

Texas Mental Health Transformation Work Group Meeting Minutes – October 16, 2006

A meeting of the Texas Transformation Work Group (TWG) was held in the Commissioner Board Room M-739 at 1100 West 49th Street, Austin, Texas on Tuesday, October 16, 2006.

Transformation Work Group (TWG) Members present:

Dave Wanser, **TWG Chair** (Texas Department of State Health Services)
Stephany Bryan (Consumer / Family Member Representative)
Allyson Brandt (Central Texas Veterans Health Care System; alternate for Kathryn Kotrla)
Richard Poe (Texas Education Agency; alternate for Gene Lenz)
Heidi McConnell (Office of the Governor)
Vonzon Tolbert (Texas Juvenile Probation Commission; alternate for Vicki Spriggs)
Tom Valentine (Health and Human Services Commission; alternate for Dr. Bell)
Dee Wilson (Texas Department of Criminal Justice; alternate for Brad Livingston)
Erin Ferris, (Texas Department of Housing and Community Affairs)
Robert Alexander (Texas Department of Assistive and Rehabilitative Services; alternate for Terry W. Smith)
Sue Milam (Texas Department of Family and Protective Services)
James A. Cooley (Texas State House of Representatives)
Mike Halligan (Consumer / Family Member Representative)
Valarie Garza (Consumer / Family Member Representative)
Linda Reyes (Texas Youth Commission)

New Freedom Commission Members present:

Deanna Yates (New Freedom Commission)

Implementation Team Members present:

Vijay Ganju, Project Director
Wendy Andreades (Center for Policy and Innovation, Texas Department of State Health Services)
Stacey Stevens, Subcontractor for Assessment (UT School of Social Work)
Delia Presley, Subcontractor for Community Collaboratives (Texas Health Institute; alternate for Camille Miller)
Sam Shore, Assistant Director (Texas Department of State Health Services)
Pat Wong and Staff, Subcontractor for Assessment (LBJ School)
Amanda Broden – (Center for Communication and External Affairs, Department of State Health Services)

I. Call to order/Approval of minutes

Dr. Dave Wanser, Deputy Commissioner for the Texas Department of State Health Services (DSHS) and Chair of the Texas Mental Health Transformation Work Group (TWG), called the meeting to order at 1:45 p.m. and welcomed agency directors and representatives who constitute the membership of the Transformation Work Group. Dr. Wanser called for the approval of the minutes from the September 20, 2006 meeting, which were approved unanimously without changes.

II. Transformation Activities and Updates

A. Informational Items:

DSHS Commissioner

Dr. Eduardo Sanchez, Commissioner of DSHS, resigned his position effective October 6, 2006. Dr. Charles Bell is Acting Commissioner, and interviews are starting this week for a permanent replacement.

Health Information Technology Award

Healthcare Information and Management Systems Society (HIMSS), the trade association for Health IT, gives an annual Davies' Award for excellence in Health Information Technology. DSHS was the recipient of that award this year, which is even more exciting, given that information technology is one of the cornerstones of transformation efforts. The press release can be viewed at:

<http://www.dshs.state.tx.us/news/releases/20061016.shtm>

New website for Transformation

Dr. Wanser announced the new website for transformation, independent of DSHS and other participating groups: www.mhtransformation.org. He will follow up in writing and ask each agency to link to this site and include postings related to mental health transformation.

New Transformation Team Member

Dr. Ganju introduced Ms. Ellen Trevino, who began October 16th as a Program Specialist.

Ms. Trevino has, in a sense, returned full circle: her first 10 years of professional experience were as a project coordinator of a NIMH primary prevention and intervention grant for children and youth in a community mental health center, and later as a public information officer with the same center. She also has six years of experience with state-level substance abuse services under the former Texas Commission on Alcohol and Drug Abuse. She has spent the past 10 years serving as a program administrator for U.S. Department of Labor employment and training programs for farm workers and farm worker youth. Among her experience with DOL

was the development and administration of a system-change demonstration grant for youth in the Lower Rio Grande Valley.

