McKenna Foundation
Mental and Behavioral Health Task Force
Report to the Board of Directors

The Mental and Behavioral Health Task Force was launched in September of 2014 with the goal of identifying local funding priorities based on community mental and behavioral health needs. The Task Force included representatives from 52 participants representing 29 local entities, each of which provides or plays some role with in the mental and/or behavioral health services arena. (A complete list of participating agencies is included as Appendix I of this report.) The members came together for a series of five half-day meetings to share ideas, engage in stimulating conversation and to prioritize both the most critical areas of need and strategies to address them.

The initiative was designed with several goals in mind:

- Engage a wide cross-section of community stakeholders in an effort to describe, align and improve the mental health delivery system in the New Braunfels area;
- Increase knowledge regarding available behavioral and mental health services and providers in the community;
- Identify gaps in services;
- Coordinate funding to address the gaps and to comprehensively meet the needs of the community.

Accordingly, the group developed the following community vision statement:

- We envision unfettered access to quality, community-based mental health services throughout Comal County for families, children and adults. We expect that services will reflect evidence-based practices whenever possible. In order to accomplish this vision, we intend to work together in multiple ways to:

    - Promote community education and prevention;
    - Develop a comprehensive continuum of locally available services that addresses the needs of the community, and
    - Expand and improve access to services for the outlying communities.

Chronology

In the first meeting, the objectives were to educate the participants regarding the current state of local mental health services, including services currently available, opportunities for collaboration and common needs. The process included table discussions regarding both national and local mental health trends. Many of the issues that emerged from these discussions continued to rise to the top throughout the series of meetings. Some of the key points were as follows:

Table Discussion Topics

1. ***A recent Duke University study involving more than 10,000 American teenagers revealed that more than half of adolescents with psychiatric disorders go untreated. For those who do receive treatment, schools are the most likely source. What role are the local schools playing in mental health services delivery, and how might that be improved or expanded?***

    - Our schools have counselors, primarily academic, that are taxed for time; we have CIS staff on some campuses, occasional visits from CPS liaisons or advocates.
    - We have some counseling grants; some campuses have social workers with 2400 students to manage, and a few other resources such as bullying programs.
    - Opportunities to improve or expand could start with staff awareness of psychiatric disorders (teachers were trained in bullying and child abuse) and how to recognize and report. Provide training for staff in recognizing psychiatric disorders.
    - Provide a clear referral process – step by step.
    - Parent education – we need more parent education about when to seek treatment. Examples of programs that could touch on this include bullying, LGBTQ – school groups.
    - Juvenile Mental Health First Aid – very much at the forefront in CISD – has been very prevalent in teacher training. Have gotten Sheriff's deputies involved. Can look at expanding it – would definitely be beneficial to expand to community.
    - NBISD – we have an 8-hour training course for teachers, so it's hard to do during the school year. We're working with that, and are looking at offering it to community parents as well. Excellent program.
    - Comal ISD – we have social workers that offer school-based mental health services at all three high schools. CIS comes to our other campuses, and

we have a grant that puts a social worker on 4 of our elementary campuses. We still need more.
- The Mental Health Authority teaches coping skills at the schools.
- LGBTQ – Comal has a program, and NB does not. Suicide rates and mental illness among LGBTQ are very high.

2. ***Disproportionate numbers of people with mental illness are involved in the criminal justice system often as a result of untreated or undertreated mental illness. With enactment of SB 7 Texas charged local mental health authorities with ensuring provision of assessment services, crisis services and intensive disease management practices for children and adults. The legislation requires local mental health authorities to incorporate jail diversion strategies into disease management practices to reduce involvement of people living with serious mental illness in criminal justice systems. Are there any jail diversion strategies in place in Comal County and have they been effective? Why or why not?***

   - There is an evening reporting program that diverts youth from detention, but is not equipped for severe mental health cases.
   - The wraparound program uses Family Partners to provide Mental Health First Aid, works with veterans court and the crisis stabilization unit (CSU). We keep bumping up against lack of psychiatric resources.
   - We need an MCOT team definitely.
   - I'm with adult probation and work with a lot of offenders with mental health issues. Have a program called TCOMI – for people on felony probation that have both mental and behavioral health issues.
   - I represent Comal County Jail, and we implemented a state mandated program where jail staff identify MH issues, then refer to a magistrate to address whether they are incompetent/ need to be diverted. We have tried to proactively address the population and get the treatment in lieu of prosecution. There has been a drastic increase in the last couple of years of people found incompetent to stand trial, and we've had to refer out to other counties.
   - We've increases nursing and psychiatric services at the jail, and work with MHTD and everyone else to do that. It's a growth issue. Every inmate is screened for MH disorders, and we collaborate with MHTD.
   - New Braunfels Police Department is getting more MH calls as well.

