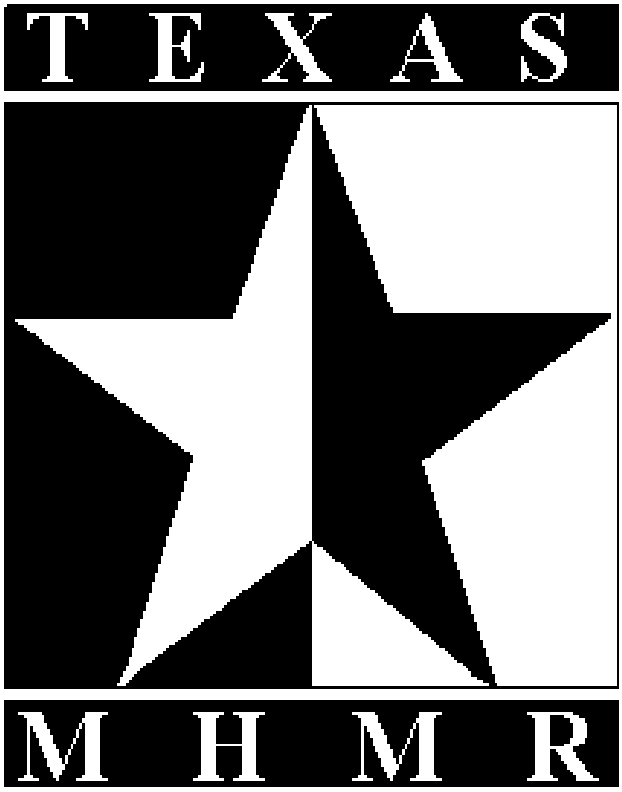
New Freedom Summit

Select Proceedings



Transforming Mental Health

In Texas

OCTOBER 21-23, 2003, AUSTIN, TEXAS

FINAL VERSION: July 31, 2004

ACKNOWLEDGMENTS

Members of the Texas Board of Mental Health and Mental Retardation

express appreciation to the following organizations

for sponsoring the New Freedom Summit:

AstraZeneca

Bristol-Myers Squibb Company

Eli Lilly and Company

The National Alliance for the Mentally Ill (NAMI)

Pfizer

Copies of this report and reprints of individual sections are available from the Office of Policy Development, Texas Department of Mental Health and Mental Retardation, PO Box 12668, Austin, Texas 78711-2668, phone 512/206-4516.

Contents

1. Executive Summary

On October 21-22, 2003, the Texas Department of Mental Health and Mental Retardation (TDMHMR) convened national and state mental health experts—consumers, family members, advocates, administrators, researchers, and providers—to develop recommendations about how Texas will implement the goals of the President's New Freedom Commission on Mental Health.

National leaders, including Charles Curie, the administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), and six commissioners of the New Freedom Commission on Mental Health, explained the commission's goals and recommendations for improving mental health services in the United States.

Experts described current and future research initiatives in support of evidence-based practices and disease management. State leaders outlined activities affecting current service delivery and the framework for future coordination of mental health, health, and substance use services.

The reorganization of state mental health, health, and substance abuse agencies into the new Texas Department of State Health Services will occur on September 1, 2004. The new agency will provide central focus for:

- integrating mental health, health, and substance use services in primary care settings;
- conducting a comprehensive media and education campaign to eradicate stigma and prevent suicide;

- integrating public sector financing;
- establishing the need for insurance parity;
- creating cross-discipline training and service opportunities; and
- fitting the "pieces" of the health system together and reducing expenses associated with duplication.

The New Freedom Commission Report served as the framework for participants in the summit to evaluate mental health services in Texas and recommend system improvements. Invited participants and other interested attendees met in facilitated workgroups and developed action plans for each of the six New Freedom Commission goals. The group action plans, found in Chapter 8, include a description of Texas today, a vision for the future, and barriers and assets to achieving the vision.

Need for Comprehensive Planning Effort

To implement the recommendations with the least delay requires a comprehensive plan. Many recommendations are overlapping or require synthesis and interrelated sequencing to be achieved efficiently. The recommendations in this report must be integrated into a master plan that takes into account other required plans already in force. If the goals are to be realized, the evaluation of the recommendations and their integration into a comprehensive state mental health plan must be given the highest priority in the new Department of State Health Services.

Barriers to the Achievement of the New Freedom Commission Goals

Information and education. The need for information and education about mental illnesses is pervasive. The general public does not understand mental illness or know when or how to access services. Statewide training on basic aspects of providing mental health services, such as treatment planning, is needed in professional education programs for physicians, nurses, psychologists, social workers, and other allied health professionals. The lack of education about mental illnesses is seriously affecting educational and personal outcomes for elementary and secondary students, and an educational initiative is needed for not only students, but teachers, administrators, and parents.

Coordination of care. Coordination of care for people with serious mental illnesses is problematic. Interagency issues of responsibility, jurisdiction, and treatment are negotiated state-level agreements that take years to be realized at the local level. Providing adequate care requires identifying people who need care, without regard to whether they present at a mental health, health, or substance use services provider. Ensuring that treatment is evidence-based and meets a common standard of excellence across multiple service systems will be easier with the consolidation of mental health, health, and substance use in one department, but treatment in other service systems, such as protective services and the justice system, also requires effort.

GOALS AND RECOMMENDATIONS

New Freedom Commission Goal 1 Americans Understand that Mental Health is Essential to Overall Health

Nothing less than "a campaign for all minds" is needed to eradicate the stigma of mental illness and to implement a statewide strategy for suicide prevention. Public information must be backed up by services. Effective treatment for mental illnesses and substance abuse disorders must be made as available, affordable, and accessible as primary care.

Goal. 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention. *[See model program desscrptions on page 117, Figure 1.1.]*

Fifty percent of people with serious mental illness are untreated. The tragic outcome of untreated mental illness is suicide. Groups most affected by stigma are older adults, ethnic and racial minorities, and people who live in rural areas—groups underrepresented among those who receive mental health services in the state. Texas must participate in the national campaign to reduce stigma.

Recommendations of Summit Participants

- Public information. A comprehensive multimedia public information campaign is needed.
- Integration of care. Co-locate and coordinate treatment settings so that treatment for mental illnesses and substance use disorders is available in the same way and with the same ease of access as primary care.
- Public education. Educate administrators, teachers, parents, and students in primary and secondary schools about mental illnesses, substance use, and how to get help.

Dr. Eduardo Sanchez, Commissioner, Department of State Health Services, stated that suicide is evidence that treatment and interventions have not been available or successful, and that *the primary focus for the state health system should therefore be on making effective treatment available and accessible*.

Recommendations of Summit Participants

- Suicide prevention plan. Develop a plan that builds on the US Surgeon General's Call To Action, the Texas Suicide Council Plan, and successful programs, e.g., Air Force suicide prevention program, with emphasis on developing continuity of services among the helping professions.
- Standardized professional education and practice. Develop minimum staff competencies and standardized patient assessments for evaluating and treating individuals at risk of suicide.
- Public information. Publicize suicide prevention and treatment programs. Seek public support for government funding by clearly stating current and future capacity issues and emphasizing that education about suicide prevention is ineffective if necessary treatment is not available.

Goal 1.2 Address mental health with the same urgency as physical health.

More resources alone are not enough. Additional funding alone will not improve the system. The system is fragmented and in disarray and without a complete transformation, nothing will change. The consolidation of state oversight in the Department of State Health Service is key to achieving this goal.

Recommendations of Summit Participants

- Integration of care. Develop a single point of access for mental health, health, and substance use services. Coordinate with federally qualified health centers (FQHC) to maximize services.
- Maximization of third party (federal funding and private insurance) funding. Develop and implement methods to maximize third party funding, including identification of essential services.

New Freedom Commission Goal 2
Mental Health Care is Consumer and Family Driven

The state mental health system must be one in which consumers and family members play a central role in developing and implementing individual plans of care. Disease management relies heavily on

consumer and family involvement in the development and successful implementation of the treatment plan.

Goal 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance. *[See model program descriptions on page 119, Figure 2.1.]*

In Texas today, the general public does not have a basic understanding of mental illness. For example, understanding of issues associated with serious emotional disturbances is limited or lacking in schools, often resulting in an increased likelihood of juvenile justice involvement. Similar problems face homeless adults with serious mental illness who are often perceived as public nuisances. The state mental health and substance abuse authorities have not taken an active role in providing education to the public. Additionally, the local authorities have failed to address the growing problem of serious emotional disturbance in the classroom.

For individuals who have been diagnosed, Texas has strong advocacy organizations and well-organized consumer and family networks. Technical support for developing an effective plan of care is central to disease management. Barriers to achieving the goal of an individualized plan of care for each individual are resource related.

Recommendations of Summit Participants

- Public information. Use the media to raise awareness about serious mental illnesses and serious emotional disturbances.
- Systems integration. Promote the development of legislative measures to facilitate integration of care across systems, e.g., schools, Medicare.
- Evidence-based practice. Continue developing evidence to identify and support evidence-based practices.
- Patient and family involvement. Incentivize patient- and family-oriented treatment outcomes and family involvement.
- Standardized professional education and practice. Develop competency training and certification for treatment plan development.

Goal 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

In Texas today, the service delivery system is not sufficiently focussed on the individual patient's preferences or on the contributions that families make to the recovery of family members.

Providers are sometimes reluctant to involve families in treatment because families lack training and "speak a different language." The challenge is greater if the patient and family are in an ethnic minority because cultural competency among staff is limited. The logistics of involvement, e.g., childcare, work schedules, distances, can pose barriers to involvement, and without assistance, families can become discouraged. Stigma also figures in the willingness of families to be involved.

Recovery is a radical notion to patients and families who have learned to see serious mental illness as a disability *de facto.* Disease management brings knowledge that mental illness is a disease with symptoms that can be reduced or eliminated. Mental illness no longer has to mean a life of chronic disability. Disease management will make recovery a reality for many Texans.

Recommendations of Summit Participants

- Public education. Develop and improve public education materials including information on available service options.
- Planning. Empower local planning advisory committees. Develop formal

mechanisms for local and state planning advisory committees to communicate.
- Consumer and family involvement. Ensure that agency boards and advisory committees have majority representation by consumers and family members. Empower consumers and families to direct resources to providers who promote evidence-based, recovery-oriented practices.

Goal 2.3 Align relevant federal programs to improve access and accountability for mental health services. *[See model program descriptions on page 120, Figure 2.3.]*

Texas needs to take better advantage of existing opportunities for federal support, including Medicaid and Medicaid waivers, Social Security Administration work incentives, and federal housing funds. Efforts may require state plan modification, blended funding, and interagency collaboration.

Goal 2.4 Create a comprehensive state mental health plan. *[See model program descriptions on page 121, Figure 2.4]*

Currently several plans are required, including the Mental Health Block Grant, the Medicaid State Plan, agency strategic plans, and the Promoting Independence Plan. An integrated plan across all systems is critical if limited resources are to be fully utilized.

The plan would address the use of a standardized mental health screening tool as a routine part of every physical exam, with a mental health assessment for those determined to need one. It would establish a uniform rate-setting methodology and mechanisms for more efficient administration of contracts for services. It also would require adherence to evidence-based clinical guidelines and a uniform standard of care.

Goal 2.5 Protect and enhance the rights of people with mental illness.

<u>Recommendations of Summit Participants</u>

- Legal assistance. Make legal assistance available to consumers, e.g., Texas Appleseed. Utilize deferred adjudication options. Establish a repository of advanced directives.
- Legal procedures. Develop mental health courts. Pursue a 4-E waiver to purchase care to help parents avoid relinquishment of custody as the only means to obtain treatment for their children.
- Education. Coordinate the training resources of various advocacy organizations. Ensure judges are trained regarding mental health and system access.
- Consumer and family involvement. Involve consumer groups in providing training on rights.
- Funding. Integrate funding for the many agencies responsible for providing children's mental health services, including juvenile justice, education, mental health, and family and protective services, to streamline the provision of comprehensive care.

New Freedom Commission Goal 3 Disparities in Mental Health Services Are Eliminated

All Texans must access the best available services regardless of race, gender, ethnicity, or geographic location. Services must be tailored for culturally diverse populations. Mental health research must include underserved populations. Providers must be available in rural areas to provide necessary services in a timely manner. General healthcare providers must be trained to recognize mental illness and provide basic treatment and referrals to specialty care.

In eliminating disparities, Texas must

ensure equity in the availability of both public and private health insurance. Texas must increase the availability of culturally competent, well trained mental health practitioners, i.e., develop good clinical training programs to prepare clinicians to provide mental health services to culturally diverse populations.

Providers and provider agencies must be held responsible for analyzing the populations they serve and hiring staff with the competency to care for them. The state must identify appropriate models for rural and frontier areas. It must educate children about mental illness in an effort to address stigma and promote mental heath wellness.

Goal 3.1 Improve access to quality care that is culturally competent. *[See model program description on page 122, Figure 3.1]*

Goal 3.2. Improve access to quality care in rural and geographically remote areas.

Recommendations of Summit Participants

- Require the utilization of a cultural competency tool in the community MHMR centers through the performance contract.
- Empower by education and collaboration consumers and family members on the right to demand cultural competency in providers.
- Develop a strategic plan to ensure access to quality, culturally competent mental health and primary health service to all rural Texans.
- Direct efforts toward ensuring that pharmaceutical companies include a statistically significant number of ethnic minorities in drug trials.
- Develop a culturally competent training program for all providers (current mental health staff) to encourage and promote "capacity building" in the development of an ethnic/minority mental health provider network.

New Freedom Commission Goal 4
Early Mental Health Screening, Assessment, and Referral to Services are Common Practices

All medical and allied health, education, and human service providers must be trained, competent, and motivated to screen for and address mental illness and substance abuse issues across the life span of individuals.

Goal 4.1 Promote the mental health of young children. *[See model program descriptions on page 123, Figure 4.1.]*

Promoting the mental health of young children is challenging because physicians are unwilling to include mental health in histories and physical examinations provided in primary care, with the exception of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid program. Funding for mental health services is not at parity with funding for physical health services. A broad array of providers and services is not consistently available in all areas of the state. The referral process is fragmented. Children wait longer for a referral to mental health services than to primary care.

Recommendations of Summit Participants

- Consultation. Establish consultation mechanisms for public mental health, the academic sector, and the private sector using telehealth, other innovative methods, and reimbursement incentives.
- Screening and assessment. Identify or develop an agreed-upon statewide screening tool and assessment instrument and guidelines for their use for mental health and substance use services.
- Referral. Establish a statewide call center (internet) system, e.g., the San Diego

- model, that includes providers as clients.
- Evidence-based practices. Implement evidence-based practices for primary prevention.
- Funding. Ensure funding for early childhood intervention services.

Goal 4.2 Improve and expand school mental health programs. *[See model program descriptions on page 124, Figure 4.2.]*

School-based services are a promising practice. Exemplary programs exist as models in some areas, e.g., Ft. Worth, Dallas.

The school system has not made mental health a priority. University preparation programs in mental health are sometimes inadequate. Interagency collaboration to develop in-service programs is minimal. Agencies that are required to serve children often have competing agendas due to competing priority populations and legislative mandates. Definitional problems make interagency collaboration and funding difficult.

Recommendations of Summit Participants

- Education. Provide teachers easy access to consultation and training by mental health professionals.
- Interagency collaboration. Create liaison between the state mental health authority, the Texas Education Agency, teacher preparation at university level, and other departments and training programs.
- Model programs. Explore the integration of PBIS within Texas schools. Examine Project Mainstream as model for teacher training in mental health.
- Evidence-based practices. Review evidence-based school mental health curricula and skill-based interventions.

Goal 4.3 Screen for co-occurring mental and substance abuse disorders and link with integrated treatment strategies.

Progress is being made on several fronts. Mental health, health, and substance use agencies are being reorganized. Texas requires cross-training of its mental health and substance abuse providers who provide public community-based mental health services. Screening for co-occurring mental and substance use disorders is mandated in mental health authority programs and Texas Commission on Alcoholism and Drug Abuse (TCADA) treatment sites. The state is blending funding in NorthSTAR. Federally qualified health centers are integrating mental health into services at three sites. Juvenile probation departments use a nationally recognized instrument to screen all youth coming into detention settings. Jail diversion pilots and programs are under way.

Inconsistencies in expectations, implementation, and methods exist statewide. Statutory inconsistencies continue in reimbursement responsibilities (county versus state). Gaps exist in professional preparation and in ongoing training. The evidence base in this area is smaller.

Recommendations of Summit Participants

- Professional education. Increase web-based training for integrated treatment. Add continuing education and degree credits. Change training requirements at the pre-license level. Require staff to demonstrate knowledge through licensing examinations and competency requirements. Disseminate information about evidence-based practices and promising practices through a variety of mechanisms. Provide incentives for training and for providing integrated services.
- Consultation. Develop a telemedicine consultation system and provider reimbursement mechanisms.
- Screening. Identify integrated screening tools for different venues. Provide web-

- based screening.
- Public information. Conduct a major media campaign (public and professionals).
- Funding. Utilize a blended or braided funding approach.
- Evidence-based practices. Develop substance abuse treatment algorithms.
- Disease management. Move to a continuing care, disease management public health model.

Goal 4.4 Screen for mental disorders in primary healthcare, across the life span, and connect to treatment and supports. *[See model program descriptions on page 125, Figure 4.4]*

Today in Texas Project Mainstream is being conducted, federally qualified health centers are providing behavioral health services, IMPACT is being conducted, and EPSDT has a behavioral tool. However, traditional silos perpetuate the lack of communication and the cultural bases for stigma have not been addressed.

Recommendations of Summit Participants

- Model programs. Investigate the Baylor Senior Clinic model.
- Screening. Ensure behavioral health screening at multiple points.
- Continuity. Develop strategies to ensure continuity of care across transition points.
- Professional education. Integrate behavioral health into medical and allied health training, licensing, and continuing education requirements. Liaise with Higher Education Coordinating Board.
- Integration of services. Expand co-location of services. Coordinate services between primary health and behavioral health.
- Funding. Liaise with Texas Department of Insurance.

New Freedom Commission Goal 5 Excellent Mental Health Care Is Delivered and Research is Accelerated

Research on how to translate research findings into practice is needed. All reputable scientific research needs to be considered in defining evidence-based practices. Private sector support for non-pharmacological research is needed. The workforce trained about mental illness must include school staff and teachers.

Goal 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses. *[See model program descriptions on page 126, Figure 5.1.]*

Research funding in Texas has been cut although signs point to a positive climate for research. Policymakers are interested in research and promote evidence-based practices. Pressures exist to do research to improve efficiencies, and mandates for research, although narrowly focussed, are in state legislation. The state has maintained a critical mass of talented researchers in good, longstanding public-academic relationships. Data is available for research although its integrity is questionable. The role of the private sector in conducting and supporting research is growing.

Nevertheless, implementation of evidence-based practices (EBPs) is inconsistent. Involvement of academia in a broader array of research (psychosocial, multi-disciplinary) is less than optimal. The state has either a lack of resources or commitment for research in the serious mental illnesses and funding streams do not stimulate collaboration. Resources to analyze, and to ensure the quality of, the existing data are lacking. Uniformity in operational definitions

of outcomes and processes and in measures used is lacking.

Recommendations of Summit Participants

- Standardized measures (for services, outcomes). Keep measures simple; direct research toward simplifying measures.
- Involvement of consumers and families. Enlist consumers and families in defining measures in meaningful ways.
- Data collection. Align data collection efforts across agencies; develop an agreed upon minimum data set.
- Funding. Pursue funding for research through joint efforts.
- Incentivize clinical research. Create other policies/mandates (like HB 2292) to stimulate relevant research by the private sector. Develop strategies to enhance public-private collaboration around research. Develop centers of excellence, especially around psychosocial areas.

Goal 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation. *[See model program descriptions on page 127, Figure 5.2.]*

Texas has a track record of demonstrating evidence-based practices. The disease management initiative and related legislation promote implementation of evidence-based practices. Strategies are needed to disseminate information about evidence-based practices and to *sustain* and enhance implementation. Differences in funding for inpatient and outpatient services can create barriers to consistent implementation of evidence-based practices across settings.

Recommendations of Summit Participants

- Primary prevention. Promote and fund research to identify models for early intervention.
- Standardized training on evidence-based practices. Develop dissemination strategies utilizing approaches that facilitate broad-based exportability, e.g., video connectivity, web-based services.
- Professional competency requirements. Eliminate disparities in professional competency requirements in public and private sectors, ensuring availability of licensed professionals regardless of care setting.
- Integration of services. Conduct a demonstration of the integration of mental health services with *primary care* services to establish evidence-based practices that go beyond screening to treatment.
- Cultural competency. Provide information about evidence-based practices within faith-based and other community-based settings, such as schools, i.e., making use of where people naturally go for support.
- Public information. Identify public and private funds to support dissemination and implementation of evidence-based practices. Create a broad stakeholder group to identify dissemination issues and to help prioritize evidence-based practice demonstration efforts. Bring community leaders from outside of the mental health system into these efforts. Bring together payors, i.e., legislative staff, private employers, Texas Department of Criminal Justice, Texas Department of Health, Texas Education Agency, Medicaid, Veterans Affairs, private insurers, to promote evidence-based practices.
- Demonstration. Extend Medicaid disease management demonstrations to mental
- health as appropriate, i.e., this may not be appropriate for children and adolescents.