B. VA Regional Meeting

Dr. Kotrla, Dr. Wanser, and others attended a meeting at the hospital at Fort Hood about a month ago related to services for returning veterans and their families; attendees represented the VA, Department of Defense, DSHS, NAMI, Texas National Guard, Texas Veterans Commission, and the mental health service provider community. Two deliverables were agreed upon at that meeting:

1. Set up a regional coalition / town hall meeting for January, with the purpose of furthering “no wrong door”, and invite any community organization that might be able to impact the returning vets population. Attendees could include agency representatives, schools, faith-based organizations, military family support organizations, and others. One of the country’s leading resources on the consequences of deployment on spouses and families will be the keynote speaker for that event. Dr. Wanser will send out a list of counties they are interested in and will ask TWG membership to respond with contacts in this area.
2. Also, several large corporations, particularly in the technology sector, are interested in helping with this population. An organization will be established specifically to work with these technology companies in this area.

C. American Red Cross Disaster Management Initiative

Over the last year, this group and others have talked about the behavioral health consequences of disasters in Texas, and efforts to respond. There continues to be more of a demand for services than actual capacity. DSHS has been working with the Red Cross about policy barriers regarding shelters. Additionally, the Red Cross is launching a program called Access to Care, where people can receive, at a low cost or free, mental health / substance abuse services after a disaster. This would allow providers to be reimbursed for providing these services. Materials and formal announcements will be forthcoming for agencies to share with their stakeholders.

D. Mentally Ill Offenders Act

There is currently an effort in Washington to do something about funding through an act that passed 3 years ago – the Mentally Ill Offenders Act. The Act passed and there was grant money associated with it, but no money had been appropriated until this year. Now, it looks like there will be some grants coming out, in three different levels. Particularly with the focus we’ve had on cross-system initiatives, and justice-involved persons with mental illness, we would be in an excellent position to apply for one of these grants. Dr. Wanser asked Vonzo Tolbert and Dee Wilson to review this information and get back to him the week of October 23, 2006 with their thoughts and recommendations. His preference is to run this through an existing committee, if possible.

E. Consumer Voice Report / Update

- Each of the implementation workgroups, including the Housing Subcommittee, will include at least one consumer or family representative; the four consumer / family

representatives of this Transformation Workgroup will provide that representation and will also discuss the possibility of inviting others.

- The Consumer Voice listserv will be operational by the end of October.
- The Consumer Voice Coordinator position will be posted in about a month.
- The group is working to set up a statewide meeting of consumer voice advocacy groups as to how we can connect consumer voices across the state.
- One or more consumer / family representatives will be attending the national grantee meeting in about a month.

F. Consumer Voice Story: Mike Halligan

Mike was raised in a fundamentalist Baptist family in Oklahoma, which created significant amounts of guilt and insecurity. At age 15, he was sexually assaulted; when reported, the response was met with laughter and threats of disclosing to other family members. Mike went from an A/B student to a C/D within a year after the incident. He dropped out of sports and became a loner.

Soon after graduating from college, Mike experienced some hard times – he went through a divorce and couldn't find a job. For a period of about three months, he was virtually unable to sleep and became psychotic. He spent 10 days in a psychiatric hospital in Oklahoma and after his release, went home to his parents' house. At one point, he was in the process of preparing to shoot himself, but reconsidered when his grandfather realized the significance of his depression and asked that Mike get help.

Mike then spent eight months in a county mental health hospital, while experiencing serious degrees of rage and depression. During his stay, he was restrained in leather straps to prevent his jumping out of two-story hospital windows.

He was subsequently diagnosed with paranoid schizophrenia and started taking medication – Thorazine, Stellazine, and Cogenten. Later, he was taken to a private hospital in Newton, Kansas, where he spent another three months, and later three months in a half-way house. While at Prairie View hospital, Mike met a woman who had had about 150 ECT's (electroconvulsive therapy), which he found very disturbing... He learned not to fight or argue, but just be compliant. When placed into a half-way house, the attending psychiatrist advised him not to remarry or go back to school. He was told he couldn't work; he was told not to have children or even to drive a car. Basically, he was a failure and should just hang it up.