3. ***Youth Substance abuse was identified in the 2008 Youth Community Needs Assessment as an issue of high priority and high concern; however, only two service providers had substance abuse prevention and treatment programs at the time. What is the story today? Are there community education***

initiatives in place to inform parents and students about dangers, warning signs and resources? Has the level of available services increased?

- The two providers then were Connections and Crisis Center; Connections is still functioning.
- The Sheriff's office does Citizens Academy and Junior Academy every summer to provide education. The problem is there is just one provider.
- The other problem is that parents are in denial – they don't think their kids have a problem. There are now even more drugs and substances they can get into or make on their own; there is a large need for education and treatment.
- We don't have a substance abuse treatment center in Comal – we have to send clients to San Antonio. Parents also can't afford the treatment.
- Hospitals are typically where people go with crisis issues. There isn't a place to go to after the emergency room.
- Other services available include:
    - *Mental Health for Youth* is an awareness program provided by the Mental Health Authority.
    - OSAR – if you call the crisis hotline for substance abuse they refer you to OSAR (Outreach, Screening, Assessment, Referral). Every community has this – it's a requirement in Texas.
    - We have counselors that do cognitive behavioral therapy that deal with drug use.
    - We do wraparound services for children that have intense needs, where we get a variety of services from the entire community, i.e. recovery coaches, etc.
    - River City Advocacy offers a substance abuse support group for kids; preparing to do one for adults as well.
    - Changing Ways has 2 LCDC's on staff.
    - The MHA has an LCDC for co-occurring disorders.
    - We have a Substance Abuse Coalition, but haven't formally launched services.

4. ***One of the new trends in mental health service delivery is technology-based therapies, i.e. software applications designed to relieve anxiety or provide cognitive behavioral intervention exercises, phone-based therapies to eliminate transportation barriers, group or individual therapy via video-chat applications such as Skype, etc. Are you aware of any such efforts in Comal County and do you think implementation of these or similar programs would benefit the community? Why or why not?***

- We think it's very useful, particularly for outlying areas. River City Advocacy: transportation is definitely an issue. Hill Country – 2500 people – very active in tele-medicine.
- MH court – creating 72-hour hearings thru video so we have constant intervention. Would be great for so many populations.
- Salvation Army – they concentrate on food and utilities, but can provide transportation as well.
- If the school could provide a secure area, we could do a clinic on site.
- We are actively looking at tele-health for geri-psych services, which is one of the specialties we offer in neurology. From an outpatient perspective, we're exploring those opportunities for mental health services.
- I've spoken with CHRISTUS and other clinic – we have a mobile clinic to implement tele-medicine in outlying areas –we're ready to start that now.

5. ***The most rapid growth in Comal County is the 25-54 year old age group. By 2040 the over 55 group will become the most rapidly growing cohort. How does this impact the community related to mental health services and service delivery? Are there proactive strategies that should be put into place now to address that growth?***

- We have increased assistance programs – Meals on Wheels, etc.
- Transportation is only available 2 hours a day.
- We have a lack of geriatric physicians and counselors, nurse practitioners, psychiatrists. Many providers refuse Medicare, and people have to go to San Antonio for services.
- We need education services and trained professionals; we need more local providers.
- Last time an independent service provider came in to compete with ART, they dropped their prices until they left, and plan to do it every time a new company starts up. From a city viewpoint, we don't have anyone else to fund. The elderly and low-income communities are suffering.
- Institute for Longevity – accepts Medicaid and Medicare. Have a LCSW on staff to provide therapy.
- Based on meeting with the Senior Citizens Foundation – long-term planning around new facility – they are updating services for younger people – over 55 but not yet seniors or geriatrics. That's something they identified as a need, and we can explore the mental health services available through them.
- People in Canyon Lake often can't get care because they can't get here.
- One of the issues is that even if you have means, there are only 2 doctors and they're not taking any new patients.

- I'm in Canyon Lake, and the ART bus serves a purpose but not at all everything that we need. From kids to seniors – there's no way for anyone to get anywhere – lack of transportation is a huge issue.
- We're dealing with our residents that are seniors, plus the Winter Texans that come here, which is a huge influx for many months.

6. ***Part of the issue related to deficits in mental health services in Comal County appears to be related to human capital, specifically a shortage of mental health professionals. What recruitment strategies could be employed to attract the professional community to New Braunfels and the surrounding area?***

