Interim Report

TO THE EIGHTY-NINTH TEXAS LEGISLATURE

HOUSE SELECT COMMITTEE ON YOUTH HEALTH AND SAFETY

DECEMBER 2024

HOUSE SELECT COMMITTEE ON YOUTH HEALTH AND SAFETY
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2024

A REPORT TO THE
HOUSE OF REPRESENTATIVES
89TH TEXAS LEGISLATURE

SENFRONIA THOMPSON
CHAIRWOMAN

COMMITTEE CLERKS
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Select Committee On
Youth Health and Safety

December 16, 2024

Senfronia Thompson
Chairwoman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Dade Phelan
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Select Committee on Youth Health and Safety of the Eighty-eighth Legislature hereby submits its interim report including recommendations and drafted legislation for consideration by the Eighty-ninth Legislature.

Respectfully submitted,

Senfronia Thompson, Chair

Lacey Hull, Vice Chair

Steve Allison

Giovanni Capriglione

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Ann Johnson

Tracy O. King

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INTRODUCTION

The House Select Committee on Youth Health and Safety ("Committee") was created on September 16, 2021 by Speaker Phelan to evaluate and improve the condition of youth in Texas. Throughout its inception, the committee has served as a platform for its members, stakeholders, and most importantly – parents and youth, to highlight the unique needs and complexities Texas children face on a daily basis.

Speaker Phelan maintained the committee during the 88th Regular Session to continue its invaluable work to approach youth issues holistically and bring about solutions in a collaborative and bipartisan manner.

The Texas Legislature has done an excellent job in recognizing that our youth's needs can no longer be viewed or solved in a silo; therefore, it is our hope that the House Select Committee on Youth Health and Safety becomes a standing committee for the 89th Regular Session and future sessions.

Following the conclusion of the 88th Regular Session, the committee was charged with:

1. Monitoring: Monitor the programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

    - HB 3, relating to measures for ensuring public school safety, including the development and implementation of purchases relating to and funding for public school safety and security requirements and the provision of safety-related resources; and

    - HB 18, relating to the protection of minors from harmful, deceptive, or unfair trade practices in connection with the use of certain digital services and electronic devices, including the use and transfer of electronic devices to students by a public school.

2. Behavioral Health Services for At-Risk Youth: Evaluate programs and services currently available to children and families that are either involved with, or at high risk for becoming involved with, the foster care and juvenile justice systems. Study the current barriers for accessing community-based behavioral health services for children with intense behavioral health needs, with an emphasis on ensuring that parents do not have to give up custody of children to gain access to services.

The Committee was scheduled to have two separate interim hearings to address its charge related to behavioral health services for at-risk youth on July 9, 2024 and July 31, 2024; however, due to the impact of Hurricane Beryl, the Committee canceled its July 9th hearing and combined its invited witnesses for the July 31st hearing.

On September 19, 2024, the Committee held its final hearing to address its charge on monitoring the implementation of House Bill 3, *relating to the measures for ensuring public school safety, including the development and implementation of purchases relating to the funding for school safety and security requirements and the provision of safety-related resources.*

Although the Committee was charged with monitoring the implementation of House Bill 18, *relating to the protection of minors from harmful, deceptive, or unfair trade practices in connection with the use of certain digital services and electronic devices, including the use and transfer of electronic devices to students by a public school*, upon the advice of the Attorney General's Office and due to pending litigation, the Committee did not take up this portion of its interim charge. For those reasons, it will not be included within the detailed text under Charge I: Monitoring.

The archived video recording of the Committee's interim hearings can be found at the following links:

July 31, 2024: https://www.house.texas.gov/videos/20683
September 18, 2024: https://www.house.texas.gov/videos/20704

The Committee would like to express deep gratitude for all of the witnesses who provided testimony and recommendations on the above interim charges. Your insights are invaluable and together, we will work to remove barriers so that children and families have greater access resources proven to improve their overall well-being and create better outcomes.

INTERIM STUDY CHARGES

CHARGE I: MONITORING

Monitor the programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

HB 3, relating to measures for ensuring public school safety, including the development and implementation of purchases relating to and funding for public school safety and security requirements and the provision of safety-related resources; and

HB 18, relating to the protection of minors from harmful, deceptive, or unfair trade practices in connection with the use of certain digital services and electronic devices, including the use and transfer of electronic devices to students by a public school.

CHARGE II: BEHAVIORAL HEALTH SERVICES FOR AT-RISK YOUTH

Evaluate programs and services currently available to children and families that are either involved with, or at high risk for becoming involved with, the foster care and juvenile justice systems. Study the current barriers for accessing community-based behavioral health services for children with intense behavioral health needs, with an emphasis on ensuring that parents do not have to give up custody of children to gain access to services.

CHARGE I: MONITORING

Monitor the programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 88th Legislature. Conduct active oversight of all associated rulemaking and other governmental actions taken to ensure the intended legislative outcome of all legislation, including the following:

HB 3, relating to measures for ensuring public school safety, including the development and implementation of purchases relating to and funding for public school safety and security requirements and the provision of safety-related resources.

BACKGROUND

Protecting the safety and security of Texas students and staff has become an increasingly urgent need due to gun violence at Texas' public schools. In 2018, a 17-year-old gunman killed eight students and two teachers at Sante Fe High School. In response to this tragic event, the 86th Legislature passed SB 11 to ensure the safety and security in public schools including active shooter training for certain peace officers. SB 11 also created the school safety allotment, threat assessment teams and the Texas Child Mental Health Care Consortium.

In 2022, the city of Uvalde, Texas unfortunately experienced a similar school shooting at Robb Elementary where an 18-year-old gunman entered the school and killed nineteen students and two teachers. During the 88th Legislative Session, the legislature passed HB 3, another major school safety bill, that required an armed security officer at every campus, school safety audits and increased funding in the school safety allotment.

Under HB 3, the Texas Education Agency (TEA) was charged to establish an office of school safety and security within its agency. In addition, TEA, in coordination with Texas State University's Texas School Safety Center (TxSSC) and local law enforcement, would provide technical assistance to school districts and education service centers to support the safety plans and the security requirements established in HB 3. As part of the technical assistance, TEA was required to conduct district vulnerability assessments and on-site intruder detection audits.

TxSSC, in collaboration with the Department of Public Safety (DPS), was required to provide resources to assist schools with safe firearm storage. Schools were also required to provide DPS with an accurate map of each school district campus and an opportunity to conduct walk-throughs.

House Bill 3 required sheriffs in counties with a population of less than 350,000 to conduct school safety meetings two times a year and submit a report to the TxSSC identifying attendees and the topics discussed, such as coordinated law enforcement response to school violence events. Out of the 237 counties impacted, 21 counties have not yet submitted any documentation to the TxSSC. The reports are publicly available on the TxSSC website.

Lastly, HB 3 required TEA, or if designated by TEA, the TxSSC to establish and publish a directory of approved vendors of school safety technology and security equipment, such as silent panic alarm buttons, lockdown technology, surveillance cameras and mass communication software.

SUMMARY OF COMMITTEE TESTIMONY AND FINDINGS

The Committee held a public hearing on September 18, 2024 to address the above interim charge and heard invited and public testimony from the following witnesses:

Witnesses listed in alphabetical order.