Goal 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Most professional training programs do not contain education regarding evidence-based practices within their curricula, e.g., schools of medicine, nursing, social work. Most mental health professionals are not oriented toward using evidence-based practices. Continuing education often does not focus on evidence-based practices.

Capacity is lacking within educational institutions, e.g., faculty, resources, and TDMHMR for training mental health care professionals. A lack of expertise exists within academia to teach evidence-based practices for serious mental illnesses, e.g., Texas Medication Algorithm Project (TMAP), as cited in the President's New Freedom Commission report. It is very difficult to add new approaches to academic training curricula. Reimbursement systems engender disincentives to practicum training.

Recommendations of Summit Participants

- Maximize the use of professionals who have appropriate expertise and training.
- Train health professionals to practice as part of interdisciplinary teams, e.g., medical and professional school seminars.
- Make efforts to influence continuing educational requirements.
- Work within HHSC to broaden definitions of who can be reimbursed for providing services, e.g., other professionals, consumer and family providers, and explore waiver possibilities.
- Mandate involvement of consumers and families in training professionals within academia and the mental health system.
- Promote the utilization of peers
- (consumers and families) as providers.
- Educate providers in the use of technologies that can enhance implementation of evidence-based practices.
- Educate the public and policymakers about the value of mental health services and treatments.
- Make state licensing boards integral in ensuring the adequacy of training curricula for the public mental health sector service.
- Change the rules of managed care to allow reimbursement for training.
- Develop a model and provide technical assistance for the inclusion of consumers and families for use in medical and allied health professional training programs.

Goal 5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

No evidence-based practices are identified for diagnoses other than the priority population disorders. The knowledge base on other disorders is more limited. Recommendations of Summit Participants Expand research into promising practices for serious mental illnesses and severe emotional disturbances.

- Expand research on pharmacogenetics and ethnicity.
- Conduct research on the neurological and psychological impact of trauma on the development and treatment of mental disorders.
- Expand research regarding the long-term effects of medication and drug interactions.

New Freedom Commission Goal 6 Technology is Used To Access Mental Health Care and Information

The core infrastructure for statewide health information technology is lacking. Providers resist state efforts to standardize practices. Multiple information systems are

used depending on the locus and funding of services, e.g., CARE (the Client Assignment and Registration system), Behavioral Health Integrated Provider System (BHIPS), city public health departments. Systems do not communicate or share common standards. A state plan for how to use technology in health services, including mental health and substance abuse services, does not exist. A universal health record has not been developed. Confidentiality laws that have not contemplated telemedicine may require updating to protect patient's privacy rights while not unduly impeding the use of the newer technologies.

Goal 6.1 Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in under served populations. *[See model program descriptions on page* 127*, Figure* 6.1*.]*

The infrastructure for statewide health information systems is lacking. Necessary infrastructure exists at many community MHMR centers but systems are largely isolated and non-interactive due to lack of coordination.

Medicaid reimbursement for telehealth for many potential providers, including community MHMR centers, does not exist in Texas. A central database of IP addresses does not exist.

Public and private information technology systems cannot communicate. A readily available means of financing an initiative to consolidate and standardize information technology for health services does not exist.

Standard medical records procedures and standard business rules do not exist. Community MHMR centers do not use uniform software. There is a perception that information technology requirements increase the burden on private providers.

Recommendations of Summit Participants

- Address financing to secure necessary reimbursement for telehealth services.
- Define the essential content of the information to be collected. Inventory information technology resources currently used in the health community; identify overlap to avoid duplication.
- Collect information about information technology practices. Survey Texas Best Practices from TIFI grants. Compare expenditures on information technology in public and private sectors.
- Develop acceptable open architecture for software including identification of a set of common data fields and security standards and levels of permission.
- Use the information technology committee developed by HHSC as a vehicle to disseminate this plan and expand as necessary to build business process rules. Clinical staff and consumers should be involved in all phases.
- Mandate compliance with common standards across the publicly funded system. Regardless of vendor, software must comply. Adopt "play to get paid" approach for standard information technology.

Goal. 6.2. Develop and implement integrated electronic health record and personal health information systems. *See model program descriptions on page XXX, Figure 6.2.]*

The computerization of medical documentation of evidence-based practices has been developed as part of Comp TMAP, but the technology is not used statewide. There is no electronic medical record, but building blocks exist— the CARE (the Client Assignment and Registration system), NorthSTAR Data Warehouse and analysis

tools, and Behavioral Health Integrated Provider System (BHIPS).

Recommendations of Summit Participants

- Actively seek funding to develop an information sharing system that will achieve savings, e.g., lease infrastructure instead of purchasing.
- Create a template for structuring an electronic record, beginning with a crosswalk of existing fields/systems. Line up information content of existing system with attributes. Create uniform standards for child and adult mental health and substance abuse records. A single entry system should be developed to create a record which is scaleable and/or appendable to ensure coordination and information sharing occurs, i.e., don't start over. Ensure data collection systems communicate at a high level.
- Build on the work of the Veterans Administration and the Network of Care. Pilot the Veterans Affairs integrated medical record system, the most advanced system in the public domain, which includes, in addition to primary care, labs, pharmacy, and all specialties, including mental health and substance abuse.
- Explore university-state and private-state partnerships. Use new DSHS to establish broad coordination.
- Guiding principals for developing the system: openness, flexibility, and collaboration. Involve consumers, providers, and policy makers.

2. Welcome and Overview

RUDOLFO ARREDONDO, JR, EDD

COMMISSIONER, PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH
CHAIRMAN, TEXAS BOARD OF MENTAL HEALTH AND MENTAL RETARDATION

Ladies, Gentlemen, and Distinguished Guests,

It is my great pleasure to welcome you to the New Freedom: Transforming Mental Health in Texas Summit.

I am Rudy Arredondo and I had the honor of serving as a commissioner on the President's New Freedom Commission on Mental Health. I am also very proud to serve as the chair of the Texas Board of Mental Health and Mental Retardation.

The three purposes for this summit are to present to you, first, an overview of the recommendations from the President's Commission final report; second, a description of how these recommendations were formulated; and third, a discussion of what these recommendations mean for the future of mental health care in Texas. Here in the President's home state, we take his recommendations very seriously and plan to design the means by which to implement them in Texas. To assist with this effort we also plan to publish the proceedings of this summit and we will use the information collected here today and tomorrow to guide our state through its planning and implementation process.

At this point I would like to introduce Karen Hale, commissioner of Texas Department of Mental Health and Mental Retardation. Karen has done an excellent job in providing leadership for mental health in the State of Texas. Her leadership qualities are recognized nationally as she was recently elected by her fellow state directors to serve as vice president of the National Association for State Mental Health Program Directors. Please help me welcome Commissioner Hale, who will introduce our lieutenant governor of the great State of Texas.

3. Charge to Summit Participants

THE HONORABLE DAVID DEWHURST
LIEUTENANT GOVERNOR OF TEXAS

Commissioner Karen Hale: It is my privilege to introduce to you Lieutenant Governor David Dewhurst, who is here to guide us in our charge. Before being lieutenant governor, he was the commissioner of the Texas General Land Office. He has also served as chairman of the Governor's Task Force on Homeland Security, where he helped to develop many recommendations that make Texas a safer state…..

President George W. Bush said recently, "…mental disability is not a scandal—it is an illness. And like physical illness, it is treatable, especially when the treatment comes early."

I know each of you believes this or you wouldn't be here today. By being here today you are helping to make a commitment for the State of Texas to improve the standard of mental health care in Texas.

When President Bush established the New Freedom Commission on Mental Health in April 2002, he recognized that in the area of mental health we were not quite where we needed to be here in America. By establishing this presidential commission to study and provide recommendations on treatment of mental illness, the president was trying to set the nation on the right course….

I think we can see through the summit today here in Texas, there is big support for the president's initiative. From consumers to stakeholders to providers to legislators, we all recognize the need for change, and we are Texans, so we want to get it done *now*. I challenge you to find any state that has put as much vigor into trying to respond to the commission's call to improve mental health care right here in America.

…we all recognize the need for change, and we are Texans, so we want to get it done now —
DAVID DEWHURST, OCTOBER 21, 2003

Because of the good folks here at MHMR and through the mental health community, Texas now stands a very good chance of being selected to be a pilot state to implement the [New Freedom] Commission's recommendations. I understand only four states will be chosen, so we've got our fingers crossed. By the mental health community coming together as you are today, you are improving our chances that Texas will receive this much needed federal funding. I applaud your efforts and I encourage and support you, as does the entire legislature, as you are working through mental health issues here in Texas.

On behalf of Governor Perry, myself, and the legislature, I want to thank you for being here, I want to thank you for caring, and I want to say, bless your hearts for working as hard as you do to help those in our society to lead healthy and productive lives.

4. Keynote Address

CHARLES G. CURIE, MA, ACSW
ADMINISTRATOR, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION
US DEPARTMENT OF HEALTH AND HUMAN SERVICES

Commissioner Karen Hale: I have another distinct honor, and that is to introduce Charles Curie…. He oversees an agency with a $3.2 billion budget that is responsible for improving accountability, capacity, and effectiveness of the nation's substance abuse prevention, addictions treatment, and mental health services systems.

Mr. Curie has over 25 years of professional experience in mental health and substance abuse services. Prior to his work at SAMHSA, he was appointed by then-Governor Tom Ridge as deputy secretary for mental health and substance abuse services for the Pennsylvania Department of Public Welfare. During his tenure he implemented nationally recognized mental health and drug and alcohol Medicaid managed care programs, streamlined fractured service delivery systems, and promoted policy to reduce and ultimately eliminate the use of restraint and seclusion in state hospitals.

He is responsible for many innovations. What is equally important about Charles Curie is not just his accomplishments, but his vision. He has a vision of a life in the community for everyone, and he realizes that to realize this vision, SAMHSA's mission is to build resilience and facilitate recovery—an important vision for the future of mental health services in our nation.

He really believes and he is really promoting services and programs and systems change that will make sure that people with mental illnesses and substance abuse problems have the opportunity to have a fulfilling life in their community--a job, a home and a meaningful personal relationship with their friends and their families. And so I want you to know a real visionary leader in our field and I am pleased to introduce to you Charles Curie.

Thank you for the warm welcome and for keeping the hope of recovery alive and well in Texas. That's what you represent here at this summit.

I just came from a meeting with Governor Perry. It was clear to me that the governor clearly believes in the power of recovery and holds to the belief that treatment can and does work.

I am pleased to tell you we had a very productive meeting. I had the opportunity to present the governor with two federal grants, which combined totaled over $21 million. You have real reason to be proud here in Texas because you competed for these grants. It's tremendous. Basically you are being funded to help Texans prevent the onset of addiction and recover from co-occurring substance abuse and mental disorders.

I presented two big checks signed by US Department of Health and Human Services Secretary Tommy Thompson. The first is for$17.5 million to fund early intervention services in hospitals and other general and community settings to reach people at risk of dependence on alcohol or drugs. This award will allow community health centers, school-based health clinics and student assistance programs, occupational health clinics, hospitals, and emergency departments to conduct brief interventions that can reorient many people away from

behavior that unchecked can lead to severe addiction. Texas is one of six states to receive this grant.

…we know that co-occurring disorders are the expectation, not the exception. —CHARLES CURIE, OCTOBER 21, 2003

In addition to this grant I was also very pleased to present Governor Perry with an additional $3.9 million to increase the capacity of your state treatment systems to provide effective, coordinated, and integrated treatment services to persons with co-occurring substance use and mental disorders. Texas was one of seven states to receive this grant. We know that more than four million Americans nationwide suffer from co-occurring serious mental illness as well as an alcohol or drug disorder. In fact, for the first time we have been able to quantify that one of every five individuals with a dependence or abuse issue with substances has a serious mental illness–that's 20 percent. That does not include individuals who have a mental illness not classified as serious, which brings the figure closer to 40 to 50 percent of the population. So clearly we know that *co-occurring disorders are the expectation, not the exception*.

In Texas you've gotten real about it, competed for it, gotten the dollars, and you are going to bring up the bar. We are going to be watching you and working with you to see what we can learn and what other states can learn and adapt from you. I want to congratulate you again, and again you deserve a hand for winning these awards.

I also want to congratulate the State of Texas today—I congratulate Governor Perry and I congratulate Karen and I had a great meeting also with Commissioner Albert Hawkins this morning, who is a wonderful leader. What I found today in meeting with these great leaders is the fact that there's a commitment to wanting to do things right. There's a vision. There's a focus to meeting the needs of individuals, to meeting the needs of children, and I just want to congratulate you for restoring S-CHIP benefits for mental health to children. That's being announced today and I think that speaks well of the governor and his leadership.

I'll tell you, states are being strapped as they haven't been strapped in decades, some states as never before. The state budget crises are painful and the fact that tough decisions have to be made is unfortunately the reality. The good news is that it also gives you the opportunity to try to work out how you spend the dollars and to spend them on the things that work. That's what this summit is about: striving to make sure we use our limited resources the best way possible. The governor made it very clear today in our meeting that he was very pleased to see the CHIP benefit restored. He expressed confidence that as you move ahead, you will know exactly how those dollars are going to be used, and a lot of it is making sure that the dollars are going to be used well.

The model programs already in Texas, the great things going on–the NorthSTAR program has a tremendous track record, integrating funding streams and services. Of course we all know about your medication algorithm program here in Texas. In fact we stole that in Pennsylvania, it was so good. I can't say enough good things about Steve Shon and the folks that hold that together and worked on that through the years, and the

experts in this state that have contributed to that. It's making a profound difference.

There are so many things we can point to here in Texas where you truly are unique. You can tell when you have a governor who gets it, a lieutenant governor who gets it, Commissioner Hawkins who gets it, Karen Hale who gets it, Dave Wanser who gets it over on the drug and alcohol side–you just have an unbeatable team in this country—and again, a room full of people today to make that change happen. It's extremely exciting.

Our vision at SAMHSA is defined as a life in the community for everyone.

Each of you in this room today is working to make sure that no one struggles alone in the Lone Star State. And I'm thankful for your everyday work. I want you to know you are critical to our vision at SAMHSA. As Karen [Hale] shared, our vision at SAMHSA is defined as *a life in the community for everyone*. Together with our many partners, SAMHSA is working to ensure that people with or at risk for mental or addictive disorders have an opportunity for a fulfilling life.

A fulfilling life that's rewarding–that includes a job, a home, and meaningful relationships with family and friends. We've defined a rewarding life not by what it might mean to the people who work at, and not by what it might mean to professionals. We have defined *a rewarding life* by talking to people in our service delivery systems, to our consumers and the families, those individuals working to attain a sustained recovery.

I am a "recovering provider" and I'm also a social worker. The first position I held as a clinical social worker was in a satellite clinic in Ohio. I ran—and this goes back about 25 years–I ran what back then was called an "aftercare group" for individuals who were coming out of state hospitals. At that time it wasn't unusual for many of those individuals to have been in the hospital for a decade or more. Because of the advent of ongoing psychotropic medications, these individuals were at a point where people thought they could make it in the community. The aftercare group was a way of keeping them connected and giving them support.

I remember asking the question of the individuals in that aftercare group, "What do you need in order to deal with your mental illness?" Now I don't want to offend Steve Shon and others, but they didn't say they needed psychiatrists. They didn't say they needed psychologists. They didn't say they needed case managers. They didn't even say they needed social workers, which I still don't understand, but I accept.

What they said they needed was "a job, a home, and a date on the weekends." And that's a quote. And basically when you think about it—a job, a home, and a date on the weekends—when you think about what you need in your life, how you are affirmed in your life, your identity, when someone asks you the basic fundamental question, "What do you do?" you don't say, "Well, I get up in the morning. Take a shower. Get ready. Shave. Watch *Good Morning, America*. Make some toast. Have some coffee. Read the paper." Believe me, if you answer the question that way, you'll never be asked that question again.

When you are asked, "What do you do?" you tell them what you do daily for a living, or what your identity is in terms of type of vocation.

What they said they needed was "a job, a home, and a date on the weekends." And that's a quote.

Many, no, *most* of the individuals we work with who are seriously mentally ill, especially those individuals at the onset of mental illness, which is not uncommon to occur in the late teens or early twenties--just

when they are beginning to build their lives, they are disabled by this disease. It is not until their late 20s or early 30s that the symptoms may begin to be alleviated and they may be able to begin to build a life, but already they have lost a decade or more of their life trying to build a life. So when we put them in the community–and we know today that they can't answer that basic question "What do you do?"–how can we expect them to be part of that community or be integrated in that community unless we help them to answer that question? How are we helping individuals find and attain recovery unless we are helping them find stable housing, a place called home where they feel safe? How can they attain a sustained recovery unless we are helping them understand how to connect with their families and their friends and recognize the fact that we all need to be affirmed in relationships and we need to affirm others, and that's part of life and living.

That's why facilitated recovery is important. That's why building resilience is important. That aftercare group that I talked about is not the only group that answered the question that way. I asked that question throughout my career, including times I spent the night at state hospitals when I was commissioner of mental health in Pennsylvania. Or I would go to a drop-in center or I would talk to people who are in addiction treatment programs. You know what? They answered the question the exact same way. They don't answer it in terms of a program they need. They answer it in terms of what they need in life.

People seeking recovery from mental illness and addictive disorders, again, need most to feel connected, affirmed, and to have a real life. Those of us who are not mentally ill should be able to understand that. When you think about your life and the top five things that are important to you, I bet three of those things are a job, a home, and a date on the weekends.

One of my rewards in life is serving as administrator of SAMHSA. It is a privilege to serve President Bush and work for Tommy Thompson, our secretary of Health and Human Services. I am convinced that never before has an administration taken so much action to address the nation's mental health and substance abuse prevention and treatment needs. Again, this is an administration that knows treatment works and recovery is real.

In the president's words—the lieutenant governor shared this quote—"Political leaders, healthcare professionals, and all Americans must understand and send this message: mental disability is not a scandal—it is an illness. And like physical illness, it is treatable, especially when treatment comes early."

Our mission is to build resilience and facilitate recovery.

SAMHSA's mission statement was built on this truth. The vision of *a life in the community for everyone* is the end goal. The way you accomplish a vision is through a mission. Our mission is *to build resilience and facilitate recovery*. This is action oriented and it's measurable.

The traditional mission statement for an agency like SAMHSA is to assure access to quality assessment, treatment, and prevention services. I want to go on record: That is still a core part of our mission. We have not abandoned that. That is absolutely essential. But we are now also talking in our mission about the end game, recognizing that we are not finished unless we are focusing on building resilience and facilitating recovery and actual outcomes in people's lives. Because we recognize that unless people are attaining sustained recovery, and daily, understanding

what that means–managing your illness and managing your life–relapse is more likely to occur. We have failed individuals unless we frame it in terms of recovery.

That's what is so significant about what you are doing today. As you look at the recommendations and findings from the president's mental health commission report, it's beginning to build a system that embraces recovery and understands recovery.

The two grant awards announced this morning will distribute funds over a five-year period. Those resources will not only help build, but also help sustain, both treatment for co-occurring disorders and screening and brief intervention services for substance abuse. While these dollars are limited, their focus provides an opportunity to make informed choices, to bring more clarity to our work, and to bring both our vision and mission from paper to practice.

…there's a real temptation, because the needs are so great, to live by a philosophy of "let a thousand flowers bloom…."

We have created a matrix of priorities and principles to help guide us as we look to accomplish our mission (Figure 1). This matrix guides program development and resource allocation. It serves as our guidepost for budget decisions as well.

The reality is that we do have the matrix on boards blown up in our conference rooms and offices at SAMHSA. It's Velcro too because we have to change priorities every once in a while. We really do use this.

In fact, I call the blue axis, which you see on the left hand side of the page, the leadership axis. That's making sure we are doing the right things. Those are the priorities. If it doesn't fit on the blue axis, we don't fund it. It's so easy–and I think Karen [Hale] can attest to this, and Steve Mayberg can attest to this, anyone who has managed a large public system–that there's a real temptation, because the needs are so great, to live by a philosophy of "let a thousand flowers bloom" because there are so many well-intended programs.

But as you know, we have limited resources. And what we need to be thinking about–those of us who are public servants—is not about letting a thousand flowers bloom, because flowers fade after a season. We need to be thinking about raising up and growing some solid redwoods that are going to sustain themselves and be there after we leave. These priorities represent redwoods based on the data, based on information from consumer and families and providers in the field, based on being aligned with the president and secretary's priorities, so that we are putting our resources where we are focused and this is helping us accomplish our mission.

