individual settings. CBT can be seen as an umbrella term for many different therapies that share some common elements. For adults and older adults, CBT is often used to treat depression, anxiety disorders, and symptoms related to trauma and Post Traumatic Stress Disorder.


CBT can also be used for Substance Abuse, Eating Disorders, and ADHD. It can be used with family intervention. The premise is that a person can change the way they feel/act despite the environmental context. CBT programs can include a number of components including psychoeducation, social skills, social competency, problem solving, self-control, decision making, relaxation, coping strategies, modeling, and self-monitoring.

**Collaborative Care.** Collaborative Care is a model of integrating mental health and primary care services in primary care settings in order to: (1) treat the individual where he or she is most comfortable; (2) build on the established relationship of trust between a doctor and consumer; (3) better coordinate mental health and medical care; and (4) reduce the stigma associated with receiving mental health services.73

Two key principles form the basis of the Collaborative Care model:

1. Mental health professionals or allied health professionals with mental health expertise are integrated into primary care settings to help educate consumers, monitor adherence and outcomes, and provide brief behavioral treatments according to evidence-based structured protocols; and
2. Psychiatric and psychological consultation and supervision of care managers is available to provide additional mental health expertise where needed.

Key components of the Collaborative Care model include screening, consumer education and self-management support, stepped up care (including mental health specialty referrals as needed for severe illness or high diagnostic complexity), and linkages with other community services such as senior centers, day programs or Meals on Wheels.74

Several randomized studies have documented the effectiveness of collaborative care models to treat anxiety and panic disorders,75 depression in adults,76 and depression in older adults.77 For example, a study of IMPACT (Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression) – a multi-state Collaborative Care program with study sites in multiple

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See also President’s New Freedom Commission on Mental Health Final Report at 66.
states – led to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission as compared to usual primary care. The 2003 Final Report of the President’s New Freedom Commission on Mental Health suggested that collaborative care models should be widely implemented in primary health care settings and reimbursed by public and private insurers.

**Dialectical Behavior Therapy (DBT).** Dialectical Behavior Therapy (DBT) is a modification of cognitive behavioral therapy in which an ongoing focus on behavioral change is balanced with acceptance, compassion, and validation of the consumer. Services are delivered through individual therapy, skills group sessions, and telephonic coaching.

Randomized studies have shown that DBT reduces severe dysfunctional behaviors that are targeted for intervention, increases treatment retention, and reduces psychiatric hospitalization. Although published follow-up data are limited, the available data indicate that improvements may remain up to one year after treatment. DBT is specifically designed to address the particular needs of people who have borderline personality disorder and/or self-harming behaviors.

**Family Psychoeducation.** Family psychoeducation is a method of working in partnership with families to provide current information about mental illness and to help families develop increasingly sophisticated coping skills for handling problems posed by mental illness in one member of the family. They last from nine months to five years, are usually diagnosis specific, and focus primarily on consumer outcomes, although the well-being of the family is an essential intermediate outcome. Under this approach, the practitioner, consumer, and family work together to support recovery, incorporating individual, family, and cultural realities and perspectives.

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Family psychoeducation can be used in a single family or multi-family group format and can vary in terms of the duration of treatment, consumer participation, and treatment setting, depending on the consumers and family’s wishes, as well as empirical indications. Although several treatment models exist, the following are essential elements of any evidence-based program:\footnote{See literature review provided in McFarlane, W., Dixon, L., Lukens, E., and Lucksted, A. (2003). Family Psychoeducation and Schizophrenia: A Review of the Literature. 29 Journal of Marital and Family Therapy, 2, 223-245.}

1. The intervention should span at least nine months.
2. The intervention should include education about mental illness, family support, crisis intervention, and problem solving.
3. Families should participate in education and support programs.
4. Family members should be engaged in the treatment and rehabilitation of consumers who are mentally ill.
5. The information should be accompanied by skills training, ongoing guidance about management of mental illness, and emotional support for family members.
6. Optimal medication management should be provided.

Extensive research demonstrates that family psychoeducation significantly reduces rates of relapse and re-hospitalization. When compared to consumers who received standard individual services, differences ranged from 20-50% over two years. Recent studies have shown employment rate gains of two to four times baseline levels, especially when combined with supported employment, another best practice. Families report a decrease in feeling confused, stressed, and isolated and also experience reduced medical care costs. In addition, studies consistently indicate a very favorable cost-benefit ratio, especially in savings from reduced hospital admissions, reduction in hospital days, and in crisis intervention contacts.

The SAMHSA/CMHS Family Psychoeducation Resource Kit suggests that family psychoeducation is most beneficial for people with the most severe mental illnesses and their families. Although most research involves consumers with schizophrenia, improved outcomes have been found with other psychiatric disorders, including bipolar disorder, major depression, obsessive-compulsive disorder, anorexia nervosa, and borderline personality disorder.

