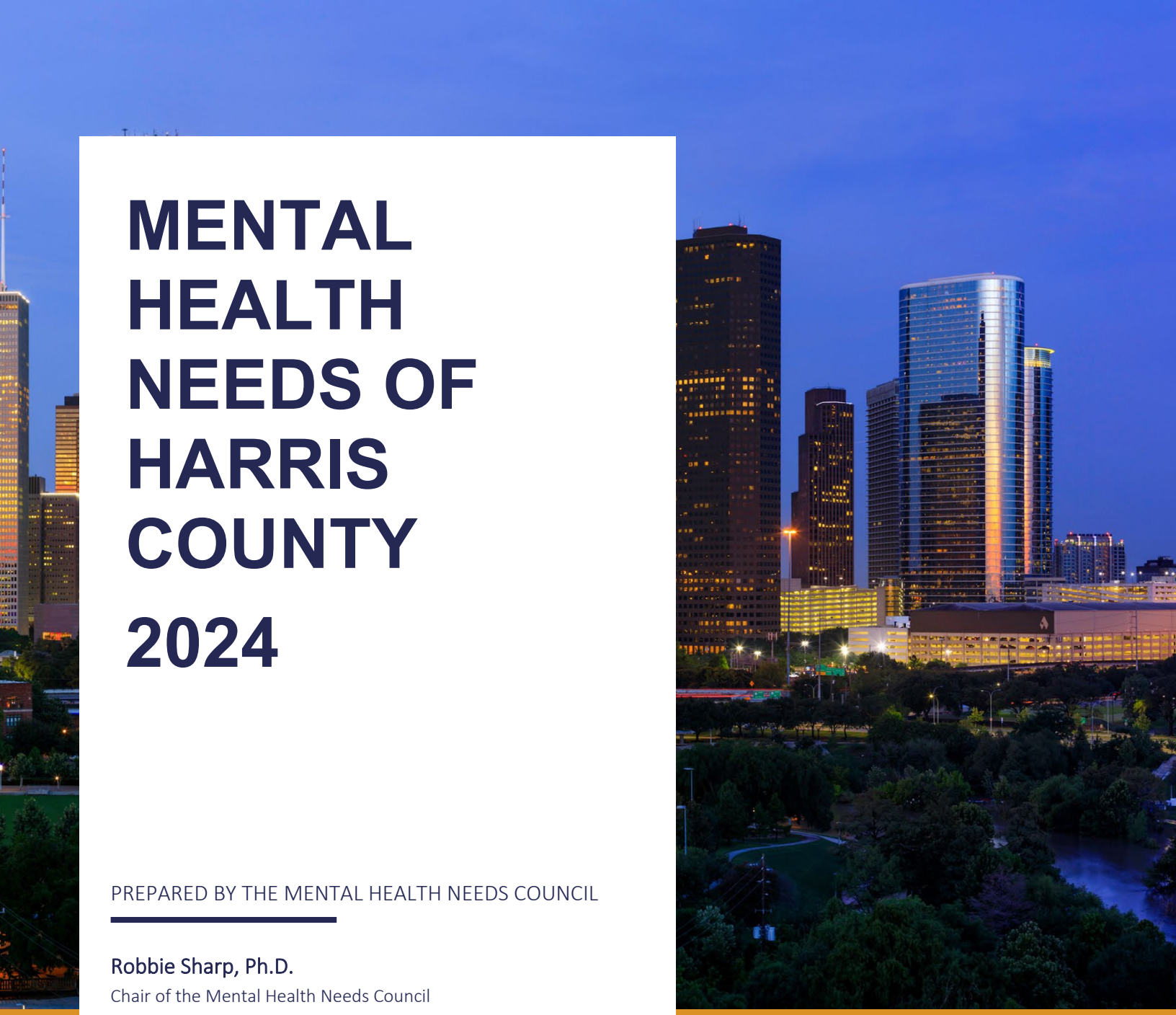

MENTAL HEALTH NEEDS OF HARRIS COUNTY 2024

PREPARED BY THE MENTAL HEALTH NEEDS COUNCIL

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Introduction

The Mental Health Needs of Harris County

The Harris County Mental Health Needs Council, established in 1977 by the Harris County Commissioners' Court and charged with investigating mental health problems and recommending solutions, promotes communication between the primary mental health leaders and county and state officials. We offer a monthly forum for information-sharing and collaboration for those who lead the mental health community. We have previously published a report on the current state of services and needs in Harris County prior to each legislative session. The global pandemic disrupted the Council's work, and we hope to capture some changes to the Harris County system from 2020 to the present in this report.

The large population of Harris County is diverse, multicultural, urban, suburban, and rural. Added to this is the income disparity, availability of private or public medical insurance, poor access to transportation, and disparate locations of available services. Despite the ongoing work of mental health advocates and public and private agencies, many mental health needs in Harris County go unmet. Persons with severe and persistent mental illness need community-based services that provide accessible, timely, affordable mental health care to stabilize functioning. Still, these community-based services are critical following a return to the community after experiencing crises or decompensation and subsequent hospitalization or arrest. These services should include access to medications, therapy, psychosocial supports, and, when necessary, hospitalization.

We have frequently written about the legislature's focus on emergency, crisis, and hospitalization services. Although these are necessary parts of the mental health continuum, they are also the most expensive, most restrictive, and of the shortest duration. A continuum of mental health services must include prevention and early identification, as well as early intervention and ongoing access to a range of services, including medication, therapy, and individual and family psychological support. Access to these broader, non-crisis services has been shown to decrease the need for and utilization of crisis services.

In this report, we will focus on 1) gaps in early intervention for mental and behavioral health services, 2) the workforce shortage of persons to provide mental and behavioral health services, 3) the needed funding to close these gaps in services, and 4) how and why a balanced system can better utilize the limited funds available for mental and behavioral health services.

Contents

County Demographics

Harris County continues its rapid growth, with an estimated population in 2021 of 4.73 million people, 26.2% (1.24 million) of whom were 18 and under. Its residents have a median income of $63,022 and a poverty rate of 16.4%. The city is among the most diverse in the country. Individuals enjoying this community's economic growth do not share equally in this prosperity: the median income for Black adults is $50,135, a figure 26% lower than the county average, and for Hispanic adults, it was $56,565, 11% lower. Persons of color are over-represented in the county's poverty population. [1]

The role of The Harris Center as a safety net provider of services is highlighted when one considers the mental health and financial needs of our county residents. In 2020, 925,189 Harris County residents were uninsured – roughly 22.4% of the total population. The most recent U.S. Census data estimates that 17% of Texans are uninsured.[2] Furthermore, 26% of adults under 64 are uninsured.[3] A recent statewide survey conducted by The Episcopal Health Foundation indicated that 72% of Texans favored Medicaid expansion, though Texas is among only ten states that have not adopted Medicaid expansion.[4]

Per Capita Funding for Mental Health

In April 2019, the Texas Legislative Budget Board reported an unfortunate but improving assessment of funding levels for public mental health.[5] They noted a substantial increase in funding from its low ebb in 2013, reporting an increase from $829.6 "inflation-adjusted community mental health-related revenues" to $1.2 billion in 2017. The LBB noted, however, that "despite the funding available to provide access to care for uninsured individuals, 43.2% of local mental health authorities have experienced a decrease in per-capita funding from General Revenue Funds since fiscal year 2008."

The expiration of the 10-year Section 1115 Waiver Delivery System Reform Incentive Payment demonstration program in 2021 and the attendant revenue loss was partially offset by the new Directed Payment Program, which, for instance, yielded $15.4 million to The Harris Center in 2022. This is about half the peak DSRIP reimbursement amount.

88th Legislative Session

The latest Texas Legislative Session, which adjourned in May 2023, marked a historic milestone by committing unprecedented funding to mental health initiatives. Out of the $312 billion state budget for the 2023 to 2024 biennium, $11.6 billion, representing 3.7% of the total budget, was earmarked for mental health services.[6] This funding increase, while not insignificant, is expected to address a whole host of issues, including skyrocketing rates of depression and anxiety among Texas children and adults, increasing rates of children in crisis as

[1] U.S. Census Bureau QuickFacts: Harris County, Texas
[2] 2022 Census Data: The Uninsured Population of Texas
[3] Texas Residents' Views on Health Policy
[4] Status of State Medicaid Expansion Decisions: Interactive Map
[5] Funding Trends and Challenges in Community Mental Health Services
[6] NAMI Texas 88th Legislative Session Update

reported by emergency rooms, school shootings, lingering effects of the COVID-19 pandemic, and a full or partial Mental Health Professional Shortage in all Texas counties but one.[7]

$280 million was allocated toward the Texas Child Mental Health Care Consortium to add Educational Service Centers, improve access to child psychiatry, and hire more mental health clinicians.[8] Concurrently, a dedicated funding stream for school counselors and psychologists was cut. However, numerous bills that would have addressed improving the mental health of school-aged children were not passed. One such bill would have required health insurance plans to provide services for serious emotional disturbance in children; another would have set aside funding for school districts to pay school counselors' and social workers' salaries. Around one in six children in Texas experience mental illness each year, but 71% of those youth will go untreated. In youth access to mental health care, Texas ranks last among all 50 states.[9]

To address the mental health workforce shortage, $158.6 million was set aside to increase salaries for mental health workers, especially direct service workers in crisis and hospital programs. In addition to that funding, S.B. 532[10] was passed to reduce the number of years mental health professionals must work in the public sector to apply for a loan repayment program from 5 years to 3 years.

Much of the mental health funding determined by the 88th Texas Legislative Session was focused on acute care systems, such as the $2.3 billion for state hospital infrastructure. Legislature failed to expand Medicaid, as outlined in HB 12 and HB 1357, when 17.3% (more than double the national average) of Texans are uninsured.[11] With the highest rate of uninsured individuals in the country, Texas's public behavioral health services are overburdened. A lack of insurance also contributes to the overutilization of emergency rooms and acute care, which comes at a much higher cost than preventive care.

However, two aspects of Medicaid were expanded. Per HB 12, Medicaid coverage was extended from 6 weeks postpartum to 12 months following child delivery or involuntary miscarriage for eligible pregnant women. HB 1357 was also passed, which allows for Medicaid reimbursement for some medication-assisted treatments for opioid use or substance use disorder.[12]

Jail Diversion Programs received $252 million in funding in a similar spirit to preventive or alternative care. Substance Abuse Treatment and Coordination received $74.5 million, both small increases compared to the 87th Legislative Session. Preventive services tend to be more cost-effective than their criminal justice and acute care systems alternatives.

[7] NBHP 88th Legislative Session Wrap-Up Q&A Panel Discussion
[8] 88(R) HB 12
[9] Child Behavioral Health
[10] 88(R) SB 532
[11] 2022 Census Data: The Uninsured Population of Texas
[12] 88(R) HB 1357

Barriers to Mental Health Care

Uninsured Texans

The Affordable Care Act (ACA) broadened Medicaid coverage to encompass almost all adults with an income at or below 138% of the Federal Poverty Level (which is $20,783 for an individual in 2024). Additionally, the ACA has provided states with an enhanced federal matching rate to incentivize the expansion of programs like Medicaid and the Children's Health Insurance Program (CHIP). Texas is among only ten states that have refused to adopt Medicaid expansion.[13] In 2020, 925,189 Harris County Residents were uninsured – 22.4% of the total population. A recent survey conducted by The Episcopal Health Foundation indicated that 72% of Texans favored Medicaid expansion (see Footnote 3). Lack of medical insurance represents a barrier to access to health care, including mental health care. The funding per person living in poverty within a single region can vary from an exceptionally low $78.00 per year to as much as $301.00 per year, according to the Texas Legislative Budget report issued in 2019.[14]

Mental Health Parity

Although federal policy mandates parity in insurance coverage between mental health and medical/physical health issues (Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008[15] and the Affordable Care Act (ACA) of 2010[16]), many Texans continue to face several systemic barriers to care. Texas was ranked 48th among the states, for instance, due to its rate of children who were insured but whose coverage did not extend to emotional or behavioral problems.[17] In its most recent strategic plan, the Texas Behavioral Health Coordinating Council concluded that,

> "Underserved populations include people with substance use disorders; people with co-occurring psychiatric and substance use disorders; people with SMI; and those who are frequently booked in jails and admitted to emergency rooms and inpatient services. Depending on each person's needs and preferences, they may face challenges accessing services that address these needs."[18]

Workforce Shortage

Like much of the country, Texas faces a growing shortage of behavioral health professionals as its population increases. The majority of its counties are designated Mental Health Professional Shortage Areas, meaning they lack sufficient mental health service providers with more than 30,000 residents per clinician.[19] The looming retirement of many seasoned experts worsens this situation. This shortage directly limits the number of

[13] Status of State Medicaid Expansion Decisions: Interactive Map (kff.org)
[14] Funding Trends and Challenges in Community Mental Health Services (texastribune.org)
[15] The Mental Health Parity and Addiction Equity Act (cms.gov)
[16] About the ACA (hhs.gov)
[17] The State of Mental Health in America by Reinert, Fritze, and Nguyen. Copyright 2021 by Mental Health America, Inc.
[18] From "Texas Statewide Behavioral Health Strategic Plan Fiscal Years 2022–2026". 2022 by HHS Texas.
[19] Texas' shortage of mental health care professionals is getting worse (texastribune.org)

available outpatient and inpatient services. To address these challenges, the SBHCC released a report in 2020 titled "Strong Families, Supportive Communities: Moving Our Behavioral Health Workforce Forward," which suggests that state agencies, professional groups, and academic institutions should adopt their recommendations to enhance the workforce and examine obstacles to their execution.

