

The Future Mental Health System in Texas

Recommendations for Mental Health Transformation



**Report of the Mental Health Transformation
Workgroup to the Senate of Texas
Committee on Health and Human Services**

November 1, 2006

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MENTAL HEALTH TRANSFORMATION: THE HOPE

This is Valarie Garza's story about her son Daniel. Valarie Garza is a family member representative on the Texas Mental Health Transformation Workgroup. She is a former nurse and mental health worker and currently works for the Manor School district. She has three sons: Tony, who is a Marine; Riley, who is 12 years old and in school; and Daniel, who is 20, and was recently arrested. He now faces up to 80 years in prison.

Daniel's story is the rationale for transformation. Transformation is about changing the lives of people, not just making changes at state or agency levels. The objective of transformation is to learn from Daniel's experience and not repeat it.

Daniel had a troubled childhood. In the first grade, he was recommended for special education classes and was enrolled in mental health services through school and the local community mental health center. He had his first psychiatric hospitalizations at age 10 and was then involved with child protective services. At one stage, he had 19 hospitalizations in 3 months. His longest hospitalization was 7 months after which he was placed in a residential treatment center. Over the years, Daniel has received services or been involved with mental health agencies (public and private), child protective services, special education, juvenile justice, residential treatment centers, state hospitals and private hospitals.

At age 12, Daniel was enrolled in a System of Care initiative. This was the most successful two year period of his life with no incarcerations and only short term hospitalizations for stabilization. The System of Care initiative produced positive outcomes because treatment plans were individualized, strength-based, provided community-based supports and involved collaboration across several agencies.

But for the most part, services and documentation were duplicative and uncoordinated. Services did not support Daniel staying at home. Daniel's plan of care did not build on his strengths and abilities. Services were deficit-based and not responsive to his specific needs.

Using her records, Valarie developed an estimate for the costs of services that Daniel received:

• 3 years in residential treatment centers at an average of \$200 a day -	\$219,000
• One hour therapy sessions each week for 8 years at an average of \$45 per session -	\$18,720
• One psychological evaluation per year for 12 years at an average \$650 per evaluation -	\$7,800
• One medication management per month for 12 years at an average \$60 per appointment-	\$8,640
• Psychiatric hospitalizations at an average of 6 per year for 12 years at an (\$5,560 per stay)- stay for 10 days	\$400,320
• One 7 month psychiatric hospitalization	\$17,600
• Medication at an average of \$400 per month	\$38,400

The total of all these costs is **\$710,480**

Note that this estimate does not include the costs of special education services, child protective services, juvenile justice incarcerations and probation supports, lab work, informal supports, lost income to family, and the long-term trauma experienced by family members as a result of Daniel's challenges.

And now, Daniel faces up to 80 years in prison.

Unlike many others who need services, Daniel was able to get services from multiple agencies. Enormous resources were expended but positive outcomes were difficult to obtain because services were inappropriate or not coordinated.

The challenge of transformation is to ensure that this does not happen again. The hope is that persons with problems like Daniel's will have a successful and productive life.

THE FUTURE MENTAL HEALTH SYSTEM IN TEXAS: SUMMARY AND RECOMMENDATIONS

The ultimate objective of transformation is to build a mental health system that promotes wellness, resilience and recovery. Such a system is radically different from the system that exists today in which access to care is limited, quality of care is uneven, and coordination and continuity of care across agencies and providers is, for the most part, disjointed. To move the existing system in the direction of the vision of a transformed system will require broad-based commitment, consensus and support. Transformation will not occur just because there is a plan for transformation.

At one level, the mental health system must address the activities and immediate circumstances that exist in its current operations. At another, the system has to introduce change and innovation to remain responsive to the needs and priorities identified by consumers and family members.

Texas has existing interagency initiatives involving criminal justice, juvenile justice, rehabilitation services, and early intervention and a combination of urgent need and energy to drive transformation. Through a historical capacity to develop partnerships with universities, the mental health system has been able to incorporate the results and lessons learned from research into practice.

The building blocks for implementing transformation will be the use of new technologies, partnerships among agencies, and active and coordinated consumer and family member networks. Identifying key pivotal areas and learning from initial implementation experiences will be basic to the transformation process. The report highlights the findings of the Mental Health Transformation Workgroup which address the issues outlined in the August 7, 2006 letter from Senator Jane Nelson, Chair of the Senate Committee on Health and Human Services (Appendix 1):

- Building a mental health system that addresses early intervention, both in the course of illness and in the lifespan;
- Reducing disparities, across populations of different races/ethnicities and across geographic areas;
- Implementation of evidence-based practices in uniform, standardized ways across agencies;
- The use of new technologies, data coordination and sharing to enhance access and the quality of care; and
- Ensuring that consumers and family members have mechanisms to reflect their needs and priorities in policies, plans, and their own care.

The report also provides insight about the need for the transformation of the public mental health system and the service needs and priorities identified by consumers,

family members, and other stakeholders. However, it is not comprehensive in defining the future mental health system in Texas. *The Comprehensive Mental Health Plan for the State of Texas* and *Voices Transforming Texas: Assessment of Mental Health Needs and Resources* developed by the Mental Health Transformation Workgroup as part of the requirements of the federal Mental Health Transformation grant are companion documents to this report. (These documents are available at <http://www.mhtransformation.org>.)

In order to move forward with the transformation of the statewide mental health system, the following policy initiatives need to be considered:

- 1. Recognizing that early intervention and recovery are the policy direction for mental health services across agencies in the state.**
- 2. Requiring the Mental Health Transformation Workgroup to develop and assess screening tools and models for early detection of mental health problems in individuals, including children and adolescents.**
- 3. Developing interagency behavioral health data sharing protocols and coordination requirements to achieve efficient and effective care.**
- 4. Requiring the Mental Health Transformation Workgroup to develop, pilot and present recommendations for standardized definitions, training and contracting requirements for behavioral health services to the Senate Health and Human Services by November 1, 2008.**
- 5. Requiring the Mental Health Transformation Workgroup to develop a report about the return on investment of mental health services, including the cost effectiveness of behavioral health interventions in emergency rooms and in adult and juvenile justice systems as well as assessments of average daily school attendance and dropout rates in schools where behavioral health interventions are and are not used or were previously not used, by November 1, 2008.**
- 6. Developing common metrics and outcomes measures related to behavioral health interventions for state agencies which provide behavioral health services.**
- 7. Requiring the Mental Health Transformation Workgroup to submit a report to the Senate Health and Human Services Committee on the progress made related to mental health transformation and the strategies in this report by November 1, 2008.**

THE MENTAL HEALTH SYSTEM IN TEXAS: THE STATE OF THE STATE

The President's New Freedom Commission on Mental Health described the mental health system in America as being in "shambles". The system was identified in various ways as fragmented, inadequate, inefficient, and deficient.

