Study on Mental Health Services for Children and Adolescents

YEAR 1 REPORT

DECEMBER 2024

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TEXAS A&M UNIVERSITY HEALTH

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TEXAS A&M UNIVERSITY
HEALTH

Executive Summary

Rationale: The 88th Texas Legislature provided funding to Texas A&M University Health Science Center (Texas A&M Health) for a two-year study to ascertain the needs for and the use of inpatient beds for child and adolescent mental health care in Texas as a critical point in the continuum of care. There is a paucity of critically needed information for the development of a statewide Texas strategic plan to ensure the availability and delivery of appropriate evidence-based services to children and adolescents with acute psychiatric health concerns. The findings of this study are vital to estimating the current need for acute psychiatric child and adolescent mental health care services in Texas, and the development of a deep understanding of the challenges and opportunities related to providing such services to families in need. Understanding the number, types, and locations of services needed across the state will guide the appropriate and efficient allocation of resources.

General Approach: The Texas A&M Health is responding to this request with an effort led by Drs. Israel Liberzon (College of Medicine) and Marcia G. Ory (School of Public Health). These efforts were coordinated with the Children's Hospital Association of Texas (CHAT), the Statewide Behavioral Health Coordinating Council (SBHCC), and the Texas Health and Human Services Commission (HHSC) Office of Mental Health Coordination (OMHCC). The overall goal of this effort is to assess current inpatient and wrap-around services for children and adolescents who require acute psychiatric care and to identify the gaps in these services and the changes needed to align current services with requirements. Our findings will be shared with SBHCC to develop a strategic plan with recommendations for children's mental health.

Key Takeaways

- Based on national benchmarking, the number of beds per total population in Texas (22 beds per 100,000) is below the minimum optimal level (30 beds per 100,000), as is the workforce available to provide necessary mental health care. Thus, the issue must be framed as "staffed" beds, not just beds.
- Nearly half of all inpatient hospitalizations (as measured by the number of discharges) of those aged 5-17 were due to a primary psychiatric condition, which illustrates the magnitude of the acute mental health challenges in this population and amplifies the need for appropriate inpatient and step-down services.
- There is a critical need for improved data infrastructure and data operability to facilitate the identification of service gaps and evaluate the impact of different care innovations.
- Contemporary best practices in acute inpatient mental health services for children and adolescents focus on family-centered care, integrated care models, the use of technology, staff training, and quality improvement initiatives.
- Texas needs to better integrate and coordinate services across the continuum of care, expand clinical and community partnerships to leverage shared resources, build workforce capacity, improve inpatient psychiatric care reimbursement levels, and ensure access to affordable care.
- Two primary challenges identified are: 1) the limited availability of inpatient psychiatric beds for the youngest children, and 2) the difficulties encountered in obtaining inpatient beds for youth with severe co-morbid conditions including those with intellectual and developmental disorders (IDD).

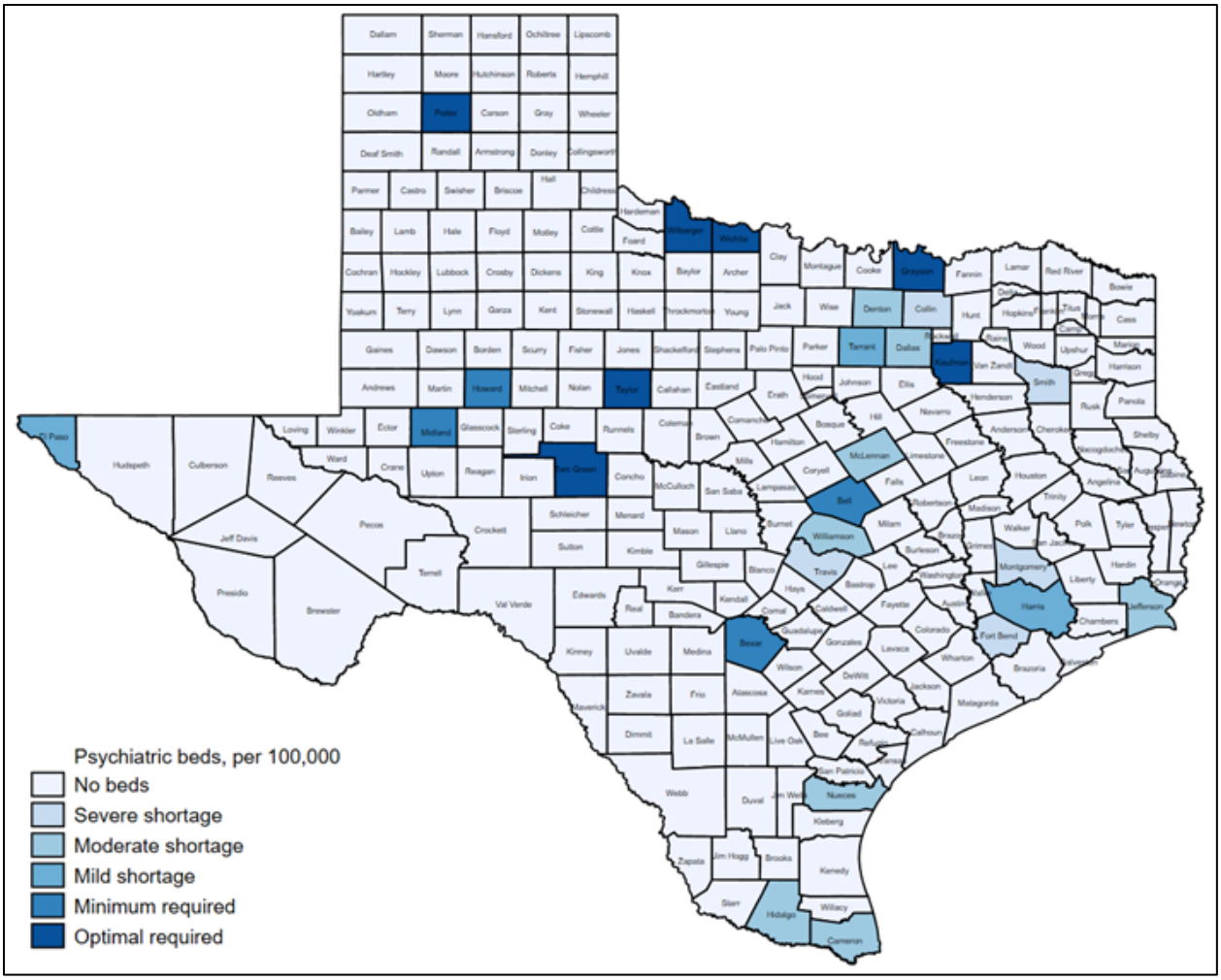
Organization of Findings: This first-year annual report includes three topical reports that are described in greater detail in three sub-reports. These reports are briefly summarized in the Executive Summary below.

- **The Need for and Use of Inpatient Psychiatric Care: What Public Databases Reveal**

This initial data report paints a snapshot of the need and capacity to respond to the acute mental health needs of children and adolescents in Texas. *Based on national benchmarking, the number of beds per population in Texas is below the optimal level, as is the workforce available to provide necessary mental health care*. Available national data on adequate bed capacity reflects a moderate shortage at the aggregate state level. Texas has an overall rate of 22 beds per 100,000 population (a minimum of 30 is suggested in the literature) with variations across Texas counties that will be highlighted in the report (Figure 1). Most telling, the 2023 report by Mental Health America ranks Texas 50th in the United States with a mental health workforce availability ratio of one mental health provider for every 760 Texans. Providers include psychiatrists,

psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health. Note that our estimates of inpatient psychiatric bed availability are based on total bed counts reported by hospital facilities in which beds dedicated to children and adolescents are inconsistently reported and cannot be reliably ascertained based on public databases alone. Thus, "moderate shortage" likely reflects an overestimation of current availability for children and adolescents, especially those in the youngest age ranges or those living with multiple co-morbid conditions.

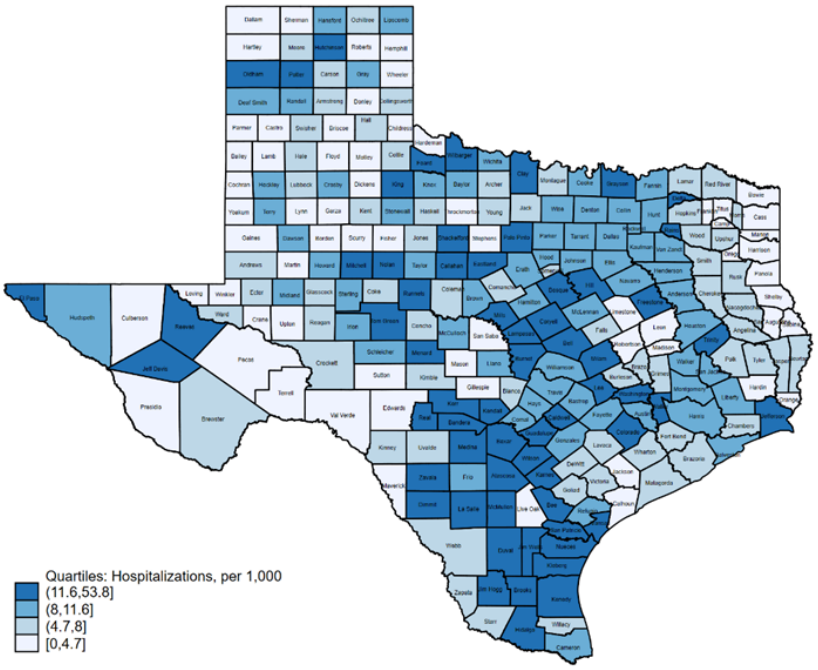
Figure 1. Heat maps: Inpatient Psychiatric Beds per 100,000 Total Population



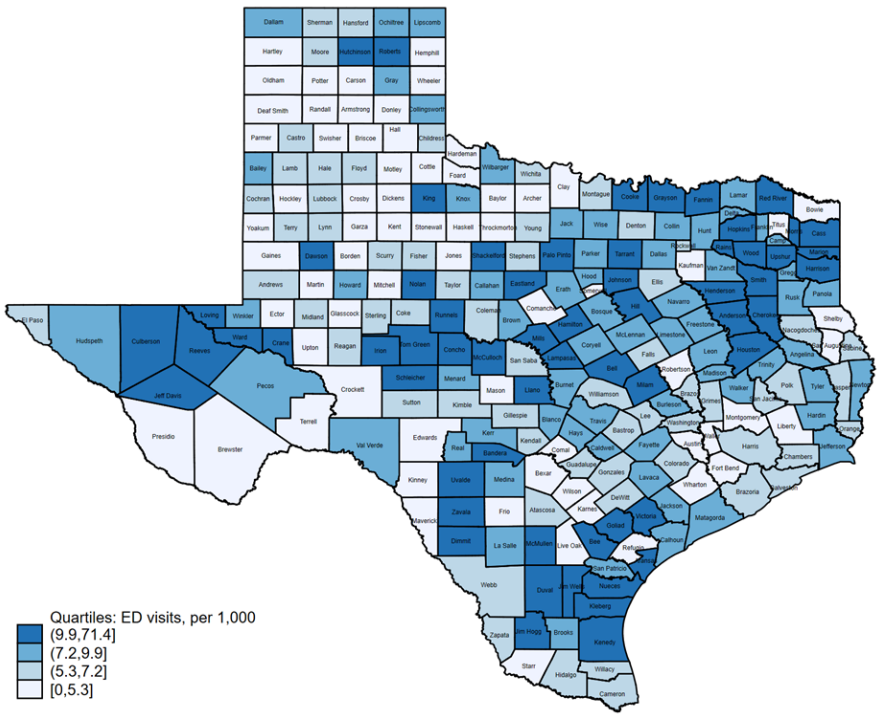
Our analyses characterize who is receiving what types of emergency department (ED) and inpatient services and where those services are being offered. Socio-demographic and visit characteristics of the inpatient psychiatric and emergency room discharges of Texas children and adolescents aged 5-17 are displayed with heat maps (Figure 2) showing county-level utilization.

