

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

A meeting of the Texas Mental Health Transformation Workgroup (TWG) was held in the Robert D. Moreton Building, Board Room (M-739), 1100 W. 49th Street, Austin, Texas on Tuesday, August 5, 2008, from 1:00 pm – 4:30 pm.

Transformation Workgroup (TWG) Members present:

Dr. David Lakey, **TWG Chair** (Department of State Health Services)
Mike Maples (Department of State Health Services)
Ann Marie Price (Office of the Governor)
Nnenna Ezekoye (Texas State Senate)
Tom Valentine (Health and Human Services Commission)
Jon Weizenbaum (Aging and Disability Services)
Jim Hanophy (Department of Assistive and Rehabilitative Services)
Sue Milam (Department of Family and Protective Services)
Brenda Hull (Department of Housing and Community Affairs)
John Fuller (Texas Workforce Commission)
Richard Poe (Texas Education Agency)
Kathryn Kotrla (Texas A&M College of Medicine)
Tracey Levins (Texas Youth Commission)
Charles Buerschinger (Texas Veterans Commission)
Mike Halligan, Maurice Dutton, Stephany Bryan (Consumer, Youth and Family Member Representatives)

MHT Community Collaborative Representatives

Dallas County Project Transform

Dan Salas (North Texas Behavioral Health Authority)

Williamson County Mental Health Task Force

Kathy Grimes (Williamson County)

Coastal Bend Rural Health Partnership

Barbara Giovannone (Coastal Plains Community MHMR Center)

Llano Estacado Alliance for Families (LEAF)

Kay Brotherton (Floyd County Courthouse)

Jere Newton (Consumer)

Bexar County Safety Net Community Collaborative

Leon Evans (Center for Health Care Services)

Isaac Martinez (Center for Health Care Services)

Gilbert Gonzales (Center for Health Care Services)

Tarrant County Transformation Project

Kelly Mays

Richard Vickers

Mollie Kuchla

Michelle Dooley

Project Implementation Team Members present:

Sam Shore, MHT Project Director, DSHS
Dolly Klinefelter, Executive Assistant, DSHS
Steve Eichner, IT Project Manager, DSHS
Ellen Trevino, Contracts Manager, DSHS
Mimi McKay, MHSA Information Center Director, DSHS
Stacey Stevens, UT Center for Social Work Research
Camille Miller, CEO, Texas Health Institute
Susan Griffin, MHT Community Development Specialist, Texas Health Institute
Valarie Garza, MHT Consumer Coordinator, Texas Health Institute

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
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1. Call to Order / Review and Approval of Minutes

- a. Dr. David Lakey, Commissioner of the Texas Department of State Health Services (DSHS) and Chair of the Texas Mental Health Transformation Workgroup (TWG), called the meeting to order at 1:04 pm.
- b. Dr. Lakey called for the approval of the minutes from the May 6, 2008 meeting. A motion was made and seconded to accept the minutes without change. The motion was approved unanimously.

2. Director's Report – Sam Shore, MHT Project Director

- a. **2008 Policy Academy**
An application has been submitted for the 2008 Policy Academy on developing systems of care for transition age youth with mental health needs. The application is not for a grant, but for the opportunity to attend advanced technical assistance in policy planning through the National Technical Assistance Center for Children's Mental Health at Georgetown University in the Washington DC area. If selected, a delegation of 7 representatives from Texas will be funded to attend the Academy and will receive one year of technical assistance as the policy changes are implemented. All award applicants will be notified of selection results by August 29, 2008.
- b. **Community Collaboratives**
Representatives of the Community Collaboratives attending the TWG meeting were acknowledged. The Collaboratives have scheduled their quarterly meetings to coincide with the TWG meetings in order to facilitate information sharing between the state and local level.