The Health Resources and Services Administration (HRSA) has designated Harris County as a Health Professional Shortage Area for mental health based on its number of low-income residents.[20] In addition, major providers of mental health services (the Harris Health System and Harris County Psychiatric Center) have also been designated based on providing services to low-income patients. This designation permits professionals to apply for relief from student debt in return for service.

In 2019, there were 70,642 licensed providers of mental health services in Texas, with an average of 242 providers per 100,000 population. Harris County was one of 222 Texas counties with less than the statewide ratio.[21] Mental health care providers include clinical nurse specialists, community health workers or promotors, licensed baccalaureate social workers, licensed chemical dependency counselors, licensed clinical social workers, licensed master social workers, licensed professional counselors, licensed psychological associates, licensed psychologists, licensed specialists in school psychology, marriage and family therapists, nurse practitioners, provisionally licensed psychologists, and psychiatrists.

Workforce Shortage at The Harris Center

The Harris Center for Mental Health and IDD is experiencing a health and mental health professional shortage area (HPSA and MHPSA, respectively), reflecting the prevailing patterns observed throughout Texas. Data collected tracking the number of days clinical roles remained vacant after the job listings were posted embody this trend. Comparing data from 2021 to 2022, The Harris Center saw a staggering increase of up to (and sometimes more than) 200% in the duration of vacancies.

Vacant clinical positions at the Harris Center include any job requiring a license from the Texas Behavioral Health Executive Council or the Texas Medical Board. These professionals play vital roles in providing quality patient care, and their limited availability has far-reaching implications for delivering vital mental healthcare services to the Houston community. In addition to increasing workloads for existing staff, this shortage results in longer wait times for medical appointments, delaying access to essential healthcare services, and negatively impacting patient outcomes.

The average number of open days per clinical position was slightly higher than non-clinical positions from 2019 to 2021. However, the gap between clinical and non-clinical positions widened significantly in 2022, taking on average 156 days to fill vacant clinical roles (85% longer than the time to fill non-clinical positions). There was a similar jump in the number of vacant days per clinical position from 2021 to 2022. From January to July 2021, there were 162 open clinical positions, averaging 49 days to close. From January to July 2022, the total number of open clinical positions reached 390, taking an average of 156 days to close.

The shortage of licensed healthcare workers primarily affects three crucial roles at The Harris Center: doctors, nurses, and therapists, such as LPHAs and MLCs. When broken down by profession, doctors made up the positions that took the longest to fill in 2022. It took an average of 300 days to fill vacant psychiatrist positions at the agency in 2022, a 190% increase from the year prior. The agency's combined number of open medical

[20] What Is Shortage Designation? | Bureau of Health Workforce (hrsa.gov)
[21] How is the Mental Health Workforce in Texas Distributed? (dshs.texas.gov)

positions (including nurses, PAs, doctors, and pharmacists) paints a similar picture, with the number of vacant days increasing by 218% from 2021 to 2022, when it took an average of 182 days to fill each vacancy. For nurses (LVNs, NPs, RNs, and APRNs), there was a 194% increase in vacant days per position from 2021 to 2022.

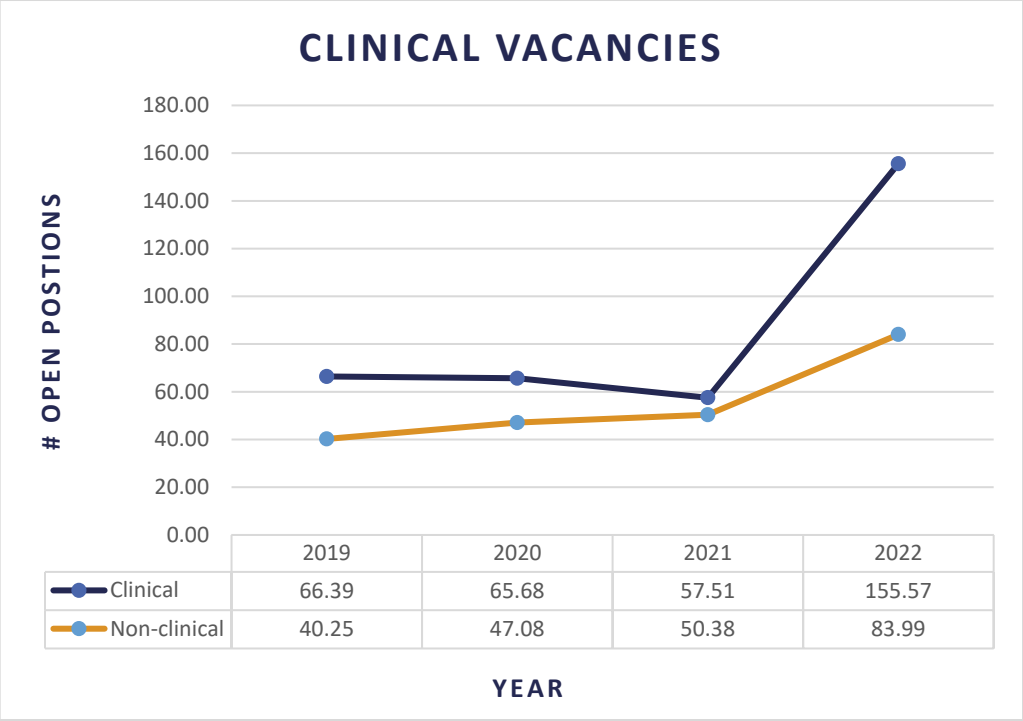

Figure A1 Clinical vacancies at The Harris Center, 2019 – 2022

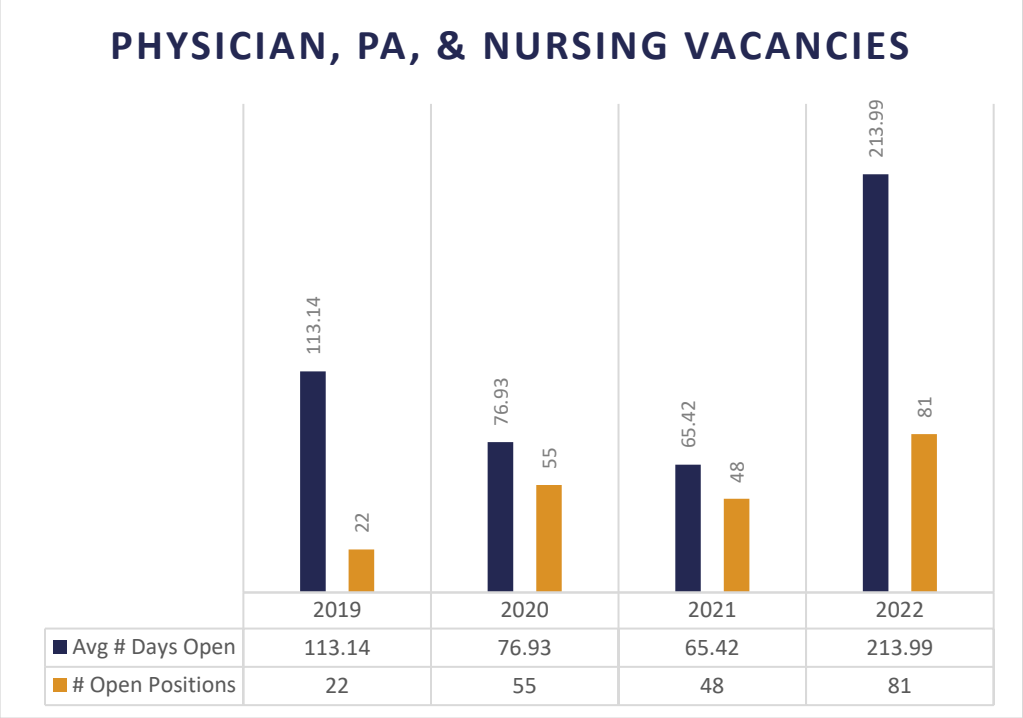

Figure A2 Physician, physician assistant, and nurse vacancies at The Harris Center, 2019 – 2022

COVID-19 Pandemic's Influence on Behavioral Health Hospitalization in Harris County

To examine the impact of the COVID-19 pandemic on behavioral health admissions to Harris County hospitals, a dataset was obtained from the Texas Health Care Information Collection (THCIC) maintained by the Texas Department of State Health Services. THCIC was created by the 74th Texas Legislature in 1995. THCIC's charge is collecting data and reporting on healthcare activity in hospitals and health maintenance organizations operating in Texas. The goal is to provide information enabling consumers to impact Texas's cost and quality of health care.

The Texas Public Use Data File (PUDF) obtained for this purpose contains data on discharges from Texas hospitals. While the file contains demographic and diagnostic information, some personal identifiers are omitted to protect confidentiality. Records of admissions and discharges cannot be linked to individual patients. All hospitals in Texas must submit these claims on all discharged inpatients. Hospitals are required to submit claims on all discharged inpatients attended or treated by physicians. Required data elements are specified in the Hospital Discharge Data Rules.[22]

Method

Data from 2019 to the present has been examined for this study. The PUDF has been released through the second quarter of 2023. The third quarter of 2023 is tentatively scheduled to be released in July 2024.

Local records of hospital discharges have been culled from the statewide record by matching against the registry of licensed hospitals in Harris County.

Records have been further limited by examining the admitting ICD-10 diagnostic codes and the first ten discharge diagnoses for each patient admission. All records containing a behavioral health diagnosis in any of these fields have been included. Behavioral health diagnoses include mental health, substance abuse, and developmental disability categories.

[22] Texas Administrative Code (state.tx.us)

Behavioral Health Hospitalizations from 2019 to 2023

Over the course of this four-and-a-half-year period, Harris County hospitals reported 11,244 behavioral health discharges per quarter or 44,974 discharges per year. These numbers are presented by calendar quarter in the graph below. One can observe two trends of note. First, in the initial phase of the COVID-19 pandemic (from 2020 Quarter 1 to 2020 Quarter 2, the number of behavioral health hospital discharges dropped from 11,282 to 9,339, a decrease of 17.3%. Second, the number of discharges quickly recovered in Quarter 3 and has since shown an upward trend. By Quarter 2 of 2023, the last available reporting period, discharges had increased to 13,024, a 32.6% increase over baseline.

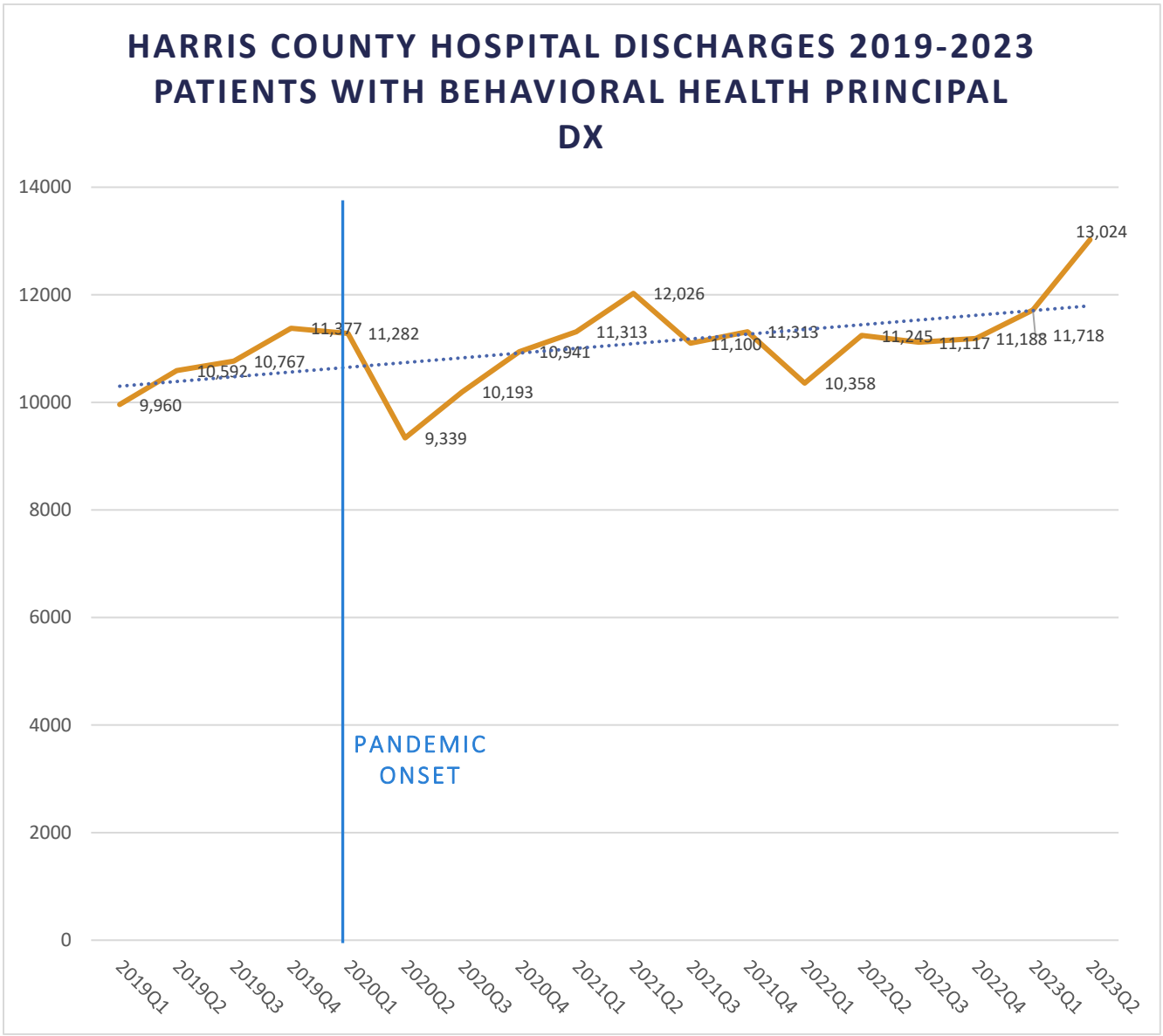

Figure B1 HCIC data – Harris County hospital discharges of patients with principal diagnoses of behavioral health issues, 2019 – 2023

Behavioral Health Hospitalizations 2019 to 2023: Diagnoses

As can be observed in the table below, most hospitalizations for behavioral health disorders were for "the big three": depression, schizophrenia spectrum disorders, and bipolar and related disorders. When substance use disorders are also included with "the big three," over 90% of discharges were covered. Given the high rates of incidence of depression in epidemiological studies, it is not surprising to find that discharges for depressive disorders are the most frequent.