Figure 2. Heat maps: Discharges

Panel A: Inpatient Discharges per 1,000 Children and Adolescents



Panel B: Emergency Department discharges per 1,000 Children and Adolescents



Notably, *nearly half of all inpatient hospitalizations (as measured by the number of discharges) among those aged 5-17 were related to a primary psychiatric condition, which illustrates the magnitude of the acute mental health challenges in this population and amplifies the need for appropriate inpatient and step-down services.* Children and adolescents who are hospitalized for psychiatric conditions, on average, share the same demographic profile as those using the ED apart from health insurance, with roughly half of the inpatient stays covered by private insurance and just over half of the ED visits covered by Medicaid. This differential in healthcare coverage should be explored further to identify existing underlying disparities in access to appropriate inpatient services. Further, based on our analyses, several Texas regions are well below the optimal number of per capita inpatient psychiatric beds (there are 227 Texas counties, out of 254, with no psychiatric beds), suggesting the potential need for policy and practice intervention to address geographic care disparities.

There is a critical need for improved data infrastructure and data operability. Substantial effort was expended to identify appropriate data sets and outcomes of interest including the continuum of care and the definition and operationalization of the acute psychiatric conditions and diagnoses likely to trigger the need for inpatient care for children and adolescents. Unfortunately, we could not identify a public-use data set that would allow us to observe the trajectories of psychiatric care across different outpatient and inpatient services. The lack of utilization data for patients across different facilities and settings makes it impossible to follow care trajectories and assess which types of interventions are most effective in reducing hospitalizations and readmissions of children and adolescents with an acute mental health diagnosis, or the impact of wrap-around services. Further, current publicly available data also limited our ability to differentiate between types of psychiatric inpatient beds in terms of their classification as adult or child/adolescent beds. Separate reporting of child/adolescent and adult inpatient psychiatric bed availability is critically important to more accurately identifying shortages of inpatient psychiatric services for specific segments of the youth population.

- **Best Practices in Acute Inpatient Mental Health Services for Children and Adolescents: A Literature Review**

The provision of acute inpatient mental health services for children and adolescents is crucial to the management of severe psychiatric crises in this vulnerable population. Ensuring the efficacy and safety of these services requires the implementation of best practices grounded in recent research and evidence-based approaches. Contemporary best practices in acute inpatient mental health services for children and adolescents focus on *family-centered care, integrated care models, the use of technology, staff training, and quality improvement initiatives.*

- **Community Perspectives and Resources: A Summary of Key Informant Interviews**

With a legislative request to develop a deeper understanding of the need for and the use of inpatient pediatric psychiatric services as a critical element in the continuum of care, we explored this public health challenge from a community perspective. Seventeen key informant interviews were conducted in Year 1 of the study to provide a community perspective on the services available, gaps and challenges, and desired solutions and successes. Themes from the information provided by key Texas informants are presented in this report, along with illustrative quotes to highlight community voices. In summary, the key informant interviews we conducted brought into focus the complexity of addressing the acute behavioral and mental health needs of our youngest population. In concert with the themes identified in the best practices review, five key messages emerged that included the need to: 1) *better integrate and coordinate services* across the continuum of care, 2) expand clinical and *community partnerships* to leverage shared resources, 3) *build workforce capacity*, 4) improve inpatient psychiatric care *reimbursement levels*, and 5) ensure access to *affordable care*. Two challenges were noted by Texas informants: 1) the limited availability of inpatient psychiatric beds for the *youngest children*, and 2) the difficulties encountered in providing inpatient beds to youth with severe *co-morbid conditions* including those with IDD. Two case studies of states that address systemic challenges to ensure adequate and effective mental healthcare for children were conducted. The successful policies and programs of the New Jersey Department of Children and Families and the Ohio Children's Hospital Association provide evidence of best-practice solutions.

Year 1 Activities Accomplished:

- Established four interrelated Texas A&M Health teams representing expertise in psychiatry and mental health, community context and perspectives, data management and analytics, and research and administrative support.
- Coordinated with CHAT, SBHCC, and HHSC through planned periodic communication check-ins and briefings that were supplemented by participation in SBHCC Steering Committee meetings, attendance at key expert presentations, and membership in the data outcomes and metrics working group.
- Completed introductory literature review and environmental scan of the approaches and best practices of other states including a review of materials compiled by SBHCC.
- Conducted and reviewed interviews with 15 key clinical and community informants to develop a deep understanding of current needs and proposed solutions.
- Identified appropriate data sets and outcomes of interest that included the definition and operationalization of acute psychiatric conditions and disorders likely to trigger the need for inpatient care.

- Assessed psychiatric hospital beds available to children and adolescents in Texas that included their location and description in the context of population, health professional capacity, rurality, and other relevant community characteristics.
- Conducted initial analyses of trends in the prevalence of psychiatric conditions warranting hospitalization for children and adolescents aged 5 -17 in Texas over the past decade.
- Conducted initial analyses of the number of ED visits and the discharge statuses of children and adolescents with billing codes warranting hospitalization for psychiatric conditions.
- Conducted initial analyses of the numbers of inpatient admissions and discharge statuses for children and adolescents with billing codes for psychiatric conditions.

Year 1 Deliverables: Interim Annual Report outlining the status of the acute mental health services available to children and adolescents in Texas based on our initial analyses of public use databases, a literature review of best practices for acute inpatient psychiatric services, and community perspectives on challenges and successes in providing acute mental health services for children and adolescents in the context of the broader continuum of care drawn from key informant interviews. Our initial focus centered on what is known and what has yet to be learned to fully understand the need for dedicated inpatient psychiatric beds for children and adolescents.

Future Directions

Working collaboratively with CHAT, SBHCC, and HHSC OMHCC has enhanced our work and we are committed to continuing and strengthening these important collaborations. Over the next year, the study team will expand on this work to identify longer-term trends in bed counts, inpatient and ED visits, and general child and adolescent mental health indicators. The study team will seek additional data sources and alternative approaches to differentiating pediatric from adult inpatient beds and distinguishing the mental health care service utilization by adolescents from that of younger children, as well as the special challenges faced by youth with severe co-morbid conditions including those with IDD. The study team will also continue their efforts to obtain data that enables the tracking of episodes of psychiatric care for youth and highlight disparities in access to inpatient psychiatric services based on population demographics (e.g., different age ranges) and geographic characteristics (e.g., Texas regions). Our initial report will be distributed to key thought leaders to solicit their responses and feedback on next steps. Finally, an invitational roundtable is planned for Year 2 to reflect on major takeaways regarding successes and challenges in delivering accessible and quality inpatient psychiatric care to meet the needs of children/adolescents and their families in Texas.

TEXAS A&M UNIVERSITY HEALTH

Report #1
The Need for and Use of Inpatient Psychiatric Care: What Public Databases Reveal

Study on Mental Health Services for Children and Adolescents

December 2024

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Report 1

The Need for and Use of Inpatient Psychiatric Care: What Public Databases Reveal

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Summary of Findings

Study aims were to: (1) define minimum and optimal standards for inpatient psychiatric bed availability, (2) analyze the status of inpatient psychiatric bed availability in Texas counties, and (3) examine the utilization of hospital inpatient and emergency department (ED) services for psychiatric conditions by children and adolescents 5-17 years old.

Our findings highlight a critical need for attention to the psychiatric needs of children and adolescents as nearly 50% of hospital discharges in this population are for a hospital stay with a psychiatric disorder as a primary diagnosis. At the same time, Texas can be classified as experiencing a moderate shortage of inpatient psychiatric beds with 22 beds per 100,000 population compared to the minimum standard bed count of 30 beds per 100,000 population. Texas bed capacity falls substantially below the 60 beds per 100,000 population, considered optimal to meet the mental health care needs of its population. However, there is significant variation in bed availability across Texas counties (Objective 3, Figure 1). Of the 254 Texas counties, 227 (representing 20% of the total state population) have no inpatient psychiatric beds. Children and adolescents living in areas with critical bed shortages (particularly in Central and South Texas) experience among the highest rates of hospitalization for psychiatric conditions—one measure of unmet demand for psychiatric services.

Existing public use data is limited in many ways with constraints that impact the type of questions that can be answered comprehensively and interpreted clearly. Our estimates of inpatient psychiatric bed availability are based on total bed counts reported by facilities, but, given the inconsistency in reporting separate beds available to children and adolescents, our data likely reflect an overestimate of current bed availability for this population. In addition, with only encounter-level data available from public use data, we were unable to follow patients over time to identify repeat users or observe the hospitalizations of individuals previously treated in a hospital ED setting. Furthermore, we were not able to identify hospital-based sources for additional analyses of existing data in either large urban hospital systems or smaller rural hospitals for in-depth comparability. Finally, it is important to clarify that estimates of numbers of beds per 100,000 population is a standard demographic reporting metric and includes the total population, not just children and adolescents.

Despite these limitations, our study provides a deeper understanding of what is known about the availability and use of inpatient psychiatric beds by children and adolescents in Texas in line with current standards of care. In year 2, the study team will seek other databases and conduct additional analyses as indicated in the future planned activities section of the report.

Introduction and Scope of Work

In Year 1 (September 1, 2023-August 31, 2024) the study team at Texas A&M Health Science Center (Texas A&M Health) conducted an initial planning study coordinated by the data management and analytics team. Study objectives accomplished through the following priority tasks were addressed:

1) Conducted introductory literature review and environmental scan of other states' approaches to determining adequate inpatient psychiatric care capacity.
2) Identified appropriate data sets and outcomes of interest, including the continuum of care and definition and operationalization of the acute psychiatric disorders and conditions likely to trigger the need for inpatient care.
3) Identified the status of psychiatric hospital beds for children and adolescents in Texas in the context of where they are located in terms of population, health professional capacity, rurality, and other relevant community characteristics.
4) Examined trends in the prevalence of psychiatric conditions warranting the hospitalization of children and adolescents 5-17 in Texas.
5) Analyzed the number of inpatient visits and discharge statuses of children and adolescents with billing codes for psychiatric conditions.
6) Analyzed the number of ED visits and discharge statuses for children and adolescents with billing codes warranting hospitalization for psychiatric conditions.

In this Interim Report covering Year 1 activities, we will highlight progress on these objectives, and, in closing, highlight planned activities for Year 2 (September 1, 2024-August 31, 2025) of the study.

Objective 1. Review of Psychiatric Resources and Standards of Care

The minimum standard bed count per 100,000 population is 30 beds while 60 beds per 100,000 population is considered optimal to meet the mental health care needs of the population. Historically, Texas does not meet either standard.

Several existing state reports and academic papers have documented the need to expand psychiatric bed availability and clinical staff capacity to meet the rising mental health demand in the United States. The 2023 Tennessee Department of Mental Health & Substance Abuse Services report suggests that a standard minimum of 30 inpatient psychiatric beds per 100,000 population is necessary to meet regional needs (Tennessee Department of Mental Health & Substance Abuse Services, 2023). The report highlights that as current bed availability falls short of this benchmark, strategic efforts to increase resource capacity are needed. The 2022 Michigan Department of Health and Human Services report also indicates a need for policy adjustments to expand psychiatric bed capacity through the Certificate of Need (CON) program (MDHHS, 2022). Finally, Mundt et al. (2022) suggested that 60 psychiatric beds per 100,000 population level are optimal,

while 30 beds per 100,000 population should be considered the minimum. Given these benchmarks, bed shortages are categorized as mild (25-30 beds), moderate (15-25 beds), and severe (fewer than 15 beds), highlighting the critical need for adequate bed numbers to meet mental health care demands effectively (Mundt et al., 2022).

Several studies also specifically compared mental healthcare resource capacity in Texas to other states. Based on data from the US Department of Health and Human Services, the number of available psychiatrists needed to address the mental health professional shortage area (HPSA) is 614, assuming that the optimal provider level is 30,000 to 1 (or 20,000 to 1 in high-need areas). Estimates suggest that Texas meets 31.4% of its need for psychiatrists, which is ranked 18th in the nation (HRSA, 2024; KFF, 2024). The 2023 report by Mental Health America ranks Texas 50th in the U.S. with a mental health workforce availability ratio of 760 people per mental health provider in Texas. Providers include psychiatrists, psychologists, licensed clinical social workers, counselors, marriage and family therapists, and advanced practice nurses specializing in mental health (Reinert et al., 2021).