**Gatekeeper Program.** The Gatekeeper Program engages and trains a range of community members who have frequent contact with older adults – such as utility, cable telephone, bank, housing, and postal workers – as well as emergency medical technicians, firefighters, police
officers, and other first responders to identify older adults who may need mental health services and report them to a central information and referral office.\(^{83}\)

After referral, a clinical case manager and nurse visit the individual at his or her home, making repeat visits as needed to overcome the individual’s suspicion and promote engagement. An interdisciplinary team, usually including a psychiatrist and physician, develop a plan of care and, if appropriate, meets with the individual’s family with a goal of providing community-based rather than institutional services.

Research suggests that the Gatekeeper Program is effective in reaching older adults with mental illnesses who are more likely to be economically and socially isolated than older adults referred by a medical provider or other traditional referral source.\(^{84}\) Some studies found that Gatekeeper referrals were no more likely to be placed out-of-home than those referred by other sources.\(^{85}\) Although there is limited data regarding specific clinical outcomes associated with the Gatekeeper Program, a recent literature review suggests that multidisciplinary approaches to serving older adults in their homes may be effective in reducing symptom severity.

**Illness Management and Recovery.** Illness Management and Recovery (IMR) is a set of specific evidence-based practices for teaching people with severe mental illness how to manage their disorder in collaboration with professionals and significant others in order to achieve personal recovery goals. These practices include: (1) psychoeducation; (2) behavioral tailoring to improve medication adherence; (3) relapse prevention training; (4) increasing coping skills; and (5) social skills training. IMR involves a series of weekly sessions in which specially trained professionals use these practices to help people who have experienced psychiatric symptoms in developing personal strategies for coping with mental illness and moving forward in their lives.\(^{86}\)

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\(^{84}\) Van Citters, A.D. and Bartels, S.J. (2004). A Systematic Review of the Effectiveness of Community-Based Mental Health Outreach Services for Older Adults. Psychiatric Services, 55,1237-1249.


Practitioners educate consumers on nine topic areas, ranging from recovery strategies and illness information, to coping with stress and finding help in the mental health system. IMR practitioners combine motivational, educational, and cognitive-behavioral strategies aimed at helping consumers make progress towards personal recovery goals. The program can be provided in an individual or group format and generally lasts between three and six months.

Research has demonstrated that IMR can increase an individual's knowledge about mental illness, reduce relapses and hospitalizations, help consumers cope more effectively, reduce distress from symptoms, and assist consumers in using medications more effectively. In addition, when using IMR practitioners often report a high rate of job satisfaction as consumers learn to reduce relapses, avoid hospitalization, and make steady progress toward personalized recovery goals.

This intervention is most appropriate for people who have experienced symptoms of schizophrenia, bipolar disorder, or depression at various stages of the recovery process. Emerging research suggests that this intervention may also be effective for people with serious mental illnesses in the criminal justice system.

Integrated Dual Disorder Treatment (IDDT) for Co-Occurring Mental Illness and Substance Use Disorders. Integrated Dual Disorder Treatment (IDDT) provides mental health and substance abuse services through one practitioner or treatment team and co-locates all services in a single agency (or team) so that the consumer is not excluded from or confused by multiple programs. IDDT encompasses 14 components, each of which is evidence-based, including but not limited to: (1) screening and assessments that emphasize a “no wrong door” approach; (2) “blended” treatment to ensure compatibility in treatment approaches; (3) stage-wise treatment that recognizes that different services are helpful at different stages of the recovery process; and (4) motivational interviewing and treatment, using specific listening and counseling skills to develop consumer awareness, hopefulness, and motivation for recovery.

Combined mental health and substance abuse treatment is effective at engaging people with both diagnoses in outpatient services, maintaining continuity and consistency of care, reducing

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hospitalization, and decreasing substance abuse, while at the same time improving social functioning. Integrated treatment also reduces symptoms of mental disorders and overall treatment costs. Fidelity to the components of IDDT is clearly tied to better clinical outcomes.

This intervention is appropriate for individuals with co-occurring mental illness and substance use disorders. A “conceptual framework” developed jointly by the National Association of State Mental Health Directors (NASMHPD) and the National Association of State Alcohol and Drug Abuse Directors (NASADAD) suggests that mental health and substance abuse treatment should be provided along a continuum of coordination, collaboration, and integration among service systems, depending on the severity of the mental illness and substance abuse disorder.

**Motivational Interviewing.** People with substance use disorders or co-occurring mental illness and substance use often are not ready to attempt to make changes in their use of substances. Clinical leaders and researchers argue that if people have not moved beyond the stage of preparing for or becoming determined to make changes in their behavior, then the focus needs to be not on changing behavior but on increasing motivation so that the person is ready to take action toward making these changes.

