REPORT SUMMARY:

Rio Grande Valley Behavioral Health Systems Assessment

BACKGROUND

The Valley Baptist Legacy Foundation (Legacy Foundation) engaged the Meadows Mental Health Policy Institute (MMHPI) in 2016 to study the capacity and performance of the behavioral health systems in Cameron, Hidalgo, Starr, and Willacy counties, located in the Rio Grande Valley (RGV). The goal of the assessment was to conduct an independent analysis of the county behavioral health care (mental health and substance use) systems and provide the Legacy Foundation with specific strategies for developing a responsive, clinically effective, and efficient regional behavioral health care system for the RGV. MMHPI staff gathered data from more than 75 interviews and site visits with local stakeholders, and combined these data with county-specific prevalence estimates of behavioral health needs across the four-county region to create a population-level view of the region's strengths and needs. This summary document provides an overview of the behavioral health needs and service capacity identified in the Rio Grande Valley, some of the major systems level findings and opportunities across six key areas, and best practices to consider for each key area. Please see the full report for more information on the findings and recommendations discussed here, as well as citations for the data provided in this summary.[1]

HIGHLIGHTS OF BEHAVIORAL HEALTH NEEDS AND CAPACITY IN THE RIO GRANDE VALLEY

In a 12-month period, an average of one in three children and youth in the RGV (just under 120,000 total) and one in five adults (about 220,000 total) will have mental health needs. For children and youth (ages 6–17), more than 75% (over 90,000) will have mild to moderate needs (such as anxiety and routine depression) that can be addressed with the right evidence-based supports in a primary care setting. Just over 25,000— the vast majority of whom (80% or 20,000) live at or below 200% of the federal poverty level—will have severe needs (such as bipolar disorder, complex depression, and post-traumatic stress disorder [PTSD]) requiring more intensive treatment.

Similarly, of the 220,000 adults in the RGV region who will have mental health needs each year, just over 75% (about 170,000) will have mild to moderate needs that can be addressed in an integrated primary care setting. An additional 45,000 will have a serious mental illness (such as schizophrenia, bipolar disorder, severe depression, and PTSD) requiring more intensive treatment. Again, the vast majority of these adults with the most severe needs (approximately 35,000) live in poverty.

We also identified three smaller subsets of people with more severe, specialized needs for whom expanded access to best practice care could make a real difference—both for those individuals and their families as well as the community overall. The first group are the approximately 700 adults in the RGV caught in cycles of "super-utilization," a term that refers to the experience of people with highly complex needs whom systems repeatedly fail to engage and help despite extremely high rates of service provision through inpatient and emergency hospital services and the justice system. The second group are the approximately 2,000 children and youth (less than one in 100 of the overall group in need) whose needs are so severe that they are at risk of not being able to live at home or stay in school. The third subset are the approximately 200 RGV adults between the ages of 18 and 34 years who will manifest a first episode of psychosis each year, a condition that can be best treated if addressed aggressively in the first few months of symptoms, rather than the five years or more that most people across the RGV (and the nation) still tend to wait before receiving intensive services.

SUMMARY OF MAJOR SYSTEMS LEVEL FINDINGS AND RECOMMENDATIONS

The Need for Collaborative County-Level Planning

Within the overall behavioral health care systems in the RGV, there are significant areas of strength, including new programs and services that have been developed and examples of significant collaboration among individual providers and counties. However, there is a lack of organized, collaborative planning at the county level to support the shared management of behavioral health resources and systems. The primary recommendation in this area is to form comprehensive behavioral health leadership teams (BHLTs) that focus on the behavioral health needs of each county; BHLTs would also include a dedicated position to support collaborative efforts. BHLTs should be made up of local decision makers (e.g., representatives from the city, county, health care) who represent the diversity of the community. BHLTs may also consider establishing issue-based workgroups dedicated to addressing the needs of the region and engaging prevention coalitions in BHLT activities to expand current efforts.

