COMMUNITY ADVANCEMENT NETWORK

EVERYBODY HAS A ROLE

CAN COMMUNITY COUNCIL MENTAL HEALTH REPORT

2023

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RESEARCH & DATA WORK GROUP FINDINGS

Background and Supporting Data

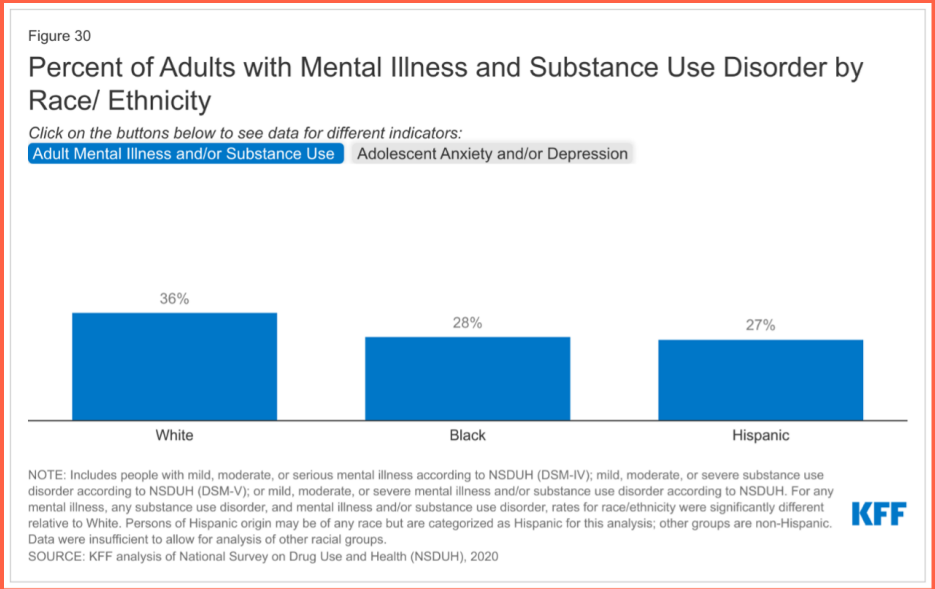
The CAN Community Council selected mental health as a focus area for 2020. Mental health professionals had been warning about a mental health crisis in the country for some time, even before the pandemic. The COVID-19 pandemic brought this future into sharp focus and accelerated the need to both understand and act on the mental health impacts on all of us. Today, major mental health organizations and leaders are calling this situation a crisis of epic proportions. Data relating to mental health and wellness indicated that our local community faced significant challenges similar to other communities.

The CAN Community Council work in 2021 was aimed at better understanding the mental health situation in the Central Texas community and how the Council might participate in this important conversation. The Community Council's *Community Mental Health & Wellness Report* was published in early 2022. When selecting the Community Council's areas of focus for 2021, mental health became a clear choice due to the data presented in the CAN Community Dashboard and the need for action and collaboration to address the mental health issues in our community.

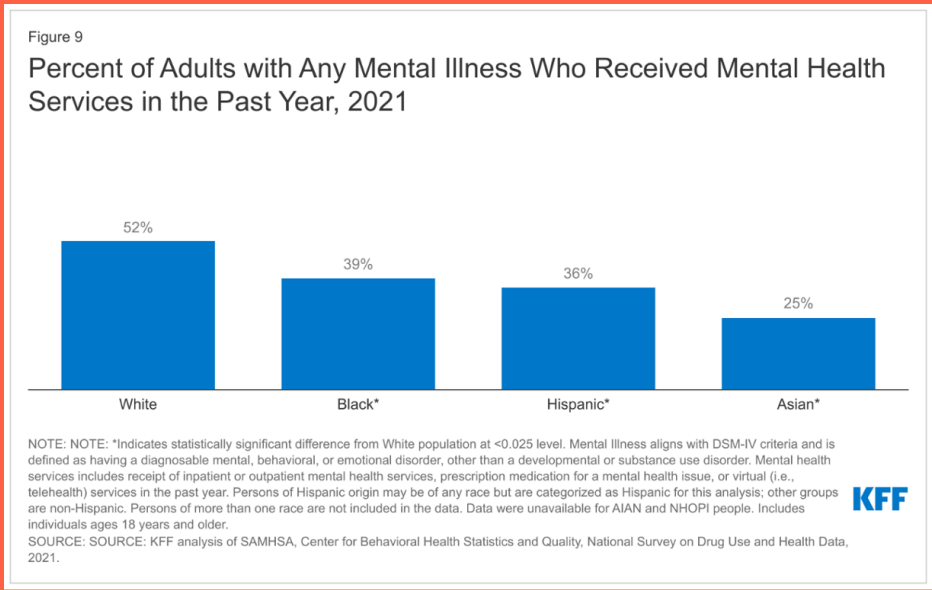
National and Local Data

Since the publication of the CAN Community Council's report in early 2022, local and national data relating to mental health and wellness continues to show that the problem is worsening and that disparities in outcomes for racial/ethnic groups remain. In this section, national trends and data are provided, followed by local trends and data broken out by different variables and affinity groups.

A recent report published in the Kaiser Family Foundation, *Key Data and Health and Health Care by Race and Ethnicity (March 2023)* included several indicators relating to mental health for the first time. The following chart compares the prevalence of mental illness and substance use disorder for non-elderly adults across different racial/ethnic groups.



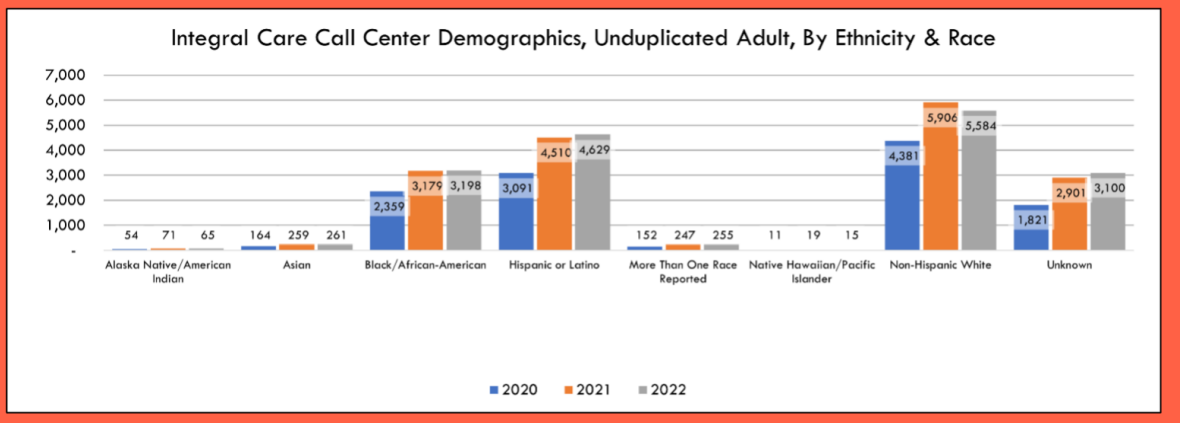
Another chart in the Kaiser Family Foundation Report outlines disparities with regard to the percentage of adults with a mental illness who receive services.



The national data presented above suggests that people of color were less likely to report mental illness and a substance use disorder than Whites. Once a mental illness or a substance use disorder was identified, people of color were also less likely to receive services.

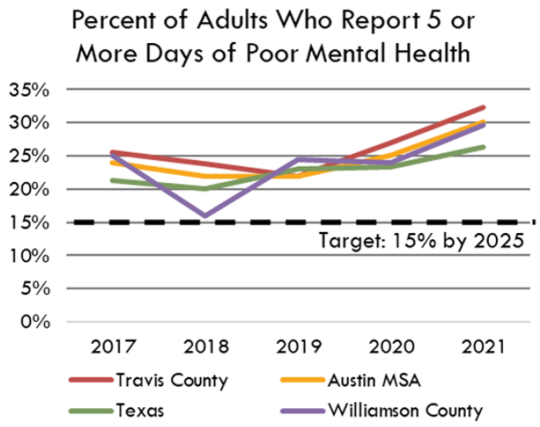
Looking at a more local data source, the local “call center” data from the Integral Care hotline shows that calls to the hotline by African-American, Asian-Americans and Hispanics increased at a higher rate from 2019 to 2021 than the calls to the hotline by

Whites (i.e., a 27% increase during that time period for Whites compared to a 59% increase for Asian-Americans, a 49% increase for Hispanics and a 31% increase for African Americans).



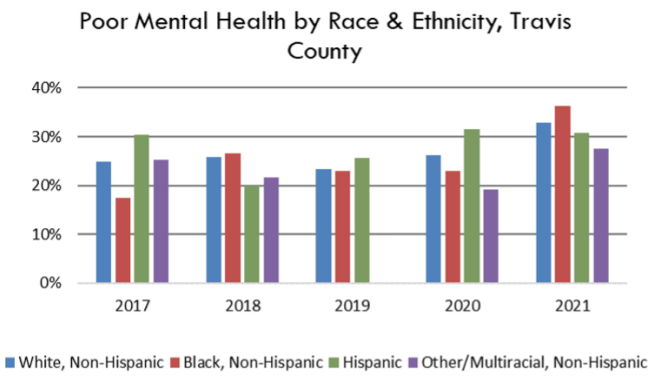
Source: Integral Care

The CAN Community Dashboard reports that in 2021, 32% of Travis County Adults reported poor mental health. In this indicator, with data collected from a self-report survey, mental health does not mean "suffering from a diagnosable mental illness," but instead is described as not feeling well emotionally, having too much stress, or feeling isolated.