While at the half-way house, Mike obtained a job at a factory cutting foam to size using a vertical saw. On that job, he was injured while using a power saw, (resulting in 14 stitches in his right arm), but was amazed that he didn't feel significant pain from this injury. This disturbed him more than the actual injury did. It was stitched up without any anesthesia, which made him realize that he wasn't "feeling" life. Although realizing that pain is not good, it does have a purpose – it lets you know that something is wrong. He stopped taking his medication, determining that over time, he would become psychotic and his life would end.

Mike was told he could be eligible for benefits, but felt uncomfortable about not working. He worked for a year at a plant, and then moved to the oilfields in Utah. Mike eventually made a career in the oilfield, finishing his career as a Senior Drilling Technician. During this time, he married, fathered 3 children, and bought homes. But, after seven years of realizing his children were growing up without his presence, he resigned from Exxon and returned to college to work on his Master's degree in counseling psychology.

It was during his return to college that Mike experienced several depressive episodes and was hospitalized once. He was able to graduate from college and has been in the mental health field for over 17 years.

Mike always felt shame about being hospitalized with a mental illness. The oilfield was the perfect place to live a nomadic life and avoid society and people. Due to support from his wife and children, medication, some economic success, and maybe some hardheadedness, he overcame the shame, and although probably not the most perfect specimen to exhibit or model recovery, lives a life that permits him to pay his bills, put his daughter through school, pay taxes, and live a fairly normal life. He now does things that he's never done before.

Follow-Up Comments

- Ms. Garza commented that all organizations need to adjust, change, and continue to improve services to consumers, whether it's a company (Dell, Southwest Airlines, etc.) or a public organization.
- Dr. Wanser relayed to the group that this issue of people falling through cracks is not just a resource issue; it's how we design systems and services.

G. Housing Initiative

Erin Ferris reported on the Housing Initiative Subcommittee: At the first meeting, there were representatives from TDHCA, DARS, DADS, DSHS, TDCJ, TFPS, APS, HHSC, LBJ team, Office of the Governor, and Transformation Project Director. Three charges came out of this first meeting:

1. Evaluate the programs that currently exist for housing in mental health populations and educate agencies about the opportunities for collaboration;
2. Assess needs of the mental health community in terms of what types of housing are needed, what regions have the greatest need, and what regulatory or statutory barriers, if any, exist which prevent certain populations from participating in housing programs; and
3. Create a document with recommendations for agency collaboration of funds, policy initiatives, and inter-agency programs to evaluate the housing issues or services during an individual's move from facilities to communities, and making sure that the community setting is the goal for that individual if that is what they wish.

The next meeting will be held on October 20th at 1:00 pm to work through the first charge. They hope to have something drafted soon, possibly for the Senate Interim Report to Senator Nelson.

Dr. Wanser asked if there is a focus on a particular population group. Ms. Ferris responded that it might be premature to look at specific groups right now, before we have the additional detail necessary to really understand the housing issues. The comments from the Consumer Town Hall meeting were somewhat vague and so the subcommittee would like to gather more details around those comments at the next Housing meeting. Ms. Garza offered that the subcommittee could contact consumers directly and ask for more information. Dr. Ganju also suggested the listserv of people from the Consumer Town Hall meeting.

Dr. Ganju talked about a potential target population to start with. Many housing issues cross agencies and multiple populations; it may be a good idea to look at the particular group of people who are accessing multiple agencies. There are some good models, interventions, and evidence-based practices related to supportive housing. SAMHSA is finalizing a toolkit related to supportive housing. Some of the experts in this area are based in Austin; we may be able to access some of that expertise.

Dr. Ganju thanked Erin for championing this effort, especially after attending just one TWG meeting. This level of collaboration could be a model for some of the other workgroups.