Motivational Interviewing (MI) is an EBP that was developed to help increase motivation to

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reduce use of substances and to recover from substance use disorders. Motivational Interviewing combines principles of empathic responding with elements of behavioral analysis, including careful identification of the unique set of rewards and punishments that influence a given person's behavior. The clinician helps the person clarify his or her most important goals and the advantages and disadvantages associated with achieving those goals. Clinicians adopt an objective, nonjudgmental stance in their work with consumers. Reviews of studies generally find MI to be an effective substance abuse intervention, with some indication that it is particularly effective in ethnic minority study samples. Although the evidence base for MI with adolescents may not yet be quite as strong as for adults, MI is widely used in the juvenile justice system as a behavior change intervention.

In a review of studies, Apodaca and Longabaugh (2009) found that certain aspects of MI were associated with better outcomes and that when therapists' behavior was inconsistent with MI principles outcomes were worse. Core principles of MI include the following (Corrigan et al., 2005):

- **Express Empathy** – Use reflective listening to help consumers clarify the advantages and disadvantages associated with behavior change. It promotes honest discussion of the person's reluctance and concerns about reducing use.
- **Develop Discrepancy** – Clinicians help clarify, in a non-confrontational manner, the ways in which not changing substance use and other behaviors associated with it are interfering with the attainment of consumers' most important goals.
- **Avoid Argumentation** – Clinicians avoid direct confrontation of the person and slipping into an argumentative style of relating.
- **Roll with Resistance** – Motivational Interviewing clinicians view clients' resistance as an indication that they (the clinicians) are not addressing issues the consumer believes are important or relevant; they use resistance as a way to try to help the person focus on actual barriers to change.
- **Support Self-Efficacy** – The Motivational Interviewing approach assumes that consumers are responsible for change. Clinicians attempt to convey confidence in the consumers—that she or he will decide to change and begin to reduce substance use when they are ready to do so.

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**Supported Employment.** Supported Employment promotes rehabilitation and a return to mainstream employment for persons with serious mental illnesses and co-occurring disorders. Supported Employment programs integrate employment specialists with other members of the treatment team to ensure that employment is an integral part of the treatment plan. Employment specialists are responsible for carrying out vocational services while all members of the treatment team understand and promote employment. All Supported Employment programs are based on the following principles:

1. Eligibility is based on consumer choice. Individuals interested in employment are not screened for job readiness.
2. Supported employment is integrated with treatment. Employment specialists coordinate plans with the treatment team, including the case manager, therapist, psychiatrist, and others.
3. Competitive employment is the goal. The focus is on community jobs in integrated settings that anyone can apply for that pay at least minimum wage, including both part-time and full-time work.
4. Job search starts soon after a consumer expresses interest in working. There are no requirements for completing extensive pre-employment assessment and training, or intermediate work experiences (like transitional employment or sheltered workshops). Follow-along supports are continuous.
5. Individualized supports to maintain employment continue as long as consumers want the assistance.
6. Consumer preferences are important.
7. Vocational Specialists collaborate with the person’s natural support networks and with employers (when the consumer wants his or her status as a mental health consumer disclosed to the employer).

A considerable body of research indicates that Supported Employment models, such as Independent Placement and Support (IPS), are successful in increasing competitive employment among consumers. A seven-state, multi-site study supported by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) found that Supported Employment participants were significantly more likely (55%) than comparison participants (34%) to achieve competitive employment. A review of three randomized controlled trials found that, in

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general, 60-80% of people served by a Supported Employment model obtain at least one competitive job.\textsuperscript{101}

In addition, the research consistently shows that specific consumer factors such as diagnosis, age, gender, disability status, prior hospitalization, co-occurring substance abuse disorder, and education are not strong or consistent predictors of an individual’s work outcomes.\textsuperscript{102} Supported employment remains more effective than traditional vocational services for consumers with both good and poor work histories. This intervention should be offered to all individuals with mental illnesses and/or co-occurring disorders who want to work, regardless of prior work history, housing status, or other population characteristics.\textsuperscript{103}

**Promising Practices for Adults and Older Adults**

**Case Management.** The primary purpose of case management is to coordinate service delivery and to ensure continuity and integration of services.\textsuperscript{104} There are many models of case management for people with mental illnesses. Clinical case management and targeted case management generally include at least five integrated functions: (1) assessing consumers’ needs; (2) planning service strategies to respond to identified needs; (3) linking consumers to appropriate services, including non-mental health specialty services such as housing, employment supports, or other social services; (4) monitoring consumers’ progress to detect changing needs; and (5) providing follow up and ongoing evaluation.\textsuperscript{105} Some models may also include limited skills building techniques.