Harris County Behavioral Health Hospital Discharges X Diagnostic Group: January 2019 – June 2023

Diagnosis Category	Grand Total	% of Total
Depressive Disorders	69,891	34.53%
Schizophrenia and Related Disorders	55,551	27.45%
Bipolar and Related Disorders	42,069	20.79%
Substance Use/Abuse Disorders	18,446	9.11%
Other	11,894	5.88%
Trauma and Stress-Related Disorders	2,087	1.03%
Anxiety Disorders	1,289	0.64%
Disruptive, Impulse Control and Conduct Disorders	730	0.36%
Autism Spectrum Disorders	308	0.15%
Feeding and Eating Disorders	40	0.02%
OCD and Related Disorders	29	0.01%
Intellectual Developmental Disorders	27	0.01%
No Diagnosis This Axis/Priority	22	0.01%
Grand Total	**202,383**	

Figure B2 HCIC data – Harris County hospital dischargers by diagnostic group, 2019 – 2023

A more detailed look at the change in discharges can be examined by plotting the change in the number of hospital discharges attributable to the major diagnostic categories. These four categories account for 91.8% of discharges. Depressive disorders were the most frequent principal diagnosis. Over the study period, the number of discharges per quarter increased from 3,416 to 4,446, a 30.25% change. Schizophrenia Spectrum Disorder discharges climbed by 45.12% from 2,662 to 3,863. Substance Use/Abuse disorders recorded a 39.57% increase, from 892 discharges to 1,245. Bipolar Disorders was the only category that did not demonstrate a notable increase, declining slightly (0.59%) from 2,385 to 2,371 discharges.

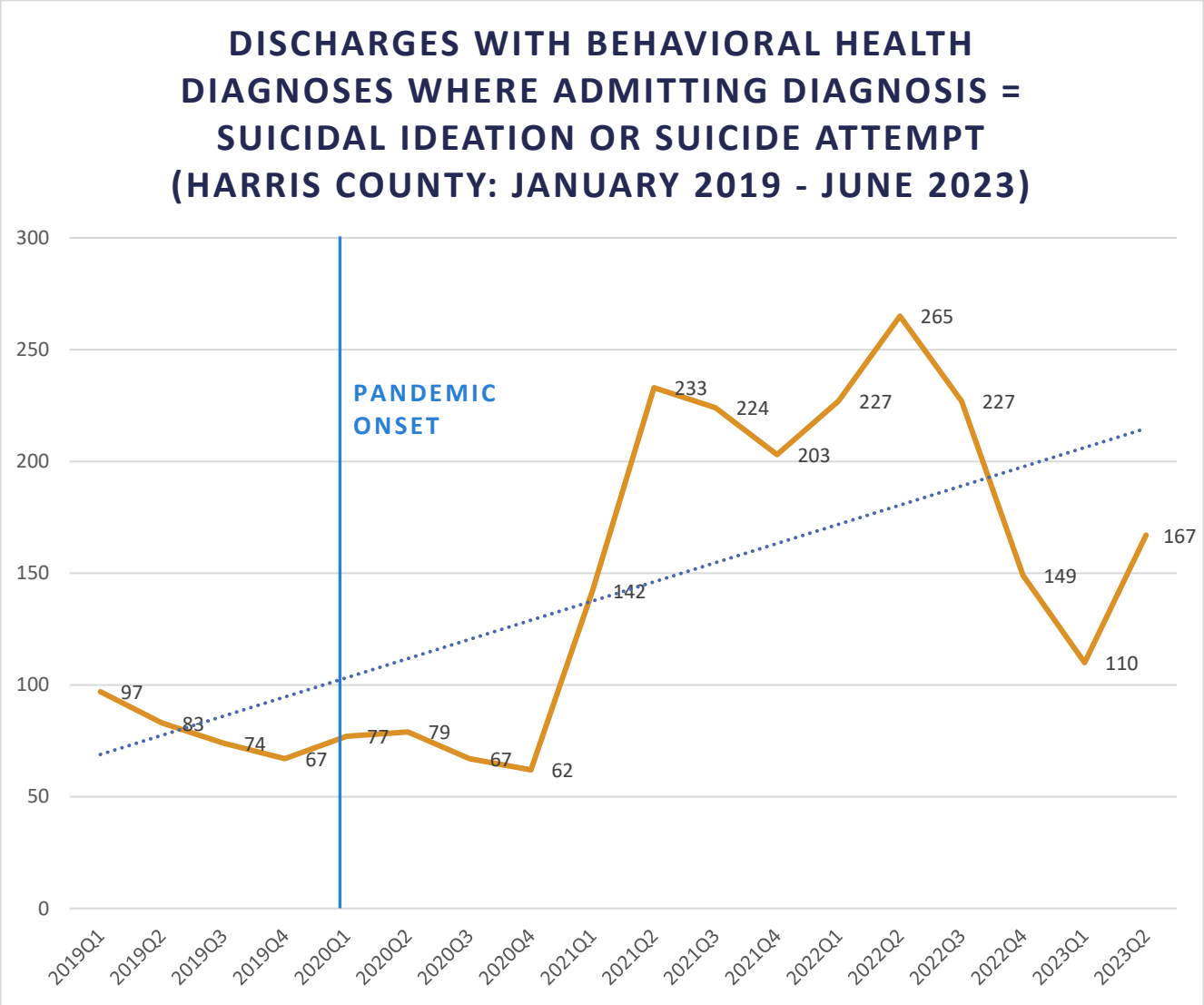

Figure B3 HCIC data – hospital discharges with principal admitting diagnoses of suicidal ideation or attempt, 2019 – 2023.

The numbers are vastly enlarged when the diagnostic criteria are expanded to include discharges in which the patient's suicidality was noted in the admitting, principal, or other diagnoses (1-10). A steady increase in suicidality among hospitalized patients is evident.

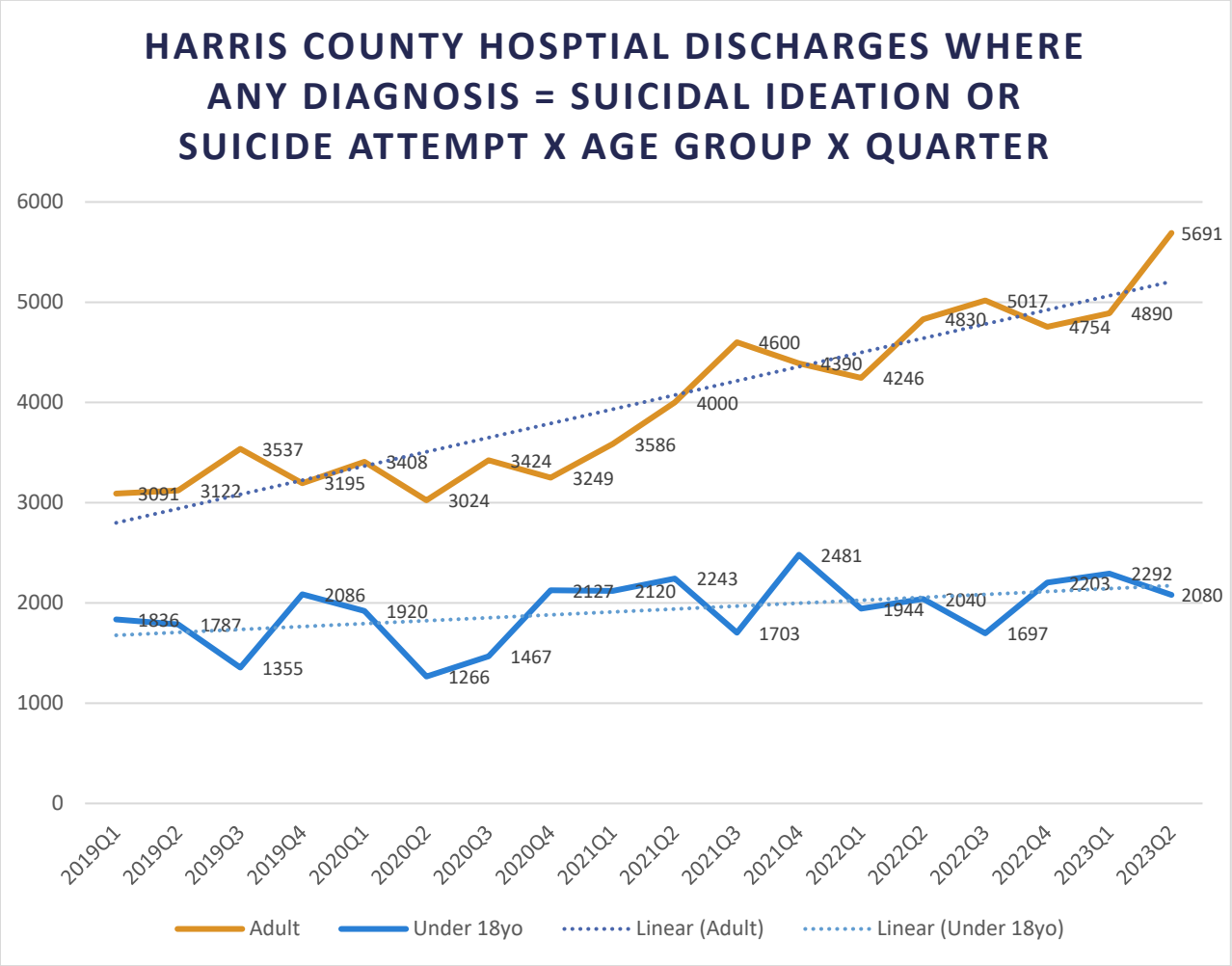

Figure B4 HCIC data – hospital discharges with suicidal ideation or attempt, by age group by quarter, 2019 – 2023

Finally, the chart below illustrates the most substantial increases among working-age patients regarding suicidality. These instances of suicidality may be related to the "deaths of despair" among working-age people who lost sources of meaning in their lives during the pandemic.