The national picture also describes Texas. This situation has developed both nationally - and in Texas - paradoxically because of the success of mental health services being increasingly community-based. Over the last three decades, an increasing number of persons needing mental health care have received services in their home communities. As more people have remained in the community a multitude of programs and services, including those related to housing, employment, criminal justice, child welfare and education, have developed to meet the needs of adults and children with mental health disorders. The different eligibility criteria, standards of care, funding source reporting requirements and regulations, and a lack of coordination among the various federal, state, and local agencies involved have resulted in the fragmented and disjointed nature of the mental health system.

Mental health problems pervade our social fabric. An estimated 26.2% of Texans aged 18 years and older and about 1 in 4 adults suffer from a diagnosable mental disorder in any given year. Mental disorders are the leading cause of disability for individuals aged 15-44. A significant consequence of this prevalence of mental illness is the demand this places on social and human service agencies. The needs assessment conducted by the transformation initiative indicated that the following entities play major roles in treating Texans with mental illnesses: law enforcement, education, Medicaid, CHIP, the criminal justice system, the juvenile justice system, the Veteran's Health Administration and hospitals. A summary of the needs assessment is in Appendix 2.

The "public mental health system" is much larger than the perspective previously held. In Texas, the traditional definition of the public mental health system has been narrow. For the most part, it has been limited to the sliver of services provided and funded by the agency designated as the state mental health authority. The services have focused on a priority population of adults with serious mental illness and children with serious emotional disturbances, creating circumstances which have affected eligibility and definition of responsibility for adults and children who need mental health services but are not part of the priority population. In many cases, persons seeking services have had to decompensate or deteriorate in functioning or relinquish custody of children before they could obtain services.

This situation also created the need for other state agencies to develop mechanisms and services to address the mental health needs of persons not meeting the definitions of the state mental health authority priority population. Multiple agencies provide

mental health services and supports for different segments of the population in need. At the same time, the care for an individual may involve multiple agencies with varying degrees of coordination and continuity of care. Without coordination, services provided are sub-optimal and costly, not only in terms of the actual services but also in terms of the quality of life for persons with mental illness and overall costs to society as a whole.

The impact of behavioral health issues on Texans is very costly:

- 75% of children placed in foster care have parents with behavior health problems
- 75% of children in the juvenile justice system have behavioral health problems
- 30% of children in the juvenile justice system will end up in the adult justice system
- The best predictor of being involved in the child welfare system is having a parent in the adult justice system
- 46% of all emergency room visits involve behavioral health as a basic or contributing factor
- 30% of all truancy is related to behavioral health problems

This picture is exacerbated by demographic projections for the state. Currently, minority populations account for a large proportion of the demand for institutionalization and services through the juvenile justice system (for example, 76% of the youth receiving services from the Texas Youth Commission in FY 2005 were Hispanic (43%) or African-American (33%).). According to Dr. Steve Murdock, the state demographer, the state is projected to experience dramatic demographic shifts, in particular the growth of minority populations.

The Texas economy will be greatly strained if current rates of institutionalization and incarceration continue. The picture that emerges is serious. The inability to assure early intervention for school-age children increases the demands on the juvenile justice system. Participation in the juvenile justice system is a predictor of who winds up in the adult criminal justice system. Having a parent in the criminal justice system is a predictor of the use of the child welfare system. This is an intergenerational cycle and, if current trends continue, will only get worse.

While behavioral health issues permeate each stage of this cycle, interventions can reduce the current and projected economic burden confronting the state. The keys to halting the cycle is to adopt evidence-based mental health interventions that produce positive outcomes, to adopt the public health model to support early detection and intervention, and to promote interagency coordination of services.

Mental Health Services are a shared responsibility among a variety of state and local agencies. While this is currently the situation, with substantial resources being expended on mental health services outside the purview of Department of State Health Services (the state mental health authority), and several coordination and collaboration efforts underway, the interagency character of the public mental health system has not been formally recognized in policy.

The “public mental health system” has several strengths on which to build this future. Many of the current initiatives provide a platform to build this future. The incorporation of evidence-based practices through the resiliency and disease management (RDM) system, the crisis redesign initiative, initiatives related to interagency data coordination, experience with the development of S-systems of Care initiative for children and adolescents, and successes in jail diversion are the components of the future mental health system in Texas. Also, the mental health transformation initiative provides an opportunity to catalyze and facilitate needed activities to implement a public health service delivery model focusing on early intervention. A major challenge is shifting these initiatives from being time-limited projects to established interagency programs.

A public health approach which emphasizes early intervention is critical. To break the intergenerational cycle described above, a radical shift in the approach to mental health services is needed. No longer can the mental health system be a system which focuses on the “back end” where Texans must be increasingly dysfunctional to access and receive services. A new perspective which emphasizes early intervention, both in the lifespan and in the course of illness, must be explored if mental health interventions are to have a meaningful impact on the future for all Texans. Data are emerging from various studies which suggest that effective and timely access to mental health services can result in substantial cost offsets to other systems. A public health approach is not only appropriate from the perspective of outcomes for people, but is economically wise for the state.