In addition, intensive case management may also involve the actual delivery of service. ACT is sometimes thought of as a model of intensive case management, although many distinguish


intensive case management as usually relying less on a team approach to service delivery, likely involving more brokering than delivery of services, and focusing more on facilitating participation by consumers in treatment decisions.

Considerable research suggests the effectiveness of intensive case management models, including ACT, in reducing inpatient use among high-risk consumers. Several studies also suggest improvements in clinical and social outcomes over conventional case management approaches. However, at least one recent study has suggested that intensive case management programs are effective only in community settings where there is an ample supply of treatment and support services.

There is less of a research base to support more traditional clinical and targeted case management approaches. One review of the research found that clinical case management was as effective as ACT in reducing symptoms of illness, improving social functioning, and increasing consumer and family satisfaction with services. However, that review also found that clinical case management increased hospitalizations and the proportion of consumers hospitalized.

**Comprehensive Crisis Services.** In general, crisis services involve short-term, round-the-clock help provided in a non-hospital setting during a crisis with the purposes of stabilizing the individual, avoiding hospitalization or other high-cost services, and helping individuals return to pre-crisis functioning as quickly as possible. Crisis services can also help assure that emergency room, ambulance, law officer, and jail resources are not inappropriately utilized for behavioral health crises.

Best practice components of comprehensive crisis services include but are not limited to:

1. A 24-hour telephone response system staffed by qualified mental health professionals with immediate capacity for face-to-face assessment and on-call consultation with a psychiatrist.
2. Mobile services capacity with transportation to assist individuals in getting to stabilization facilities.

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3. Access to short-term intensive residential treatment resources for stabilization and hospital diversion.
4. Cultural and linguistic competency to facilitate assessment.
5. Access to appropriate linkages with other healthcare resources.

Research suggests that when crisis services are provided in non-hospital settings, the likelihood of inpatient admission is reduced.\(^{110}\) At least one study has found that, for individuals with serious mental illness in need of hospital level care and willing to accept voluntary treatment, residential crisis centers provided the same outcomes as inpatient hospitals for significantly less cost.\(^{111}\)

Comprehensive crisis services are appropriate for individuals with an acute mental illness experiencing a crisis that puts them at risk of hospitalization or other high-cost care.

**Peer Support.** Peer Support is a service through which consumers can: (1) direct their own recovery and advocacy process and (2) teach and support each other in the acquisition and exercise of skills needed for management of symptoms and for utilization of natural resources within the community.\(^{112}\) This service typically provides structured, scheduled activities that promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills, often under the direct supervision of a mental health professional. Peer Support can also encompass a range of supports delivered by consumers, including informal services or as part of a consumer-operated service.

An innovative Georgia model, which receives Medicaid reimbursement for Peer Support and which has been replicated in several states, emphasizes the role of Certified Peer Specialists, who provide direct services to assist consumers in developing the perspective and skills to facilitate recovery and who also model the possibility of recovery through their own experiences as consumers engaged in self-directed recovery. A job description defines specific support activities, including helping consumers create a wellness recovery action plan and supporting vocational choices.

The Georgia certification process includes two required weeklong trainings followed by a written and oral examination, as well as periodic continuing education seminars and


workshops. Certified Peer Specialists are paid employees of public and private providers and operate as part of a clinical team, which can be integrated into a range of emergency, outpatient (including ACT), or inpatient settings. A Georgia-model Peer Support service reimbursable under Medicaid must be operated at least 12 hours a week, at least four hours per day for at least three days per week.

Emerging evidence suggests that integrating peer specialists into a range of treatment approaches may lead to better outcomes for consumers. For example, one controlled study found that individuals served by case management teams that included consumers as peer specialists had experienced increases in several areas of quality of life and reductions in major life problems, as compared to two comparison groups of individuals served by case management teams that did not include peer specialists.113

Under the Medicaid-reimbursable model implemented in Georgia, peer support services are geared toward consumers with severe and persistent mental illness. These consumers may have co-occurring mental retardation or substance abuse disorders.114

**Respite Care.** Respite care is designed to provide community-based, planned or emergency short-term relief to family caregivers, alleviating the pressures of ongoing care and enabling individuals with disabilities to remain in their homes and communities.115 Respite care frequently is provided in the family home. Without respite care, many family caregivers experience significant stress, loss of employment, financial burdens, and marital difficulties.