- Augustine, Dwaine (Hamshire-Fannett ISD)
- Birt, John (Keller ISD)
- Driskell, Dahria (Friendswood ISD & Texas Council of Administrators of Special Education)
- Estrada, Mark (Lockhart ISD)
- Hairston, Andrew (Texas Appleseed)
- Hawthorne, Brian (Sheriffs Association of Texas)
- Hill, Brittany (EZY PA)
- Hoffman, Sarah (Texas Department of Public Safety)
- Hoffman, Shannon (The Hogg Foundation for Mental Health)
- Holubec, Bryan (Texas Association of School Boards)
- Humphrey, Nancy (Plano ISD)
- James, Bruce (Texas Department of Public Safety)
- Martinez-Prather, Kathy (Texas School Safety Center at Texas State University)
- Rhodes, Fran (True Texas Project)
- Ross, Leesa (Lock Arms For Life)
- Salazar-Zamora, Dr. Martha (Tomball ISD & Texas Association of School Administrators)
- Scott, John (Texas Education Agency)
- Stanage, Frank (Texas Association of School Boards)
- Volk, Maia (Disability Rights Texas)
- Warren, Vicki (Arlington ISD)

Armed Security Officers

The committee received the most testimony concerning the requirement of having an armed security officer on every campus of a public school district and open-enrollment charter school. The Association of Texas Professional Educators (ATPE) stated "HB 3 requires schools to pay for active shooter plans, mental health training, silent panic buttons, infrastructure improvements and an armed officer guard on every campus. The cost of an armed guard alone can cost an upward of $70,000 per campus." While the witnesses agreed that HB 3 was a positive step forward in enhancing school safety and provided a welcome financial support, many witnesses stated that the funding provisions fell short of meeting the safety needs of Texas students, particularly in the area of mental health.

The increased school safety allotment of $15,000 per campus and $.28 per student fails to meet the demands required under HB 3 and leaves districts scrambling for money. For example, Manor ISD had to forgo opening a new elementary school and reduced the amount of money allocated for the maintenance of its air conditioning units to comply with the armed security officer requirement.

Many districts are utilizing the "good cause" exception rather than redirecting funds to pay for an armed security officer but as the Texas American Federation of Teachers (AFT) noted and other witnesses shared similar concerns "it is nonetheless troubling that the state does not appear to be monitoring the use of those exceptions or reporting them in a timely and transparent manner." Written testimony provided by TEA stated that as of September 13, 2024, 940 districts completed their compliance reporting. Of those districts, 52% used the good cause exception, 2.55% were adopting good cause exception or working to meet compliance and 45% were fully compliant.

Despite the flexibility in using the school safety allotment (SSA) funds, most districts use SSA funds to help pay for the cost of campus security while only a small percentage use SSA funds in behavioral health services, even though mental health professionals are critical in addressing underlying causes of violence in schools.

As stated in the background section of this report, HB 3 required school districts to provide parents of K-12 students information about safe firearm storage. Texas Gun Sense noted that they have been tracking the implementation of the safe gun storage policy and have recommended strengthening the law to include disseminating the information at the start of the school year and before holiday and summer breaks when students are at home and potentially vulnerable. They also recommended a stronger tracking system to ensure districts are sharing the information with parents by following the suggested messaging and guidelines from the Texas School Safety Center.

When asked by the chair if schools can utilize metal detectors on their campuses, TEA responded that schools are allowed to install metal detectors if they choose to do so.

Mental Health Support

Another common concern among the witnesses was the need to provide a state dedicated funding allotment for mental health. Although Texas made great strides in mental health training, access and support through the Texas Children's Mental Health Care Consortium, funding to its Texas Child Health Access Through Telemedicine (TCHATT) program remains critical.

The Texas Coalition for Healthy Minds noted that in April 2024, TCHATT was appropriate for 11,295 of the over 4 million students who can access services, however, most of the students who used TCHATT required a referral to their local health services for continued care. A 2022 statewide survey found most school districts were using federal elementary and secondary school emergency relief (ESSER) funds to address student's mental health, however, ESSER funding is scheduled to expire this year putting current programs at risk.

Schools play a vital role in identifying early warning signs of students struggling with bullying, substance abuse, suicidal ideation, and violence. Schools also play a critical role in helping students connect to resources before they are in a crisis. Programs such as the Multi-Tiered System of Support (MTSS) are essential for fostering positive school climate and helping schools identify and address mental health needs early. As the Texas Coalition for Healthy Minds noted, addressing mental health and behavioral needs early can significantly improve test scores, attendance, graduation rates and student-teacher relationships while reducing bullying, substance use and symptoms of depression among both students and staff.

While HB 3 required mental health training of school employees, the training was not funded, leaving the districts to pick up the cost to train their teachers and other school personnel on youth issues that may pose a threat to school safety. Many of the witnesses identified the need to fund hiring social workers, school psychologists and counselors. The Texas Counseling Association testified that in some rural districts, a school counselor may be the only mental health professional in the area and the creation of a mental health allotment will provide these counselors with the necessary resources to foster positive environments for all the students in their care.

On-site Audits and Threat Assessments

House Bill 3 required the Texas Education Agency (TEA) in coordination with the Texas School Safety Center (TxSSC) to monitor school districts and charter schools' compliance with safety and security requirements, including unannounced on-site audits of each campus. The intruder detection audit is designed to randomly check the exterior doors of a school to ensure the doors are closed and properly locked. If a local education agency (LEA) has an interior classroom door locking policy, the audit inspector conducts a random check of classroom doors to make sure they are closed, latched and locked.

If the audit finds any of the exterior doors to be non-compliant, the LEA, within 60 calendar days, must conduct a live training session to train campus staff that all exterior doors must be closed and properly locked. The LEA must also develop a corrective action plan to address any doors that were unlocked, broken or improperly secured. For the LEAs that have a classroom door locking policy, any deficiencies of unlocked classroom doors will be flagged as a notice to the superintendent. For the 2023-2024 school year, out of the 8382 campuses that were audited, 7293 campuses had no deficiencies.

House Bill 3 also required the TEA to transfer a student's disciplinary record and any behavioral threat assessments when a student transfers to a new school. The Disability Rights Texas raised concerns that maintaining threat assessment records until the students 24th birthday has had unintended and harmful consequences on students with disabilities. They stated that a student's disability which may cause them to act out, become verbally aggressive, or have defiant reactions is sometimes misinterpreted as a threat, triggering a threat assessment instead of offering mental health services on what they see may be an outcry. The threat assessment also causes undue hardship on the student and the parents and, at times, have been used to bypass the legal and civil protection of the student. They recommended a periodically review and expungement of records removing threat assessments that were done illegally. They also recommended that a mental health professional, social worker, or counselor be assigned to the safe and supportive teams when a special education (SPED) student is going under an investigation.

The TEA was required to adopt a policy for providing parental notification, including notifying students and staff, regarding violent activity that has occurred or is being investigated at a school campus, facility or district-sponsored event. The policy required electronic notification by text or email, an option for real-time notification and student privacy protection. The parental notification could also be used to send out notices regarding school evacuations, severe weather or lockdowns.

While HB 3 required the establishment of safe and supportive teams at every campus, witnesses were concerned about the lack of communication between the teams and the educators who work directly with students. The Texas AFT also stated that educators are not provided with notification regarding any campus threats. They recommended that any relevant threat assessments be shared with educators who work directly with the affected students and any campus threat notification be provided to all educators working on that campus.

CONCLUSION

The primary focus of a child in school should be learning and a teacher's primary focus should be teaching. Unfortunately, the academic goals of both the student and the teacher are threatened when the mental health needs are unmet.

House Bill 3's emphasis on physical security and armed security officers comes at the expense of funding for mental health and behavioral interventions. Effective school safety requires more than a fortified campus. By focusing on prevention, mental health and early intervention, Texas can foster safer schools for all students where they are not only safe but also feel supported, valued and empowered to succeed.

The committee staff learned about a potential clean-up bill for HB 3 that would be considered for the 89th Legislative Session. The committee looks forward to working on a balanced approach that does not force districts to choose between security and mental health but rather build a sustainable mental health framework for the safety and well-being of Texas youth.