Cross-cutting principles, the red axis across the top–I call that the management axis. That's basically making sure we do things right, making sure that these things are at play in everything we do. Like cultural competency–we need more than just a cultural competency initiative. We need to be sure that every thing we do is culturally competent. We know what works, so let's begin doing it in everything that we do. The same is true in terms of evidence-based practices, science to service. Let's fund those things that have a track record and that we know work and really make a difference. We shouldn't just have one or two programs we are funding that are evidence-based. Everything we do and fund should be evidence-based. So that's how the cross-cutting principles work for us.

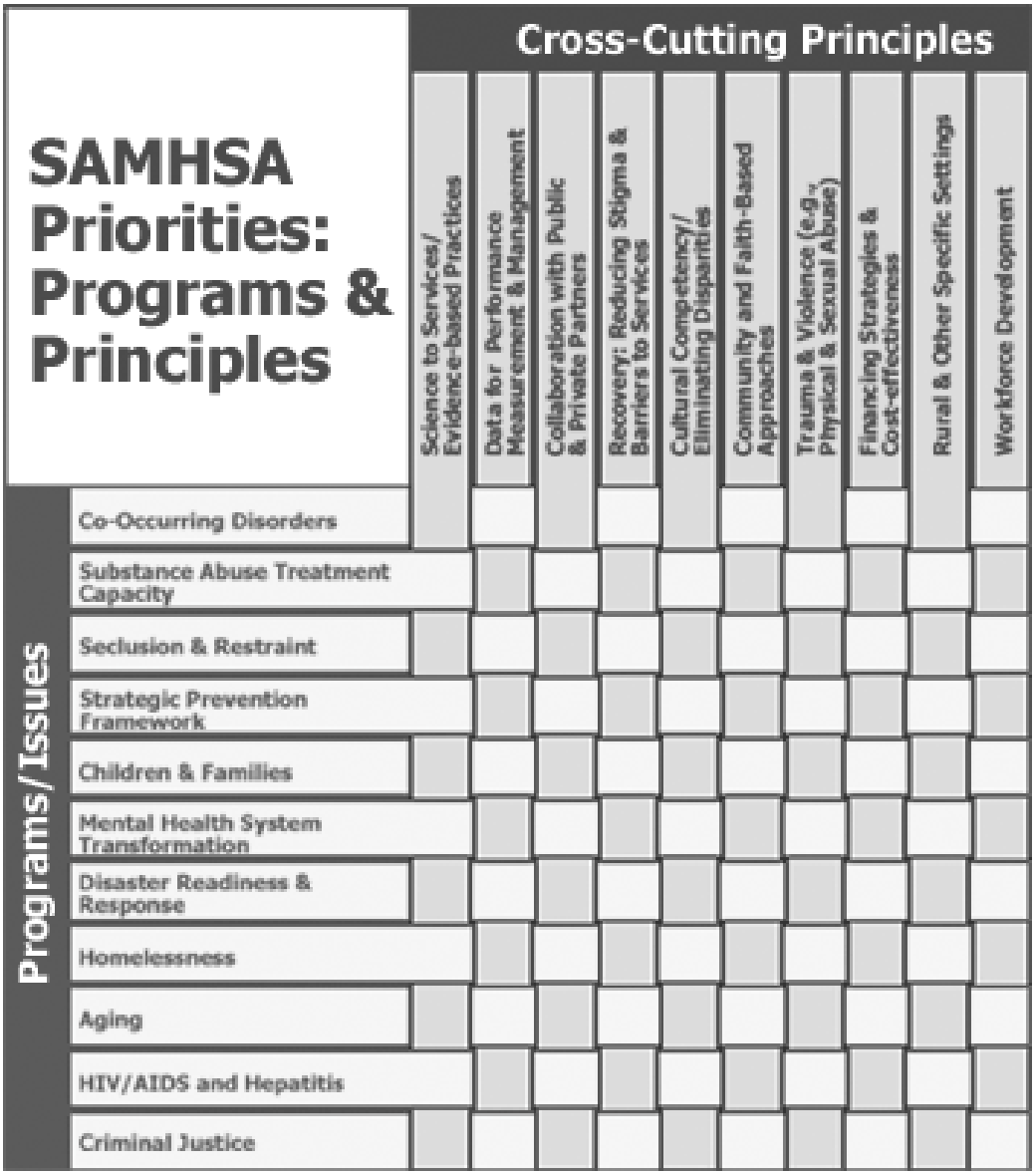
You may be wondering why I'm talking so much about SAMHSA when you thought I was here to talk about implementing the recommendations of the President's New Freedom Commission on Mental Health. I'm here to tell you that SAMHSA is being transformed to respond to the President's New Freedom Commission on Mental Health

report. In fact, the matrix that I just pointed out has undergone a major revision.

US Department of Health and Human Services

Substance Abuse and Mental Health Services Administration (SAMHA)

Accountability • Capacity • Effectiveness



"BUILT ON THE PRINCIPLE THAT PEOPLE OF ALL AGES, WITH OR AT RISK FOR MENTAL OR SUBSTANCE USE DISORDERS, SHOULD HAVE THE OPPORTUNITY FOR A FULFILLING LIFE THAT INCLUDES A JOB, A HOME, AND MEANINGFUL RELATIONSHIPS WITH FAMILY AND FRIENDS." CHARLES G. CURIE, MA, ACS,W ADMINISTRATOR, SAMHSA

When I developed the original black and white version of the matrix more than a year ago, I said that we'd be reviewing it every year and changing some things if things are changing in the field. This is the first time we've done this. I call this "The Matrix Reloaded." The matrix was changed to reflect the progress we've made and to reflect changing priorities. As a result of the commission's work, "mental health system transformation" is now listed on the blue axis as a SAMHSA priority.

Currently numerous federal, state, and local governmental entities oversee mental health programs. It's not just the mental health authority. The commission identified in the process that there were 46 federal entities alone, the largest one being the Social Security Administration, which pays more in disability payments than Medicaid pays in health benefits. These agencies have ended up determining mental health policy. They have ended up determining mental health funding. And they oversee a diverse network of public and private providers. Clearly, more efficient organization and better coordination of services and funding streams will assist providers in making sure effective treatment is received by those in need.

Meeting treatment need is what President Bush had in mind when he appointed the New Freedom Commission on Mental Health. He appointed the commission to conduct a comprehensive study of our nation's mental health service delivery system, including public and private sector providers, to advise him on methods of improving the system.

When he announced the commission in April of 2002, he spoke frankly about the poor quality of mental health care in this country in terms of a fragmented delivery system. He talked about the many points of contact we have with people with mental illness, all too often the criminal justice system or the welfare system. He talked about missed opportunities to diagnose and treat individuals suffering from mental disorders. And he also acknowledged the difficulty of achieving a diagnosis and providing the state-of-the-art care we know should be delivered. He spoke of the many Americans that fall through the cracks of our current delivery system and equated that with years of lost living and of lives entirely lost before help is given, if it is ever, in fact, even offered. President Bush drew upon the all too often common example of a 14-year-old boy who suffered from severe depression and began experimenting with drugs to self-medicate and alleviate the symptoms. You are familiar with the scenario of the honor student turned drug addict. You know of the nation's young who, instead of posing for senior pictures, end up standing still for a mug shot. This young man, like many American of all ages, slipped through the cracks. Just like him–and he wasn't diagnosed until the age of 30 with a bipolar disorder–they wait half their lifetimes for someone to notice that their behavior was *not* simply a matter of poor choices.

To quote President Bush on the day he announced the appointment of New Freedom Commission, "…To make sure that the cracks are closed, I am honored to announce what we call the New Freedom Commission on Mental Health. It is charged to study the problems and gaps in our current system of treatment and to make concrete recommendations for immediate improvements that will be implemented… and these will be improvements that can be implemented, and must be implemented, by the federal government, the state government, local agencies, as well as public and private health care providers."

SAMHSA has been given the lead role to conduct a thorough review and assessment of the report and develop an action agenda. This action agenda will detail the steps we plan to implement strategies to transform the

mental health system. My lead staff person for developing this action agenda is Kathryn Power. Kathryn recently joined SAMHSA as our new director for the Center for Mental Health Services. Kathryn, who is a colleague of Karen [Hale], Steve [Mayberg], and mine, who was a commissioner of mental health for many years in Rhode Island, understands recovery, has been an advocate for recovery, and has effectively managed that system there. She is working to craft what we call a "to-do list" that is built around the six goals and 19 recommendations contained in the commission's report. In short, President Bush asked the commission to give the mental health system a physical. It did, and the diagnosis is fragmentation and disarray.

The commission report found the nation's mental health system to be well beyond simple repair. It recommends a wholesale transformation that involves consumers and providers, policymakers at all levels of government, and both the public and private sectors. This transformation will require a shift in beliefs of most Americans. It will require the nation to expand its paradigm of public health care. Everyone from public policymakers to consumers must come to understand that mental health is a vital and integral part of overall health.

Along with this updated way of thinking, Americans must learn to address mental health disorders with the same urgency as other medical problems. With our most recent national household survey results indicating that an estimated 17.5 million adults have a serious mental illness, improving the mental health cannot remain just a concept or just "a good idea." It must be incorporated into an everyday action agenda. It goes without saying that *it cannot wait until tomorrow's planning meeting or next year's budget*. If it does, tomorrow or next year we will see the ramifications of the nearly five million children and teens who received treatment or counseling for emotional behavior problems in this country last year.

The problems are still emerging, evidence in themselves. We need to be prepared. We need to think of ways of assuring that the next generation of Americans coming up have access to appropriate treatment early on and that we become preventive in our measures so that we can cut off the disabling aspects of these illnesses.

So in short, the mental health system recovery plan, if you will, requires the implementation of the to-do list, currently being developed by SAMHSA on behalf of the Bush administration. However, like you, we aren't waiting around with the "we are doing what we can for now" approach. We have a plan and will not wait for people to absorb the report to get started. We are not waiting for it to sink in while lives fall by the wayside, especially since the results of the report did not come as a shock. I doubt if anyone in this room read the report and said, "Gosh, there's a problem in the mental health service delivery system. I didn't know." If you didn't know, I'd like to talk to you afterward.

The report serves more as a concrete fact sheet, rather than a list of revelations. The SAMHSA matrix has been juxtaposed with the commission's recommendations for transformation. The report validates the unmet needs of Americans, illustrates the country's system shortcomings, and shifts the emphasis to recovery.

To accomplish the shift, Kathryn Power and her transformation task force, SAMHSA's executive leadership team, and relevant federal agencies are already beginning to work together to determine ways to provide states the flexibility needed to bring to bear the full force of the resources available to meet the needs of people with mental illness. I'm counting on the relationship that SAMHSA has with our state partners to play a

critical role in transforming the mental health delivery system.

As we move forward, each state will be responsible for developing an action agenda of its own. I commend you for already getting started here in Texas. I would say you are the first state–because you are the first state to do it this way absolutely-- although I do know that Senator Randolph Townsend from Nevada, who was part of the commission, would debate me right here and now, because they also are getting ready and they're rolling. I will let Texas and Nevada duke it out on who's first.

So any door the individual walks through for health care, any door–the mental health center door, the drug and alcohol treatment center door, the primary health care setting door, the school system door where the problems may evidence themselves–any door is the right door to receive the appropriate assessment and treatment.—CHARLES CURIE, OCTOBER 21, 2003

I also am looking forward, because as the lieutenant governor said, you are showing yourself as a model. I think there's a lot to be learned here. That's why we are here today. That's why we are here from SAMHSA. That's why the commissioners are here who aren't from Texas. They are committed to see to it that Texas, which is already taking up the charge, succeeds, and that you move forward.

The new state agendas must be consumer and family driven. I know you get that here in Texas. We cannot become bureaucratically bogged down. Consumers of mental health services must stand at the center of the system of care. Consumers' needs must drive the care and services that are provided. Families must also be at the center of driving services. The result will be more of our family members, coworkers, neighbors, and friends living that rewarding life in their communities that I talked about earlier.

Developing the action agenda for transformation will be an ongoing process. That's why the term "action agenda" is used. I'll credit Kathryn Power for coming up with that. Also, "transformation" is being used instead of words like "reform," and definitely instead of words like "tweaking" or "band aid."

"Transformation" is being used because it is a process. It's not just a one-shot deal that we are going through—as if we're going to transform ourselves in this next six months and then we are done. Transformation is an ongoing process.

Our to-do list will cross over into other priority areas for SAMHSA. Again, you'll notice co-occurring disorders is an area that is a passion of mine. When I first was appointed to this position, during my interview process, I was asked if I could choose just one issue for SAMHSA to address and get relevant about, what would it be. Of course I had a list of 12 that I could reel off very quickly, but the one priority area I chose was co-occurring disorders, because again, so many people lose their lives and lose years of quality life because of misdiagnosis, because of being bumped around a treatment system, a well-meaning treatment system, but a treatment system that has been irrelevant. We know so much more today about how to address co-occurring disorders. As we work toward transformation we will build on 's

report to Congress on prevention and treatment of co-occurring substance abuse and mental disorders. Again, too often individuals are treated for only one of the disorders. They get better, because they get better with one disorder, but they wonder why and they realize [treatment is not addressing the full spectrum of problems]. Professionals in both fields need to see individuals with co-occurring disorders. Again, it is the expectation, not the exception.

In essence, grants like the one that Texas received are part of SAMHSA's action plan to help states create a system for treating people with both disorders. So any door the individual walks through for health care, any door–the mental health center door, the drug and alcohol treatment center door, the primary health care setting door, the school system door where the problems may evidence themselves–any door is the right door to receive the appropriate assessment and treatment.

The cross-cutting principle of science to services and evidence-based practices supports the commission's call to reduce the time it takes from research discovery to everyday practice. According to the Institute of Medicine–the commission studied this–it takes 15 to 20 years for research findings to be realized in everyday practice. Waiting for research to make its journey down an already clogged pipeline equates to a generation of people lost in the process. Too many Americans are already under-served and many more are done a disservice when their quality of life remains poor while they wait for the latest research to crawl into their communities. Our efforts at SAMHSA to build substance abuse treatment capacity also will bring more people into care. Our 2002 national household survey results found an estimated 22 million Americans suffered from substance dependence, abuse due to drugs, alcohol, or both, many of whom, again, have co-occurring mental health disorders.

To reach out to those seeking care, the president has proposed Access to Recovery. I want to talk to you a little bit about the substance abuse side because this Access to Recovery program is a major initiative. We all know that both the mental health field and substance abuse field are struggling in every state with cuts, with capacity being threatened. In his January 2003 State of the Union address, the president recognized that "Too many Americans in search of treatment cannot get it." That's a quote.

We know that about 100,000 American every year recognize they need treatment for drug abuse. They looked for that treatment and they didn't get that treatment—100,000 people. You understand that when people recognize they have an addictive disorder and they are ready for treatment, that is the time resources need to be available to them.

The president proposed $600 million over three years for substance abuse treatment that can be used in conjunction with co-occurring disorders as well. It's a voucher program. Consumer choice, *the epitome of accountability*, is involved. We have crafted standards around an RFA that will be issued to states to be sure there is accountability, that there are more portals open to individuals to receive assessment and treatment by use of these voucher programs, that we expand the array of providers, and that we expand the current capacity of providers to provide treatment. And again, the reason I am stressing this is that it's bogged down on Capitol Hill right now, in Congress. I am concerned that the whole $200 million may not get passed in the budget. It is the only proposal in the nation today to expand substance abuse services. If we lose that $200 million, and the subsequent $200 million in the next two years, for a total of $600 million–well, I'll tell you, I'm not the loser. The loser is the people with addictive disorders, the people with co-occurring disorders. The loser

is the American people. So, I encourage you think about it, say a prayer for Access to Recovery, make a phone call to appropriate representatives about Access to Recovery.

I'm proud of you all today. I'm proud of you for coming together. I know you're going to be showing the way in Texas how to transform the mental health system. I've felt the enthusiasm in the room. I see the excitement of folks I'm talking to. You have six goals, 19 recommendations. You have the people from the commission who have knowledge and passion about this.

I'm looking to be very closely tied to you as you develop your plan. We are going to offer our resources and technical assistance and support to help you craft that plan. As we develop an action agenda, we are going to make sure you are fully involved, helping us inform that agenda, so that we have a true partnership.

I have a feeling that I'm going to be spending more time in Texas as we move ahead. Well, it was wonderful here. I don't know why they say it is hot and humid. The last day or two I just thought, "This is Texas? It's like a paradise." There's a lot that can be accomplished. You are going to be hearing from people who just are so knowledgeable and the leaders in this nation today. I'm excited for you.

I'd like to leave you with a thought for recovery because the hope for it and the belief in it is what drives each of us in this room to do better, to work harder, to work faster, and to help the millions of people who continue to struggle. And again you've heard me say, operationalizing recovery and funding recovery and having recovery guide our public policy and building resilience and prevention into our early intervention agenda and addressing issues with children are going to be critical as we move ahead and expand our vision of that public health mission and what we need to be doing.

I learned a lot about recovery when I was in Pennsylvania. I came across a quote that I use often (some people say too much), but I keep using it because it speaks the truth. The quote is from General Douglas MacArthur. Now MacArthur was not a mental health advocate, but he spoke the truth when he said:

In the central place of every heart, there is a recording chamber. So long as it receives a message of beauty, hope, cheer, and courage, so long are you young. When the wires are all down, and your heart is covered with the snows of pessimism and the ice of cynicism, then and only then are you grown old.

If these words of MacArthur are true, then the person with serious mental illness–distracted by the voices, devastated by the moods that spin life out of control, a person trapped in addiction, the youth trapped in a neglectful environment–these are individuals who over time become more and more cut off, more and more isolated, who truly do have all the wires down in many ways, and grow old before their time.

This then tells us that once treatment begins to take hold, once symptoms are being alleviated, once the wires begin to come up, we must then do everything in our capacity as a system to make sure that messages are sent to that central place in the heart, messages which convey beauty, hope, cheer, and courage. For when those messages come through and truly melt away the ice of cynicism, they melt away a glacier of despair. This then invites recovery, a message of hope. You are going to give it to hundreds of thousands of people here in Texas when you are through with your plan. And I'm proud to partner with you in it. Let's get real and let's do it. God bless.

5. Transforming Mental Health Care in Texas

JOE LOVELACE, JD
NATIONAL ALLIANCE FOR THE MENTALLY ILL

I am representing a group of folks–consumers, families, and advocates–and want to thank the commissioner and Dr. Arredondo for the opportunity that has been given to us to be a part of this proceeding.

I want to open with the words of the president to set the stage for what you are about to talk about: "If we apply our medical knowledge and social insights fully, all but a small portion of persons with mental illness can eventually achieve a wholesome and a constructive social adjustment. Here more than in any other area, an ounce of prevention is worth more than a pound of cure"–the remarks made on October 31, 1963, by John Fitzgerald Kennedy, announcing the last great effort of this nation to come to terms with how we treat people with serious mental illnesses.

Many of you in this room can think about how the system evolved over that time and the good intentions that the nation under the leadership of Presidents Kennedy and Johnson had in transforming the system. It's not an indictment upon anybody that we stand here today again saying we've fallen short of the mark, especially with what we know from science about how to diagnose and effectively treat serious mental illness and how we can, at the earliest stages, engage it, and if successfully we do, the outcomes are that much better.

I'd like to mark this distinction between 1963 and now with an example. Back then, I can remember to this day because it was not but a few more days later before President Kennedy was assassinated, and we are coming up on that 40th anniversary. I was a junior in high school, getting ready for football. That's how far back that was, but there may be people in this room who were part of the original transformation.

I'd like to think we have in the audience today a marked distinction that is going to focus us entirely differently than back in 1963. I would like for those who are consumers of mental health services, who are family members with mental health services, and who are advocates for persons with serious mental illnesses to please stand.

Turn around and look at the overwhelming commitment that will be in your presence to ensure that this time we don't fall short of the mark. Thank you for being here, and thank you, commissioner, for allowing us to attend and be a part of this process.

Charles Curie has already mentioned that we have three from Texas from the Freedom Commission and that we have three commissioners from out of state. Each

commissioner is going to come to the mike and talk briefly about their insight into the goals and into the prospects.

Goal 1. Americans Understand that Mental Health is Essential to Overall Health

DEANNA F. YATES, PHD
PSYCHOLOGIST

Joe Lovelace: Dr. Deanna Yates from San Antonio is a psychologist in private practice specializing in children and adolescents She is an adjunct faculty member of the educational psychology department at Texas A&M University. She completed her clinical internship at the University of Texas Health Science Center at San Antonio. In 1987 she received an MA from Trinity University in the School of Psychology. In 1975 she received an MS in education and supervision from Texas A&M International University. A small vignette about Dr. Yates, and this will be very appropriate to some consumers and family members, is that she has by marriage been the sister-in-law of Fred Fries, who is a well known NAMI member who suffers from schizophrenia and who has been on our national board.

The mission that was given to us was to conduct a comprehensive study of the U.S. mental health service delivery system and to recommend improvements to the president. The principles that we focused on were positive individual outcomes; community based care; cost effectiveness in reducing barriers; and moving best research to best practices, with innovation, flexibility, accountability at all levels of government. The charge from the president for our goal was, "The commission…shall…recommend improvements to enable adults with serious mental illness and children with severe emotional disturbance to live, work, learn and participate fully in their communities.