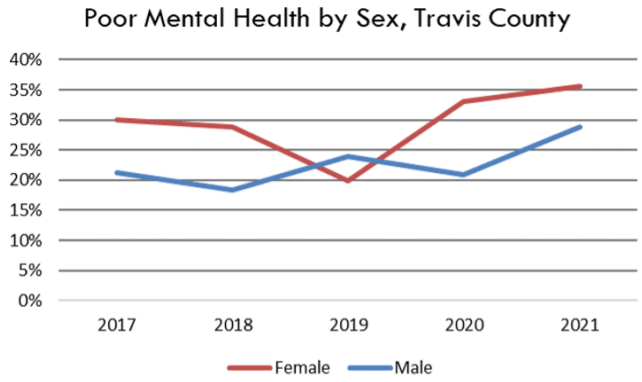
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, most groups saw an increase in the percentage of people reporting poor mental health. Black adults in Travis County had the highest rate (36%), followed by non-Hispanic White adults (33%), Hispanic adults (31%), and other/multiracial, non-Hispanic (28%). Poor mental health can include stress, depression, and emotional issues.



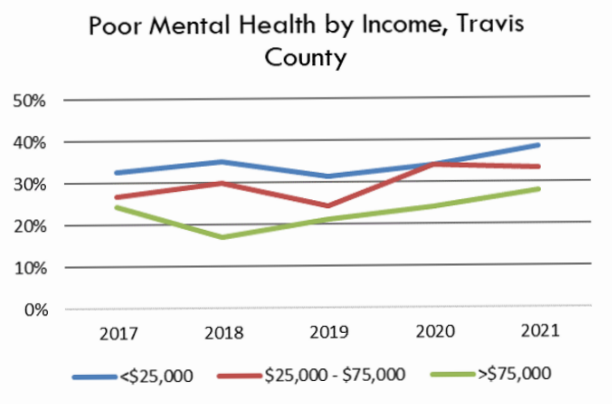
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

Between 2017 and 2021, a greater share of women reported 5 or more days of poor mental health within the past 30 days. In 2021, 36% of Travis County women reported poor mental health. The only year where a greater share of men reported poor mental health was 2019.



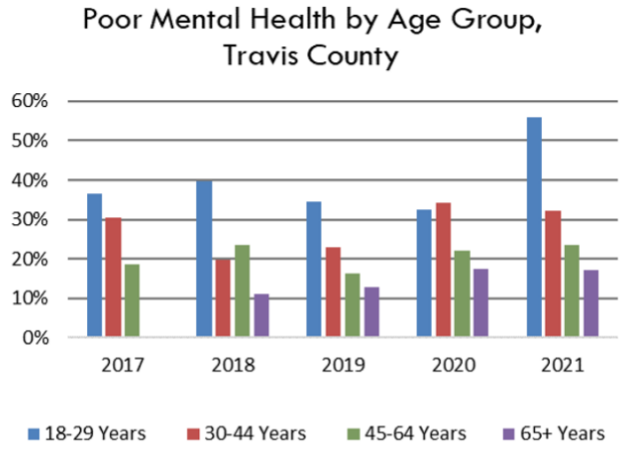
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, 38% of low-income Travis County adults reported experiencing five or more days of poor mental health within the past 30 days, according to data from the Behavioral Risk Factor Surveillance System (BRFSS). An estimated 33% of middle-income, and 28% of upper-income Travis County adults reported experiencing five poor mental health.



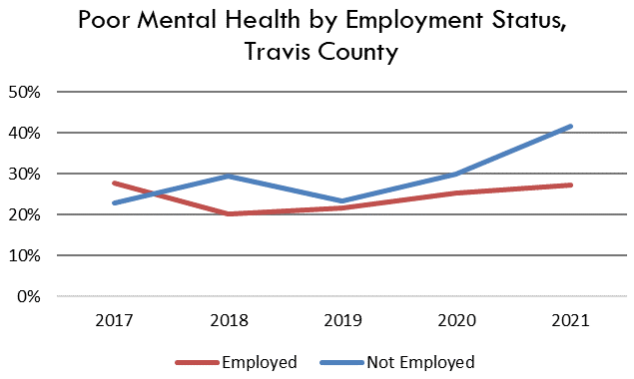
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

An estimated 56% of Travis County residents between the ages of 18 and 29 reported 5 or more days of poor mental health over the past 30 days in 2021, more than 70% higher than the 2020 rate. Travis County adults aged 45-64 years also reported an increase in poor mental health for 2021. In 2020, three out of four age groups saw an increase in the percentage of people who reported 5 or more days of poor mental health within the past 30 days.



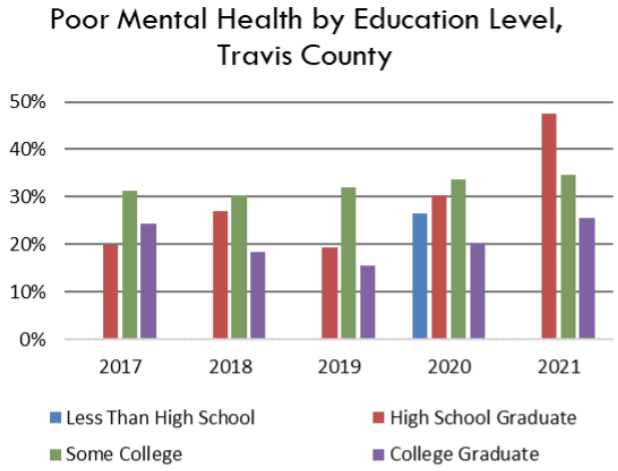
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, 42% of unemployed Travis County residents reported experiencing five or more days of poor mental health within the past 30 days. The trend in this drilldown shows some variability but has generally increased over the past 5 years.



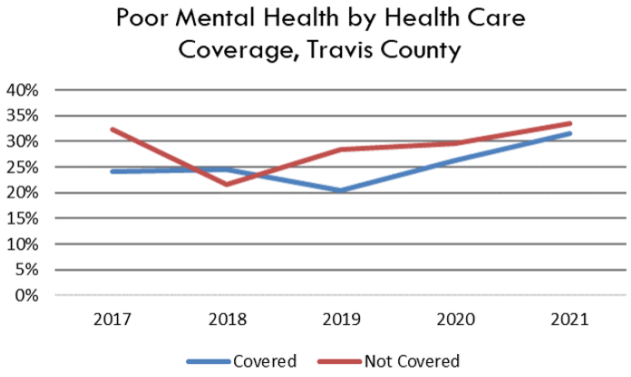
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, there was a sharp increase in the percent of Travis County adults with a high school diploma who reported poor mental health 2021, increasing to 48%. The rate of Travis County adults with some college who reported 5 or more days of poor mental health in 2021 was 35%. Including college graduates, all three groups saw an increase in this metric over the 2020 rate, but the high school graduate group's rate increased the most.



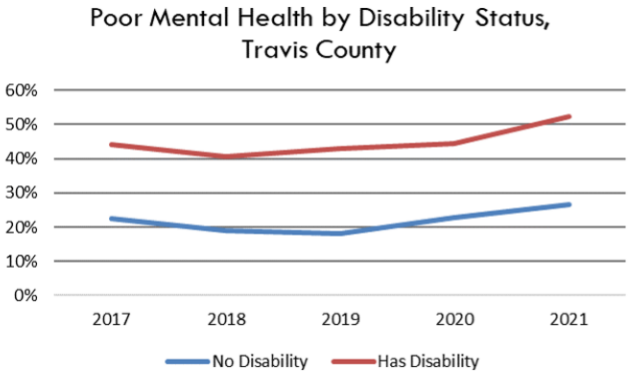
Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, an estimated 34% of Travis County residents without health insurance reported experiencing five or more days of poor mental health within the past 30 days, closely followed by an estimated 32% of Travis County residents with health insurance. Although the Mental Health Parity and Addictions Equity Act of 2008 should help make mental health treatment and support more accessible, significant barriers persist.



Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

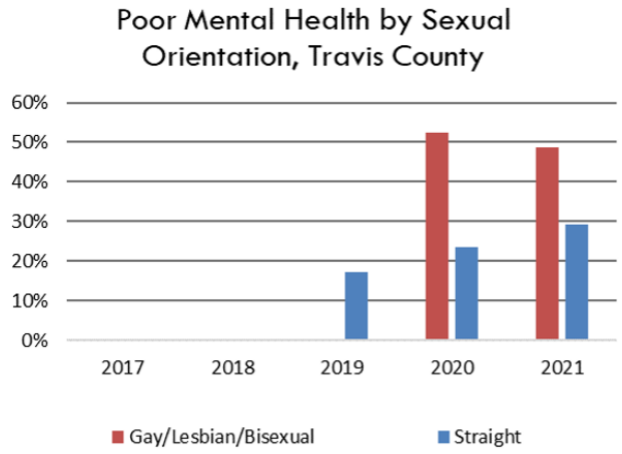
In 2021, approximately 52% of Travis County residents who have a disability reported experiencing five or more days of poor mental health within the past 30 days, compared with approximately 27% of Travis County residents who do not report a disability. Both groups have seen increases in the rate of poor mental health since 2019.



Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

In 2021, approximately 49% of Travis County residents who identify as gay/lesbian/bisexual reported experiencing 5 or more days of poor mental health over the previous month. In contrast, 29% of Travis County residents who identify as straight reported experiencing 5 or more days of poor mental health over the previous month.

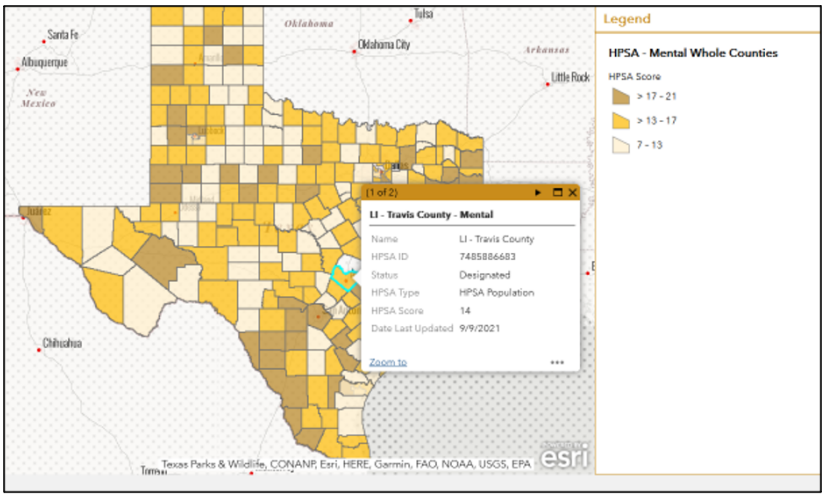
In 2013, the U.S. Centers for Disease Control and Prevention developed questions to collect data on sexual orientation and gender identity, and in 2014 it began giving states the option to add these questions to their BRFSS questionnaires.



Source: Texas Behavioral Risk Factor Surveillance System (BRFSS) and Austin Public Health

Mental Health Provider Shortage Area (HPSA) Designation for Travis County

In addition to the trends outlined above, we can also look at the assessment of our community's availability of health care professionals to meet local mental health needs. The below map below shows the HPSA score for Travis County, which is 14 out of 25 (the higher the number, the greater the shortage of health professionals). The score suggests that efforts to increase the number of mental health providers (through recruitment and retention) could help to improve our score and better address local needs. Since providers who work in areas that are designated as having a "shortage" are eligible for loan forgiveness, then this which offers one strategy to draw providers to Travis County.



Source: Texas Department of State Health Services - https://experience.arcgis.com/experience/323d93aa45fd43e88515cdf65365bf78/

PEER SUPPORT WORK GROUP FINDINGS

Background

The CAN Community Council published a report with recommendations for addressing mental health and wellness in 2021 in response to the COVID-19 pandemic's effects on our community's mental health. According to the Texas Behavioral Risk Factor Surveillance System and Austin Public Health, in 2019, 22% of Travis County adults reported 5 or more days of poor mental health within the past 30 days of when the survey was taken. A year after the pandemic in 2021, 32% of Travis County adults reported poor mental health—the highest it has been since we began tracking the indicator. Mental health issues existed in our community before the pandemic but were exacerbated by the pandemic through loneliness, isolation, and loss. Our community also experienced Winter Storm Uri and many demonstrations of civil unrest during this time. It is safe to say that stressors were piling up, thereby affecting many individuals and our community collectively . Our report is called "Everybody has a Role" because, in situations like these where something was experienced as a community, it will take a community effort to make sure everyone receives the support they need.

Beginning in 2022, CAN as a whole focused on mental health, launching the Language Access Project for Mental Health and Wellness in 2023. This project will create 3 mental health toolkits in different languages (i.e., Spanish, Vietnamese, and Arabic) to help reach different language speaking communities and reduce stigma around seeking mental health care and community support when it's needed. The Community Council understands that, with the reduction of stigma and the sharing of mental health resources, there will be an additional strain on mental health providers, already a stretched system, and therefore there has to be other ways for community members to seek support as stated in our previous report's recommendations. This year, the Community Council decided to delve deeper into some of the recommendations made in the *Community Mental Health and Wellness Report*, specifically the recommendations focused on mental health data collection and sharing (recommendation number 6 on page 19 of the CMHW report) and peer support (recommendation number 4 on page 19 of the CHMW report).

Over the past year, the Community Council's Peer Support Workgroup heard from various organizations and individuals regarding peer support and this report will focus solely on what the peer support workgroup learned about the current state of peer support programs in our community; the barriers to expanding peer support programs and retaining peer support specialists; and innovative ways to promote community based wellness. A comprehensive update on the remaining recommendations from the *2022 Community Mental Health and Wellness Report* can be found in an addendum to this report.

Return on Investment

In an article entitled *A Brief History of Peer Support*, Patrick Tang, MPH references an initial usage in a hospital in late 18th Century France where recovered patients were utilized to help patients in recovery (Peers for Progress.org/pfp_blog/a-brief-history-of-peer-support-orgins/6.7.13). Since this initial reference, the philosophy has steadily grown in acceptance as a way for people to advocate for themselves and others in similar circumstances. It has become a part of the mainstream and is used in many fields such as chronic disease management (e.g., with diabetes, mental health, heart disease, cancer, asthma, HIV/AIDS, substance abuse), screening and prevention (e.g., with cancer, HIV/AIDS, infectious diseases), and maternal and child health (e.g., with breastfeeding, nutrition, postpartum depression). As such, the concept/philosophy of peer support is part of our larger community vocabulary, generally promoting awareness but not necessarily with specific understanding of the relevant details and implications.

There are many references to usage of peer support and there is a growing body of literature and references to the need to systematize the knowledge, skills, and training, to professionalize the field. This includes certification and credentialing of individuals to participate in this much needed workforce. Peer support is seen as a transformative service as it adds value to the recovery support system. This additional support is desperately needed due to the increasing demand for services and the dearth of trained professionals in the field, as well as the length of time it takes to prepare these individuals for work in the field. Accordingly, the Community Council has concluded that a peer support behavioral health workforce can effectively extend the reach of treatment outside of the clinical setting, thereby supporting the recovery process. Little actual research on the return on investment with actual dollar comparisons was found. There are reports on the programs available and the need for such services, as well as findings that these services improve outcomes such as reducing hospitalizations, improving self-determination and symptom management, increasing social support, and bettering one's quality of life (MHA, 2018).

The Texas Tribune (February 23, 2023) reported that, since 2016, the warnings about the future of the Texas mental health care workforce were clear. The report noted that: "More than 80 percent of Texas counties are designated as Mental Health Professional Shortage Areas, which are defined as more than 30,000 residents per clinician," as the Texas Statewide Behavioral Health Strategic Plan stated seven years ago. "Many of the most experienced and skilled practitioners are approaching retirement… Texas higher education institutions have been unable to produce enough graduates to meet the predicted demand."

The COVID pandemic exacerbated the situation beyond measure and brought it to the attention of the general public. The aging workforce and the fact that many of these trained workers are of retirement age makes the situation untenable. In 2021, a report issued by Substance Abuse and Mental Health Services Administration (SAMHSA) indicated that the number of peer specialists are not enough to meet the service needs not being met by the professionally prepared behavioral health specialists (https://www.mhanational.org/sites/default/files/Evidence%20for%20Peer%20Support%20May%202019.pdf)

A solution, as has been mentioned, is the building and strengthening of the peer support workforce.

The return on investment is apparent, but the evidence base needs further research. The Mental Health National Organization published *Evidence for Peer Support* (May 2019). This report indicates that the return on investment of the peer support framework can show its true value by measuring the improvement in a person's quality of life, their increases and improvements in engagement with services, and their increases in whole health and self-management. Below is a summary of the evidence presented in the report.

In the introductory section, peer support is introduced as "an evidence-based practice for individuals with mental health conditions or challenges." Both quantitative and qualitative evidence indicates that peer support lowers the overall cost of mental health services by:

- Reduced re-hospitalization rates
- Reduced in patient days
- Lowered overall cost of services
- Increased use of outpatient services

- Increased quality of life outcomes
  - Table demonstrating results of a survey regarding impacts of CPS
  - Table outlining outcomes of a variety of peer support programs
- Increased engagement rates
- Increased whole health

Existing State-Level Standards for Certification

As of May 2018, 45 states and the District of Columbia have established or are developing programs to train and certify peer specialists. Texas is part of this list. Five states had no certification and no process or plan to develop or implement one.

A listing of such states, including Texas, shows that, as of January 2017, states are reimbursing for peer support services through Medicaid.

National Certification

As of March 2017, Mental Health America (MHA) launched the first national, advanced peer support specialist certification.