Little existing research is available regarding the effectiveness of this intervention either for family caregivers or mental health consumers. The majority of family caregiving studies identify a need for greater quality, quantity, variety, and flexibility in respite provision.116

**Standardized Screening for Substance Abuse Disorders.** Effective treatment for co-occurring disorders begins with accurate screening and assessment in settings where individuals present

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for treatment. Failure to detect substance abuse disorders can result in a misdiagnosis of mental disorders, sub-optimal pharmacological treatments, neglect of appropriate substance abuse interventions, and inappropriate treatment planning and referral. In addition, since use of even limited amounts of alcohol or other drugs can be associated with negative outcomes among people with mental illnesses, routine screening is an important component of mental health prevention and treatment.

The clinical screening process enables a service provider to assess if an individual demonstrates signs of substance abuse or is at risk of substance abuse. Screening is a formal process that is typically brief and occurs soon after the consumer presents for services. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment.

A broad range of effective screening tools exist for specific populations. Many are brief self-report screens that can be completed as part of an initial intake interview for an individual with a severe mental illness. For example, Washington State is currently using the Global Appraisal of Individual Needs – Short Screener (GAIN-SS), a shortened version of a leading tool for a broad range of substance use. In addition, the Michigan Alcoholism Screening Test (MAST) is considered reliable and valid as a screening tool for persons with primary alcoholism, but includes items that are irrelevant or confusing for people with severe mental illness. Research suggests that the Dartmouth Assessment of Life Style Instrument (DALI) is effective for individuals with acute mental illness.

121 RachBeisel, et al. (1999).
Prevention and both early identification and intervention of substance abuse disorders are appropriate for individuals of all ages, but are especially critical for young people and individuals whose substance use problems have not risen to the level of seriousness to require treatment.

**Supportive Housing.** Supportive housing (sometimes called supported housing) is a term used to describe a wide range of approaches and implementation strategies to effectively meet the housing needs of people with disabilities, including people with mental illnesses. Supportive housing may include supervised apartment programs, scattered site rental assistance, and other residential options. NASMHPD has identified supportive housing as a best practice in the field, and SAMHSA’s Center for Mental Health Services is in the process of developing an Evidence-Based Practice Implementation Resource Kit for this approach.

The overall goal of supportive housing is to help consumers find permanent housing that is integrated socially, reflects their personal preferences, and encourages empowerment and skills development. Program staff provide an individualized, flexible, and responsive array of services, supports, and linkages to community resources, which may include such services as employment support, educational opportunities, integrated treatment for co-occurring disorders, recovery planning, and assistance in building living skills. The level of support is expected to fluctuate over time.

Numerous studies of consumer preferences agree that mental health consumers generally prefer normal housing and supports over congregate residential living. Furthermore, people tend to want to live alone or with another person of their choice, rather than with groups of people who have psychiatric disabilities. Residential stability and life satisfaction are increased when consumers perceive they have choices and when their housing and support preferences are honored.

All supportive housing models should maximize, to the extent possible, the following components of an ideal model of supportive housing: (1) choice of housing; (2) separation of

housing and services; (3) decent, safe, and affordable housing; (4) housing integration; (5) access to housing; and (6) flexible, voluntary services.\textsuperscript{129}

A significant body of research demonstrates that people in supportive housing experience reduced homelessness, increased residential stability, reduced recidivism to hospitalization and shorter lengths of stay, and reduced time spent incarcerated.\textsuperscript{130} A few studies relate supported housing to reductions in psychiatric symptoms, increased social functioning, and improved quality of life.\textsuperscript{131}

Supportive housing program models have been successfully adapted and implemented to meet the needs of people with serious mental illnesses and co-occurring substance abuse and developmental disabilities, including those with special needs such as veterans, people who are homeless, families with children, transition-age youth, people who have histories of trauma, people with HIV/AIDS, and offenders leaving prisons or jails.

**Telepsychiatry.** Telepsychiatry is a method of providing expert psychiatric treatment to consumers at a distance from the source of care. Its use has been suggested for the treatment of consumers in remote locations or in areas where psychiatric expertise is scarce.\textsuperscript{132} Telepsychiatry sometimes includes educational initiatives for providers and other non-clinical uses.

Psychiatric interviews conducted by telepsychiatry appear to be generally reliable, and consumers and clinicians generally report high levels of satisfaction with telepsychiatry.\textsuperscript{133} Current technologies make telepsychiatry feasible, increases access to care, and enables specialty consultation.\textsuperscript{134} There is little evidence to date regarding clinical outcomes or cost-effectiveness of telepsychiatry as compared to in-person treatment. However, at least one randomized, controlled study has found that remote treatment of depression by means of

\textsuperscript{129} Fidelity Scale for Ideal Permanent Supportive Housing (2007). Draft in progress for inclusion in SAMHSA Supportive Housing Implementation Resource Kit.
telepsychiatry and in-person treatment of depression have comparable outcomes and equivalent levels of consumer adherence and satisfaction.\textsuperscript{135} In that study, telepsychiatry was found to be more expensive per treatment session, but this difference disappeared if the costs of psychiatrists’ travel to remote clinics more than 22 miles away from the medical center were considered.