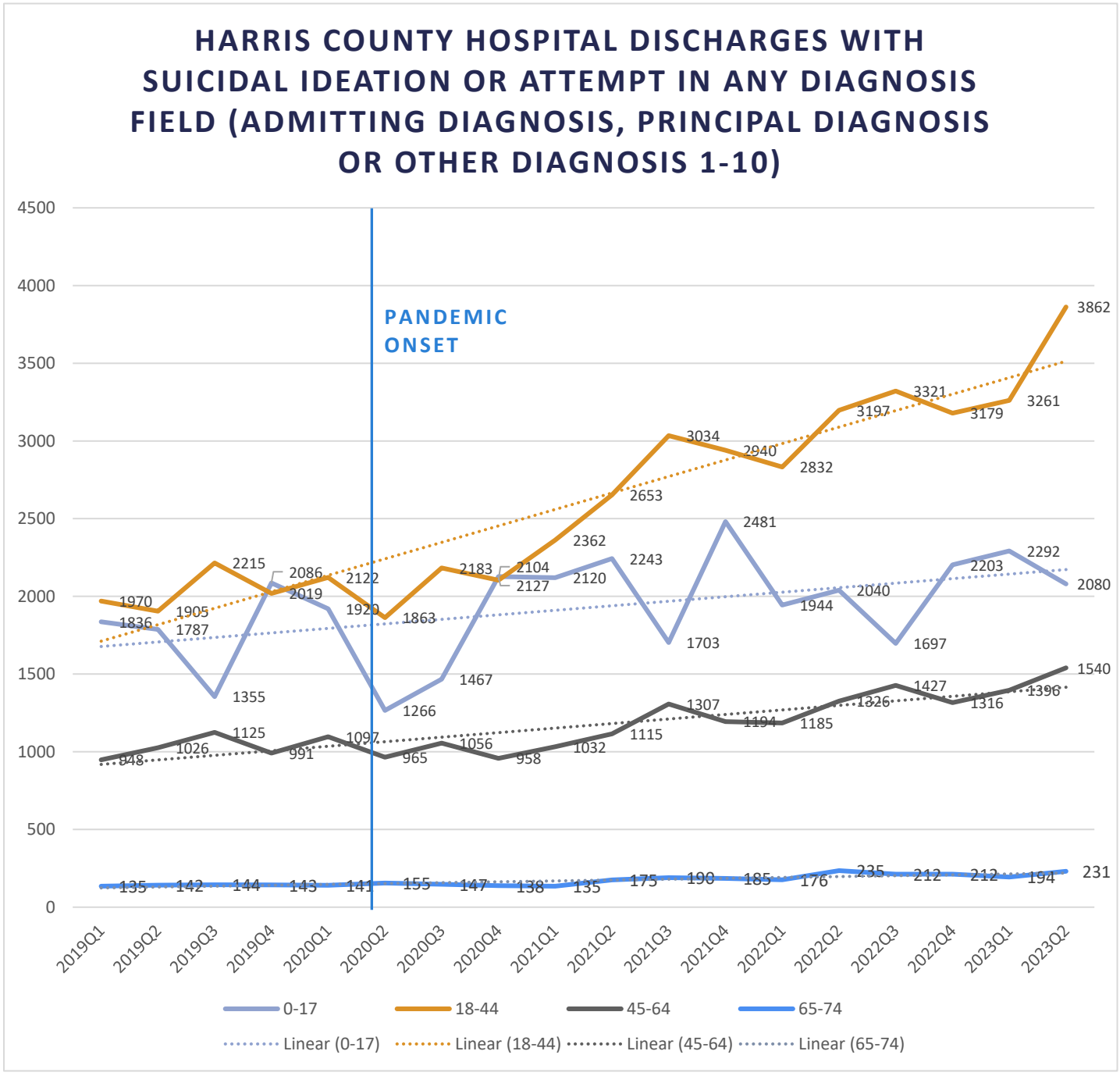

Figure B5 HCIC data – hospital discharges with suicidal ideation or attempt, 2019 – 2023

Discharge Diagnoses x Age Group

Over the study period, adults accounted for 85% of behavioral health psychiatric discharges. Increases were noted for both Adults (+32.76%) and Children and Adolescents (+20.76%) when comparing the first measurement quarter to the most recent.

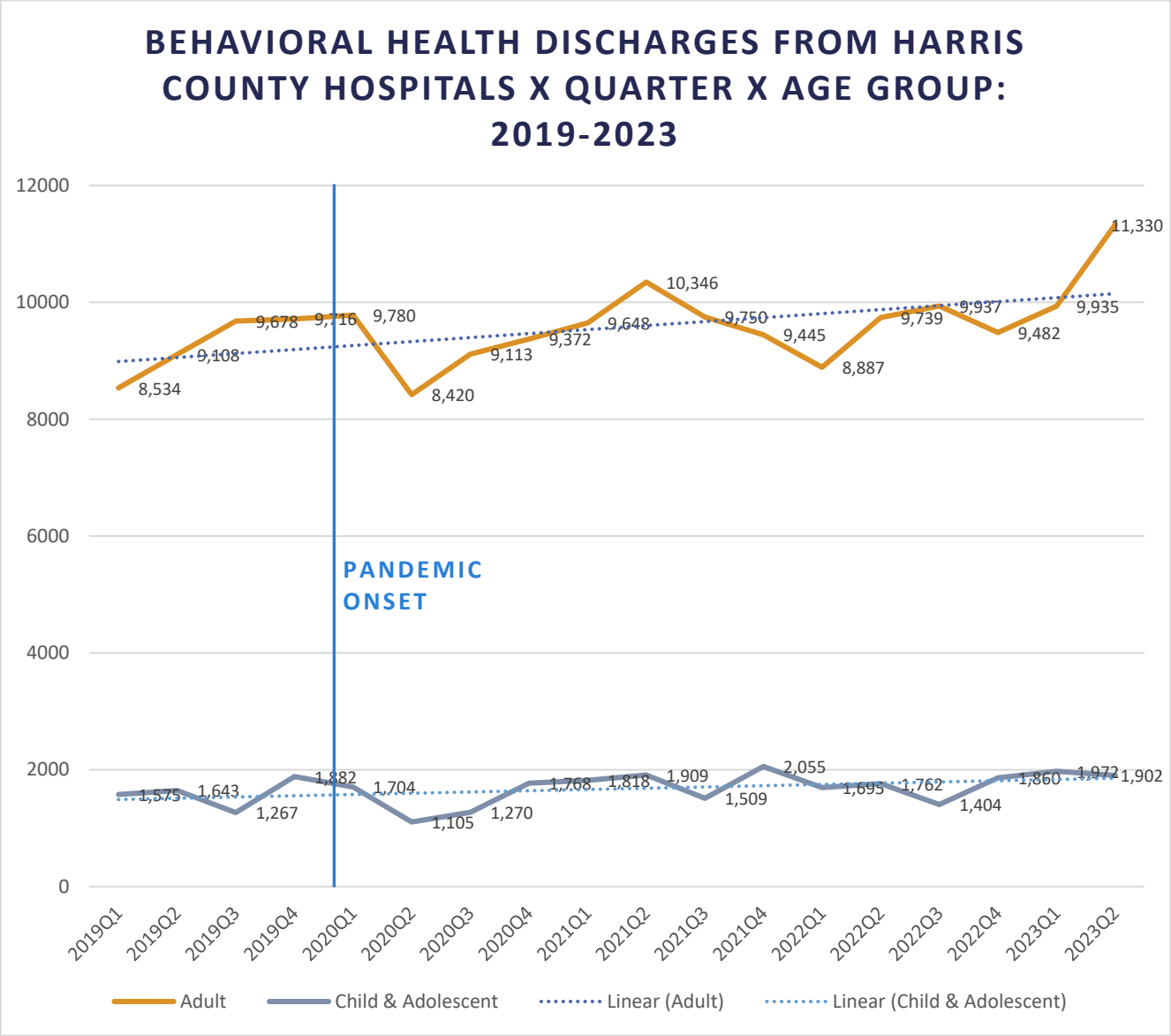

Figure B6 HCIC data – hospital discharges with behavioral health diagnoses, by quarter by age group, 2019 – 2023

Discharge Diagnoses x Race/Ethnicity Group

Below is a graph depicting the hospitalization rates for behavioral health disorders by race/ethnicity. When the rates for the first measurement interval (2019 Quarter 1) are compared with the most recently published interval (2023 Quarter 2), one can observe that the Hispanic and Other categories recorded the highest increases (59.75% and 62.42%, respectively). White people recorded the smallest increase (11.47%), and Asian or Pacific Islanders recorded the subsequent most significant increase (21.83%). Black people were hospitalized for behavioral health disorders at an increased rate of 33% higher than baseline.

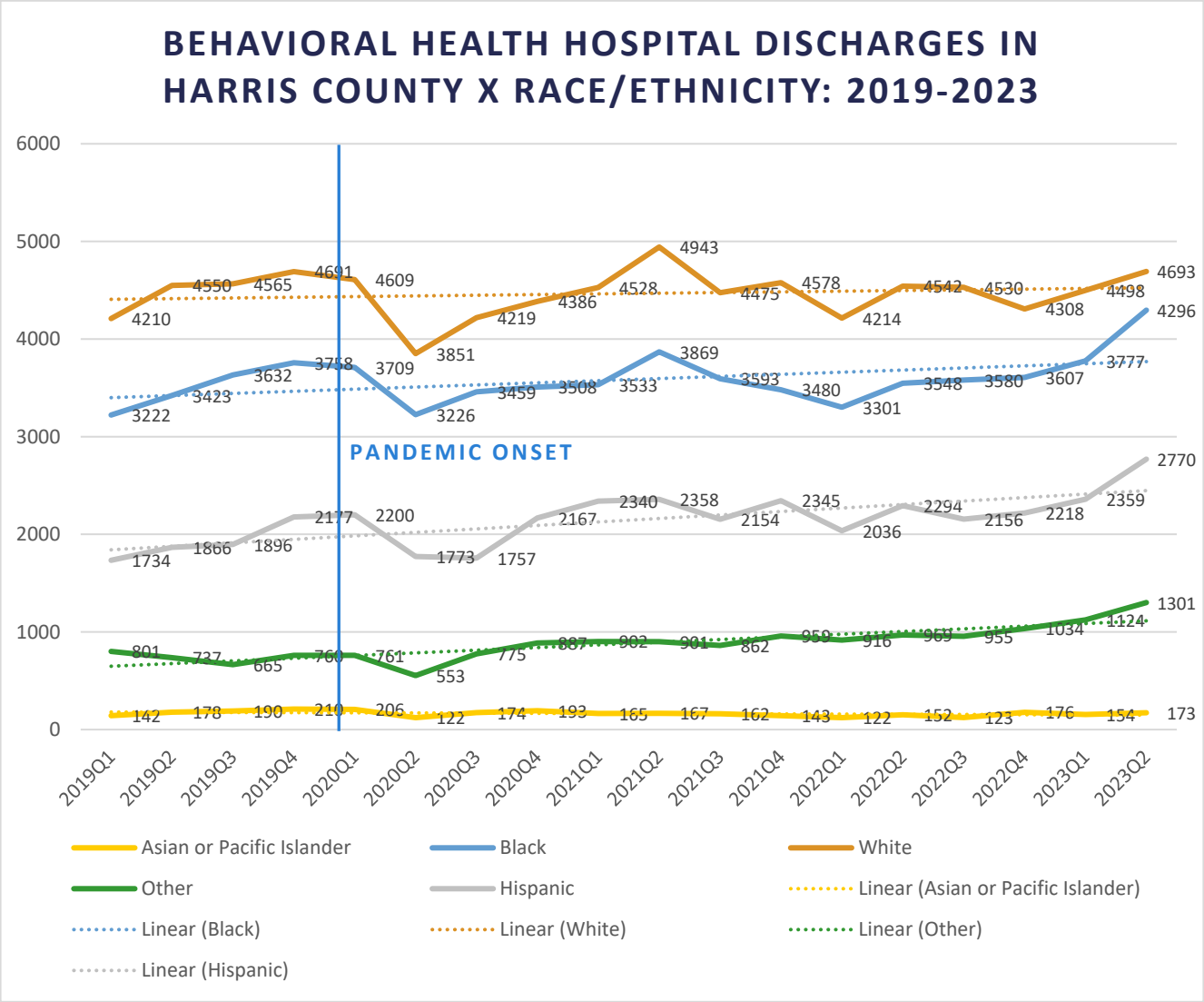

Figure B7 HCIC data – hospital discharges with behavioral health diagnoses by race/ethnicity, 2019 – 2023

Behavioral Health Discharges x Medicaid Insurance vs. Medically Uninsured

As displayed below, discharges to medically uninsured patients peaked in the first quarter of the pandemic (2020 Quarter 1) and trended toward declines in the remaining measurement periods. In contrast, discharges to Medicaid patients trended upward during this period. One may note that Texas Medicaid enrollment gradually increased during the pandemic because disenrollment was not permitted, and re-enrollment was not required. This prohibition was lifted in 2023, Quarter 1. More recent data (2023 Quarter 2) will be published in July 2024.

