Behavioral Health in Harris County:
Who's Who and What They Do

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Acknowledgments

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Purpose of the Study and Methodology

The mental health of our community is an issue of growing concern in Harris County. In surveys and community conversations around the region, concerns have centered around several issues[1]:

- A lack of awareness about resources that are available and how to access them;
- Insufficient availability of mental health services;
- How to recognize when someone is in need of mental health support and how to refer them to services if needed;
- Stigma related to seeking mental health care and how to support people experiencing mental illness/mental distress more effectively.

"People just don't know what to do. It is not easy to access care." [2]

Although recent studies have been conducted about mental health services in Harris County, these studies have focused largely on the public mental health system - understood as The Harris Center (MHMRA), Harris Health, and the Federally Qualified Health Centers (FQHCs) in the region – which provides services predominantly for those with severe mental illness. But to look only at these providers and this narrow population is to overlook, and potentially underutilize, a number of agencies that provide valuable services to people who are not severely mentally ill but have a need for mental health and/or substance use services.

Accordingly, the purpose of this study is to get a more expansive understanding of behavioral health services available in Harris County, where behavioral health services are understood to include mental health services, substance use treatment and prevention, and integrated health care. The goal is to identify agencies that provide these services in Harris County and describe the services they offer, the population they serve, and their organizational capacity.

Several criteria guided the selection of agencies to include in the study. Specific interest was in providers that offer outpatient clinical services to residents who live in Harris County. Given the focus on direct clinical services, agencies that provided only education, support groups, hotlines, or referrals were excluded. Once these criteria were established, local resource listings - including 211, UTHealth's Harris County Psychiatric Center, The Guide from Mental Health America of Greater Houston, and membership of the Network for Behavioral Health Providers (NBHP) - were reviewed to develop a comprehensive list of agencies to include.

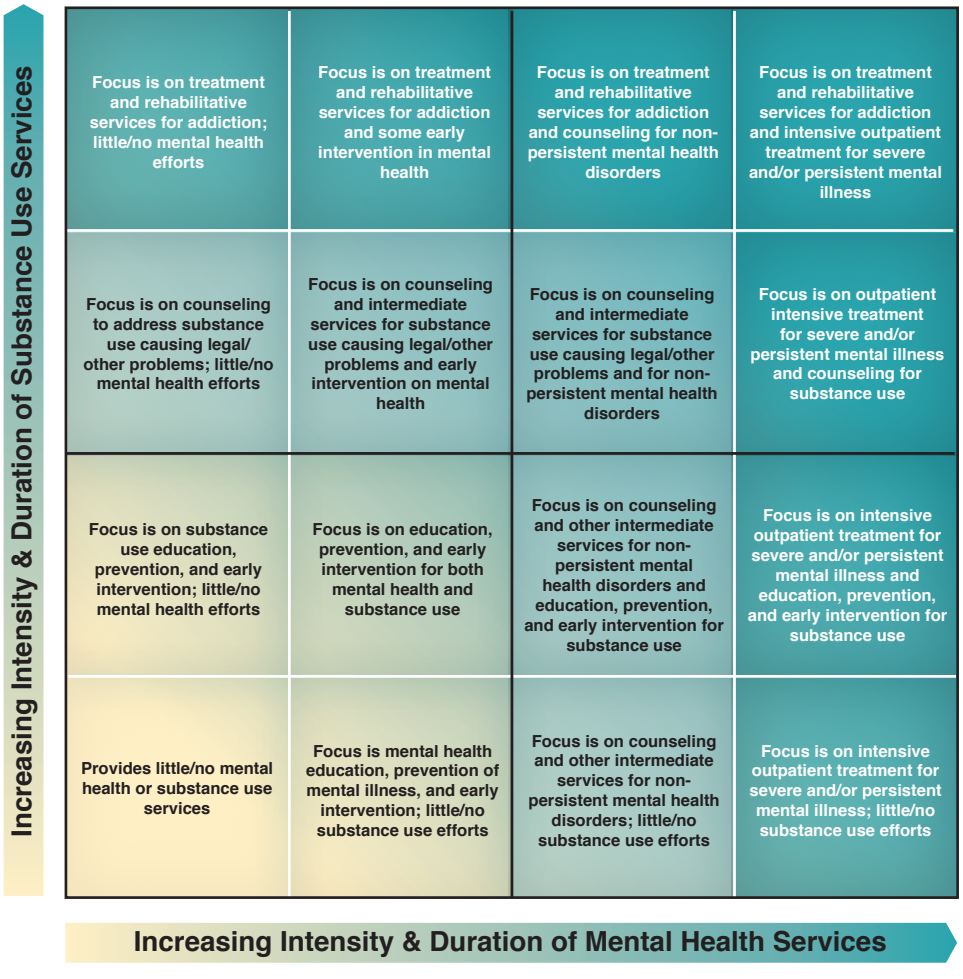
1 Items listed were noted specifically in a survey conducted by Episcopal Health Foundation. Article found at https://www.episcopalhealth.org/en/congregational-engagement/congregation-connection/congregation-connection-october/congregations-and-mental-health/

2 Ibid

Upon conclusion of this selection process, a total of 61 behavioral health agencies were invited to participate in the study. Agencies that participated were asked to complete a comprehensive survey about their services and organization, and to participate in a follow-up interview. Agencies that participated fully in the process were given a $500 incentive payment in appreciation of agencies sharing their time and expertise.

Finally, to focus the description of each agency's services, a revised version of SAMSHA's 4 Quadrant Clinical Integration Model was developed to understand where agency services fell along the mental health and substance use continuums of care – from prevention and early intervention, to counseling for non-persistent issues, to intensive treatment for severe or persistent issues – and the extent of their integration of these services. While most agencies provide some level of services along a continuum, agencies were placed into the revised model based on the emphasis of their work. The intention is to highlight where agency strengths lie on the continuums so that referrals to agencies can be targeted effectively.

The model below provides a description of the nature of services offered at key points along the mental health and substance use continuums. The research team initially placed agencies into the model based on what was learned during the study. Agencies were subsequently offered the opportunity to review and approve the placement. The chart on page 19 of this report shows where agencies are placed into the completed model.



Who is Included in the Study

INCLUDED IN THE STUDY		
PRIMARILY MENTAL HEALTH (MH)	PRIMARILY SUBSTANCE USE (SU)	INTEGRATED HEALTH CARE (IHC)
Bo's Place	Archway Academy	Baylor Teen Health Clinic (Baylor THC)
Catholic Charities	Houston Recovery Center	El Centro de Corazon
Children's Assessment Center (CAC)	Santa Maria Hostel	Hope Clinic
Communities in Schools (CIS)	Teen & Family Services	Legacy Community Health
Daya	The Council on Recovery	Memorial Hermann Behavioral Health Services
DePelchin Children's Center	The Salvation Army	Spring Branch Community Health Center (SBCHC)
Family Houston	Unlimited Visions Aftercare	Texas Children's Psychology Services (TCH)
Harris Center	Volunteers of America (VOATX)	Vecino
Hope & Healing Center		
Houston Area Women's Center (HAWC)		
Houston Galveston Institute (HGI)		
Inner Wisdom		
Innovative Alternatives		
Jewish Family Services (JFS)		
Memorial Assistance Ministries (MAM)		
Menninger Clinic		
Montrose Center		
Nick Finnegan Counseling Center		
The Alliance for Multicultural Services		
The Lighthouse of Houston		
University of Houston ADAPT		
University of Houston Anxiety Clinic		
Youth Advocate Programs		

Sixty-one (61) primarily mental health, substance use, and integrated healthcare agencies were invited to participate in the study and 40 agencies participated fully.[3] Given the size of agencies that participated and of those that did not, these summary findings represent about 90% of services provided.