RECOMMENDATIONS

The committee concludes that while HB 3 includes necessary measures for enhancing school safety, it has some shortcomings in its current form.

The committee makes the following recommendations:

1. **Increase the School Safety Allotment**: Allocate additional funding to ensure the full cost of HB 3 implementation is covered.
2. **Increase Funding for Mental Health Services**: Establish a dedicated mental health allotment, or similar funding, to ensure districts can invest in necessary mental health support for student and staff.
3. **Expand Resources for Preventative Measures**: Provide funding for additional staff such as social workers, mental health professionals and school counselors.
4. **Support Comprehensive Multi-Tiered System of Support (MTSS) Implementation**: Provide schools with sufficient resources to implement MTSS programs effectively at all academic levels, ensuring students receive tiered mental health support through preventative guidance and responsive services.
5. **Support a HB 3 clean-up bill**: Support efforts made by the 89th Legislative Session to improve the implementation of HB 3.

CHARGE II: BEHAVIORAL HEALTH SERVICES FOR AT-RISK YOUTH

Evaluate programs and services currently available to children and families that are either involved with, or at high risk for becoming involved with, the foster care and juvenile justice systems. Study the current barriers for accessing community-based behavioral health services for children with intense behavioral health needs, with an emphasis on ensuring that parents do not have to give up custody of children to gain access to services.

BACKGROUND

Mental health, behavioral health and developmental conditions have been present throughout history. As research evolves, the identification and treatment of those conditions also change. Today, youth face many added challenges that are difficult to navigate - even with parents, family, or other supportive individuals.

According to the U.S. Department of Health and Human Services (HHS) Office of the Surgeon General, "youth mental health challenges are the leading cause of disabilities and poor life outcomes in young people." [1] Mental and behavioral health issues are shaped by biological factors like brain chemistry and environmental factors such as adverse childhood experiences (ACEs). [2] ACEs are commonly associated with traumatic events that undermine a child's sense of safety, stability and bonding.[3,4] Some examples of ACEs include but are not limited to abuse, neglect, substance abuse, parental separation, witnessing violence, having an incarcerated parent or family member, or unaddressed mental health or substance abuse in the household.[5] There are many individual, family, and community risk and protective factors that increase or decrease the probability for children to be adversely impacted. If children experience strong, frequent, or prolonged trauma(s), those experiences can be detrimental to their development. [6] Stress responses to ACEs are known to disrupt brain development, negatively impact behavior and learning, increase the risk of poor health outcomes and cause attendance issues in school.[7]

The needs of youth with behavioral health conditions or intellectual and developmental disabilities differ from adults with persistent mental illness; therefore, care must be tailored and coordinated to meet their unique needs. The Committee was charged with evaluating the programs and services available to children and families involved with, or at high risk for becoming involved with, the foster care and juvenile justice systems and identifying barriers for accessing community-based behavioral health services for children to ensure that parents do not have to give up or share custody with the state to gain access to services. The findings and summary of testimony below will provide information on the Legislature's investment in youth mental health, delve into the services available to youth, highlight common themes heard through testimony, identify barriers for youth access to care and provide recommendations to reduce the gap in services.

SUMMARY OF COMMITTEE TESTIMONY AND FINDINGS

The Committee held a public hearing on July 31, 2024 to address the above interim charge and heard invited testimony only from the following witnesses:

Witnesses listed in alphabetical order.

- Bernstein, Jamie (Supreme Court of Texas Children's Commission)
- Black, Kate (Disability Rights Texas)
- Carter, Shandra (Texas Juvenile Justice Department)
- Castillo, Alycia (Texas Civil Rights Project)
- Crow, Monya (Texas Counseling Association)
- Dudensing, Jamie (Texas Association of Health Plans)
- Fox, Shana (Council on At-Risk Youth)
- Gandy, Rachel (Texas Juvenile Justice Department)
- Garnett, Susan (Texas Council of Community Centers)
- Gonzales, Jaci (SJRC Texas)
- Goode, Jenny (Texas Council of Community Centers)
- Hoffman, Shannon (Texas Coalition for Healthy Minds)
- Ita, Trina (Texas Health and Human Services Commission)
- Jew, Rachel (Texas Child Mental Health Care Consortium)
- Jordan, Tommy (Our Community Our Kids)
- Keller, Andy (Meadows Mental Health Policy Institute)
- Kravitz, Kelly (Texas Education Agency)
- Mayes, Valerie (Texas Health and Human Services Commission)
- Murphy, Kate (Texans Care for Children)
- Muth, Stephanie (Texas Department of Family and Protective Services)
- Norman, Brittany (Disability Rights Texas)
- Porter, Justin (Texas Education Agency)
- Reyes, Brittany (Texas American Federation of Teachers)
- Scott, Cam (Child First)
- Seals, Courtney (Texas Network of Youth Services)
- Serafin, Brady (Texas Association of Behavioral Health Systems)
- Talamantes, Monique (Texas Network of Youth Services)
- Taylor, Kalyn (Texas Counseling Association)
- Tinney, Becky (Texas Association of Substance Abuse Programs)
- Williams, Laurel (Texas Child Mental Health Care Consortium

Youth Behavioral Health by the Numbers

In the United States, nearly 20% of children and youth ages 3-17 have a mental, emotional, developmental, or behavioral disorder;[8] and research indicates that half of all mental health conditions manifest by age 14.[9] Although suicidal behaviors among high school youth have increased more than 40% from 2010-2019 and emergency room visits for children's mental health increased by 25% from 2016-2018, in 2020, only 44% of adolescents with a major depressive episode reported receiving treatment in the last year.[10]

The Texas Education Agency (TEA) reported that the number of high school students in Texas who felt sad and hopeless for at least two-weeks in a row in the last 12-months has more than doubled since 2001.[11] In a Spring 2022 TEA survey of school districts reported perceptions of student mental health concerns post-pandemic, 86% reported increases in anxiety or stress, 64% reported increases in sadness or depressed mood, 61% reported increases in behavioral problems, 52% reported distress related to trauma or grief, and 46% reported increases in suicidal ideation or behaviors.[12]

Both the Texas Department of Family and Protective Services (DFPS) and the Texas Juvenile Justice Department (TJJD) have experienced an increase in youth with a higher level of need. Although there were fewer youth served by both agencies than anticipated, both agencies shared similar needs and characteristics among the population they serve. For example, in Fiscal Year 2023, the TJJD admissions profile showed that of the 562 youth admitted, 57.8% of children had experienced four or more ACEs.[13]