- People don't understand the magnitude of the problem. The MH issue is so much bigger now than it was when the original needs assessment was conducted. There used to be a mental health-related police call once a month county-wide. Now, five years later, you'll have as many as 4-5 every single day, just in New Braunfels. There's an officer at the hospital now with one or two people.
- If you need an appointment with a psychiatrist here, it's a 2-3 month wait. People have to go to other cities. Demand is huge here, but in San Antonio and other cities it's 50 times more. We have to have incentives – what are the public and private incentives we should offer? What can we provide to MH treatment facilities – tax-free loans? No property taxes?
- I'm on the non-profit provider end of this – we struggle to get funding to pay quality people quality wages. I can't pay them twice what I make – the Board won't let me. I can't recruit people with love. It's not about new businesses but about supporting the ones that are here.
- From the City perspective – 4B Board – we can contribute funds to quality of life and job growth. Mental health qualifies for both. We should try to get those public funds – it's a good option.
- We're growing fast – we have to find the funding to pay the providers. Counselors need higher pay. The shortage of psychiatrists is real and we'd have to have something amazing to get them here. Maybe an inpatient treatment facility would be an enticement.
- The other thing we have to grapple with is the stigma. Families don't understand mental illness – we need to step up community education. Because of the stigma, people wait to respond to a crisis and throw early intervention to the curb.
- Howard Payne University – will produce graduates that will stay here. Working as hard as we can. I hope we can help provide long-term human capital solutions. Our hope is to attract students from other parts of the state to this community and encourage them to stay here. We're

providing graduates with an excellent education, and are recruiting individuals to the field of social services as well.

Evidence-Based Practices Literature Review

One of the issues that often arises in the area of evidence-based practices is the actual definition of the term, as it is often used casually and applied in different ways. An evidence-based practice does, however, meet very strict and specific standards in reality, and for the purposes of this initiative the group has adhered to the following definitions put forward by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Social Work Policy Institute respectively:

An evidence-based practice is…

- included in Federal registries of evidence-based interventions,
- reported (with positive effects on the primary targeted outcome) in peer-reviewed journals,
- documented evidence of effectiveness, based on guidelines developed by SAMHSA/CSAP and/or the State.

Additionally, an evidence-based practice is…

- any practice that has been established as effective through scientific research according to a set of explicit criteria (Drake et al., 2001).

Examples of evidence-based practices in the mental health services arena include medication management, tele-medicine services, a Mobile Crisis Outreach Team (MCOT) and Assertive Community Treatment, all of which are referenced in this report and appendices. Using an activity called a Book Study, participants were divided into small groups and given a 2-3 page section of a literature review on current evidence-based practices in mental health. (The literature review is included as Appendix 2 of this report.) The groups were tasked with identifying and agreeing upon the 3-5 most important takeaways from the materials and sharing those with the larger group. They were also asked to discuss questions such as:

- How important do you think it is that Comal County develop and expand its network of programs based on evidence-based practices? Why?

- Considering the evidence-based programs that you know currently exist in your community, is there more demand than supply? Would it be better to expand what you currently have or to add additional program models?
- What programs currently exist in the community that reflect the evidence-based practices you read about?
- Does this community have the infrastructure it needs to develop a coordinated, collaborative system of care to promote the delivery of mental health services? If not, what are the biggest gaps?
- How would you characterize the availability of funding for mental health services in this community? Assuming that there are unmet, unfunded needs, would you prioritize evidence-based practices?
- To what extent does current policy support or inhibit the development of new and/or expanded mental health services, i.e. school policy, city and county policies, etc. If you were to pursue policy changes, what might they be?

Some of the most relevant responses reported to the larger group after these conversations included the following:

1. We need more psychiatrists and to build more and better relationships with the medical community.
2. We need continuous employment support.
3. We need integrated treatment programs for both mental and behavioral health; this is one of the biggest gaps.
4. We as a community need to reduce the level of competition for funds and engage more in collaborative efforts.
5. We can save/reallocate money by working together to eliminate the duplication of services and to identify needed additions to our service continuum.
6. Geography and transportation are significant challenges in terms of service delivery/access.
7. Collaborations should include shared public facilities access and the innovative use of technology.

Based on these discussions and findings, the group spent time in the following two meetings identifying community assets, needs and resulting gaps. The Gaps Analysis Matrix is included as Appendix 4 with this report.

Participants worked in small groups to review the gaps analysis and identify the top 3 gaps for prioritization. There was almost complete agreement among the groups regarding the priority gaps, especially considering that they were

reviewing more than 50 types of services. The following six major gaps rose to the top of the comprehensive list:

Gap	# of times cited
Medical Support/Medication	5
Inpatient Treatment	5
Evidence-Based Practices	4
Supportive Housing – long-term	2
Employment/Life Skills	1
Psychiatric Services	1

Significant time was devoted in meetings 3-5 to develop goals and action steps that offer solutions to the above-listed deficits in community services. The final goals are included as Appendix 3 with this report.

Because many of the goals and action steps described in the strategic plan were often more long-term in nature and frequently more generalized, time was spent in the final meeting identifying the group's perceptions around prioritized community needs based on target populations and specific program services. These align with priorities described in the earlier meetings, and provide a brief and targeted reference list.