These findings represent a snapshot of the supply of behavioral health services provided in Harris County. Without an estimate of demand for behavioral health services among the general population, the extent to which the supply of services meets demand cannot be determined.

3 Note that Clearhope Counseling participated fully in the study. However, understanding that the majority of the agency's work is for-profit, Clearhope was taken out of the study to keep the focus on non-profit services.

In recruiting agencies to participate in the study, a few issues emerged that temper the findings in this report:

1. Because not all invited agencies participated in the study, the total numbers reported here likely under-estimate the number of people who received behavioral health services in Harris County in 2018.
    a. Among Primarily Mental Health agencies, 23 of 35 (66%) invited agencies participated. However, given what is known about the capacities of the agencies, those that did participate likely serve the vast majority of people served in primarily mental health settings, lending confidence about numbers reported in this care setting.
    b. Among Primarily Substance Use agencies, 8 of 12 (67%) invited agencies participated in the study. In this instance, some relatively large agencies did not participate. As a result, numbers reported here likely under-count people served in this care setting.

    c. Among Integrated Healthcare (IHC) agencies, 8 of 16 (50%) invited agencies provided data for the study. Although Harris Health did not participate in this study, diagnosis data collected from a 2017 study of primary care providers in Harris County was used to estimate the total served with behavioral health services by Harris Health. Similarly, Healthcare for the Homeless did not fully participate, but they provided numbers served, which were included in the total. While the IHC agencies that participated are the largest providers of behavioral health services in this setting, the number served reported here is likely an under-estimate of people served in this care setting.

2. Unlike federally funded community health centers that use a set of common measures and definitions that can be aggregated to assess the volume of patients served and various health outcomes at a given level, there are no common measures that are used within the behavioral health field. As a result, some of the data reported by agencies was incomplete or incomparable, creating challenges to aggregating and reporting totals. As such, the results presented in this report represent a best estimate based on the data agencies were able to provide accurately. It is worth noting that while some of the data here is incomplete, much has been learned about agency data that can provide guidance for how data in the field can be improved to enhance understanding about the sufficiency of supply and outcomes.

3. Finally, findings presented here represent only a snapshot of the supply of behavioral health services provided in the region. Lacking an estimate of demand for behavioral health services beyond the severely ill population prevents an assessment of the extent to which the services described here meet existing need.

Care Settings and Accessibility

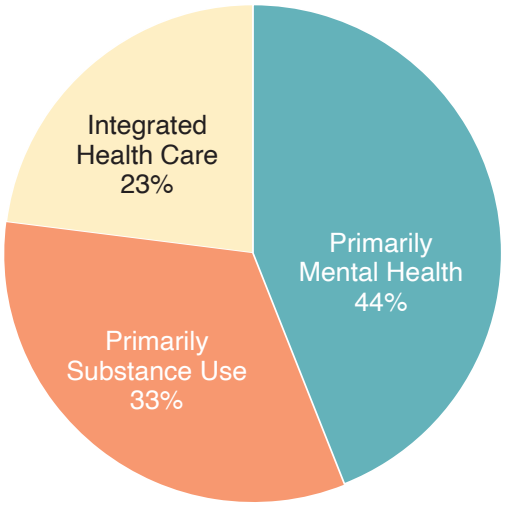
To increase clarity about the nature of services provided in Harris County, agencies were grouped into three care settings – Primarily Mental Health, Primarily Substance Use, and Integrated Healthcare – in order to compare their populations, services, and funding streams.

While more than 282,000 clients were served with behavioral health services in 2018, there are questions about sufficiency of services and accessibility of services to the general population.

Taken together, agencies that participated in the study served more than 282,000 clients in 2018.[4] The distribution of care among the different settings was somewhat balanced, with 44% of people receiving care in primarily mental health settings, 33% receiving care in primarily substance use settings, and 23% being served in an integrated healthcare setting.

4 While the number reported by each agency is unduplicated, some patients may seek behavioral health services at more than one agency throughout the year. As such, it is possible that the total unduplicated number reported (282,000) may include some duplicates between agencies. Due to the nature of this study, it is not possible to assess duplication between agencies.

Percentage of Total Served by Care Settings

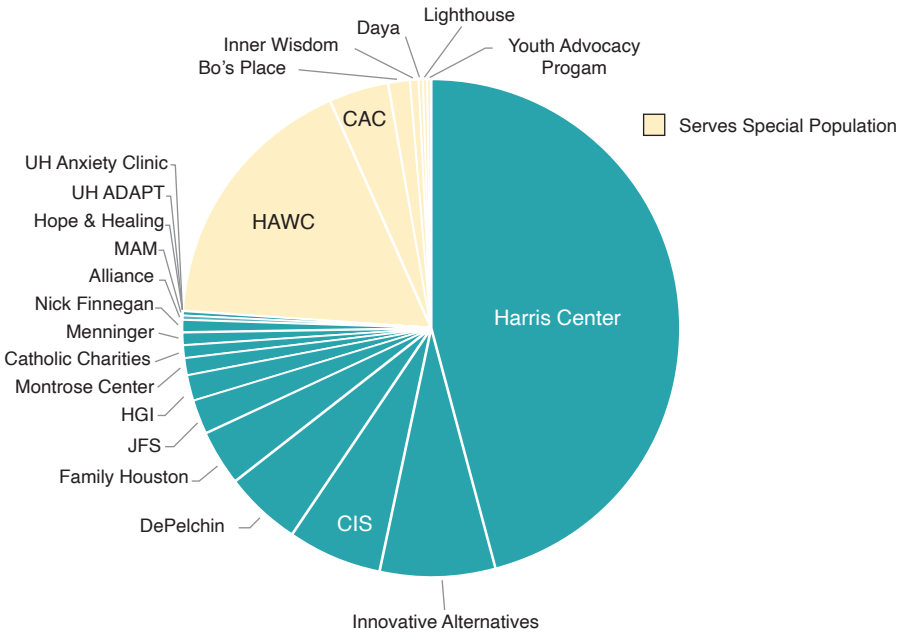


However, within each care setting, the distribution of patients served was more uneven between agencies which raises questions about sufficiency of services and accessibility of services to a general population.

Primarily Mental Health Setting

Within the primarily mental health setting, 125,000 clients were served in 2018. Harris Center served nearly half (46%) of these clients, with the remaining 22 agencies serving a little more than 67,000 clients. Given the significantly greater resources at the disposal of Harris Center, the imbalance in clients served is not a surprise.