EXAMPLES OF INNOVATIVE COLLABORATIVE COUNTY-LEVEL PLANNING

DENTON COUNTY BEHAVIORAL HEALTH LEADERSHIP TEAM | Denton, TX | *www.dentoncountybhlt.org*

Since the inception of the Denton County Behavioral Health Leadership Team (BHLT), the group has accomplished several goals, including developing a mental health resource directory for Denton County, launching the Veteran Community Navigator Program with funding from the TV+FA program, partnering with the Military Veteran Peer Network to conduct Veteran Cultural Competency Training, and partnering with MMHPI in the Okay to Say™ campaign (www.okaytosay.org).

PANHANDLE BEHAVIORAL HEALTH ALLIANCE (PBHA) Amarillo, TX | *www.panhandlebehavioralhealthalliance.org*

Formed in 2016, PBHA comprises a broad group of stakeholders representing the behavioral health service delivery systems of 26 counties in the Panhandle region. It has three areas of focus: 1) access to behavioral health care and alignment with physical health care; 2) workforce and recruitment for behavioral health professionals; and 3) prevention and early intervention for behavioral health problems.

Legislative Opportunities

Several pieces of legislation from the 85th Legislative Session present opportunities for implementing the recommendations for county-level planning and supporting programs modeled after the innovative examples provided above.[2] House Bill (HB) 13 will provide matching grants to support community mental health programs that provide services to individuals experiencing mental illness. The Texas Veterans + Family Alliance (TV+FA) program was continued and provides matching grants to support programs that will help address gaps in behavioral health services and treatment in local communities for veterans and their families. Senate Bill (SB) 1 (the state budget) and SB 74 combined to increase access to Targeted Case Management and Mental Health Rehabilitative Services for children with high needs. Budget Rider 172 in SB 1 appropriated $2 million to establish a statewide grant program to increase access to these services for children with high needs who are involved in the foster care system. SB 292 established a program to provide matching grants to county-based community collaboratives to reduce the recidivism of people with mental illness and to decrease wait times for criminal justice-related commitments to state psychiatric hospitals. Lastly, the Healthy Community Collaborative (HCC) program was continued and provides an additional opportunity for providers to secure funds for supporting local collaborations that focus on mental health service provision.[3]

Services for Individuals Caught in Cycles of "Super-Utilization"

The RGV's local mental health authorities (LMHAs), Tropical Texas Behavioral Health (TTBH) and Border Region Behavioral Health Center (BRBHC), provide an array of services within the RGV's adult mental health system of care for individuals with serious mental illness (SMI). However, because the LMHAs were developed as two separate systems of care, they both lack the array of services necessary to avoid reliance on inpatient care and to fill significant gaps in overall services. We believe a cross-payer effort to develop ongoing assertive and intensive services would have the potential to make a

positive impact on adults caught in cycles of "super utilization." Therefore, we recommend that county BHLTs make it a priority to develop sufficient capacity for ongoing care for adults with highly complex needs, and also develop a strategic plan that addresses the use of inpatient bed capacity across the entire RGV region, outpatient services for adults with mild to moderate needs (possibly drawing on current capacity for integrated behavioral health care), and independent housing options for adults and transition-age youth moving to independent living.

EXAMPLES OF SUCCESSFUL PROGRAMS ADDRESSING "SUPER-UTILIZATION"

TTBH'S FIRST EPISODE PSYCHOSIS (FEP) PROGRAM
Cameron, Hidalgo and Willacy Counties, TX | *www.ttbh.org*

It is notable that TTBH has begun to implement an FEP care program (modeled after the OnTrack FEP care program[4]) that has the potential to reduce the future prevalence of "super-utilization," especially for people whose experiences of psychosis are identified within the first 18 months from the point of symptom onset.[5] Planners should consider matching this emerging capacity with the level of need, which we have estimated to be 200 adults in a given year.

