

## Meadows Mental Health Policy Institute

### Youth Crisis Outreach Teams – April 2026

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In 2024, the 88th Texas Legislature made a historic investment in children’s mental health by funding the state’s first eight **Youth Crisis Outreach Teams (YCOTs)**. YCOT is modeled after Mobile Response and Stabilization Services (MRSS), recognized by the Substance Abuse and Mental Health Service Administration (SAMHSA) as an evidence-informed practice for addressing immediate and crisis-level mental health needs among children, youth, and families through a home-, community-, and team-based approach. MRSS for children, youth, and families is an intervention designed to de-escalate behavioral health crises; provide immediate, community-based intervention and stabilization; and prevent unnecessary emergency room visits or justice system involvement. Communities with established MRSS teams have shown positive outcomes,<sup>1,2,3</sup> and decreased truancy and missed school days.<sup>4</sup>

The 89th Texas Legislature saw the benefits of the eight initial YCOTs and increased the investment in the program from \$14M to \$54M for the 2026-2027 biennium. This investment allowed the program to more than double the number of service areas and prioritize delivery of YCOT resources in urban areas with the highest demand. Beginning in 2026, the Texas YCOT program will serve **56 counties**, with **18 total teams**.

### What are YCOTs?

YCOTs are an essential component of the mental health crisis continuum of care. Mobile crisis teams are interdisciplinary in nature, making them uniquely equipped to deal not only with mental health needs but also address other non-medical needs through referrals to community-based resources.

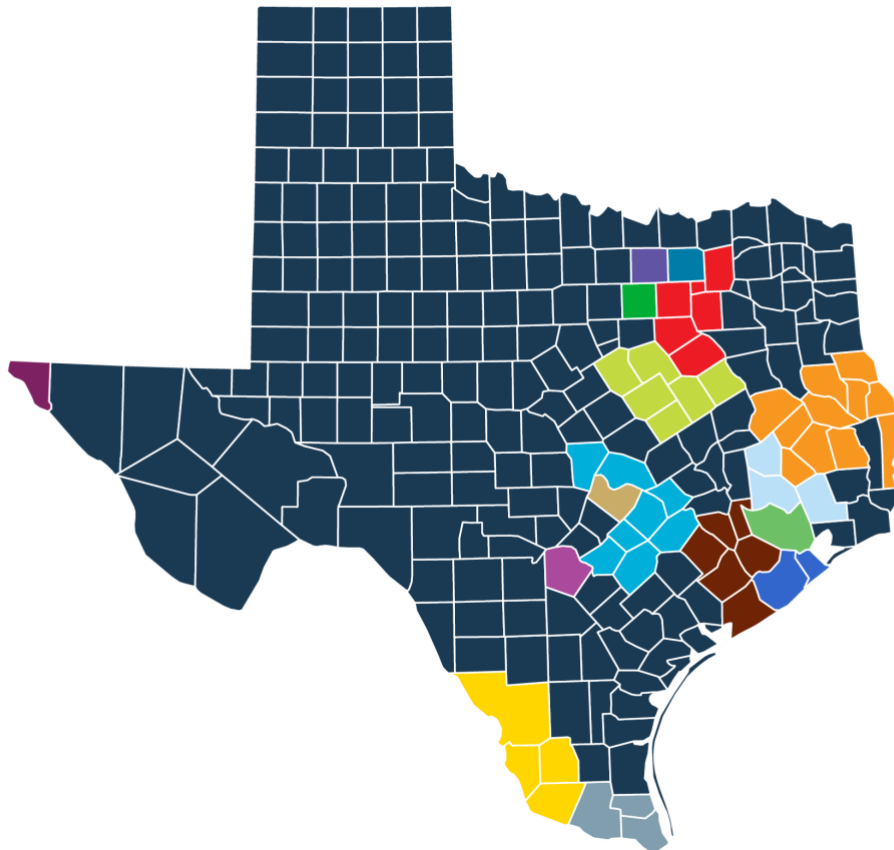
While YCOTs share several common components with other mobile response services in Texas, including crisis de-escalation and stabilization, screening and assessment, and safety planning, they also have important distinctions. YCOTs function as “emergency rooms without walls,” stabilizing situations in real time, preventing unnecessary hospitalization, arrest, or family separation, and connecting children to the care they need. YCOTs are uniquely effective for children, youth, and families through several core components:

- **YCOTs deliver immediate crisis care to children wherever they are, when it matters most.** With YCOT, crises are responded to in the home and community.
- Whereas other crisis response services focus on triaging for urgency, in YCOT, **crisis response is person-centered**, meaning “crisis” is defined by the caller. This approach prevents unstable situations from progressing, often allowing for earlier intervention, and avoiding more intensive, costly, and restrictive treatment.




- **YCOTs provide follow-up services connecting children, youth, and families with ongoing mental health services and community-based supports.** These connections are critical as crisis services are often a child’s first encounter with the mental health system.<sup>5</sup> With mental health treatment engagement among youth<sup>6</sup> and access barriers a significant factor, YCOTs represent an early and effective intervention opportunity.
- There is strong evidence for the bidirectional impact of a child’s mental health and that of their close family members’.<sup>7</sup> **YCOTs are designed to work closely with anyone in the family or household who needs support,** skill building, and connection to resources. This family-centered approach strengthens the whole family unit, better equipping the child and family to avoid repeat crises.






### Access to YCOT Services in Texas

During the 2024-25 biennium, the first eight YCOT teams served 40 counties. With additional funding appropriated in the 89th Legislative Session in 2025, the Health and Human Services Commission (HHSC) selected eight additional sites, increasing YCOT coverage to 56 counties, including all the state’s most populous regions. The most highly populated urban sites, covering Dallas and Harris counties, each have two teams to meet anticipated demand. The map below indicates all counties served by YCOTs:



**Original YCOTs:**

-  **Bluebonnet Trails:**  
Bastrop County  
Burnet County  
Caldwell County  
Fayette County  
Gonzales County  
Guadalupe County  
Lee County  
Williamson County
-  **Border Region Behavioral Health Center:**  
Jim Hogg County  
Starr County  
Zapata County  
Webb County
-  **Burke Center for Youth:**  
Angelina County  
Houston County  
Nacogdoches County  
Newton County  
Polk County  
Sabine County  
San Augustine County  
San Jacinto County  
Shelby County  
Trinity County  
Tyler County

-  **Emergence:**  
El Paso County
-  **Heart of Texas:**  
Bosque County  
Falls County  
Freestone County  
Hill County  
Limestone County  
McLennan County
-  **My Health My Resources of Tarrant County:**  
Tarrant County
-  **North Texas Behavioral Health Authority:**  
Dallas County  
Ellis County  
Hunt County  
Kaufman County  
Navarro County  
Rockwall County
-  **Tri County Behavioral Healthcare:**  
Liberty County  
Montgomery County  
Walker County

**New (2026) YCOTs:**

-  **Bexar Co. CHCS**  
Bexar County
-  **Denton Co. MHMR**  
Denton County
-  **Gulf Coast Center:**  
Brazoria County  
Galveston County
-  **Harris Center:**  
Harris County
-  **Integral Care:**  
Travis County
-  **LifePath Systems**  
Collin County
-  **Texana Center:**  
Austin County  
Colorado County  
Fort Bend County  
Matagorda County  
Waller County  
Wharton County
-  **Tropical Texas:**  
Cameron County  
Hidalgo County  
Willacy County

**The Meadows Institute’s Role Supporting YCOT**

The Meadows Institute identified a profound need for YCOTs in Texas based on increasingly acute pediatric mental health concerns with few community-based solutions. Over several years, our Children, Youth, and Families team learned from MRSS programs in other states and brought implementation information to interested members of the Texas Legislature, HHSC, and many community partners.