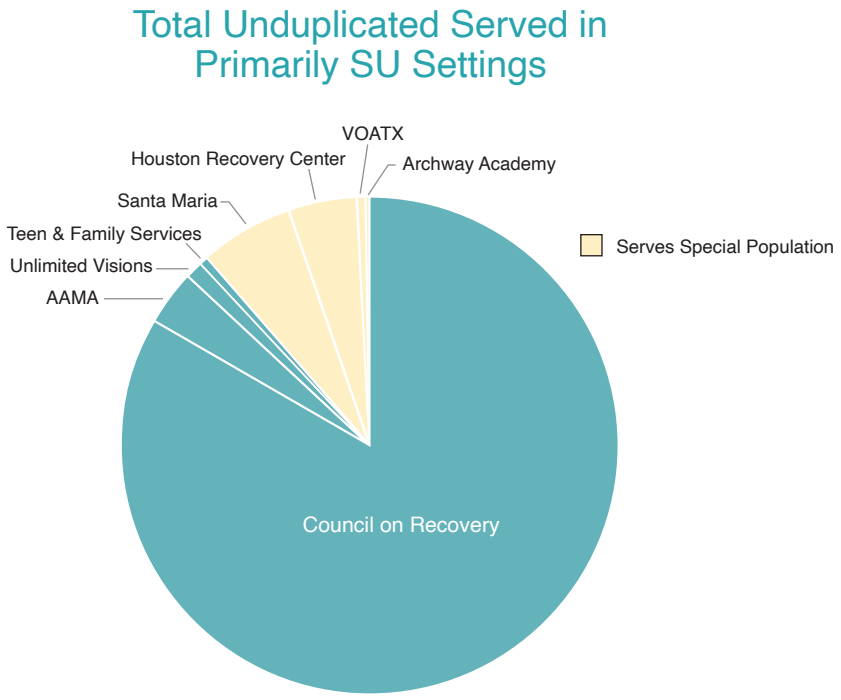
Total Unduplicated Served in Primarily MH Settings



However, from the viewpoint of accessibility of services for the general population, it raises a concern. Seven (30%) of the 23 agencies serve special populations, which is to say that the services are not available to the general population without meeting certain criteria (e.g., suffering grief from the loss of a family member or being a victim of domestic violence). The picture of accessibility for the general population diminishes even more given that Harris Center's outpatient services are focused primarily on keeping a severely mentally ill population stable in a community setting. Regarding Harris Center more appropriately as an agency serving a unique population (the severely mentally ill) greatly reduces the availability of mental health services for the general population.

Primarily Substance Use Setting

Within the primarily substance use setting, the eight primarily substance use agencies served a total of 93,000 clients in 2018[5]. The Council on Recovery served 84% of those clients, their larger number reflecting people served with educational programming as well as clients served with counseling services. Of the remaining seven agencies that reported numbers served in counseling and treatment services, five serve special populations (including adults who are legally detained for intoxication, ex-offenders, and youth needing alternative educational settings).

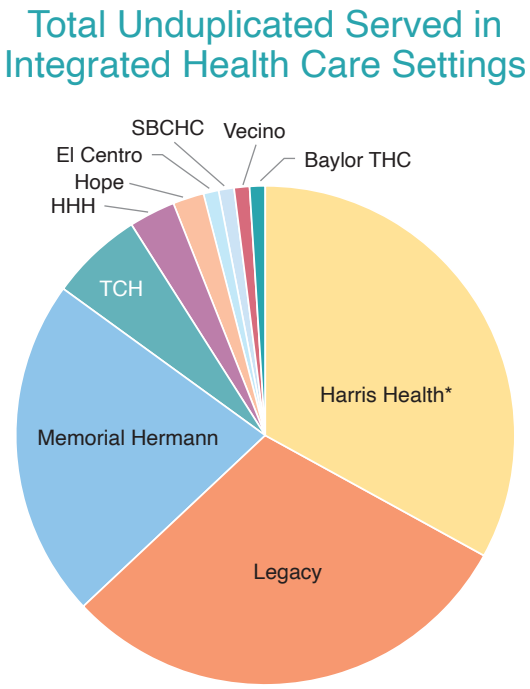


Integrated Health Care Setting

In 2018, the 10 integrated healthcare agencies, all of which serve a general population, served nearly 65,000 people with integrated health services. Harris Health, Legacy, and Memorial Hermann account for 85% of clients served in this setting. While the nature of behavioral health services provided in integrated healthcare settings continues to evolve, much of the care in this setting is focused on psychiatry, if only because these agencies

5 Note that AAMA did not participate in the study, but an estimate of people served as pulled from their 2018 annual report was used to get a better estimate of people served in this setting in 2018. Also, The Salvation Army did not provide total unduplicated served so they are not included in this total or the chart below.

have access to most of the psychiatrists in the region. To the extent that there is duplication of clients among agencies, it is in this setting, as many of the primarily mental health agencies send their clients to these agencies – especially to Harris Health and Legacy – to receive psychiatric care.



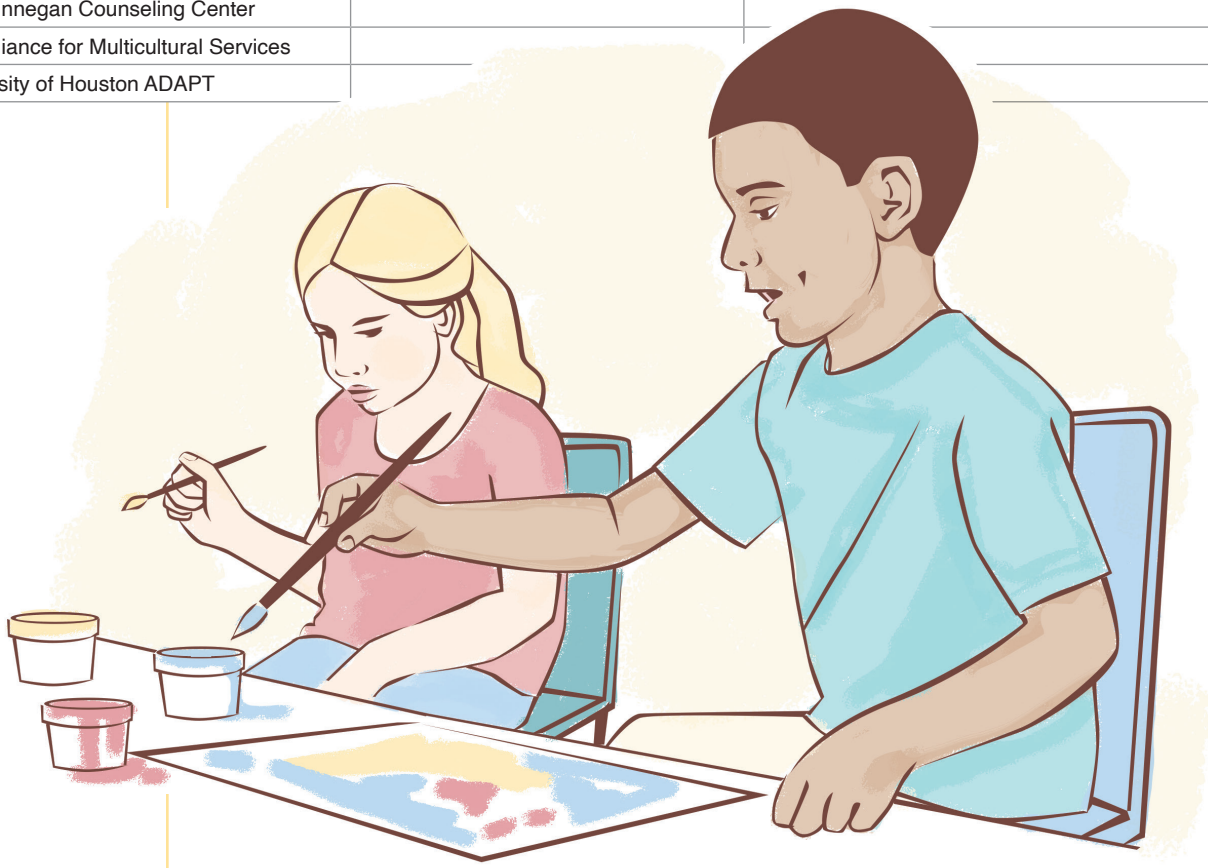
** Harris Health numbers are estimates based on 2017 data*