THE FUTURE MENTAL HEALTH SYSTEM: VISION AND STRATEGIES

The Mental Health Transformation Workgroup developed a vision of the future system that incorporates the following principles:

- Texans will understand that persons living with mental illness are productive citizens who contribute richly to their communities.
- Children and adolescents will live with their families and families will receive needed supports.
- Texans will understand and support the prevention, early intervention and appropriate treatment of mental illness as an investment rather than a cost to improve the quality of life for all Texans.
- Texans having, or living, with mental illnesses and their families will have a strong voice in system design, implementation and resource allocation and will have choice, self determination and hope related to the services that are available.
- Texans will have quick, easy access to the services that they need.
- Texans will be able to access appropriate services through a multiplicity of agencies so that there is “no wrong door” and be able to get the right set of services regardless of where they access the system.
- The mental health system will incorporate “recovery” values related to choice, self-determination, hope and dignity.
- The service delivery system will have an adequate and competent workforce trained in state-of-the-art services.
- Data and information will be shared across agencies at both state and local levels to optimize care for individuals.
- Mental health, like physical health, will be an integral component of the well-being of Texans, contributing to positive outcomes related to performance in schools, employment, housing and quality of life.
- Partnerships will be forged among state agencies and local communities so that interventions related to behavioral health will mutually support and reinforce the goals of individuals and the goals of individual agencies.

The components of the workgroup’s plan related to the charge from the Senate Committee on Health and Human Services are provided below (an overview of the approach to transformation is provided in Appendix 3).

A. BUILDING A MENTAL HEALTH SYSTEM THAT ADDRESSES EARLY INTERVENTION, BOTH IN THE COURSE OF ILLNESS AND IN THE LIFESPAN

A focus on early intervention places a priority on interventions early in life – that is, interventions for pre-school and school-age children and on interventions in the early stages of experiencing problems or disorders (for example, returning veterans at risk of post traumatic stress disorder, receiving mental health screenings in primary care settings, persons receiving appropriate crisis services).

Based on the needs assessment activities, other populations identified were families/children involved in the child welfare system, adolescents transitioning to adult services, and children exiting the child welfare system as adults.

Early interventions in school settings emerged as a priority. This is consistent with findings at a national level which report that school administrators believe that the need for mental health services is increasing.

From the needs assessment component related to agency plans and interviews with the executive staff of the child-serving agencies, there was a consensus that many of the demands placed on their systems could be alleviated by early detection and strategies in pre-school and school settings. The focus of transformation activities on this population was considered to have high potential pay-offs in terms of societal goals of improving education outcomes and reducing the involvement of youth with the juvenile probation and juvenile justice systems. ***Early intervention is the fiscally responsible strategy for the state.***

Most children and adolescents who receive mental healthcare get it through their schools, not from primary medical or specialty mental healthcare providers. There is no uniform approach or standards for staffing or resource requirements to deliver such services. In a national survey, 13 percent of schools reported providing no mental health services, one-third use school or district-based staff and others contract with community-based programs.

A review of research on school-based mental health services published between 1985 and 1999 found that although there is a subset of strong programs that have evidence of their effectiveness, most school-based programs have no evidence to support their impact and no programs targeted to specific clinical syndromes such as anxiety, attention deficit hyperactivity disorder, and depression. This same study noted that precisely what is provided by schools under the rubric of mental health services and whether these services are effective are largely unknown (Rones and Hoagwood, 2000).

In a more recent survey of school districts, social, interpersonal, or family problems were identified as the most frequent type of mental health issues for both girls and boys (Abt Associates, 2006). For males, aggression or disruptive behaviors and

problems associated with neurological disorders were the second and third most-identified problems; for females, anxiety and adjustment issues were the most-cited problems. As children aged through school, depression and substance use and abuse were increasingly reported for both girls and boys. At the same time, less than half of all schools provide any substance abuse counseling: survey respondents identified it as a “very difficult” service to deliver. Similarly while high schools reported that substance abuse was the most frequent problem for boys, less than four percent of high schools have a substance abuse counselor.

Survey respondents identified the financial constraints of families, along with insufficient school and community-based resources, as key barriers to the delivery of needed mental healthcare in schools. More than 40 percent of school districts access Medicaid as a source of funding for mental health programs. Financing for school-based mental health services came from multiple streams, with the Individuals with Disabilities Education Act (IDEA) cited most often as the primary funding source.

National experts on school-based mental health services note that: (1) schools should not be responsible for meeting all mental health needs of their students (in some cases they are already overburdened with demands that should be addressed elsewhere); and (2) connections between school-based mental health services and substance-use treatment services are nonexistent or tenuous (Institute of Medicine, 2006).

These national findings have potential implications for the Texas transformation initiative. The Texas education system is already implementing several activities to address these issues. They include: the development of a “school climate” within which there is a continuous process of evaluation that covers behaviors which are potential barriers to learning; the implementation of a Texas collaborative on emotional development in schools; and a focus on addressing the role of the broader community in supporting children and adolescents.

At the same time, there are experiences in the Texas system to inform school-based and early intervention initiatives. The Texas Children’s Mental Health Plan funded a 0-3 prevention program, an early childhood intervention-substance abuse program for pregnant and new mothers and their children, and school-based mental health services. Over time, there was an attrition of these programs but there are “lessons learned” that can be applied to the proposed initiative. Also, the activities and infrastructure developed for early childhood intervention are potentially keys for proposed transformation initiatives.

Currently, the state is implementing an adolescent screening program that has tremendous potential for informing the transformation initiative. The adolescent behavioral health screening in primary care initiative represents efforts to transform primary care practices for youth with behavioral health needs. The public-private partnership (Texas Team), which represents DSHS and other public agencies, medical professional societies, medical schools, private practitioners, and advocacy groups in the public and private sectors, is developing a strategy to implement evidence-based

behavioral health screening as a regular part of primary care practice, incorporating a screening, assessment, and referral to treatment triage system in a variety of primary care settings, facilitating linkage to integrated treatment, when appropriate.

This supports the idea of a full-service medical “home” that behaves as a single point of access for overall health needs that include substance use/abuse, mental health and physical/medical care. By increasing the number of screenings conducted in primary care settings, the system is expected to be able to provide intervention earlier, thereby reducing the overall impact of behavioral health problems for children and adolescents.

Another set of initiatives that informs transformation activities for this population are based on the System of Care approach promoted by Substance Abuse and Mental Health Services Administration (SAMHSA). The SAMHSA program has funded four Texas communities, and the Texas Integrated Funding Initiative (TIFI) has also funded four communities (with possible expansion to eight or ten communities). Materials developed by TIFI committees related to core competencies and financing will also be a useful basis for proposed activities.