Areas of Need – Target Populations

Children & Youth

- Pre-teens are the biggest gap, including youth considered as Individuals w/Developmental Disabilities (IDD)
- Early intervention/prevention
- Family treatment/education
- Lack of providers
- Early identification of issues
- Dealing with stress/building resiliency
- Awareness
- Parent training
- Connections to physical health
- Partners: barriers to collaboration
- 18-21 age group is also a gap
- Social Workers/Therapists @ schools
- Education/advocacy w/in ISD's
- Professional development for school staff
- Expand successful programs

Seniors

- Aging/decline
- Need for medications
- Dementia
- Medication management
- Affordability/access
- Depression/Isolation/Anxiety
- Lack of social opportunities
- Identification of MH issues
- Transportation
- Connections/communication/education
- Poverty

Areas of Need – Programs

Law Enforcement

- Overall process for evaluation/diagnosis
- Case management
- Deficit of placement beds
- Education/early intervention
- Clear roles
- Lacking assessment services and follow-up services/personnel
- Substance use is most frequent trigger
- Emergency detention not currently a practice
- Prevention/early intervention for children, youth and families
- Expand successful programs (ERC)

Substance Use/Abuse/Misuse

- Youth and seniors
- MS & HS
- 12-25 – including young adults
- Kids are self-medicating issues like depression and anxiety with drugs and alcohol
- Dual diagnosis
- Geography is an issue – Ex: "Mobile Home Estates" – methamphetamine use is prevalent
- Inpatient/outpatient

- Detox
- Services for uninsured
- Treatment after detox – working on root cause
- Education and prevention through ISD's – mental health and substance use
- Parents/denial
- Community education
- Crisis services– suicide, etc.
- Seniors – meds, dementia, substances

Summary of Findings

1. Crisis services, inclusive of both inpatient stabilization and outpatient emergency intervention services, is a major need. The Task Force identified the creation of a Mobile Crisis Outreach Team (MCOT) as a priority for funding. The MCOT model is an evidence-based practice that involves collaboration between several key stakeholders, including local law enforcement, local hospitals and mental health providers.

2. Mental health and behavioral health services for teens and young adults also represent both a high level of need and multiple gaps in existing services. School-based services such as counselors, mentors, after-school and summer programming and other student engagement opportunities offered through organizations that have established successful programs and partnerships with the local school districts are the most logical initial intervention step.

3. The need for parent education seems to be a root cause factor, the lack of which creates an inability on the part of parents to recognize and intervene early in mental and behavioral health issues. A lack of awareness on the part of parents and other adults also contributes to systemic problems related to substance use and abuse, bullying, students dealing with LGBTQ issues, etc.

4. The shortage of qualified psychiatrists, nurse practitioners, licensed social workers and counselors and other mental health professionals across the local area is a fundamental need that must be addressed in order to create the continuum of services designed to meet local needs.

5. The creation of inpatient treatment options at the local level, either through recruiting new providers or establishing treatment beds through local hospitals, is a critical need.

6. The lack of transportation services is a significant issue, both in terms of transportation to and from outlying areas to local mental health services, and in terms of transportation for seniors to mental health services, medical services and to social activities.

7. Much of the need for intervention related to senior citizens has to do with the reduction of isolation through the creation of opportunities for social, spiritual, creative and educational activities.
8. There is a significant need for integrated treatment programs for those consumers dealing with dual diagnosis issues (mental health and substance abuse).

9. A continuum of services needs to be developed, meaning a series of programs through which a consumer could pass from highest level of need to lowest level of need. For example, a comprehensive continuum of care would offer services related to crisis intervention, detox, and stabilization, culminating in outpatient, community-based treatment services aimed at the maintenance of health and wellness.

10. Community education and advocacy are important elements at all stages of development to ensure successful prevention, early identification and intervention, and an increased understanding of mental health issues with a corresponding reduction in stigma and its many consequences.

Appendices

Appendix 1: Participant List
Appendix 2: Literature Review
Appendix 3: Community Goals
Appendix 4: Gaps Analysis Matrix

McKenna Foundation
Mental Health Task Force Attendees

1. Mechelle Salmon	**Bulverde Spring Branch EMS**
2. Joyce Ross	Bulverde Spring Branch EMS
3. Norma Blackwell	CASA of Central Texas
4. Melanie Linder	CASA of Central Texas
5. Trendy Sharp	Children's Advocacy Center of Comal County
6. Fayemeh Hagne	CHRISTUS Santa Rosa-New Braunfels
7. Jackie Logan	Comal County Adult Probation
8. Dana Lloyd	Comal County Adult Probation
9. Jason Krampitz	Comal County Court at Law
10. Crystal Andrews	Comal County Juvenile Probation
11. Kris Johnson	Comal County Juvenile Probation
12. Meliss Oehler	Comal County Senior Citizens Foundation
13. Lynn Mahaffey	Comal County Senior Citizens Foundation
14. Brent Paullus	Comal County Sheriff's Department
15. Kristen Butler	Comal Independent School District
16. Susan Wetz	Communities in Schools
17. David Ricker	Communities in Schools
18. Sasha Roskos	Communities in Schools
19. Kellie Stallings	Connections Individual and Family Services
20. Maureen Schein	CRRC of Canyon Lake
21. Tiffany Leal	District Attorney's Office
22. Stacey Minor	Family Promise
23. Donna Eccleston	Hill County MHDD
24. Randy Consford	Hill County MHDD
25. Dale Meinecke	Howard Payne University
26. Jaci Gonzales	McKenna Parenting Program
27. Robin Rogers	Mental Health Consumer
28. Nadine Mardock	NB Housing Authority
29. Brett Mosher	New Braunfels Christian Ministries