TTBH ASSERTIVE COMMUNITY TREATMENT (ACT) TEAMS | Cameron, Hidalgo and Willacy Counties, TX | *http://www.ttbh.org/en/tropical-texas-behavioral-health-services/adult-mental-health*

The TTBH Assertive Community Treatment (ACT) teams operate in three locations, providing an integrated clinical and rehabilitative team approach to service provision for individuals with the most severe behavioral health needs.[6] The TTBH ACT program is accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF) and employs the current state-of-the-art Tool for Measurement of Assertive Community Treatment (TMACT)[7] to monitor and report on the fidelity of its operating ACT teams. Such an approach is particularly critical because high fidelity implementation of ACT and other evidence-based programs is a predictor of good outcomes[8] and system-wide cost savings.[9]

FRONT STEPS' SUPPORTIVE HOUSING PROGRAM |
Austin, TX | *www.frontsteps.org*

Front Steps' Supportive Housing Program provides subsidized, scattered-site housing with intensive case management and other support services. The program uses the Housing First model, which is designed to ensure that each tenant is successfully housed and integrated into the community.[10] This approach has shown impressive results: data on housing stability show a 94% success rate at the one-year point,[11] and the Front Steps program shows an 80% tenancy rate at 25 months.[12]

Creating a Comprehensive Crisis System

While there are some excellent crisis intervention services in the RGV, there are no comprehensive county-wide crisis intervention programs. The benefits of implementing and operating a full array of crisis services accrue across systems and, therefore, each partner has a programmatic and financial stake in a comprehensive crisis system and should be called upon to provide support for its development and implementation. We recommend that developing a regional integrated crisis system should be the highest priority for enhanced county-level and/or cross-county collaboration. As outlined in the MMHPI report,[13] *Behavioral Health Crisis Services: A Component of the Continuum of Care,* which was developed for St. David's Foundation, a full array of crisis services ideally includes a comprehensive, integrated continuum of services created with the intention of stabilizing and improving an individual's symptoms and facilitating engagement in treatment in the least restrictive setting possible. For example, intensive treatment provided through 23- to 48-hour crisis stabilization/observation beds, the incorporation of peer crisis services, and walk-in locations for crisis triage/urgent care are important components of a comprehensive crisis system. Additional information on key components of the ideal crisis services continuum of care can be found in our full report.

EXAMPLES OF INNOVATIVE COMPREHENSIVE CRISIS SYSTEM EFFORT

SOUTH TEXAS CRISIS COLLABORATIVE (STCC) |
Bexar County, TX

The South Texas Crisis Collaborative (STCC) steering committee is a collaborative local planning entity comprising stakeholders from both private and public sectors (e.g., hospital system, fire department, police department, LMHA, funders). STCC emphasizes shared metrics and accountability across providers, strives to address public health challenges with behavioral health services, and

aims to develop coordination strategies that can improve the effectiveness and scope of existing resources.

JUDGE GUY HERMAN CENTER FOR MENTAL HEALTH CRISIS CARE | Austin, TX | *www.integralcare.org/judge-guy-herman-center-for-mental-health-crisis-care/*

Through a grant from St. David's Foundation and additional public and private funding sources, Integral Care (the LMHA for Travis County) created the Judge Guy Herman Center for Mental Health Crisis Care (Herman Center). Herman Center is a 16-bed facility that offers short-term emergency psychiatric crisis care through services such as crisis assessment, crisis stabilization and extended observation, medication, therapy, nursing services, case management, discharge planning, and linkages to community resources.

Expanding Services for Children and Youth

Behavioral health care delivery systems for children, youth, and family services in the TTBH and BRBHC regions operate as separate systems. While overall capacity is underdeveloped throughout the RGV (just as it is throughout Texas and the nation), TTBH and BRBHC provide a relatively strong foundation of evidence-based services and best practices to build upon and expand. There is a need to develop a unified, system-wide planning process within each of the counties in the RGV that involves all child- and family-serving providers and major payers. County planning efforts can build on and expand the work of the TTBH Children's System of Care and its existing collaboration with juvenile justice and child protective services. Expanded access to intensive, time-limited, home and community-based supports is needed to meet the needs of the 2,000 children and youth at highest risk of out-of-home placement.