Some of the strategy areas considered for this population are listed below.

Strategy A.1: Assess the current situation in Texas on the availability, linkages with the community, and financing for school-based mental health services.

Strategy A.2: Develop linkages between the community collaboratives proposed under the transformation initiatives and the education collaboratives. (In some cases, depending on the priorities of a community, the education collaborative could serve as the community behavioral health collaborative.)

Strategy A.3: Build on current initiatives related to early childhood intervention, SAMHSA-supported Systems of Care projects, and the Texas Integrated Funding Initiative related to the objective of building a population-based, early intervention approach for children/adolescents.

B. REDUCING DISPARITIES, ACROSS POPULATIONS OF DIFFERENT RACES / ETHNICITIES AND ACROSS GEOGRAPHIC AREAS

The issue of race and ethnicity is linked not only across agencies but also across generations. Data analyses within the Texas system suggest that persons receiving inadequate mental healthcare over time are likely to be increasingly involved with the justice system (for both adults and youth). The children of adults involved in the criminal justice system also have a higher probability of being involved in the child welfare system and that being involved in the child welfare system increases the

chances of being involved in the juvenile justice system, and that those in the juvenile justice system are more likely to be involved in the adult criminal justice system. That is, there is an intergenerational cycle that perpetuates itself across agencies. Disparities in the types and availability of services along race and ethnicity lines are part of this cycle.

The Transformation Workgroup recognized these linkages across agencies related to disparities, especially in terms of the impact on communities of color. Each agency has its own initiatives in this regard. The challenge is to establish uniform and consistent metrics to address the issue of disparities in a concerted fashion. A major objective will be to identify these individual initiatives, examine the potential for collaboration, and develop some metrics that could be used among agencies.

Strategy B.1: Identify key state agency initiatives related to the reduction of disparities and opportunities for collaboration.

Strategy B.2: Develop and implement metrics related to reduction of disparities across agencies.

Furthermore, there is a lack of adequate services and human resources in rural areas. In many counties, access to mental health professionals is difficult; recruitment and retention of mental health professionals is an ongoing problem; and transportation for consumers and family members is an issue. Consumers, advocates and state agency representatives were consistent in this regard.

Many of the other strategies in this report are targeted at building models and developing initiatives in rural areas. The use of new technologies is of special relevance where the potential of telemedicine will be explored. Similarly, the availability of evidence-based practices and workforce development initiatives, which both supplements training on mental health issues for primary care providers and addresses recruitment of mental health care professionals, will also have a special focus on initiatives for rural areas. As transformation at the local level is addressed, at least one of the proposed community behavioral health collaboratives will have a rural focus.

Strategy B.3: Assess the use of telemedicine and new technologies to increase access and quality of behavioral healthcare in rural areas.

Strategy B.4: Explore initiatives related to workforce development that address shortages of mental health professionals in rural areas.

Strategy B.5: Establish community behavioral health collaboratives in rural areas as a prototype for development of infrastructure related to behavioral health services in rural areas.

C. IMPLEMENTATION OF EVIDENCE-BASED PRACTICES IN UNIFORM, STANDARDIZED WAYS ACROSS AGENCIES

A major concern noted in both the Surgeon General's Report on Mental Health and the President's New Freedom Commission Report was the lag time between what is known through research and the implementation of effective programs and services in actual practice. Even when implementation does occur, it is often limited to demonstration sites or proves to be difficult to sustain over time. Increasingly, infrastructure issues related to training/workforce development, integration with existing services and programs, data and financing are factors which affect the implementation status of effective practices.

Texas requires that services provided through the state mental health authority (Department of State Health Services) are evidence-based. The Resiliency and Disease Management System is a response to this mandate. This model provides different levels of services for persons with different levels of need.

As the emphasis shifts to a population-based public health initiative, the populations receiving services, the services themselves, and the agencies involved are broader. The implication of this is that evidence-based practices such as those identified by SAMHSA'S current toolkits that target adults with serious mental illnesses will not suffice. Evidence-based services related to prevention and early intervention, to persons receiving services in primary care, school and justice-related settings and to consumer-run services are needed.

SAMHSA'S second generation activities take this broader perspective and are targeting areas such as older adults with depression, children with disruptive behaviors, consumer-run programs, supported housing and mental health promotion. The practices developed in these activities will complement Texas' transformation effort.

Another challenge is the different perspectives on evidence-based practices by the various agencies involved with the transformation initiative in Texas. As the TWG subcommittees are convened, this is an issue that will need to be broached and resolved.

Coordination of evidence-based services

Currently, each state agency has its own approach to the delivery of evidence-based or promising behavioral health services. It is not clear whether definitions and standards are consistent for such services. Also, as noted above, the range of services that are "evidence-based" needs to be expanded to address the broader population and the expanded range of services envisioned in the Texas transformation effort. As implementation workgroups are formed, this will be a specific area that they will address.

Strategy C.1: Develop and coordinate uniform standards, processes, data and contracting requirements for behavioral health services across state agencies.

Another aspect of developing the uniform availability of such evidence-based practices is the development of an adequate, well-trained workforce training infrastructure. Training and workforce development were identified as critical areas requiring urgent attention by most of the agencies in Texas involved in the delivery of mental health services. Data presented in the needs assessment also reflected that manpower projections for mental health professionals such as psychiatrists, nurses and social workers in the higher education pipeline would not be adequate to meet the demands of population growth and changing demographics in the state. The other area of training which needs to be addressed is building up the competencies of the existing workforce. However, there are several initiatives currently occurring within the state related to workforce development and training, models are emerging in other parts of the country, and activities under the transformation rubric have uncovered some opportunities and could help contribute to advances in building the needed infrastructure.

Some of the key issues identified are:

- There is an inadequate professional workforce to address the mental health needs of special populations such as children and youth, and older adults. In Texas, as in the rest of the country, this lack is more acute in rural areas. In some parts of the state, university sponsored stipends and scholarships to address this need have been developed but the response has been relatively poor.
- University and community college programs are not preparing graduates for the realities of practice. They are also not addressing emerging practices and concepts such as evidence-based practices, cultural competence and recovery.
- Primary care physicians and other health care professionals are inadequately trained to screen, detect or address mental health problems.
- Human service professionals and others who have to help or provide services to persons with mental illness (law enforcement, child welfare, teachers) do not have adequate training about mental illness, the treatment and expectations in terms of behaviors and responses.