McKenna Foundation
Mental Health Task Force Attendees

30. Aja Edwards	New Braunfels City Council
31. Karen Schwind	New Braunfels Independent School District
32. Rose Zamora	New Braunfels Municipal Court
33. Mike Penshorn	New Braunfels Police Department
34. Deb Mahone	Resolute Health
35. Jennifer Quackenbush	Resolute Health
36. Merideth Erickson	River City Advocacy
37. Judi Appel	River City Advocacy
38. Capt. Roman Leal	Salvation Army
39. Levi Maxwell	Salvation Army
40. Tara Roussett	St. Jude's Ranch for Children
41. Samantha Scarfo	St. Jude's Ranch for Children
42. Richard Ney LCSW	Autumn View Alliance
43. Dr. Bill Ellis	Howard Payne University
44. Bruno Schwab	Community Member
45. Michael Spain	McKenna Board Member
46. Brit King	New Braunfels Area Community Foundation
47. Mary Ann Thompson	Community Member
48. Keith Mask	Howard Payne University
49. Dan Warwick	Howard Payne University
50. Norma Herrera	Comal County Juvenile Probation, McKenna Board Member
51. Lyn Litchke	Texas State University
52. Chanel Wilkinson	Bulverde Spring Branch EMS

A Review of the Literature Regarding Evidence-Based Practices in Mental and Behavioral Health

Purpose

The purpose of the following document is to highlight evidence-based practices for the delivery of mental and behavioral health services across multiple age groups and populations for use by community stakeholders in Comal County. For the purposes of this paper, behavioral health refers to mental health with the inclusion of substance use treatment services. The short synopsis that follows summarizes the merits and limitations of using evidence-based practices in the delivery of mental health services to consumers, how these 'best practices' are effectively implemented, and explores cost considerations. At the conclusion of the literature review, we have explored the implications for Comal County.

Evidence-Based Practices: An Overview

A 'best practice' for the delivery of treatment and services to consumers (i.e. patients), is referred to in mental and behavioral health literature as an 'evidence-based practice'. Evidence-based practices (EBP's) must have "consistently demonstrated effectiveness in helping people with mental illness achieve their desired goal" (SAMHSA, 2008, p. 1). Fifteen years ago, a report of the Surgeon General on Mental Health (1999) referred to the need to establish

evidence-based practices through rigorous scientific study of what treatment options work best for consumers. Over time, the standards for what constitutes an evidence-based practice have evolved to be much more stringent. Today, evidence-based practices are reviewed rigorously by the scientific community, and are often tested in randomized control trials to ensure that treatment results are valid (Lehman et. al, 2004).

Limitations

While evidence-based practices are vetted through a process of scientific research, there are limitations to their use. Mental illness is highly variable and ranges in severity. Use of an EBP on one patient may lead to a different treatment outcome with another. Furthermore, replicating results of a treatment in a controlled scientific setting does not mean that the treatment will transfer effectively to the clinical setting (Davis & Whitley, 2007). Finally, people at all stages of life are affected by mental and behavioral disorders, and require different treatment options. Appropriate treatments and services to consumers with behavioral and mental illnesses will certainly vary across age groups, characteristics of the population, and geography.[1] For example, in a 2001 journal article, authors Hoagwood et al. found, "An evidence-based practice that is effective in the treatment of adolescent depression may well be

[1] See page 6 for a list of evidence-based practices based on subgroups of the population

ineffective or even harmful for children who have not reached puberty" (p. 1181).

Even with these limitations, evidence-based practices are considered the gold standard in treatment. With modern scientific advancement and the evolution of treatment options available to doctors constantly evolving, there are literally hundreds of evidence-based practices that could be applicable to a patient given their age and diagnosis.[2] However, there are common methodologies that govern best practices for providing treatment to consumers that generally are thought to span the spectrum of age and illness.

In 1998, the Robert Wood Johnson Foundation sponsored a project in which federal and state organizations and leaders collaborated with consumers and their families to help patients access effective services. The project identified six areas of intervention with strong research support and created toolkits that helped providers successfully implement reforms. A description of the six evidence-based practices can be found on the next page, followed by a discussion of the important factors that must be considered in the implementation of services.