3. Consumer Voice Update – Valarie Garza, MHT Consumer Coordinator

The Consumer Voice Report covered multiple initiatives which are actively seeking to transform the roles and integration of Consumer, Youth and Family participation in Transformative efforts across the state. The packet of Consumer Voice documents for this meeting included a synopsis of the *Engaging Voice and Choice* leadership training packet, a listing of Consumer Voice Activities and Events, *Consumer Voice Accomplishments*, the Consumer Voice Annual Report, Year II, and a report on the Texas Youth Voice Summit: July 10-11, 2008.

- a. There was acknowledgment of the efforts of the TWG consumer representatives for giving time and effort – volunteering resources and personal effort because Transformation is “not their job, but their hope for consumers.”
- b. Preface to the Consumer Voice Report – Must understand the difference between *Change* and *Transformation* as outcomes are determined for Consumer, Youth and Family participation. Change is everyday – temporary in nature. Transformation is longer lasting in its impact. Examples of Transformation include HIV awareness, Crisis Redesign, Respite Care, development of the Consumer Voice Network and formation of Youth Advisory Councils.
- c. **Texas Youth Voice Summit**
The summit was held in Austin, Texas, from July 10-11, 2008. Participation included young people representing San Antonio, Fort Worth, El Paso, Houston and West Texas. Additionally, four CPS Youth Coordinators attended, representing a youth-service agency and three from System of Care communities. Presentations delineated what youth voice looks like in their communities, lessons learned and what youth voice could be in the future. The youth attending the Summit decided to support a leadership effort to voice concerns to the Texas Legislature during the next session and offer their recommendations.

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

Youth perceived the Summit as extremely useful and made plans to continue to coordinate efforts through monthly teleconferencing and webinars, and work on their goals of developing local Youth Advisory Councils (YAC) and a State Youth Advisory Council (SYAC).

d. **Consumer Advocacy Network**

The Consumer Advocacy Network has applied for collaborative funding for sustainability. Network meetings are posted on the MHT website; to date the meetings are frequent but not on a regular scheduled basis.

e. **Leadership skills**

Leadership skills on the community level are being developed through the Engaging Voice and Choice curriculum. The training is a customized curriculum for Texas involving community readiness, beyond readiness, and actualizing transformation / transformation activities.

TWG state agencies are requested to get information to their local level offices as partners in local Transformation implementation. Trainings have been compressed into an intensive short form applicable for consumers, youth and family members, professionals and community leaders.

f. **Universal Declaration of Human Rights**

The Declaration was read at a recent Collaborative meeting. Consumer Voice requests that a copy be placed in every building and office for human services, and requests that the TWG agree to adopt these rights and support the rights for all people.

4. **Returning Veterans and Their Families**

a. Colonel Connie McNabb – Texas Military Forces

Colonel McNabb serves as the Joint Surgeon for the Texas Military Forces. Her priority is the mental and physical health issues that surround returning veterans. The only times that gets trumped is when there is an emergency such as a hurricane. Taking care of the mental health needs of those returning is not a new problem or a new awareness. It is the responsibility of the military medical system to help those who are hurt in any way in the line of duty.

The type of engagement in Iraq and Afghanistan does not have a rear area or a front line, instead the entire arena is consistently under fire. The types of casualties coming home from Iraq and Afghanistan conflicts is very different from previous generations – more are surviving but coming home with traumatic brain injuries (TBI) and with severe post-traumatic stress syndrome (PTSD).

“Rub of the cloth”, meaning the closeness and support troops provide to each other through shared experience- is an important concept in providing services to veterans. There is considerable identity with others who have served. There is a preference for receiving services and information from others who have had shared, or similar, experiences.

While operating as a unit, troops appear to not demonstrate short-term impacts. The mental wounds tend to not manifest until they go home and lose the support of their military associates. When they demobilize, veterans may realize their frame of reference is different. They don't have other people who have shared their experience. If someone was injured while in uniform, it was a line-of-duty injury and it is the military's responsibility to take care of them. If they're coming to other providers, and they are

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

taxing the system, how does the military partner with other providers so that it is not coming out of the wrong checkbook. A system needs to be in place so that if other, state providers wind up with veterans, the Guard can contribute to their care.