The commission was made up of 15 appointed members from public and private sectors, including state governments (as we had a senator on the commission), the judicial branch (we had a judge from Florida), and mental health providers and advocates. We also had seven ex-officio federal members from different departments–the Department of Health and Human Services, the Center for Medicare and/Medicaid Services, the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, the Department of Education, the Department of Housing and Urban Development, the Department of Labor, and the Department of Veterans Affairs.

When we were looking at the mental health delivery system, we knew it reached much more broadly than just what we think of as provisions for mental health. We had 15 members on the commission and we early broke up into 15 different subcommittees as we identified major issues that we thought needed to be dealt with: acute care, children and families, consumer issues, co-occurring disorders, criminal justice, cultural competence, employment and income support, evidence based practices and medication issues, housing and homelessness, Medicare, Medicaid, the mental health interface with general medicine, older adults, rights and engagement, rural issues, and suicide prevention. That was quite a bit for us to cover in a year.

The role of each subcommittee was to analyze problems, look at programs, identify federal programs that were working and programs that we saw as models of excellence, and then to consider policy options and to identify recommendations for consideration.

"…Americans must understand and send this message: mental disability is not a scandal--it is an illness. And like physical illness, it is treatable, especially when the treatment comes early." That is a quote from President Bush in April 2002 when he announced the formation of the commission.

The commission gathered information. So much information is overwhelming. I can't tell you how many cabinets I have in my library of materials that we received from people. We had public hearings at each meeting. We met monthly. We heard from experts in all the areas I mentioned. We did field visits to Chicago. We saw a wraparound program for children. Most of us went to Los Angeles. I didn't get to go to California but I think they saw housing programs that were working. We reviewed numerous reports and documents and at each hearing we had, we had public comment time, and so we were able to hear from the public, from consumers.

We also individually did a lot of outreach to different areas. I met with my community mental health system. I met with some school districts around the state that were doing special things. All the commissioners did this–traveled around and met with groups. We also had our own special web site which is still up, I believe. We had over a million hits on that web site and 50 thousand visitors.

The interim report which came out midway through our year basically focused on fragmentation and gaps in care for children and for adults with serious mental illnesses; high unemployment and disability for people with mental illnesses; older adults with mental illnesses who were not receiving care; and mental health and suicide prevention, which was not and is not yet a national priority.

Our final report is a vision for a transformed system. As Mr. Curie said, this system is beyond repair. We need to transform it and there are certain principles underlying the transformation. There are goals and recommendations in the report. Probably many of you have read the report. The next question is, where do we go from here, and I'm happy to say that Texas looks like it is going to get on board and we are going to go somewhere from here.

There are six goals and the other commissioners will be dealing with those. The first goal has to do with understanding the importance of mental illness and getting rid of stigma. Stigma was not something the president told us to deal with. He mentioned that it was an issue but we were really supposed to deal with a fragmented mental health system. But as a commission as a whole, we couldn't really do that without looking at the issue of stigma. Stigma plays a big role in why we don't have mental health services for everyone who really needs them.

The first goal is to make Americans understand mental health is essential to overall health. We have to stop separating physical and mental health. They go together. We are one person, and the idea of separating them is an ancient idea that needs to be done away with. The failure to establish mental health as a priority may contribute to two-tiered care. I'm sure those of you who work in the field understand that there is a different level of care in physical health than there is in mental health.

My husband went the other day to his physician, who sent him to an ear, nose, and throat specialist. He spent five minutes in the office and the physician said my husband didn't have a problem. The bill was $235. My husband paid $20. We have pretty good insurance, and insurance will pay the rest.

I can get a referral from a physician to do an assessment on a child, and I can do a 12-hour assessment, and if I come to the conclusion that the child doesn't have an illness, I don't get paid. Insurance doesn't pay for that in mental health. Many insurances don't pay unless it is a serious mental illness or a serious emotional disturbance. It is not the same for physical health.

In this country alone, we have 30 thousand suicides annually. Many of these are older adults but many of these are adolescents, the folks that I treat. Mental illness is the leading cause of disability, of school failure, of incarceration, and homelessness.

Concerning the funding of mental health, 57 percent of all mental health is funded through public sources: Medicare, state and local, and Medicaid. Private insurance only covers 24 percent.

Suicide is the leading cause of violent deaths in the world. It is higher than homicides. And yet you hear about homicides on the news every night. You don't hear much about suicides but there are more suicides every year than there are homicides. There are more suicides than there are war-related deaths. Yet we haven't made that a priority.

In terms of causes of disability, mental illness is the highest cause of disability in the country and yet it is probably the least addressed. To achieve Goal 1, we had two recommendations.

Recommendation 1.1 is to advance and implement a national campaign to reduce the stigma of seeking care, and a national strategy for suicide prevention. The stigma in this country is still so great. I will tell you, Fred Fries is a relative through marriage. I did not know he was schizophrenic until one of my sisters-in-law saw him speaking on television just a few years ago. Another sister in law happened to be watching the same program. I don't watch television that much. So they called me and said, "Did you know this?" I said no. And then we found out that my nephew also has schizophrenia. I taught him when he was a child. I saw him in high school. I knew he had problems. I wasn't a psychologist then. I couldn't diagnose anything then, but I know he went a long time before he was diagnosed. He is still struggling to stay on medication and to get medication. This is in a family that understands these things, and yet his illness was kept a secret. Stigma is still there. It is a major reason why people do not seek help.

We also need to deal with suicide prevention. We need to have a national strategy to accomplish this. And to accomplish Goal 1 we would hope that we could promote a theme of recovery. It is a major theme that we dealt with throughout our work on the commission, the idea of recovery, and to increase the understanding of mental illnesses. I am tired of watching television programs where schizophrenics run around killing people, when we all know here that schizophrenics are seldom violent. We give this message out on television to the community. This is what people see. If they see it on television, and of course if they hear it on the internet, they believe it.

We need to change that. We need to get out the true message. We need to encourage help-seeking. We need to implement a national strategy for suicide prevention.

By increasing the public's understanding that mental illnesses are treatable and recovery is possible, stigma and discrimination will be reduced for people with mental illnesses. We heard about a program in the Air Force, which was a model evidence-based program, where they put the message out to active duty people that it was a good thing to seek help, that they would not be punished if they came forward to seek help. Through education and improved surveillance, and critical incident stress management, and integrated systems of care, within a few years they cut the suicide rate in half.

The second recommendation for Goal 1 is to address mental illness with the same urgency as physical illness. To accomplish

this, we need to examine the impact of mental health and illness on physical health and illness. We already have an abundance of research to show how intertwined mental illness, especially depression, is with some of the physical illnesses such as heart disease and diabetes. We need to encourage flexible, accountable financing that pays for what works. We know the discrepancy between physical and mental health. We know that Medicare pays 80 percent for physical and 50 percent for mental. We know that Medicare does not even provide drug benefits. That needs to change. If we are ever going to take stigma away, we need to treat mental illness the same way that we treat physical illness and we need to pay for it the same way.

We need to consider mental health care critical to the national dialog on health care reform. We need to look at issues like prescription drug benefits, choice of services, and support for self-direction. These are the kinds of issues we need to deal with. Mental health is the key to overall physical health. Good mental health improves the quality of life for people with serious physical illness and may contribute to longer life in general.

Goal 2. Mental Health Care is Consumer and Family Driven

STEPHEN MAYBERG, PHD
DIRECTOR, CALIFORNIA DEPARTMENT
OF MENTAL HEALTH

Joe Lovelace: Steve Mayberg, who you already understood to be the director of the California Department of Mental Health, was appointed to that position in 1993 and re-appointed by Governor Gray Davis in November of 1999, and has an appointment with The Terminator in two weeks. Dr.Mayberg earned a Ph.D. in clinical psychology from the University of Minnesota, and a B.A. from Yale University. He completed his internship in clinical psychology at the University of California-Davis and has worked in the California mental health system since that time, and I assume it was on his watch that we stole Dr.Shon.

Those of us who have been engaged in this process, which took over a year, are overwhelmed by the intensity of what we heard, by the intensity of feeling we all brought to the table, and certainly even more than that, we were overwhelmed by the passion that people brought to talk to us, to share with us their stories and their beliefs to move the system forward. Clearly for all of us, early on we realized that we had to make a fundamental shift. The system was not about the system, the system was not about maintaining bureaucracies, but the system was about recipients of services. Until we make that shift, believing that this is about recovery, resilience, and that we have to design programs to benefit consumers and their families--until we do that, rather than maintain the status quo, we really aren't going to succeed.

Goal 2–"Mental health care is considered family driven"–makes easy sense but it took us a long time to get there, a whole long time. "Mental health care is considered value driven" makes easy sense but it took us a long time to get there. As you struggle to transform the Texas system, be aware that platitudes are easy, but doing things that you really have passion about is hard.

We were talking about things we learned in high school. I remember having to read material that had no relevance to me at that time. I read *The Education of Henry Adams*. There was a quote from that book has stuck with me. The quote was,

> *No one means all he says and yet very few say all they mean.*
> *For words are slippery*
> *and thought is viscous.*

And so it's easy for us to say the words, it's easy for us to think the thought at the moment. What's more difficult, as Charlie [Curie] was talking about before, is to have this be something from your heart that is backed up by facts. All of us are here, I think, because we do believe in the words and we do believe in the thoughts.

Goal 2 represents a lot of those feelings. People say, "Well what is this President's Commission Report? Is it going to make any difference?" And the answer that Mike Hogan, the chair, always comes up with is, "No one ever got better with a treatment plan." This [the commission report] is a treatment plan. Again, no one every got better with a treatment plan. What makes people better is doing the things in the treatment plan. So you have to develop the treatment plan, the care plan for the Texas Department of Mental Health, the Texas mental health system. I think that's really critical.

I am here today because I believe in this process but also because I think it is really essential that states like California and Texas partner. This morning I was meeting with some of the staff at MHMR and there was a comment about "toy states." Do you know what toy states are? Those are the little states. They are real little states. You can do all kinds of things really easily because they are little states. They know everybody who lives in the state. Taking a risk means just driving 30 miles down the road to the border and you can get it resolved personally.

You live in a state that is big, it's complex, and it's diverse, and there's a lot of pressure from a lot of sources to make things happen and change. Often times it is easy to say that it is so big, it's ungovernable, it's unmanageable, and so let the status quo exist. And certainly the further you are away from the Beltway--Washington, D.C.--it's the same thing: "That's their problem. Out of sight, out of mind. That's just Texas. That's just California." I'm sure a lot of people would be happy if California fell into the ocean and you guys became the biggest. That's just the way it is.

What we heard time and time and time again was family members and consumers saying, "I have no clue how the mental health system works. I get good treatment, there are great people in the system, but I don't know how it works. It's opaque to me."

What we have done in our system is that we have asked people, be it either consumers or family members or both, to navigate that system, to become case managers in a system that they have no map for. They have no way to figure out how that system works. So we have placed the burden of finding care, or accessing care, on persons who are least able to do it because they don't have information and they are in the midst of dealing with some kind of crisis.

I can barely negotiate my managed care contract provider, calling up, getting the recording, pushing one, pushing four, waiting five minutes, getting the nurse practitioner, saying the right words, and then pushing two and three and then moving on. Never seeing anyone. We've done that to folks in our system. And when they don't do it very well, we say, "Gee, you're non-compliant. You would be much better off if you would just follow what we tell you to do." Of course, we aren't going to tell you what to do because you can't get hold of us or get in.

So the challenge we have is to build a system that is based around those needs and principles and one that is driven by a value system of recovery and resilience. Our belief, my belief, and my goal is that the only way you do that is to give people the information that they need, and not start at the top, but start where services begin.

So our first recommendation, because this is really about people, is that every time we deal with someone who comes into our system, we deal with an individualized plan of care for that person. This is a very different concept because we don't do a good job with planning.

Treatment is not just symptom reduction. It includes all the other parts that go on in a person's life and all the supports that are necessary, make it possible, as Charlie [Curie] said, to live, to learn, to work, and to be social in the community. When we look at how we develop a care plan, we need to look at how we engage other entities in the development of that plan–not only listening to consumer and family preferences and choice, but also engaging whoever else is involved in their lives. For children, that means listening to the school system, or the child welfare system, or sometimes, unfortunately, the juvenile justice system. For adults, that means listening to folks who are engaged in

vocational rehabilitation or in housing. All of those things really become critical.

To do that, we have to coordinate across different programs. We don't do that very well. You heard Charlie Curie talk earlier about silos. It's a myth [that there is coordination]. I run arguably the largest mental health system in the country and maybe in the world--35 million people, a $3.5 billion dollar budget. But I *don't* run the mental health system because the mental health system is also run by Social Security, SSDI, housing, special education, the child welfare system, the criminal justice system, the substance abuse system, and of course, Medicaid and Medicare. When you add up all of those things, the amount they contribute is more than the amount I contribute. So arguably, do I run the system?

It's something you need to think about. You are at a place, a great opportunity for change right now. You are in the midst of the chaos of reorganizing the whole system. Think about how you tie this in, not about what works for the bureaucracy, but what works for the end result, the people who are going to receive the services, the constituents. You have great providers, but they can only do as much as they have access to. You have great administrators, but the same thing is true for them. So figure the system, not from the top down, but from the bottom up.

When you do that in partnership, you don't need to know what other states have done. You need to know what you need to do. You need to involve consumers and families. Talk to the people who are providing the services but also talk to the people who are receiving the services.

It should not be just in the context of who should be in the system design. The consumers and family members should be at the table for everything you do, every policy, every decision, every evaluation, the whole range of recovery and support services. And that includes spilling into consumer-operated services. Often we don't do family education or peer support because insurance doesn't pay for it or Medicaid doesn't pay for it or it's not directly related to our traditional view of the system. That needs to be included when you do your redesign of what the new mental health system is going to look like, how that is part of the continuum. So you start there.

What we have found, and it was most troublesome, and I'll think you'll hear that from Larke [Huang], was that time and time again family members, especially parents of children with serious emotional disturbance, talked about being isolated and left out of the whole process. A schism had developed between what was going on in their treatment and what was going on in the family. Even though they spent 24 hours a day, seven days a week with their child, and they had a lot to offer, that wasn't being listened to. We need to promote that and there are some evidence-based practices to talk about.

To make this work you really do need to align with federal resources. We know of at least 46 different funding sources that drive mental health. Every one of those funding sources has a different eligibility requirement, a different charting requirement, a different audit requirement. It is vexatious, to say the least, for state administrators. It really does encourage the development of silos, partly because you want to maintain the program but also because it is too hard to learn another language. I think that was one of the things that you heard earlier this morning when Administrator Curie was talking about the NorthSTAR project. At least you are doing something about trying to blend some of that money to get services to the whole range of problems people present.

People should be able to come in any door. They shouldn't have a wallet biopsy that says, if you have insurance, you go here. If

you are indigent, you go here. If you have Medicare, you go here. If you have Medicaid, you go here. If you're abused, you go to this door. If you're drunk, you go to this door. That's what we do. We're busy sending them to all the doors and we don't have to do anything. So we need at some level to align the federal programs to have that kind of accountability so we can do the blending of funding so that people don't have to be diagnosis- or eligibility-driven, but look at functionally what is going on.

Part of that has to do with two issues that are very, very strongly promoted: supported housing and supported employment. Time and time and time again, we heard that the key to recovery, the key to resilience, was having a place to live or having a job, having something to look forward to. Unless we do something about that, we are going to fail. It is as simple as, those of you who remember, Maslow's hierarchy of needs. If you are hungry or need a place to live, you aren't going to think much about inter-personal relationships. You are going to think about how you are going to feed yourself.

The other thing that we found out is that more and more, our mental health system has transmigrated from our institutions and from our mental health clinics to the streets or to the jails or to the prisons or to the youth camps, and that we have to do active outreach either to divert folks or to get them out of that system and to move back into our treatment system. As I said about treatment compliance, if you give people choice and give them the opportunity to be a part of this, they are much more apt to participate. Not to say that everybody will, but most people will. We're doing that in California. We are focused in on the homeless population there. No one ever wanted to deal with them because they are so complex. What we found was that 85 percent of the folks with repeated visits, if we offered them whatever they needed– sometimes it was dental care, sometimes it was a pair of socks, sometimes it was food, sometimes it was psychotherapy, sometimes it was medication—they ended up participating in the mental health system. Most of them got off the streets, with an 85 percent reduction in jail costs, a 73 percent reduction in emergency room costs, and 25 percent are now working 18 months later. So it's possible. People we had given up on, *and we had given up on people*, can be helped. That's the whole concept of flexible funding.

What this really boils down to, and this is really the challenge for all of you here, is the issue of a state plan. Most of the mental health decisions are made by the states. We complain about Medicaid and Medicare, but the decisions about eligibility, about access, about array of services, about waivers, are all made at the state level.

Goal 3. Disparities in Mental Health Services Are Eliminated

Rudolfo Arredondo, Jr, EdD
Professor of Neuropsychiatry
SOUTHWEST INSTITUTE FOR ADDICTIVE DISEASES
Texas Tech University
Health Sciences Center

Joe Lovelace: Many of you already know Rudy Arredondo. He has spoken previously. He serves on the faculty at Texas State University Health Science Center and has been there since 1972. He is a tenured professor with the primary academic appointment to Texas Tech University Health Sciences Center Department of Neuropsychiatry and a secondary appointment to the Department of Health Organization Management. Dr.Arredondo is the first person that walked into the room that really spoke knowledgeably from the perspective of dual diagnosis comorbidity in persons with serious mental illness. It is under his leadership that I think many of us credit the advances that have been made in Texas.

In a transformed mental health system all persons share equally in the best available services and outcomes regardless of race, gender, ethnicity or geographic location. The members of the New Freedom Commission felt that we could not address all disparities and that we should focus on disparities of mental health care of ethnic minorities and of people who live in rural or frontier America. We felt that we should focus on four ethnic groups who historically have been underserved in the mental health system. African Americans, Asian Americans/Pacific Islanders, Hispanic/Latino Americans, and Native Americans

I will present the part of this goal that focuses on ethnicity and Nancy Speck will present the rural focus. Nancy chaired the Rural Health Issues Committee and Norwood Knight-Richardson chaired the Cultural Competence Issues Committee. Steve Mayberg, Larke Huang, Dr Fran Murphy, and I were involved in the Culture Competence Issue Committee.

We had excellent consultants for in all issues. Two of our four consultants on cultural competence are participants and presenters in this summit: Dr. Steve Shon, medical director of the Texas Department of MHMR, and Dr. King Davis, who is on the faculty of UT Austin and is also the executive director of the Hogg Foundation for Mental Health.

Failure to eliminate disparities in mental healthcare may contribute to less access to care and a higher burden of disabilities for racial and ethnic minorities. Historically ethnic minorities have been underserved or inappropriately served in the mental health system. This has contributes to high rate of disability from mental health disorders. The report of the Institute of Medicine referenced over 100 studies that demonstrate consistently in research findings: that people of color are less likely than the white population to receive needed services. These disparities exist in a number of disease areas, including mental illness, and are evident across a range of procedures and interventions.

The sources of mental health disparities may be attributable to multiple factors, including the operation of health care and the legal and regulatory climate in which it operates; the cost of care; societal stigma, the fragmentation of organization of services, clinical and consumer bias, lack of training in providing care cross culturally, and many other reasons. The inequities in mental health care were also dramatically documented in the US Surgeon General's landmark reports: *The Surgeon General's Report on Mental Health* and *The Surgeons General's Mental Health Report: Culture, Race and Ethnicity*. These reports not only present the problems, but also offer recommendations to improve the system.

To aid in transforming the mental health system, the Commission makes two recommendations:

3.1 Improve access to quality care that is culturally competent.

3.2 Improve access to quality care in rural and geographically remote areas.

Goal 4. Early Mental Health Screening, Assessment, and Referral to Services Are Common Practice

LARKE N. HUANG, PHD
DIRECTOR OF RESEARCH
CENTER FOR CHILD HEALTH AND MENTAL HEALTH POLICY
GEORGETOWN UNIVERSITY

Joe Lovelace: Larke Huang is senior policy associate in the National Technical Assistance Center for children's mental health and the director of research at the Center for Child and Human Development in the Department of Pediatrics at Georgetown University Medical Center. She has worked in the field of mental health for more than 20 years with the primary focus on mental health services for children and the under-served, culturally diverse populations. She received her doctorate in clinical community psychology from Yale University. Since then she has done teaching, research, clinical practice, and policy development. Very important, most recently she was involved in the planning and formation of the National Asian-American Pacific Islander Mental Health Association.

The following is an excerpt from New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

In a transformed mental health system, the early detection of mental health problems in children and adults - through routine and comprehensive testing and screening - will be an expected and typical occurrence. At the first sign of difficulties, preventive interventions will be started to keep problems from escalating. For example, a child whose serious emotional disturbance is identified early will receive care, preventing the potential onset of a co-occurring substance use disorder and breaking a cycle that otherwise can lead to school failure and other problems.