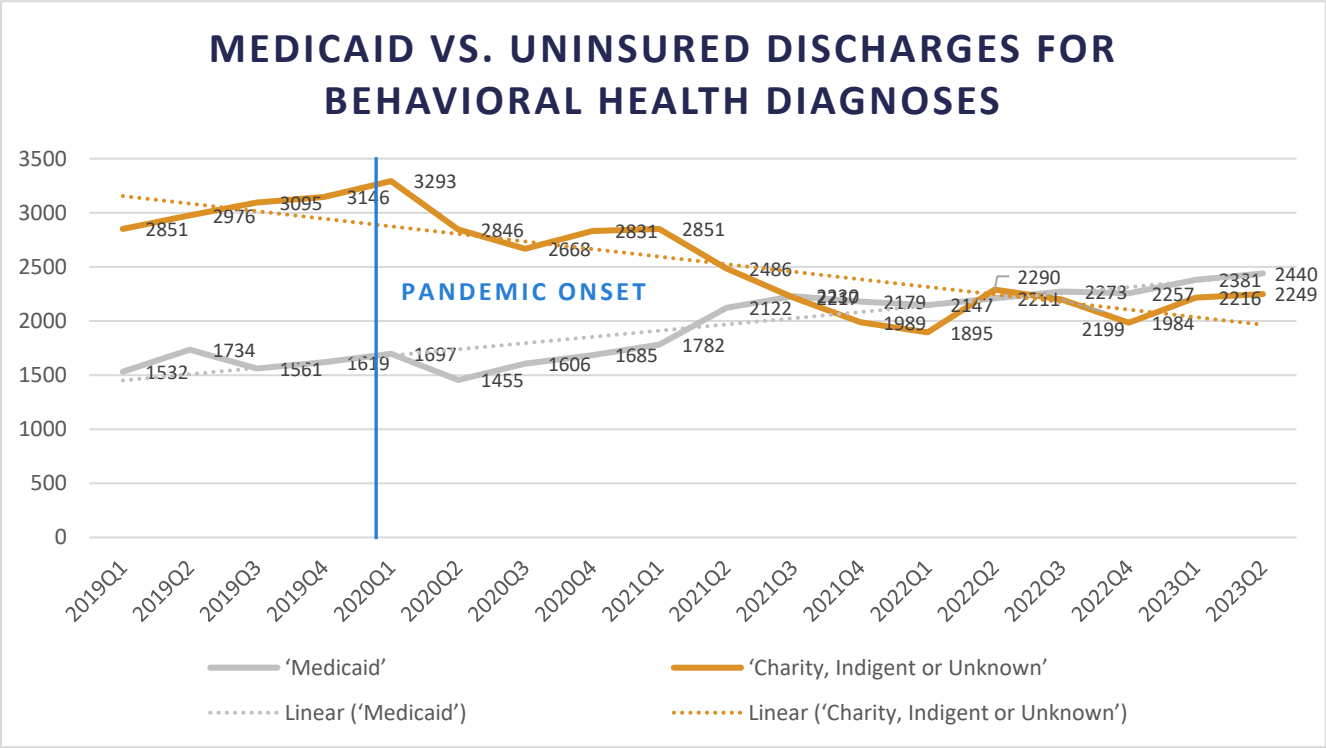

Figure B8 HCIC data – hospital discharges with behavioral health diagnoses: Medicaid vs. uninsured, 2019 – 2023

Conclusions

While these data indicate a significant increase in hospitalizations for behavioral health disorders since 2019, one might keep in mind that utilization does not necessarily accurately reflect need. The availability of behavioral health beds might limit utilization since capacity may not meet the needs. Further, hospitalizing decisions may vary based on local judgments, customs, and circumstances.

In each of the analyses presented above, the onset of the COVID-19 pandemic brought an initial reduction in behavioral health hospitalizations, whether one considers diagnosis, age group, or race/ethnicity. Exceptions were: 1) discharges for bipolar disorders, which declined during this period, and 2) discharges among medically uninsured, which gradually declined as Medicaid discharges rose.

Of particular concern were the dramatic increases in admissions for suicidal ideation and suicide attempts, which rose dramatically as the pandemic continued and eased as the impact of COVID-19 subsided.

We propose to examine the THCIC Emergency Department data set in our following review to understand community needs in a setting where resource limitations are less impactful.

Suicide

The Centers for Disease Control reported national trends in suicide deaths, noting that the gradual upward trend in the number of fatalities briefly subsided during the COVID-19 pandemic but once again resumed its upward trend. "Suicide rates increased 37% between 2000-2018 and decreased 5% between 2018-2020. However, rates nearly returned to their peak in 2021," they note.[23]

Texas Department of State Health Services reported both Texas and Harris County suicide rates since 1999, observing significant increases in both during that period. Harris County rates track parallel to the state rates but have been slightly lower in the past decade.

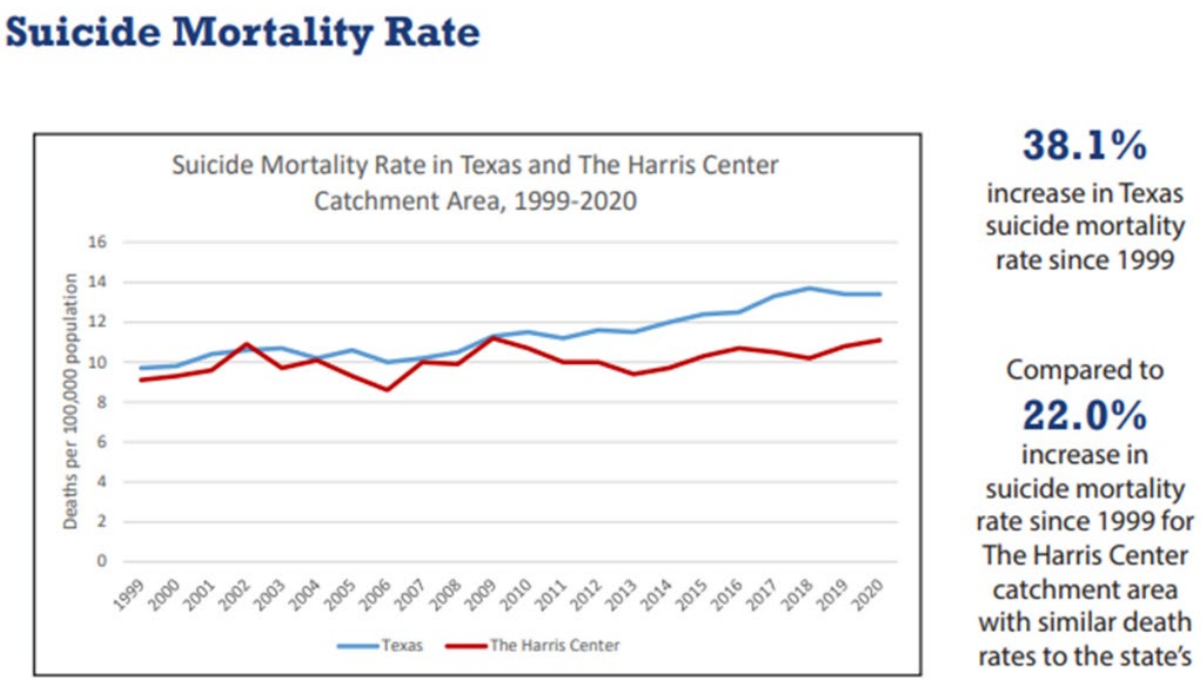

Figure C1 Suicide rate in Texas and The Harris Center catchment, 1999 – 2020

[23] Suicide Data and Statistics (cdc.gov)

National Survey on Drug Use and Health Results – Suicide

In January 2023, the Substance Abuse and Mental Health Services Administration (SAMHSA) issued the results of the National Survey on Drug Use and Health (2021), reporting Americans' experiences with substance use, mental health conditions, and treatment. The summary below shows that one-quarter of adults reported mental illness in the past year, and one-fifth of adolescents reported major depressive episodes during the past year. When available, we looked at the percentages for Texas and the US for the most extensive age range of 12 years and older.[24]

Mental Health Measures in the Past Year

Mental Illness	Texas	US
Any Mental Illness (Age 18+)	21.94%	23.08%
Serious Mental Illness (18+)	5.42%	5.86%
Major Depressive Episode (12-27)	18.40%	20.17%
Major Depressive Episode (18+)	8.35%	8.63%

Figure D1 NSDUH data, 2021 – mental health measures in the past year

Had Serious Thoughts of Suicide in the Past Year

Age	Texas	US
Age 12-17	12.05%	13.16%
Age 18+	4.98%	5.04%
Made Any Suicide Plans		
Age 12-17	5.45%	6.35%
Age 18+	1.53%	1.45%
Attempted Suicide		
Age 12-17	3.33%	3.67%
Age 18+	0.72%	0.67%

[24] 2021 NSDUH Detailed Tables | CBHSQ Data (samhsa.gov)

Substance Use Disorder

The summary of SAMHSA's National Survey on Drug Use and Health (2021) below shows that over 20% report illicit drug use, most commonly marijuana. Sixteen percent met the DSM-5 criteria for substance use disorder, nearly 30 million people with alcohol use disorder, and 25 million for drug use disorder.

Illicit Drug Use in the Past Year

Drug	Texas	US
Marijuana Use	14.74%	20.48%
Cocaine Use	1.31%	1.79%
Heroin Use (Age 18+)	0.23%	0.42%
Hallucinogen Use	2.17%	2.86%
Methamphetamine Use	0.82%	0.95%
Prescription Pain Reliever Misuse	3.15%	3.09%
Opioid Misuse	3.27%	3.26%

Alcohol in the Past Month

Alcohol	Texas	US
Alcohol Use	44.37%	48.05%
Binge Alcohol Use	21.88%	21.67%
Alcohol Use (Age 12-20)	13.65%	15.37%
Binge Alcohol Use (12-20)	7.29%	8.40%

Tobacco Products in the Past Month

Tobacco	Texas	US
Tobacco Product Use	18.96%	19.07%
Cigarette Use	14.82%	15.28%

Substance Use Disorder in the Past Year

Disorder Type	Texas	US
Substance Use Disorder	14.63%	17.00%
Alcohol Use Disorder	10.25%	10.55%
Drug Use Disorder	7.19%	9.20%
Pain Reliever Use Disorder	1.84%	1.89%
Opioid Use Disorder	1.88%	1.89%

Deaths by Drug Overdose

Over 1.1 million people have died from drug overdose since 1999. In 2022, the United States saw nearly 108,000 drug overdose deaths. The age-adjusted rate of overdose deaths increased by 15.19% from 2020 (28.3 per 100,000) to 2022 (32.6 per 100,000).[25] Synthetic opioids are emerging as a distinct driver of these deaths.[26]

Figure 3. Age-adjusted rates of drug overdose deaths involving opioids, by type of opioid: United States, 1999–2019

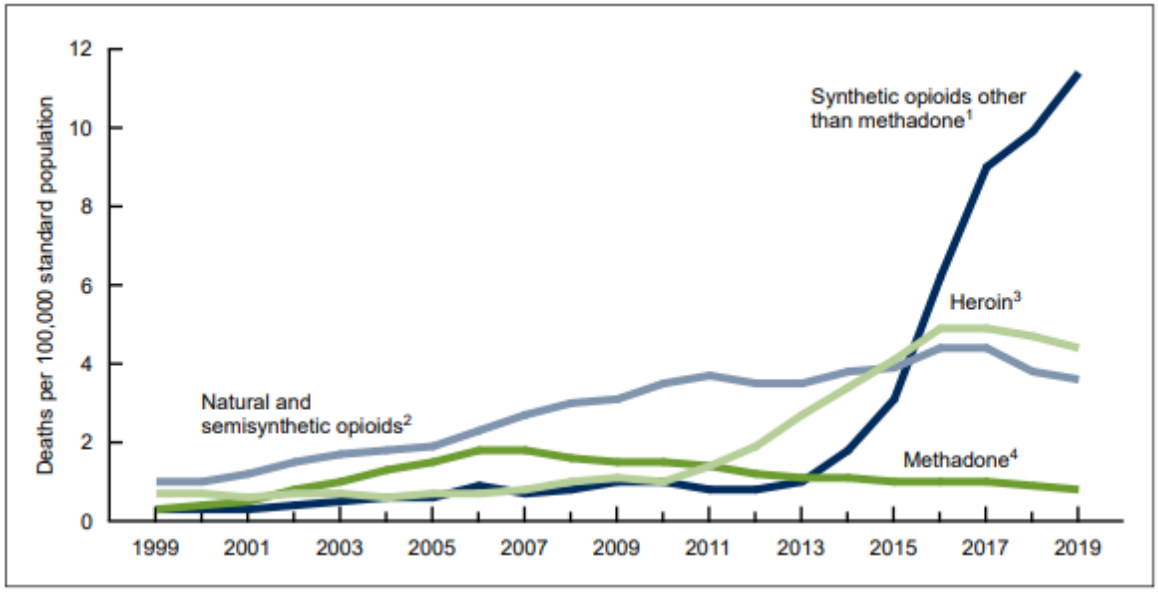

Figure E1 Drug Overdose Deaths in the United States, 1999 – 2019. Holly Hedegaard, M.D., Arialdi M. Miniño, M.P.H., and Margaret Warner, Ph.D.

[25] Overdose Data 1999-2022 (wonder.cdc.gov)
[26] NCHS Data Brief, Number 394, December 2020 (cdc.gov)

Texas is experiencing a more rapid escalation in drug overdose fatalities than the rest of the nation. In 2022, there were at least 5,489 recorded drug overdose deaths in the state, meaning the state saw a rate of increase of approximately 66.83 per month from 2021 to 2022. The most recent CDC data indicate that Texas has a drug overdose fatality rate of 18.2 deaths per 100,000 people.[27] The state has also seen a 174.1% increase in synthetic opioid deaths over the course of a year.[28] Data from the Harris County Institute of Forensic Sciences are presented below. Since 2017, Harris County has registered 20% more suicide deaths. An alarming 75% increase in accidental drug overdose deaths is presented in Figure E2 below.