H. Comprehensive State Mental Health Plan

The Comprehensive Plan was submitted to SAMHSA on September 29th as part of grant requirements, slightly different in structure from the original plan. All TWG members should all have copies of the report, which will be driving the work we do, especially as we flesh out specific strategies and action plans.

III. Senate Interim Committee Report

An August 7, 2006 letter from Senator Jane Nelson, Chair of the Committee on Health and Human Services, requested 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 focus for today's meeting is to use the Comprehensive Plan as a platform in the development of this report to the senate interim committee, which is due on November 1st. 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."

The Senate Committee on Health and Human Services is 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.”

Heidi McConnell made a request of the group that we look at the policy implications and needs related to this transformation work, as opposed to specific operational details at this point. She commented that this is our opportunity to inform what will be considered by the next legislature and to provide guidance to them regarding what tools will be needed to move transformation forward.

Dr. Ganju discussed some of the timing opportunities for action: 1) the next two weeks, Senate Interim Committee report will be submitted; 2) the next legislative session, we may want to consider housing as an area of opportunity; and 3) the following legislative session, what opportunities would be appropriate to pursue. As we develop plans around these and other timeframes, Dr. Ganju discussed the need to look at: 1) the barriers with moving this work forward; 2) the larger goals of transformation; and 3) the directions already established by the Comprehensive Plan.

James Cooley suggested to the group that it may be a good idea to put into a statute the policies of the state with regard to mental health systems and services, such as: we will have a transformed system, we will have interagency collaboration, the goal is a recovery model, etc. These items may seem obvious but they help drive other actions, such as the development of performance measures, the development of LAR’s, and others. For example, Senate Bill 1188 had policy goals in it, as well as directional and specific implementation goals. It stated where they would like to go, not just the specific changes requested. If we state in a formal statute what direction we’d like the mental health system to go, then agencies and teams could refer back to it, to see how we are tracking with those goals and what we’re doing to move toward that end. Having that filter and that goal in a statute, it is amazing how much happens because people know where the legislature wants them to go. Mr. Cooley mentioned that the statute would also need to include the following: 1) documentation of who will be accountable for ensuring that this policy happens; interagency issues are inherently more difficult, 2) reporting requirements for each goal, and 3) some flexibility with implementation, so that we can innovate on how to get there. The legislature has two tools in their toolbox: pass laws and spend money. Within the realm of those tools, what things should they do, even if it’s just that they agree with the direction?

Dr. Ganju suggested that we start with what has been documented in the Comprehensive Plan and add any other appropriate items, as well as barriers to getting the work complete, to flesh out the Senate Interim Report.

Dee Wilson recommended that technology issues be included in the report, since that is a major thrust with the transformation effort.

Dr. Ganju agreed. He further commented that this workgroup has talked about a data sharing / coordination workgroup, but should now document technology proposals that have statutory

implications, as well as potential barriers, some of which are federal, some state, and some imaginary. In the next couple of years, the hope is to track those barriers more formally.

James Cooley commented that they are writing legislation on data policy for all state agencies. Beyond that, this group needs to define and document what a transformed mental health system looks like? For example, the system must have these points: focus on early intervention, recovery model, the ability for client data to be accessed by different state agencies, etc. Data sharing could be one of the policy goals for the transformed system. In the legislative session, they will talk about barrier removal, but in the larger goal of a transformed system, we need to define what it will look like. Legislators need to know what they are removing barriers for.

Ms. Ferris stated that a statement from the legislature would be imperative. TDHCA strongly recommends that this general statement of why we are doing transformation be included in legislation.

James Cooley agreed and responded that a statute like this would help answer future questions of why certain strategies are being followed.

Dr. Ganju talked about the fact that much of this vision of a transformed system is included in the Comprehensive Plan. Based on recommendations in this meeting, this could be an overarching driver of other components of the report.