[2] For a free, searchable database of EBPs, visit http://www.nrepp.samhsa.gov/

Evidence-Based Practices: Examples

Medication Management Approaches in Psychiatry

Medications, which may or may not produce side effects, are still deemed to be among the most effective treatments for many illnesses that affect the behaviorally ill, and can help patients recover a sense of normalcy that — when used in combination with psychosocial treatments — is among the most effective treatment outcomes. Medication management appears to be particularly important for people with severe mental illnesses, in which delusions and hallucinations may affect their daily lives (Lehman et al., 2004, p.6).

Illness Management and Recovery

Effective management of a patient's illness may allow them to regain much-desired independence and freedom to manage their symptoms on their own. Strategies to help a consumer could include social skills training and cognitive therapies (Robert Wood Johnson Foundation, 2005, p. 4).

Assertive Community Treatment

When a consumer is receiving assertive community treatment, they are receiving tailored care that may increase their chances of remaining in treatment. An example of this would be a caregiver meeting a consumer in his or her community, rather than requiring the consumer to go into the office for treatment. More options closer to home for the consumer and more flexibility to have their needs met helps people achieve their treatment goals. (Robert Wood Johnson Foundation, 2005, p. 5)

Family Psycho-education

Family Psycho-education is essentially the idea that family members can be involved in the process of their loved ones' recovery by becoming more educated about their relative's illness and learning how to effectively handle disease symptoms. This is very important for the consumer as well, who values social inclusion and their family's support (Wallcraft et al., 2011).

Supported Employment

The principles of supported employment include the ideas that a consumer must be able to: choose work that is competitive, has a personalized benefit to them,

and is integrated with their comprehensive mental health treatment. Supported employment works when follow-along supports are continuous, rather than short sighted, and when the support moves through the job search with the consumer (SAMHSA, 2008).

Integrated Dual Disorders Treatment

The Substance Abuse and Mental Health Services Association describes integrated treatment as the process by which "consumers receive combined treatment for mental illnesses and substance use disorders from the same practitioner or treatment team, and they receive one consistent message about treatment and recovery" (2008, p. 6).

Obviously this list is not inclusive, and depending upon the needs of the community, could be expanded to include evidence-based practices in the realms of child protection, parent training and coaching, family violence, cultural competency, aging services and many other issues. Perhaps the most significant point to be made across all evidence-based practices is that effective implementation is dependent upon system-wide collaboration and communication within a community.

Implementation of Evidence-based practices

Systems of Care

For the above examples of evidence-based practices for treatment to be effectively implemented in a community, there must be partnerships and collaborations across community systems. This collaboration, in which a "coordinated network of community-based services and supports" is organized to meet challenges that consumers are facing is commonly referred to as a

system of care (SAMHSA, 2006). Systems of care are particularly important when it comes to vulnerable populations, like the severely mentally ill, and children and youth (Stroul et al., 2014). Integrated service delivery, or the coordinated treatment of consumers, their direct caregivers, and their doctors, requires: effective leadership and collaboration among providers, better preventative care from primary care physicians, and more collaboration between a patients' primary care and mental health care doctors (Lopez et al., 2008). Service coordination and interagency collaboration are elements of the system of care philosophy, as are family involvement and cultural competence. The development of the infrastructure for a system of care is important. But none of these elements is the sole focus of system of care development. First and foremost, systems of care are a range of treatment services and supports guided by a philosophy and supported by an infrastructure. (Stroul, B. 2002).

Cost Considerations

Fidelity to an evidence-based practice is extremely important for its effectiveness in a clinical setting; however, one of the oft-cited reasons at the community level that programs — such as supported employment or integrated treatment — are not successful is that they require financial support that is often tied up in other programs. It is important to incentivize quality integrated care and other evidence-based practices, including mental health interventions that

return consumers to functional status, to avoid unnecessarily fragmented care and reduce the risk that patients will drop out of programs due to frustration or lack of results (Drake et al., 2001).

For evidence-based practices to flourish in a community, they require investment. Mental health services suffer from a historical lack of under-investment, yet when they are effective and help consumers reach their goals, the return on investment is very high. The Washington State Institute for Public Policy found in a 2006 report that the average evidence-based treatment produces a 22 percent reduction in the probability that a person would have a serious incidence related to their mental illness disorder if they were offered the treatment (Aos, Mayfield, & Yen, 2006). Furthermore, the study found that these practices can save a lot of money in economic terms — the average evidence-based treatment for people with serious drug, mental, or alcohol disorders has an average of a 56 percent rate of return on investment (p. 4).

Implications for Comal County

In 2008, the UT School of Public Health facilitated a needs assessment of Comal County, focusing on the "*Social and Environmental Determinants of Well-Being.*" Findings from the needs assessment indicate that cost, lack of sufficient insurance coverage, limited access to services, and a lack of awareness all contribute to the under-utilization of mental health services in Comal County (p.