**Wellness Recovery Action Plan (WRAP).** The Wellness Recovery Action Plan (WRAP) approach is a self-management and recovery system designed to help consumers identify internal and external resources and then use these tools to create their own, individualized plans for recovery. Under the WRAP model developed and disseminated by Mary Ellen Copeland,\textsuperscript{136} WRAP services are provided by facilitators who have developed and used their own WRAP and who are trained and certified through participation in a five-day seminar.

A WRAP includes the following six main components: (1) developing a Daily Maintenance Plan, including a description of oneself when well and tools needed on a daily basis to maintain wellness such as maintaining a healthy diet, exercise, or stable sleep patterns; (2) identifying triggers to illness; (3) identifying early warning signs of symptom exacerbation or crisis; (4) identifying signs that symptoms are more severe; (5) developing a crisis plan or advance directive; and (6) developing a post-crisis plan.

The WRAP model includes a pre-test/post-test tool to measure the impact of the intervention. At least one study using this tool found significant increases in consumers’ self-reported knowledge of early warning signs of psychosis; use of wellness tools in daily routines; ability to create crisis plans; comfort in asking questions and obtaining information about community services; and hope for recovery.\textsuperscript{137} Another widely-cited study found increases in consumers’ self-reporting that they have a support system in place; manage their medications well; have a list of things to do every day to remain well; are aware of symptom triggers and early warning signs of psychosis; have a crisis plan; and have a lifestyle that promoted recovery.\textsuperscript{138}

The WRAP model has been integrated into MHD’s current peer counseling training curriculum, and federal block grant funds have been used to support training in the last fiscal year.

\textsuperscript{135} Ruskin, P.E., et al. (2004).
Cultural Brokers. To supplement the lack of diversity in the health care workforce, standards have also been developed regarding the strategy of employing cultural brokers. The potential utility of cultural brokers in mental health settings has been described, and the National Center for Cultural Competence (NCCC) at the Georgetown University School of Medicine has developed a guide to promote the development of cultural broker programs. The NCCC guidelines take a broad view of culture, including factors related to sexual orientation, age, disabilities, social economic status, religion, political beliefs, and education. The guide defines a cultural broker broadly as an advocate between groups of differing cultural backgrounds; it defines the role more specifically for health care settings as a particular intervention to engage a range of individuals with diverse backgrounds to help span the boundaries between the culture of health care delivery and the cultures of the people served. These individuals range in their roles within the health care delivery system from consumers to providers to leaders. Singh and his colleagues (1999) describe the broker as acculturated in the mainstream health care delivery culture and one or more minority cultures. The NCCC guidelines note that, while cultural brokers generally achieve acculturation in a particular minority culture through their own experience as a member of that culture, membership is neither a sufficient nor a necessary requirement. The guidelines instead center on the person’s

\[\ldots\text{ history and experience with cultural groups for which they serve as a broker including the trust and respect of the community; knowledge of values, beliefs, and health practices of cultural groups; an understanding of traditional and indigenous wellness and healing networks within diverse communities; and experience navigating health care delivery and supportive systems within communities.}\]

The NCCC guidelines focus on the development of programs within health care organizations to expand the availability of cultural brokers for the specific communities served by those organizations. The guidelines include the following:

1. “Cultural brokering honors and respects cultural differences within communities,” recognizing that diversity within specific communities is as important a factor as diversity across communities.
2. “Cultural brokering is community driven,” building on the principle that community engagement and respect for the need for communities to determine their own needs is essential.

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3. “Cultural brokering is provided in a safe, non-judgmental, and confidential manner,” underscoring the professional responsibilities of the cultural broker to provide the service responsibly.

4. “Cultural brokering involves delivering services in settings that are accessible and tailored to the unique needs of the communities served,” emphasizing the importance of flexibility in the implementation of cultural brokering programs.

5. “Cultural brokering acknowledges the reciprocity and transfer of assets between the community and health care settings,” acknowledging that skills and knowledge must be built both within the health care organization and the broader community being served.

It should be noted that, while membership in a specific cultural group is not necessary to serve as a cultural broker, a high level of acculturation is necessary. In order for a person to bridge two cultures, a level of acculturation in both cultures is needed. While a successful cultural brokering program can also promote awareness and skills that build cross-cultural competence (related to CLAS Standard 1, emphasizing the cultural competence of the entire health care workforce), the specific mechanism of the cultural broker focuses on their ability to bridge cultures they know well (related to CLAS Standard 2, emphasizing the match between the diversity of the health care workforce and the communities served).