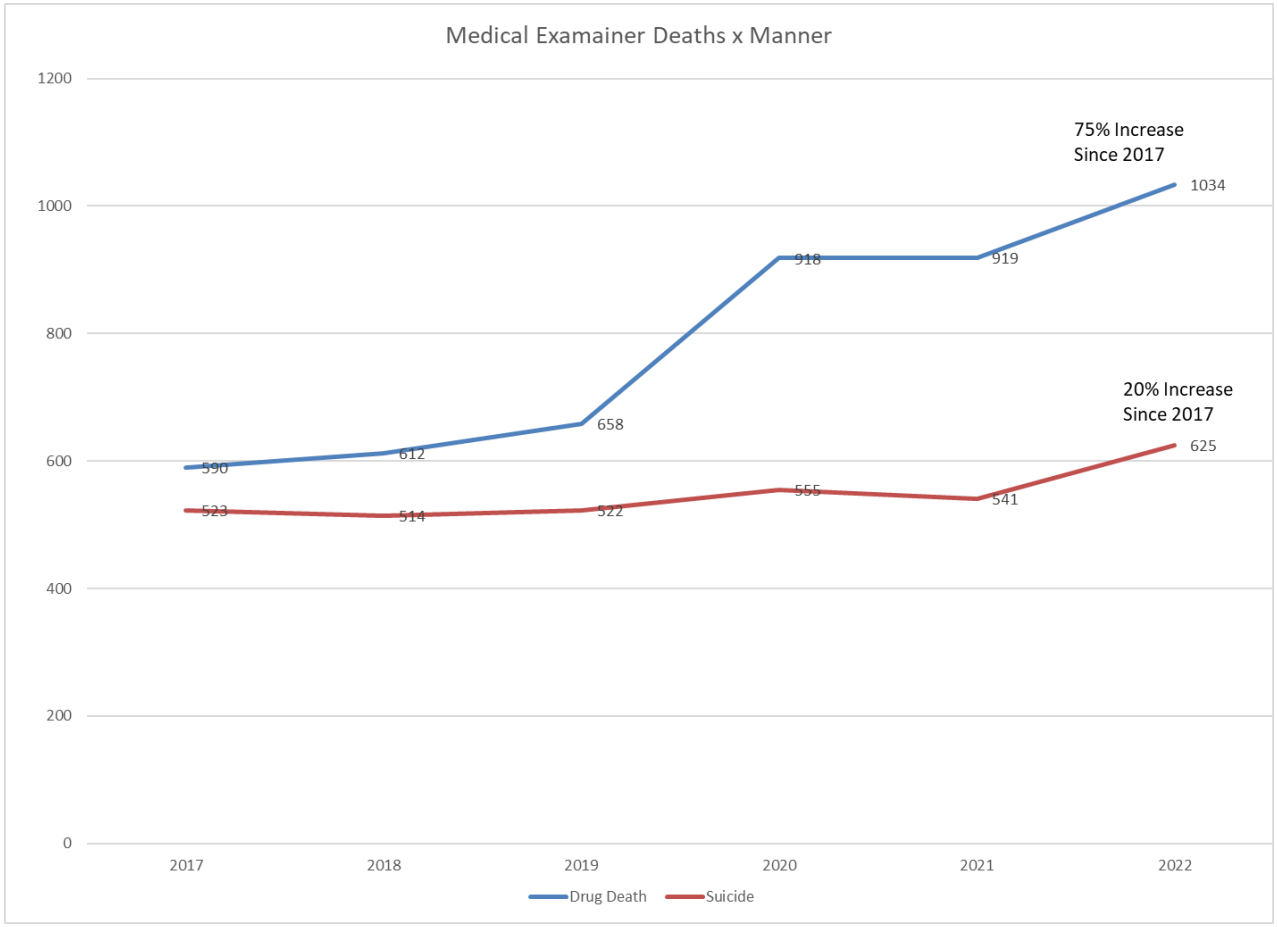

Figure E2 Harris County accidental drug overdose deaths and suicides, 2017 – 2022

[27] Texas (cdc.gov)

[28] Fatal Drug Overdoses Are on the Rise in Texas (247wallst.com)

Homelessness in Harris County

Beginning during Annise Parker's time as mayor of Houston, preventing and decreasing homelessness became a priority. The Way Home is a collective effort to address homelessness in Houston, Harris County, Montgomery County, and Fort Bend County, as well as at least 100 separate nonprofits. The Coalition for the Homeless is the lead agency. The goal is to get people into housing and provide the support they need to stay there. HUD had designated Houston as a priority community twelve years ago, so something needed to change. (HUD's definition of chronic homelessness is four or more occasions of homelessness within the past three years for a total of twelve months or longer or one or more current consecutive years of homelessness. In addition, the individual must have a disabling condition that makes daily activities difficult (e.g., medical, psychological, substance abuse) and prevents them from holding a job. A chronically homeless family meets the above definition, with at least one child under the age of 18 years living with their parent(s). Sheltered individuals must stay in an emergency shelter or safe haven but not transitional housing.) The cost savings can be seen by comparing the cost of putting someone in their own apartments, costing $18,000 per year, to the cost of jail, emergency room visits, hospitalizations, etc., which can run three to four times more.

> "Houston has accomplished something practically no other jurisdiction has done. It's created a true system to combat homelessness. Not long ago, Houston and Harris County, their housing agencies, and dozens of separate nonprofit groups barely spoke to one another about what they were trying to accomplish. By this point, close coordination has become a habit, with duplication and wasted effort, to an impressive extent, wrung out of the process."[29]

One measurement of homelessness is the annual Point-In-Time Homelessness Count and Survey carried out each year as a requirement of the U.S. Department of Housing and Urban Development, coordinated in Houston by The Coalition for the Homeless. The Count is a way to assess the numbers of those without a home and delineate some of those people's characteristics on the night of the survey. We have summarized and interpreted the trends from the 2019 to 2023 Counts below.

In 2019, the Count showed 3,567 persons who were homeless in Harris County, 1,515 who were unsheltered, and 2,052 persons who were sheltered. This Count noted that 23% were aged 18-24, 41% were White, and 55% were Black. In 2020, the Count showed 3,753 persons who were homeless, 1,551 who were unsheltered, and 2,202 who were sheltered. This Count noted 39.9% identifying as White, 56.2% as Black, 0.05% as Asian, 0.4% as American Indian/Alaska Native/Native Hawaiian/Pacific Islander, 2.4% as Multiple Races, and 14.1% of the above as Hispanic. In 2021, the Count showed 2,893 persons who were homeless, 1,439 who were sheltered, and 1,454 who were unsheltered. Because of the COVID-19 pandemic, the methodology of the count was altered, thus not directly comparable to past years. Also, one in seven cited COVID as the reason for their homelessness. In 2022, The Count showed 2,964 persons who were homeless, 1,534 who were sheltered, and 1,430 who were sheltered. One in eight cited COVID-19 as the reason for their homelessness. In 2023, the Count showed 2,989 persons who were homeless, 1,803 who were sheltered, and 1,186 who were unsheltered.

Reports from Homeless Program clinicians and managers indicate that while the Houston homeless initiative has connected more than 7,000 individuals with permanent supported housing, those permanent slots are at a premium. Individuals with serious mental illnesses who apply for permanent slots are more frequently offered

[29] From "How Houston Cut Its Homeless Population by Nearly Two-Thirds," by Gleenblatt. (2023). Governing.

"rapid re-housing" placements. These temporary slots expire after one year. Reports from clinicians indicate that gains in daily functioning and symptom status for participants are often lost when they are required to move out of these rapid re-housing residences.

Mental Health and Criminal Justice

In 2003, The Harris Center first matched patients in its client services database with records of bookings into the Harris County Jail. The result was eye-opening – 25% of adults served in The Center had also been booked into the Harris County Jail. Since that time, the criminalization of mental illness has been widely publicized.[30]

Some have suggested that the jail has become a prime path of entry for adults who need mental health treatment. In the Texas Observer, Emily DePrang concluded that the public mental health system is underfunded and was built to respond to crises rather than ongoing care of those with mental illness.[31]

Nguyen and Hickey (2007) reported at the Annual Conference for Restorative Justice (summarized on the Grits for Breakfast blog) that people with serious mental illness were over-represented in the County Jail. They reported that 24% of the Harris County jail population (9,000 people at any one time) have been diagnosed with a mental illness, and 11% have serious mental illness, defined as schizophrenia, bipolar disorder, and major depression.

> "People with mental illness end up spending more time in jail than others with similar charges. A large number are there for minor things, Hickey said, but it's incorrect to assume that's always the case. Those with MH diagnoses in jail are slightly more likely to be charged with felonies than non-MH offenders, though in many cases these are low-level drug felonies instead of more serious crimes." [32]

People with serious mental illness are more vulnerable to involvement in the criminal justice system. Regular citizens accumulated 2,565 charges per 100,000 county residents. For people with mental illness, though, that figure skyrocketed to 16,354 per 100,000: a 6:1 ratio.

Fewer than 55,000 Americans are treated in psychiatric hospitals, while almost ten times that many, nearly 500,000 mentally ill people, are serving time in US jails and prisons.

It is estimated that 6-7% of Americans have a mental disorder severe enough to impair day-to-day functioning, and said rates for mental illness have been flat over the years. Less than half of the mentally ill get treatment, and when they do, most have already suffered and delayed treatment for ten years.[33]

[30] The New Asylums | FRONTLINE (pbs.org)
[31] Want treatment for mental illness in Houston? Go to jail. (texasobserver.org)
[32] From "Criminalization of Mental Illness," paper presented by Hickey and Nguyen. 2007 Annual Conference for Restorative Justice.
[33] National Comorbidity Survey (harvard.edu)

Those with mental disorders are more likely to stay in the system longer for low-level offenses than their "regular" counterparts – while people with mental illness are six times as likely to be charged with a crime. In Harris County, they are twelve times as likely to end up in jail as people without them.

Hickey and Nguyen performed preliminary estimates to discover the cost of treating mental illness through the Harris County criminal justice system. Community care costs less than half of a typical jail stay.

The magnitude of the association between mental health issues and juvenile justice involvement among incarcerated teens was documented by The Houston Chronicle.[34]

When The Harris Center matched mental health records with the juvenile probation rolls, they found 12% of kids matched, having had prior mental health treatment.

Juvenile Probation's Operation Redirect surveyed about 3,500 juveniles in detention, or about 90% of those in lock-up awaiting a court hearing. Identified problems ranged from mood to psychotic disorders for kids arrested for crimes such as theft, drug possession, and violence against a family member.

Of the youths with serious emotional disorders in juvenile detention, 22% had been physically abused, and 12% were abused sexually, the new data show. More than half have experienced some form of traumatic loss.

Current Status

Demand for mental health services in system elements contiguous with the criminal justice system must be considered from many perspectives. In the first six months of 2023, 22,481 emergency calls to law enforcement were identified as mental health calls. At present, 78% of Houston Police Department officers have received specialized training in responding to mental health calls. Crisis Intervention Team (CIT) training is a specialized police curriculum that aims to reduce the risk of severe injury or death during an emergency interaction between persons with mental illness and police officers. As a result, 89% of these calls were dispatched to CIT-trained officers.

In the first six months of 2023, there were more than 51,000 bookings into the Harris County Jail. Pre-trial release was granted to 40% of those arrested, but only 17% of those with mental disorders enjoyed a similar release. Of those booked into the jail, 25,000 exhibited histories or behaviors or reported mental health issues leading to a need for screening. More than one-third of these screenings (35.92%) yielded positive findings, creating a need to attend to the mental health needs of more than 9,000 inmates.

Of those receiving probated sentences, 21% failed to meet conditions and were subject to revocation. The overall failure rate for probationers was 3.6%, but among probationers with mental disorders, the rate rose to 5.9%.

The Harris Center provides mental health services within the Harris County Jail. In Fiscal Year 2022, over 18,000 individuals were served in its programs. That number nearly doubled in fiscal year 2023, coinciding with the implementation of a more comprehensive electronic health record.

All individuals treated in the jail receive aftercare mental health referrals. More intensive case coordination and aftercare planning are offered to more than 2,000 individuals annually.

[34] Half of youths in Harris custody have mental health woes, by Viren. (2008). Houston Chronicle.

Low-level misdemeanor offenders with mental disorders can be shunted by police in consultation with the district attorney's office away from jail to the Judge Ed Emmett Jail Diversion program. More than 900 offenders with mental disorders were escorted by law enforcement to the diversion center during the first six months of 2023.