Behavioral Health Services in Schools

Another setting in which behavioral health services are growing rapidly is in schools. Among the agencies that participated in the study, 22 currently offer some level of services in schools and several others report plans to work in schools in the coming year. The extent and nature of the services offered in schools varies; some agencies provide targeted counseling or early intervention programming through a collaboration with Communities in Schools while others have larger scopes developed in partnership with specific schools.

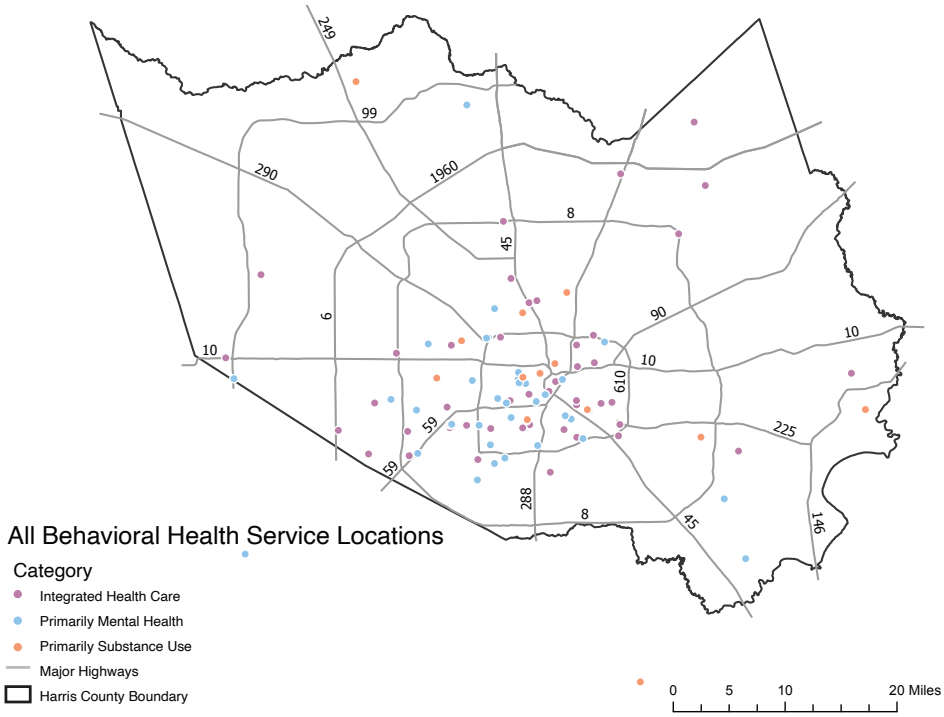
A lot of behavioral health services are being offered in schools. However, not enough is known about what is happening in individual schools or school districts to know if the efforts are being leveraged for the best impact.

AGENCIES PROVIDING SERVICES IN SCHOOLS		
Primarily Mental Health (MH)	Primarily Substance Use (Su)	Integrated Health Care (IHC)
Bo's Place	The Council on Recovery	Baylor Teen Health Clinic
Catholic Charities	Santa Maria Hostel	Legacy Community Health
Communities in Schools	Teen & Family Services	Memorial Hermann Behavioral Health Services
DePelchin	Unlimited Visions Aftercare	Vecino
Family Houston		
Harris Center		
Houston Area Women's Center		
Houston Galveston Institute		
Innovative Alternatives		
Menninger Clinic		
Montrose Center		
Nick Finnegan Counseling Center		
The Alliance for Multicultural Services		
University of Houston ADAPT		



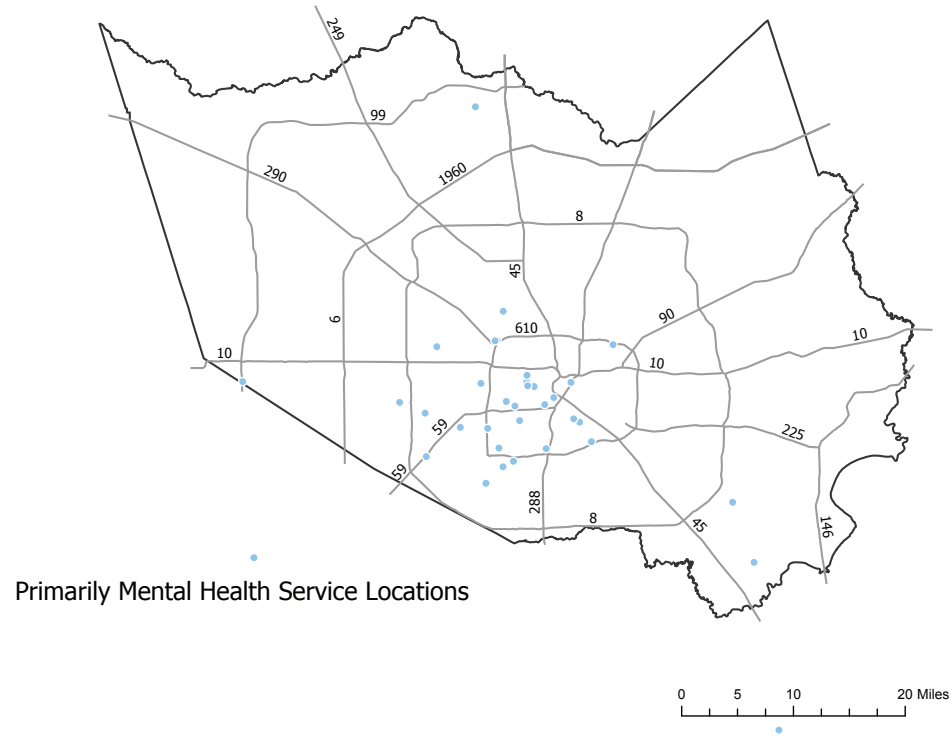
Geographic Accessibility

When all the service locations of participating agencies are mapped, it appears that services are located throughout the county with a concentration inside Loop 610.