With the establishment and growth of the program, the Meadows Institute has worked alongside the Texas Council of Community Centers and HHSC to provide direct support to YCOTs. In 2025, the Meadows Institute led a learning community to support the initial teams with early implementation, providing training and technical assistance on a range of topics including staffing, clinical best practice, community coordination, data driven quality

improvement, and working with children and youth with complex needs. Building on the success of the first learning community, the Meadows Institute launched a second learning community series in 2026, serving existing and new YCOTs across the state.

## Access to YCOT Services

### Who Can Use YCOT:

- All children and youth between ages 3-18 living or attending school in the counties served by YCOTs.
- YCOT does not have insurance requirements.
- YCOTs can be dispatched directly by a young person, their family, schools, or any other concerned individual.

### How to Use YCOT:

- YCOT calls are primarily received through the 24/7 crisis hotline operated by local mental health authorities.
- Most YCOTs operate during regular business hours, with several YCOTs offering after-hour services.
- YCOTs not operating 24/7 have additional resources they can provide as a bridge until a YCOT is available.

## Early Outcomes

Since launching in 2024, Texas's initial eight YCOTs have achieved meaningful results. YCOTs are successfully managing highly complex cases and have significant anecdotal data suggesting many of their cases would have resulted in out-of-home placement had they not intervened. Preliminary quantitative data from HHSC's September 2025 YCOT report show that the teams served 1,427 children and youth in the first 11 months of program implementation. The actual number of individuals served by YCOTs is likely much higher due to data lag time and family and household members not being represented in the count.

As YCOTs continue to hire staff and increase their reach, measurable results from the program are expected. HHSC is developing strategies for tracking outcomes, and community partners are already reporting some of the successes anticipated from the program, including emergency room diversion and avoiding out-of-home placements.

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<sup>1</sup> Vanderploeg, J. J., Randall, K. G., Becker, S., & Theriault, K. (2023). Mobile response for children, youth, and families: Best practice data elements and quality improvement approaches. Child Health and Development Institute. <https://www.chdi.org/index.php/publications/resources/mobile-response-children-youth-and-families-best-practice-data-elements-and-quality-improvement-approaches>

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<sup>2</sup> Washington Wraparound with Intensive Services. (2023). Cross System Involvement at Entry.

[https://fortress.wa.gov/hca/wisebhasreports/KingCounty.html#Cross\\_System\\_Involvement\\_at\\_Entry](https://fortress.wa.gov/hca/wisebhasreports/KingCounty.html#Cross_System_Involvement_at_Entry)

<sup>3</sup> Washington Wraparound with Intensive Services. (2023). Previously cited.

<sup>4</sup> Vanderploeg, J. J., Randall, K. G., Becker, S., & Theriault, K. (2023). Previously cited.

<sup>5</sup> Gill, P. J., Saunders, N., Gandhi, S., Gonzalez, A., Kurdyak, P., Vigod, S., & Guttman, A. (2017). Emergency department as a first contact for mental health problems in children and youth. *Journal of the American Academy of Child & Adolescent Psychiatry*, 56(6), 475–482. <https://doi.org/10.1016/j.jaac.2017.03.012>

<sup>6</sup> Wang, S., Li, Q., Lu, J., Ran, H., Che, Y., Fang, D., Liang, X., Sun, H., Chen, L., Peng, J., Shi, Y., & Xiao, Y. (2023). Treatment rates for mental disorders among children and adolescents: A systematic review and meta-analysis. *JAMA Network Open*, 6(10), e2338174. <https://doi.org/10.1001/jamanetworkopen.2023.38174>

<sup>7</sup> Robertson, E. L., Piscitello, J., Schmidt, E., Mallar, C., Davidson, B., & Natale, R. (2021). Longitudinal transactional relationships between caregiver and child mental health during the COVID-19 global pandemic. *Child and Adolescent Psychiatry and Mental Health*, 15, 66. <https://doi.org/10.1186/s13034-021-00422-1>