Observations

Peer support is a transformative service utilizing people helping people, connecting with each other and reducing the feelings of isolation in multiple ways. Yet the people who are making the difference, the peer support workforce, are stuck in low wage jobs with limited room for growth. These jobs often do not pay a living wage and do not offer a career path.

To consider peer support as a cost-saving strategy simply because it is "cheap labor" is untenable. Instead, it must be seen as a solution to the provision of much needed services in our community that can help mitigate the demand for highly trained professionals whose training takes years, as well as a solution helping get patients back to their home environment.

In conclusion, peer support is being recognized by professionals and communities alike. It is growing into an established profession and researchers are continuing to build on the evidence base. The medical establishment, insurers (and legislatures), and communities are seeing the benefits and understanding the enormous support peer workers provide both to patients and medical professionals. We can do more together, and peer support is one of the pillars of community wellbeing.

Summary of Deliberations

Over the course of the past year, the Community Council and the Peer Support

Workgroup heard from six (6) different presenters, each of which provided insights on the current availability of peer support programs, the peer specialist credentialing process, the barriers to receiving credentials, the role of Community Health Workers (CHWs) in peer support, and the challenges for minority mental health providers, as well as the barriers minority community members face when seeking mental health supports.

From each of the groups that presented, we learned that there are not enough peer support programs available, especially in languages other than English. The National Alliance on Mental Illness (NAMI) offers all their peer support programs in both Spanish and English. Integral Care has some bilingual staff that can provide peer support in Spanish, but it relies mostly on a Language Line to provide services in languages other than English. The lack of services in other languages was further echoed by our presenters from the Asian Behavioral Health Network and Latinx Behavioral Health Network. Elexia Lowe, with the Asian Behavioral Health Network, stated that there is an issue with getting people from Asian communities interested in the field and retaining them once they have entered the field. Western practices have appropriated many South Asian healing practices, and non-White therapists and their patients can often feel disconnected from the larger professional community. Manuel Zamarripa, with the Latinx Behavioral Health Network, stated that in the Latinx community, many people aren't educated about mental health and have other more culturally relevant methods for solving issues, such as through pláticas, or community discussions.

To learn about credentialing, we heard from Via Hope and Peer Force. We learned that the credentialing process can require a lot of time and money, both of which can be barriers for people wanting to be peer support specialists. For example, the credentialing steps include applying to take/taking the core training ($75), applying for the supplemental training for either mental health or substance use peer support specialist ($650), and applying for certification with Texas Certification Board (TCB) with a background check ($120), for a grand total cost of $845. Peer Force helps peer support specialists with finding employment, training for earning credentials, continued education, training, and connections to supervisors, internships, financial assistance during the credentialing process, and statewide coordination. If a person does become a credentialed peer support specialist, staying in the field becomes difficult due to the poor compensation. Peer specialists are highly utilized within local mental health authorities however, the Medicaid reimbursement rates for peer services are as low as $1.90 for 15 minutes. Thus, peer specialist employers need to identify additional funding streams to provide livable wages. Bluebonnet Trails Community Services

(serving Bastrop, Burnet, Caldwell, Williamson counties), Hill Country Mental Health and Developmental and Disabilities Centers, and Integral Care (Travis County) are Central Texas' Local Mental Authorities and major providers. Hill Country Mental Health and Developmental and Disabilities Centers hire peer specialists for $16.50 per hour. Bluebonnet Trails Community Services' peer specialist hiring salary is between $16.00 and $18.75 per hour. Integral Care raised its minimum wage to $20.00 per hour and pays its peer specialists $20.03 an hour.

To learn about stigma and access to mental health care, we heard from the minority behavioral health networks in our community. Vicky Coffee, with the Austin Area African American Behavioral Health Network, shared that "The stigma is so deep when it comes to communities of color. You also have to think about the education it takes to become a professional in mental health. You have to have access to education and access to finances to get an advanced degree. A lot of our healing doesn't come from licensed professionals. You have to value and recognize non traditional providers that people have been going to and seeking help from for centuries and find ways to support them and their work." Manuel Zamarripa, with the Latinx Behavioral Health Network, shared that "Mental health is starting to be recognized as a medical condition which is great for insurance purposes and giving legitimacy to clients, but clinicians have been advocating to demedicalize mental health care for years. It limits care, its individualistic, and a western view of care. The field in general is individualistic and doesn't include other worldviews." Elexia Lowe, with the Asian behavioral Health Network, stated that "Instead of trying to control people providing help who aren't licensed, why not take trainings to the helpers in the community. For instance, training religious leaders and community helpers in mental health first aid."

Lastly, we heard from Ricardo Garay, a Community Health Worker with Dell Medical School, about the role of Community Health Workers in community healing. Ricardo shared that people in communities have been natural helpers for centuries, but nationally, community health workers began trying to formalize the community health worker role in 1970. At the end of 2021, there were 4,208 certified CHWs in Texas. Community health workers build trust in the community and work to address social determinants of health instead of just medical diagnosis. The State of Texas defines a community health worker as a person who, with or without compensation, provides a liaison between health care providers and patients through activities such as assisting in case conferences, providing patient education, making referrals to health and social services, conducting needs assessments, distributing surveys to identify barriers to health care delivery, making home visits, and providing bilingual language services. As

we learned about Community Health Workers, we wondered if there was a way that they could address community mental health needs in the same way as peer support specialists.

As shown in the table below, these organizations in our community use a variety of peer support models and provide a variety of peer support programs, training, and related services.

EXISTING PEER SUPPORT RESOURCES

Peer Support Programs

Organization	Topics	Modality	Languages Available
National Alliance on Mental Illness (NAMI)	Peer-to-Peer; Family-to-Family; Family and Friends; Basics (Parenting); Homefront (Veteran)	Virtual and In-Person	English and Spanish
Center for Grief and Loss	Grief & Loss Support Groups	Virtual	English and Spanish
Communities for Recovery	Substance Use Peer Support Groups or Mentors	In-Person	English
OutYouth	Caregiver peer support; teen peer support	In-Person	English
Austin Mental Health Community	Peer Mentor; Peer Crisis Recovery; Peer Support Groups	Virtual and In-Person	English and Spanish
SAFE	Survivor Peer Support	In-Person	English
Lifeworks	Community-Based Peer Support	In-Person	English
Recoverytexas.org	mental health and substance Peer Support	Virtual	English and Spanish

Peer Support Training

Organization	Services Offered	Languages Available
Via Hope	Training	English
Peer Force	Trainings, CEU Calendar, Job Board, Financial Assistance, and Supervisor Network	English

RECOMMENDATIONS

Based on the data shared in the previous section, it is clear that the need for mental health services increased dramatically from 2017 to 2021 and that additional resources, including peer support programs, should be allocated to more effectively address the need. Accordingly, the CAN Community Council offers the following 14 recommendations to improve the use and effectiveness of various peer support strategies and data collections.

Recommendations for CAN Member Organizations as Employers

01 — Ensure mental health insurance benefits for employees are adequate

Since all CAN member organizations are employers, CAN members should first and foremost ensure mental health parity in the health coverage that they provide their employees (i.e., that the coverage provided for mental health support is meaningful). If there is a "gold standard" achieved by one or more CAN members, then those examples should be documented and publicized.

Peer Support Recommendations

02 — Provide Funding for or Provide Supports for Peer Specialist

If peer support programs and peer support specialists are something that we will lean on to alleviate some strain on mental health providers while still providing support to people who may need them then we need to ensure we are able to recruit and retain peer support specialists.

a. Vouchers - We need to ensure that we support peer specialists adequately so that we can retain them. We need to ensure that they are able to get through the credentialing process by providing any vouchers they may need for exams professional services to allow them to connect with training and employment opportunities. Organizations like Peer Force have vouchers, a list of supervisors, and job boards for peer support specialists.

b. Liveable Wage Compensation - Some organizations are able to provide compensation to peer support specialists that are still going through the process of getting fully credentialed based on experience (for example the closer to being fully credentialed, the higher the pay) and this may be something more organizations should practice. It is a good incentive to encourage people to become peer support specialists and to retain them as peer support specialists.

RECOMMENDATIONS

03 — Expand Peer Support Programs in Spanish (and other languages)

As CAN moves forward with a focus on language access, we have to pay attention to the small amount of peer support programs available in Spanish, especially since Spanish-speakers make up 19% of the people in Travis County, with 251,531 people being Spanish speakers in 2021 according to the American College of Surgeons (ACS) 5-Year Estimates of our community. Non-English speakers deserve access to meaningful and culturally appropriate care just as much as English-speakers.

04 — Utilize Existing Trusted Systems like Community Health Workers

Community Health Workers already have established relationships with communities.

a. We recommend that peer support specialists and their employers partner with community health workers to offer more services to the community.

b. Create a dual role for Community Health Workers with lived experience.

c. Support legislation to provide tiered Medicaid reimbursement for Certified Community Health Workers and additional reimbursement for CHW certified to provide peer support services.