Texas has historically had fewer psychiatric beds than recommended to meet mental health demands. An older (2008) report by the Treatment Advocacy Center ranked Texas 39th in the U.S. with only 12.1 *public* psychiatric beds available per 100,000 population. This ranking, based only on public beds, reflected a significant shortage, considering expert recommendations at the time suggested that 50 public psychiatric beds per 100,000 population were needed to meet the demand for mental health services (Fuller Torrey et al., 2008). However, a more recent study by Hudson (2021) estimated that Texas had approximately 25 beds per 100,000 population (this includes all beds, public and private), a figure which was still somewhat below the 30-bed level that is considered a minimum by some researchers (Mundt et al., 2022) or optimal by others (Hudson, 2021). The current Texas A&M Health study is designed to obtain a more updated estimate of the number of psychiatric beds available in Texas.

Objective 2. Datasets and Definitions

Several public data sets are available that provide a cursory view of inpatient psychiatric use and capacity for children and adolescents in Texas. However, several limitations in these current data sources/analyses are noted: 1) data are only presented at the encounter level, 2) pediatric beds are not accounted for separately, 3) there are variations in patient admission ages, and 4) the initial analyses only focused on primary diagnosis at discharge.

This study used three primary sources of data. First, we used the 2022 Texas Health and Human Services Commission (HHSC) Department of State Health Services (DSHS) (Inpatient Public Use Data File (PUDF) to obtain statewide hospital discharge records (Texas Department of State Health Services (DSHS), 2023b). This database contains encounter-level information for each inpatient hospital stay and includes such characteristics as *demographic information* (age, sex, and race/ethnicity), *socioeconomic information* (insurance coverage and residence zip codes), and *clinical information*

including diagnosis codes, revenue codes, length of hospital stay, and discharge status. Second, we used the 2022 HHSC DSHS Emergency Department PUDF to obtain statewide outpatient ED records (Texas Department of State Health Services (DSHS), 2023a). This database contains *encounter-level information* for each outpatient ED visit and is comprised of information similar to that included in the Inpatient PUDF. These two data sources allowed us to analyze the complete census of Texas hospital discharge and ED records without the restriction of insurance status (yes/no) or type (commercial vs. Medicare/Medicaid or CHIP) or different health plans.

For each encounter, there is one *principal* diagnosis coded in ICD10-CM, which we used to identify inpatient and ED encounters for psychiatric-related conditions based on the Agency for Healthcare Research and Quality (AHRQ) Clinical Classification Software Refined (CCSR). The CCSR categories used to identify psychiatric diagnoses are provided in the Appendix (Table A3). We also identified inpatient psychiatric encounters using revenue codes that indicate the type of bed in which the patients spent most of their hospital stay. The full list of revenue codes is provided below (see Objective 4). We limited our analysis sample to encounters for individuals aged 5-17 who resided in Texas and were diagnosed with a psychiatric-related condition in 2022.

The third source of data was the 2022 American Hospital Association (AHA) Annual Survey, which contains information on the operational characteristics of hospitals in Texas including *facility status* (children's hospital, psychiatric hospital, general-acute hospital), *ownership status* (for-profit, not-for-profit, public), and *capacity* (total number of beds and number of psychiatric beds). We limited our sample of hospitals to those with at least one inpatient/ED encounter for a patient 5-17 years of age who had been diagnosed with a psychiatric-related condition in 2022.

First, we created heatmaps to illustrate hospital capacity (in terms of the number of psychiatric beds per 100,000 county population) and the prevalence of hospitalization and ED visits (encounters per 1,000 county population aged 5-17) across Texas counties. We also provided descriptive statistics for the main sample of inpatient and ED encounters.

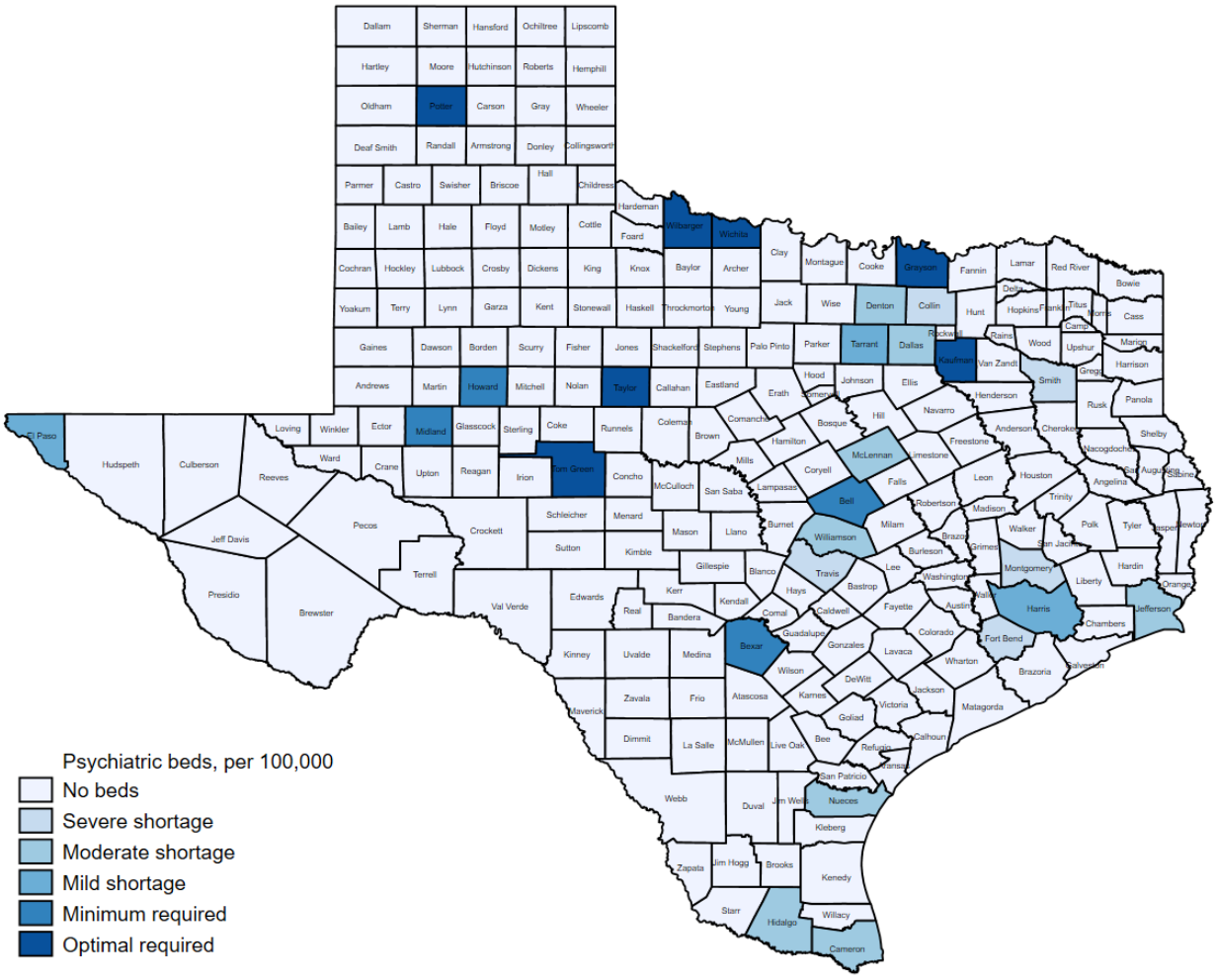
Our analysis has several limitations. First, since inpatient and ED data are at the encounter level, we cannot follow patients over time to identify repeat users or observe hospitalizations of individuals previously treated in a hospital ED setting. This limits our ability to describe the full continuum of psychiatric care in Texas. Second, since few hospitals outside of pediatric facilities report pediatric psychiatric beds separately, we can only present the total number of psychiatric beds (pediatric, adult, and geriatric) across Texas counties, some of which might be unavailable to children and adolescents. Third, hospitals included in our analysis may have different policies regarding minimum admission age. These policies may impact our estimates of inpatient and hospital ED utilization by age. Last, our sample was selected using only the primary diagnosis. It is likely that we excluded many children and adolescents with co-occurring conditions who may experience disparate access due to physical or intellectual disabilities.

To address these limitations, we will investigate the availability of restricted inpatient and ED data files from Texas DSHS for examining episodes of care from outpatient to inpatient in Year 2. Additionally, we will conduct a more thorough investigation of the availability of pediatric beds for children and adolescents by surveying hospital facilities directly and examining potential disparities in utilization by age and the presence of co-occurring conditions.

Objective 3. Inpatient Psychiatric Bed Availability in Texas

There are an estimated 22 inpatient psychiatric beds per 100,000 in Texas, which is below the minimum threshold of 30 beds per 100,000 and well below the optimal level of 60 beds per 100,000. Of the 254 counties in Texas, 227 (representing 20% of the state's population) had no psychiatric beds.

Figure 1. Inpatient Psychiatric Beds per 100,000 Population



Note: Psychiatric bed capacity need is based on Mundt et al. (2022).

Figure 1 illustrates the number of county-level psychiatric beds in 133 hospitals with an inpatient/ED encounter for a patient 5-17 years old with a psychiatric-related diagnosis in 2022, which may not represent every hospital with psychiatric care capacity. We normalized the number of beds by the total county population of children and adults (i.e., adjusted data values so they are on a similar scale and can therefore be compared and analyzed with additional data). In terms of service type, 51.9% of hospitals were general acute, 24.8% were psychiatric, and 12% were children's hospitals. In terms of funding, 43.6% of hospitals were for-profit, 33% were non-profit, and 11.3% were public. We note that approximately 10% of hospitals are missing services and funding type information.

The 133 hospitals identified in the discharge data are in 46 counties. The overall number of psychiatric beds per 100,000 population in the state of Texas was 22, which implies that overall, Texas is in moderate shortage. However, county-level analysis points to a significant variation in bed capacity across Texas counties. The counties with the optimal number of psychiatric beds included Wichita, Wilbarger (home to North Texas State Hospital and North Texas State Hospital – Vernon), Potter, and Grayson in the north; Kaufman in the east (home to Terrell State Hospital); and Taylor and Tom Green in west central Texas. Counties with the minimum number of required beds included Midland, Howard, Bell, and Bexar, while counties with a mild shortage included metro counties like Harris, El Paso, and Tarrant. Most Texas counties (227 of 254), which represent approximately 20% of the overall population, were found to have zero psychiatric beds.

Objectives 4-5. Inpatient Hospital Discharges for Texas Child and Adolescent Psychiatric Care

Approximately half of all inpatient discharges of children and adolescents in Texas in 2022 involved psychiatric diagnoses. Depressive disorders and specified and unspecified mood disorders accounted for more than 80% of all psychiatric inpatient discharges in the pediatric population.