As veterans are brought home, they have got a tremendous amount of service available to them, directly from the military, for the first six months. The historic frame of reference is the veteran knew within six months if there was a physical or mental injury. The system is designed to support this. Staff identifies the problem and sees that it gets treated. Many Guardsmen, on return, do not want to stay at the armory: they want to return to their community. The system supported this activity. They've learned how to get through the checklist to get home. Now that a change in injury patterns has been noticed, the system is changing.

New programs- the "Yellow Ribbon Program" and the Joint Family Support Assistance Program have been launched, requiring Guardsmen to – put on uniform, come in to the Armory, and bring their families to help understand what care is available and address veterans'- and their families- needs. The Guard is working in partnership with state agencies to leverage resources for rural locations, for those who do not want to return to military service hospitals or counseling. The Guard recognizes that it should work to support the veterans across both state and military care environments.

Within the Guard, providing care for those in metropolitan areas with military bases is not overly complicated. The Guardsmen are easily identified and care can be provided. It is more difficult in rural areas. Do providers in the area accept TriCare? What other services are being provided, and who is providing them (at a cost to whom?)

There is a need to partner with state (and local) agencies for those seeking mental health services in the community and link with military resources. The Guard has a strong desire to partner. Texas is not the first or only state that has done this, but probably the biggest state with the most veterans. The Guard would like to work with partner agencies to develop a plan and system to make this a navigable path, not another bureaucracy.

b. Dr. Kathryn Kotrla – Texas A&M Medical School

VISN-17 has assigned a new representative, Dr. Stephen Holliday, from the VA to attend future TWG meetings.

Dr. Kotrla had a single page summary and a 40+ page document added to the TWG meeting background packet.

The VA mental health system is a very comprehensive system and is recovery-oriented. Services include vocational rehabilitation and vocational training. The system allows for fee-based or contracts with community based agencies if there are not any services already provided from VA sources available. All services provided (from the VA or through contracted providers) must be evidence-based and best practices.

A real concern is what will happen 5 years post-discharge, which is when Guard, Reserve, or Active Duty who leave the service no longer have a free pass to VA services. Currently, only 10% of those returning from Iraq and Afghanistan are seeking counseling or mental health services.

VA has taken President's NFC goals seriously and formed a strategic plan. Elements include that every individual who seeks services is assigned a primary care health

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

provider and MH provider (includes both mental health and substance abuse). A holistic model based on re-entry clinic is used. Mental health will be embedded in a physical health clinic to help avoid the stigma issue. This will move down the road for what we're trying to do, which is transform health care.

According to Dr. Kotrla, "If it is black and white and in the handbook, it really is a mandate."

The VA recognizes issues in Rural Texas (reference page 40 of document in packet). The strategic plan (and supporting legislation) allows the VA to contract with community agencies. In order to receive compensation, the provider must document that there is a demand not being addressed by the existing provider system.

Family issues are also addressed. Cooperation with other agencies and linkage in mutual help is also an identified opportunity. Crisis care and acute care guidelines – language that suggest that the local resources should receive payment with federal funds, rather than state dollars, is included.

The plan also addresses coverage for special populations (Homeless, incarcerated, geriatric, etc.) Rich document with detailed, prescriptive information. The system will self-correct if problem areas are identified.

One area for improvement may be better coordination with outreach activities. Multiple agencies are making multiple calls. In some cases, veterans are getting frustrated because they don't see a coordinated effort among calls.

Dr. Kotrla suggested there may be opportunities to coordinate outreach efforts, such as focus on spouses and their children.

c. **Jason Doran, Texas Workforce Commission Representative to the TWG**

Mr. Doran is a retiree from the Marine Corp and supports everything Col. McNabb presented. Young veterans engage in most activities as a team effort as they are deployed together. This remains after they come back.

Units disband after return, and that produces a feeling of being alone. Veterans separate out into their communities. There's no longer a first sergeant to go to, or gunny, or CPO to see to find the resource available to find assistance.