Recommendations for Expanding Availability of Mental Health Professionals and Mental Health Training

As stated earlier in the report, community issues take community effort. If we have a shortage of mental health providers and are still working on scaling up peer support programs, community members could help respond to minor mental health episodes. Even if we do not deal with individual mental health issues for ourselves, we may have people in our families, our friends, in our neighborhoods, or people we may run into at the grocery store that do have mental health issues, and there are trainings available to help community members know how to respond to and support people dealing with a mental health issue. Some ideas for training or community support groups are: Mental Health First Aid Training; Red Bench; Community Healing Circles etc.

RECOMMENDATIONS

05 — Initiate a Collaboration to Train and/or Recruit More Mental Health Professionals to Travis County.

CAN should encourage local higher education institutions, healthcare providers, and public health entities (including nonprofits that focus on mental health or health generally) to collaborate on a program to increase the number of mental health professionals practicing in Travis County, especially since Travis County has an identified shortage of mental health professionals.

06 — Launch a Campaign to Train Service Providers and Community Members to Respond to Mental Health Episodes

CAN should move forward with plans to expand the number of individuals in our local community who are trained in Mental Health First Aid. We suggest the following:

- If the overall goal is to train 3% of the overall population in Travis County in Mental Health First Aid, then CAN could launch the campaign by having each partner commit to train 3% of its own staff.
- CAN should identify individuals who are trained in the delivery of the Mental Health First Aid training so that we can leverage their skills in support of a broader community campaign.
- Trainings will likely not be made available "free of charge." In order to ensure access for community members who may not be able to pay for the training, efforts should be undertaken to establish a scholarship pool that community members can access. One option may be that individuals who register could be given the option of donating into a scholarship pool.
- CAN partners should collaborate to host a "train the trainers" for Mental Health First Aid each year so that training capacity is increased on an annual basis.

RECOMMENDATIONS

Recommendations for the Targeting of Resources

Target resources to populations in Travis County that are most at-risk based on the above data analysis.

07 — Use Data Sources, Like the Ones Shared in this Report and Others, to Direct Mental Health Services to High Need Populations.

If resources are limited, resources should be targeted to address the health disparities outlined in the data shown in this report. The groups that appear to show the greatest levels of mental health needs are LGBTQIA+ individuals, people with disabilities, individuals in the 18 to 29 age category, individuals who are unemployed and individuals who have not attended college. All of these subgroups have a proportion of 40% or greater reporting "poor mental health."

- ·CAN member organizations could serve as champions and exemplars with regard to serving the needs of these particular demographic groups as an employer, particularly if the individual workforce of a particular member may have many members who are part of one of these subgroups. Here are a couple of related recommendations:
  - A good first step may be to assess what percentage of an entity's workforce falls into these categories and then prioritizing support based on the findings.
  - Since mental health for low-income workers (i.e. those making less than $25,000) and those who do not have a college degree report a higher rate of poor mental health, specific CAN members (as employers) may consider increasing pay for these individuals (or articulate a plan for doing so over time) as a way of helping their economic and mental health.
- ·Work with local chambers (e.g., LGBTQIA+ Chamber, Women's Chamber, the Young Chamber, Minority Chambers, and CAN Chamber of Commerce members), Quality of Life Commissions and the Joint Inclusion Committee, and Workforce Solutions to see how we might better serve these high need populations.
- ·Goodwill Central Texas may be a good CAN member with whom to partner on helping individuals with disabilities.

RECOMMENDATIONS

Recommendations for Direct Additional Culturally and Linguistically Appropriate Mental Health Supports for Communities of Color

08 — Focus on People of Color.

While the proportion of people of color who report "poor mental health" does not reach 40% as the subgroups outlined in Recommendation 7, we did see a large increase of poor mental health in these communities. We suggest focusing resources to better serve communities of color since the above data that we shared shows that people of color may be currently accessing mental health services at a lower rate than Whites.

09 — Publicize Available and Developing Toolkits for Spanish, Vietnames, and Arabic Language Speakers.

Since CAN is in the process of creating mental health toolkits for three different language communities (i.e. Spanish, Vietnamese & Arabic), CAN partners should work to publicize these to health/mental health service providers and other community stakeholders to help ensure that these resources are effectively shared in those communities.

10 — Consider Developing Toolkits for Other Language Groups.

If additional resources are secured, CAN should consider developing toolkits for other language communities.

Recommendations to Improve Access to Data Documenting Mental Health Needs

11 — Establish a Clearinghouse of Information About Local Mental Health Needs.

Identify a CAN member organization to serve as a clearinghouse for data and information about local mental health needs so that this information is available in one place (thus limiting the need for each agency to figure out how to share out that information). The kinds of data that would be useful to have include call center data, student climate surveys, client surveys, quality of life studies, academic studies and other published research, etc.

RECOMMENDATIONS

12 — Annual Report.

Publish an annual report of data from the clearinghouse documenting local mental health needs.

13 — Data Tracking.

Track data relating to the number of new peer support support specialists and community health workers whose focus is intended to be mental health support.

14 — Assessment and Evaluation.

For any mental health training programs, ensure an evaluation component that tracks the number of individuals trained and the number of community members served through those programs. An assessment of the client experience and outcomes should also be a part of the evaluation process.

ADDENDUM: UPDATE RELATING TO RECOMMENDATIONS FROM THE 2022 COMMUNITY COUNCIL MENTAL HEALTH AND WELLNESS REPORT

Introduction

In last year's Report on Community Mental Health and Wellness, the CAN Community Council offered a number of short-term and long-term recommendations to address our community's mental health, prioritized according to their urgency and impact and following these timeless CAN community principles of care:

- Focus on vulnerable people, esp. children and youth and their caregivers.
- Ensure comprehensive coverage and early and timely identification of those most in need.
- Ensure rapid referral to comprehensive and appropriate services and interventions.
- Follow Person-Centered Care/Community Framework principles and practices, including 2-Gen, family friendly, wrap-around, and integrated/case managed service models.
- Promote equity, inclusion, and long-term sustainability principles.

While this year's report extends community recommendations to include much needed peer support approaches and services and data systems and reporting, this section of the report provides an update of the status of last year's recommendations, in order to maintain a strong and continuing focus on these fundamental and ongoing issues.

Summary of Ongoing and Unmet Community Mental Health Needs

As thoroughly discussed in the Research & Data Work Group Findings section of this year's report, today's children and youth are experiencing alarming rates of undiagnosed and untreated mental health disorders. The *2021 Texas Behavior Risk Survey* of high school students has documented these conditions and Kids Living Well also reports data through its new website, which shows LGBTQ+ youth in particular are suffering higher rates of mental health problems (https://kidslivingwell.org/data/). Rates of mental illness and suicide attempts over the last year have not improved; and, in many cases, they have worsened. By the end of 2022, 1 in 3 teenagers contemplated suicide! And, half of our kids and teens won't get the treatment they

need. In cases where suicide is a risk, providers often have little choice but to send families to the emergency room. ERs are not designed to deal with mental health emergencies, especially the rising numbers of pediatric mental health emergencies arriving at their doorsteps. Families often wait long hours in the ER only to be discharged with additional referrals and a handout. The most severe cases might be admitted; however, they often stay in ER beds, in limbo, waiting days or weeks for mental health placement. Fortunately for our community, families can call the 9-8-8 hotline and get connected to the Mobile Crisis Response Program or Integral Care's Psychiatric Emergency Services (PES) emergency walk-in clinic on Airport Blvd.

A disturbing cycle has ensued for kids, families, and primary care clinicians in which children repeatedly arrive at the pediatricians' offices with untreated mental health problems. Families are unable to find a mental health provider in their community which treats teens, accept their insurance, or don't have a wait list. Many providers feel overwhelmed and unequipped to manage mental health disorders. They continue to refer families to mental health providers in the community, but there remain long waiting lists. One study showed only 30% of referred families received any kind of mental health services. Poor youth mental health is affecting enrollment, attendance, graduation, and classroom discipline in our schools as well as parents' ability to work.

Accordingly, this part of the report is organized into two sections, corresponding to last years' report on short-term recommendations, to wit: "In the Schools and In the Homes" and "In the Clinics". It emphasizes the recommendations in this years' report (e.g., Expanding Availability of Mental Health Professionals and Mental Health Training). Long-term recommendations (i.e., "In the Community") from last years' report are not addressed herein, since many of them have already been launched or are in the process of launching (e.g., toolkit, language access, and the public engagement campaign mentioned in this report). Other recommendations, such as data, measurement, evaluation, and information-sharing and peer support and related approaches, are addressed elsewhere in this year's report.

In the Schools and In the Homes

1. Early/Rapid Assessment and Referral
2. Service Capacity and Capabilities

Original Recommendations

We recommend that school districts adopt and employ a "Family Assessment Tool"—

like the one developed and employed by Austin Voices for Education and Youth (AVEY) and The Austin Project (TAP) for many years, in their community schools—as soon as is practicable but no later than the beginning of the year, to identify all potential students/families needing mental health services and immediately refer and assign people to case managers, counselors, and other service providers. This recommendation is consistent with the CAN Community Council Child Poverty report, which noted that "The 'community schools' model is an approach that connects schools, parents, and community partners to ensure that children and families have what they need to succeed. Many of the needs highlighted in the Child Poverty report could be addressed if a robust community school model can be advanced. The model focuses on a comprehensive family needs/risk assessment and wrap-around services for the entire family, including early childhood education, expanded learning and enrichment time, student-centered learning, health and wellness, family stability and workforce development.