Figure 2. Inpatient Discharges per 1,000 Children and Adolescents

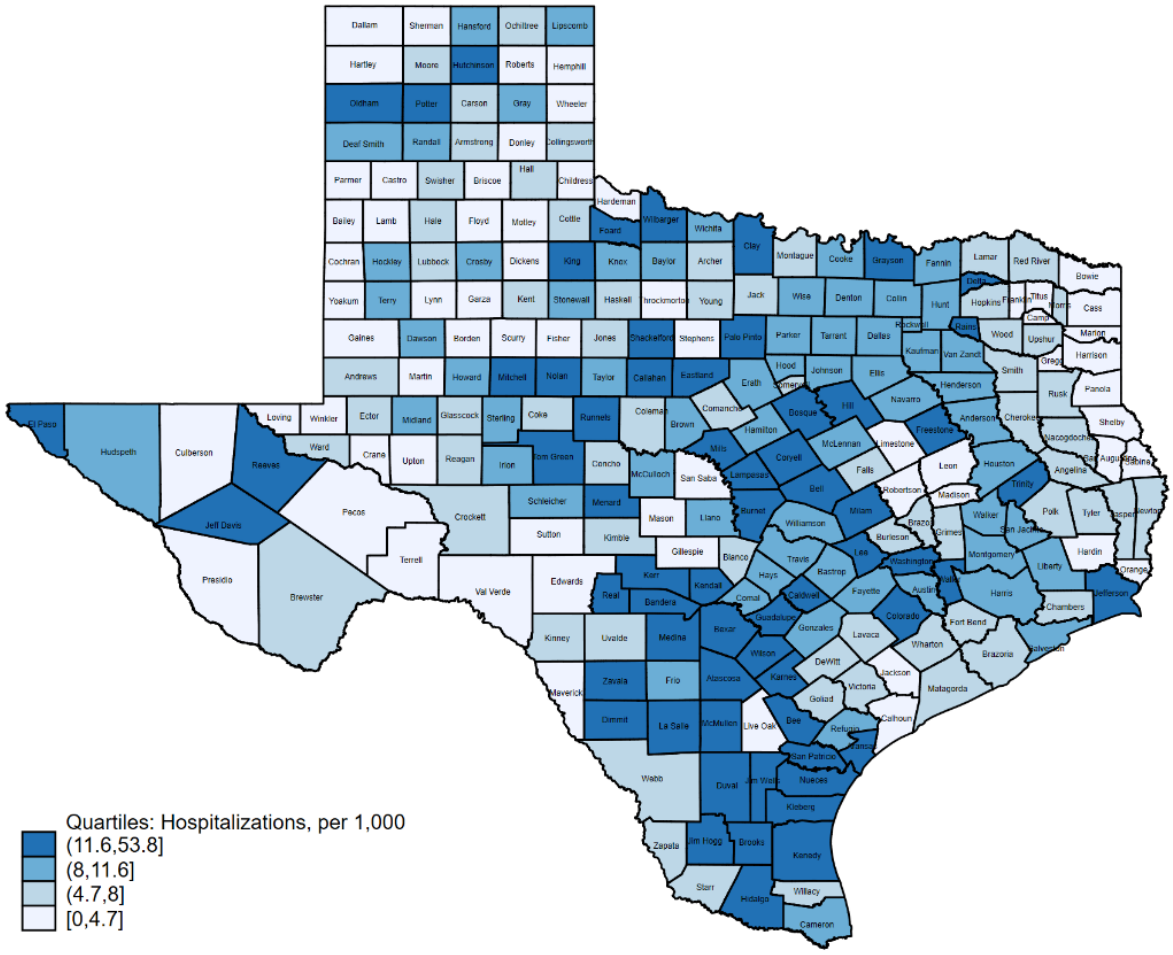


Figure 2 depicts per capita county-level inpatient discharges for patients 5-17 years of age with a psychiatric-related diagnosis. The prevalence of inpatient hospitalizations for psychiatric conditions among children and adolescents is highest in counties located in South Texas and around San Antonio (Bexar County). Several counties in Central and West Texas also have discharge numbers in the top quartile of the distribution (11.6-53.8 inpatient stays per 1,000 persons 5-17 years old).

Sociodemographic and visit characteristics of inpatient psychiatric discharges of Texas children and adolescents aged 5-17 years are summarized in Table 1. Inpatient psychiatric hospitalizations were defined in two ways. Columns 1-2 show characteristics of inpatient visits where psychiatric hospitalizations are defined as any psychiatric diagnoses listed in the first position (Definition 1). Columns 3-4 display characteristics of visits where psychiatric hospitalizations are defined using revenue codes 0114, 0124, 0134, 0144, 0154, 0204, and 0964 (Definition 2), which identify billing for inpatient services in which most of the hospital stays occurred in a psychiatric unit.

A complete list of ICD-10 diagnosis codes used for definition 1 is provided in the Appendix (Table A3). There were more than 50,000 inpatient discharges in 2022, representing between 44 and 49 percent of all hospital inpatient discharges of children and adolescents aged 5-17 years across both definitions.

Based on Definition 1, the majority (78%) of inpatient psychiatric hospitalizations involved children and adolescents aged 10 to 17 years while those aged 5 to 9 years represented just five percent of inpatient discharges. The difference in rates of hospitalization by age is likely driven by both demand and differential age-based admission policies of hospital facilities. Sex was unknown or not reported in 57% of psychiatric discharges. Children and adolescents who were identified in the data as non-Hispanic White (40%), Hispanic (33%), and non-Hispanic Black (17%) represented the largest number of psychiatric hospitalizations. Private insurance (50%) and Medicaid (39%) were most often listed as the expected source of payment for most hospitalizations. There was little difference in sociodemographic characteristics using the more restrictive Definition 2 (Table 1, columns 3-4). The average length of stay ranged from 7.65 to 8.71 days.

In the Appendix, Table A1, we have listed the top 10 inpatient psychiatric diagnoses ranked by occurrence. Depressive disorders (56.23%) and other specified and unspecified mood disorders (26.15%) accounted for more than 82 percent of the psychiatric hospitalizations of children and adolescents 5-17 years of age in 2022.

Table 1. Characteristics of Hospital Inpatient Visits for Psychiatric Conditions by Texas Children and Adolescents Aged 5-17, 2022

	First Listed Diagnosis Code		Revenue Code for Psych Bed	
	N	%	N	%
Age (Years)				
5-9	2,962	5.35	2,792	5.58
10-14	23,735	42.84	21,651	43.27
15-17	19,696	35.55	17,414	34.80
Not reported/Missing	9,017	16.27	8,180	16.35
Sex				
Female	16,092	29.04	13,391	26.76
Male	7,681	13.86	6,608	13.21
Not reported/Missing	31,637	57.10	30,038	60.03
Race/Ethnicity				
NH-Black	9,271	16.73	8,596	17.18
NH-White	22,258	40.17	20,405	40.78
NH-Asian	830	1.50	755	1.51
NH-Other	4,797	8.66	4,449	8.89
Hispanic	18,252	32.94	15,830	31.64
Missing	2	0.00	2	0.00
Insurance				
Private	27,563	49.74	24,949	49.86
Medicaid	21,364	38.56	19,584	39.14
Self-Pay	2,878	5.19	2,252	4.50
Other	3,602	6.50	3,249	6.49
Missing	3	0.01	3	0.01
Mean Length of Stay (days)	8.71	std. dev (16.01)	7.65	std. dev (7.13)
Inpatient Stay in Psychiatric Unit				
No	5,458	9.85	3	0.01
Yes	49,952	90.15	50,034	99.99
Psych Visits as Percent of Total Inpatient Visits		48.98		44.22
Total Discharges (N)	55,410		50,037	

Source: 2022 Texas DSHS Inpatient Discharge PUDF. **Notes**: ICD-10-CM Codes were collapsed into clinically meaningful categories using the AHRQ Clinical Classification Software (CCS) for ICD-10-CM diagnoses. Age and sex are not reported for diagnoses indicating alcohol or drug use or an HIV diagnosis. Race and ethnicity are assigned by the provider for reporting to DSHS.

Objective 6. ED Discharges

There were more than 40,000 emergency department visits by children and adolescents in 2022 for psychiatric conditions. Suicidal ideation/attempt/ intentional self-harm was the most common emergency department primary diagnosis (43.97%) in 2022, followed by anxiety and fear-related disorders (14.42%), and depressive disorders (13.82%).

Figure 3. Emergency Department Discharges per 1,000 Children and Adolescents

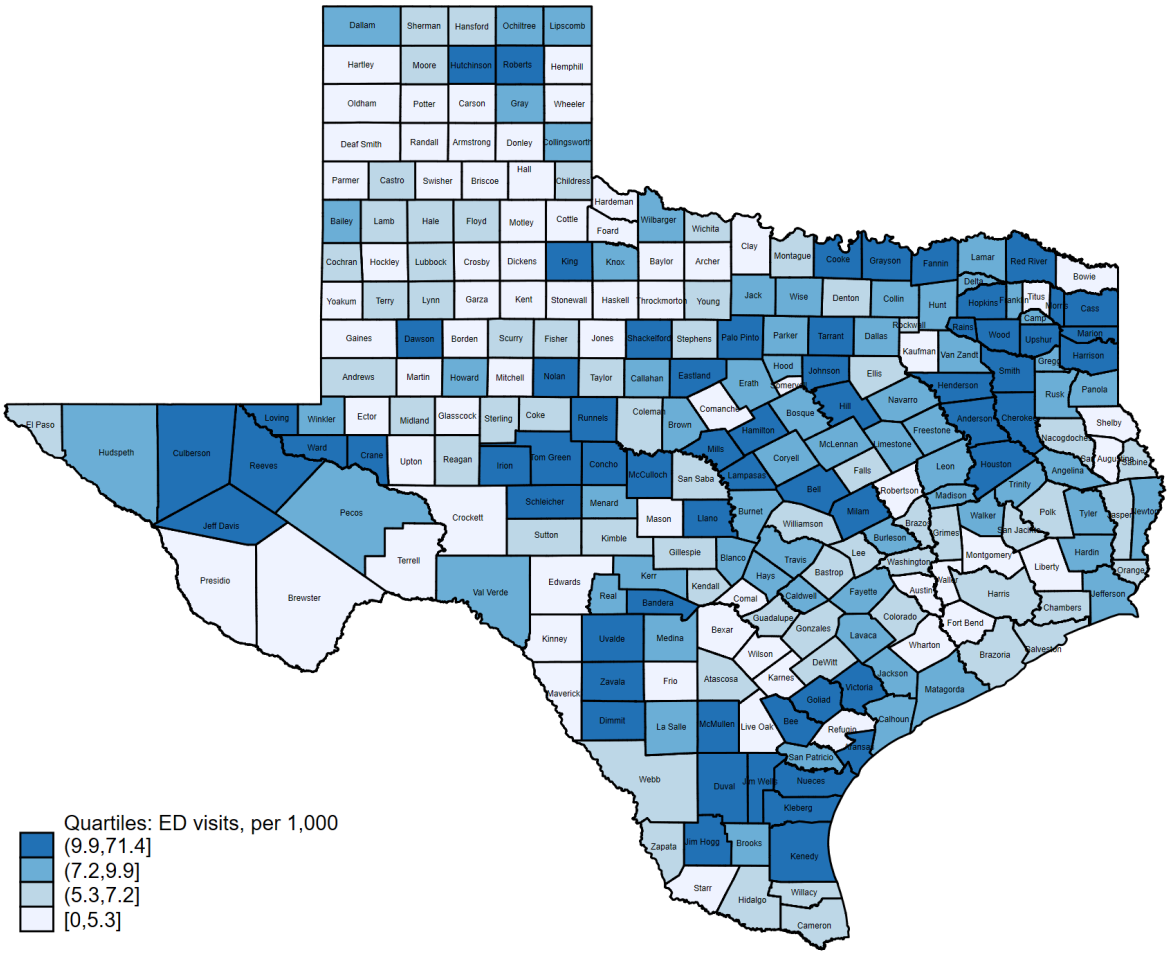


Figure 3 depicts per capita county-level outpatient ED visits for patients 5-17 years of age with a psychiatric-related diagnosis. The prevalence of ED visits for psychiatric conditions in children is highest in counties located in South, West, and West Central Texas. Contrary to lower prevalence of hospital stays in Northeast Texas, we also observed a higher per capita volume of ED visits in Northeast Texas.

Sociodemographic characteristics of psychiatric ED visits by Texas children and adolescents aged 5-17 are summarized in Table 2, and the ICD-10 diagnosis codes used to identify ED visits for psychiatric conditions are provided in the Appendix (see Table A2). Overall, in 2022 there were 40,338 ED visits for psychiatric conditions (listed in the

first position), representing 2.53% of all ED utilization. Children and adolescents aged 5-9 accounted for 6% of ED discharges while the majority (79%) of visits occurred among those aged 10-17 years. Sex was not reported or missing for nearly 24% of visits. Children and adolescents who were identified in the data as Hispanic (39.43%), non-Hispanic White (38.64%), and non-Hispanic Black (15.89%) represented the highest ED utilization for psychiatric conditions. Medicaid was the primary expected payer in more than half of all ED visits (52.25%), followed by private insurance (36.02%). Other sources of payment, including self-pay, represented 11.73 percent of ED discharges in 2022.