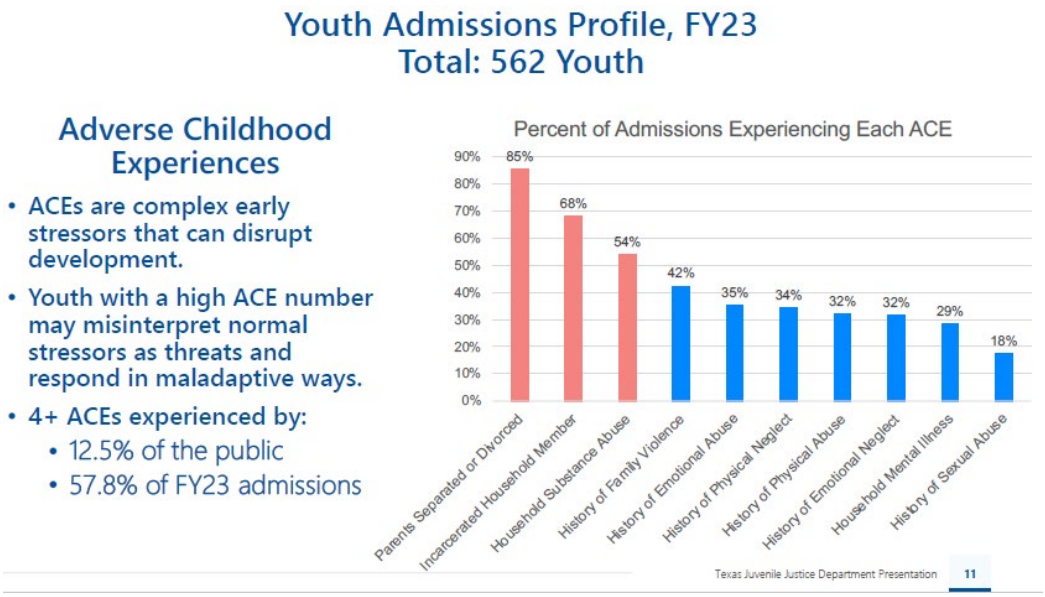


Figure 1: TJJD ACEs Admission Profile FY 23

TJJD's testimony to the Committee highlighted that fewer youth who have committed lower-level offenses are entering the state's care, as county probation departments are working to serve those children in their respective communities. Most of the youth admitted to TJJD have a higher acuity of need, require intensive, specialized treatment, and have significant histories of trauma. The agency also underscored that histories of trauma directly correlate with behavioral health issues as untreated mental health following an ACE often manifests in aggression.[14] In Fiscal Year 2023, TJJD reported that new youth were over seven grade levels behind in reading and math.[15]

While DFPS' Refusal to Accept Parental Responsibility (RAPR) population was reflective of a lower number of children compared to other removal reasons, the youth who are in care because of RAPR have a higher average age, higher level of need, higher specialized level of care, limited family support, and make up a high percentage of Children Without Placement (CWOP).[16]

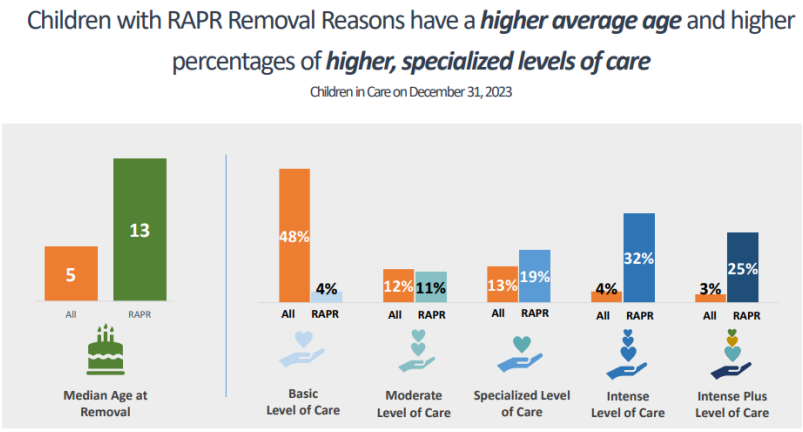


Figure 2: DFPS RAPR Removal Levels of Care

The correlation between a child's stress response after experiencing an ACE and its impact on learning, development and behavioral health is evidenced by what state agencies are experiencing in their systems as it relates to high acuity needs, intensive services, higher levels of care, and educational attainment difficulties.

Children with disabilities are disproportionately represented in Texas' foster care system. In April of 2024, DFPS reported 56% of children in care had at least one disability and nearly all of Disability Rights Texas (DRTx) clients have mental and behavioral health challenges even when it is not their primary disability.[17] DRTx testimony supports TJJD's statements regarding the high acuity youth entering the state's care. Although TJJD is in the process of building new facilities to address the waitlist of committed youth, the agency still suffers from systemwide understaffing, continues to experience an increase in the needs of committed youth and a reduction in placement options after a youth's release.

DRTx and the Texas Civil Rights Project (TCRP) stated that as counties refer higher needs youth to the state's secure facilities, youth are still falling through the cracks due to staffing shortages and waitlists for treatment.[18,19] These systemic shortcomings often impede youth progress toward successful outcomes. For example, committed youth who are assigned specialized treatment programs are transferred from one facility to another to receive treatment because staffing shortages prevent facilities from providing an array of treatment options within each facility. Delaying treatment due to waitlists prohibits youth from completing treatment in a timely manner. Even when these circumstances are beyond the youth's control, their treatment team can use completion as a factor when considering transfer, parole, or discharge. DRTx also stated that staffing shortages are also attributed to inconsistent programming schedules, which limit program opportunities and increase the mental and behavioral needs of youth within TJJD.[20]

The Legislature's Investment in Youth Mental Health

Over the last five sessions, the Legislature has consistently increased funding for behavioral health from $6.59 billion annually during the 84th Legislative Session to $11.68 billion annually during the 88th Legislative Session.[21] Last session alone, the Texas Legislature increased its investment in behavioral health funding by $2.8 billion.[22]

While state agencies and advocates have expressed their deep appreciation for the Legislature's investment in mental health, there appears to be a consistent, increasing need for a full continuum of mental health services. Each level of the service continuum requires sustained funding for existing services plus additional investments to fund evidence-based programs where the need has outpaced the number of youth Texas is currently able to serve. Although inpatient, residential treatment, and crisis level intervention is critical to stabilize youth, there are not enough step-down or early intervention services for youth. Stability in funding creates an atmosphere for mental health providers to build capacity in Texas where the state is experiencing gaps in care.

Services Available to Texas Youth

Texas Health and Human Services Commission

The Texas Health and Human Services Commission (HHSC) operates a relinquishment avoidance project known as the Residential Treatment Center (RTC) Project which has been funded by the state to serve 50 slots.[23] In a residential treatment center setting, youth are provided with intensive mental health services through a Local Mental Health Authority

(LMHA) while their guardian maintains legal responsibility. The average length of stay is approximately six months; however, time can be extended based on the youth's need. In Fiscal Year 2023, the agency was operating 15 sites across the state and had received 249 referrals but were only able to make 41 placements. At times, the agency will receive referrals to the RTC Project and encounter families who are unaware of the services provided outside of the Project. If a safe referral can be made for services outside of the Project, the agency will connect those families to services through an LMHA. In Fiscal Year 2023, HHSC connected 105 families to LMHAs for mental health treatment.[24]

The Youth Empowerment Services (YES) Waiver program through HHSC serves children ages 3-18 who have serious mental, emotional and behavioral needs.[25] The YES waiver provides services to children that are outside of traditional Medicaid services. HHSC's YES Waiver cycle runs for five years and was renewed on April 1, 2023. From April of 2022 to March of 2023, the agency served 2,692 children of the 3,591 slots it had available.[26] Of those children and youth served, 312 were involved with DFPS. There are 180 reserved capacity slots for children under DFPS conservatorship or for children and families who have high acuity needs and are at serious risk of relinquishment.[27]

The 88th Legislature appropriated funding to HHSC for several new programs and services targeted specifically for youth and families such as the Youth Crisis Outreach Teams (YCOT), Multisystemic Therapy (MST), System Navigator, Coordinated Specialty Care (CSC) and Children's Crisis Respite. YCOT is a resource for children and families who need crisis intervention. Post-intervention, YCOT maintains contact with the family to ensure they continue to have access to community-based services and supports to mitigate crises in the future.[28] Utilization of YCOT can reduce DFPS and TJJD involvement, reduce truancy and missed school days, and reduce or divert youth from hospitalizations.[29]

MST is a resource that treats youth who are justice-involved and exhibit antisocial behavior. Service delivery occurs in the youth's community or in their home and is available to youth around the clock for 90 days. HHSC has received 28 referrals from DFPS caseworkers and currently operates 22 teams with 16 providers.[30] According to the Meadows Mental Health Policy Institute (MMHPI), the primary goals of this treatment modality are to reduce violence, criminal activity, antisocial behavior and save taxpayer dollars by reducing out-of-home placements and incarceration. MST is proven to reduce violent crimes by 75% and works better than institutional care.[31]

HHSC also operates System Navigator, a pilot program designed to assist child-serving agencies enhance service coordination. It is operating within six LMHAs to make internal staff aware of the array of services available and to educate other child-serving agencies through outreach efforts.