Mr. Cooley stated that a good starting point for language around what a transformed system would look like could come from the 5 bullet points that are in the letter from Senator Nelson.

Ms. Garza agrees – the 5 bullet points are a good starting point. Includes what we've been trying to get at.

Ms. Ferris recommended that on the fourth bullet point, we add “across agencies” after “data coordination and sharing”.

Mr. Cooley agreed and added “and units of government” to the recommended change. Data that follows the person – from private employer insurance to state to multiple agencies, etc., subject to privacy protection.

Ms. Garza also suggested adding “from program to program” to the fourth bullet point, in addition to the other changes suggested.

Dr. Ganju suggested that we first review what has been submitted in the Comprehensive Plan, to ensure that this report is consistent with it, and then include language around the five bullet points included in Senator Nelson's letter. Referring to page 4 of the PowerPoint presentation, let's look at what has worked in the state and what other states have done with regard to anti-stigma campaigns. Stigma is not only outside our system, from individual to individual, but also within our service system. We may want to look at mechanisms to address this stigma. Lastly, once we have models for integrating health and behavioral health, operational plans to implement would need to be developed.

Ms. Wilson asked Mr. Cooley what the chances are that a bill would get passed that would incorporate everything we would like to recommend?

Mr. Cooley responded that omnibus detail bills are tough, because they are long. “Brevity is the soul of wit.”

Ms. Wilson suggested that we consider what is likely to pass in legislation; is anti-stigma likely to pass?

Mr. Cooley remarked that agencies have within their innate authority anti-stigma efforts. If we move to recovery model, how will stigma change? There used to be a stigma with cancer, but there isn't anymore.

Ms. Garza commented that we have to decide which things with anti-stigma we want to include in legislation.

Dr. Ganju responded that since stigma is something that agencies can work on, it may not be appropriate to address legislatively.

Mike Halligan talked about stigma with the group. The state has been talking about evidence-based practices, but he has never seen one that reduces stigma. Stigma is discrimination. It's still there, but it's driven underground; we're not as overt about it. He would rather work on programs that improve consumers' life versus stigma.

Ms. Wilson asked if it would be helpful if the legislation stated that mental health is part of public health.

Ms. Ferris added that we could say that mental health is a disability. It may be obvious but it impacts qualification for services and assistance.

Dr. Wanser presented to the group that this month's issue of Journal of Public Health is about mental health – mending our broken mental health systems. We know what the predictors are, and the science supports it. If we turn what we know into things we do with legislation, what would those be? What are the best ways to reduce this discrimination in communities and agencies?

Deanna Yates agreed with Mike Halligan – we are never going to get rid of stigma completely. The point of addressing stigma is that it's a barrier to people getting care. We need to have a system where it's OK for teachers or others to seek help for people – anything we can do within the system to help people feel comfortable seeking help.

Ms. Garza stated that all the way down to Pre-K, we address physical health with children, but we don't do that with mental health as part of their health.

Dr. Ganju summarized the discussions so far by saying that implications to the report would be to state that mental health is part of health, and to reflect the information in the Journal of Health.

Tom Valentine stated that stigma and parity go hand in hand. It's somewhat like a chicken and egg syndrome: do we not provide parity in insurance because of the stigma associated with mental health, or does the stigma in mental health not allow us to provide parity of insurance?

Mr. Cooley relayed that it would be a good idea to bring these things up with legislation. Very powerful to the effort here would be to have a stack of witness cards saying they are in favor of the mental health bill. It impacts education, criminal justice, housing, and the interplay between mental and physical health – a person with diabetes is more likely to have depression and a person with depression is more likely to have diabetes. Mental health and physical health – where does one start and the other one end? If we want a transformed system that takes care of the whole person, we should have a person-centered approach to service delivery, where the data follows the person, the services follow the person. The first issue to address is planning for interagency projects; this is the largest interagency project we've had. Last one this big was the Y2K conversion. This hits all the committees and silos in existence, but we're not organized that way. We may want to stress this in the report.