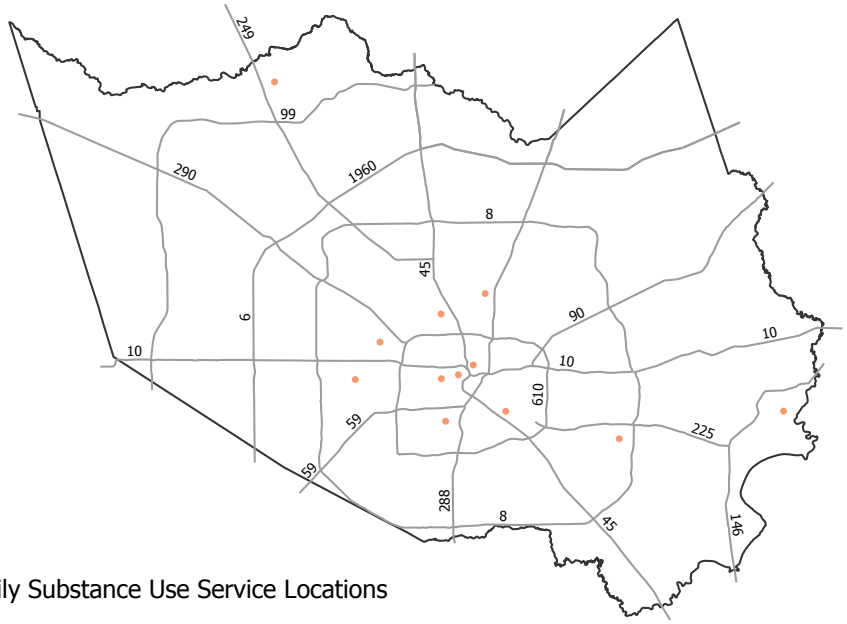


However, when broken down by care settings, gaps in accessibility become evident:

- Primarily MH providers are largely in the center/SW portion of the county, with few services available in the eastern and northern portions of the county.

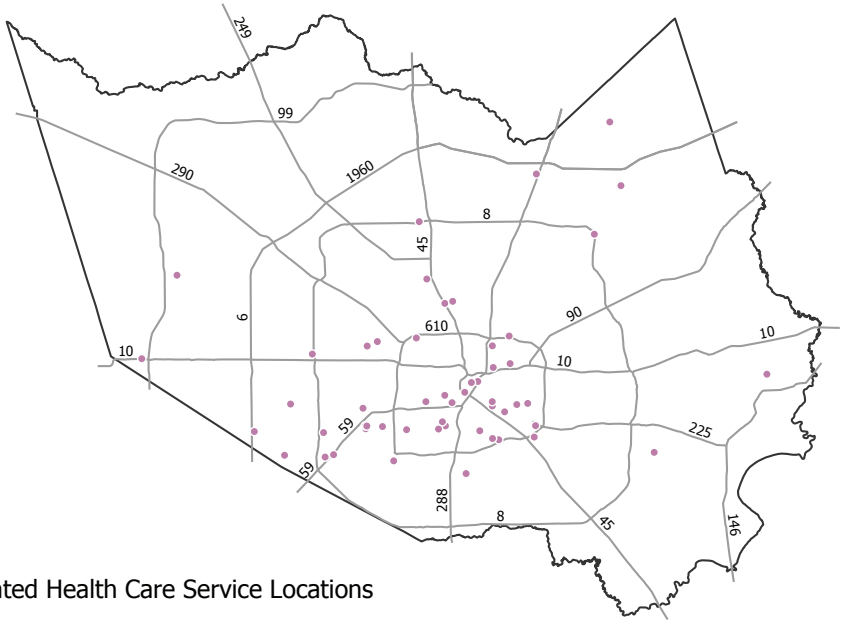


- Substance use providers appear to be even more concentrated in the center of the county, within Beltway 8.
- IHC services appear to have more coverage, but the distribution of IHC locations may



Primarily Substance Use Service Locations

overstate the availability of behavioral health services as services are not available at every clinic location.

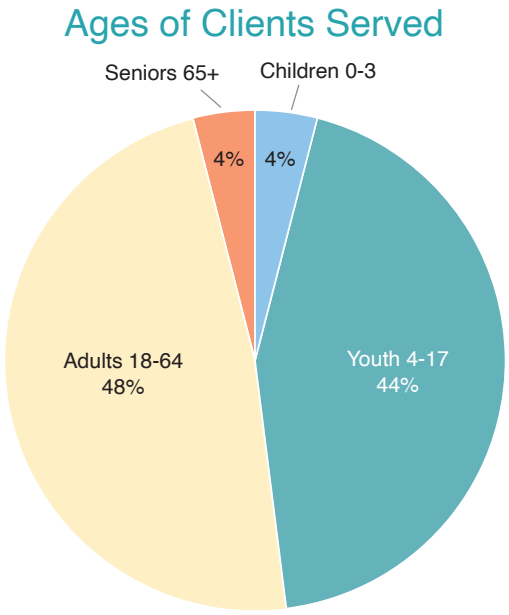


Integrated Health Care Service Locations

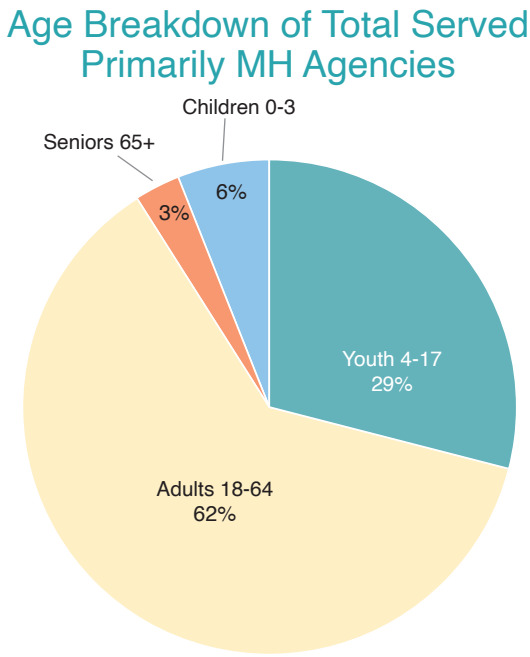
Clients Served

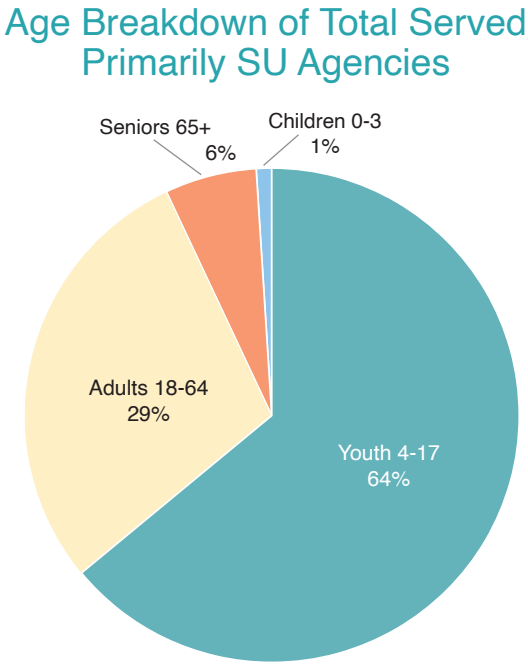
A good picture of the population that was served by behavioral health agencies in 2018 is hard to capture given that many agencies collect limited information about clients. Besides enrollment and client age, there is little other demographic data that is uniformly collected by all agencies.