Children's Crisis Respite operates across five sites and has served 77 youth (Fiscal Year 2023) who were in crisis but did not meet an inpatient level of care.[32] Crisis respite provides youth and families with the support they need to transition back into the community. HHSC noted in testimony that there is a 48% decrease in crisis episodes following a crisis respite stay and in Fiscal Year 2024, the agency will have 28 additional beds made available through four additional sights.

Coordinated Specialty Care for First Episode Psychosis is a service available for youth who experience their first encounter with the system. It takes a multidisciplinary approach to providing an array of services to ensure the youth receives psychiatric services and other supports to prevent future crises.

In addition to the operation of state hospitals and the services listed above, HHSC also purchases psychiatric beds in the community to ensure that individuals experiencing crises are served close to home. In Fiscal Year 2024, HHSC purchased 555 psychiatric beds, including 20 extended stay beds for youth served by DFPS.[33] The 20 extended stay beds for DFPS involved youth are intended to strengthen the continuum of care, especially for the DFPS CWOP population. Both agencies have experienced situations where youth who received services through an acute stay still need continued services to ensure they are ready for a stable placement in the community.

Texas Child Mental Health Care Consortium

The Texas Child Mental Health Care Consortium (TCMHCC) was established in 2019 to address youth mental health and currently operates five initiatives: Texas Child Health Access Through Telemedicine (TCHATT), Child Psychiatry Access Network (CPAN), Perinatal Psychiatry Access Network (PeriPAN), Child Psychiatry Workforce Expansion (CPWE), Child and Adolescent Psychiatrist (CAP) Fellowships and Children's Mental Health Research.

TCHATT provides access to telemedicine programs to identify, assess, and provide short-term, school-based treatment for youth who need mental health treatment.[34] Referrals are typically made by school staff who identify students that might benefit from TCHATT services. After a referral is made, written parental consent is obtained prior to a child receiving services. Providers often deem family engagement as essential to helping the child. Because of the Legislature's investment in this program, children receive services at no-cost to the family.

TCHATT is embedded within 6,486 school campus across 846 voluntarily enrolled school districts in the state. As of May of 2024, TCHATT is now accessible to four million students. Based upon data provided by the agency, TCHATT continues to see a growth in need for services. The top two reasons for referral are anxiety and depression, followed by anger, disruptive behaviors, and attention problems. Other reasons for referrals include low self-esteem, academic issues, trauma, suicidal concerns, grief, and self harm.[35]

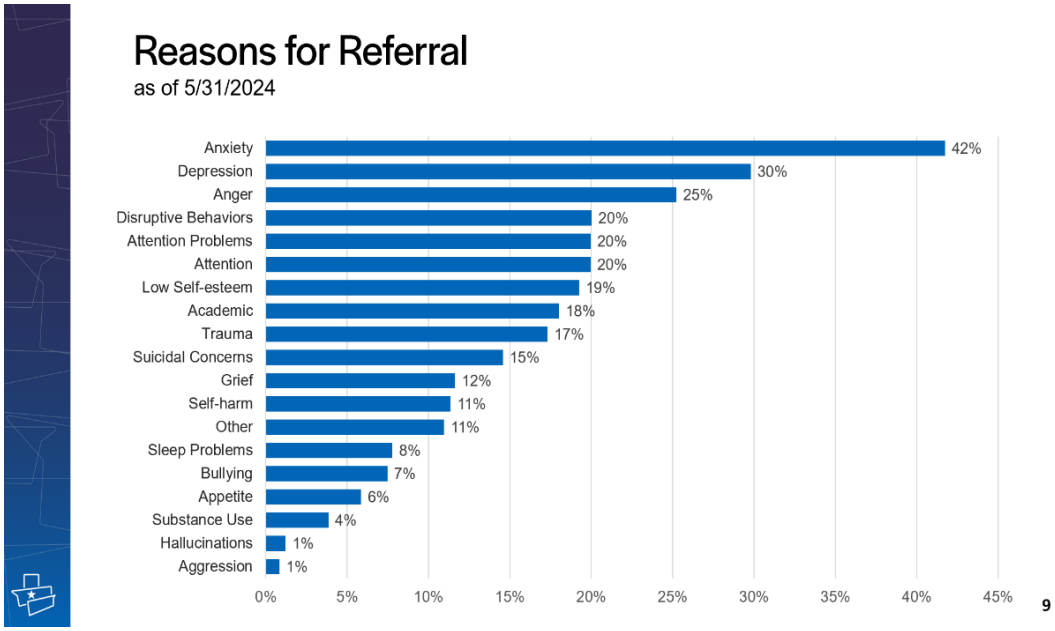


Figure 3:TCMHCC Reasons for Referral

Because of the short-term nature of the services provided through TCHATT, families are often referred for continued services. The Consortium testified that about half of the young people served by TCHATT were identified as benefitting from continued services.[36] The TCMHCC surveyed 1,191 parents through the end of May of 2024 and found that the vast majority of parents felt like their child or family was doing better.[37] Despite improvements in youth served by TCHATT, reported challenges include managing the demand for services, recruiting and retaining staff, accommodating requests for service outside of normal school hours, and limited access to mental health services in the community following TCHATT intervention. [38] The Consortium noted that these challenges can impact a student's short-term treatment goals.

Another service available through the Consortium is a five-hour evidence-based mental health program for high school students, Youth Aware of Mental Health (YAM), which is funded by the American Rescue Plan Act (ARPA). YAM is offered in schools who wish to partner with the Consortium to educate youth on emotional intelligence, and life-long coping and resilience skills to prevent high risk behavior.[39]

While the Consortium's CPAN program does not provide direct services to youth, it allows primary care physicians who serve children and youth access to a phone-based consultation with a child psychiatrist or mental health professional in less than 30 minutes should the provider need guidance on talking with families about mental health concerns.[40] The Consortium testified to CPAN's ability to provide care coordination for families who need assistance with referrals to community-based providers. CPAN has had an upward trend of enrolled providers and an increase in providers' knowledge, skills, and confidence in addressing mental health care in their clinics.

Like CPAN, the Consortium operates a similarly structured ARPA funded program called PeriPAN. PeriPAN supports obstetricians, gynecologists, pediatricians, family physicians, nurses, and midwives through phone consultations, referrals and resource assistance for youth and families in need of mental health care. PeriPAN now operates statewide and has also experienced increased number of consults, particularly between July of 2023 and May of 2024.[41]

Aside from the Consortium's direct-service programs to children and providers, one of its fundamental components involves research projects on child and adolescent mental health to understand trends, improve services, and understand gaps in service delivery. Through its research initiative, the Consortium established the Youth Depression and Suicide Research Network and the Childhood Trauma Research Network. Both networks found strong correlations between youth who have experienced trauma/ACEs and mental/behavioral health issues.[42]

Finally, the Consortium provided the committee with future considerations including addressing statewide children's mental health professional workforce shortages, incorporating initiatives currently funded by ARPA into its core programs, maintaining TCMHCC in the continuum of care when demand for services exceeds the supply, and continuing to be involved in a multidisciplinary and multi-agency effort to address the increased and ongoing need for a larger continuum of care to address children's mental health needs.[43]

Supreme Court of Texas Children's Commission

In 2021, the Supreme Court of Texas Children's Commission, Office of Court Administration (OCA), and the DFPS Prevention and Early Intervention (PEI) division partnered to create a pilot program in three counties to strengthen the relationships between the courts and community

resources. The piloted program located in Galveston, Lubbock, and Bell counties added an early intervention court liaison to provide community resources for professionals serving in the child welfare space.[44] The liaisons have met with the community, attended family team meetings, identified gaps in community resources and met with providers to help bridge those gaps to avoid family DFPS system involvement.[45] Several additional counties across the state are considering similar liaison positions in their courts.