Table 2. Characteristics of Emergency Department Visits for Psychiatric Conditions by Texas Children and Adolescents Aged 5-17, 2022

	N	%
Age (Years)		
5-9	2,354	5.84
10-14	15,568	38.59
15-17	16,212	40.19
Not reported /Missing	6,204	15.38
Sex		
Female	20,329	50.40
Male	10,364	25.69
Not reported/Missing	9,645	23.91
Race/Ethnicity		
NH-Black	6,411	15.89
NH-White	15,586	38.64
NH-Asian	629	1.56
NH-Other	1,805	4.47
Hispanic	15,907	39.43
Insurance		
Private	14,530	36.02
Medicaid	21,077	52.25
Self-Pay	3,546	8.79
Other	1,153	2.86
Missing	32	0.08
Psych Visits (N) and Percent of Total ED Visits	40,338	2.53

Source: 2022 Texas DSHS Emergency Department PUDF.
Notes: Age and sex are not reported for diagnoses indicating alcohol or drug use or an HIV diagnosis. Race and ethnicity are assigned by the provider for reporting to DSHS.

In the Appendix, Table A2 we have listed the top 10 psychiatric diagnoses ranked by occurrence in ED visits. Suicidal ideation/attempt/intentional self-harm was the most common primary diagnosis (43.97%) reported for ED visits in 2022, followed by anxiety and fear-related disorders (14.42%), and depressive disorders (13.82%).

Discussion/Recommendations

Based on our analyses, we determined that several Texas counties were well below the optimal number of per capita inpatient psychiatric beds and 227 Texas counties (home to approximately 20% of the Texas population) had no beds, which suggests the potential need for policy and practice intervention. For example, children and adolescents aged 5-17 who resided in South Texas, a severe bed shortage area, also had among the highest numbers of inpatient and ED visits for psychiatric conditions. While our current analysis does not consider access to community-based services, this factor should be considered to adequately capture the unmet need for psychiatric services.

Nearly half of all inpatient utilization by children and adolescents aged 5-17 was due to a psychiatric condition (2.5% of total ED visits and 50% of hospitalizations), with most patients between 10-17 years. Our results suggest that children and adolescents who are hospitalized for psychiatric conditions, on average, share the same demographic profile as those using the ED, apart from health insurance. Most hospitalized patients were White (40%) or Hispanic (33%) and over 90% were admitted to a psychiatric unit for an average stay of 8.7 days. Approximately half of inpatient hospitalizations (~50%) were covered by private insurance while slightly over half of ED visits (52.3%) were covered by Medicaid. Additionally, the most common reason for an inpatient stay for psychiatric care was depressive disorders, which ranked third among ED visits behind suicidal ideation/attempt/intentional self-harm and anxiety and fear-related disorders. We used primary diagnosis codes to identify psychiatric visits. Differences in coding/billing practices between the ED and inpatient settings may be influencing some of the differences in utilization and payment sources we observed.

Lastly, the study team is unaware of any mechanism that requires hospital facilities to report the number of pediatric and adult inpatient psychiatric beds separately. Therefore, we chose to report the total number of psychiatric beds and cross-referenced two sources of data to obtain our bed counts. Separate reporting of child and adult inpatient psychiatric beds will be necessary to more accurately identify shortages of inpatient psychiatric care for children and adolescents.

Planned Year 2 Activities

Over the next year, the study team will expand on our first-year work to identify longer-term trends in bed counts, inpatient and ED visits, and general child and adolescent mental health indicators. Additionally, we will identify and characterize disparities in access to inpatient psychiatric services based on population demographics and geographical characteristics. Year 2 objectives are listed below:

1. Identify and characterize trends in each outcome (beds, inpatient stays, ED visits) from 2016 to the most current year of data available.
2. Identify and characterize trends in the mental health status of Texas children using data from the Youth Risk Behavior Surveillance System (YRBSS) from 2016 to the most current year of data available.
3. Identify and characterize disparities in access to inpatient psychiatric services based on age, presence of co-occurring conditions, county and/or zip code, population characteristics including rurality/urbanicity, income, and proximity to other healthcare resources.
4. Calculate average distances from the population centroid of each Texas zip code to the nearest hospital facility with psychiatric beds.
5. As feasible: Develop a plan to obtain an estimate of the number of pediatric psychiatric beds as a proportion of the total number of psychiatric beds (e.g., test the feasibility of contacting hospitals with inpatient psychiatric discharges to gather this information).
6. As feasible: Identify sources and analyze available existing data from the state hospital system, non-state hospitals, and select rural counties for in-depth comparability.
7. If made available: Use restricted inpatient and ED data files from Texas DSHS to quantify repeat visits to hospitals and ED and hospitalizations of those who had a previous ED visit within the same year.

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Appendix: Psychiatric Diagnosis Codes

Table A1. Top 10 Inpatient Hospitalization Psychiatric Diagnoses Ranked by Occurrence in Texas, 2022

CCSR Category Code	CCSR Category Description	N	%
MBD002	Depressive disorders	31,155	56.23
MBD004	Other specified and unspecified mood disorders	14,488	26.15
MBD003	Bipolar and related disorders	4,585	8.27
MBD012	Suicidal ideation/attempt/intentional self-harm	1,669	3.01
MBD001	Schizophrenia spectrum and other psychotic disorders	908	1.64
MBD008	Disruptive, impulse-control and conduct disorders	648	1.17
MBD007	Trauma- and stressor-related disorders	595	1.07
MBD010	Feeding and eating disorders	526	0.95
MBD014	Neurodevelopmental disorders	384	0.69
MBD005	Anxiety and fear-related disorders	142	0.26
OTHER	…	310	0.13
Totals			99.57
		55,410	

Source: 2022 Texas DSHS Inpatient Discharge PUDF.

Notes: Inpatient hospitalizations of children and adolescents aged 5-17 for psychiatric conditions were identified above using the first listed diagnosis code. ICD-10-CM Codes were collapsed into clinically meaningful categories using AHRQ Clinical Classification Software (CCS) for ICD-10-CM Diagnoses.

Table A2. Top 10 Emergency Department Visit Psychiatric Diagnoses Ranked by Occurrence in Texas, 2022

CCSR Category Code	CCSR Category Description	N	%
MBD012	Suicidal ideation/attempt/intentional self-harm	17,736	43.97
MBD005	Anxiety and fear-related disorders	5,816	14.42
MBD002	Depressive disorders	5,574	13.82
MBD019	Cannabis-related disorders	2,131	5.28
MBD007	Trauma and stressor-related disorders	1,581	3.92
MBD004	Other specified and unspecified mood disorders	1,173	2.91
MBD017	Alcohol-related disorders	1,101	2.73
MBD008	Disruptive, impulse-control and conduct disorders	1,014	2.51
MBD014	Neurodevelopmental disorders	950	2.36
MBD025	Other specified substance-related disorders	809	2.01
OTHER	…	2,453	0.13
Totals		40,338	94.05

Source: 2022 Texas DSHS Emergency Department PUDF.
Notes: ICD-10-CM Codes were collapsed into clinically meaningful categories using AHRQ Clinical Classification Software (CCS) for ICD-10-CM Diagnoses. Psychiatric visits by Texas children and adolescents (5-17 years of age) were identified using the first listed diagnosis code.

Table A3. Default CCSR Categories Identifying Psychiatric Diagnosis

Default CCSR Category Code	CCSR Category Description
MBD001	Schizophrenia spectrum and other psychotic disorders
MBD002	Depressive disorders
MBD003	Bipolar and related disorders
MBD004	Other specified and unspecified mood disorders
MBD005	Anxiety and fear-related disorders
MBD006	Obsessive-compulsive and related disorders
MBD007	Trauma- and stressor-related disorders
MBD008	Disruptive, impulse-control and conduct disorders
MBD009	Personality disorders
MBD010	Feeding and eating disorders
MBD011	Somatic disorders
MBD012	Suicidal ideation/attempt/intentional self-harm
MBD013	Miscellaneous mental and behavioral disorders/conditions
MBD014	Neurodevelopmental disorders
MBD017	Alcohol-related disorders
MBD018	Opioid-related disorders
MBD019	Cannabis-related disorders
MBD020	Sedative-related disorders
MBD021	Stimulant-related disorders
MBD022	Hallucinogen-related disorders
MBD023	Inhalant-related disorders
MBD024	Tobacco-related disorders
MBD025	Other specified substance-related disorders

Notes: The AHRQ Clinical Classifications Software Refined (CCSR) can be found here: https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

TEXAS A&M UNIVERSITY HEALTH

Report #2
Best Practices in Acute Inpatient Mental Health Services for Children and Adolescents

Study on Mental Health Services for Children and Adolescents

December 2024

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Report 2

Best Practices in Acute Inpatient Mental Health Services for Children and Adolescents

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Rationale

The provision of acute inpatient mental health services for children and adolescents is crucial to the management of severe psychiatric crises in this vulnerable population. Ensuring the efficacy and safety of these services requires the implementation of best practices grounded in recent research and evidence-based approaches. This project explored contemporary best practices in acute inpatient mental health services for children and adolescents with a focus on family-centered care, integrated care models, the use of technology, staff training, and quality improvement initiatives.

Introduction to Best Practices

Acute inpatient mental health services for children and adolescents are designed to provide intensive care and support to young people in severe psychological distress or crisis. The goal of these services is to stabilize patients, manage acute symptoms, and develop a plan for ongoing care. Given the unique developmental and psychosocial needs of children and adolescents, it is essential to adopt evidence-based best practices that ensure high-quality care, patient safety, and optimal outcomes. This paper is a review of the latest research that identifies and validates best practices in this critically important area of mental health care for this population. The unique challenges faced by this age group, including their developmental stages, family dynamics, and social contexts, require tailored approaches that are distinct from those used for adults.

Family-Centered Care

Multidisciplinary Assessment and Personalized Treatment Plans

Recent studies have emphasized the importance of multidisciplinary assessment and personalized treatment plans in acute inpatient settings for children and adolescents. A comprehensive evaluation including medical, psychological, social, and developmental factors is crucial to the development of effective treatment strategies. This approach ensures that all aspects of patient health are addressed, resulting in more accurate diagnoses and tailored interventions (Arakelyan et al., 2023). Personalized treatment plans that consider individual patient needs, preferences, and goals lead to better engagement and outcomes. For children and adolescents, incorporating developmental milestones and age-appropriate interventions is critical. Additionally, recognizing the unique stressors and challenges faced by young patients, such as school pressures and peer relationships, allows for more effective and empathic care.

The pivotal role of multidisciplinary treatment teams for inpatient psychiatric care for children and adolescents must be recognized and highlighted. Multidisciplinary team involvement ensures that all aspects of a patient's condition are addressed, and holistic recovery can be achieved (Brown et al., 2024). Each team member brings a unique perspective and expertise, which allows for a more thorough and nuanced understanding of patient needs. Regular team meetings and collaborative treatment planning are key components of this approach. Effective communication within the team ensures that

treatment plans are cohesive and that the medical, psychological, educational, and social needs of the patient are considered.

As opposed to traditional treatment teams in a general acute hospital setting (e.g. physician, nurses, physical/occupational therapists), the optimal inpatient psychiatric team for children and adolescents will also involve child and family psychotherapists (commonly clinical psychologists or social workers), substance use counselors, education specialists (commonly teachers) and others. However, a shortage of available professionals in a particular hospital or geographic area will adversely affect the ability of healthcare professionals to provide state-of-the-art care.

Family and Caregiver Involvement

Involving families and caregivers in the treatment process has been shown to improve patient outcomes and satisfaction. Family members can provide valuable insights into a patient's history and support the continuity of care discharge. Structured family therapy sessions and regular communication with caregivers are commonly recommended practices (Haselden et al., 2019) that are important to optimizing the post-discharge environment, and including families in the treatment process not only helps in gathering comprehensive patient information but also strengthens the support system available to the patient, which facilitates a smoother transition back to community life. Engaging families in treatment planning and education about mental health conditions can empower them to better support the recovery of their child and manage any ongoing challenges.

Large geographic areas in Texas that do not have inpatient providers create a need for children to be hospitalized 100 miles or more from their homes. In these cases, special attention should be paid to ensuring family/caregiver involvement and access. When travel for inpatient care is required, families should be involved in placement decisions, and transportation and housing for overnight stays should be subsidized to reduce family stress and economic burdens. During inpatient care or after discharge, families and other caregivers should also be actively involved in the treatment process through regular therapy sessions, family counseling, and scheduled meetings with the treatment team. For example, caregivers may participate in bi-weekly meetings to discuss patient progress, provide insights into the home environment, and receive guidance on how to continue supporting the patient after discharge. Additionally, caregivers can be trained in specific coping strategies that can be used to help the patient manage symptoms at home.