Mr. Valentine stated that along with interagency focus, we need to bring to the table the community collaborative piece. It will need to be successful at the local level, as well as at the agency level.

Mr. Cooley agreed – this is the first attempt at a complete break from how we do things, which has implications on a lot of other things in the state. The only way it's going to work is if all agencies – state and local – collaborate. This is the big area, as far as a policy shift forward. Legislature would like that; they also would like to address agency silos.

Vonzo Tolbert asked Heidi McConnell and James Cooley about possible legislation around earlier intervention in the school systems. There are children with mental health issues that are punished because of their behavioral issues, are transferred to another classroom and further stigmatized, and the behavioral trend continues to the criminal justice system. In what ways can we identify these children earlier, and would this receive opposition in the legislature? This would impact all agencies.

Linda Reyes agreed and commented that over the last 30 years, we've had a transformation away from community-based mental health services to the criminal justice system. There are more people with mental health issues in criminal justice than all the hospitals. We need to go back and re-transform the system to where we have a better "bang for the buck" – at the early intervention stage. That's the commitment she would like to see. Least expensive, most effective place to intervene is the first point of identification. She stressed that if we only put resources to identification, but not intervening, we are just identifying the same problem over and over all the way to prison. Put the resources for intervention at the place of identification. This would reduce the need for more prisons, TYC beds, juvenile detention facilities, homeless shelters, etc. Redirect the resources and energy to another point in the process. She raised the question of whether the real intention was to promote such early identification.

Dr. Ganju said that yes, the goal is to retransform the system. The ideas brought up are very good ones; how will we do those things and what needs to happen legislatively to start those

changes? First step is to document in statute where we want to go. Step two is to figure out how to get these things done, how we can use transformation initiative to meet agency initiatives and have goals that benefit not only transformation, but also the agencies. We've talked about some direction and policy issues that might be stated legislation; are there also some process items we want to address? For example, are there barriers that need to be addressed in order to have earlier identification and intervention in the school systems?

Mr. Poe stated that since TEA's mission is education, our approach must be related to education and on removing barriers to education, not providing mental health service per se.

Ms. Reyes asked about the reasons that kids are not getting identified and referred to services.

Mr. Poe talked clarified that prevention is not under the purview of special education. Special education is a model built on services provided after a certain amount of failures and problems that a child experiences. True prevention and early intervention should be for all children, at all ages, which really is a multi-agency approach.

Mr. Tolbert asked if there a mechanism for identifying kids at risk?

Mr. Poe responded that there are some available, but kids are having to enter other systems to get services.

Mr. Cooley relayed that there are legislative concerns that too many kids are in special education. He also understands that there are controversies around the country about evaluating all kids in kindergarten. Mr. Cooley recommends that the focus be on the ones that clearly need help – everyone has identified the problem, including teachers, administrators, and parents. How do we get assistance for those already identified, those who are already at a crisis point?

Ms. Reyes explained that often, the level to which problems get diagnosed or interpreted depends on resources available (insurance, mental health services, etc.). So, if there aren't any resources available, the child is labeled as having a behavior problem and is transferred to an alternative school. One reason that more minority kids are in TYC is because resources aren't available for them in private insurance; the problem is identified as delinquency and the child as a "bad seed". Once a clinical assessment is made, there is often found a history of mental health issues (depression, child abuse, sexual abuse, etc.). Depression at age 10 could turn into a personality disorder at age 15 or 16. It's not just about exchanging information – it is also a commitment to provide the resources at the point where we are most likely to have success. It saves money later.

Mr. Cooley suggested that one of the performance goals could be the dropout rates of the kids identified with mental health issues – an indicator of how well we're intervening.

Sue Milam commented that it's hard to get the necessary resources for the children who need them. There used to be school counselors, social workers, nurses, etc. She used to be a teacher and could spot the kids that need help but the help they needed is unavailable.

Ms. Ferris suggested that we revisit No Child Left Behind, which is very specific about services available. We may want to have experts on early intervention come in and talk to us about options, especially since all the rules about this are not solidified yet.