The Commission also released a Dual Status Task Force report in 2021[46] which highlighted the unique needs of youth served by both DFPS and TJJD. Testimony highlighted that several courts throughout the state have created a dual status court docket so that families involved in both systems funnel through one court. Counties that have not created a dual status docket have staff that meet regularly to discuss the needs of children served by both systems.

Family First Prevention Services Act (FFPSA)

Congress passed the FFPSA in 2018 which restructured federal child welfare funding and provided access to federal matching funds for evidence-based programs designed to reduce foster care entry and increase access to substance abuse and mental health.[47,48] The Texas Legislature allocated funding to DFPS for the Texas Family First (TFF) Pilots over the last two sessions. The TFF pilots are making progress despite legislatively imposed eligibility restrictions and federal grant funding expiring in 2025.[49] To draw down federal funding, states are required to submit a Title IV-E Prevention Plan outlining the state's strategies for FFPSA implementation, obtain federal approval for the plan, and invest state funding for evidence-based prevention services. According to Texans Care for Children, Texas is one of four states that has not submitted the required plan but recommends the state continue to fund the established pilot programs while DFPS works on the plan and awaits federal approval.[50] Doing so will sustain the ongoing partnerships between DFPS and Community-Based Care contractors to preserve families.[51]

Overall, state agencies and organizations involved with serving children and families have experienced a shift in the demand for services and an increased need for high acuity youth to access a continuum of care in their communities to avoid system involvement. Even when avoidance of system involvement is unattainable, families still experience barriers to accessing services.

Barriers to Youth Access to Care

In general, children and families are more likely to encounter system involvement when underlying issues are not addressed before a crisis occurs. Most early encounters are made in primary care settings with pediatricians or family doctors.[52] Although CPAN serves as a basic consultation resource available to physicians, the Collaborative Care Model (CoCM) is a patient-centered, multi-disciplinary approach embedded within primary care settings that actively monitors progress toward treatment goals without the need for a referral.[53] The 87th Legislature authorized the reimbursement for the CoCM under Medicaid and allocated ARPA funding to TCMHCC for the expansion of CoCM within health systems. MMHPI noted that the CoCM helps to multiply the workforce and improves early identification and clinical outcomes.[54]

Workforce challenges remain a barrier for youth and families to access care. In the counties where the Legislature has funded MST and YCOT, the need has far outpaced the state's capacity for those services. Youth in other parts of the state are left underserved. MMHPI suggested these programs should be expanded and the Legislature should direct HHSC to broaden procurement processes beyond LMHAs so that non-profits or other qualified entities are able help the state

meet more needs.[55] While the 87th Legislature authorized Medicaid reimbursement for the CoCM, it has yet to authorize reimbursement for MST despite its efficacy or cost benefit to the state.

Medicaid is jointly funded by the state and federal government to provide healthcare and long-term services to low-income pregnant women, children, seniors, and individuals with disabilities. There are four million Texans covered by Medicaid.[56] Covered behavioral health services are shown on the following figure provided by HHSC.

Figure 4: HHSC Medicaid State Plan Benefits

The Texas Association of Health Plans testified that approximately 50% of children in the state receive their healthcare coverage through Medicaid which is administered through a managed care model. The managed care model is similar to insurance, where HHSC pays a premium to the Managed Care Organization (MCO) to cover benefits set by the state and are required to cover all medically necessary services for their members.[57] MCOs are required to maintain an adequate network of providers accepting patients, provide care coordination, and offer unique access to services beyond traditional health care services such as transportation, meals and housing.[58] Unlike private health insurance, Texas Medicaid only covers psychiatric treatment including medications and intensive inpatient hospitalization but none of the services in-between.[59] For example, services on the full continuum of care such as MST, intensive outpatient care, crisis intervention services, and residential psychiatric care fall within the coverage gap. (See Appendix A).

Testimony provided to the Committee shows a correlation between the gap of covered services through Medicaid and youth accessing treatment through the state's conservatorship. A general case example provided to the Committee by TAHP and DFPS include scenarios where parents have children who receive mental health care in a hospital and have stabilized enough to be released, but parents do not feel as though their child will be safe re-entering the home without ongoing services and supports. Parents are then forced into making a decision to relinquish care to DFPS so that their children receive care in the most appropriate setting.

The 86th Legislature approved legislation that allows Medicaid MCOs to offer In-Lieu-Of Services (ILOS) if medically appropriate and cost-effective.[60] HHSC reported that after five years of attempted implementation, Phase 1 of the ILOS is in its final states of approval for its partial hospitalization, intensive outpatient and coordinated specialty care programs. Challenges noted by TAHP include administrative burdens such as complex waivers and case-by-case approvals required by the Centers for Medicare & Medicaid Services (CMS). Even when HHSC fully implements Phase 1 of the ILOS, there are many instances where youth may still fall

through the cracks because the services are not a standard benefit under Medicaid and there is no built provider base for those services. Texas is currently fully funding multiple cost-effective, evidence-based services and programs for youth mental health with general revenue dollars; however, if the same services were added as a covered benefit (creating a full continuum of services and the workforce behind it), the state would become eligible for the federal government match of 60 cents for every dollar.[61] Several examples of essential Medicaid coverage items include intensive outpatient treatment programs (IOP), partial hospitalization programs (PHP), crisis stabilization and respite services, effective community-based services such as MST and FFT, and psychiatric residential treatment for youth.[62]

The Texas Association of Behavioral Health Systems (TABHS) is the collective voice of over 5,400 licensed psychiatric beds, and 65 freestanding non-state-owned behavioral health hospitals across the state.[63] According to testimony provided to the Committee, freestanding psychiatric hospitals provide an array of services including but not limited to assessments, contracted beds through LMHAs, medication management, therapeutic interventions, crisis services, IOP and PHP services, and acute inpatient services for all age groups.[64] TABHS suggests there is a need for investing in community-based services rather than state-owned facilities and services alone. Among the need to address workforce shortages, reimbursement rates in Texas do not support the level of care youth need nor does it attract or retain providers who serve children and adolescents with mental health needs.[65] By investing in non-state-owned hospitals, community-based services, and addressing reimbursements rates (including for YES Waiver providers), Texas can increase the state's capacity to serve adolescents and create a broader continuum of services to avoid system involvement and support families in their respective communities.

The Committee heard testimony from SJRC Texas and Our Community Our Kids (OCOK), both Texas Family First (TFF) Pilot providers that offer evidence-based models such as functional family therapy (FFT) and in-home evidence-based models to 23 Texas counties. Both programs have reported success with serving families involved with or at risk of becoming involved with the foster care and juvenile justice systems. SJRC Texas reported that 90% of families referred to the TFF pilot are in need of behavioral health supports such as counseling, medication management and psychiatric treatment in addition to the evidence-based programs SJRC offers.[66] Both organizations agree that the lack of available mental health resources in the community are detrimental to families as unmet behavioral health needs impede the development of coping and resiliency skills.

While TFF Pilots are available through DFPS and Community-Based Partnerships, testimony provided to the Committee suggests that the eligibility criteria for accessing funds for children's mental health services is too narrow. Texas has two definitions for "foster care candidacy" which determine which service qualifies for a federal match under the FFPSA.[67] Broadening the definition would enable more services to become eligible for a federal match and provide greater access to family preservation services.