These themes recurred in issues reported by various state agencies and were reinforced by a recent workshop on workforce development convened by the Hogg Foundation. Five broad areas were identified: education and training; recruitment and retention; cultural and linguistic diversity; consumer initiatives; and paraprofessionals and continuing education.

Some of the recommendations that emerged from the workshop included:

- Better use of community colleges and universities;
- Use of properly trained mid-level providers (nurse practitioners and physician assistants) to provide basic levels of behavioral health;
- Support for consumers and family members to train professionals;
- Use of technologies such as distance learning;
- Credentialing and curriculum development for front-line mental health workers;
- Support of a rural workforce development initiative;
- Recognition of consumers and family members in the workforce;
- Provision of incentives to attract and retain talented individuals to the mental health work place; and
- Coordination with accreditation and licensing entities to incorporate a behavioral health component in requirements.

Based on the needs assessment and this context, strategy areas to achieve this goal are:

Strategy C.2: Develop collaborations with universities and community colleges to develop appropriate training programs and the use of new technologies to promote distance learning initiatives.

Strategy C.3: Work with licensing/credentialing bodies and Texas Higher Education Coordinating Council to address curriculum requirements.

Strategy C.4: Facilitate the credentialing and employment of consumers and family members in the workforce.

Strategy C.5: Address rural workforce development needs through the use of telehealth and other technologies.

D. THE USE OF NEW TECHNOLOGIES, DATA COORDINATION AND SHARING TO ENHANCE ACCESS AND THE QUALITY OF CARE

The Transformation Workgroup members stressed that data and information coordination and sharing should occur across agencies, institutions, programs, and units of state and local governments.

Information technology is a linchpin of the future mental health system in Texas. Activities related to the development of electronic health records are already proceeding at a rapid rate at federal, state and local levels. In the future mental health system, electronic health care records will be used to share client data, track outcomes, and facilitate collaborative planning across service systems. There are several initiatives already underway which can be the basis for future activities. Web-based technologies that have been refined and tested for behavioral health services could potentially be modified for application to a broader set of agencies.

The Transformation Workgroup has created a data and technology coordination subcommittee to develop operational priorities and guidance for such activities. At the state level, the data-sharing projects that have been implemented or are currently underway provide a platform on which to build these activities. For example, there is an initiative to share data between DSHS and the Department of Criminal Justice; similarly, there are initiatives for youth in which data is shared across DSHS, Texas Education Agency, the Juvenile Probation Commission and the Department of Family and Protective Services.

There is a national SAMHSA initiative in which Texas is participating to obtain behavioral health data across agencies. This initiative will develop standardized protocols and instruments for obtaining data across agencies.

While such initiatives are useful for planning and evaluation, they are relatively limited in terms of improving care.

The Transformation Workgroup is cognizant of the recommendations in *The Road Map for the Mobilization of Electronic Healthcare Information in Texas*, the recent report of the Health Information Technology Advisory Council. As the report points out, mobilizing health information electronically has the potential to improve the quality and safety of healthcare by providing ready access to clinical data at the point of care and by reducing administrative costs and duplicative testing.

As the recommendations of this report are implemented, there is a need to ensure that as standards and data content requirements are established, behavioral health needs are adequately addressed.

In summary, the strategies that will be explored to advance the development of the information technology and data coordination/exchange infrastructure include:

Strategy D.1: Develop mechanisms for data coordination and exchange across agencies at the state level.

Strategy D.2: Participate in the federal SAMHSA initiative for obtaining behavioral health data across agencies using standardized protocols and instruments.

Strategy D.3: Support the use of new technologies and implementation of data and information exchange mechanisms at the local community level through the community collaborative component of transformation activities.

Strategy D.4: Develop recommendations for and participate in federal and state-level initiatives to ensure that behavioral health services are adequately reflected in EHR initiatives.

E: ENSURING THAT CONSUMERS AND FAMILY MEMBERS HAVE MECHANISMS TO REFLECT THEIR NEEDS AND PRIORITIES IN POLICIES, PLANS, AND THEIR OWN CARE

A principal goal in the President's New Freedom Commission report is that mental healthcare must be consumer and family driven, that consumers and family members must be placed at the center of service decisions, and that consumers' needs, not program requirements, must drive the services they receive.

As the report points out, today's mental health system has failed to facilitate the recovery of people with mental illness. Piecemeal approaches focusing on the introduction of specific programs, in the absence of larger shifts in underlying philosophy, have failed to have a lasting impact (Fisher, 2004).

Key to this goal is the building of a recovery culture. The National Empowerment Center has proposed an empowerment model of recovery in which the expectation is that people with mental illness can completely recover by taking control of the major decisions of their lives and thereby assume (or resume) major social roles. In this model, people may continue to experience symptoms or use medication; the hallmark of recovery is the individual regaining control of her or his life and filling valued social roles.

Within the transformation context, issues arise related to the relevance of recovery to different populations (children and youth, older adults) or across agencies. However, the basic premises of the recovery values (self-determination, choice, hope, strength-based) cut across populations and settings. ***A fundamental tenet of transformation is that persons living with mental illnesses are people with holistic needs and that their lives should not be disrupted by policy and funding silos.***

Based on this national context and priority, the consumer and family member leadership of the Transformation Workgroup has identified several strategies through which to move towards transformation that is increasingly consumer and family member-driven.

These strategies include:

- Promotion of recovery and recovery-education.
- Building a consumer education initiative related to transformation across agencies using agency conferences, development of transformation topics materials, and the use of communications technologies such as videoconferences.
- Building stronger relationships and communication networks across consumer and family member organizations.
- Supporting the development of peer support and peer support certification programs.

- Using existing models such as the System of Care initiative to build on partnerships with consumers and family members.