Quality screening and early intervention will occur in both readily accessible, low-stigma settings, such as primary health care facilities and schools, and in settings in which a high level of risk exists for mental health problems, such as criminal justice, juvenile justice, and child welfare systems. Both children and adults will be screened for mental illnesses during their routine physical exams.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening. Service providers across settings will also routinely screen for co-occurring mental illnesses and substance use disorders. Early intervention and appropriate treatment will also improve outcomes and reduce pain and suffering for children and adults who have or who are at risk for co-occurring mental and addictive disorders.

Early detection of mental disorders will result in substantially shorter and less disabling courses of impairment.

For consumers of all ages, early detection, assessment, and links with treatment and supports will help prevent mental health problems from worsening.

To aid in transforming the mental health system, the Commission makes four recommendations:

4.1 Promote the mental health of young children.

4.2 Improve and expand school mental health programs.

4.3 Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

4.4 Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

Goal 5. Excellent Mental Health Care is Delivered and Research is Accelerated

Robert N. Postlethwait, MBA
CONSULTANT

Joe Lovelace: Bob Postlethwait is retired from a more than 28-year career with Eli Lilly and Company. From 1994 until his retirement in 1998, he led the Neuroscience Unit at Lilly. The last position he held there was president of the Neuroscience Product Group. He is a member of NAMI Indiana. Mr. Postlethwait completed the advanced management program at Harvard in 1988 and earned an M.B.A. from Buckman University in 1974. He received a B.S. in chemical engineering from Purdue in 1970.

For more information about Goal 5, refer to New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

Right now there is a significant deficit, and this deficit needs to be closed. And the major recommendation here–because nothing happens unless you have a plan and you implement the plan—is to develop a plan for training, recruitment, and keeping qualified workforce participants in the mental health provider system. That's the third recommendation.

The fourth recommendation for this goal has to do with studying to inform policy in four basic areas of research. Now it shouldn't be interpreted that this is precluding studying other areas. But the four have to do with what Rudy talked about earlier, cultural competency. The second one has to do with acute care and the situation around acute care; long term exposure to pharmaceuticals; and trauma. And trauma is extremely important. So there are four sub-recommendations to the fourth recommendation, which is to do additional research to inform policy decisions concerning evidence-based practices.

If you were to read a ticker—How many of you watch CNN news? How many of you have noticed a runner down below? It's distracting, isn't it? If there were a ticker for the New Freedom Commission mental health final report, on Goal 5 it would say something like this: "Much is known about effective treatments and supports; not put into practice for 15-20 years, severe, unnecessary disability exists. A blueprint to stop this costly waste is contained in Goal 5. Leadership and alignment are called for." Thank you.

Goal 6. Technology is Used To Access Mental Health Care and Information

NANCY C. SPECK, PHD
TELEHEALTH CONSULTANT
UNIVERSITY OF TEXAS MEDICAL BRANCH
GALVESTON

Joe Lovelace: Dr. Nancy Speck, another Texan, is a telehealth regional consultant and coordinator at the University of Texas Medical Branch at Galveston. She is retired from the faculty and administration of Stephen F. Austin University, where she had previously served as vice president. She has extensive experience in the areas of community mental health, public and higher education, and community development. She brings to her credentials the fact that she has been very active from the inception with the community mental health system movement.

I would like to start by calling your attention to some specific points as we chose Goal 6 to help achieve the promise. It is focused on technology. The fortunate thing about Goal 6 is that it just awaits the will of those of us in this room and all across the nation to achieve. Texas is particularly rich as a result of the legislation over a decade ago to provide the Texas Infrastructure Fund. We have the lines, the groundwork is laid. What we don't have is sustainable funding and we don't have programming to adequately fill that electronic highway. So we are two-thirds of the way home.

I hope that in helping us to achieve the promise in Texas we will, from you in this room, have the leadership ability to work with both the feds and the will of the State of Texas to use our funding to help maximize the technology that that we currently have to help us to train and retrain those people who are professionals in the field so that we might use this technology in extending quality mental health care to all Texans, and to help us design and deliver these projects in an efficient and cost effective manner.

The most frequent questions and the most frequent requests we heard throughout the commission from consumers was, "Please give us access." From providers we heard, "Please give us the money, the funding, and the professional staffs to be able to provide that access." So we know that there is one thing in achieving the promise and that is that we all agree–providers, consumers, families–that what we want to continue what was begun 40 years ago. In a little less than 48 hours I'll be standing on the Hill in Washington commemorating the event on Thursday of the signing of the John F. Kennedy [community center legislation]. So, Mr. Lovelace, you do know someone who has been around 40 years and been in the field and who will be back. I wasn't in Washington in '63 but I will be there in 2003.

Technology can help us to do one of the three things outlined by the president as we began the search for a promise and its answers, and that is to reduce disparities in our nation, in the rural areas as well as the in others. Rural is 90 percent of our land mass. It is roughly one third of our population. One of the items that we discussed in rural was that roughly the incidence of mental illness does not discriminate where you live in terms of the opportunity you might have to be in that population. There is enormous disparity in the services that are available, the accessibility in rural areas, the availability–one person a week or one person every two weeks in an itinerant mental health unit is hardly accessibility. And then [there is disparity] in the cultural competency area for those who are living in rural areas. My colleague, Dr. Mayberg, had a wonderful short brief of what we mean by that: "Race in place." It depends on what you get in mental health care.

Technology allows us to overcome that barrier. It allows us to achieve the dreams we all want, which is recovery and prevention for all mental health and social emotional disorders. We can use what we have in high tech and we can use that in such a manner that it leads to recovery with high touch from the professionals.

It allows us to put on the web information that we can empower the families and the individuals with mental illness to research and be better informed and in touch with what is happening in the field of mental health by using the internet and communications. It allows us the potential, with much caution, to develop a national mental health records system, and also to sustain and enable telemedicine, the actual treatment. It will help us to not only overcome the disparity of the services, it will allow us to more wisely and more completely utilize the professional force that we have. We know that we will not lose mental health specialists or other medical health specialists from the concentration in cities, but we can move their services, their knowledge, their ability to heal, by taking it there through telecommunications.

The health and technology improvements and coordination of mental health care is one of the key recommendations. Goal 6 only had two recommendations. One has to do with telemedicine and the support and sustainability of telemedicine. The second one has to do with the health record. I would like to call your attention as you look through the report and as you read, that we need public and private partnerships. We began about six months ago meeting as a strategic health partnership to design the vehicles and enumerate the kinds of system outcomes that we would like to have as we implement the bill to take mental health to be a part of public health in Texas over the next few years, to achieve the promise for people in this state, as well as to achieve the goals of this commission.

So let us decide here. Let us decide today. Let us decide this moment. Why delay? Why shouldn't we take Texas to the summit? Why shouldn't we bring Texans to better care? Why shouldn't we make [real] that new sound byte I just got this afternoon from Charlie Curie that "No Texan will struggle alone." Let's say to ourselves and let's say to this state and let's say to every official that has an opportunity to help us make that vision true, that no Texan should struggle alone in Texas. No family with a child struggling with mental illness should struggle alone in Texas. Let's hang a sign, "We're open for business and we're prepared to deliver services." Thank you very much for being here today

6. Science to Services

KING DAVIS, PHD
EXECUTIVE DIRECTOR, HOGG FOUNDATION

As we were going through earlier parts of the program, it reminded me, having come here fairly recently from Virginia, that we indeed have been on this path for a very long time, by my estimation approximately 243 years.

Mental health service and the search for science and for evidence started in this country in 1760 with an article in the *Williamsburg Gazette*. The purpose of the article was to identify what worked, what the problems were, what caused them, and what cured them. That was followed soon after by the establishment of the first hospital for the mentally ill in the United States.

In some respects we have continued that same approach to the treatment of mental disorders and a variety of other problems throughout much of American history. Treatment has, for the most part, reflected the state of our science, the state of our beliefs, the state of our hypotheses, and the state of our ideas. Throughout the 243 years, obviously we have had some extraordinary, some marvelous science, but one of the questions that has been raised here throughout the day is the extraordinarily long period of time that it seems to take for us to make the transition from science into practice. Today we have three really very good people to address a number of those issues.

(left to right) Karen Hale with Drs. Davis and Shon

Texas in the National Landscape of Change

VIJAY GANJU, PHD
DIRECTOR, CENTER FOR MENTAL HEALTH QUALITY AND ACCOUNTABILITY
NATIONAL RESEARCH INSTITUTE
NATIONAL ASSOCIATION OF STATE MENTAL HEALTH PROGRAM DIRECTORS

King Davis: The first of our presenters is Vijay Ganju, who probably most everybody in this audience knows. He is currently the director of the Center for Mental Health Quality and Accountability at NASMHPD, which is the National Association of State Mental Health Program Directors, in their National Research Institute (NRI). In this role he is involved in a wide variety of projects related to the development and the implementation of evidence-based practices and performance management and outcomes systems. He is the co-director of the SAMHSA-funded Data Infrastructure Coordinating Center, and he consults with the World Health Organization in the areas of mental health financing, quality improvement, and services evaluation and research. He is currently chairing a mental health statistics improvement workgroup, developing the next generation of mental health performance measures that have recovery as their major focus. Prior to joining NRI, he served as the director of planning, research, and evaluation for the Texas Department of Mental Health and Mental Retardation. It is a pleasure to invite him back.

It is very good to be back here in Texas, to see old friends and colleagues. As Dr. Davis pointed out, I have been involved with mental health issues at the national level for the last few years. Before that I spent 20 years with the Department of Mental Health, so I cut my teeth–and lost my hair, pulling it out–here at the Texas Department of Mental Health. It's great to be back.

"…evidence-based practices are not a passing fad or fancy. They are not transitory or ephemeral. They are here as the beginning of a new era in mental health.—VIJAY GANJU, OCTOBER 21, 2003

What I was asked to do was to present a national landscape of what's going on with evidence-based practices and relate what is going on in Texas to that national context. In the spirit of brevity, I'm going to tell you the two major points I'm going to make.

The first is that evidence-based practices are not a passing fad or fancy. They are not transitory or ephemeral. They are here as the beginning of a new era in mental health. The surgeon general's report reflects that there is new science and that we have to somehow take that science and put it into practice, but it is just the beginning of that science. Evidence-based practices are not an end state. They are a state that is essentially starting off. This is the future of mental health, and we have to go forward down this track.

The second point is that as we understand better what it takes to implement evidence-based practices, we must understand the systemic components that need to be in place, and that Texas is very well situated to move forward on this front.

Just to be clear, when we talk about evidence-based practices, we are talking about

interventions that have strong, consistent scientific evidence that they produce positive outcomes. These are practices that work. I think that sometimes people raise the issue, "What about all the other services? Don't they have the evidence?" *They don't have the evidence.* They don't have the strong, unequivocal kinds of ways that you can make conclusions. That doesn't mean that they are not effective. The science either hasn't been done or doesn't support their implementation.

We're going to talk about evidence-based practices in terms of Goal 5 from the President's Commission. We've seen that what we are trying to do is increase access to things that work. This is really about making sure that evidence-based practices are part of the array and arsenal of services so that people have choices to treat their illnesses in the best manner possible.

I think we make the analogy sometimes with health. Do you want your health service to be able to provide bypass surgery or not? You don't necessarily need it, but you want to make sure that if you need it, it's there. That's part of the thrust of moving forward with evidence-based practices. The second point is that few evidence-based practices exist, so the other major agenda is to make sure that there are more and more of these practices.

We are talking about contextual kinds of issues. The context in which we are moving forward with evidence-based practices is related to all the kinds of problems we've just heard. More than 40 states are experiencing major budget shortfalls. There are still issues in terms of people's perception of the adequacy of the science and practice related to mental health. People do not equate mental health services at the same level with health services. The message has not gotten through that mental health services are in many cases as effective, if not more so, than standard health practices, such as for the treatment of heart disease or diabetes, and that you really have to have these services.

Other kinds of contextual issues also figure in this, like fragmentation of services. Given all of these problems, what we are advancing, not just in mental health but in health as well, is the next generation of activity, which some people call the "third wave" in mental health services, which is focussed on quality and accountability of services. We had institutional systems, we have built community systems, and now we are concentrating on what happens within those systems so that we can be effective and efficient as we move forward.

As state mental health commissioners look at this as part of their drive toward quality and accountability, the emphasis is on producing outcomes. The three pillars on which some of the state mental health commissioners have felt that this is going to be built are *evidence-based practices, performance measurement, and quality improvement*. Evidence-based practices alone are not the panacea or silver bullet. They are just one mechanism, and they need to be placed appropriately in the larger context for them to have the kinds of outcomes and meet the kinds of expectations that one has of them. As was pointed out in the last session, the big plus is that we know they work. The big problem is that people aren't necessarily doing them. This represents the opportunity and the basic thrust of why people are pushing this idea of evidence-based practices.

At the national level, we recently completed a survey of all the states. This is a second-generation survey in which we surveyed states on a select few evidence-based practices to see what they were doing. Most states are doing something in the area of evidence-based practices. What's interesting about this is that many states have not implemented these practices on a statewide basis but they are already implementing them

in some parts of the state. Many states are in the process of planning or piloting some of these things, so they are just starting some of this process.

Where does Texas fit in all of this? Is it implementing statewide or is it implementing in parts of the state? What is exciting is that when you look at the subset of evidence-based practices that were covered in our survey, Texas is implementing all of these things on a statewide basis. There are issues in terms of how well they are being implemented, but the infrastructure is there to move forward with implementation.

One of the things one finds for children's evidence-based services is that there is a smaller set and they are being implemented less prevalently than adult services. Again, when we see where Texas fits, we find that it is implementing these in some parts of the state. I want to emphasize that we asked people about just two evidence-based services for children. There are more than two evidence-based services but these were the two included in the survey.

One of the issues that we also surveyed was fidelity. Fidelity keeps coming up because when there are budget shortages, people worry about how well they are implementing particular evidence-based practices. Fidelity refers to how true you are to the critical components of what makes the evidence-based practice work. People monitor those critical components, and if you are adhering to them, you have higher fidelity. We asked how many states actually monitor fidelity. As you look at the array of services, you see that most states aren't monitoring fidelity. This is an issue that we have to deal with because if you don't know what you are doing, it is very hard to bring in the quality improvement cycle to move forward. I know that as Texas is going to be focusing on the fidelity issue.

Just to paint the landscape of what is going on with evidence-based practices, I will point out a couple of them. The first one is the SAMHSA national evidence-based demonstration project. What this project focuses on are six evidence-based practices: assertive community treatment, supported employment, family psychoeducation, self-management recovery, integrated dual diagnoses, and medications. For each one of these, SAMHSA has sponsored the development of what are called "implementation resource kits" (some people call them toolkits). These are used to provide information not just to practitioners, but to consumers, to family members, to providers, and to policymakers, so that everybody understands how they can be supportive. Several related grants have been issued by SAMHSA.

I also want to point out that SAMHSA is creating a national registry for effective practices. This is going to provide opportunities for local programs to identify things that work. One can look at not only what scientists have found works, but also what practitioners are finding works. That information can inform science, so that you can essentially build the loop, not only from science to service, but as you learn more, as practice is implemented, and services are provided, from services to inform the knowledge base of science.

Let me talk about federally qualified health centers, because I think it does fit with some of the discussion we had earlier in terms of the primary care setting. What is very exciting about what is going on with the primary care health setting under federally qualified health centers is that they are emphasizing behavioral health evidence-based practices and their implementation.

So basically what is beginning to happen is that there is ferment and energy

around evidence-based practices at the federal level, the state level, and the local level. I just came from a very exciting meeting in Ohio where a local community has decided to move forward with evidence-based practices to implement recovery. They have aligned their information systems, their funding systems, and other infrastructural components to make that happen. We'll be hearing more about that because it really does provide a model.

We are learning as we move forward with the implementation of evidence-based practices. We used to think that all we needed to do was to provide knowledge to the practitioner through continuing education programs and somehow that would translate into the implementation of the practice. We are finding that is not enough and that you really need to consider other kinds of components. On the consumers' side, you have to look at their understanding of what is happening, their commitment, their choices, and their lifestyles.

We are learning that the nature of the evidence-based practice itself makes a difference. You look at the cost, the complexity, and how it fits in with what you are doing. All those factors are related to whether there is uptake of that service or not. Similarly, to sustain the evidence-based practice, you have to look at it systemically and look at factors related to the information technology, the administrative supports, the organizational culture, and the leadership. Without those, you can implement and you can practice, but you cannot sustain, the evidence-based practices.

At state level, we also need to make sure that the leadership, the policies, the regulations, and the standards are in place. It is a systemic kind of intervention that we are talking about as we move forward. All of the components that have come out of the President's Commission report are well organized to work together to move forward with implementation of evidence-based practices.

The implementation of evidence-based practice is not just a question of transforming or transmitting knowledge. It is really about transforming systems and it involves infrastructural issues, organizational culture issues, how one provides measures, and how one puts this in a loop so that there is continual planning and improvement. It is not a static world in terms of how this gets implemented. This is not just true of mental health services. We heard earlier that this is how innovation, adaptation, and adoption occur in other sectors, like the business world and other areas as well.

We did the second iteration of the survey after all the budget shortfalls had become apparent and [it helped to assess] whether people really wanted to stay on track in terms of implementing evidence-based practices. Most states said this was going to stay a high priority. Clearly there is lot of energy, a lot of commitment, and a lot of prioritization occurring in this area.

What is it that people are saying they need, the areas in which they need support? In terms of funding, how is Medicaid going to support this? How do incentives help? How do you do the infrastructure? How do you do consensus building? How do you do the human resource development, not just in-service to people who are providing services, but pre-service at universities as people are being trained and coming into the service delivery sector? How do you do the outcomes measures? How do you do the technical assistance?

As we look at these things, there's a model that's appealing but we first have to deal with awareness, consensus building, and people doing things in parts of the state before they can move forward on a statewide basis. To move forward on a statewide basis, you

have to develop a training infrastructure and the other infrastructures in terms of contracts, licensure, quality improvement, monitoring, and feedback.

In summary, what you have is a system where you need these different components, and you can look at each of these components and see how Texas fits. This meeting is a testament to the leadership, not only within the state, but also at the national level. There has been the leadership we heard about–TMAP and NorthSTAR–and more than that, there has been leadership in the state in terms of commitment and administrative will, in terms of consensus building. For all of these different aspects, we can give Texas a checkmark.

Looking at organizational consensus building, when Joe [Lovelace] asked people to stand up, a partnership was evident. It was clear that consumers and family members are not just part of the team here, but that there is a strong partnership, and there is a history of it, a culture which has been built over the last 15 years. So Texas can put a checkmark for that.

We heard Dr. Speck talk about the information technology, about how the infrastructure has been laid. But the other thing is that Texas has also built outcome systems that, at least in my travels around the country, are not available in most states on a statewide basis. So Texas has all these checkmarks.

In terms of policies and procedures, Texas has standards and Texas has contracting mechanisms to move forward. Clearly in all of these areas, there is need for improvement. In the area of human resource development and training, there are still issues that need to be addressed.

It does finally and ultimately take resources. There's just so much juice in the lemon. Texas does have to worry about where resources are going to come from and how they are going to be aligned and dedicated. Those are issues that Texas has to struggle with. One of the dangers that we know from hindsight is that these are the things that get devalued when dollars are scarce. These are the kinds of things that other systems are striving to build and Texas has these.

One of the important messages that I would leave would be a message of caution. These are the things on which the future of the Texas mental health system are going to be built. These are what other states are essentially trying to get a hold on. So I would say please, hang on to these things, because these are going to be critical components in terms of sustaining evidence-based practices in the future.

There are challenges and I'm going to stress these. These are the challenges that one has to deal with continually: challenges of buying; challenges of people feeling threatened because the status quo changes when some of these things are introduced; how one introduces these things in times of budgetary restraint; how to sustain statewide effort over time; and what one does about remote and rural areas. These are all areas that need to be addressed. One of the things our center is trying to do is help states go forward in all of these areas.

Thank you. I hope I have been able to provide the national landscape and how Texas fits in.

Using Technology To Implement TMAP

MADHUKAR TRIVEDI, MD
ASSOCIATE PROFESSOR AND DIRECTOR
DEPRESSION AND ANXIETY DISORDERS PROGRAM
THE UNIVERSITY OF TEXAS
SOUTHWESTERN MEDICAL CENTER AT DALLAS

Thank you very much. Thank you, Dr. Davis, for the invitation to join the panel. My task is, in a way, simple. I have to convince you using two analogies. One is a hammer and nail analogy and the other is a lemon with little or no juice.

We have been provided with the two challenges that I want to address. One is that we heard the real amazement in the voices of both Mr. {Charles] Curie and Commissioner Robert Postlethwait when they talked about how 15-20 years or longer go by before the existing treatments that we know work get into clinical practice settings. This large gap between science and service is where a lot of us are working. That is what the Texas Medication Algorithm Project (TMAP) does, speeding up the availability of existing treatments that are very good for chronic mental illnesses so that they come to the practitioner much earlier. That is the first and the foremost challenge.