The Texas Council on Community Centers (TCCC) is the collective voice of the local authority systems which include 39 statutorily authorized Community Mental Health Centers (CMHCs) and Intellectual or Developmental Disabilities (IDD) centers across all 254 counties.[68] Many of the CMHCs and IDD centers also serve as the LMHA, Local Behavioral Health Authority (LBHA), and Local IDD Authority (LIDDA) for their respective areas. See Appendix B for services offered through local authorities. TCCC testified that barriers for providing services include ongoing costs coupled with increased needs within the local authorities.

The YES Waiver program operated by HHSC provides therapy, support services such as respite care, and supports families in managing their child(ren)'s complex mental health challenges. The program was developed to prevent hospitalization, residential treatment, foster care, and other out-of-home placements for children with high acuity needs. Despite the increased number of children and families inquiring about YES Waiver services over the last five years, the number of youth served by the program has declined.[69] Testimony provided by both TCCC and Texans Care for Children emphasized the need to increase YES Waiver reimbursement rates to expand the provider network and improve access to care. Low reimbursement rates set by HHSC prevent providers from enrolling more children into the program and hinder the attraction of providers to the workforce.

Children with Autism also face barriers to treatment. The gold standard treatment for Autism is Applied Behavior Analysis (ABA), but because of low Medicaid reimbursement rates, providers have long waitlists and access to care is impacted.[70] DRTx suggested that increasing reimbursement rates/payments for qualified providers using evidence-based treatments will increase the workforce and access to care.

The testimony provided by Texas Network of Youth Services (TNOYS) supported findings from previous testimony citing increased mental health needs, provider shortages, COVID funding investments ending and insufficient community-based resources to fill the gap in the continuum of care.[71] Their testimony also underscored the need for more counselors and therapists in schools to provide greater access for children who need mental health support and prevent the escalation of crisis. Testimony noted that providing support for parents to navigate mental and behavioral health systems may reduce barriers to accessing care.[72]

Schools can serve as one of the stopgaps for identifying children's mental health needs. The Texas Coalition for Healthy Minds, stated in testimony that investment in community-school partnerships is a strategy to improve youth behavioral health *before* a crisis occurs and youth become system involved. By increasing resources to both communities and schools, specific needs can be identified to bolster the services and supports required to foster safe and supported children. When needs are identified early, even if a youth does not require a clinical or crisis intervention, a lower intensity of services should be available for youth to receive support.[73] This range of support for varying needs is often referred to as Multi-Tiered Systems of Support (MTSS). Within school mental health, examples of prevention, intervention and treatment can be seen on the following figure provided by the Texas Coalition for Healthy Minds.

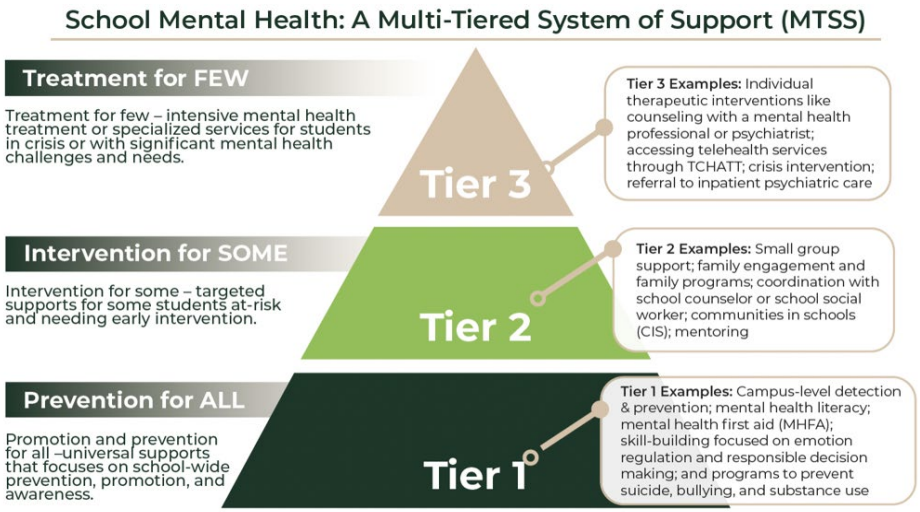


Figure 5: Multi-Tiered Systems of Support, provided by Texas Coalition for Healthy Minds

School counselors are often the first line of prevention and intervention support for Texas school children. The Texas Counseling Association (TCA) testified that they too have experienced a rise in behavior issues with students, school discipline referrals, and teachers asking for assistance with classroom management. Testimony provided by the school counselors also supports the Committee's findings on mental health workforce challenges, and the lack of community-based resources to connect families with outside referrals. One of the distinct challenges professional school counselors face is the lack of clarity on their role by campus administrators. School counselors are often assigned administrative duties rather than counseling duties as required by Texas law.[74]

The Texas American Federation of Teachers (AFT) provided testimony that underscored the need for more mental health staff in schools in the form of school social workers. Like school counselors, school social workers are also on the front lines of prevention and intervention for Texas school children. The School Social Work Association of America recommends a ratio of one school social worker for every 250 students, but Texas' ratio far exceeds that recommendation with one social worker for every 4,819 students.[75] Social workers provide an array of interventions from crisis management to referrals to community resources and often advocate for student academic support.[76]

Testimony and research suggest that investing in evidence-based prevention services upstream can reduce mental and behavioral health crises that cost more to address on the back end. The Texas Association of Substance Abuse Programs (ASAP) stated that prevention services targeting risk and protective factors reduce substance use, mental health, violence, academic underachievement, delinquency, and criminal behavior. Funding and/or grant restrictions may have unwittingly participated in the fragmentation of service delivery.[77] Due to the complex needs of youth, ASAP recommended the state develop a cross-agency prevention system based on a Shared Risk and Protective Factor (SRPF) model to better coordinate and respond to youth mental and behavioral health. This model approach to intervention may improve service coordination, streamline service delivery, and build efficiencies across various systems that serve children and families.[78] Similar testimony from TCRP suggested the state create the Office of Youth Health and Safety.

Finally, the Committee heard testimony from two organizations that provide upstream services. The first was The National Service Office for Nurse-Family Partnership & Child First. Child First is an evidence-based, two-generation, in-home mental health program that serves families from pregnancy through age five to enhance strong and loving relationships.[79] The program assists families experiencing challenges such as poverty, maternal depression, abuse and neglect, substance use, incarceration, etc. and is eligible for state and federal dollars. As mentioned under the Background section of this charge, toxic levels of stress related to those challenges impact the developing brain. Without protective factors like nurturing relationships, the developing child can have long-term mental, emotional, behavioral, learning and health problems.[80] The second program, CARY4Kids is provided by the Council for At-Risk Youth (CARY). It is an evidence-based prevention and intervention model aimed at reducing violence and juvenile justice system involvement through a community-school partnership.[81] CARY works to teach social skills, emotional control, and prosocial behavior to promote social-emotional learning. Both organizations providing upstream services underscored the need for additional funding to support evidence-based programs.