PROMISING APPROACHES TO EXPANDING SERVICES FOR CHILDREN AND YOUTH

DEVELOPING AN IDEAL SYSTEM OF CARE FOR PEDIATRIC MENTAL HEALTH

Too often, children and youth across Texas (and the nation) end up in inpatient care and residential treatment. It is important to understand that these levels of care are not places for ongoing treatment; they are specialized settings designed to address either acute needs (inpatient care) or an inability to reside at home (residential treatment). In a report developed for the Houston Endowment titled *Harris County Mental Health Services for Children, Youth and Families: 2017 System Assessment,* MMHPI developed a map of the "ideal system of care for pediatric mental health" as a model for ensuring that children and youth receive the right level of care for their behavioral health needs.[14]

The model consists of four components: 1) Integrated Behavioral Health in a Pediatric Primary Care Setting, which research suggests can meet approximately two-thirds of pediatric behavioral health care needs; 2) Specialty Behavioral Health Care, provided by specialists in separate clinical settings, which is most appropriate for about one-fourth of children and youth with more complex behavioral health needs requiring specialized interventions (e.g., bipolar disorder, post-traumatic stress disorder); 3) Rehabilitation and Intensive Services, which are provided to children and youth whose behavioral health conditions are so severe that they impair functioning across multiple life domains and require time-limited and intensive evidence-based rehabilitation and specialized treatment; and 4) Crisis Continuum, which consists of mobile teams that are able to respond to a range of urgent needs outside of the normal delivery of care, and includes placement options ranging from crisis respite to acute inpatient care. While this array does not currently exist in any county in Texas, some components exist in the RGV region across the mental health, child welfare, and juvenile justice systems. Additional information on each component can be found in the full RGV Behavioral Health System Assessment report, as well as on pages 2–12 in the report for Houston Endowment referenced above.

MASSACHUSETTS CHILD PSYCHIATRY ACCESS PROJECT (MCPAP) | Boston, Holyoke, Middleboro & Salem, MA | *www.mcpap.com*

MCPAP was established in 2004 and currently supports over 95% of the pediatric primary care providers in Massachusetts. Six regional behavioral health consultation hubs (consisting of a child psychiatrist, a licensed therapist, and a care coordinator) operate dedicated hotlines that can include services such as timely clinical consultation over the phone, expedited face-to-face psychiatric consultation, and care coordination for referrals. This model has inspired many other states to create similar programs.

TTBH'S YES MEDICAID WAIVER WRAPAROUND PROGRAM | Cameron, Hidalgo and Willacy Counties, TX | *www.ttbh.org*

Through the YES Medicaid Waiver program, TTBH has developed a strong wraparound program for youth with

serious emotional disturbances. Wraparound is a service coordination function that, when combined with effective treatment, achieves positive outcomes. The current TTBH wraparound supervisor is certified. The TTBH wraparound team engaged in a six- to nine-month process of fidelity monitoring and will likely become the first wraparound program in the nation to be certified.

Moving Toward Integrating Physical and Behavioral Health Care

As mentioned in the previous section, integrated behavioral health (IBH) models used in pediatric settings (such as those in MCPAP) can address the behavioral health needs of approximately two-thirds of children with mild to moderate needs. IBH also offers the most promise for expanding capacity to treat mental illnesses and substance use disorders more routinely and in the most cost-effective manner for adults with mild to moderate behavioral health needs. Approximately 80% of these adults can have their needs addressed in these settings, allowing communities and health systems to focus their specialty resources on more severe subsets of need. There is a strong commitment to IBH among many providers in the region, with many implementing similar or at least complementary approaches to care. However, some providers are unable to meet the IBH needs of all the people in their settings. Stakeholders may consider developing an overarching strategy for creating cost-effective improvements in IBH for priority populations in the RGV, including the development of new strategies to coordinate care between and among providers to reduce the potential for duplicating services.