Looking at the ages of people served, it appears that services were evenly split between youth and adults.



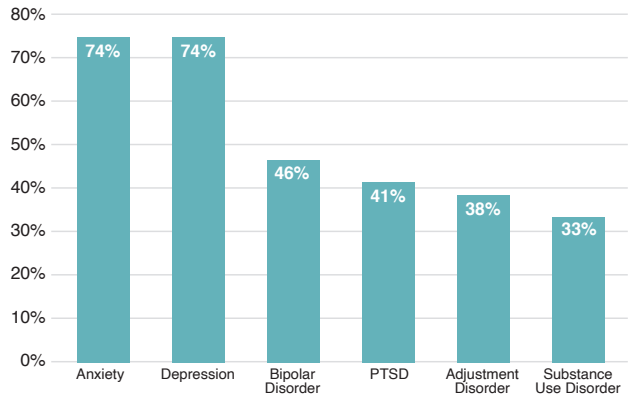
However, looking at age by care setting shows that primarily mental health agencies are more likely to be serving adults while primarily substance use agencies and integrated healthcare agencies are more likely to serve youth.





Regardless of age, it is perhaps no surprise that anxiety and depression are the top diagnoses of clients.[6] Nearly every agency noted the high levels of trauma they are seeing among patients. It is surmised that trauma is increasing as sources of stress and trauma – including storms, immigration policies, gun violence, social media, and the pressures of busy lives – become more ubiquitous.

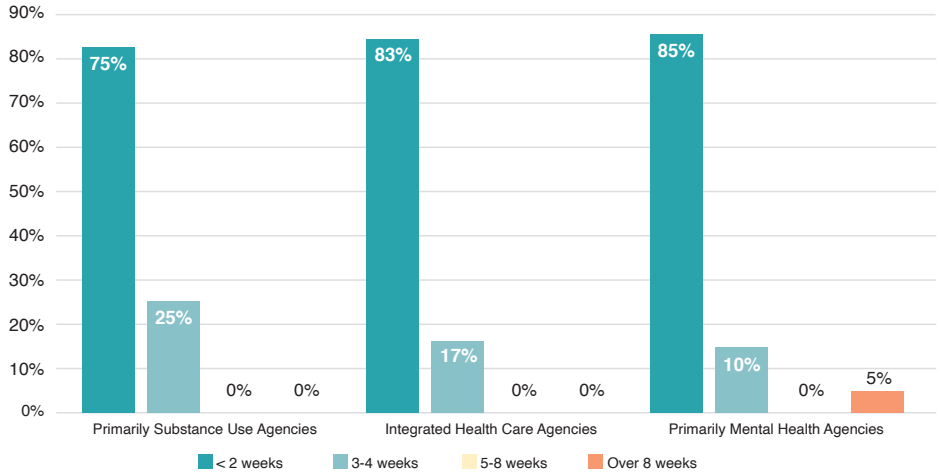
Top Diagnoses - Percentage of Agencies Listing the Diagnosis Among their Top 5



When asked about barriers that clients face in accessing care, agencies cited transportation and language barriers most frequently. Notably, wait times do not appear to be a barrier to accessing services other than psychiatry. Nearly every agency reported being able to get a client into care within two weeks of initial contact. While a two-week window may not always be an acceptable wait time for clients in need of behavioral health care, the data suggests that behavioral health agencies have capacity to serve more people.

"There's a lot of urban legend around wait lists. I think waits to see a psychiatrist are real; however, it is relatively easy to get in to see a counselor." – Agency CEO

Wait Times by Care Setting
(Percentage of Agencies in Each Care Setting)

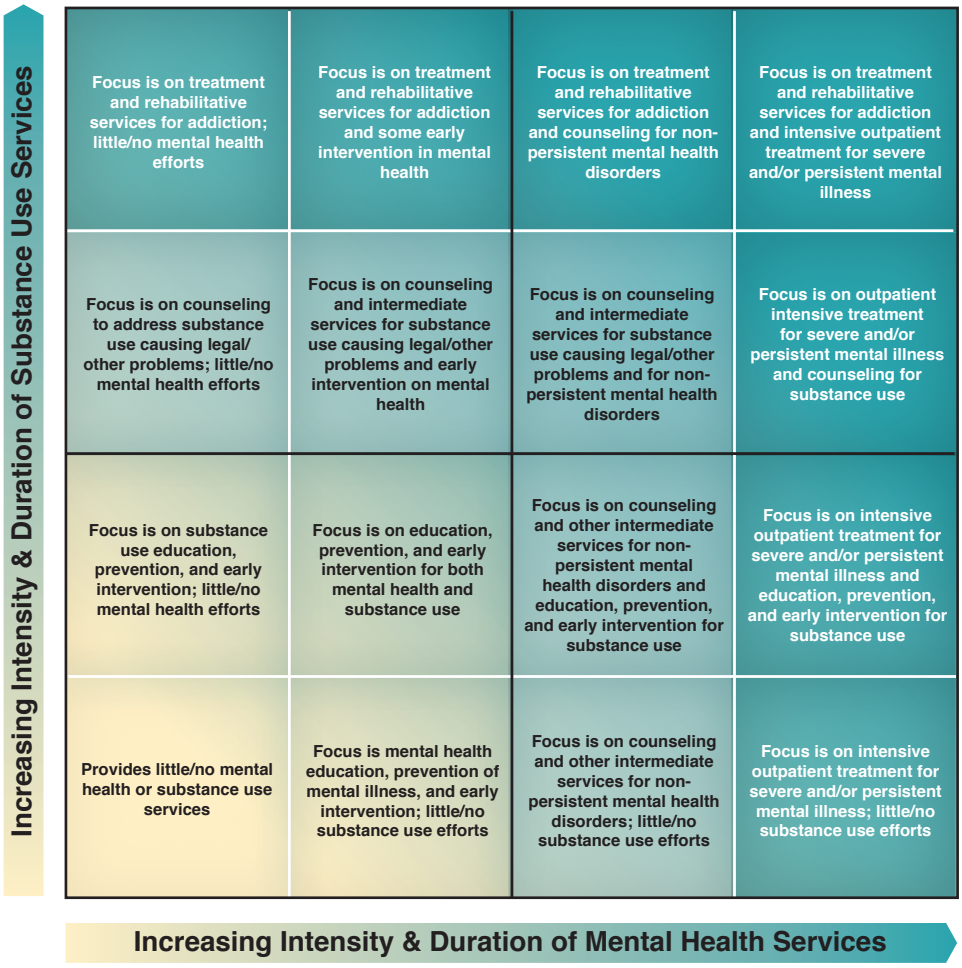


6 Agencies reported their top 5 diagnoses but not in rank order. The percentage reported in the graph represents only the percentage of agencies with a particular diagnosis in their top 5 diagnoses in 2018.