115). Furthermore, residents responded that substance abuse among the youth population in Comal County is a top concern.

All of these factors will influence the evidence-based practices that will be most beneficial for consumers of mental health services in Comal County. For example, the inter-relatedness of substance abuse and mental health conditions may lead stakeholders to focus their attention on Integrated Treatment for Co-Occurring Disorders. Furthermore, because parts of Comal County are somewhat rural, problems of access to care and transportation are exacerbated. The needs assessment demonstrated that adequate roads from the Outer Loop of the County to more central areas are a prime concern among residents (p. 31). It is a well-established finding in the research that "rural individuals with mental health problems are significantly less likely to receive mental health services than individuals in urban and suburban areas" (Harman et al., 2010, p. 2).

Conclusion

While this literature review was compiled from a variety of authoritative sources, it is not intended to be a comprehensive list of every evidence-based practice that has been established as effective. Rather, it highlights the findings of methodologies that are most-frequently cited as having positive outcomes that are applicable to large swaths of the population that are suffering from unique illnesses but have common needs. There are many online resources that

explore the range of evidence-based practices in more depth that may be useful for Comal County Stakeholders to consider moving forward.

Evidence-based Practices List

**This list is not meant to be comprehensive, but rather provides examples for each of the following categories. Additional categories exist, such as severity of mental illness & gender*. Evidence-based practices are bulleted beneath each category.*

Age

Children[3]

- Acceptability of engagement and treatment
  - Access issue→ Must find ways to effectively engage/treat children who need services
- Empirically supported psychosocial outpatient treatments
  - Successful treatments transfer from research-based settings to clinical setting
- Family-focused treatments
  - Often short term and combined with other therapies
- Integrated community-based treatment
- School-based interventions
- Psychopharmacology
  - Proper choice of medication and effective management of dose

Adults[4]

- Illness Management and Recovery
- Assertive Community Treatment
- Family Psycho-education
- Supported Employment
- Integrated Dual Disorders Treatment

Seniors[5]

- Screening and prevention
- Increase the number of providers with expertise in mental health and aging
- Enhance caregiver and peer support services
- Reduce stigma associated with taking advantage of treatment

Location

Rural[6]

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[3] (Hoagwood et al., 2001) & (Hoagwood, 2003)
[4] (Robert Wood Johnson Foundation, 2005)
[5] (Bartels, 2003)
[6] (Fuertes,Gale, & Sawyer, 2006) & (Harman et al., 2010)

- Outreach
- Financing and System Reform
- Innovative Community-Based Programs

Demographics

Minority and Low-income populations[7]

- Reduce stigma & promote social support through campaigns targeted to minority groups
- Culturally adapted therapy may increase retention rate for continued treatment

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[7] (Davis & Whaley, 2007) & (Davis & Whaley, 2007)

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McKenna Foundation
Mental Health Task Force
Community Goals

Introduction

Beginning in October, 2014, the McKenna Foundation established and convened a Mental Health Task Force with the goal of identifying community needs, gaps in services, and ultimately a comprehensive list of funding priorities related to mental and behavioral health. Approximately 29 provider agencies as well as city and county officials participated in the series of five meetings, which culminated in February, 2015 with a discussion about carrying forward the enthusiasm and momentum created by the initiative. The following pages describe the community vision related to mental and behavioral health services and the plans to create a comprehensive continuum of services that will effectively meet the needs of New Braunfels, Comal County and the surrounding areas.

Community Vision

- We envision unfettered access to quality, community-based mental health services throughout Comal County for families, children and adults. We expect that services will reflect evidence-based practices whenever possible. In order to accomplish this vision, we intend to work together in multiple ways to:

    - Promote community education and prevention;
    - Develop a comprehensive continuum of locally available services that addresses the needs of the community, and
    - Expand and improve access to services for the outlying communities.

Promote Community Education and Prevention

Goal 1: Reduce stigma associated with mental and behavioral health disorders by educating the community regarding prevention of mental illness, early warning signs and the impact of stigma.

Goal 2: Explore research and educational opportunities to increase the availability of qualified mental and behavioral health service providers in our area.

Develop a Comprehensive Continuum of Community Services

Goal 3: Expand local services to establish a complete continuum of care that can respond to mental health crises 24 hours per day.

Goal 4: Develop a shared client database that is HIPPA compliant.

Goal 5: Prioritize the development of integrated treatment programs for both mental and behavioral health, inclusive of both inpatient and outpatient services.

Goal 6: Develop programs to provide continuous employment support for persons with mental and behavioral health disorders.

Goal 7: Create an effective support system and prevent relapses by collaborating to form a partnership between mental and behavioral health providers and local hospitals to establish detox beds and follow-up services.

Accessibility to Care

Goal 8: Expand the availability of services through collaborative efforts that include sharing public facilities and the innovative use of technology.

Goal 9: Utilize satellite offices and home visits throughout the community to ensure services are accessible by consumers**.**

Goal 10: Implement and expand the use of tele-med services to improve accessibility.