EXAMPLES OF SUCCESSFUL INTEGRATED BEHAVIORAL HEALTH CARE STRATEGIES

BEST PRACTICES IN INTEGRATED HEALTH CARE: IDENTIFYING AND IMPLEMENTING CORE COMPONENTS

In collaboration with St. David 's Foundation, MMHPI developed the report, *Best Practices in Integrated Behavioral Health: Identifying and Implementing Core Components*,[15] which identifies seven core components of IBH that can be used to determine the extent to which physical health and behavioral health care can be integrated (versus simply co-located) for patients. The report offers a roadmap for providers, funders, advocates, and policymakers interested in promoting IBH and working systematically toward achieving its promise. For example, population health management, integrated organizational culture, and universal screening are all important components of integrated health care. Additional information and detail about the other core components can be found in the report.

DALLAS CHILDREN'S HEALTH (FORMERLY CHILDREN'S MEDICAL CENTER) INTEGRATED BEHAVIORAL HEALTH CARE MANAGEMENT PROGRAM | Dallas, TX | *www.childrens.com*

In 2013, Dallas Children's Health launched the Integrated Behavioral Health Care Management program within its pediatric outpatient clinics, and by July 2015 the program was fully implemented with care managers covering all 18 Children's Health Pediatric Group clinics. The co-located behavioral health teams provide consultation and direct treatment to patients who obtain care from primary care providers within the clinics. This program improved care coordination by using a shared electronic medical record system that offers both primary care and specialty behavioral health providers access to a patient's records.

DOCTORS HOSPITAL AT RENAISSANCE – UNIVERSITY OF TEXAS RIO GRANDE VALLEY (DHR – UTRGV) FAMILY MEDICINE CENTER | McAllen, TX | *www.dhrfamilymedicinecenter.com*

The DHR – UTRGV Family Medicine Center offers integrated health care services using the Primary Care/Behavioral Health Integration (PCBHI) model. Staff provide services primarily to individuals who are uninsured, have no access to medical care, and often experience the added stress of seeking services without immigration documentation. This provides a much-needed service to individuals with some of the greatest barriers to accessing care. At the time of MMHPI's site visit, the clinic was in the process of receiving certification as a Family-Centered Medical Home.

Building Up the Behavioral Health Workforce

All providers reported significant gaps in the behavioral health workforce, and there does not appear to be any region-wide, strategic behavioral health workforce effort or plan to address shortages. There is particularly high demand for professionals who are able to meet the specific linguistic and cultural needs of the significant monolingual Hispanic population of the region, and for licensed providers specializing in services for children and youth. The use of telemedicine, a key resource in a large geographic area with limited availability of licensed behavioral health professionals, has expanded

throughout the RGV, but access to board certified psychiatrists and other licensed professionals remains a challenge. Stakeholders in the region may consider ways of recruiting colleges and universities to train and certify culturally diverse behavioral health specialists to provide services to enhance the local workforce. This effort can also be enhanced through expanded use of certified peer support specialists and family partners as well as exploring the potential for using telemedicine resources that are available through public and private sources outside of the RGV.

INNOVATIVE APPROACHES TO BUILDING THE BEHAVIORAL HEALTH WORKFORCE

THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY SCHOOL OF MEDICINE DEPARTMENT OF PSYCHIATRY PSYCHOLOGY INTERNSHIP PROGRAM | Harlingen, TX | *www.utrgv.edu/som*

The UTRGV School of Medicine (UTRGV– SOM) opened in the summer of 2016 with an inaugural class of 55 students. In addition to developing its residency programs, the Department of Psychiatry is spearheading the development of a pre-doctoral psychology internship program accredited through the American Psychological Association. As the anchor institution for the internship, UTRGV– SOM Department of Psychiatry, together with MMHPI, has engaged local stakeholders to begin planning a training experience, with the goal of enticing early career psychologists to remain in the RGV.

THE UNIVERSITY OF TEXAS RIO GRANDE VALLEY FAMILY MEDICINE RESIDENCY PROGRAM AT DOCTORS HOSPITAL AT RENAISSANCE | Edinburg, TX | *www.utrgv.edu/som/gme/training-programs/family-medicine-doctors-hospital-at-renaissance*

The UTRGV Family Medicine Residency Program at DHR offers training on the integration of behavioral health into primary care as part of a three-year residency program in family medicine. Family medicine residents are coached in working with behavioral health providers and consultants in their day-to-day work, as well as providing instructions to patients on seeking behavioral health care at the clinic. Providers who have not been exposed to this type of team-based approach early in their careers often find it difficult to work in integrated care settings, and this type of training for residents addresses this difficulty and supports the implementation of IBH in primary care settings.