The second challenge is to promote these systems so that evidence-based practice and its promise can be realized. Evidence-

King Davis: The second of our presentors today is Madhukar Trivedi, a physician who is an associate professor and director of the Depression and Anxiety Disorders Program at the University of Texas Southwestern Medical Center at Dallas. Dr. Trivedi has been involved with evidence-based medicine for more than 12 years. He has a vast and established expertise in the treatment of depression. He has been funded extensively through peer-reviewed federal grants to develop treatment strategies for patients with severe and persistent mental illness. He has also worked with patients in the public sector to answer a variety of questions related to long-term outcomes in the treatment of depression as well as being involved in the TMAP project. He has received a variety of awards for his work and has published more than 100 articles in scientific journals, and it is a delight to welcome him as well.

based practice is ultimately jingoism unless clinicians use it and begin to figure out how best to use it. Very few people will argue, "I don't want to use evidence-based practices. I just want to do my own thing and then go home." The problem is in the details of how best to implement evidence-based practice. I want to share some of the work that we've done and give you an idea of what we can do.

Using algorithms is one way of trying to implement some of these evidence-based practices in clinical settings. A lot of our effectiveness research at UT Southwestern that is related to the three major illnesses has been in trying to use algorithms and find better ways of implementing them.

One really interesting question is, *Can we enhance patient care?* Whether we can utilize algorithms in routine clinical practice is one issue. The second issue is, as new treatments appear on the horizon, the ability to monitor how best to use them starts becoming compromised. To give you an idea, in the last 6 to 7 years, there have been 500 to 600 randomized controlled trials for the treatment

of major depressive disorders with antidepressant medications. There is a significant wealth of evidence that these antidepressants work and in fact, compared with clinical trials for a number of other chronic medical illnesses, our treatments have the stronger weight of evidence behind them. The challenge is whether you can bring that evidence into practice fast enough. Regularly updating and adopting treatment algorithms in routine clinical practice is the challenge.

I'll give you an idea of the difficulties in implementing the algorithms in terms of treatments for depression (and the same thing holds true for schizophrenia and bipolar disorders—in fact, more so). Only about a third of patients achieve remission on a single antidepressant treatment. Most patients have to go to second, third, and fourth line treatments, and this is in the acute care setting. When you start thinking about long-term care and maintaining improvement and recovery (which the report identifies as a goal), we have to find more ways to use algorithms to improve care.

If people buy into the argument that evidence-based practice is the way to go and algorithms may be a potential option to use, then the question remains, *Do they really improve clinical care or are they just better ways of putting diagrams on the board?* Again, the problem is with details. People assume that because algorithms are available, they must work. The good news, from Texas's point of view, is that the Texas Medication Algorithm Project was the first algorithm study that used algorithms in routine clinical practice in the public health sector to show whether or not the algorithms worked better than usual care. Although on the face of it, it sounds like algorithms must work, most clinicians have not done the hard work involved in those studies. So the question remains, *Do they really improve clinical care?* I'll show some of the evidence from TMAP that clearly shows that they improve clinical care.

If you do find that algorithms improve clinical care, the question becomes, *Can they be made flexible or not?* Without that, they are very hard to use. But if they are *very* flexible, like some of the guidelines, from, for example, the American Psychiatric Association, they serve only as very general texts that say you should do good for patients. Very few people argue with that, but try to use it in routine practice. Practice guidelines have to be somewhat prescriptive, otherwise you don't get to good care.

Finally, the most important thing, systems of care–*Will clinicians use them in routine clinical practice or not?* Using algorithms, we have to deal with large charts, to go through what happened on the last three visits, and then identify the next best thing to do, and we have 7 minutes, or 10 minutes, or 15 minutes to do this. Whether clinicians will use these algorithms in routine care needs to be addressed.

TMAP algorithms were developed to identify strategies and tactics for the three major illnesses [major depressive disorder, schizophrenia, and bipolar disorder]. This is, by the way, not an indictment of any other form of treatment. These were medication algorithm projects to begin with and other treatment approaches will and should be incorporated in these approaches.

In the medication algorithm sequence one example is the depression algorithm. There are others for psychotic depression, schizophrenia, and bipolar disorders. These algorithms provide recommendations of what to do at each of the time points. The study in the end involved more than 1,500 patients, being one of the largest studies of public sector patients in terms of algorithm versus usual care. It showed that algorithms produced better outcomes than usual care.

I am going to use depression as an example because it is my area of work and the

concepts involved apply to the other disorders. The study showed that the algorithms produced better outcomes than usual care, both in terms of what clinicians noticed as well as in terms of what the patients observed on self-rated measures.

Not surprisingly, usual care patients also improved with treatment. The algorithm group experienced a significantly greater drop in symptom severity during the first quarter of treatment, a drop that was maintained throughout the rest of the year. This has been shown even with functional measures, so there is clear evidence from this study that the outcome for the algorithm was better than for usual care.

To use the algorithms, there are additional staff needs, and that's where the lemon juice analogy that Vijay [Ganju] mentioned aptly applies. You cannot pile on more and more work and not have additional staff needs. Expert availability is essential.

Algorithms are difficult to modify in real time. When new treatments are approved for use, it takes time before they get incorporated in these algorithms. There is a continuing expense in terms of implementing these algorithms as you do enhancements.

In order to address some of these questions about implementing algorithms, we have taken on one aspect of it. There are multiple things to be done, but one aspect is to see if we can speed up the ability of the clinicians to use algorithms. We have therefore developed prompts, or decision support tools, that can be computerized.

We have developed a computerized version of this that is easy to install. It can be obtained easily. It is timesaving and it suggests treatments in accordance with the algorithms. Again, we have to test things out and we have begun those tests and I'll describe some of that.

It is an easy-to-use tool using four computer screens: an assessment screen; a treatment selection screen; a prescription screen; and a screen that prints out the progress note.

The assessment screen shows the patient's symptom severity when the patient started, the patient's symptom severity at the last visit, the patient's medications, the patient's note, and the physician's current assessment of symptoms, functions, and side effects. Based on the patient's clinical status, the treatment selection screen gives recommendations and suggests either an increased dose or adding another treatment, as appropriate, at this point. The prescription screen is used to do that. The final screen creates an automatic progress note. It provides a CPT code. It adds additional comments and also brings up the progress note and the prescription. The final screen also provides some additional tools that ensure proper quality of care. That ends the clinical visit. It is one way of providing immediate feedback to the clinician and providing tools so that the algorithm is used more often.

We have used this tool in clinical practice settings in two community mental health centers. From the experiences of clinicians, staff, and patients, it is clear that we can catch a number of medication errors. Clinicians have been very surprised that it has prompted them to change treatments at the right time so that delays in treatment changes are avoided. One of the cardinal problems that we have identified in clinical practice in our research settings is that patients remain on the same treatment much longer than they should despite a lack of improvement. A treatment change at the right time is not made for various reasons. This tool provides prompts that prevent delay.

Staff also find that chart notes are more readable and easily available because they are on the computer. When my friends

who are not in medical field complain about being frustrated, I tell them to do a chart review. This provides easy access because reading charts is one of the cardinal problems in a clinical visit. Jokes aside, when you inherit a chart for a patient who is being treated by someone else, it is impossible to tell what happened to the patient unless you are willing to spend three hours.

There are a number of other advantages that we can talk about. Suffice it to say that based on TMAP, and based on the understanding that evidence-based practice is here to stay, we are looking for better methods to implement evidence-based practices much faster and to evaluate and modify them based on what clinicians are saying, what patients are saying, and what outcomes are saying about the systems that we have developed.

We have also been very interested in finding out at what cost these things come. We have a federally funded grant trying to identify the cost effectiveness of utilizing this method of implementing evidence-based practices as opposed to a couple of other ways. We're in the midst of that study so we'll find out in a few years.

Finally, I want to give you an idea of why this particular line of work is going to be important and helpful. As opposed to some other institutes at the National Institutes of Health that have been involved in multiple large community practice clinical trials (for example, heart disease, hormone replacement treatment), the National Institute of Mental Health has traditionally not been involved in large trials. Currently they are involved in three large trials, one of which is being done by us in Dallas. John Rush is the principal investigator and I co-direct the trial with him. A number of other people are involved. It is called Sequenced Treatment Alternatives to Relieve Depression (STARD).

Here lies another question with evidence-based practices. We can applaud the concept of using evidence-based practices, but of those 600 antidepressant treatment trials that I described, can anybody tell me how many clinical trials have been done to answer the question of what happens if the first treatment doesn't work? Fewer than five trials have been done to answer the question of what happens if the first treatment doesn't work, which happens for more than 70 percent of patients with major depressive disorders. STARD is a trial that is designed to answer that question.

STARD is a multi-center trial of 4,000 patients across the country, all of them coming from clinical practice settings, none of them from research settings. This is opposed to the 600 randomized controlled trials that I described, in which co-occurring substance use was absent. We don't see these kinds of patients [who have no comorbidity] in clinical practice. This trial is looking at the patient population that suffers from major depressive disorders with a number of other conditions. It involves 14 regional centers. There will be more than 42 clinical sites across the country, with 40 percent coming from primary care practices. I was very excited to learn that the commission report is recommending that we look at the relationship between primary care and specialty care, or at least the treatment of mental illnesses in primary care settings.

More than 300 clinicians across the country are treating patients with major depressive disorders using our protocols to answer questions such as, *If patients have not responded to the first treatment with an SSRI (for example, citalopram or Celexa), then what is the next best treatment?* An honest answer to this question is *I don't know*. We don't have the evidence that tells us exactly which one to use. Therefore this study will answer which of seven different treatments should be used.

The beginning of the question is *Which one of these seven should be used*? If the SSRI didn't work, is it better to go to another SSRI, *or* to a medication that is not an SSRI (like buproprion or Wellbutrin), *or* to psychotherapy (which is cognitive therapy), *or* should you switch and stop that medication, *or* should you augment that medication and add another treatment like a medication or a psychotherapy? The principles involved are simple but the studies have not been done. This study will begin to answer the question.

We have now 100 patients enrolled across the country. After the study is done and this question is answered in the next six to nine months, the trick is put it into real practice.

Remember Mr. Curie's admonition that it may take 20 years to do that. We have to speed that up so it doesn't take 20 years and that's the task of moving from science to practice. Thank you.

Building on Current Achievements

STEVEN P. SHON, MD, CO-DIRECTOR,
TEXAS MEDICATION ALGORITHM PROJECT
MEDICAL DIRECTOR, TEXAS DEPARTMENT OF
MENTAL HEALTH AND MENTAL RETARDATION

King Davis: Our last presenter is Steven Shon, M.D. Most of you are familiar with Dr. Shon and his work. He is currently the medical director of the Texas Department of Mental Health and Mental Retardation. He attended the University of California in San Francisco for both medical school and for his residency training in psychiatry. He has run mental health programs at the community level and hospital programs, and he was formerly the medical director of the California Department of Mental Health. Dr. Shon is on the faculty of the University of Texas College of Pharmacy in Austin as well as the Department of Psychiatry at the UT Medical School in San Antonio. He is currently on the board of directors of the National Asian and Pacific Islander Mental Health Association. He has served on the National Advisory Committee to the Center for Mental Health Services, and recently served as a consultant to the President's New Freedom Commission on Mental Health. Dr Shon is a co-director of the Texas Medication Algorithm Project.

Just to reiterate what Vijay [Ganju] said, evidence-based practice is not a fad. It is here to stay. It will be the direction of the future. Texas is well positioned because of what we have done.

Dr. Trivedi talked about the Texas Medication Algorithm Project (TMAP), which is in the President's Commission report as a model best practice. He talked about Comp TMAP, which addresses both Goals 5 and 6 in the commission report—Bob Postlethwaite as well as Nancy Speck, the evidence base and the technology—and putting those two together in a way that will help clinicians make better decisions. Finally he talked about some of the cutting edge research going on here in Texas. He didn't mention that our folks here at The University of Texas Southwestern—it was a very competitive grant, about a $25 million grant—beat out the Harvard group to bring those dollars and that research program here to Texas.

We are positioned in this state to do these kinds of things, we are doing these kinds of things, and people are looking to this state in the future to continue to do these things.

I am going to talk about translating sciences to services in a little more detail and a little bit about the Texas Medication Algorithm Project, which is system process improvement. We do medication practice here in the State of Texas, but we also look at ways to improve that practice through quality improvement and process improvement.

This is why we did TMAP, because we saw an enormous variation in prescribing practices in this state, people treating patients with major depression or schizophrenia and doing it a lot of different ways that didn't quite make sense. It wasn't really following the science that was up to date. This could be cognitive behavioral therapy, it could be psychosocial, or it could be any one of number of practices with this enormous variation.

The idea is to align the arrows [of organizational effort] so that the framework that people are practicing in is consistent. It is

following the science. It is standardized so that we understand what people are doing, why they are doing it, and that the decisions that they are making are based on the best current evidence.

These were the clinical reasons we identified for developing the algorithm project. The primary issue was to facilitate clinical decision-making because there are dozens of journals in mental health that come out every month—in psychiatry about prescribing, about different kinds of therapy; in psychology; in social work; in case management—just a whole variety of different arenas of treatment or by profession. It is impossible for any individual to read dozens and dozens of journals from cover to cover every month and incorporate the findings into clinical practice. What the algorithms can do is to synthesize the science and the evidence into clinical decision-making tools that will ultimately improve quality of care if clinicians follow the processes.

These are important issues because people are concerned about lack of resources and accountability for care. The citizens of Texas, who are taxpayers, and the legislature, who represents them, want to know if the money they are putting in, the hundreds of millions of dollars a year they are putting into mental health care, is achieving anything. If they know, which they do, that there is scientific evidence about how to do it right, and they are putting all of this money into the system, but people aren't following the science, it forces them to scratch their heads and say, "Is this money worth it? Should we continue to put this money in? Is it better used somewhere else? Why should we give even more money if people aren't following the science and the evidence, and even after a 15- to 20-year lag?"

The components of the TMAP and TIMA, the Texas Implementation Medication Algorithm, consist of three parts: the algorithms themselves, a uniform documentation strategy, and a patient-family education, or psychoeducation, strategy. There is a wealth of evidence for effectiveness in this arena of algorithms as well as for patient-family education.

The algorithms are for the three major disorders [major depression, schizophrenia, and bipolar disorders]. We also have two for children's disorders [attention deficit hyperactivity disorder and depression]. They contain strategies, i.e., what you do, and tactics, i.e., how you do it. It is really the tactics that achieve success. You may use the right medication but if you use the wrong dose, then you are not going to achieve success.

The algorithms have rating scales that measure outcomes. You know that if you have hypertension, you go to your doctor, who measures your blood pressure with a blood pressure cuff. Whether it is in Austin, or Miami, Florida, or Seattle, Washington, or Honolulu, Hawaii, your doctor understands what that means and uses the cuff the same way to measure your outcomes. But in mental health, whether it is medication, whether it is psychotherapy, or whether it is psychosocial interventions, often, in fact most often, we don't do that, and that's what is included in this algorithm process.

Uniform documentation using standardized rating scales also includes patient self-rating scales that bring the patients into the process, teaching them to monitor the signs and symptoms of their own illness. Just like you, if you have diabetes, you may do your own finger stick and monitor yourself. If you have hypertension, you may have your own blood pressure cuff at home. It's very clear that adherence improves and outcomes improve the more that patients are involved in their own treatment, the more they understand it, and the more they are

involved with measuring outcomes and being part of their own treatment system.

Uniform rating scales of associated symptoms are included, because associated symptoms, which are often treated with medications, create confusion from one doctor to the next. Often we are not sure which medication is associated with which symptoms. Uniform rating scales also improve continuity of care and reduce redundancy as a uniform documentation system that's understood, just like a blood pressure is understood wherever you go in this country and in this world. If we can achieve that, we can enormously reduce redundancy and save resources and put those resources back into treatment.

There are numerous studies that show the value of psychoeducation. It is an evidence-based practice. It is part of what we have incorporated into the algorithm process. It teaches disease management, both to the clinician and to the patient, and clarifies clinical decision-making. In fact, the idea is that consumers being treated in the system understand the rationale for treatment as well as the prescriber or the clinician does. It involves patients in treatment choices and the overall goal is to optimize treatment benefits.

I'll share with you some conclusions. In the treatment of schizophrenia using the algorithms, when compared with treatment as usual in the $6.5 million research study, patients in the algorithm clinics had better cognitive functioning (and cognition is what is most related to functioning for someone with schizophrenia), overall more rapid improvement in symptoms, and at a lower cost. This is one of those win-wins where you say, *Gee, you get much better improvement in cognitive functioning—one of the symptomatic measures—and at a lower cost .Why would you not do this kind of thing?* But the fact of the matter is, people are not doing this kind of thing.

In the bipolar disorder study, when compared to treatment as usual, patients in the algorithm had fewer manic symptoms. Mania of course is the destructive component of this illness-—people get very grandiose, have high energy, spend all their money, get into debt, sell the family home. Bipolar disorder has the highest incidence of co-occurring substance use disorders with it. They start drinking, using drugs—very destructive. Patients in the algorithm had fewer manic symptoms, more rapid improvement, and at an equivalent or lower cost. Again, you say, *Gee, why wouldn't you want to do this kind of thing?* Fact of the matter is, most folks around who are treating are not doing this kind of thing.

For major depressive disorders—Dr. Trivedi showed this to you—patients in the algorithm clinics sustained clinically lower symptoms and the increment of change was even greater than for the other two disorders. The cost was higher, but from a cost-effectiveness point of view, each dollar obtained an equivalent change in terms of lowering symptoms.

Clearly all three were more effective than treatment as usual in terms of improving clinical symptoms. This is why, as Charlie [Curie] said, Pennsylvania—the state that he was commissioner in—has adopted this process. Twelve other states have adopted this process. We have five more that intend to adopt this process and we'll probably have even more.

From the point of view of adopting evidence-based practices in the medication area, Texas has been in the forefront. We do struggle, though, with people here in Texas using this process. *Sustaining implementation is very difficult. There are always barriers and resistance in terms of people saying, "Well, it is too expensive," or "I'm already doing good clinical work." The fact of the matter is, we've*

demonstrated that when you do follow these processes, you do get better results.

I want to talk about benefit design a little bit because this really is a system transformation, not just process improvement (improving on the things you are already doing). This is redesigning the system so that what you are doing, you are doing in a different way, in order to get a better system and outcomes. This was a quote from Dr Arredondo, the chairman for our board for the Texas Department of Mental Health and Mental Retardation:

The Texas Department of Mental Health and Mental Retardation is committed to a disease management approach to the delivery of mental health services. Effective disease management requires a fundamental change in the way that mental health services in Texas are delivered and managed. Benefit design is the framework for operationalizing TDMHMR disease management.

Disease management is a systematic collaborative approach to health care delivery. It requires proactive identification of the population with the condition you want to treat, in this case, the seriously mentally ill population with schizophrenia, bipolar disorders, and major depressive disorders. It emphasizes prevention of relapse and complications. It is a long-term approach, not an episodic approach. It looks at what you do in the long-term to treat these illnesses, not just a crisis approach. It utilizes evidence-based practice guidelines. It relies on patient empowerment strategies. You've heard a lot about all of these things earlier today.

Benefit design integrates a set of clinical interventions with a financing strategy. That is what is so unique about it. That is what we are doing in Texas, and they're not doing this in other places around the country. They're beginning to look at doing it, but we have begun that step.

There are four levels of care, each with a separate case rate, plus crisis services for those who need crisis services. In each level of care, the clinical interventions are evidence-based, standardized, and outcome-oriented. What we are saying here is that the State of Texas is going to pay for evidence-based interventions, not interventions that 30 different people are doing 30 different ways because that's the way they believe it should be done—but the evidence doesn't really say that's the way it should be done. With so few resources here, what we are saying is that we can only afford to pay for evidence-based interventions. I think that's what the public wants to know: Are the hundreds of millions of dollars going into mental health being used to buy services that are based on the science, not something somebody likes to do or thinks is worth it?

It contains a standardized assessment called TRAG used to determine the level of care, so there is standardized way of putting people into a level of care. Fidelity to the model is required for clinical interventions and measured using fidelity instruments so that we know that when people say they are doing assertive community treatment (ACT), or they are doing TIMA, or they are doing cognitive behavioral therapy, that in fact what they are doing is based on the evidence. Standardized business practices are required—data collection, billing, records, accounting—so that our data system is done the same way statewide.

The TRAG, which is the Texas Recommended Authorization Guidelines, takes the diagnostic profile and looks at a quantified assessment of service needs to determine reliable recommendations for authorization into levels of care, which I will describe.

The TRAG measures nine dimensions of service need. We have spent months and

months and months and probably thousands of hours of time, from folks in the field as well as Central Office, identifying these and ways to measure them. They look at risk of harm, support needs, hospitalizations, functional impairment, employment problems, housing instability, co-occurring substance use, criminal justice involvement, and response to medication for treatment.