A cultural broker does not have knowledge of how to work with “all cultures” or even “all members of a specific culture,” as such a standard is simply not attainable. They instead have sufficient knowledge and skill to be viewed as credible by a sufficient number of the members of the specific communities being served to function as a bridge. This poses challenges to regulations and systematic efforts to require cultural competence, as will be seen below. While mental health specialists are regulated in terms of a minimum level of competence, the broader array of potential cultural brokers are not. In addition, cultural brokers typically are paraprofessionals, whose skills are vital but do not include the level of mental health expertise to deliver services or consult independently.

The tradeoff between ensuring a minimum level of competency and access to a broader array of skills is one that the health care workforce is continually seeking to balance, whether it be between prescribers and prescriber extenders, licensed mental health professionals and unlicensed mental health workers, or professional and peer support. While regulation can ensure that a set of minimum defined standards are met, it can be problematic when misconstrued as an endorsement of high quality or expert status or as a barrier to a broader array of resources.

Promotores de Salude. Promotores de salud (health promoters) provide culturally competent assistance to people in accessing and utilizing a range of health and/or mental health services in the community, including prevention and early intervention services. Promotores are from the
communities they serve, they speak the primary languages of the communities they serve, and they understand the culture. They also know the service systems that they help people navigate. Because of their unique knowledge of culture and systems, and because of their credibility within the communities they serve, promotores are especially well positioned to enhance access to and optimize utilization of services. Promotores assist people by providing health (and/or mental health) education to community members and they assist both community members and providers in identifying and overcoming barriers to services, such as language, stigma, mistrust, transportation, and others.\textsuperscript{141}

\textsuperscript{141} Summary was based on a description of the role of Promotores de Salud found on the California Institute for Mental Health Website. See http://www.cimh.org/LinkClick.aspx?fileticket=Qw5mqcEahTi%3d&tabid=568 for the CiMH report.
Appendix Four: Glossary of Key Terms

1115 Transformation Waiver: This refers is a frequently used short-hand reference to the Texas Health Care Transformation and Quality Improvement Program (authorized under a federal 1115 transformation waiver). This waiver allows the state to expand Medicaid managed care while preserving federal hospital funding previously received as upper payment limit (UPL) payments. Under the waiver, two funding pools replace the UPL payment methodology: (1) the Uncompensated Care Pool helps offset the costs to hospitals for treating people who are uninsured and (2) the Delivery System Reform Incentive Pool (DSRIP) funds programs and strategies that enhance access to health care, quality of care, and cost-effectiveness. Payments will be based on performance outcomes and not simply on delivering a service. Eligibility for DSRIP payments requires participation in a regional health care partnership (RHP). Texas has designated 20 RHPs and has identified an “anchor entity” for each to coordinate efforts to develop and implement regional plans. Each partnership is comprised of participating entities that can provide public funds known as intergovernmental transfers (IGT).

Cultural and linguistically appropriate services: As used in this report, this term refers to clinical services that comply with the National Standards for Cultural and Linguistically Appropriate Services in Health Care (CLAS Standards), which were adopted in 2001 by the U.S. Department of Health and Human Services’ (HHS) Office of Minority Health (OMH) with the goals of “equitable and effective treatment in a culturally and linguistically appropriate manner” and “as a means to correct inequities that currently exist in the provision of health services and to make these services more responsive to the individual needs of all patients/consumers” in order “to contribute to the elimination of racial and ethnic health disparities and to improve the health of all Americans.”

Delivery System Reform Incentive Pool (DSRIP): This is a component of the 1115 Transformation Waiver used to fund specific programs and strategies across Texas to enhance access to health care, quality of care, and cost-effectiveness.

Department of Family and Protective Services (DFPS): This is the child and adult welfare agency for the State of Texas.

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143 For more information see: http://www.dfps.state.tx.us.
Department of Aging and Disability Services (DADS): This is the agency that oversees long-term care for older adults and people with disabilities in Texas. For more information see: http://www.dads.state.tx.us.144

Department of State Health Services (DSHS): This is the state agency in Texas that includes the state behavioral health authority. For more information see: http://www.dshs.state.tx.us.145

Electronic Health Record (EHR): This is a digital version of a paper chart that contains all of a person’s medical history. While this term is often used synonymously with “electronic medical record,” and EHR includes more than data collected in a given provider’s office to include a more comprehensive history. EHRs are typically designed to contain and share information from all providers involved in a person’s care. EHR data can be created, managed, and consulted by authorized providers and staff from across more than one health care organization. For more information see: http://www.healthit.gov/providers-professionals/electronic-medical-records-emr.146