COMMON THEMES IN TESTIMONY

The most common themes provided through testimony to the Committee include the need to address:

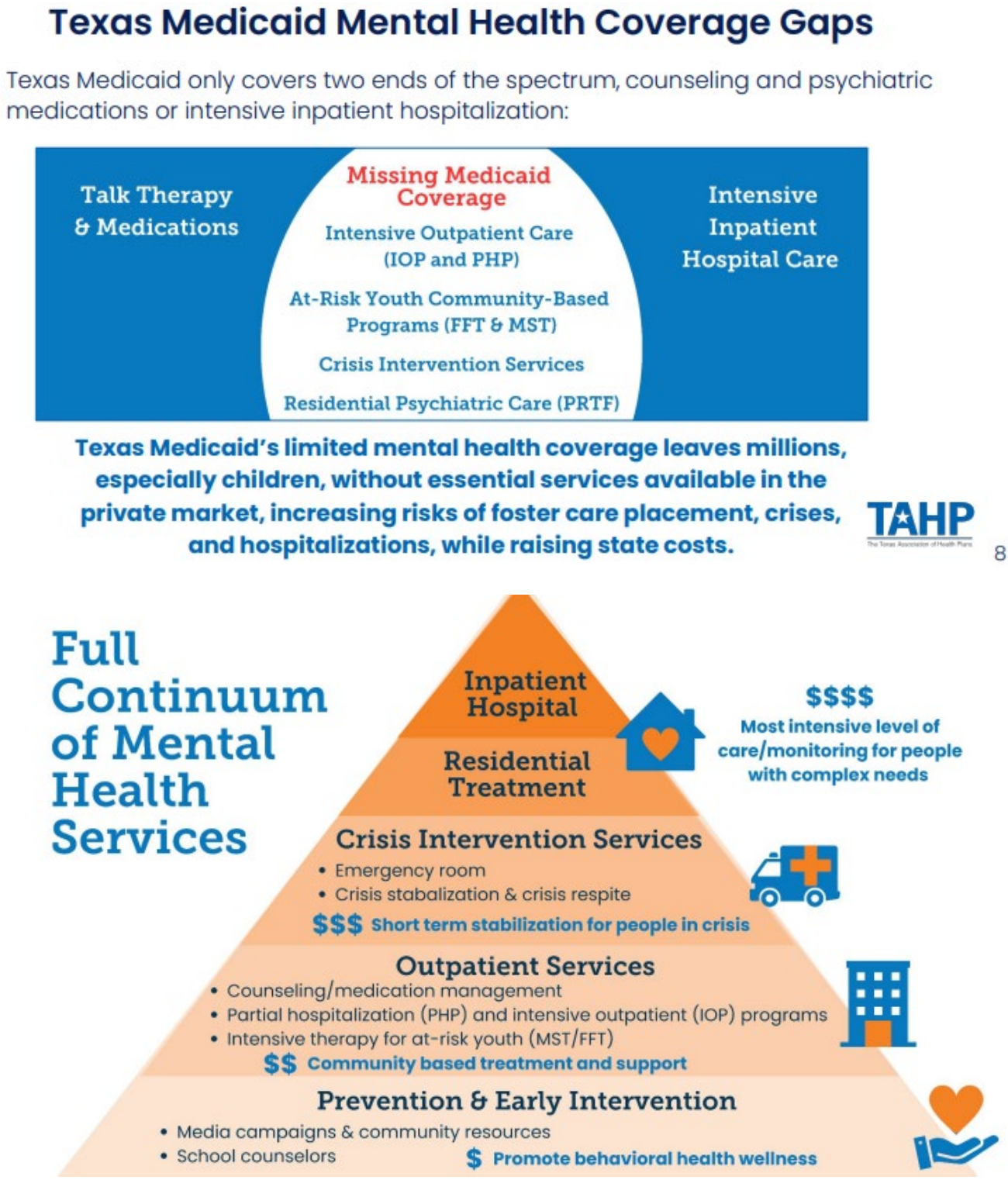
- Mental and behavioral health workforce shortages,
- The lack of standard Medicaid benefits and low reimbursement rates to broaden the array of child and adolescent mental health services,
- The need for accessing mental and behavioral health services in the community, as increasing needs far outpace Texas' current capacity,
- The increased need for a full continuum of services to provide families the most appropriate intervention tailored to each child's needs,
- The need for funding community-based services,
- The need to invest or expand investment in community settings *(ex: schools or health settings)* where children and families have earlier encounters with professionals who can intervene sooner and prevent unaddressed mental health concerns from becoming crises farther upstream, and
- The need to continue and increase the state's investments in its existing evidence-based programs and services.

RECOMMENDATIONS

Based upon the Committee's findings and summary of testimony, the Committee recommends the Legislature reduce barriers for youth and families by doing the following:

- Ensure coverage for mental and behavioral health services through Texas Medicaid.
- Increase reimbursement rates for the YES Waiver program.
- Increase funding for the state's current evidence-based programs and invest additional funding to expand access to a wider array of evidence-based services.
- Revise procurement processes to allow other qualified entities to provide evidence-based services in their respective communities.
- Invest in community-based services to significantly reduce and divert families from DFPS and TJJD involvement.
- Create greater access to relinquishment prevention programs.
- Create access to in-home and out-of-home crisis support such as crisis stabilization and respite care.
- Create a sustainable plan to continue and expand the Texas Family First Pilot Programs.
- Broaden criteria for federal matching funds as it relates to evidence-based family preservation services.
- Support infrastructure development for dual-diagnosis youth, including adolescent substance use treatment.
- Create a dedicated mental health allotment, or similar funding, to ensure children and adolescents have access to Multi-Tiered Systems of Support in schools.
- Ensure school district adherence to state statute relating to school counselor duties.
- Continue and expand the Collaborative Care Model initiative.
- Continue to the study root causes of the rise in mental health conditions.
- Continue the multi-agency coordination and planning efforts to address the increased needs of children's mental health services in the community.

Appendix A


Texas Medicaid Mental Health Coverage Gaps
Texas Medicaid only covers two ends of the spectrum, counseling and psychiatric medications or intensive inpatient hospitalization:
Talk Therapy & Medications
Missing Medicaid Coverage
Intensive Outpatient Care (IOP and PHP)
At-Risk Youth Community-Based Programs (FFT & MST)
Crisis Intervention Services
Residential Psychiatric Care (PRTF)
Intensive Inpatient Hospital Care
Texas Medicaid's limited mental health coverage leaves millions, especially children, without essential services available in the private market, increasing risks of foster care placement, crises, and hospitalizations, while raising state costs.
TAHP
8

Full Continuum of Mental Health Services
Inpatient Hospital
Residential Treatment
$$$$
Most intensive level of care/monitoring for people with complex needs
Crisis Intervention Services
• Emergency room
• Crisis stabalization & crisis respite
$$$ Short term stabilization for people in crisis
Outpatient Services
• Counseling/medication management
• Partial hospitalization (PHP) and intensive outpatient (IOP) programs
• Intensive therapy for at-risk youth (MST/FFT)
$$ Community based treatment and support
Prevention & Early Intervention
• Media campaigns & community resources
• School counselors
$ Promote behavioral health wellness

Appendix B

Statewide
Certified Community Behavioral Health Clinics (CCBHC)
Texas Resilience and Recovery (TRR) Model
Accredited Crisis Hotlines
Jail Diversion Planning
Mobile Crisis Outreach Teams
Locally Purchased Psychiatric Beds
Crisis Transitional Services
Intensive Ongoing Services
Benefits Assistance
Medication-Related Services
Skill Training (psychosocial rehab)
Case Management
Therapy (CBT, TF-CBT, PCIT and Family)
Supported Employment
Supported Housing
Assertive Community Treatment
Mental Health First Aid (MHFA)
Youth Empowerment Services Waiver (YES Waiver)
Peer Support & Family Partner Services
Substance Use Disorder Services

Local Authority Services

(Highlighted items are Child & Adolescent services and/or services available to both children and adults)

Certain Local Service Areas
Diversion Centers
Community Psychiatric Hospital
Crisis Stabilization Units
Extended Observation Units (23-48 Hours)
Crisis Residential Services
Crisis Respite Services
Crisis Step-Down
Jail-based Competency Restoration
Outpatient Competency Restoration
Homelessness Services
Coordinated Specialty Care (CSC)
Multisystemic Therapy (MST)
School-Based Services
Youth Services Navigators
Youth Crisis Outreach Teams (in process)
Community Health Workers

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