We also recommend that schools expand their capacity to provide comprehensive mental health counseling and related services (and special ed and learning disabilities services) to serve 100% of the need, in a timely manner, consistent with effective practices and standards of care.

Current Status

It is difficult to determine the full extent to which students in Austin area school districts are receiving assessments and referrals and whether schools have the capacity and capabilities to provide services to all those that need them. Some school districts—like Manor ISD, Pflugerville ISD, and Del Valle ISD—are using a services model provided by Integral Care. In the 2021-2022 school year, Integral Care served 1,245 students in Pflugerville, Del Valle, Manor, and East Austin Prep. As of April 2023, 623 unduplicated students were receiving services at least once per week in their school setting through these programs.

We understand that AISD is providing a renewed focus on physical and mental health, but those efforts are still in the formative phase. The district has done a good job with social and emotional learning and youth mental health first aid strategies and is providing school nurse staffing through Ascension-Seton. We encourage that those strategies be continued and enhanced. Referrals to community health providers are still being made by school counselors, Family Resource Center social workers, principals, and others but the level of services provided is likely still below pre-COVID levels, despite the greater need. Many schools have staff shortages and/or turnover in campus leadership. Some campuses do not have a counselor, informed AP, or other

point person to consistently ensure timely assessments and referrals.

Also of importance is the main campus referral process—i.e., Child Study Teams (CST)—which needs to be strengthened and consistently utlized. It is the hub for a tiered system of mental health supports, with counselors, APs, teachers (as needed), CIS and AVEY social workers all coordinating supports for dozens of students each week. It is the structure that keeps students from falling through the cracks, including following them after a referral is made to a health provider. When the CST process works, it really works, but it needs lots of support.

We encourage AISD to continue its efforts with a sense of urgency, and we urge all school districts to continue to solicit and take advantage of the advice, expertise, and services provided by community-based organizations (e.g. Child Guidance Center), the private sector (i.e. insurance companies and employers), federally authorized and funded options, and other public sector agencies and political subdivisions of the state (i.e., City of Austin, Travis County, Integral Care, Austin Community College, Workforce Solutions, Dell Medical School, Hogg Foundation, and other U.T. entities, and others). Ultimately, AISD and other school districts should develop a comprehensive, integrated, multi-disciplinary, and evidence-based approach (including all related policies, plans, and programs) to mental and physical health and wellness, using a tiered approach that involves TIC and ACES and that provides all campuses, esp. Title I schools, with sufficient staffing of counselors.

School districts should involve all of the community's mental health providers, along with others who are working in the referral and prevention space, to develop and maintain this coordinated system (e.g., Austin Child Guidance, Integral Care, Lone Star Circle of Care, People's Community Clinic, CommUnity Care, etc.) in planning on a long-term basis to constantly review how to improve connections and leverage resources to make sure referrals are followed and capacity is developed.

Youth Mental Health First Aid (MHFA) is also available to high school students. Peers can often recognize needs before an adult does. The training helps young people feel more comfortable having conversations about mental health and substance use with their friends. Integral Care worked with Eanes ISD, for example, to provide Youth Mental Health First Aid Training to the entire sophomore class at Westlake High School. This year's Community Council report addresses recommendations associated with peer support services; and, CAN is launching an initiative in May 2023 to provide MHFA training to 1,000 CAN member employees as well as to deploy a strategy for this training more broadly for the whole community.

Helping address students' (and their families) mental health will be a significant factor in reducing the stress on and turnover of educators. Therefore, school districts should also have policies, plans, and programs to address the mental health and wellness of those who care for children and youth—i.e., educators and staff and parents. Unless their well-being is addressed, our schools will continue to struggle with challenges in staff turnover and student enrollment, attendance, and graduation and, consequently, in achieving their academic goals; and, our community will continue to struggle to achieve a just economic recovery.

National Guidance

The Surgeon General's Report (Protecting Youth Mental Health, The U.S. Surgeon General's Advisory) contains detailed suggestions, which we encourage school districts to follow. TheU.S. Secretary of Education has provided similar recommendations. The entire report is worth reading, but here are the main recommendations for educators:

Create positive, safe, and affirming school environments. This could include developing and enforcing anti-bullying policies, training students and staff on how to prevent harm (e.g., implementing bystander interventions for staff and students), being proactive about talking to students and families about mental health, and using inclusive language and behaviors. Where feasible, school districts should also consider structural changes, such as a later start to the school day, that support students' wellbeing.

Expand social and emotional learning programs and other evidence-based approaches that promote healthy development. Examples of social, emotional, and behavioral learning programs include Sources of Strength, The Good Behavior Game, Life Skills Training, Check-In/Check-Out, and PATHS. Examples of other approaches include positive behavioral interventions and supports and digital media literacy education.

Learn how to recognize signs of changes in mental and physical health among students, including trauma and behavior changes. Take appropriate action when needed. Educators are often the first to notice if a student is struggling or behaving differently than usual (for example, withdrawing from normal activities or acting out). And educators are well-positioned to connect students to school counselors, nurses, or administrators who can further support students, including by providing or connecting students with services.

Provide a continuum of supports to meet student mental health needs, including

evidence-based prevention practices and trauma-informed mental health care. Tiered supports should include coordination mechanisms to get students the right care at the right time. For example, the Project AWARE (Advancing Wellness and Resilience in Education) program provides funds for state, local, and tribal governments to build

Expand the school-based mental health workforce. This includes using federal, state, and local resources to hire and train additional staff, such as school counselors, nurses, social workers, and school psychologists, including dedicated staff to support students with disabilities. For example, a lack of school counselors makes it harder to support children experiencing mental health challenges. The American School Counselor Association (ASCA) recommends 1 counselor for every 250 students, compared to a national average of 1 counselor for every 424 students (with significant variation by state). The American Rescue Plan's Elementary and Secondary School Emergency Relief funds can be used for this purpose and for other strategies outlined in this document.

Support the mental health of all school personnel. Opportunities include establishing realistic workloads and student-to-staff ratios, providing competitive wages and benefits (including health insurance with affordable mental health coverage), regularly assessing staff wellbeing, and integrating wellness into professional development. In addition to directly benefiting school staff, these measures will also help school personnel maintain their own empathy, compassion, and ability to create positive environments for students.

Promote enrolling and retaining eligible children in Medicaid, CHIP, or a Marketplace plan, so that children have health coverage that includes behavioral health services. The Connecting Kids to Coverage National Campaign also has outreach resources for schools, providers, and community-based organizations to use to encourage parents and caregivers to enroll in Medicaid and CHIP to access important mental health benefits. Families can be directed to HealthCare.gov or InsureKidsNow.gov. Schools can use Medicaid funds to support enrollment activities and mental health services.

Protect and prioritize students with higher needs and those at higher risk of mental health challenges, such as students with disabilities, personal or family mental health challenges, or other risk factors (e.g., adverse childhood experiences, trauma, poverty).

Older Youth and Young Adults

To target the needs of young-adults, often referred to as "transition-age youth", the Center for Youth Mental Health, through the Department of Psychiatry at Dell Medical School and as a part of U.T. Health Austin, has established the Amplify Center, as a pilot project, whose mission is to connect young adults with timely and appropriate mental health support on the Austin Community College's Eastview campus. The Amplify Center is a product of a multifaceted partnership between ACC and Dell Med that strives to improve the quality of life among young people experiencing mental health distress by helping them obtain support grounded in their personal interests and lives - including work, school, and relationships. The Amplify Center is a young-adult specific clinic designed to effectively intervene in mental health challenges that develop during adolescence and young adulthood.

While currently in a two-year pilot phase and currently only open to ACC students, the aim of the Amplify Center is to address a critical gap in the mental health continuum of services, where critical supports are difficult to access for older youth and young adults. The pilot seeks to understand creative funding approaches and uniquely responsive services, and it is young-adult driven through its selection of services and young-adult advisory process. The Center is modeled after the international approach, headspace, out of Australia. The Center is the first of its kind in Texas.

3. Telehealth and Technology

Original Recommendations

We recommend that school districts expand their tele-health services during in-school and out-of-school times, taking full advantage of resources available to them, such as Dell Medical School's programs mentioned in last year's report and others to employ technology to help. There are literally thousands of mental health apps and systems. Accordingly, we do not recommend any specific software or system. While technology is not a panacea, it has the potential to reach larger numbers of people who might otherwise resist or avoid care for personal or cultural reasons and those who have transportation and other time and scheduling barriers.

Current Status

Telehealth has been a mainstay of the COVID experience, and it looks like it is here to stay, in part because of its cost-effectiveness and because of its ability to overcome stigma and transportation barriers. The following is a description of state legislation and programs available to educators in central Texas.