Level 1 is medication plus case coordination. This is for folks who respond essentially just to medication. We have a certain percentage of those.

Level 2 is oriented to people with affective disorders, particularly major depression. If they have not had a full response at Level 1 to medication, after going through a series of treatments, not just one, then they are eligible at a certain point to go into Level 2, which adds cognitive behavioral psychotherapy. The format will be an evidence-based, manualized, goal-oriented, time-limited psychotherapy. In the psychology literature, a lot of research was done in the '90s in this arena. We had a consensus conference a year ago here in Texas to look at that literature.

Level 3 includes rehabilitative case management, which includes a number of evidence-based practices—supported housing, supported employment, etc.—which are combined along with medication, primarily targeted to folks with schizophrenia.

Level 4 is assertive community treatment, which was talked about a little earlier. Clearly there is a large evidence base for the effectiveness of ACT. All of these have or will have fidelity instruments that we have worked on here in Texas.

Crisis services have several components. I won't go into all of these because these are crisis components we are familiar with here in Texas.

For outcome measures, there will be individual outcomes that look at the effectiveness of treatment as assessed by measuring response to treatment in relation to defined outcomes. We are defining what kind of response is expected as a reasonable outcome. There will also be systems outcomes that look at the effectiveness of the service delivery system. This is assessed utilizing aggregated individual outcomes, cost data, encounter data, and fidelity data, because we know that it is the system of putting these things together that often determines how effectively you treat folks and what kind of outcomes you get. You may have one piece that is working really well and two or three others that aren't. How well is that individual going to get? We are trying to have the system ensure that all of the components are working well at a certain level as measured by fidelity.

The benefit design adult outcome measures for system components consist of access to services, criminal justice involvement, functioning, symptomatology, hospitalizations, employment, homelessness, substance use, and consumer satisfaction. There are instruments to measure all of these.

Implementation at four sites started in September 2003: Hill Country, Lubbock Regional, Tarrant County, and Texas Panhandle. We will continue to refine processes based on the experience that we have and there will be system-wide implementation next year. So we are on a fast time track. These are very compatible with everything we have heard today in terms of the President's Commission report.

This is an exciting time. We here in Texas have been moving down a track that is very consistent with the report. I think this report will give us a boost to continue to move forward, to continue to bring more dollars into Texas to allow us to even further pilot these

things to build on the bases we have and really move Texas to the forefront of what is going on in this country in mental health. We all know we need to do that here. Nobody believes that the system today is anywhere near where it can be and where it should be. By incorporating your input into what we'll do for the President's Commission in six breakout groups—those of you who will be involved with that—we think we can take some greater strides forward more quickly.

7. State of the State

KAREN F. HALE, MSSA
COMMISSIONER, TEXAS DEPARTMENT OF MENTAL HEALTH
AND MENTAL RETARDATION

What we hope to do in this final panel is give you an assessment of where we are in relation to the contextual issues that we need to grapple with as we look at transformation of the mental health system

Consolidation and Transformation of Health and Human Services in Texas

ALBERT HAWKINS, MPAFF
EXECUTIVE COMMISSIONER, TEXAS HEALTH AND HUMAN SERVICES COMMISSION

Karen Hale: Our first presenter is Albert Hawkins. Many of you know Executive Commissioner Hawkins, who was appointed by Governor Rick Perry in January 2003 to be the commissioner for the Texas Health and Human Services Commission (HHSC). Commissioner Hawkins has, from many perspectives, an overwhelming responsibility–the oversight of 11 state agencies, 500,000 employees, and an annual budget of 17 billion dollars. It is a significant undertaking. He is going to talk about some very major transformational efforts that he is leading us through. Prior to his appointment as HHSC executive commissioner, he served as assistant to the president and secretary to the cabinet from January 2001 to December 2002. He worked very closely with President Bush in Washington. But he is a Texan by roots. He was budget director when President Bush was our governor from 1994 to 2000. Prior to that he served on the Legislative Budget Board staff in several capacities. He holds a master's degree in public affairs from the LBJ School.

Many of you are probably familiar, to some extent, with the historic changes enacted by the last session of the legislature through House Bill 2292. It really sets out a different way of managing and delivering health and human services in this state.

It is an historic and exciting opportunity for us as well. It is not often that a public servant gets a chance to sit back and look at the ideal ways of providing services to a broad range of clients and then put into place that ideal. And that is indeed what we are trying to do.

We have been working from the framework established in House Bill 2292, which reduces the number of agencies that deliver health and human services from 12 to 5. A great deal of thought went into that framework through the legislative session, and I believe it puts in place a very rational organizational framework that we will be able to build upon.

One of the key goals from our consolidation effort is to streamline some of the administrative processes, eliminate redundant systems, and save as much money as we can in the cost of managing agencies, so that we have more resources that can be provided to direct services program delivery to the clients across the state. I believe that's the clear expectation from the governor and legislature. That's a challenge that we are stepping up and trying to meet it as best we can.

One of the key elements that relates largely to your interests is the formation of a new Department of State Health Services. For the first time, we will be able to put into place an organizational structure that really looks at the need to better integrate mental health services with substance abuse services and also with the other physical health services that have been provided by the Texas

Department of Health. It's an exciting opportunity for us to see how we can integrate and blend those policies and funding sources together better to serve the clients who present themselves for some of the services we are able to provide.

Not only is it a great opportunity, it is a significant challenge. We are going to be relying on a lot of people in this room to help us understand the best way to organize ourselves to deliver those services in the most effective way, using evidence-based practices as have been presented this afternoon.

When we look at the structural framework that has been laid out in that area, it really does support a lot of the key elements that are reflected in the New Freedom Commission report. It is fortunate that the timing for us is lined up with the delivery of that report and the opportunity for us to redesign this system and to put in place something that is directly responsive to the goals and objectives laid out in the New Freedom Commission report, as well as some recognized needs that you and others who have worked in the system have identified for many years. We are hopeful we will be able to put in place a strong response to those needs and carry out the activities in a way that achieves those same goals and that vision.

We are moving through fairly aggressively in our consolidation and transformation activities. We have developed a draft transition report that was required by statute. For those of you who might be interested, you can access it on the Health and Human Services Commission web site, at www.hhsc.state.tx.us. It does begin to lay out the roadmap for how we bring 12 agencies to 5, how we best integrate the services with our focus being on the client, and what kind of organizational structures need to be put in place, not just here in Austin but throughout the state, to achieve that end goal.

We do have a public hearing on that transition plan scheduled for tomorrow morning beginning at 9 o'clock It is being conducted by the Legislative Transition Oversight Committee, of which Representative Davis is a member also.

I know that you have some other responsibilities you are taking care of, but it is not your only chance to provide comments to us. We are available to receive your comments through the internet. We have a place on the web site for you to forward your comments in response to the transition plan or any other thoughts or ideas you might have.

The transition plan is a dynamic document. It is an iterative process. We recognize there are a lot of things about consolidation and transformation that we don't know up front. What we have lain out is a process and as we get closer to a consolidation opportunity, we'll know more about it. The other things we'll plan and then move toward that end. As we go along, we will be updating our transition plan to reflect the additional knowledge and understanding about what needs to take place, how it needs to take place, and when it needs to take place.

I encourage your input throughout the whole process. It doesn't end tomorrow with the hearing on the transition plan. It will be ongoing. We will have specific development workgroups and opportunities dealing specifically with the new Department of State Health Services and other activities and agencies that you might be interested in. We'll create separate forums and workgroups for each of those agencies as we start to move forward.

One of the real goals of our consolidation is to develop a system that works better and costs less. We've been focusing a lot on gaining additional

efficiencies. I think you may have already had this shared with you today, but I am very pleased that, because of some of the efficiencies that we have identified with some of the administrative consolidations, we have been able to set aside an amount of money that will enable us to restore mental health benefits in our CHIP program. There is a tremendous need that exists. It is a very critical service. The legislature struggled with how to deal with that and unfortunately had to come down on the side of holding the money back. On the other side, when we identified that opportunity, you couldn't have asked for greater support than what has been given by the legislative leadership. I do appreciate their willingness to trust us to manage programs in an effective way as stewards of the public's money. And one clear example of that is their agreeing to restore mental health and substance abuse benefits in CHIP. Thank you very much.

Integration of Health and Mental Health

DEBRA C. STABENO, MPH
DEPUTY COMMISSIONER, TEXAS DEPARTMENT OF HEALTH

Karen Hale: Our second panelist will be Debra Stabeno. Debra is the deputy commissioner for the Texas Department of Health. She has oversight for several executive offices, including border health, two of the health care facilities, the Center for Health Statistics, and the Bureau of Vital Statistics. She is a member of the executive team and provides leadership for many of the department's cross-functional workgroups and is very involved in many of their leadership activities. She has been at TDH since 1974, when she began work in the WIC [Women, Infants, and Children] program, so she is a real veteran of important public health arena work. She holds a master's degree in public health from Tulane.

Good afternoon. I want to talk to you for just a moment about the Texas Department of Health (TDH) and our partnership with mental health and with substance abuse. The vision for the Texas Department of Health is *healthy people in healthy communities*. Our mission is to partner with people and communities in Texas to protect, promote, and improve health. We can't accomplish that mission without you, our mental health partners. At TDH we define health as *optimal physical, mental, and social well being*. So from the start we acknowledge that health and mental health have a natural and necessary connection.

Dr. Eduardo Sanchez, the commissioner of health, could not be here today. He will be able to join you tomorrow. But he wanted me share a few thoughts on his behalf. Let me read you his comments.

I believe that health care must be redefined as public health and mental health and medical care. I have practiced for years as a primary care physician and I am familiar with the plethora of mental health issues that present in the exam room. It is our challenge and one we must do better to bring together primary care physicians and community mental health providers as partners to detect and treat mental illness as early as possible with recovery as a goal.

Last October the Department of Health joined with more than 100 public and private providers, now called the State Strategic Health Partnership, to see how we could work more closely together and with a greater focus to improve public health in our state. We all know that public health and mental health issues are much larger than one or two state agencies.

Six critical health status goals were put forward as a focus for that partnership and one of the goals was to recognize mental health as a public health issue. And this is consistent with the national agenda we have heard about today.

Now I would like to add a couple of comments. We are proud of this partnership and the opportunity it brings for a closer working relationship. One of the partnership workgroups, which is co-chaired by Dr. Nancy Speck and Dr. Rudy Arredondo, will serve as a catalyst to promote mental health.

But this is not the first time that we have worked together. We have a long history of collaboration with both MHMR and TCADA. We have locally based service plans for special needs children whose complex needs can only be met through interagency coordination. There are 161 local community resource coordination groups with representation from multiple agencies to address the needs of persons with complex needs. TDH and MHMR have collaborated to produce a behavioral health screening tool for children enrolled in the well child portion of our Medicaid program, or Texas Health Steps, and to provide permanency planning training with MHMR through the No Place Like Home curriculum. We have been partners in fetal alcohol syndrome prevention projects, and our TDH tobacco program collaborates with TCADA and other state agencies on its programs, most recently trying to understand why our youth are purchasing tobacco products at increased rates. MHMR and TCADA have been members of our interagency council on HIV and hepatitis, and MHMR and TCADA actively participated with TDH and stakeholders from around the state in developing a statewide suicide prevention plan. With MHMR we have companion rules for private psychiatric hospitals and crisis stabilization units, and we have been participants on your advisory committee for inpatient mental health services.

And the list goes on. These are just a few of the examples that show what can be done in the spirit of collaboration. Mr. Hawkins has talked about the opportunities to come and we look forward to joining with you, the mental health leaders of Texas, to build an integrated approach to health.

For our part, we look forward with hope to the possibility of offering better services to the people of Texas as we work with our vision for healthy people in healthy communities.

The Legislative Perspective

REPRESENTATIVE JOHN DAVIS
HOUSE DISTRICT 129

Karen Hale: Our third panelist will be Representative John Davis. In November 1998 Representative Davis was elected to the Texas Legislature representing House District 129, Clear Lake. He is currently serving on the House Appropriations Committee and of particular note to us, on the Subcommittee on Health and Human Services. He has taken a very important leadership role working in the area of mental health and mental retardation services. He is also chairman of Budget and Oversight of the House State Affairs Committee. House Speaker Tom Craddick appointed Representative Davis to serve as state chairman for the American Legislative Exchange Council, the nation's largest bipartisan organization of state legislators.

I'll never forget, here in my third term, being appointed to the Appropriations Committee, and then hearing, "You're going to be on the Health and Human Services Subcommittee," and on top of that "You are going to be our mental health and mental retardation expert." That's a long way for a roofer to come.

I won't forget trying to learn this business. Dr. Arredondo came down in March with Karen Hale and Joe Lovelace. Dr. Arredondo explained about fragmentation. And he said "John, it's all going to come out."

So here it is. The report is out. I've learned a whole, whole lot on fragmentation and health and human services and mental health issues. It's been a real eye opener. One thing I've learned is that mental health doesn't Discriminate—it attacks Democrats and it attacks Republicans, and it attacks all of us. I'm becoming a kind of geek reading *Health Affairs* and the latest issue of *Mental Health*.

…I feel like Bill Murray in *Baby Steps*. Richard Dreyfuss is the doctor on the morning show and he's all nervous and tense, and Bill Murray says, "It's meat and potatoes. It's very basic." He just told it like it was and won the crowd over on the morning show.

I feel like Bill Murray: "It's meat and potatoes." To me it's where the rubber meets the pavement. Are we getting results? That's what I'm going to be looking at as member of the Appropriations Committee and as a member of the Legislative Oversight Committee in this transformation. Are we getting results?

[With reference to a newspaper account of a woman with mental illness who allegedly killed her nine-year old daughter as a result of her illness] It makes me angry…so I had a visit with Dr. Lois Moore. She's with Harris County Psychiatric at the UT Health Science Center. It was straight talk. I asked her, tell me, what's going on, what's happening, and she said, "The problem is, when folks are released from state hospitals, there's a three to four week gap before they are picked up in the community. Somebody's dropping the baton."

I want to make darn sure that baton doesn't drop. That's what I'm going to be looking for. I don't know about all the other high talk, but I'm going to make sure the meat and potatoes are there, that we have results, and that the baton isn't dropped. Don't drop the baton. Pass over the baton. Let's keep a connection….That's the goal.

8. Workgroup Recommendations

GERRY MCKIMMEY
TDMHMR DEPUTY COMMISSIONER FOR COMMUNITY SERVICES

Each workgroup that was assigned to one of the six goals of the New Freedom Commission identified the barriers to achieving the goal. Not surprisingly, many of the barriers the workgroups identified were the same as those the New Freedom Commission members identified for the nation as a whole. Barriers that were identified in all six workgroups included focus on funding constraints, lack of appropriate educational and training opportunities for both the public at large and professional groups, and the lack of coordination of care within and across the myriad settings in which people receive services

GOAL 1. AMERICANS UNDERSTAND THAT MENTAL HEALTH IS ESSENTIAL TO OVERALL HEALTH

Our Vision for Texas	
Joe Lovelace, Facilitator **Heather Shiels, Co-facilitator** **Maureen Adair** **Joeseph Burkett** **Lana Castle** **John Dombroski** **Beth Epps** **Carolyn Karbowski** **Merily Keller** **Diana Kern** **Aaryce Hayes** **Rich Risley** **Eric A. Schmidt** **Steve Schneider** **Eduardo Sanchez** **Sandy Skelton**	A "campaign for all minds" eradicates the stigma of mental illness. Texas implements a statewide strategy for suicide prevention. Mental health, health, and substance use services are integrated in a single system of care. ✯ Communities, schools, all professionals, and the public are educated about mental illness and substance use disorders and suicide prevention. ✯ The Texas strategy for suicide prevention involves mobilizing community resources. ✯ Treatment is integrated across all disciplines that are impacted by mental health needs. ✯ Public financing equity is achieved for the treatment of mental health, health, and substance use disorders. ✯ Disparities in insurance coverage for mental health, health, and substance use disorders are eliminated.

Goal 1.1 Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

STIGMA REDUCTION

Action Steps

1. Make Texas a pilot site in the national campaign to decrease stigma.
   - ✯ Target and focus on businesses.
   - ✯ Build on the Substance Abuse and Mental Health Services Administration (SAMHSA) grant.

2. Implement a campaign to eradicate the stigma of mental illness through educating the public.
   - ✯ Utilize public relations and public information strategies involving all types of media, including:
     - ✯ public service announcements tailored to specific groups and audiences (similar to the anti-smoking campaign);
     - ✯ resources from the national stigma campaign;
     - ✯ activities in mental health awareness months, May and October;
     - ✯ the arts (can get the message across creatively);
     - ✯ community focus; and
     - ✯ speakers' bureaus.

2. *continued*
   - ✯ Correct the myths!
     - ✯ Sixty-two percent of people surveyed believe mental illness comes from bad families.
     - ✯ Forty-three percent of those surveyed believe mental illness is caused by the person.
     - ✯ Fifty percent of psychiatrists denied mental illness in themselves.
     - ✯ Sixty-six percent of people surveyed said they would not want to work with, or be friends with, people with schizophrenia.
   - ✯ Utilize models, e.g., Australia has developed an effective public education campaign to reduce the stigma of mental illness.

3. Make effective treatment for mental health and substance use disorders available in primary care settings. Consolidate treatment settings to eliminate the two-tiered health system.

4. Make elementary and secondary schools primary sites of emphasis in the education campaign against stigma.
   - ✯ Take a positive approach in Texas schools, e.g., the anti-bullying program.
   - ✯ Develop a curriculum to educate youngsters (as was done with race relations, child abuse, etc.).*
   - ✯ Provide orientation to teachers on mental illness and substance use disorders and how to initiate a support system.

   **A resource for this is Scott Poland.*

Barriers to Action Step 4 are:
✯ Teachers are not educated on mental health and substance use.
✯ School counselors are not able to devote enough time to counseling and educating students about mental illness and substance use.
✯ A curriculum on mental health and social skills is not available.

SUICIDE PREVENTION

Today in the United States*

- ✯ Suicide is a major cause of death with a rate higher than homicide.
- ✯ Effective screening with "one additional question" reduced suicide by 28%.
- ✯ In the United States, dentists have the highest rate of suicide of medical professions followed by psychiatrists. *(Note: This was discussed in the workgroup but has not been verified.)*
- ✯ Statistics show that there are 87 suicides in the U.S. daily. This is an understated number because many deaths do not get recorded as suicides if they appear accidental.
- ✯ Ninety percent of people who attempt or commit suicide have an underlying mental illness. Fifty to seventy percent have seen a medical professional for treatment within the previous month.

**An excellent source of additional information is http://www.nimh.nih.gov/research/suicideiom.cfm.*

Today in Texas

- Requirements concerning prevention of suicide in Texas are limited.
  - Suicide prevention plans in schools are no longer followed.
  - Legislation in the 78th session to promote suicide prevention in Texas did not pass.
- Community efforts are in place, e.g., Fort Worth has a model for community suicide prevention activities, with adult and children's plans in place for addressing suicide.
- Some faith-based initiatives are in place.
- An interim report on a suicide plan for Texas was developed following the last legislative session. The report could be used as a guide.
- The Texas State Strategic Health Partnership addresses relevant issues and could be built upon in areas of:
  - reducing risky behavior,
  - providing education, and
  - reducing environmental and health hazards.
- Consolidation of human service agencies provides an opportunity for multi-agency involvement of:
  - the Health and Human Services Commission;
  - the Texas Department of Criminal Justice;
  - the Texas Commission on Alcoholism and Drug Abuse;
  - the Texas Department of Mental Health and Mental Retardation; and
  - the Texas Education Agency.
- Commissioner Eduardo Sanchez, M.D., Texas Department of Health, stated that suicide is evidence that treatment and interventions were not successful and treatment therefore should be the primary focus for any system developed.

Barriers

- The following resources are lacking;
  - resources to engage individuals;
  - funding of services and awareness programs;
  - access to treatment; and
  - time.
- Suicide prevention is not a priority.
  - The Texas Council on Suicide Prevention was *not* created in the 78th Legislature.
  - Very little is written in Texas law regarding suicide prevention.
  - It is difficult to expand general awareness.
- Privacy and confidentiality laws restrict the cross-utilization of patient information.

Action Steps

1. Develop and implement a Texas plan to address suicide prevention with emphasis on suicide as the end result of not being treated effectively. The plan should include the following elements:
   - ✯ a system of continuity of services in the helping professions, with treatment alternatives;
   - ✯ a community approach that incorporates select elements of current programs in Austin, San Antonio, Dallas, Ft. Worth, Burnet County, Victoria, and Fredricksburg;
   - ✯ the U.S. surgeon general's call to action; and
   - ✯ the Texas Suicide Council plan.

2. Involve the following in developing and implementing the plan:
   - ✯ school counselors (Texas School Counseling Association);
   - ✯ parents (Southwest Texas – Communities in Schools for parent education);
   - ✯ faith-based organizations;
   - ✯ trade organization training programs and resources;
   - ✯ primary care physicians (Texas Association of Family Practitioners provides CME training programs);
   - ✯ university systems;
   - ✯ private providers;
   - ✯ charitable organizations and foundations; and
   - ✯ known successful programs, e.g., Major Mark Oordt is a local expert who speaks about the Air Force Model for suicide prevention.