Independent evaluation of Diversion Center outcomes was summarized as follows:

> "This study collected data from The Harris Center for Mental Health and IDD and the Harris County Jail to determine if the program impacted future jail bookings for new offenses. The treatment group was comprised of 692 people who were referred to the Diversion Center. First, we examined the in-person differences between pre and post periods of 12 months to determine if there was a substantive effect on reducing jail bookings. Second, the treatment group was matched to a comparison group that had been booked into the jail previously, and both were tracked 12 months after the initial intake/booking.
>
> Overall, the persons who went to the Diversion Center had fewer jail bookings than the comparison group even after controlling for the differences in the two groups. In fact, the comparison group was 1.4 times more likely to be booked into the jail on a subsequent new charge than the treatment group. Examining the populations in greater details, individuals from the comparison group who had no prior bookings in the past year were also 44.9 times more likely to return to jail for a new offense. Interestingly, those individuals who were booked into jail five or more times in the previous year were 2.9 times more likely to be booked into jail within the next 12 months than the similarly situated treatment group. In addition to the improved outcomes, the Diversion Center proved to be a valuable investment in that, for every $1 spent on the program, the program avoided spending $5.54 on future jail bookings."[35]

A second independent evaluation was intended to extend findings to longer-term outcomes and to use other intensive services (psychiatric hospital and emergency services). The findings were summarized as follows:

> "The study examined several important outcomes among first year and second year jail diversion participants, including future jail incarceration, psychiatric hospitalizations, use of psychiatric emergency services and outpatient services. We found evidence that people who participate in the Harris Center Jail Diversion Program are less likely to have future jail bookings and are more likely to access outpatient services after participating in the program. First year participants experienced an average reduction of 2.52 jail bookings per month after participating in the program. Second year participants had an average reduction of 2.14 jail bookings per month following their program participation. The size of the reduction in jail bookings were largest among Black participants,

[35] From "The Judge Ed Emmett Mental Health Diversion Center Evaluation," by Lovins. 2020 by Justice System Partners.

male participants, and homeless participants. Participants experienced significant increases in usage of outpatient services following their participation in the program. However, their use of outpatient services declined over time, underscoring the importance of mobilizing additional resources and services that help keep program participants connected to services over time.

Harris Center Participants experienced upticks in psychiatric hospitalizations and usage of psychiatric emergency services in the short-term period following their program participation. However, we found significant declines in the number of psychiatric-related events over time during the post-intervention periods. First year participants experienced an average reduction of .67 psychiatric hospitalizations per month after participating in the program, and second year participants had an average reduction of .84 psychiatric hospitalizations per month after participating in the program. The reductions in psychiatric hospitalizations were largest among people who were homeless. First year participants had an average reduction of 1.47 psychiatric emergency incidents per month. Second year participants had an average reduction of 1.91 psychiatric emergency incidents per month after participating in the program. The reductions were largest among people who were homeless at the time when they participated in the program."[36]

The Harris Center and Criminal Justice Overlap

The Patient Care Intervention Center[37] integrates Harris County data from multiple participating agencies, including medical, social service, and legal agencies. Of interest is their overlap analysis of The Harris Center and The Harris County Criminal Record, a database of criminal justice involvement that includes citations, arrests, and bookings. The Harris Center dataset included individuals recently treated and had current open episodes. Between January 1, 2020, and September 30, 2023, patients in The Harris Center's electronic health record accumulated 88,000 incidents. These events were roughly equally split between felonies (40,567) and misdemeanors (37,289).

The Harris Center has been matching Jail Information Management System (JIMS) records of charges resulting in jail bookings since 2011. The match is all-inclusive. All individuals who have ever received Harris Center services can be matched. Since individuals may be booked into jail on a single occasion for multiple charges, both are presented below in Figure F1.

[36] From "Evaluation of the Judge Ed Emmett Mental Health Diversion Center," by Lovins and Menefee. 2022 by JSP.
[37] Patient Care Intervention Center (pcictx.org)

Harris County Jail Bookings of Individuals with Harris Center Histories

Year	Bookings	Charges
2011	39,854	66,492
2012	38,296	64,589
2013	39,205	66,219
2014	37,586	66,426
2015	39,665	71,012
2016	40,066	108,602
2017	34,303	61,110
2018	42,557	70,288
2019	34,669	66,662
2020	24,715	45,531
2021	29,089	58,704
2022	34,393	60,824
Total	*434,398*	*806,459*
Average	*36,200*	*67,205*

Figure F1 Matched Harris County jail booking data with patient histories at The Harris Center, 2011-2022

Most individuals whose data are captured in this table were diagnosed with serious mental illnesses. Bipolar Disorders, Major Depressive Disorders, and Schizophrenia Spectrum Disorders (in decreasing order) accounted for almost two-thirds of diagnosed inmates. Whether individuals also suffered from substance use disorders was essentially a coin toss since 49.5% of Harris Center-diagnosed inmates received these secondary diagnoses.

When ANSA ratings taken in outpatient settings for those who have connected post-release for ongoing care are considered, both Residential Stability scores and Substance Use Severity scores are associated with the frequency of subsequent recidivism. Substance use and homelessness predict recidivism.

The Harris County Sheriff's Office reported that in the first six months of 2023, just under 40% of those booked into its jails were released before their trials. In contrast, just 16.68% of inmates with mental health needs were released before trial. Inmates with mental disorders and treatment histories with The Harris Center average 66 days in custody. Those who have been sentenced will stay 115 days.

The Texas Judicial Commission on Mental Health (2021) has observed in its white paper entitled "Eliminate the Wait,"

> "Texas faces a growing crisis in the number of people who are waiting in county jails for inpatient competency restoration services after being declared incompetent to stand trial (IST). Not only has this increased costs and overburdened state agencies and county jails but it also is taking a significant toll on the health and well-being of people waiting in Texas jails for inpatient competency restoration services. Meanwhile, resources available to the behavioral health and justice professionals serving our communities are becoming scarce."[38]

[38] Eliminate the Wait Toolkit (JCMH)

In the referenced period, 862 individuals were referred for evaluation of their competency to stand trial, most of whom were housed in jail while awaiting evaluation.

The responsibility to provide compassionate mental health care to incarcerated citizens continues to grow.

Implementing Outpatient Competency Restoration programs has offered an alternative to the waits in Harris County Jail for lower-level offenders.

As noted by recent reviewers of OCR programs,

> "It is no secret that prisons and jails have replaced large state psychiatric hospitals as the de facto treatment centers for large numbers of mentally ill persons in the United States over the past few decades. As a result, much of the work of mental health policy makers in recent years has centered on diverting persons with mental illness away from the criminal justice system…. The goal has been to end the mass incarceration of persons with mental illness who would be better served by treatment than punishment. What, then, does it say when we propose jail-based restoration—that is, to detain persons, who are mentally ill and have not been convicted of any crime, in a correctional facility rather than in a hospital?"[39]

The Outpatient Competency Restoration project, implemented in October 2021, has served 156 patients to date (February 13, 2024). The Outpatient Competency Restoration (OCR) Project aims to provide access to mental health services in a less restrictive environment that will reduce demands on the Harris County Jail as a provider of behavioral health services.

Police and Fire Department Crisis lines also serve as pathways to mental health services through alternate means. The Crisis Call Diversion (CCD) program diverts requests for law enforcement or emergency medical service involvement to more appropriate mental health resources. In Fiscal Year 2023, 6,715 calls for 9-1-1 emergency services were steered away from police and fire department calls with a mental health nexus to the CCD program. The majority (61.5%) of those calls were successfully diverted, resulting in an economy of emergency resource use. These callers were connected with the most appropriate resource. In one-third (32.1%) of cases, the crisis prompting the call to 9-1-1 was successfully de-escalated during the phone call. More than one-quarter of callers (26.1%) were engaged in either suicide or violence prevention safety plans. CCD staff provided 1,093 hours of crisis counseling while engaging these emergency callers.

The staggering number of people with mental illness who become entangled in the criminal justice system has been reduced through these innovative programs. Outpatient services can be provided in a less restrictive setting at a fraction of the institutional cost. Scaling up these programs to the local need level would be compassionate and more cost-effective than continuing to house these individuals in The Harris County Jail.

[39] From "Lookin' for beds in all the wrong places: Outpatient competency restoration as a promising approach to modern challenges.," by Gowensmith, et al., 2016, *Psychology, Public Policy, and Law, 22*(3), 293-305. Copyright 2016 by American Psychological Association.

Children and Adolescents

Estimated Treatment Gap

Mental Health America has reported that most youth with Major Depressive Disorder go untreated (See Footnote 17). This problem may be more pronounced in Texas, as the state ranked last in the percentage who went untreated for this disorder. Seventy-three percent of youth (255,000) experiencing a major depressive episode (MDE) did not receive mental health services.

Texas moved from being ranked 30th in the Youth Rankings: State of Mental Health in America to 41st, indicating that there is a higher prevalence of mental illness and lower rates of access to care in the state. The most significant reason behind this decline is that Texas' percentage of children with private insurance that did not cover mental or emotional problems increased from 11.5% in 2017 to 2018 to 13.8% from 2018 to 2019. [40]

In Mental Health America and other surveys, roughly half of all affected adults recalled that their mental disorders started by their mid-teens and three-quarters by their mid-twenties.[41] Since at least half of those who will have a mental, emotional, and behavioral (MEB) disorder during their lives experience onset in childhood, prevention resources need to be focused on this period of life.

In addition to universal prevention programs, research on the prevention of mental, emotional, and behavioral disorders among young people suggests that there may be a window of opportunity lasting two to four years between the first symptom and the full-blown disorder when preventive programs might be able to reduce the rate of onset of specific disorders (Footnote 41).

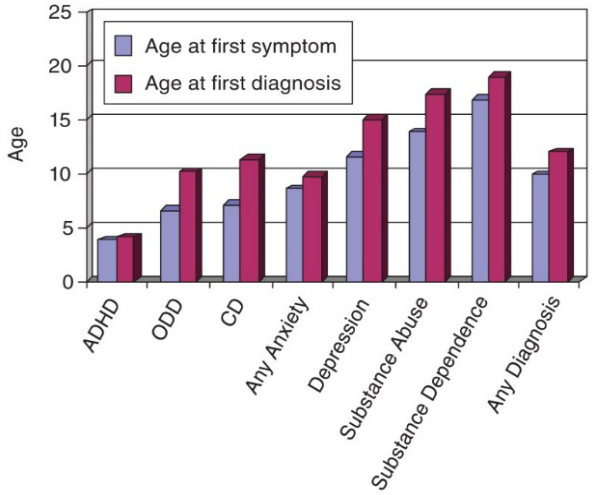

Figure G1 Age at onset of first symptom and of full psychiatric disorder, by age 21: Data from Great Smoky Mountains

[40] Ranking the States 2022 | Mental Health America (mhanational.org)
[41] Preventing Mental, Emotional, and Behavioral Disorders Among Young People (National Academy of Sciences)

Incidence of Serious Emotional Disorders Among Harris County Children and Youth

Meadows Mental Health Policy Institute (see Appendix A) estimated that 8% of Harris County's children and youth between 5 and 17 years old had experienced a serious emotional disturbance in the past year (65,000). Serious Emotional Disturbance is characterized as a diagnosable mental disorder resulting in functional impairment that substantially interferes with a child's functioning in family, school, or community activities.

Estimated Children and Youth with Substance Use Disorders

The Substance Abuse and Mental Health Services Administration (2021), in its annual survey[42] reported that 21% of youth between 12 and 17 years old had used illicit drugs in their lifetimes, with two-thirds of those reporting use in the past year. While the largest reported category was marijuana use (13.2%), a substantial number reported inhalant abuse (8.8%) and use of hallucinogens (2.3%).

Texas School Survey

The Texas School Survey reported similar findings of drug use amongst high school students in 2022. [43] Specifically, 19.2% of high school students in Texas reported that they had ever used illicit drugs, with 14.8% of students reporting use within the last year. Like the findings of SAMHSA's survey, the Texas School Survey also found that marijuana was the most frequently reported category of illicit drug use. In fact, 16.8% of Texas high school students reported ever using marijuana. The survey also found that the average age of first use of marijuana for Texas high school students was 14 years old.

Prevalence of Mental Health Stressors in HISD

Rice University Kinder Institute for Urban Research partnered with the Houston Independent School District (HISD) to assess the needs of HISD students from December 2021 to January 2022.[44] The study explored student needs across different areas, including mental health. Notably, the study found that a little over half of middle and high school students in HISD (54%) reported experiencing at least one mental health stressor. In comparison, 67% of elementary students reported the same. When middle and high school students were asked which sources of support they had the most trouble accessing (therapist, support group, or medication), the majority reported trouble accessing a therapist. The top reported barrier for middle and high school students accessing mental health support was feeling "nervous or embarrassed to ask for help." These findings are indicative of the need to not only ensure access to mental health therapists for students but also to increase efforts to destigmatize mental health and empower youth to seek help.

[42] Section 1 PE Tables – Results from the 2021 NSDUH Survey (SAMHSA)
[43] Texas School Survey (Texas Public Service and Administration)
[44] HISD Student Needs Survey: Fall 2021 (Rice University Kinder Institute for Urban Research)

Child and Adolescent Programs Addressing Behavioral Health Care Shortage

The Texas Child Mental Health Care Consortium, or TCMHCC, was developed in 2019 by the 86th Texas Legislature to confront the pressing child and adolescent-specific mental health care challenges by harnessing the capabilities of twelve higher education Health-related Institutions (HRIs).[45] Of the four major programs that the TCMHCC created, the Child Psychiatry Access Network, or CPAN, was designed to address the shortage of child and adolescent behavioral health providers. CPAN provides over 430 primary care providers across 85 counties in Texas with consultation services and training opportunities in child and adolescent behavioral health. Psychiatrists affiliated with the University of Texas Health Science Center at Tyler (UTHSC-T) are some of the CPAN participants who provide free consultation to primary care providers in Northeast Texas (Footnote 18).