Under the leadership of the TWG consumer and family member representatives, a consumer town-hall meeting was convened at the State Capitol to identify consumer needs and start the process of building a network. This town-hall meeting included consumers from all agencies that provide mental health services, not just consumers of the state mental health agency. The directions proposed above were substantiated and supported through the comments received. The meeting also identified several specific issues that will require attention both at state and local levels.

An outstanding issue is defining a “consumer and family driven” system. Although the President’s New Freedom Commission Report proposes the system, the actual process to implement such a system is not addressed. This is an area that the Texas transformation initiative will need to address, especially given the broad, population-based approach that the state is proposing to implement. Implicit in moving forward on this effort is defining “consumer” and “family member”.

To achieve this goal, a consumer advisory committee under the leadership of the TWG consumer and family members is being formed. Also, to support these activities, a consumer coordinator position is also proposed.

In summary, the strategy areas related to this goal are provided below.

Strategy E.1: Build a recovery culture through education and networking initiatives at the state and local levels.

Strategy E.2: Build improved education, networking and information exchange opportunities for consumers, family members and their organizations.

Strategy E.3: Initiate a state-level effort to implement peer support programs across the state.

Strategy E.4: Explore partnership models with consumers and family members at state and local levels.

**APPENDIX 1: Charge from Senate Interim
Committee on Health and Human Services
to the Mental Health Transformation
Workgroup**



THE SENATE OF TEXAS
COMMITTEE ON HEALTH AND HUMAN SERVICES

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SENATOR JON LINDSAY
SENATOR ROYCE WEST
SENATOR JUDITH ZAFFIRINI

August 7, 2006

Albert Hawkins
Executive Commissioner
Texas Health and Human Services Commission
4900 North Lamar Blvd.
Austin, TX 78751

Dear Commissioner Hawkins:

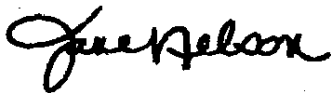
It is my understanding that the partnership of state agencies represented on the Mental Health Transformation Workgroup is beginning to make headway. I cannot emphasize enough the importance of this initiative in building the future mental health service delivery system in Texas. The participation of your agency is critical, as consideration of your programs and consumers is integral to the success of this effort. As you know, the Senate Committee on Health and Human Services is also charged this interim to study and make recommendations for improving delivery of Texas' mental health services; consider local and regional delivery systems including access to care, cost effectiveness, choice and competition, and quality of care."

The priorities of the Workgroup to reduce fragmentation and build a solid foundation for delivering and sustaining mental health and related services, address stigma and the role of consumers and family members, reduce disparities, and focus on the quality and efficiency of care is fully aligned with the intent of the interim charge to the committee. To aid the work of the committee, we would like to receive a report from the Mental Health Transformation Workgroup with specific recommendations for the future mental health system that would be both optimal and achievable. The report should consider the mental health system to be inclusive of services purchased or provided with public funds. This report should address (but not necessarily be limited to):

- Building a mental health system that addresses early intervention, both in the course of illness and in the lifespan;
- Reducing disparities, across populations of different races/ethnicities and across geographic areas;
- Implementation of evidence-based practices in uniform, standardized ways across agencies;
- The use of new technologies, data coordination and sharing to enhance access and the quality of care; and
- Ensuring that consumers and family members have mechanisms to reflect their needs and priorities in policies, plans, and their own care.

In order to assist the work of the Senate Committee, we need to receive this report from - the Transformation Workgroup no later than November 1, 2006. I have charged Commissioner Eduardo Sanchez with coordinating the compilation of all Workgroup agencies' input into this report. If you have any questions regarding this request please contact our Committee Director, Amy Herzog.

Very truly yours,



Senator Jane Nelson

cc: Governor Rick Perry
Representative Dianne Delisi
Texas Mental Health Consumers: Mike Halligan, Stephany Bryan,
Valerie Garza
NAMI Texas: Robyn Peyson

APPENDIX 2: Needs of the Future Mental Health System

(This is an overview of a major needs assessment conducted as part of mental health transformation activities. The comprehensive needs assessment is available at <http://www.mhtransformation.org>).

NEEDS OF THE FUTURE MENTAL HEALTH SYSTEM

To prepare the Comprehensive Mental Health Plan for Texas as part of the Transformation Workgroup (TWG) Initiative, the TWG sponsored or used several activities that reflected mental health needs and priorities. These included: a “Consumer Voice” town hall meeting conducted at the State Capitol on August 8, 2006; an analysis of state agency strategic plans; interviews conducted with the executive staff of the 14 state agencies represented on the TWG; public hearings conducted on crisis redesign held in February 2006 at Big Spring (rural area), San Antonio (urban area), Harlingen (border area) and Austin (statewide). The results of these different efforts are provided in a companion document, *Voices Transforming Texas: Assessment of Mental Health Needs and Resources* (September, 2006).

The results of these various needs assessments are summarized in this section.

I. State Capitol Consumer Voice Forum (August 8, 2006)

The Texas TWG held a consumer voice forum at the State Capitol in Austin on August 8, 2006. Consumers came from across the state to provide verbal or written testimony. Those who could not attend in person had the opportunity to access the forum via webcast. The webcast is now posted on the Texas transformation website: <http://www.mhtransformation.org> and at <http://www.dshs.state.tx.us/transformation>

Approximately 180 consumers attended the forum: 70 provided verbal testimony and 39 provided written testimony. Testimony was organized in terms of the questions posed:

- What is working well in the system?
- What are the high priority needs not being met?
- How can the system be more responsive to your needs?

A unique aspect of the forum was that the consumers attending were consumers not just of the traditional specialty mental health sector but included consumers of other agencies such as the Texas Veteran’s Commission, the Texas Education Agency and the Texas Department of Assistive and Rehabilitation Services. Consumers attending the forum had accessed services through twelve different agencies and many indicated specific projects and local programs that had helped them.

The themes that emerged are reflected on the next page.