The Texas Workforce Commission is providing services to meet these needs. One service is the Texas Veterans Leadership Program, based on the Vietnam Veterans Program. The plan includes hiring veterans to provide consulting services to other veterans, helping to meet needs to get veterans into employment. Resources are tracked to ensure specific resources are not overused. A recognized challenge is PTSD. Many veterans perceive it as a mental cage that they want to break out of; they want to just re-integrate into society. Program launch is scheduled for September 1, 2008.

d. **Charles Buerschinger, Texas Veterans Commission Representative to the TWG**

Mr. Buerschinger introduced Jim Richman, Director of Claims and Jim Wilson, Director of Employment Services, both of the Texas Veterans Commission.

The Texas Veterans Commission is the latest in a string of state offices with the responsibility of assisting veterans in securing services. The Commission has a presence

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

in every VA facility and, through its efforts, secures the most compensation and highest per capita compensation, and the highest rate of compensation of all the states. Programs include the Veterans' education program and workforce development activities (in 100 offices). In a recent year, TVC assisted 43,000 veterans in getting jobs, 50,000 in getting claims processed, and provided other services, touching over 100,000 per year.

Mr. Jim Richman presented information on their claims representation and counseling program. He reemphasized "the rub of the cloth"- specifying that counselors' veteran status was vitally important to their success, that results might not be realized for some months, that PTSD is increasing, that TBI is an issue, and that veterans are seeking assistance from organizations other than the VA, including community-based services. There is a peer assistance / peer education conference later this month to train counselors to be facilitators for accessing services. Services are delivered in one-on-one sessions.

Bill Wilson, Director of Employment Services, Texas Veterans Commission presented information on the Employment services offered. The TVC presents a full range of employment assistance to any veteran, including job matching, referral, employer matching, vocational guidance, training, and supportive services. As a result of their efforts, Texas ranks first in veterans' employment- due to the work of a TVC employment representative.

Services are provided by 190 representatives around state in 100 workforce facilities.

Residential programs are provided at the Temple VA facility where domiciliary services are provided for clients with serious behavioral health issues. Participation in these programs is focused on the ability for a veteran to interact with society and maintain employment. The goal is to return to workforce as soon as possible. The TVC employment program at Temple usually has 80-100 people enrolled. Many of these vets have dual diagnoses. Almost all participants must complete a substance abuse training program prior to entering the employment skills program.

A number of barriers have been identified, including substance abuse, depression, PTSD, Criminal records, and no drivers license (due to DUI or substance abuse). A lack of permanent residence and a lack of job history are also barriers to reentry.

A response to a question asked by Maurice Dutton: The Commission tries to address problems by customizing employment opportunities and searches for each individual, not force individuals to enter certain careers or jobs.

In response to a question asked by Mike Maples (What has been your experience with veterans and PTSD? Are there special challenges?) A: We're not (clinical) counselors. We focus on our mission: employment. We work with the VA to understand how PTSD is affecting the individual. We recognize there are no blanket solutions.

e. Community Collaborative Presentation on Working with Veterans - Isaac Martinez (Bexar County Community Collaborative)

Dr. Issac Martinez, Bexar County Community Collaborative is the principal investigator of Suicide Prevention, funded by SAMHSA/DSHS, which is focused on the prevention of suicide of youth between ages of 10-19. Dr. Martinez has developed a data set to improve referrals and treatment for youth in veterans' families. He has found that 10-30% have some sort of psycho-social need or dysfunction. The project has encouraged the

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

delivery of inpatient evaluation or partial day treatment. 56 individuals have been referred to treatment.

Dr. Martinez has also engaged in working with San Antonio Operation Reunion (OEF/OIF) to utilize evidence-based practices in working with families of veterans in coping with injury. The project considered methods of addressing changes and examining reactions to stress, coping skills, spirituality, relaxation. PTSD, suicide, depression, and anxiety were all addressed. Practices including discussion groups, yoga, writing, block, art, have all been introduced.