Integrated Care Models

Coordination with Community Services and Outpatient Care

Effective coordination with community mental health service providers, schools, and primary healthcare providers is critical to ensuring continuity of care (Storm et al., 2020). Discharge planning involves critically important steps that ensure continuity of care after discharge, which can include scheduling follow-up appointments with outpatient providers before the patient leaves the inpatient facility, coordinating with community mental health services for ongoing support, and setting up medication management reminders. Before

discharge, the treatment team should arrange the first three outpatient therapy sessions and establish a communication plan between the outpatient provider and the primary care physician of the patient to monitor progress and adjust treatment as needed.

Scheduling appointments with outpatient providers reduces the risk of readmission and supports long-term recovery. By bridging the gap between inpatient and community care, patients will receive critically needed ongoing support that will help them maintain their progress and reduce the likelihood of relapse. Coordination with schools is particularly important for children and adolescents as educational support and accommodation can significantly impact their overall wellbeing and academic success. This specific point is important in considering the provision of required inpatient beds, as these beds cannot be considered in a "vacuum" but rather within the continuum of care. Ensuring that all aspects of the mental health care continuum are considered will, in turn, reduce the demand for inpatient services by reducing readmissions and improving timely care and prevention.

Use of Technology

Electronic Health Records (EHRs)

The adoption of EHRs has significantly improved the management of patient information and care coordination in acute inpatient settings. EHRs facilitate real-time access to patient data, enhance care provider communication, and support the implementation of evidence-based practices (Brands et al., 2022). The ability to quickly access and share accurate patient information can lead to more timely and effective interventions. EHRs also help in monitoring patient progress and ensure that all care providers are consistently informed about patient treatment plans and any changes to them. In pediatric settings, EHRs can be particularly useful in tracking developmental progress and integrating information from various care providers such as pediatricians and school counselors. In geographically dispersed communities, it is critical that healthcare records be readily available to ensure timely and effective continuity of care, especially in emergencies. This accessibility allows healthcare providers to quickly access patient histories and coordinate care across different locations, which is essential to avoiding delays in treatment and improving patient outcomes.

Telepsychiatry

Telepsychiatry has emerged as a valuable tool for expanding access to psychiatric care, especially in underserved areas. It allows for timely consultations, continuity of care after discharge, and support during crisis situations (Sharma & Devan 2023). Integrating telepsychiatry into inpatient care models has the potential to enhance service delivery and improve patient outcomes. Telepsychiatry offers a flexible and convenient way for patients to receive ongoing psychiatric support, particularly when in-person visits are not feasible. Telepsychiatry can be particularly beneficial for patients in remote or rural areas where access to mental health services may be limited. For children and adolescents,

telepsychiatry can also facilitate the involvement of family members who may not be able to attend in-person sessions regularly (Salmoiraghi & Hussain 2015).

While telepsychiatry has been proven to be effective in increasing access to psychiatric care, particularly in remote or underserved areas, several limitations may impact its effectiveness. These limitations include the availability of reliable broadband home internet access, local cell coverage, access to smartphones or computers with video capability, and the ability of patients, especially older adults, to navigate telehealth platforms. Addressing these barriers is crucial to fully leveraging the potential of telepsychiatry to expand mental health care access.

Staff Training and Development

Ongoing Professional Education

Continuous evidence-based staff professional development and training focused on the latest clinical guidelines, evidence-based therapeutic techniques, and crisis intervention strategies is critical to maintaining high standards of care (Ennis et al., 2015). Regular supervision and the provision of staff support are also important for preventing burnout and ensuring quality care. Keeping staff updated with the latest knowledge and skills ensures that they can provide the best possible care for patients. Additionally, ongoing healthcare team training helps to foster a culture of continuous improvement and professional growth. For those working with children and adolescents, specialized training in child development and pediatric mental health issues is essential.

Trauma-Informed Care

Implementing trauma-informed care principles is essential in acute inpatient settings in which many patients may have experienced significant trauma. Training staff to recognize and respond to trauma-related symptoms can improve patient engagement and outcomes (Muskett, 2014). Trauma-informed care involves using effective evidence-based trauma care to create a safe and supportive environment that acknowledges the impact of trauma on mental health. Healthcare providers can help patients feel more secure and supported by understanding and addressing the underlying trauma of the patient, a strategy that leads to better treatment adherence and outcomes. For children and adolescents, this approach can build trust and encourage open communication crucial for effective treatment (SAMHSA, n.d.).

Quality Improvement Initiatives

Monitoring and Evaluation

Continuous monitoring and evaluation of care processes and outcomes is vital for identifying areas for service delivery improvement. Implementing quality improvement initiatives that employ regular audits, patient satisfaction surveys, and other feedback mechanisms helps in maintaining high standards of care (Kilbourne et al., 2018). The use of these strategies can provide valuable insights into the level of effectiveness of current

practices and identify opportunities for enhancement. By systematically assessing and refining care processes, healthcare providers can ensure that they are delivering the highest quality of care. In pediatric settings, feedback from both patients and their families can be particularly informative and should be actively sought to guide improvements.

Evidence-Based Practices

Adopting evidence-based practices and regularly updating treatment protocols based on the latest research ensures that patients receive the most effective care. Clinical guidelines and best practice recommendations should be integrated into daily practice (Ee et al., 2020). Staying informed about the latest developments in mental health care allows providers to implement the most current and effective treatment strategies. This commitment to evidence-based care promotes better patient outcomes and enhances the overall quality of mental health services. In the context of treating children and adolescents, evidence-based practices should also be based upon considerations of developmental appropriateness and the specific needs of this age group.

Conclusion

Implementing best practices in the provision of acute inpatient mental health services for children and adolescents requires a multifaceted approach that includes family-centered care, integrated care models, the use of technology, ongoing staff training, and continuous quality improvement initiatives. By adopting these practices, mental health service providers can improve patient outcomes, ensure safety, reduce relapses, optimize the utilization of available resources, and provide high-quality care. The findings and recommendations resulting from this project are validated by recent research that underscores their relevance and applicability in contemporary acute inpatient mental health care settings. Tailoring these practices to the unique needs of children and adolescents will ensure that this vulnerable population receives the specialized care necessary for their recovery and long-term wellbeing.

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TEXAS A&M UNIVERSITY HEALTH

Report #3A
Community Perspectives and Resources: A Summary of Key Informant Interviews

Study on Mental Health Services for Children and Adolescents

December 2024

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Report 3A

Community Perspectives and Resources: A Summary of Key Informant Interviews

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Summary and Overview

Behavioral health challenges are the leading cause of disability and poor life outcomes in young people. Current trends show that depression, anxiety, and suicidal ideation is a growing health problem among Texas children. About 20% of children and young people aged 3-17 in the United States have a mental, emotional, developmental, or behavioral disorder and, for high school students, suicidal behaviors increased more than 40% in the decade before 2019 (Agency for Healthcare Research and Quality, 2022). Mental health challenges in children and young people were the leading cause of death and disability in this age group, a crisis that was exacerbated by the COVID-19 pandemic.

Children and adolescents face hurdles in accessing appropriate behavioral and mental health services due in part to the fact that pediatricians typically don't have significant behavioral health training, and behavioral health providers often have long wait times for new patients. Similar workforce problems exist in the emergency department (ED), which is often the first point of treatment for young people struggling with acute behavioral health crises, and in inpatient psychiatric services, which can help to stabilize those with acute psychiatric disorders if resourced appropriately.

With a request from the 88th Legislature to better understand the need for and use of inpatient pediatric psychiatric services as a critical element in the continuum of care, Texas A&M University Health Science Center (Texas A&M Health) embarked on a two-year project to explore this public health challenge from a community perspective. Key informant interviews were conducted in Year 1 to provide evidence that will inform the development of strategic goals. The vision of this initiative is to establish a state-wide infrastructure to improve mental healthcare for Texas' youngest population.

Key informants in this study communicated **five key messages** that address improving acute inpatient pediatric care:

- **Integration and coordination of services** to support the full continuum of care. Inpatient care does not operate in isolation and needs to be linked to outpatient and community step-up and step-down services. This integration and coordination strategy requires strong linkages between the psychiatric inpatient health care team, primary care physicians, social services, and school and juvenile justice systems.
- **Expanded partnerships** to provide necessary resources that may be lacking to create a safety net for families and children in a time of crisis. Also, leveraging local resources and services can ensure better health outcomes for pediatric patients with unique needs.
- **Increased workforce capacity** to ensure high-quality team-based inpatient care includes sufficient staffing levels of psychiatrists, nurses, child and family psychotherapists, substance abuse counselors, etc. A trained multidisciplinary

workforce is necessary to address the labor-intensive needs of children with acute psychiatric conditions and their families. This is especially important for patients with multiple co-morbidities and especially those with co-occurring intellectual and developmental disabilities (IDD).

- **Higher reimbursement levels** for inpatient pediatric psychiatric care to enable healthcare organizations to create and maintain the necessary infrastructure to deliver evidence-based care. Funding to ensure adequate workforce capacity is critical to respond to the rising child and adolescent mental health epidemic.
- **Access to affordable inpatient care** that ensures that the right services are provided at the right place at the right time to the right patients in need of acute psychiatric services. There is widespread acknowledgment that many families need to travel long distances for inpatient mental and behavioral healthcare. Though it may not be feasible to have inpatient care services available in every Texas community, supportive services are needed to minimize costs and travel burdens for families.

In conclusion, our key informant interviews brought into focus the complexity of addressing the behavioral and acute mental health psychiatric needs of our youngest population. Challenges and barriers to care were leading topics in our interviews. Building workforce capacity and systemic changes, i.e., integrating services and strengthening the continuum of care, were strongly recommended solutions to address statewide problems. The detailed report that follows summarizes the content of our key informant interviews in terms of reported challenges and barriers, needs and gaps, solutions, and successes.

What We Learned

- Accessing available inpatient psychiatric beds is especially challenging for young children (under 9 years old) and for those with severe co-morbid conditions such as IDD.
- Texas can address the systemic challenges related to creating an effective and efficient mental and behavioral healthcare system for children and adolescents with acute psychiatric care needs by tapping into solutions proposed by mental healthcare professionals in Texas and beyond.

Introduction

The purpose of the study was to understand the need for pediatric inpatient care and how it can be coordinated with other care services. This report presents a summary of the findings from key informant interviews conducted to assess the status of child and adolescent mental health services in Texas. The principal investigators of this study collaborated with the newly formed Children's Mental Health Strategic Plan (CMHSP) Statewide Behavioral Health Coordinating Council. The interviews were part of an information-gathering process that was designed to assess child and adolescent mental health needs and gaps that will inform the development of state-wide strategic goals.

As part of the key informant interview planning process, the project team attended CMHSP meetings that included presentations from organizations representing a diversity of community sectors engaged in child and adolescent mental health services and other work involving youth such as schools and the juvenile justice system.

Fifteen Texas healthcare and government leaders in child and adolescent behavioral and mental health participated in interviews. Details of the methodological approach and key informant interview questions can be found in Appendices A and B, respectively.

For the purposes of this study, interview statements were classified as a "unit of analysis." Units of analysis included phrases, sentences, or paragraphs. Study findings report the unit of analysis counts, each of which represents key informant responses supporting a theme. Illustrative quotes are included to provide richness to the report.

Key Informant Findings

Themes and Descriptions: Table 1 lists the four themes identified from comments about child and adolescent mental health services by key informant interviewees.

Table 1. Themes and Description

Theme	Description
Challenges and Barriers	Systemic factors that negatively impact access to and utilization of mental health services for children and adolescents. This includes navigating the fragmented, complex mental health care system to secure appropriate inpatient hospital placements and step-up and step-down support.
Needs and Gaps	Essential requirements to improve the mental health care system for children and adolescents. These needed improvements highlight the importance of systemic reforms and strategic investments to improve services.
Solutions	Strategies and interventions are proposed to address the challenges and meet the needs of children and adolescents served by the mental health care system.
Successes	Effective practices and positive outcomes observed in the mental health care system for children and adolescents. The goal of these strategies is to create a more effective, accessible, and comprehensive mental health care system.