Ms. Wilson brought up the issue that maybe school age is too late to identify problems. Why would we wait until the child is 6 years old?

Ms. Garza said that primary care physicians could be another area for early identification and intervention. After the discussions today, she suggests that if we want the language to be broad enough, we need to include both early identification and intervention, as well as talk about mental health as a piece of public health. Don't get into specific programs or types of interventions in the statute. That way, the legislation can be a tool to develop specific strategies later.

Dr. Ganju commented that as a group, we agree on many points – for example, the idea of early intervention. The challenges are what processes will be taken to achieve that, and how will we know if we've made any progress in certain areas? We need to be accountable on our progress. We could say to legislators that they can expect periodic reports with updates and progress.

Stephany Bryan commented that we should be mindful of where the children are identified. Her children were wards of the state and were on the waiting list, as they were in the state's care, to receive mental health services, for nine months. They were assessed and returned to Stephany. They received only six sessions, even though these are children who were traumatized and severely abused. Twelve years later, Stephany is paying \$600 per month out of her pocket to make sure her son gets the mental health services he needs. Her children were identified early, even in daycare at young ages. When we look at timeframe of services, are we providing bandaids or true care? Are we providing a continuum of care through the lifespan? Alternative is to send the kid away to a residential treatment facility because there isn't money in the community to service the child. If the dollars could fall to the child, if there was a continuum of care, we would be providing better service.

Dr. Wanser summarized the discussions and suggested four recommendations that this group has expressed:

1. Effective use of resources: The science says that early intervention works and is more efficient. Would like a policy statement putting forth that: 1) early intervention is the policy of the state and that it is an effective way to address disparities, 2) prevention in schools includes behavioral health as a component, 3) all people who are likely to interact with individuals with behavioral health disorders get trained and screen for intervention (there aren't places to refer people to – need to pull training into other systems, like primary care, schools, etc.), and 4) agencies have to make any effort to address behavioral health issues cross-agency.
2. Efficient use of resources: In order to demonstrate a return on investment. Would like to see some specific studies on the following: 1) cost offsets in emergency rooms with behavioral health interventions, 2) cost offsets in justice and juvenile justice diversion with behavioral health interventions, and 3) assessments of average daily attendance and drop-out rates by use of these interventions.

3. Consistent approach: Reduces variability across systems. Specific activities could include: 1) identifying resilience and recovery-oriented performance measures that are part of our LBB reporting, 2) consistent service definitions, consistent definition of evidence-based practices, and consistent outcome measures, and 3) identifying expectations for consumer and family member involvement around behavioral health issues in each agency.
4. Timely and accurate information: In order to improve decision making. Specific activities could include: 1) sharing investments for technology across agencies, 2) proceeding with data sharing initiatives, including a policy statement around interoperability of federated data systems, and 3) if agencies don't have unique client identifiers, move forward to establish those.

Lastly, since these issues are applicable across the different committees in the legislature, maybe we should suggest a legislative study group around this issue. Include people from many committees: justice, education, health and human services, etc.

Mr. Cooley said that in his chamber the speaker does interim studies and are selective about things to suggest, due to workload capacity of members. Since this is a major cross-agency initiative, it may be something that could be pursued. If the governor, lieutenant governor, and speaker interested, then the chances are certainly good that it would be approved.

Ms. Wilson asked if it would make sense for something like this to come from Finance or Appropriations.

Ms. McConnell responded that those committees can't make general law, so it still has to go to the other committees.

Ms. Wilson remarked that some committees, like the state auditor's office and LBB, cut across all committees.

Mr. Cooley added that the LBB is an under-utilized resource, especially since they've taken on the e-Texas functions. They are looking for good ideas because they are doing more of that type of policy work. This might be something very appropriate to brief them on, particularly since the LBB includes leaders from both chambers and key committees.