In addition to these services, the TCMHCC manages the Texas Child Health Access Through Telemedicine (TCHATT) program, which delivers telehealth and telemedicine programs to school districts so they can aid in identifying the behavioral health needs of school-aged children and link them to appropriate services. The TCHATT program quickly received hundreds of student referrals from participating school districts, expanding from its original five districts in 2020 to 823 school districts across Texas today.[46]

Through TCHATT, the Texas Tech University Health Sciences Center (TTUHSC) has been able to expand the school-based services they have already offered to the schools within their region, allowing children and families to receive direct psychiatric treatment when necessary. Another model that has expanded its reach because of TCHATT and its subsequent funding is the Extension for Community Health Outcomes (ECHO). ECHO was initially developed in 2003 at the University of New Mexico Health Science Center to bridge the healthcare service gap between academic medical centers and rural communities. Major Texas universities such as Texas A&M Health and UTHealth have partnered with ECHO and now provide underserved areas with telehealth, mentorship, and consultation opportunities ranging from dentistry to child psychiatric care.[47] School personnel across the state can virtually participate in discussions (at no cost) on relevant topics such as coping strategies, vaping, etc.

TCHATT Program Metrics

- 6,392 participating campuses
- 3,982,852 students with access to services
- 823 school districts (See Footnote 46)
- 13,309 students served from 2020 – 2022.
- 35,700+ telehealth sessions from 2020 – 2022 (See Footnote 45)

[45] TCMHCC Biennial Report
[46] Texas Child Health Access Through Telemedicine (TCHATT)
[47] ECHO - UTHealth Houston

Mental Health Disorders Among Juvenile Probation Cases

Harris County Juvenile Probation reported the prevalence of youth on probation with a current or prior mental health history, history of abuse or neglect, and current substance abuse for 2019 through 2022. Figure H1 below summarizes these data.

Year	Youth on Probation	Mental Health History	Abuse or Neglect	Substance Abuse
2023	1473	888 60.3%	712 48.3%	1216 82.6%
2022	1213	806 66.5%	681 56.1%	1026 84.6%
2021	1175	822 70.0%	710 60.4%	1033 87.9%
2020	1691	1215 71.9%	993 58.7%	1467 87.8%
2019	2740	1720 62.8%	1260 46.0%	2253 82.2%

Figure H1 Harris County Juvenile Probation data, 2019 – 2023

Both traits and answers to PACT data were used to obtain these data.[48] Youth on probation do not include any deferred supervision and only include the youth counted once a year. Be aware that youth are not mutually exclusive – e.g., youth on probation in 2019 may still be on probation in 2020, leading to counting the youth twice.

The dramatic drop in cases between 2019 and 2020 is thought to be the result of multiple changes in the system, including a new slate of democratic judges, a change in the top leadership at HCJPD, increased use of the diversionary programs, and the changes in the court system and HCJPD operations because of the pandemic.

It is a beneficial outcome that fewer children are on probation and thus not in the school-to-prison pipeline.

Harris County Child Abuse and Neglect

Harris County Children's Protective Services

Children who suffer from child traumatic stress are those who have been exposed to one or more traumas over the course of their lives and develop reactions that persist and affect their daily lives after the events have ended. Traumatic reactions can include a variety of responses, such as intense and ongoing emotional upset, depressive symptoms or anxiety, behavioral changes, difficulties with self-regulation, problems relating to others or forming attachments, regression or loss of previously acquired skills, attention and academic challenges, nightmares, difficulty sleeping and eating, and physical symptoms, such as aches and pains. Older children may use drugs or alcohol, behave in risky ways, or engage in unhealthy sexual activity.[49]

[48] Harris County Juvenile Probation Department Research & Data

[49] About Child Trauma | The National Child Traumatic Stress Network (nctsn.org)

To find a measure of abuse and neglect in children and adolescents, we utilized the numbers of Harris County children being served by the Texas Department of Family and Protective Services in Family Based Safety Services and Conservatorship Services. Family Based Safety Services are provided to caregivers in the hopes that children can safely remain at home or return home safely by supporting families' abilities to protect their children and reduce future threats to their safety. Conservatorship is when the decision has been made to place children out of their homes short-term or permanently if they cannot remain safely in their homes.

From 2019 until 2022, the number of children in Family Preservation has decreased dramatically from 9,066 cases to 3,312 cases, 92.97%. The number of children in Conservatorship has also reduced from 4,892 to 2,984, a decrease of 48.45%.[50] Figure H2 below summarizes these data:

Year	Total 0-17	CPS Served in FPR	CPS Served in Conservatorship
2022	1,368,422	3,312	2,984
2021	1,349,783	8,173	3,640
2020	1,330,726	8,762	4,072
2019	1,310,915	9,066	4,892

Figure H2 CPS data – children in Family Preservation and under conservatorship, 2019 – 2022

Schools have ordinarily served as an interface between children, families, and the community. The Harris Center has observed that referrals for behavioral or emotional disorders among children and adolescents rise and fall with the school year. Public hospitalizations and outpatient clinic services drop off during school holidays and summer vacations. During the pandemic, this link to the community and the socializing influence of the schools has been diminished by remote learning. New requests to the Center for outpatient services (intake assessments) among children and adolescents have risen 12.6% from FY20 to FY21 despite closing more than 40 school-based clinic sites. The trend has continued, with 58% more children and adolescents served as compared to pre-pandemic levels.

In a national survey of 3,300 high school students, America's Promise Alliance reported:

> "Since their school buildings closed, young people's levels of concern about the present and future have increased, and indicators of overall health and wellbeing have suffered. For example, 30% of young people say they have more often been feeling unhappy or depressed, and nearly as many say they are much more concerned than usual about having their basic needs met. More than one-quarter of students (29%) say they do not feel connected at all to school adults. A similar percentage do not feel connected to classmates or to their school community."[51]

The CDC noted that hospital emergency departments (EDs) often serve as the first points of contact for services when access is limited. While noting an overall decrease in ED visits, they observed:

[50] DFPS Data Book (texas.gov)
[51] The State of Young People during COVID-19 (America's Promise Alliance)

> "…the proportion of mental health-related ED visits increased sharply beginning in mid-March 2020…and continued into October… with increases of 24% among children aged 5-11 years and 31% among adolescents aged 12-17 years, compared with the same period in 2019."[52]

While not definitive, these findings underscore the importance of monitoring the impact of COVID-19 on this age group.

As cited in JAMA Pediatrics, the COVID-19 pandemic may worsen existing mental health problems and lead to more cases among children and adolescents because of the unique combination of the public health crisis, social isolation, and economic recession.[53] Economic downturns are associated with increased mental health problems for youth that may be affected by the ways that economic downturns affect adult unemployment, adult mental health, and child maltreatment.

Since the pandemic started in 2020, many have been concerned about the prevalence of mental health issues in children and adolescents. During the 2021 school year, 31.3% of Texas high school students completing the Youth Risk Behavior Survey (YRBS) reported that their mental health was "most of the time" or "always" not good." The YRBS also found that 44.6% of Texas students reported feeling so sad or hopeless almost every day for two weeks or more in a row that they stopped doing some usual activities during the past 12 months. In addition to mental health issues, suicide rates also have seen an increase in high school students. Twenty-one percent of students reported "making a plan to attempt suicide," while 12% reported that they actually attempted suicide. These data are concerning for Texas but especially so for the Houston area, which has seen an increase in children reporting to emergency rooms for urgent mental health needs. Texas Children's Hospital, for example, reported a staggering 800% increase in children reported to the emergency room with a mental health crisis. [54] Texas Children's also reported that 400 to 450 children and adolescents are reporting to emergency centers with mental health crises such as suicidal ideations and aggressive behaviors. This is compared with the roughly 50 kids per month during pre-pandemic years.

[52] Mental Health–Related Emergency Department Visits Among Children During the COVID-19 Pandemic, by Leeb, et al. (2020). MMWR Weekly Report.
[53] Coronavirus Disease 2019 (COVID-19) and Mental Health for Children and Adolescents, by Golberstein, et al. (2020). JAMA Pediatr.
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Mental Health Needs Council's Recommendations

Mental health is critical to the community's collective health; thus, Houston's leaders must acknowledge that good health is not merely defined by lack of sickness.

The Mental Health Needs Council recommends that the governor of Texas, members of the legislature, Harris County Commissioners Court, and the Health and Human Services Commission should:

1. Enhance funding for the public mental health safety net
2. Expand service capacity commensurate with estimated community need
3. Balance resources between crisis services and ongoing care
4. Support integrated care for individuals with behavioral disorders
5. Continue to develop alternatives to incarceration of individuals with mental disorders
6. Prioritize the development of housing and residential services
7. Support professional workforce development
8. Increase funding in public schools to prevent, evaluate, treat, and educate students with behavioral needs
9. Support local control and accountability for public mental health services

These proposals are crucial to delivering effective, optimal, and necessary care to the residents of Harris County.

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Appendix A

Prevalence Estimation Methodology

Introduction

To provide meaningful estimates based on the most rigorous and contemporary epidemiological sources available regarding the overall prevalence of serious emotional disturbance (SED) and serious mental illness (SMI), we utilize the work of Dr. Charles Holzer.[7] In 2014, we commissioned Dr. Holzer to estimate the prevalence of SMI in Texas counties, using 2012 and earlier data. We believe that Dr. Holzer's original SED and SMI estimates and our adaptation of his data, findings, and methodologies to current Texas populations provide the most practically relevant estimates. The method, described in detail below, uses statistical formulas that apply national prevalence rates to Texas population and demographic data.

Estimating the prevalence of specific mental illnesses such as bipolar disorder, depression, or schizophrenia in different age groups (e.g., children, youth, adults) is a more complicated endeavor – one requiring us to incorporate the best available national studies of the prevalence of those specific disorders. In cases where these alternative epidemiological sources are used, they are always cited and represent what we consider the best available contemporary source.

Holzer and "Horizontal Synthetic Estimation"

Beginning with his work at the University of Florida in the 1970s, Holzer drew connections between established data (drawn largely from census data), demographics, and the careful study of how these factors correlated with various needs among populations. Holzer derived principles about these connections, as presented in the Mental Health Demographic Profile System (MHDPS). This system matched demographic data from the Florida Health Survey with community demographics and known needs for mental health services, creating a model for estimating needs in places and situations where survey data were unavailable.

The method, which those on the MHDPS team termed "Horizontal Synthetic Estimation," evolved as Holzer refined his work. A crucial step came in the 1980s, following the National Institute of Mental Health's Epidemiologic Catchment Area (ECA) program, the most extensive psychiatric epidemiological study in the United States at the time. Holzer used ECA findings to develop a series of prevalence estimates for the Texas Department of Mental Health and Retardation. This project led to several similar projects in Colorado, Ohio, and Washington State. Following the 1990 Census and the 1993 National Comorbidity Survey (NCS), Holzer developed estimates in other states, including Colorado, Wyoming, and Nebraska, including county-level prevalence estimates.

Holzer's method represented a departure from previous, less-precise methods. He argued that prior approaches mistakenly assumed that local mental health systems served all people with mental health needs. He also criticized indirect methods of estimation, such as those using social indicators (crime levels, poverty, divorce, etc.) with no data on mental illnesses.

Holzer argued that if prevalence estimates and their correlates with demographic characteristics from national epidemiological studies were applied to state and county populations, he could provide more precise estimates of mental health needs. He used statistical methods that analyzed survey data from the 2001–2003 Collaborative Psychiatric Epidemiology Surveys to estimate the relationships between seven socio-demographic characteristics (i.e., age, sex, race/ethnicity, marital, education, poverty, housing status) and SED and SMI

prevalence rates. He then applied these rates to the most up-to-date, available county- or state-level American Community Survey (ACS)[8] population and demographic data, including estimates of the number of people the same seven socio-demographic characteristics can categorize.

MMHPI Adaptation of Holzer's Methodology and Data

In 2014, we hired Dr. Holzer to perform a revised county-level estimate throughout Texas, using 2012 three-year ACS data (the most recently available data). Dr. Holzer then licensed the methodology for use in estimating prevalence in Texas. From this work, and using Dr. Holzer's findings, especially his 2012 MMHPI-commissioned Texas estimates, we have developed a new series of 2019 estimates utilizing the 2019 ACS five-year dataset and the 2019 population estimates. These data were the most current at the time of our analysis.

Appendix B

Meadows Mental Health Policy Institute

Serious Emotional Disturbance and Serious Mental Illness Among Harris County Residents

The Meadows Mental Health Policy Institute. (2022). *Serious Emotional Disturbance and Serious Mental Illness Among Harris County Residents – 2020.* Available upon request.

Twelve-Month Prevalence of Mental Health Disorders Among Children, Youth, and Adults Among Harris County Residents (2020)

	Prevalence (% of Population)
Total Population – Children and Youth (Ages 6-17)[3]	**840,000**
Serious Emotional Disturbance (SED)[4]	65,000 (8%)
Total Population – Adults (Ages 18+)[5]	**3,450,000**
Serious Mental Illness (SMI)[6]	140,000 (4%)