Question – are any services targeted to children and spouses for those members who are killed? Yes, those services are contracted out.

f. Next Steps on Veterans' Activities- Dr. David Lakey, TWG Chairman

Dr. Lakey suggested that there is a need for experts in this field outline what the system is and identify gaps. This will enable the state of Texas to develop a plan to better coordinate efforts.

Sam Shore suggested a time frame for work that would allow the product to be used during the next session for legislative action. The goal should be to identify who is doing what and what needs to be done to coordinate efforts. A workgroup could be created to identify the roles and responsibilities, assess gaps and make recommendations. The task group would involve the Governor's office, VISN, the VA, and provider associations.

Carolyn Nava commented that university counseling centers should be included in resources since the youth are often lost in the network.

Comment (Dr. Dutton) – Dr. Dutton was impressed by all the programs, but the need is huge. There is some uncertainty as to who will be included in the task force. He is aware of several consumer groups. There is a children's aspect that must also be considered. This is a very large effort to undertake.

Dr. Lakey charged the task group (workgroup) to come to the next meeting with an assessment and address the gaps and possible action plans. The assessment should be available at the next Executive meeting is scheduled Oct. 7 and presented at the next TWG meeting. This will be the last TWG meeting prior to the Legislative Session starting.

Dr. Lakey – requested the Task Group to consist of Dr. Dutton, the Governor's Office, DSHS, HHSC, the Texas Guard, Dr. Kotrla, Veterans Consumer from the Texas Council, a representative from Substance abuse, TWC, TVC and others. Dr. Dutton recommended the inclusion of the VA and Vet Centers.

Action Item

Dr. Lakey requested agreement from the TWG that the task force should come to Executive Committee with recommendations prior to next TWG meeting. There was consensus among the TWG.

Mike Halligan added the suggestion that the task force look at services in trauma and PTSD.

BREAK 3:15 – 3:30 PM

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

2. Introduction to Trauma-Informed Care - Mike Halligan

- a. Presentation: Prevalence of Trauma in the Mental Health Treatment System / Workgroup Consumer Trauma Presentation, available from NSBTT website. Research is generalized, representing the U.S., including some from Texas, but tends to generalize populations. In Texas, we don't assess for trauma nor have a specific pattern of inquiry, so there is little statistical data..
- b. When PTSD occurs, it makes the illness much harder to diagnose and treat. Failure to screen for trauma often promotes misdiagnosis of the true problem. If trauma is not diagnosed or treated, treatment for mental illness is frequently ineffective. When PTSD goes untreated or is prolonged, it leads to other mental illnesses. Permanent damage may result in the neural structure and function of the developing brain (in children) when exposed to severe stress, trauma, warfare, violence, famine, etc.
- c. Concept of "wounded healer" in clinician (Jungian terms) who is in the field because of wounds in past, compensates with inflated ego to insulate against the trauma and avoid opening the past wounds.
- d. Vicarious traumatization – clinician is traumatized through empathy with the client and transference. Symptoms of this are similar to PTSD and may disrupt the clinical effectiveness.
- e. Therapist self care – need to take care of the workforce when dealing with trauma. Need education, debriefing, compassion, support, combat fatigue and depression. Remedies include counseling, massage, yoga, meditation, support groups, chiropractic services, employment assistance programs, etc. to deal with the stress.
- f. Therapy –
 - i. Trauma Incident Reduction. TIR - A regressive desensitization procedure for reducing or eliminating the negative residual impact of traumatic experience.
 - ii. EMDR (Eye movement Desensitization and Reprocessing) Francine Shapiro, PhD. – low grade electrical stimulation
- g. Trauma is pervasive. The impact of trauma is broad. The impact is often deep and life-shaping. Violent trauma is often self-perpetuating. Trauma is insidious and prey particularly on the more vulnerable among us. Trauma affects the way people approach potentially helpful relationships. Trauma has often occurred in the service context itself.
- h. Every agency in room (TWG) has to deal with trauma. The Transformation effort must deal with trauma as a unifying point – veterans; those with disabilities, those clients with DARS, DADS and DFPS are all affected.