Challenges and Barriers

Challenges and barriers to providing effective behavioral and mental health services emerged as a leading topic capturing 135 units of analysis. Fourteen sub-topics were identified related to these concerns (Table 2). Contextual factors contained the largest number of units of analysis (29) that were related to historical events, socio-cultural issues, and personal opinions related to healthcare services. Other concerns included the shortage of psychiatric facilities and inpatient beds, financial constraints such as low reimbursement rates, and workforce shortages. Stigma and mistrust of the mental health system deter families from seeking care, while the COVID-19 pandemic has exacerbated isolation and overwhelmed emergency departments.

Table 2. Theme #1: Challenges and Barriers	
Sub-topics	# Units of Analysis
1. Contextual factors (i.e., family, organizational capacity, uninsured, waitlist)	29
2. Limited facilities and resources	17
3. Workforce	12
4. Children with significant needs	12
5. Lack of inpatient beds	10
6. Funding	9
7. Healthcare system disconnects	9
8. Reimbursement	8
9. Distance/travel	6
10. Stigma	5
11. COVID-19	5
12. Local Mental Health Authority (LMHA) services	5
13. Intellectual and/or Developmental Disabilities (IDD)	4
14. Rural disparities	4

The following statements from interviewees capture several challenges and barriers:

- "*Our limitations in Texas have been the ability to get some of these kids into psychiatric facilities, either because there aren't enough of them, or they do not qualify for some reason to go into a psychiatric unit."*
- "*We really have a problem in terms of the acuity level is so high, that we simply don't have providers, anywhere in the state…to address the child's mental health needs."*
- *"That just doesn't work for families and for children to have to wait. And so that that's a real barrier is that it just takes so long right now to receive those services."*
- *"…we lose significant amounts of money on every patient, regardless of their insurance, because the reimbursement rates are so low."*
- *"The smaller kids, there's no place here, they have to literally go miles and miles away to get some form of care."*

Needs and Gaps

Need and gaps were the second important topic supported by 45 units of analysis with seven sub-topics (Table 3). The responses pointed to specific areas for improvement and were targeted to the services or resources needed to remedy identified challenges.

The quote below expresses the concerns about meeting the needs and gaps in Texas:

> *"The level of need that some of our children and youth have is just really unparalleled. And I think frankly unprecedented."*

Table 3. Theme #2: Needs and Gaps	
Sub-Topics	# Units of Analysis
1. Coordination of care	13
2. Healthcare gaps	10
3. Workforce	5
4. Inpatient services	4
5. Reimbursement	4
6. Family support	3
7. IDD	3

Solutions

Solutions suggested by the key informants were the third theme of importance, with 45 total units of analysis. Six sub-topics were identified that categorize solution recommendations. Key informant responses were largely focused on improving the mental healthcare system for children and adolescents, including coordinating healthcare services, securing sustainable funding, enhancing reimbursement, and building workforce capacity. Implementing integrated care models and preventative programs with community-based support was recommended to reduce the demand for inpatient care. In the textbox, a key informant shares a noteworthy solution about engaging kids throughout the continuum of care in a proactive manner.

Solution

"You can't wait for them to hit rock bottom in the age of fentanyl. And we try hard, we don't just dismiss kids, we have motivational, enhanced, trained therapists and contingency management rewards, and we work hard to get them engaged in outpatient."

Table 4. Theme #3: Solutions	
Sub-Topics	# Units of Analysis
1. Integrated Care	16
2. Building workforce capacity	9
3. Proven programs or practices	6
4. Investment/Reimbursement	6
5. Partnerships	5

Successes

Successes were a final theme that illustrated accomplishments or practices with positive outcomes (Table 5). There were 19 units of analysis supporting this theme with two sub-topics, programs and partnerships. Key informants reported successful programs implemented with positive outcomes. These effective programs demonstrated the importance of collaborative models that involved healthcare providers, community organizations, and schools. Community engagement was vital to improving access to care, while preventative measures such as the Positive Parenting Program modeled successful outreach efforts.

Table 5. Theme #4: Successes

Sub-Topics	# Units of Analysis
1. Programs	12
2. Partnerships	7

Below are examples of successful programs and partnerships.

- *"We have a pilot project with four large pediatric practices that collectively have a panel size of about 60,000 children, so we're not talking small here. The health plan has put mental health resources into those practices to create this integrated primary care model."*
- *"Triple P positive parenting program. It's a benefit for Medicaid in North Carolina. We offer that in our communities we have targeted for marketing, families who have children, our health plan that have a mental health diagnosis, like ADD ADHD, autism, defiant disorder."*
- *"And some of the telehealth approaches, being in schools, providing resources to primary care, you know, all of those things that are that have been funded by the state."*
- *"We work with an organization here called STRAC, which is the South Texas Regional Advisory Committee, which is kind of the crisis service collaborative. So, we communicate with them every four hours if we can take kids in certain age groups."*

Conclusion

Our key informant interviews have brought into focus the complexity of addressing the behavioral and mental health needs of our youngest population. For Texas interviews, challenges were the leading thematic topic. Building workforce capacity and systemic changes, i.e., integrating services and strengthening the continuum of care, were two strongly recommended solutions to address statewide problems.

In sum, one key informant summarized the vision for improving mental health care for children:

> "*Frankly, it should be a no wrong door. But right now, the only way that parents have to get into this system is either 911 or the emergency department because they don't know where else to go and there's nobody to help them navigate what is an amazingly complicated system."*

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Appendix A: Methods

The purpose of the study was to understand the need for pediatric inpatient care and how it can be coordinated with other care services. The study applied best practices in conducting key informant interviews which is a qualitative research methodology that allows researchers to collect information from concerned parties who have firsthand knowledge of a health-related challenge. In these interviews, key informants served as community experts who provided insight into the nature of the issue and provided recommended solutions. The interviews occurred between December 2023 and July 2024 using an online platform (Zoom or Microsoft Teams). Four project team members conducted the interviews: Ninfa Peña-Purcell, PhD, Marcia G. Ory, PhD, James N. Burdine, PhD, and Adam Bradley, MPH

Key informants were identified by several sources. Augmenting the list of key informants identified by the Texas A&M Health project team, Dr. Courtney Harvey, CMHSP chair, and Ms. Stacy Wilson, president of the Children's Hospital Association of Texas, also provided additional recommendations for key informants, who were sent an email invitation. Those agreeing to participate were emailed interview questions. With their permission, the sessions were recorded, and notes were taken to ensure that responses were documented in the event of technical issues recording the session or if the participant declined to be recorded.

The interviews were guided by a protocol containing the questions and an interview script. Appendix B provides the protocols for Texas key informant interviews. Appendix C lists the names of the 15 Texas key informant interviewees and descriptions of their organizations. There were 14 organizations represented. Two separate interviews were conducted with Texas Health and Human Services Commission. As shown, several interviews had multiple key informants.

The interviews were conversational in nature with the questions asked serving as a guideline for the discussion. Not all interviewees were asked or responded to every question listed in the protocol. The interviews were approximately one hour in length.

Interviews were recorded and transcribed in approximately 224 pages of key informant responses. The raw transcript data was cleaned and reviewed for accuracy. Through an iterative process, the content was thematically coded using an emergent framework approach.

Appendix B: Texas Key Informant Interview Questions

1. What is your current position and how does your work involve youth mental or behavioral health?
2. Does your organization provide in-patient pediatric psychiatric care?
3. In what ways does your institution provide inpatient pediatric psychiatric care?
4. What kinds of professionals do you employ to provide pediatric psychiatric services?
5. How does your institution organize the delivery of inpatient pediatric psychiatric care?
6. How many dedicated pediatric psychiatric beds for youth does your institution provide?
7. If you don't have a pediatric inpatient capacity, how do you handle an acute pediatric psychiatric situation?
8. Do you have outpatient pediatric mental health services available in your organization?
9. Do you partner with external organizations to provide outpatient mental health care for youth?
10. If you are unable to provide a psychiatric bed for a youth with acute psychiatric symptoms, where does the patient end up in your system?
11. Are there any challenges arising from these referrals? Who are you likely to turn to for assistance?
12. What are one or two other major challenges you are facing in treating youth with acute psychiatric symptoms?
13. Has your organization implemented any creative solutions to overcome these challenges? Please tell me about them.
14. Are there any you would like to share with others to improve inpatient pediatric psychiatric care?
15. Is there anything that you aren't doing now that you would like to do to improve youth mental health?
16. What could the State do to improve pediatric psychiatric care for youth?
17. If there were funds available, how many pediatric inpatient beds would your institution want over the next 10 years?

Appendix C: Texas Key Informant Organizations and Descriptions

ORGANIZATION	DESCRIPTION
Children's Health System of Texas Interviewee: • Sue Schell, Vice President and Clinical Director	• Children's Health is the leading pediatric healthcare system in North Texas and one of the largest pediatric health systems in the country
Children's Hospital Association of Texas Interviewee**:** • Stacy Wilson, President	• A nonprofit organization. • Dedicated to advancing children's health and wellbeing by advocating for policies and funding that ensure access to high quality comprehensive healthcare for children in Texas. • Focused exclusively on pediatric care, employing board-certified pediatric specialists, and utilizing equipment and medications tailored for children.
CHRISTUS Children's Hospital Interviewee: • Dr. Norman Christopher, Chief Medical Officer	• Comprehensive pediatric healthcare system offering a wide range of medical services for infants, children, and adolescents in San Antonio, Texas. • Inpatient and outpatient services catering to severe mental health crises with structured partial hospitalization programs available for intensive support.
Clarity Child Guidance Center Interviewees: • Jessica Knudsen, President & CEO • Dr. Lizmarie Gonzalez-Vega, Child and Adolescent Psychiatrist • Corey Hough, Child and Adolescent Psychiatrist	• Nonprofit mental health treatment center in South Texas. • Specializes in care for children aged 3-17. • Key services include crisis stabilization, psychiatric evaluations, ongoing therapy, and a Partial Hospitalization Program (PHP).
Covenant Children's Hospital Interviewee: • Dr. Lara Johnson, Chief Medical Officer	• Located in Lubbock, Texas, it is the region's only licensed freestanding children's hospital, offering a comprehensive range of pediatric services. • Provides extensive mental health resources through its new outpatient Relational Health

ORGANIZATION	DESCRIPTION
	Center, which is a collaboration with Texas Tech physicians.
Dells Children's Medical Center Interviewee: • Nick Vache, Service Line Director	• A pediatric acute care hospital in Austin, Texas that offers a range of mental health and substance abuse programs designed to address the diverse needs of pediatric patients. • The center's comprehensive approach includes both inpatient and outpatient services, making it a key provider of mental health care in Central Texas.
Department of Family Protective Services (DFPS) Interviewees: • Jennifer Sims, Deputy Commissioner for Operations • Audrey O'Neill, Deputy Commissioner for Programs • Yesenia Rodriguez, Senior Advisor	• Operates various facilities and services across the state to protect children, the elderly, and individuals with disabilities from abuse, neglect, and exploitation. • DFPS supports Qualified Residential Treatment Programs (QRTP) for children with severe emotional and behavioral needs and offers a range of behavioral health services including counseling, therapy, and medication management.
Driscoll Children's Health System Interviewee: • Mary Dale Peterson, Executive Vice President and Chief Operating Officer	• The Driscoll Health System offers extensive pediatric care services across South Texas. • The main campus is in Corpus Christi, Texas, and serves as a 225-bed pediatric tertiary care center. • Caters to a wide range of pediatric health needs, including mental health resources for children and adolescents
El Paso Children's Hospital Interviewees: • Cindy Stout, President and CEO • Roxanne Weisendanger, Chief Nursing Officer • Adrian Rodriguez, Social Work Supervisor	• The only separately licensed, Joint Commission Certified stand-alone pediatric hospital in El Paso. • Offers specialized mental health resources for children and adolescents, including comprehensive behavioral and developmental psychiatry services for conditions such as autism, ADHD, anxiety, depression, and trauma-related disorders.