What Agencies Do

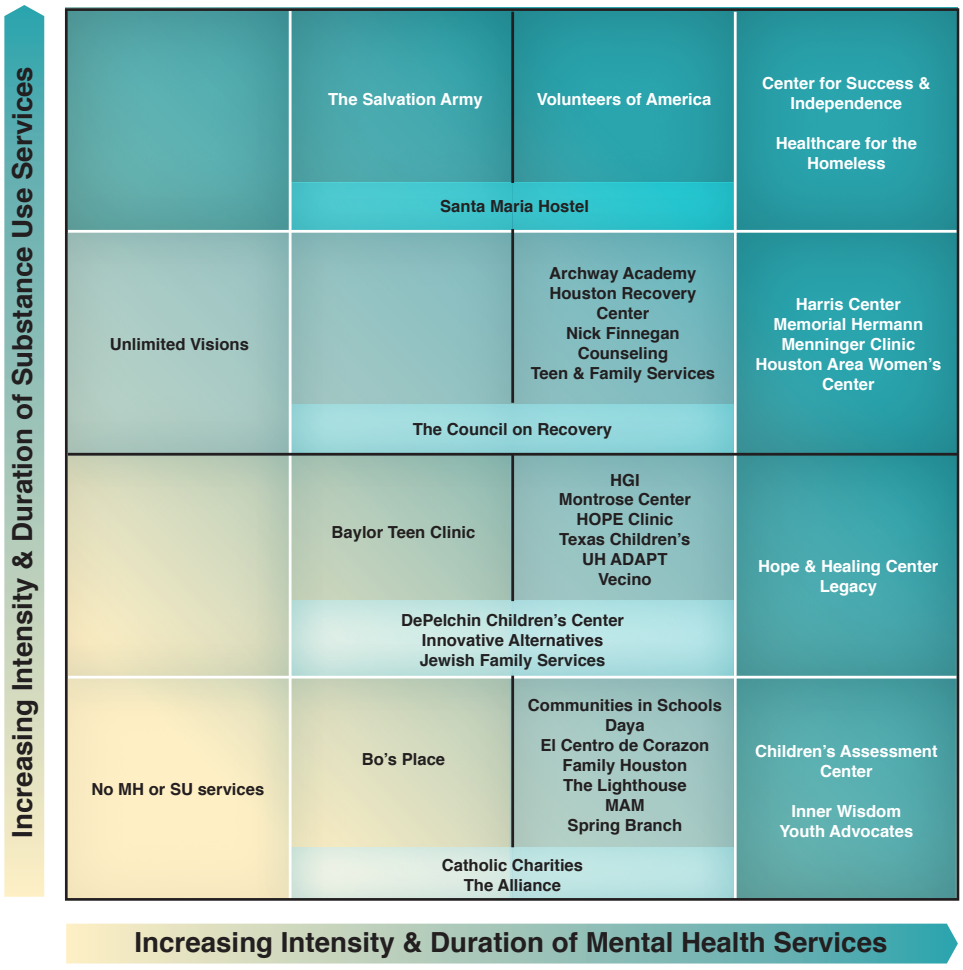
A key goal of the study is to understand the services that each agency offers. In trying to place agency efforts along mental health and substance use continuums of care – from education to early intervention, to counseling, to intensive treatment – the study found that, at the client level, agencies provide some level of all services along a continuum. This is to say that throughout the course of serving a client, an agency will often provide education, early intervention, address a crisis, and offer counseling and other supports to help clients achieve their goals.

Accordingly, in order to emphasize the *primary strength* of each agency along the continuums of care and aiming to clarify the level of integrated behavioral health that agencies can provide, the SAMSHA Four Quadrant Clinical Integration Model was revised and descriptions of the nature of care at key points along the continuums was developed.



Agencies were then placed into the model, as shown in the chart on the next page. Along the mental health continuum, agencies that are on the left side of the continuum have an emphasis on education and early intervention. Agencies on the right side of the continuum focus on counseling or treating more severe/persistently mentally ill clients in an outpatient setting. Agencies that span both sides of the continuum have intentional education (such as Mental Health First Aid) and/or early intervention programming that is offered to the general population as a specific service line.

Similarly, on the substance use continuum, agencies that are in the bottom half of the continuum have an emphasis on education and early intervention. Agencies on the top half of the continuum serve clients that are experiencing legal or other problems related to substance use or are treating clients with an addiction.



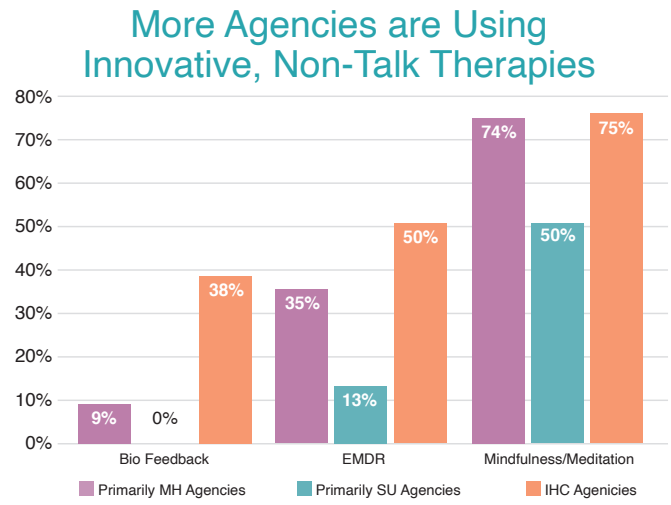
It is perhaps notable that so few agencies are focused on education and early intervention along both continuums. This could be a function of the agencies that were selected to participate in the study, as agencies that offered solely education, support groups, hotlines, or referrals were excluded. Alternatively, it could be a reflection of the stigma around seeking care, as several agencies noted that many clients wait until their condition is more serious before seeking help. A further explanation could be attributed to how agencies are funded, as funding is more often available to serve people in need of more intensive services.

It is also evident that many providers are not well-positioned to offer integrated behavioral health, which recognizes and addresses co-occurring mental health and substance use disorders. This is especially the case among primarily mental health and integrated healthcare agencies. Of the 23 primarily mental health providers in the study, eight (35%) reported having no capacity to address substance use issues and six (26%) offer limited educational services around substance use. While several of these agencies noted that they will connect their clients to a substance use provider and work with that provider – assuming client approval – in the client's care, the level of integration in these arrangements appeared to be low.

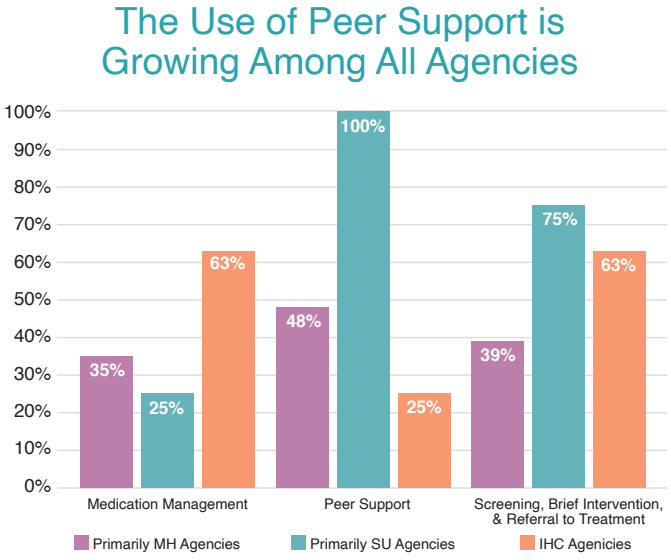
Counseling Practices

Cognitive Behavioral Therapy (CBT) is the primary practice used by behavioral health agencies, but an increasing number of agencies are incorporating more non-talk therapies into their toolkits. Use of Eye Movement Desensitization and Reprocessing (EMDR) is growing rapidly among primarily mental health agencies as they are finding this to be an especially useful approach for serving clients with trauma. Mindfulness and meditation are also being incorporated more completely into all care settings, either as a stand-alone practice or integrated into the overall practice approach used with clients.