Goal 11: Develop transportation services to improve accessibility for all, including outlying areas.

Strategic Partnerships

Goal 12: Build relationships with the medical community and create a partnership aimed at increasing the availability of psychiatrists in the area.

Goal 13: Establish a Mobile Crisis Outreach Team (MCOT).

Goal 14: Expand successful prevention and intervention programs (ERC, DARE, etc.) to new partners and consumers.

Goal 15: Utilize existing financial resources by working together to eliminate the duplication of services and to identify needed additions to our service continuum.

Children and Families

Goal 16: Develop programs designed to relieve isolation and corresponding mental health issues among senior citizens.

Goal 17: Increase the number of social workers/mental health professionals in the schools to help with early identification and intervention and to provide education for families.

Goal 18: Create a mobile school-based mental health center, staffed with a psychiatrist or licensed therapist, that rotates between school campuses.

Funding

Goal 19: Establish relationships with new funding sources and develop collaborative funding efforts.

Gap Analysis

Provider & Location	Program	In-patient	Out-patient	Criminal Justice	Employment & Life Skills	Family Violence	Supportive Housing	Substance Use/Abuse	Crisis Intervention	CBT	Medical Support & Medication	Evidence Based Practice
Adult Protective Services	Adults		●			●			●			
Autumn View Alliance	Seniors		●									
Bryan Kastleman Short-term housing	for low SES								●			
CASA of Central Te•as	0-21					●						
Catholic Charities Comal County	All ages		●				●					
Children's Advocacy Center	0-17 Forensic interview required		●			●				●		●
CHRISTUS New Braunfels Geri-Psych		●							●			●
Communities in Schools			●		●		●		●			
CISD - McKinney Vento	funding						●					
CISD – Keystone			●									
City of NB CDBG funds							●					
Comal County	Juvenile Probation		●	●	●			●		●	●	
	Adult Probation		●	●	●			●		●	●	
	Jail - Inmates			●				●			●	
	DARE			●				●				
	Drug Court			●				●				
	DA's Office			●		●						
Comal County Crisis Center	Adults & Juveniles	●	●	●	●	●	●		●	●		
Comal County Child Welfare Board							●					
Connections	Adults & Juveniles	●	●		●	●	●	●	●	●		
Cowboys for Jesus	Celebrate Recovery		●					●				
CPS Comal County	Adults & Children		●					●	●			
Crisis Center			●						●			
CRRC	Hotel/housing assistance for all						●		●			
DARS	16+				●							
Diesel Therapy Dog	Therapy Dog Adults & Juveniles		●	●		●						
Family Endeavors	Military veterans		●				●					
Family Life Center	Tree of Life Hotel/housing assistance for all		●				●		●			
Family Promise	Shelter/CM	●			●		●					
Freedom Fellowship	Door of Hope							●				
Gabriel/Rachel Projects	Young adults & pregnant teens					●	●		●			
Gruene UMC	homeless						●					
Habitat for Humanity							●					
Habitat for Safe Seniors	Adults/Seniors						●					
Hope Center	Utility assistance						●					
House of Hope Clinic											●	
Light Suite Ministries							●					
MDT	0-17		●			●			●			
MHDD	OSAR CBT CFT Wraparound Mental Health First Aid Crisis Hotline		●	●	●	●	●	●	●	●	●	●
NB Counseling Center	Individual & Family Therapy		●							●		
NB Housing Authority	Adults						●					
NB Housing Partners							●					
NBISD	McKinney Vento funding						●					
NBPD & CCSO			●	●								
New Braunfels Psychiatry	ADHD 12+		●					●	●	●	●	
New Braunfels Works					●							
New Life Children's Center Canyon Lake	Adolescent Girls 7-17	●			●			●	●		●	●
Oakwood Counseling	Peer Support & Family counseling All ages		●					●		●		
PEACE Lutheran Church					●							
Red Cross									●			
Renew Church	STEPS Program		●		●			●				
Resolute Health									●			
River City Advocacy New Braunfels	PCRP Counseling		●	●	●	●		●	●	●		●
	Life Skills All Ages		●	●	●	●						●
	Peer Support Groups		●	●	●	●		●	●	●		●
	Job Skills Training		●	●	●	●						
River City Rehab			●					●				
Riverside Community	Hope Center		●						●			
Salvation Army							●		●			
SAMM							●					
School Counselors			●						●			
Seguin Family Institute			●	●		●		●				
STEPS					●							
St. Jude's Children's Ranch		●	●		●		●		●	●		
Therapy Animals of San Antonio	In-hospital therapy	●										
TIPHER								●				
Triple H Equine Therapy	Horse Therapy		●									
Volunteers in Medicine											●	
Wayland Baptist	Peer Support Anger Mngmt Subst. Abuse 10-17		●	●				●		●		