Health Information Exchange (HIE): This refers to the electronic movement of health-related information among organizations according to nationally recognized standards. The goal of a health information exchange is to facilitate access to and retrieval of clinical data to provide better coordinated care across providers. For more information see: http://www.hrsa.gov/healthit/toolbox/RuralHealthITToolbox/Collaboration/whatishie.html.147

Local Mental Health Authorities (LMHAs): DSHS contracts with 39 LMHAs (including Emergence Health Network in El Paso) to provide or arrange for the delivery of community mental health services for a specific geographic area. The LMHAs are required to plan, develop and coordinate local policy and resources for mental health care.148

Medicaid STAR / STARPlus / STARHealth / STARKids Health Plans: The Texas Medicaid program finances managed care statewide (other than in the seven-county area inclusive of Dallas service area) through three programs: STAR, STAR+PLUS, and STARHealth. The STARHealth program is a statewide program for children in foster care and includes all Medicaid covered behavioral health services. The STAR program is a Medicaid managed care program designed for pregnant women and poor children, while STAR+PLUS is designed for dual eligibles (Medicaid and Medicare) and adults with disabilities (SSI). Both STAR and STAR+PLUS currently include all standard behavioral health services and, starting in September 2014, SB 58 expands these benefits to also include the specialty mental health services designed for persons with behavioral health needs. For more information see: http://www.hogg.utexas.edu. Page 31.148

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144 For more information see: http://www.dads.state.tx.us.
145 For more information see: http://www.dshs.state.tx.us.
146 For more information see: http://www.healthit.gov/providers-professionals/electronic-medical-records-emr.
SPMI, known as Medicaid Rehabilitative Services (Rehabilitation) and Targeted Case Management (TCM). STARKids refers to the new benefit for children authorized by the 83rd Legislature under SB 7.

**System of Care Collaborative:** As used in this report, the term refers to a functional, ongoing, empowered collaborative structure trusted to represent all key partners in a health care delivery system in an ongoing planning and system coordination role. A System of Care Collaborative must have the capacity to drive innovation and quality improvement using data on population health, costs, and the customer experience of care.

**Outpatient competency restoration (OCR):** This is an effective alternative to lengthy jail stays and costly hospital commitments for some individuals with mental illness or intellectual disabilities. Competency restoration is the criminal justice system process used when individuals are charged with crimes but deemed incompetent to stand trial. To be considered restored and competent to stand trial, a defendant must be able to consult with his or her defense lawyer and have a rational and factual understanding of the legal proceedings.149

**Primary Prevention:** Primary prevention seeks to decrease the number of new cases of a disorder or illness (incidence).150

**Recovery:** In this report, we define recovery as a way of living a satisfying, hopeful, and contributing life even with the limitations caused by illness. Recovery involves the development of new meaning and purpose in one’s life as one grows beyond the catastrophic effects of mental illness.”151

**Resilience:** In this report, we use this term to refer to an individual’s capacity (most often the capacity of a child or caregiver) for adapting to change and stressful events in healthy and flexible ways.152

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**Secondary Prevention**: Secondary prevention seeks to lower the rate of established cases of the disorder or illness in the population (prevalence).\(^{153}\)

**Serious Mental Illness (SMI)**: This term refers to adults and older adults whose diagnoses are seen as more severe, such as schizophrenia, severe bipolar disorder, or severe depression. A subgroup of these people is defined as having a Serious and Persistent Mental Illness (SPMI) that seriously impairs their ability to be self-sufficient, and has either persisted for more than a year or resulted in psychiatric hospitalization.

**Severe Emotional Disturbance (SED)**: In epidemiological studies, this term generally refers to children and youth ages newborn to 17 who have emotional or mental health problems so serious that their ability to function is significantly impaired, or their ability to stay in their natural homes may be in jeopardy.

**Tertiary Prevention**: Tertiary prevention seeks to decrease the amount of disability associated with an existing disorder or illness.\(^{154}\)

**Texas Department of Criminal Justice (TDCJ)**: This is the state agency responsible for the state-run correctional system in Texas.\(^{155}\)

**Texas Juvenile Justice Department (TJJD)**: This is the state agency responsible for juvenile justice and rehabilitation in Texas.\(^{156}\)

**Trauma informed care**: This term refers to treatment approaches of any kind that explicitly address the consequences of trauma on an individual.

**Texas Commission on Law Enforcement (TCOLE)**: This is the state agency responsible for establishing and enforcing standards to ensure that the people of Texas are served by highly trained and ethical law enforcement, corrections, and telecommunications personnel. It was formerly known as the Texas Commission on Law Enforcement Officer Standards and Education (TCLEOSE).\(^{157}\)


\(^{155}\) For more information see: http://www.tjjd.texas.gov.

\(^{156}\) For more information see: http://www.tdcj.texas.gov.

\(^{157}\) For more information see: http://www.tcole.texas.gov.