While Cognitive Behavioral Therapy is still the primary practice used by behavioral health agencies, an increasing number of agencies are incorporating more non-talk, best practice therapies into their toolkits.

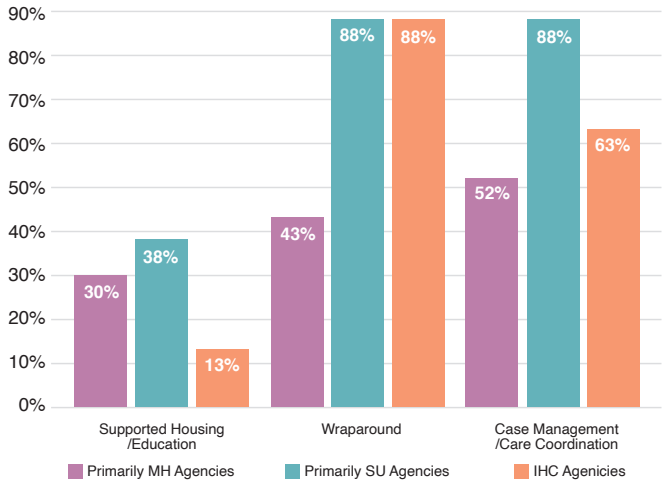


Another growing practice within all care settings is the use of peer support. While use of peer support is a best practice used most commonly among primarily substance use providers, it is being used increasingly among primarily mental health agencies as a tool to support their clients.



Finally, wraparound supports – such as connecting clients to basic needs, supportive housing and job supports - are also an area of growing practice as agencies understand the impact of, and work to address, social determinants of health that are influencing clients' emotional states. Wraparound services are offered mostly by primarily substance use and IHC agencies, though more primarily mental health agencies are implementing these supports as funding allows.

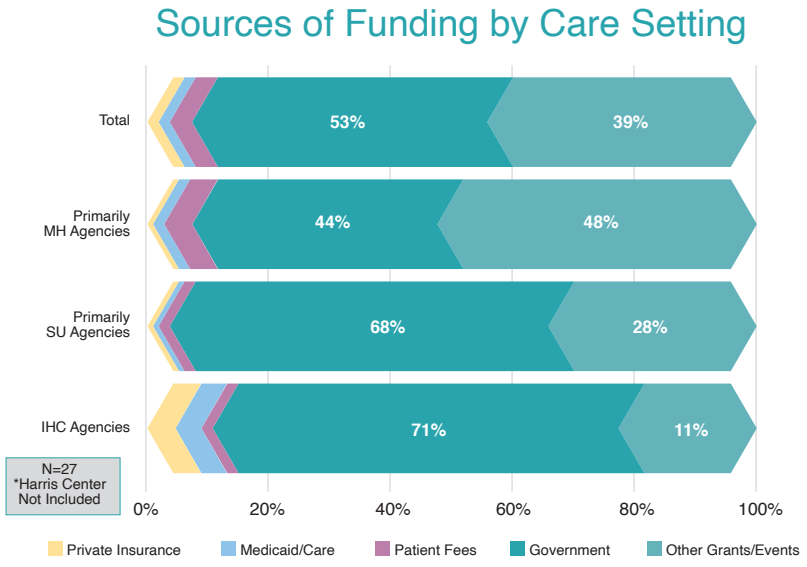
Agencies Using Non-therapeutic Support Services Are Also on the Rise



Sources of Funding

The analysis of agency finances identified a high reliance on government and philanthropic funding for behavioral health services in Harris County. Taking Harris Center out of the analysis on the grounds that their funding source and volume is unique, the majority of funds (53%) for behavioral health services comes from government grants - including Victims of Crime Act (VOCA) funds, Delivery System Reform Incentive Payment (DSRIP) funds, Texas Education Agency (TEA) funding, state substance use and Child Protective Service (CPS) funding, and county funds – which are used primarily to provide services for special populations. With only 8% of funding coming from patient fees, which includes patient self-pay and insurance (Medicaid/Care and commercial insurance) payments, foundation grants and individual giving make-up the remaining 39% of funding sources that can be used to serve the general population seeking care.

Analysis of agency finances identified a high reliance on government and grant funding for behavioral health services in Harris County.



Increasing funding from insurance was reported as a significant challenge for agencies. Although patients are generally willing to use insurance (if they have it) to pay for services, agencies struggle to get onto insurance panels, receive low reimbursement rates, and have long wait times for reimbursement payments. Taken together, these challenges make it either unattractive or too burdensome to accept insurance. Among the agencies that reported their financial make-up, 21 (64%) reported accepting insurance. Generally, agencies with large administrative offices were more likely to be able to meet all insurance requirements.

Despite the reliance on grant funding, the majority of agencies report being in good financial shape, with 71% of agencies reporting good or excellent financial health.

Another challenge that many agencies reported is around tracking meaningful outcomes. While every agency tracks client-centered measures – such as client perception of improvement or a sense of hope for the future – and uses these outcome measures in their discussions with clients, agencies struggle with how to report meaningful outcomes to funders. Other agencies track more quantitative metrics, such as no-show rates, program completion, length of abstinence, or connection of clients to needed resources. However, these agencies report frustration that these measures do not adequately reflect the impact of counseling and other supports.

Reflections and Recommendations

Implementing a study of this kind helps to illustrate the complexity and scope of behavioral health services. Agencies serve vastly different populations that have different service needs and outcomes that can be hard to see, much less measure. Yet given the increasing need for behavioral health services, it is important to have a clear understanding of the resources that are available in order to increase their accessibility.

The findings emphasize the complexity and scope of behavioral health services in Harris County.

With this goal in mind, the following recommendations are offered to support those working to increase access to behavioral health in Harris County.

1. Work to establish common metrics and definitions among behavioral health providers to bring more clarity about who is served and in what setting, as well as identify the capacity to serve more people.
2. Explore ways to get clients into care sooner. Beyond the important work of reducing the stigma of accessing care, increasing awareness of behavioral health resources in the community and among providers is needed so that effective referrals and collaborations can be developed.
3. Harness the interest schools have expressed to offer behavioral health early interventions and services on campuses. Much is happening in schools, but not enough is known about what is happening in individual schools and school districts to ensure that these resources are being leveraged with a strategic approach to meaningful early intervention.
4. Advocate for better insurance reimbursement rates and reduce agency barriers to accepting insurance.