[1] Meadows Mental Health Policy Institute. (2017, October). Valley Baptist legacy foundation Rio Grande valley behavioral health systems assessment: Final report for public release. Harlingen TX: Valley Baptist Legacy Foundation. The full report can be accessed online at http://texasstateofmind.org/wp-content/uploads/2015/11/MMHPI-VBLF-System-Assessment-Report_for-Public-Release_FINAL_2017.10.24.pdf

[2] For additional information on HB 13, SB 292, SB 74 and TV+FA, please refer to: https://hhs.texas.gov/sites/default/files//documents/laws-regulations/reports-presentations/2017/leg-presentations/hb13-matching-grant-programs-sept-2017.pdf

[3] Texas Health and Human Services Commission (2017, January). *Report on the healthy community collaborative program for fiscal year 2016.* Retrieved from: https://hhs.texas.gov/reports/2017/04/healthy-community-collaborative-program-fiscal-year-2016

[4] Dixon, L.B. et al. (2015). Implementing coordinated specialty care for early psychosis. The RAISE Connection Program. *Psychiatric Services, 66*(7), 691-698.

[5] Kane, J.M., et al. (2016, April 1). Comprehensive versus usual community care for first-episode psychosis: 2-year outcomes from the NIMH RAISE early treatment program. *American Journal of Psychiatry, 173*:4, 362-372.

[6] Tropical Texas Behavioral Health. (n.d.). *Adult mental health.* Retrieved from: http://www.ttbh.org/en/tropical-texas-behavioral-health-services/adult-mental-health

[7] The TMACT is currently the standard used in many states for statewide ACT implementation (e.g., Delaware, Indiana, North Carolina, Pennsylvania, and Washington).

[8] Teague, G.B. & Monroe-DeVita, M. (2013). Not by outcomes alone: Using peer evaluation to ensure fidelity to evidence-based Assertive Community Treatment (ACT) practice. In: J. L. Magnabosco & R. W. Manderscheid (Eds.), *Outcomes measurement in the human services: Cross-cutting issues and methods. (2nd ed.).* Washington, DC: National Association of Social Workers Press.

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

[10] Housing First programs provide quick access to real housing without imposing artificial barriers to the housing. It is a highly successful practice for individuals who are vulnerable and have high service needs. For more information, see: Front Steps. (2016). Housing. Retrieved from http://frontsteps.org/what-we-do/recuperative-care/housing/

[11] Collins, S.E., Malone, D.K., & Clifasefi, S.L. (2013). Housing retention in single-site Housing First for chronically homeless individuals with severe alcohol problems. *American Journal of Public Health, 103* (Supp. 2), S269–274.

[12] Front Steps. (2016).

[13] Meadows Mental Health Policy Institute. (2016, December). *Behavioral health crisis services: A component of the continuum of care.* Austin TX: St. David's Foundation. The full report can be accessed online at http://texasstateofmind.org/wp-content/uploads/2015/11/MMHPI_CrisisReport_FINAL_032217.pdf

[14] Meadows Mental Health Policy Institute. (2017, October). *Harris County Mental Health Services for Children, Youth, and Families: 2017 System Assessment.* Houston TX: Houston Endowment. The full report can be accessed online at: https://www.houstonendowment.org/news/meadows-mental-health-policy-institute-houston-endowment-assessment-finds-310000-harris-county-youth-have-mental-health-needs/

[15] Meadows Mental Health Policy Institute. (2016, August). *Best practices in integrated behavioral health: Identifying and implementing core components.* Austin TX: St. David's Foundation. The full report can be accessed online at: http://texasstateofmind.org/wp-content/uploads/2016/09/Meadows_IBHreport_FINAL_9.8.16.pdf

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