THEMES IN CONSUMER RESPONSES

What works well in the current system?
<ul style="list-style-type: none"> • Collaboration at local level • Peer support and self-management groups, when available • Active role in treatment planning • Peer Support, when available • Recovery Support Services, when available (e.g. Purchase books to help finish school; Housing Assistance; Medication; Job Training and Employment Assistance) • Jail Diversion
What needs are not being met?
<ul style="list-style-type: none"> • Recovery Support Services (Housing Assistance, Medical Assistance, Job Readiness, Training and Employment Assistance) • Peer Support Services and Affordable Social Interaction Opportunities • Consumer and Family Inclusion in Treatment Planning • Timeliness of Services • Lack of treatment services, providers, and caseworkers • Long waiting lists, discontinuous care, little time with clinician • Greater public awareness and education of mental health • Eligibility: “Straighten out” Medicaid; SSDI designation • Training and diversity of professionals (e.g. mh, law enforcement, physical health) • Lack of resources in the system • Transportation
How can the system be more responsive to the needs?
<ul style="list-style-type: none"> • Early identification, intervention and easier access (particularly when in crisis) • Resources for safe and affordable housing • Funding, training and implementation of peer support groups; certification of peer support programs • Increase “voice” for children, youth, and include family • Systems of care for children and their families • Outreach to Spanish-speaking communities and increased Spanish-speaking professionals • Better services for consumers who are deaf or with other disabilities • Improve specialized services for special populations such as women, veterans, homeless, the deaf, blind, or others with disability. • Training for staff (in all professions working with mental health) • Education for teachers and parents • Assistance for the uninsured • Improved coordination of service as a “one stop” so getting assistance isn’t a full time job • Reduce provider caseload • Reduce waiting time for services • Increase jail diversion

As the table indicates, what works well in the current system was collaboration at the local level, peer support services, recovery support services, and jail diversion. A point that was reiterated was that these worked well *when available*.

Many of the needs identified were related to having more of what worked well: recovery support services, peer support services, consumer inclusion in treatment planning. Other needs not being met were: lack of treatment services and providers, greater public awareness, training and diversity of professionals, and transportation.

Factors that were identified as critical for the system to be more responsive to needs were: early identification, intervention and easier access (particularly when in crisis); resources for safe and affordable housing; funding, training and implementation of peer support groups; expansion of the System of Care initiative; outreach for Spanish-speaking consumers; improved coordination and specialized services for specific target populations such as women, veterans, persons who are deaf or have disabilities, the homeless. A major underlying factor in these responses was the need for a stronger recovery orientation so that the future system could be built on people's strengths and a sense of hope and inclusion rather than a focus on dysfunction and ostracism. Another underlying current was the need to have increased "consumer voice" and to obtain support for building consumer networks and for consumer and family member education.

II. State Agency Behavioral Health Needs and Priorities

Based on an analysis of the agency strategic plans, interviews conducted with the executive staff of state agencies and input provided by state agencies participating on the Mental Health Transformation Workgroup, some key themes emerged which is the basis of the Comprehensive Mental Health Plan for Texas. These themes are presented below.

Increase access to mental health services so that there are reduced demands on other state agency services. There was general recognition across the agencies that if adequate mental health services were available on a statewide basis, this would reduce the demands on the services provided by various agencies such as the Texas Youth Commission and juvenile probation services. Also, adequate services would result in achieving societal goals related to employment and school performance.

Early intervention in the lifespan and in the course of illness is critical. This theme was related to the one above but the emphasis here was on early intervention so that problems are addressed as they are emerging rather than when they are critical and extreme. Research suggests that interventions with infants and children result in reduced demands on social services later in life. Such services essentially break the “vicious cycle” identified earlier in the report. This theme recognizes that such early intervention may need to occur in settings such as schools and pediatricians’ offices rather than in settings related to dealing with problems and illnesses.

Developing an adequate mental health workforce is a high priority need. This was a recurring need across agencies with a special emphasis on the need for an adequate workforce in rural areas. There is a lack of mental health professionals and, as the needs assessment indicates, this problem is likely to get worse if steps are not taken to address the issue. At the level of mental health professionals, there are critical shortages that exist and are projected for psychiatrists and psychiatric nurses. At the level of paraprofessionals, salaries are not competitive and there is the lack of a career ladder, resulting in high turnover rates. At the same time, current curricula do not reflect state-of-the-art practices and interventions. Incentives need to be developed to attract talent to health and human services and better coordination is needed with institutions of higher learning.

New technologies should be used to address workforce and training infrastructure shortcomings. Many agencies defined telemedicine as a potential technology to address workforce and training shortcomings but emphasized that adequate infrastructure must be provided to sustain these technologies over time. Also, other technologies such as instant messaging and use of the World Wide Web were being used to enhance direct services and were cited as models to replicate and disseminate.

Data-sharing and coordination were regarded as an essential, first step in developing an interagency culture related to mental health services. There are several initiatives underway related to data-sharing and coordination across agencies that have resulted in increased efficiency and effectiveness. These have included juvenile justice and the adult criminal justice agencies. Also, there are several such initiatives being implemented at the local level. There is a critical need to increase the number of agencies participating in such initiatives but there are regulations, both at the federal and state levels that are potential barriers to such data-sharing and coordination.

Housing needs were identified as a high interagency priority. Reflecting the priorities identified by consumers and family members, state agencies have identified housing as a basic and primary need. Research indicates that the lack of stable housing exacerbates the need for other health and human services. The Transformation Workgroup has created a special workgroup to address this need.

III. Public Hearings

While the focus of the public hearings was on crisis services, many of the issues and priorities identified were general in nature and had broader ramifications. Some of the key themes that emerged from the hearings included:

- **Transportation:** This was a huge unfunded mandate for local government; there was confusion regarding governmental responsibility; and there was a lack of availability of transportation, especially in rural areas.
- **Financial Resources:** Inadequate state resources for mental health crisis services for indigent populations; lack of understanding that crisis services like other medical emergency services are used by a community at large.
- **Admission Criteria For State Hospitals:** Widespread misunderstanding regarding the need for hospitalization as a result of inadequate community resources
- **Training:** Need for training of law enforcement, crisis workers, first responders, crisis hotline workers.
- **Integration with Health:** Need for integration with health services; training needs for medical practitioners and public health workers.
- **Attention to Families:** Family input not sought or used; little attention to families' concerns and knowledge; displacement issues for children.
- **Specialists:** The need for competent, well-trained specialists.
- **Standardized Approach:** Lack of agreed-upon, shared interpretations of rules and regulations; the need for clearer standards
- **Types of Services:** Evidence-based models are not being implemented.
- **Jail as Option:** Lack of mental health resources results in jail placement.