Dr. Wanser said that given the discussions on efficiency, effectiveness, and consistency, there are probably incentives to change the way people do things, by pilots or reward systems. ROI should be an incentive; we need to consider possible "carrots" to incentivize people to do things like avoiding the use of residential treatment centers (RTC's), looking for better community-based alternatives, training people, etc.

Mr. Cooley added that this tracks well with other initiatives. For example, the legislature likes consolidation of case managers, which is an HHSC initiative. House Appropriations is interested in that program. Another example is integration of services. This is well in line with previous legislative initiatives and things that they generally support. With regard to the efficiency discussion, budget people want to know impacts of changes on other systems. So, as we are able to track with client-centered records and coordinated care, we may find out, for

example, that jail diversion in San Antonio might keep people out of the ER. So, if we are able to do an intervention in one area, we might be able to see for this particular person, the overall gain compared to not using the intervention. The budget groups would like to see impacts on a cross-agency basis.

Ms. McConnell remarked that, based on the resource discussion, where do we want to intervene early? She suggests using community collaboratives to better target this. Until we can show the impact of different interventions and timing of interventions, it's hard to show the members of the legislature what we're trying to do.

Dr. Ganju talked about the criteria for selecting community collaboratives. We could ask the communities to respond to how they would address the five bullet points in Senator Nelson's letter and that could be the basis of selection.

Mr. Halligan remarked that the broader the language, the more subject it is to interpretation and we should keep that in mind when requesting a statute. Also, as we approach early intervention in more detail, we need to consider assessing the teachers and psychologists before they assess the kids.

Dr. Wanser commented that what we submit to the committee isn't the entire plan or strategy.

Ms. Wilson added that there are some things that don't need statutory provisions.

Dr. Ganju asked the group what they would like to see included in the report with regard to consumers and family members, as well as structure.

Ms. Garza responded that in the area of consumers, she recommends that "consumer-driven" and similar language be included in each topic we cover in the report. It is an integral piece of the success of each area, including data systems. Everything we do needs to include the consumer-driven focus.

Sue Milam commented that part of the reason we have a broken system is that resources have not been available. There's only so much savings you can get from the end; you have to do some investing at the front end. These are great ideas, but without resources, it's just talk. No amount of coordination will transform the system without some additional resources.

Dr. Wanser: Maybe that is our starting point – all of our systems that deal with adverse consequences of behavioral health issues are reactionary. Our priority population definition is restrictive and many opportunities for early intervention have already passed by the time we see consumers. May want to look at policies on how to prioritize populations.

Ms. Garza agreed; it goes back to consumer driven piece. Microsoft doesn't make products that people don't want or need. They find out what consumers want first and then manufacture those products.

Ms. Bryan commented that we shouldn't just depend on this workgroup to ensure that consumers and family members are represented. All agencies should do this and include consumers and family members with choice, policies, and practices.

Ms. Ferris recommended that the following phrase be added to the data coordination section: "sharing across agencies, institutions, programs, and units of state and local government."

Dr. Ganju brought up the topic of structure – is there something about the interagency structure that we want to include in the report?

Mr. Cooley responded that once you start locking something in statute, it is less flexible. We may want to include some wording about having a group, but not include specific numbers or details. There does need to be a way to report out on the progress of the work, but keeping the structure flexible is recommended.

Ms. Wilson suggested that doing things truly consumer-driven will be difficult; every agency will need to take responsibility to assist in that effort.

IV. Closing

Dr. Ganju closed the meeting by discussing next steps with the group. A listserv is being developed with TWG members and subgroups. There will be at least two TWG members on each of the subcommittees – Adult, Children, Data Coordination, and Workforce.

The next TWG meeting, which will be held on November 3rd, will include a presentation by Fran Silvestri about transformation efforts in other countries.

V. Public Comments

J. Mason spoke about her personal experience with mental illness and working with the agencies. She expressed a concern that she felt "dropped" and not supported in her needs. Ms. Mason also suggested advertising or education campaigns to increase the awareness levels of transformation efforts underway.