ORGANIZATION	DESCRIPTION
St. Joseph Regional Health Center Interviewee: • Dr. Micheal Spohn, Emergency Physician	• The largest emergency department and only Level II Trauma Center in the Brazos Valley. • Specialized programs address developmental and behavioral health issues, trauma, and substance use disorders that ensure holistic support for young patients.
Texas Children's Hospital Interviewee: • Laura Hardy, Vice President of the Department of Pediatrics	• Largest pediatric healthcare system in the U.S. and offers an array of services across multiple campuses and facilities. • The main campus located in the Texas Medical Center (Houston) provides a wide range of pediatric specialties and intensive care units.
Texas Health and Human Services Commission (HHSC) Interviewees: • Reilly Webb, Associate Commissioner for Mental Health and Substance Abuse • Veronica Martinez, Director of Mental Health Programs, Planning, and Policy	• Regulates various healthcare facilities to ensure compliance with state laws and protects consumer and patient health and safety. • Delivers services across Texas in collaboration with 37 Local Mental Health Authorities (LMHAs) and two Local Behavioral Health Authorities (LBHAs) to ensure community-specific care and support.
Texas Health and Human Services (HHS) Interviewees: • Christine Laguna, Director of Substance Use Programs, Planning, and Policy • William Tharp, Director of Data Services	• HHS provides a range of behavioral health services designed to support individuals with mental health and substance use issues across the state. • Facilities and programs are structured to deliver both preventative and rehabilitative care through specialized services and community partnerships.
Texas State Hospital System Interviewees: • Dr. Jeff Matthews, Chief Medical Officer • Matthew Moravec-Gallagher, Continuity of Services Manager	• Operated by the HHSC. • Nine state hospitals and one residential youth center that provide specialized inpatient psychiatric services for populations including adults, children, and individuals involved with the justice system.

TEXAS A&M UNIVERSITY HEALTH

Report #3B
New Jersey and Ohio Case Study: Bright Spots in Child Mental Health

Study on Mental Health Services for Children and Adolescents

December 2024

Prepared by: Ninfa Peña Purcell, PhD
Marcia G. Ory, PhD, MPH

Report 3B

New Jersey and Ohio Case Study: Bright Spots in Child Mental Health

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Introduction

Persistent systemic challenges to ensuring the provision of adequate and effective mental health care for children are a common problem in the United States (U.S.), but New Jersey and Ohio are "bright spots." These states have robust policies and programs to address this problem and are encouraging examples of success that can serve as a model for other states. The following case studies will present the achievements of these states, the challenges they have encountered, and the solutions they have created. The key informant interview questions are found in [Report 3B] Appendix A.

New Jersey Department of Children and Families

Christine Beyer, commissioner of the New Jersey Department of Children and Families (DCF), and Mollie Greene, assistant commissioner of the Children's System of Care (CSOC) within DCF were interviewed for this study. As national leaders in child and adolescent mental health, their perspectives provided valuable insights into programmatic and policy efforts that have been implemented to create a sustainable infrastructure. Beyers' take-home message about the need for coordinated mental health services to other states was:

> *"I would say structure is key and important. Every state commissioner I talked to about the children's system of care in New Jersey… they (other states) have significant challenges because they don't license and regulate their provider community, their congregate care community, and even the in-home community services. They have children's behavioral health services separate in the adult department maybe or connected to adult services, adult services will win out whenever it comes to resources."*

Achievements

Three key success factors in achieving goals are having a state-wide continuum of care, comprehensive and integrated services, and a strong infrastructure.

State-wide Continuum of Care

- *"And so even at that prevention, end of the continuum, our divisions have been working together to ensure that there's system integration. So, we are not siloed in that full continuum within our department, it's really the contrary."*
- *"There are a couple of entry points to the front door of our system. Some children may come in through mobile crisis response. ...some children might be assessed through a biopsychosocial assessment. …either one of those pathways can lead to a child being referred for care management organization services*."

- *"Care Management Organization (CMO) services, they're Medicaid State Plan services, and they are care management specifically for youth who are at risk of inpatient hospitalization, or out of home if they have that level of acuity where they're at high risk for hospitalization or institutionalization."*
- *"…the pathway to our residential services is that a youth becomes open with the care management. The care management organization works with the family and the youth to develop a wraparound support plan."*
- *"We have a couple of emergency pathways for youth who may not be stable in the community in our continuum. …referral for outpatient services is reviewed by our Contracted Systems Administrator (CSA) which renders a determination of the intensity of service that's appropriate for that youth."*
- *"We also have 2 intermediate units, which are sort of legacy intermediate units, they're both hospital-based. … the youth may step down from an acute setting to an intermediate unit, to a Children's System of Care (CSOC) residential, or they may go from an acute unit to a CSOC setting."*

Comprehensive and Integrated Services

- *"The CSAs (Contracted Systems Administrator) job is to look at that child's clinical presentation, and determine based on our criteria, what's the right intensity of service."*
- *"We have created a number of iterations of residential intensities of service. For youth with IDD needs and behavioral and substance use across all those populations, there's sort of 14 core service types. And so we really try to match youth with a program based on their intensity of need, and certain particular characteristics."*
- *"And so then that hospital team, that ER team there, that child has to be medically cleared, and then that team and their behavioral health and social work service are deciding as to whether or not they think that child should be referred to a Children's Crisis Intervention Services (CCIS) unit, or in another acute setting."*
- *"If the child is already duly involved with CSOC, the care management organization will be visited, the care manager will be visiting the child in the hospital, and they'll be talking and coaching the parents."*
- *"We also have several stabilization and assessment programs. … and it was kind of a revamping, of what we used to call our emergency diagnostic reception units. They were for children who were in crisis, who were in foster care, almost exclusively kids who were in foster care."*

Strong Infrastructure

- *"We license and are the sole contractor with all of the congregate programs. Our providers are licensed by the Department of Children and Families."*
- *"We have done pre-COVID, we were able to raise the rates pretty significantly, it was the first time they had had a rate adjustment in any of our Medicaid programs."*
- *"All our services are Medicaid State Plan services, the original architects created through departmental policy, an eligibility category for children who don't meet the criteria for Medicaid eligibility, or whose family doesn't meet the criteria."*

Challenges

However, state officials should be aware of the many challenges to be faced in providing effective mental health care for children and adolescents.

- *"There are challenges across all of our residential services and the CCIS units concerning staffing and bed availability."*
- *"I think it's important to say that we don't have all of the bed capacity we need."*
- *"And sometimes it's a firm decision that the hospital team does not believe that the youth meet the criteria for inpatient. This can be very frustrating because, in many instances, we've been working with a child for not just months, but years through our sister divisions of CSOC and child protection."*
- *"One of the challenges is that because those crisis units have been underfunded, and understaffed, they get a small subsidy from the state."*
- *"And there's a waiting list. How do you have a waiting list for a crisis bed? Well, because some of our beds aren't available because of our workforce challenges."*

Solutions

Despite challenges, strategies are available for overcoming challenges that might be transferred to other states, as exemplified below:

- *"This department-initiated workforce labor analysis and they looked at 10 types of positions and 10 archetypes within our social services within our department."*
- *"A very strong collaboration with our providers around taking a very close look at some of our contract requirements and the regulatory requirements around staffing, not ratios, because those are kind of inviolable, like, we didn't touch the model, but looking at where are the pain points in a very granular way."*

- *"We made changes that have impacted I think every single one of our residential programs, in terms of direct service staff, credentialing, clinical staff, program director, so that without compromising the quality of care, or the delivery of care."*
- *"We're not proponents of keeping kids in the emergency room and providing services there, that's not good practice. But it is forcing now a conversation that needs to be had with hospitals that we need to change the practice and the policy because previously, they had no interest in talking with us are sitting down with us because the child was out of their emergency room."*

Ohio Children's Hospital Associations

Nicholas Lashutka, President and CEO of the Ohio Children's Hospital Association (OCHA), and Sarah Kinkaid, Vice President were interviewed for this study. OCHA has an impressive history dedicated to improving the health of children. Behavioral and mental health is one of its specialties that is nationally recognized. OCHA has led the nation in positively changing the child and behavioral health landscape not only in its home state but in the U.S. and globally.

State-level partnerships have been instrumental in advancing OCHA's work responding to the child mental health crisis. According to President Lashutka:

> *"We are six freestanding children's hospitals in Ohio that collaborate from an advocacy lens. We're spending quite a bit of energy on pediatric mental health and the crisis that is facing kids and the whole spectrum of what that entails."*

Lashutka emphasizes the importance of clarifying your solutions to state and federal leaders:

> *"We want to be bringing solutions to our elected policymakers, whether that's at the state or federal level. And so, wherever we are on that continuum of the crisis, we're trying to identify ways in which we can recommend solutions."*
>
> *"The pediatric healthcare community must be unified and unambiguous about what we're asking for at the state and federal level."*

Achievements

Two key success factors in achieving goals included comprehensive and integrated system and state-wide support.

Comprehensive and Integrated System

- *"I am not aware of any other states that have near the number of beds that our six members have in totality and our member hospitals have been growing their number of beds over the last couple of years with more set to come online in the next coming months and couple of years."*

- *"Cincinnati Children's and their campuses are the largest inpatient pediatric mental health unit in the country. They have 100 beds, inpatient beds, and 30 residential beds."*
- *"Ohio Children's Hospitals have an extraordinarily comprehensive list of services available in behavioral health and probably, collectively speaking have the highest number of inpatient behavioral health beds in a state."*
- *"Our state created a specialized managed care program specifically for moderate to complex behavioral health supports that would be carved out of your standard managed care contracts. The goal of this is for kids who need higher acuity and behavioral health supports; there's one managed care plan that is entirely responsible for that."*
- *"And each of our hospitals has taken different types of steps depending on their relationship with other community providers and just what their footprint looks like in their service region."*
- *"Nationwide Children's Hospital, for example, has built its pavilion and created its behavioral health emergency department so to speak, so that those services are specialized for that population and then also to help alleviate some of the stressors that their emergency department, their traditional emergency department had been experiencing."*

State-wide Support

- *"One of the real assets we have in Ohio is a governor who has really invested a lot of his time to better understand this crisis, he has acknowledged that there's a pediatric mental health crisis."*
- *"One of his first actions as governor six years ago was to create an Office of Children's Initiatives."*
- *"Our state underwent a re-procurement, where they created a specialized managed care program specifically for moderate to complex behavioral health supports that would be carved out of your standard managed care contracts."*
- *"The governor and our Medicaid director had been very intentional to pump up what those outpatient reimbursement codes are, as well as what they are for inpatients."*
- *"The governor here put a bunch of money into the K-12 system for those wraparound services."*

Challenges

The Ohio Case Study also revealed challenges other states and state officials should anticipate and aim to circumvent to provide effective mental health care for children and adolescents.

- *"One of our greatest challenges from a pediatric psych inpatient unit perspective, I think is the clogging of that unit with individuals who have been admitted to a bed and then do not have a placement option or identified support or service necessary for discharge for varying reasons."*
- *"I didn't make it abundantly clear that behavioral health is the lowest reimbursed service line."*
- *"Kids with multi-system needs, being at the top of with some of the greatest challenges, though, the space that has been most top of mind for us recently, are kids who have some type of developmental disability but perhaps might fall into a gray zone."*
- *"The workforce piece has to be at the top of the list, in my opinion, not only because there's a shortage, but these are younger staff members, usually, oftentimes female who didn't go to work to get beat up."*

Solutions

Several strategies emerged as means to overcome challenges, including:

- *"Supporting school-based health care services, I think that that's going to be I think that's been a growing area that has been indisputably helpful to kids and families."*
- *"Getting people like the employer community to help rally around that is important."*
- *"Having children's hospitals and other behavioral health providers more specifically partnering with the education systems, specifically the higher education system, so that we have a trained pipeline coming into our workforce."*

Conclusion

The successful policies and programs of the New Jersey Department of Children and Families and Ohio Children's Hospital Association provided hopeful news that there are best-practice solutions currently available to guide states like Texas.

Appendix: New Jersey and Ohio Key Informant Interview Questions

1. What is your current position and how does your work involve youth mental or behavioral health?
2. What is your state's plan to address the need for, the use of, and the coordination of pediatric inpatient services with other services you offer in your state?
3. What are the major challenges you are facing in treating children and adolescents with acute psychiatric symptoms?
4. What are innovative solutions implemented by your state to address these challenges? Please tell me about them.
5. Are there any other recommendations that would you have for other states such as Texas?