APPENDIX 3: The Approach to Transformation

(This approach is part of the Comprehensive Mental Health Plan for Texas developed by the Mental Health Transformation Workgroup. This comprehensive plan is available at <http://www.mhtransformation.org>).

THE APPROACH TO TRANSFORMATION

As the scope of the Texas transformation goals indicate, the ultimate objective is to build a mental health system that promotes wellness, resilience and recovery. Such a system is radically different from the system that exists today in which access to care is limited, quality of care is uneven, and coordination and continuity of care across agencies and providers are, for the most part, disjointed. To move the existing system in the direction of the vision (on page 7) will require broad based commitment, consensus and support. The objectives of transformation are depicted in Table 1.

Transformation will not occur just because there is a plan for transformation or because the rhetoric of transformation permeates the mental health system. It is important, therefore, to be operationally clear how Texas intends to broach the daunting task and challenge of transformation.

At one level, the mental health system is attempting to address the activities and crises that arise in its current operations. At another, the system is trying to introduce change and innovation so that the system is both credible and responsive to the needs and priorities identified by consumers and family members.

How is such a transformation going to happen?

Experts who have studied transformation across a range of industries have identified some general principles that essentially constitute the knowledge base and the best thinking (the “evidence”) on transformation. It is these principles that will be applied in the Texas context. For the purposes of this plan, we will call these principles evidence-based transformation.

Evidence-based transformation essentially identifies three distinct but overlapping components: building the case and vision for transformation, promoting and learning from the implementation of innovative structures and practices; and sustaining and disseminating the innovative structures and practices so that they are key operational features of the envisioned system.

To build the case and vision for transformation, there must be consensus regarding the need and urgency for change and on the broad outlines of the proposed future system. To promote the implementation of innovation, there must be commitment and support for change among many different groups – consumers, providers, legislators and agencies and at the different levels of leadership with palpable, measurable results. These results must not only be significant but must also be sustained so that the outcomes achieved are not short-lived but achieve a degree of permanence in how business is done as usual. These outcomes also have to become expectations for the larger system and such a transition has to be supported through technology, training, workforce development, and support for consumer and family member leadership, networking, communication and education.

An important component of building innovations into the system is the continuous refinement so that innovation implementation is optimized.

For system-wide dissemination, the alignment of the infrastructural components is essential. From a policy perspective, there needs to be consistent goals across federal, state and local governments, including funding and financing incentives.

Similarly, management and administrative functions such as resource allocation, contracting, quality improvement, technical assistance and training must also support the goals and initiatives related to transformation.

Table 1: Transformation Objectives

Transformation Objectives		
<u>Current</u>		<u>Transformed System</u>
Persons receiving services	→	Population-based; early intervention
Agency “silos”	→	Coordinated care; “no wrong door”
Piecemeal, fragmented training	→	Well-defined workforce development / training infrastructure
Data Compartments	→	Data – sharing and coordination
Consumer and family member involvement	→	Consumer and family driven - system
Persons falling through agency “cracks”	→	Seamless continuity of care

What is needed to implement such a transformation initiative?

There are various models of transformation but the common themes include:

- (1) Commitment of executive and legislative leadership
- (2) Competent executive management supportive of transformation goals
- (3) A strong and vibrant consumer and family member “voice”
- (4) Resources and flexibility to support innovation
- (5) A capacity to review and refine innovation implementation
- (6) Development and implementation of the right metrics to monitor achievement of transformation goals
- (7) Local community collaboratives with strong leadership across stakeholder groups including consumers and family members
- (8) The capacity to develop protocols from the experiences of innovation implementation
- (9) The capacity to reward and provide incentives for movement towards transformation goals

Fortunately, Texas has several strengths on which to build a transformation initiative. Through a historical capacity to develop partnerships with universities, the state has pushed a research agenda with the commitment to incorporate the results and lessons learned into practice. Also, the state has implemented several funding strategies for behavioral health services which can inform transformation efforts. More recently, the state has restructured health and human service agencies so that public health, mental health and substance abuse are part of the same agency.

This organizational merger has also fostered interagency initiatives that involve criminal justice, juvenile justice, rehabilitation services, and early intervention. These initiatives are a platform on which to further develop these existing initiatives as well as new ones. The Systems of Care initiative funded by SAMHSA’S Center for Mental Health services has also provided a model for implementing interagency initiatives at the local community level.

Several other federally funded initiatives will also inform and support the Texas transformation initiative. These include the Data Infrastructure Grant through which the state reports National Outcomes Measures for mental health, and projects related to substance abuse related to prevention programs and initiatives facilitating knowledge transfer.

So, while the challenges of transformation are formidable, Texas has a track record that makes them more manageable. Texas has strengths and initiatives, and a combination of urgent need and energy to drive transformation. The building blocks for implementing transformation will be the use of new technologies, partnerships among agencies, and active and coordinated consumer and family member networks. Identifying key pivotal areas and learning from initial implementation experiences will be basic to operationalizing transformation.

First, Mental Health Transformation in Texas will build on current strengths and initiatives.

Second, this mental health transformation will address the priorities and needs identified by consumers and family members and the various agencies participating in the Transformation Workgroup appointed by the Governor.

Third, Transformation efforts will propose innovations through demonstration or community projects which will serve as learning experiences from which the larger promulgation of transformation initiatives can be based. Resources are limited and until innovations can reflect a return on investment that might garner greater funding and support, the innovations introduced will have to be selected judiciously so that they can be successful as transformation “wins.”

Finally, the emphasis will be on initiatives which have the greatest potential for movement towards transformation. The emphasis is on identifying specific populations, services and initiatives on which to build knowledge and experience to further transformation.

The biggest barrier to transformation is the lack of a collective belief in common goals. This lack of common goals exists horizontally across agencies and across stakeholder groups and vertically across state and local systems. A major objective of this plan is to continue the process of shaping and defining this belief so that the benefits are perceived as “wins,” at least in some measure, by all involved.