Passed during the 87th legislative session, House Bill 4 (Price/Buckingham) is an omnibus telehealth and telemedicine bill focusing mostly on Medicaid and plans in the Children's Health Insurance Program (CHIP). The comprehensive bill allows for telemedicine, telehealth, or other telecommunications services to be used by Medicaid recipients, CHIP enrollees, and other individuals receiving benefits under a public benefits program, if these services are clinically-effective and cost-effective. Services covered include preventative health/wellness, case management, behavioral health, and others. The bill allows for audio-only technology to be used for behavioral health. A Medicaid managed care organization (MCO) can reimburse providers for home telemonitoring services. In addition to telemedicine, telehealth services are added to benefits that a health plan provider must permit in providing covered benefits to children. Finally, the bill allows outpatient chemical dependency treatment via telehealth. Several bills were filed in the current legislative session requiring private insurance plans to have payment parity for telehealth and telemedicine services with in-person services.

In addition, Senate Bill 1107 (Price), passed in 2017, allows doctors to provide remote care and consultation with patients without a prior in-person visit, ending a contentious years-long legal battle with the Texas Medical Board over the state's requirement that telemedicine practitioners first meet face-to-face with patients. It also adds video to Texas' definition of telemedicine. Texas was the final state in the nation to eliminate the in-person requirements.

The Hogg Foundation's website has a policy guide to help policymakers, advocates, and consumers navigate these systems and services under this legislation. https://hogg.utexas.edu/what-we-do/policy-engagement/mental-health-guide
TCHATT allows for the sharing of concerns for a student's mental health for any behaviors seen or reported. This can be reported to/through a TCHATT liaison, who ensures all consent forms are properly signed by the appropriate party (i.e., student, parent, guardian). If the parent/guardian agrees to TCHATT, the liaison will collect some basic information. The TCHATT school liaison then makes a referral for TCHATT services. For urgent issues, further screening via telemedicine is scheduled with the most appropriate TCHATT mental health specialist. For less urgent issues, they schedule an assessment of the student's mental health needs.

The Texas Child Health Access Through Telemedicine (TCHATT) provides telemedicine and telehealth programs to school districts to help identify and assess the behavioral health needs of children and adolescents and provide access to mental health services.TCHATT was authorized through Senate Bill 11, and while a statewide effort, it

is not currently available to all students in Texas. Participating medical schools have identified geographical catchments areas, where Travis County and other central Texas counties fall under the Dell Medical School catchment area. Many AISD schools have access to and are using TCHATT.

After a TCHATT encounter, TCHATT staff may refer the students to a local pediatric psychiatrist or other mental health professional, a local pediatrician with support from pediatric psychiatry faculty, or the local mental health community center. TCHATT is managed by the Texas Center for Mental Health Care Consortium (TCMHCC) https://tcmhcc.utsystem.edu/tchatt/ . TCMHCC (https://tcmhcc.utsystem.edu/) also has a program called Child Psychiatry Access Network (CPAN) in which psychiatric experts from medical schools provide advice and consultation to primary care providers(PCPs) so they feel more equipped to treat children themselves. They also have two workforce initiatives to help grow the mental health workforce.

4. Tutoring/ Mentoring

Original Recommendations

We recommend that our community develop and deliver a long-term, sustained effort to provide high quality, evidence-based "high dosage/high intensity" tutoring and mentoring programs to ALL that need them, in in-school settings, summer school settings, and after-school settings. Besides addressing the well-publicized challenge of learning loss and disengagement (and in some cases dropping out) of our youth, tutoring and mentoring reduce stress and anxiety by helping students catch up to their peers. And, with many students lacking an available and resourceful parent, these programs provide students with the presence of a caring adult in their life at this critical time in their lives.

The Greater Austin Reading Coalition (managed by United Way for Greater Austin) has funded a summer extended learning pilot project for K-2 youth with the Literacy Coalition and YMCA. This pilot should be carefully studied for lessons learned and opportunities to expand it. However, while summer and after-school tutoring can be effective, the most effective and comprehensive tutoring strategies are used during regular school hours. This is not a "one and done" strategy. Our community must make a long-term commitment to sustained, high quality tutoring and mentoring for all youth in need, esp. for students in all Title I schools. There are federal funds made available to the State of Texas under the Federal Rescue Plan Act. While those funds are significant, school districts wanting to access them must follow burdensome and limiting requirements that are preventing their timely and meaningful use. Unless and

until the State streamlines and improves the process for allocation of those federal funds, our community must make a financial commitment to this strategy.

Current Status

The Greater Austin Reading Coalition (under United Way's administration) and one of its main partners—Literacy First (Charles A. Dana Center, U.T. Austin)—have worked with the CAN Community Council to develop a budget estimate requested by our legislative delegation (i.e., Rep. Gina Hinojosa and Rep. Donna Howard) to provide comprehensive high-dosage reading tutoring to all who need it. That estimate includes $23.5 million/year for a comprehensive approach. While that figure is large, the need is great. And, importantly, the district will not be able to achieve its academic and related goals (i.e., enrollment, attendance, and graduation) unless it helps students catch up. While lost learning has not worsened since schools have reopened, research has shown that it will not get better without formal and sustained interventions. The SY 2022-23 mid-year math and reading test results for economically disadvantaged third-grade students of color are evidence of this ongoing challenge. And the recent National Assessment of Education Progress (NAEP) indicates that students in all assessed grades and subjects have fallen behind, with many students experiencing historically low scores. Of all the students affected by the pandemic, this group, which entered school in the first year of the pandemic, has been hurt the worst. The test results demonstrate that they are far behind their peers in these critical subjects, an average of 22 weeks of lost learning.

Significantly, high dosage tutoring is not only a powerful strategy to address lost learning, but studies have shown that it is the most cost-effective strategy to reduce the achievement gap. So, there is a double benefit that can be realized from high dosage tutoring.

Less progress has been made in determining the need, cost, and best approach to high dosage math tutoring and for mentoring. The CAN Community Council and CAN member organizations should continue to work with the district to acquire funds for high-dosage reading tutoring and develop estimates and strategies and seek/allocate funding for high-dosage math tutoring and mentoring. As well, our community should devote significant attention and resources to recruiting, training, and supporting the large number of volunteers (paid and unpaid) required to serve as tutors and mentors.

In the Clinics

Taking a Comprehensive Approach to reach 100% of youth in healthcare settings.

1. **Pediatric Screening**

Original Recommendation

We recommend that health care professionals, esp. pediatricians, screen and assess for mental health and receive training in TIC and ACES, using U.T. Dell Med's various programs outlined in last years' report and working with local professional societies. This assessment for children and their caregivers for mental health is similar to the assessments pediatricians currently do for poverty.

Current Status

It is difficult to ascertain the degree to which children and youth in our community are receiving mental health screening in health care settings. The Greater Austin Pediatric Society and Travis County Medical Society are not able to provide estimates of the prevalence of this recommended practice, although they are considering a survey to collect that data. We recommend that these groups and others work with CAN to survey their members to develop a meaningful numerical estimate of the prevalence of these best practices and to determine where our community is falling short and what obstacles remain, including having the resources providers need to help with their assessments and to provide care once they identify a problem. Significantly, the overarching goal should be to provide universal screenings of all children and youth for anxiety and depression, making this a standard of primary care.

Pediatricians and PCPs can and should be diagnosing and treating mild to moderate behavioral health issues. More severe cases can be referred to mental health professionals. When there is an illness that impacts 20% of a clinician's patients, it's important to know how to treat it. The Travis County Plan for Children's Mental Health and Substance Misuse (page 22) notes "Both the American Academy of Pediatrics and the American Academy of Child and Adolescent Psychiatry propose that mild and moderate psychiatric disorders and substance use issues can be effectively managed in pediatric primary care settings. Even though integrated health and behavioral health care is considered a best practice and even though studies have shown efficacy, some primary care providers are hesitant to address mental health and substance use issues in the same way they would other health conditions." ("Five Year Outcomes of Behavioral Health Integration in Pediatric Primary Care," Pediatrics, Official Journal of the American Academy of Pediatrics, July 2019, on-line at: https://pediatrics.aappublications.org/content/144/1/e20183243).

In addition to telehealth services available to schools, the Texas Child Health Access Through Telemedicine (TCHATT) program and Child Psychiatry Access Network (CPAN),

provide telehealth-based consultation and training to primary care providers. This is similar to the TCHATT program mentioned previously, except it's tele-support for PCPs instead of schools.

Community Health Clinics

Community health centers across the state follow best practice guidelines in screening patients with age-appropriate depression screening tools, using the Patient Health Questionnaire (PHQ-9), which is a multipurpose instrument for screening, diagnosing, monitoring, and measuring the severity of depression. There is an adolescent screening tool as well. This includes Austin's Federally Qualified Health Centers (FQHCs) operated by CommUnityCare, People's Community Clinic, and Lone Star Circle of Care, which are members of the Texas Association of Community Health Centers (TACHC). Certified Community Behavioral Health Centers, such as those operated by Integral Care, also use this same tool. This information is critical to providing holistic care to their patients. Health centers track their depression screening rates on a regular basis through their annual submission of data to the federal Health Resources and Services Administration (HRSA), which supports other recommendations in this report regarding data and information sharing.

Medicaid Providers

As mandated by Senate Bill 672, 87th Legislature, Regular Session, 2021, the Texas Health and Human Services Commission (HHSC) is implementing policy for the *Collaborative Care Model* (CoCM) for Medicaid recipients of all ages with a mental health and/or substance use condition. The model integrates the services of behavioral health care managers (BHCMs) and psychiatric consultants with primary care physician (PCP) oversight to proactively manage behavioral health conditions as if they are chronic diseases.

