## Needs Among Texas Children and Adolescents

<table>
<thead>
<tr>
<th>Mental Health Condition – Children and Youth</th>
<th>Age Range</th>
<th>Texas Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Population</td>
<td>6-17</td>
<td>4,900,000</td>
</tr>
<tr>
<td>Population in Poverty</td>
<td>6-17</td>
<td>2,300,000</td>
</tr>
<tr>
<td>All Behavioral Health Needs (Mild, Moderate, and Severe)</td>
<td>6-17</td>
<td>1,900,000</td>
</tr>
<tr>
<td>Mild</td>
<td>6-17</td>
<td>1,100,000</td>
</tr>
<tr>
<td>Moderate</td>
<td>6-17</td>
<td>430,000</td>
</tr>
<tr>
<td>Severe – Serious Emotional Disturbance (SED)</td>
<td>6-17</td>
<td>370,000</td>
</tr>
<tr>
<td>SED in Poverty</td>
<td>6-17</td>
<td>210,000</td>
</tr>
<tr>
<td><strong>At Risk for Out-of-Home / Out-of-School Placement</strong></td>
<td><strong>6-17</strong></td>
<td><strong>20,000</strong></td>
</tr>
<tr>
<td><strong>Specific Disorders – Youth (unless otherwise noted)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depression</td>
<td>12-17</td>
<td>200,000</td>
</tr>
<tr>
<td>Bipolar Disorder</td>
<td>12-17</td>
<td>50,000</td>
</tr>
<tr>
<td>Post-Traumatic Stress Disorder</td>
<td>12-17</td>
<td>95,000</td>
</tr>
<tr>
<td>Schizophrenia</td>
<td>12-17</td>
<td>6,000</td>
</tr>
<tr>
<td><strong>First Episode Psychosis (FEP) Incidence – New Cases per Year</strong></td>
<td><strong>12-17</strong></td>
<td><strong>900</strong></td>
</tr>
<tr>
<td><strong>Specific Disorders – Children Only</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Anxiety Disorders – Children</td>
<td>6-11</td>
<td>270,000</td>
</tr>
<tr>
<td>Depression/All Mood Disorders – Children</td>
<td>6-11</td>
<td>25,000</td>
</tr>
</tbody>
</table>
The Link Between Violence and Mental Illness

- **Mild to moderate mental illness** is *not* a risk factor for violence; other factors drive violence (substance use, criminogenic risk).

- **Severe mental illness** drives slightly more risk.
  (3 in 100 versus between 1 and 2 in 100)

- Specific subsets are at higher risk:
  - 20,000 children and youth with the most severe needs and the fewest economic and family resources
  - 900 youth with new psychotic disorders each year are at the highest risk (15 times more likely to commit homicide if untreated)
The Progression of Mental Health Conditions

• **Half** of all mental health conditions manifest by **age 14**; interventions work best at this **early stage** when symptoms are **less severe, more treatable**, and **more readily kept from escalating** to more dangerous conditions that increase risk.

• By young adulthood, **75% of lifetime cases have presented**.
The Ideal Mental Health System for Children

THREE KEY COMPONENTS:

1) Helping local schools identify needs and link to help:
   - Early, before situations become harder to treat; and
   - Fast, when a severe need arises and expertise is essential to maintain safety and functioning;

2) Helping pediatric primary care providers find and treat mental illness early when it is mild to moderate; and

3) Making intensive treatment available to children and youth with the most severe needs, quickly, when needs emerge.
1. Helping Local Schools Get Expert Evaluation

All schools need someone to coordinate identification and linkage ("liaisons") – school counselors with dedicated time for mental health, school-based clinics, Communities in Schools, and others can fill this role.

• When a severe need arises, schools must be able to get expert evaluation on the scene quickly, and teachers and staff need rapid access to reliable advice and care.

• A few Texas schools have mental health experts on site, but that solution is not feasible for most schools and no single expert can answer every question.

• Telemedicine (such as TWITR) offers the infrastructure to fill the expertise gaps.
2. Leveraging Pediatric Primary Care Providers

75% of children with mental health issues who receive care, receive it in a primary care setting (family doctor, pediatrician).

• With the right early support, most would not need a specialist.

Nearly 30 states have implemented Child Psychiatry Access Programs (CPAP).

A statewide system of regional children’s behavioral health consultation and referral hubs located at academic medical centers.

Each hub can build over a few years to support the primary care needs of 900,000 children and youth.

Once fully operating, the cost is $2 a year per child.
3. Making Intensive Treatment Available

About 20,000 children and youth each year need intensive treatment because of severe behavioral dysfunction.

• *They do not all need the same treatment.*

• Highest risk of harming others: About 900 Texas youth who first experience an episode of psychosis (FEP) each year.

• **Psychosis** is characterized by hallucinations and delusions.
  - Those with *untreated psychosis* are 15 times more likely to commit homicide. Effective treatment decreases the risk.
  - They also have a dramatically elevated risk of suicide and other mortality: 24 times the risk for their peers.
  - Today, treatment is delayed for **seven years post-onset**.
Treating Psychosis: Coordinated Specialty Care

Coordinated Specialty Care, a team-based approach (also known as FEP Care), starts assertive and intensive treatment as soon after the initial psychosis as possible.

Texas currently has 12 Coordinated Specialty Care teams located at 10 community centers across the state.

- Expected caseload for each team is 30.
- Most are age 18 or over and served as adults.

Texas should at least expand Coordinated Specialty Care programs for all youth ages 14 - 18 (900 new cases a year).

- Community centers and medical schools should collaborate to provide the care, leveraging the expertise of each system.
The truth is: mental illness affects more people than you may think, and we need to talk about it. It’s Okay to say…” okaytosay.org