3. Comprehensive Mental Health Plan Implementation - TWG Members

- a. Operational Plan Review – Sam Shore
The Operational plan's purpose is to communicate information about all activities that are going on as part of the Project and to serve as a tracking tool for program activities and planning. The material distributed to the TWG is a sample and is not the complete operational plan. Comments are requested for submission within the next week. Public comments may be submitted through the web site.
- b. NFC Goals – Comprehensive Mental Health Plan (CMHP)
The original CMHP was approved in 2006 and updated in 2007. An update is to be delivered in October. The document is focused on future activities. Page 4 presents and overall timeline and page 5 presents an organization structure chart. The document

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

includes roles and responsibilities and addresses Texas' work in addressing the New Freedom Commission goals. The document lays out all the MHT projects by workgroups, tied to each of the 6 workgroups at this point. Veterans workgroup will show up under this section as a new workgroup.

Discussion: (Maurice Dutton)– Dr. Dutton was very impressed by the thoroughness and detail in laying it all out. This is background and the structure upon which those plans are based. This an organic document, which we will be working on as the project develops.

Mr. Shore requests that all comments be submitted by end of this week. Send to Sam, CC Dolly Klinefelter for tracking.

Dr. Lakey requested that email be sent to all TWG members with instructions and due date.

4. Public Comments

a. Rita Kelly – Bell County Indigent Healthcare Services

Ms. Kelly manage the accounts payable with the jail. Knows how much they pay for mental health services for jail population. A partner with the MHT grant (did not get grant). Comments about returning veterans and their families – active military duty, National Guard, Veterans Hospital in Temple, etc.

Ms. Kelly stated that Temple is a very cohesive community, especially when it comes to the military. She was impressed by all the services mentioned today...however, many of the people who need the services don't know about these services or don't feel comfortable in accessing them.

Ms. Kelly sat on a jail diversion team, and has spent time talking about how to divert, but is uncertain of the proper location to divert people to. Crisis situation which involves mental health – Ms. Kelly questions why don't we divert the crisis? She introduced the Homefront Project. She requests that a public information campaign that unifies all state organizations about stigma (erasing the stigma) be developed and that to implement this activity, there should be more effort to work closely with those in the local communities. Ms. Kelly also stated that, for those at the local level, more effort to work with the field players to coordinate initiatives and opportunities should be implemented.

Ms. Kelly also stated that she was aware of people who really need mental health services but not to the extent that they qualify for MHMR services or for military services, although she did not believe they had resources to pay for therapy and counseling.

Ms. Kelly distributed Homefront Project brochures.

b. Marlene Davillo – Bell County

Ms. Davillo spoke about a project little known outside of Bell County, established 1997 which focused on transition issues for military children. Other activities have included the transition counselor institute. Ms. Davillo believes the stress of prolonged war impacts a child's relationship not only parents, but classmates and friends. Ms. Davillo discussed *Living in the New Normal*, a 3 prong approach beginning with public engagement to identify resources on the home front, (held in Fort Hood/Killeen). The focus is to assist children in dealing with stress and trauma. Ms. Davillo presented a number of resources and references focused on: dealing with loss, death, having bad days, getting tools to families, promoting resilience, facing change, and On the Move magazine.

DRAFT v.1
Texas Mental Health Transformation Workgroup Meeting
Minutes
August 5, 2008

Ms. Davillo hopes that the Project will look at veterans, families and the broader translation to all children in all communities will include these audiences in their planning. She is especially concerned about the children of federal contractors who have died in Iraq or Afghanistan. The current system provides no federal support for those children and their families. Because contractors are not military, there is no coverage under existing rules.

c. Michelle Dulley – has 22 year old son in Austin State School and other state hospitals.

Ms. Dulley asked that the TWG remember that many families are still struggling and they need help. Money needs to be spent wisely. She also stated her son was traumatized. It is her belief that workers don't get paid enough, or get trained enough and that additional resources in these areas would improve care.

5. Next Steps

ADJOURNMENT 4:30 PM