CoCM services must be provided under the direction of the PCP and include benefits provided in an office, outpatient hospital, inpatient hospital, skilled nursing facility or intermediate care facility, extended care facility, and "other location" settings. BHCM activities may be provided in person, face-to-face (synchronous audiovisual technology) or audio only, as clinically appropriate. This model proactively assesses for and manages behavioral health conditions as if they are chronic diseases, rather than treating acute symptoms, based on a person-centered plan of care.

Training sessions for providers began in January 2023; therefore, it is too early to assess the number of providers who are implementing this model. While this model is an advancement in collaborative care for our population, it excludes FQHC's as a

provider type and additional funding is needed for our uninsured residents. The City of Austin's Medicaid providers should be made aware of the CoCM model. Additional research is also needed to identify the extent to which commercial and ACA benefits cover this model.

Finally, on the issue of maintaining insurance reimbursements for telemedicine, HHSC has made the Medicaid reimbursement for mental health telemedicine permanent and has extended coverage to audio-only visits for behavioral health. Expanding audio only coverage to substance abuse care and medical services is also critical. Many patients, particularly those with controlled conditions, see their primary care provider for on-going maintenance and extending audio only for those services would be beneficial.

National Guidance

The U.S. Preventative Services Task Force (USPTF) has released guidelines recommending that health providers screen children eight and older for anxiety, and those 12 to 18 years for anxiety and depression. USPTF believes that the best place to make sure those screenings happen is at the doctor's office during annual wellness checks.The American Academy of Pediatrics has also released new guidelines recommending that doctors screen all young adults ages 12 to 21 every year. And, the U.S. Surgeon General (in *Protecting Youth Mental Health*, The U.S. Surgeon General's Advisory), has laid out a series of evidence-based recommendations for children and youth. The entire report is worth reading, but here are the main recommendations for clinicians:

Recognize that the best treatment is prevention of mental health challenges. Implement trauma-informed care (TIC) principles and other prevention strategies to improve care for all youth, especially those with a history of adversity. In addition to working in the clinic, for example to educate families on their role in healthy child development, health care professionals should work with other sectors (e.g., schools, childcare, justice, social services, public health) on prevention strategies. For instance, health care professionals can refer patients to resources such as economic supports, school enrichment programs, and legal supports.

Routinely screen children for mental health challenges and risk factors, including adverse childhood experiences (ACEs). Screenings can be done in primary care, schools, emergency departments, and other settings. For example, primary care providers can conduct screenings during well-visit appointments, annual physicals, or routine vaccinations using principles of trauma-informed care. Screenings should account for the diverse ways in which mental health challenges can manifest,

such as changes in physical health, sleep patterns, and behaviors. It's critical that screening services link to appropriate follow-up care. The American Academy of Pediatrics offers tools and resources for screening processes. California's ACEs Aware initiative offers ACEs screening tools for children, adolescents, and young adults.

Identify and address the mental health needs of parents, caregivers, and other family members. The mental health of children and youth is closely linked to the mental health and wellbeing of their families. Screening parents and caregivers for depression, intimate partner violence, substance use, and other challenges can be combined with broader assessments of food insecurity, housing instability, and other social determinants of health.

Combine the efforts of clinical staff with those of trusted community partners and child-serving systems (e.g., child welfare, juvenile justice). For example, hospital-based violence intervention programs (HVIPs) identify patients at risk of repeat violent injury and link them to hospital- and community-based resources to address risk factors for violence. Another example initiative is school-hospital partnerships, such as behavioral health urgent care clinics supported by schools. New payment and delivery models, such as the Centers for Medicare & Medicaid Services Innovation Center's Integrated Care for Kids (InCK) Model, can be used to support the mental health-related needs of children across settings.

Build multidisciplinary teams to implement services that are tailored to the needs of children and their families. Enlist children and families as partners and engage them in all stages of decision-making, from screening to treatment. Recognize that a variety of cultural and other factors shape whether children and families are able or willing to seek mental health services. Accordingly, services should be culturally appropriate, offered in multiple languages (including ASL), and delivered by a diverse mental health workforce. Additionally, support the wellbeing of mental health workers and community leaders, building their capacity to support youth and their families.

Clinical Capacity Building

These new guidelines encourage the detection of mental health problems in children earlier; but, in many cases, primary care offices are unprepared to treat what they find. Hiring counselors, social workers, and psychologists at family medical practices and pediatricians' offices can build capacity and capabilities to serve children and youth. Primary care social workers, counselors, and psychologists can respond immediately to positive mental health screens, conduct a more thorough assessment, and offer evidence-based interventions to children and families all during the same

visit. This can be accomplished without referrals, additional appointments, and waiting lists.

This integrated approach relieves the burden on community mental health systems and can reduce unnecessary ER visits that can be expensive and stressful for both kids and families. As noted earlier in this report, there is a workforce shortage of mental health providers, particularly for children, but some communities are encouraging masters-level practitioners in counseling and social work to work in primary care settings, thereby increasing the mental health workforce. Of course, there are significant costs to building and maintaining this added capacity, and insurance parity and health care financing and reimbursement rates are significant issues. The community must find creative and sustainable ways to blend and weave funding sufficient to provide these critical services over the long term.

Embedding first-line mental health workers into pediatrician's offices will not, by itself, solve the youth mental health crisis. Many children will need extensive and long-term mental health counseling, counseling that a primary care mental health provider will not have the bandwidth to provide. But, many kids can have their mental health needs met in a primary care setting if their problems are detected early. Often times, just one session is sufficient. These kids can often avoid being referred to mental health providers in the community for longer-term treatment, thus reducing the waitlist logjam for others.

Perhaps even more important is to train doctors and PAs to diagnose and treat common mental health illnesses that impact a high percentage of their patients, which may be more feasible than embedding behavioral health professionals.

2. Access to Care
   A. Health Insurance/ Service Access
   B. Advocate to Maintain Insurance Reimbursement

Original Recommendations

We recommend doubling our community's efforts to ensure all children and youth have health insurance and access to care and that all children and youth have a medical home. Commensurately, we recommend advocating with the Texas Department of Insurance and Texas Legislature to maintain the current use of and health insurance reimbursements for telehealth techniques.

This is an obvious and ongoing need, and our community has done much to overcome the lack of attention and support from the State of Texas. Travis County has some of

the highest health insurance coverage rates in the state as well as many local options for coverage and care. However, we are including this recommendation in this report because it is central to recommendation 1 above and to the best practices idea of a "medical home" and "primary care physician". Children can't be assessed by doctors (and other health professionals) if they do not see doctors, and they will be more likely to see doctors on a periodic basis sufficient to identify latent and emerging needs if they have an established medical home with a primary care physician.

Tele-Med has been a very powerful, though imperfect, tool throughout the pandemic. It has proven to be one of the only ways to reach key groups and still serves as a strategy for serving large numbers of people and youth where they are (i.e., at home and/or in school). For now, some tele-med resources are available free of charge through the Dell Med, state funded program; however, this strategy must have a reliable funding source, either through insurance or other dedicated funding stream.

Current Status

Insurance coverage rates and children and youth who have a medical home with a primary care physician in Travis County have improved from last year, due in part to aggressive outreach and various accessible options as well as federal funding and Medicaid waivers to enroll as many people as possible. The community should continue to pursue this strategy with sustained outreach and innovative care options through Central Health's MAP and other means, especially as federal Medicaid waivers (e.g., eliminating the need to reenroll each year regardless of income eligibility) lapse, which will cause people to lose coverage.

Expanding coverage for other mental health professionals

As this report has documented earlier, there is a workforce shortage for all provider types, including behavioral health professionals. In addition to the other workforce related recommendations found herein, expanding the types of providers that are reimbursable to include LMSWs, LPC-As, and community health workers that serve as peer specialists would improve access to services. In addition, medical providers are limited in the behavioral health codes they can use on a visit. Allowing medical providers to be reimbursed when the primary diagnosis on the visit is related to mental health or substance abuse would allow for those professionals to help maintain medication regimes for patients that have their conditions under control without forcing a visit to the scarce resource of behavioral health providers.

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CREDITS

About the CAN Community Council

The CAN Community Council is one of two Councils that guide the work of the Community Advancement Network. The CAN Community Council is a self-appointed body that is made up of up to 30 people who reflect the diversity of interests, concerns, organizations, issues and populations of the Central Texas community. The role of the Community Council is to provide a link between the community at large and the policy makers and elected officials who serve on the CAN Board of Directors. If you are interested in joining the CAN Community Council, fill out a form at this site: http://canatx.org/community-council/

About this Report

In 2022, the CAN Community Council focused its work on delving deeper into 2 recommendations made in the *Community Mental Health and Wellness Report* that was published by the CAN Community Council early 2022 reflecting the research done in 2021. The 2 recommendations included peer support as well as mental health data and systems. This report focused on peer support with the aim to identify policies and programs that elected officials, policy makers, local organizations, and other decision-makers can consider pursuing or implementing to improve peer support programs, access to peer support programs, credentialing for peer support specialists, and compensation for peer support specialists in Austin, Travis County and Central Texas.

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