3. Utilize the approach taken in the current TDMHMR rule governing treatment for co-occurring psychiatric and substance use disorders (COPSD) by promoting access to the COPSD training manual (on the TDMHMR website), with emphasis on requiring:
   - ✯ minimum staff competencies, and
   - ✯ standardized patient assessments.

4. Create a positive public information campaign to implement the plan that publicizes prevention and treatment programs, utilizes existing education and federal government information resources, and includes:
   - ✯ editorial board visits; and
   - ✯ articles and editorial comments to change funding priorities by clearly stating current and future capacity issues and emphasizing that education about suicide prevention does not mean access to necessary services.

Goal 1.2 Address mental health with the same urgency as physical health.

Barriers

- ✯ Fewer dollars are allocated to private mental health treatments.
- ✯ Denial of insurability is too common in both Medicaid and private insurance.

-
- Mental health preventative service is not funded or reimbursed.
- Coverage for mental health, health, and substance use disorders is disparate.

Assets

- Mental health, health, and substance use services are being integrated at the state level through the consolidation of state agencies in the Department of Health Services. Consolidation:
  - creates cross-discipline opportunities,
  - focuses on the "whole" person, and
  - better defines the health system and reduces duplication.
- The Texas Department of Health sponsored the Texas State Strategic Health Partnership, which had the following goals:
  - providing effective mental health and substance use treatment;
  - reducing risky behaviors;
  - improving education; and
  - reducing environmental and health hazards.

Action Steps

1. Develop and implement an integrated public system for delivering mental health, health, and substance use services utilizing a single point of access for services and supports.

2. Develop and implement a method to establish parity in public funding for mental health, health, and substance use disorders, which is based on achieving standardized outcomes.

3. Develop and implement a method to maximize third party (federal, insurance) funds, including identification of essential services.

4. Develop and implement tax credits at the state level to motivate private providers to provide services to public consumers.

5. Coordinate with federally qualified health centers (FQHC) to maximize the availability of services.

GOAL 2. MENTAL HEALTH CARE IS CONSUMER AND FAMILY DRIVEN

Our Vision for Texas	
Sam Shore, Facilitator **Mike Maples, Co-facilitator** **James Baker** **Barbara Duren** **Cliff Gay** **Mike Halligan** **Charlotte Kimmel** **Lynn Lasky** **Catherine Matthews** **Sarah Swinney** **Jon Weizenbaum** **Inman White**	Texas provides assistance to those who need it in identifying plans, goals, etc. This assistance can be provided from outside the formal system by advocates, family, etc. This option is available. The plan evolves and is flexible. Coordination between systems occurs and responsibilities are clear.

Goal 2.1 Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Today in Texas

- ✯ Teachers' understanding of issues associated with serious emotional disturbance is lacking, resulting in increased likelihood of juvenile justice involvement.
- ✯ Work is being done on school-based mental health services (pilots, models, etc.).
- ✯ The required Senate Bill 490 service evaluation required creates an opportunity to make recommendations.
- ✯ The community lacks understanding and needs education concerning serious mental illnesses and serious emotional disturbances.

Assets

- ✯ Mechanisms and processes are in place, e.g., the Texas Recommended Authorization Guidelines (TRAG).
- ✯ Strong advocacy organizations assist consumers and family members.
- ✯ Consumer and family networks are well organized.
- ✯ Substantial expertise exists in the state.
- ✯ The system is trying to correct problems, e.g., disease management; jail diversion; NorthSTAR.

Barriers

- ✯ Time and resources to properly develop plan are lacking.
- ✯ Assessment does not address trauma.
- ✯ Access to all needed services is not available.
- ✯ The system does not value recovery or the recovery of families.

Action Steps

1. Review system-of-care grants for strategies to replicate.

2. Raise awareness of serious mental illnesses and serious emotional disturbances through the media.

3. Use memoranda of understanding or other mechanisms for coordinated planning.

4. Ensure "evidence" has been developed for people with similar needs before requiring the evidence-based practice.

5. Develop competency training and certification for treatment plan development and offer incentives to deliver this type of planning.

6. Incentivize consumer and family-oriented outcomes.

7. Develop measurements that reimburse or incentivize family involvement.

8. Develop legislative measures to facilitate integration across systems, i.e., schools, Medicare, etc.

Goal 2.2 Involve consumers and families fully in orienting the mental health system toward recovery.

Assets

- Advocacy and volunteer organizations help people navigate the system.
- Partners in Policy Making provides training in policy development.

Barriers

- The system does not recognize families' contributions.
- Other agencies do not involve consumers and families (juvenile justice, etc.).
- There are different definitions of "recovery."
- Disparate systems are difficult to integrate.
- Families lack training and speak a different "language" than policy makers.
- Geographic differences pose barriers.
- Lack of childcare creates difficulties for family involvement.
- Stigma creates barriers to involvement.
- The consumer is not the purchaser and system does not focus on consumers.
- Cultural competency is lacking.

Action Steps

1. Advocate that agency boards and advisory committees are consumer/family dominated.

2. Empower local mental health planning advisory committees.

3. Develop pilots and models, e.g., voucher programs, that empower consumers and families to control and direct resources.

4. Develop a formal communication mechanism between local and state mental health planning advisory committees.

5. Develop and improve public education materials including information on available service options.

6. Change the prevailing mindset through education

Goal 2.3 Align relevant federal programs to improve access and accountability for mental health services.

Action Steps

1. Align state and federal funding streams by requesting waivers, modifying state plans, pooling funding, and holding an annual summit of advisory committees to help ensure interagency alignment.

2. Aggressively pursue federal housing funds.

3. Take advantage of existing opportunities more fully, e.g., Medicaid, SSA work incentives, etc.

Goal 2.4 Create a comprehensive state mental health plan.

Today in Texas

- A number of plans are required for different, sometimes overlapping purposes, including:
  - the Mental Health Block Grant;
  - the Medicaid State Plan;
  - the TDMHMR Strategic Plan;
  - the Olmstead Plan; and
  - plans from other state agencies that serve people with mental illness or serious emotional disturbance.

Action Steps

1. Seek a legislative mandate to develop an integrated plan across systems.
2. Implement a standard functional assessment across systems.
3. Include strategies that address primary prevention in the state plan.
4. Include strategies that address poverty in the state plan.
5. Focus more on recovery and resiliency and less on diagnostics in the state plan.
6. Require a split between authorities and providers in the state plan; in fact, it may be appropriate to evaluate the need for a local authority.
7. Establish funding mechanisms that are fee-for-service and include state hospitals.
8. Establish common service standards across agencies.
9. Analyze the likelihood of treatment versus incarceration based on demographics.
10. Make mental health assessment a standard part of physical assessment.
11. Develop the evidence base and incentivize primary prevention.

Goal 2.5 Protect and enhance the rights of people with mental illness.

Action Steps

1. Pursue a 4-E waiver to purchase care to avoid relinquishment of custody.
2. Enforce existing rights and track and monitor complaints.
3. Redirect funds from juvenile justice to children's mental health treatment.
4. Develop a plan for providing legal assistance to consumers.
5. Develop mental health courts.
6. Ensure judges are trained regarding mental health and system access.
7. Encourage or expand Texas Appleseed or similar programs.
8. Create a centralized repository for advance directives.
9. Utilize deferred adjudication options.
10. Coordinate training resources from various advocacy organizations.
11. Involve consumer groups in providing training on rights.
12. Attain parity in insurance.

GOAL 3. DISPARITIES IN MENTAL HEALTH SERVICES ARE ELIMINATED

Our Vision for Texas	
H. Ed Calahan, Facilitator **David Luna, Co-facilitatory** **Rudy Arredondo** **Kinike Bermudez** **Stephanie Contreras** **Sonja Gaines** **Allison Jones** **Laura Jordan** **Janet Paleo** **Rick Peterson** **Donald Polzin** **Jean Setzer** **Melba Vasquez**	Texas has adopted the New Freedom Commission's vision. All Texans share equally in the best available services regardless of race, gender, ethnicity, or geographic location. Services are tailored for culturally diverse populations. Mental health research includes underserved populations. Providers are readily available in rural areas. Mental health training is available to general health care providers. In eliminating disparities, Texas: ✯ increases-the availability of both public and private health insurance for the minority population in Texas; ✯ increases the availability of culturally competent, well trained mental health practitioners in Texas; ✯ regionalizes delivery of services in prevention, i.e., primary, secondary, and tertiary; ✯ develops good clinical training programs to prepare clinicians for providing mental health services to ethnic minorities; ✯ ensures that cultural competency is a condition of employment, with providers held responsible for analyzing the populations they serve and hiring staff with the competency to care for them; ✯ identifies appropriate models for rural and frontier areas; ✯ educates children about mental illness in an effort to address stigma and promote mental heath wellness; and ✯ engages consumers through cultural competency needs assessments related to job and work relationships.

Goal 3.1 Improve access to quality care that is culturally competent.

Today in Texas

- ✯ Fourteen percent of Caucasian families don't have health insurance.
- ✯ Thirty-seven to forty percent of minority families do not have health insurance.
- ✯ Insurance parity for mental health does not exist.
- ✯ Texas needs to focus on public insurance since mental illness may be life long.
- ✯ The minority population is frequently not aware of the available public services.
- ✯ Texas should focus on the working poor (people who work, but their employers do not provide health insurance and they don't qualify for public assistance) and people who fall through the cracks.
- ✯ Only five percent of psychologists are minorities.
- ✯ There is a lack of knowledge of system and services. Individuals often don't know they have a mental illness. The tendency is to take care of issues within the family.

- When resources dwindle, training is often the first to go. With pressure for productivity, people are not approved to attend available training.
- The first entry of primary care in rural areas consists of the 3A's: access, affordability, and acceptability.
- Texas needs to train the right people for the right job. To transform the system, cultural understanding must be emphasized so that engagement can be enriched.
- How do we make research useful to practitioners?
- Asians don't have a word for mental illness. "My Ying and yang are out of balance."
- Mental illness is under reported because people do not want it on their record.
- Funding drives what services will be provided. Funding streams are ridiculously low. If you are not going to be reimbursed for traveling to provide services in the rural areas, those services are not going to be provided.
- How do we attract *good* doctors to the rural/frontier areas?
- Do we take time to "really" listen to our consumers? We tend to jump to conclusions, run out of time, etc.

3.2 Improve access to quality care in rural and geographically remote areas.

Today in Texas

- The prevailing theme of discontent with the status quo is that services are under funded and funding is haphazard and fragmented. Paperwork does not equal action. Cultural competencies do not equal disparities. Top down does not equal empowering families, consumers.
- Two laws recently passed that will not allow a teacher to give any indication that a child has or may have an emotional disturbance.
- Integration and coordination between existing services is lacking.
- Training in cultural competency is lacking.
- Providers are not listening to consumers and are diagnosing them based on symptoms only, with no understanding of culture.
- Early intervention in schools for school teachers is lacking.
- Coordination of existing services is lacking.
- Cross-system training is lacking.
- Accountability is lacking.
- Access to care that is culturally competent is lacking.
- TDMHMR does not mandate system components to complete and return cultural competency surveys.
- Everything is top down and does not equal "empowering" families and consumers.
- Consumer-centered services are needed.
- The service delivery system follows a medical model rather than a recovery model.
- In the Health and Human Services Commission Colonias model, 12 agencies are working together in satellite locations and using the Texas A & M community centers as service sites. The community MHMR centers send trainers but do not provide many services because there is no funding stream to cover the costs and the contract with TDMHMR does not require them to provide services.
- The Texas Commission on Alcohol and Drug Abuse (TCADA) is funding a rural border model that implements our Texas-Mexico Border Strategic Plan.
- Private and public sectors need to use the same measuring stick for reimbursement.

- Providers who want culturally competent staff must hire for the competencies.
- Public policy needs to state that Texas is going to address disparities, i.e., race, language, etc. It's more than just training, it's also staff-to-consumer ratios. If there is a financial sanction tied to a requirement, it will be done.

Asset	Barrier
At the policy level, mental health has been integrated into the adult criminal justice and juvenile justice systems.	Mental health is not a priority in the adult criminal justice system or the juvenile justice systems.
The jail diversion project reaches people where they are and educates people who come in contact with persons with mental illness.	The jail diversion program is not available throughout the state.
Mental health services have 26 funding sources.	Funding is fragmented.
Exciting new discoveries are being made about how the brain works.	Prevention of mental illness is not funded.
Texas has strong advocacy groups.	Groups need encouragement and promotion.
Some consumers in Texas are empowered.	Texas does not promote or fund consumer empowerment.
Opportunities exist to involve faith-based organizations.	Theological and cultural ignorance and stigma could be changed through education. Offer services in church-based clinics.
The US-Mexico border governors have added mental illness to their agenda.	The current agenda is not known.
Texas and California are developing a provider curriculum in Spanish and Asian languages.	A draft of the curriculum has been completed but has not been adopted.
Texas Department of Mental Health and Mental Retardation leadership supports services in rural and frontier counties.	All leaders are not supportive.
Consumer family support conferences are conducted in four different regions of the state.	*No barrier noted.*
Multicultural conferences have been held in Houston and Austin.	Conferences currently are not scheduled because there is a lack of funding.
Training on working with deaf and hard-of-hearing consumers is available.	Training is encouraged but not mandatory.
HHSC and the TDH commissioner are committed to cultural competency.	*No barrier noted.*
Texas will become a pilot site for implementing a state mental health plan based on the goals of the New Freedom Commission.	*No barrier noted.*
Network Advisory Committees (NACs) and Planning Advisory Committees (PACs) involve consumers and communities.	Involvement across the state is not consistent.
State mental health facilities have multicultural councils.	A similar requirement for the community mental health system does not exist.

Action Steps

1. By 2004, TDMHMR and the Health and Human Services Commission should mandate in the performance contract, with incentives and or sanctions, the utilization of a cultural competency tool in the community MHMR centers. The state facilities are using a model tool within their governance body structure.

2. By 2005, the Health and Human Service Commission should empower by education and collaboration consumers and family members on the right to demand cultural competency in providers.

3. By 2005, the Department of State Health Services should develop a strategic plan to ensure access to quality, culturally competent mental health and primary health service to all rural Texans. The plan will include a funding mechanism that is adequate and sustainable.

4. By 2005, the Texas Department of MHMR and the Health and Human Services Commission should work with pharmaceutical companies to promote and include cultural diversity in advertising segments.

5. By 2006, the Office of the Governor should mandate that all other state agencies outside of the Health and Human Services Commission collaborate and participate in the development of a culturally competent system of care in the state of Texas, e.g., the Drug Demand Reduction Advisory Committee.

6. By 2006, the TDMHMR and the Health and Human Services Commission need to involve other agencies, i.e., Texas Education Agency (TEA), licensing boards, and the Texas Work Force Commission, in the effort to assure cultural competency in the delivery of all federal and state-funded services.

7. By 2008, the Health and Human Service Commission should develop a culturally competent training program for all providers (current mental health staff) and a pipeline to encourage and promote "capacity building" in the development of ethnic/minority Mental Health Providers Network.

Notes

- The California Department of Mental Health and the Texas Department of MHMR are developing a standardized curriculum for training clinical providers who work with individuals who do not speak English. The major problem will be getting people to use the tools.
- The state mental health facilities and the state mental retardation facilities are using a cultural competency tool that could be adapted for use in the community programs.
- Given what we know about mental illness being inherited, encourage providers to ask their clients how their children are doing.
- Seventy-eight percent of the counties in Texas are rural; of that number < 26% are frontier counties.

- The Texas Education Agency (TEA) needs to be at the table. It must mandate multicultural training and training on emotional disturbances. Children must be taught inclusion at an early age. This is the best way to fight stigma.
- There is disparity in how people are treated when they go to their family physician for treatment of mental illness. The family doctor is the primary provider of mental health services, yet many lack competency in this area.
- Public practitioners need to meet with private providers to educate them about mental illness, ethnic issues related to providing services, and the need to work cooperatively in providing services.
- Mandate (federal, state levels) mental health services training for private family physicians.
- Start at the federal level when determining funding.
- It was suggested that allowing psychologists to prescribe medications would enhance services to the rural/frontier areas. However, this is a controversial issue and is not supported as an alternative.
- Work with the Higher Education Board to establish cultural competency training in the colleges and universities.
- Telephone access is universal throughout Texas. Establish statewide call centers where culturally competent professionals answer questions, advocate for the individual, and get in touch with the mental health center.
- Co-locating services would enable us to reach more minorities. Reorganization of health and human services agencies in Texas should enhance the state's ability to co-locate. This will help to promote the concept that the mind is part of the body.
- Assign mental health staff to primary hospital emergency rooms.
- TIF grants enabled centers to expand the video capabilities, but the funding to keep them in place is not available.
- Conduct a multicultural public education campaign.
- Seek corporate involvement.
- How can we make mental health as important as roads in Texas?

GOAL 4. EARLY MENTAL HEALTH SCREENING, ASSESSMENT, AND REFERRAL TO SERVICES ARE COMMON PRACTICES

Our Vision for Texas	
Regenia Hicks, Facilitator **Nina Muse, Co-facilitator** **Tamara Allen** **Steven Barnett** **Debbie Berndt** **Melanie Gantt** **Larke Huang** **Cindy Martin** **Mary McIntosh** **Scott Poland** **Hartley Sappington** **Jackie Shannon** **James Swinney** **Larry Tripp** **Tom Valentine** **Dee Yates**	All allied health, education, and human service providers are trained, competent, and motivated, and will screen for and address behavioral health issues across the life span.

Goal 4.1 Promote the mental health of young children.

Today in Texas

- TDMHMR has a memorandum of understanding with the Early Childhood Intervention Council.
- Approximately 2,900 children under age six receive mental health services through TDMHMR.
- A credentialing program for early children's mental health is available from Texas State University.
- A proposal has been submitted for a Medicaid grant to pay for parent skills training (pending).

Barriers

- Legislation related to school referral for attention deficit hyperactivity disorder (ADHD) has become more complex and has a dampening effect on referrals.
- Medicaid does not pay for family training (especially primary care) outside of the public mental health system.
- Payment for screening services is inadequate or does not exist, with the exception of the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) Medicaid program.
- Support for primary care providers to provide primary mental health care is lacking.
- Funding for mental health services compared to physical health services is lacking.
- A broad array of providers and services is not consistently available in all areas of the state.
- The referral process is fragmented. Children wait longer for a referral to mental health services than to primary care.

Action Steps

1. Establish consultation mechanisms for public mental health, the academic sector, and the private sector using telehealth, other innovative methods, and reimbursement incentives.

2. Identify or develop an agreed-upon statewide screening tool and guidelines for its use for mental health and substance use services.

3. Establish a statewide referral call center (internet) system, similar to the San Diego model that includes providers as potential call center clients. This is one of the best practices identified and discussed in the New Freedom Commission final report.

4. Explore other evidence-based practices for primary prevention.

5. Develop a statewide media campaign with the name "Family Partnerships."

6. Continue efforts to expand funding for services to children under age six.

4.2 Improve and expand school mental health programs.

Today in Texas

- School-based services are encouraged as a promising practice.
- There are 8 preliminary regional plans to promote school-based mental health, which will be further developed by the Texas Education Agency as a part of legislative action.
- Ft. Worth has a systems-of-care grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) that focuses on school-based services as the primary vehicle of change.
- Dallas has a nationally recognized school-based mental health program, which was highlighted as a part of the New Freedom Commission report.

Barriers

- Stigma about mental health services, e.g., the campaign of the Citizens' Commission on Human Rights, discourages people from seeking services.
- Legislation at the state level gives schools mixed messages regarding their role with school-based mental health treatment.
- Inadequate services are perpetuated by school system time constraints and failing to make mental health a priority.
- University preparation programs in mental health are inadequate. Interagency collaboration to develop in-service programs is lacking.
- Funding allocations for school counselors are limited. A large part of school counselor time is required to be spent on activities other than counseling students or providing information about mental illness and substance use.

- Agencies that are required to serve children often have competing agendas due to different priority populations and legislative mandates.
- Bureaucratic and cumbersome documentation becomes a deterrent for providers with expertise in serving children. Due to the low rate of reimbursement for services, providers feel that meeting documentation requirements is not adequately compensated.
- Definitional problems, e. g., SED versus ED, make interagency collaboration and funding difficult.
- Anxiety disorders, which are very common and have great morbidity, have not been identified in the school setting as a priority for intervention.

Action Steps

1. Identify school needs and the benefits that will accrue to schools through integration of mental health services.

2. Develop a program in which mental health professionals conduct teacher in-service on mental illness and substance use.

3. Provide easy access to resources for teachers. Teachers need access to mental health consultation and training and the support of behavioral aides within the classroom setting.

4. Create liaison between state mental health authority, the Texas Education Agency, and teacher preparation at university.

5. Replicate the primary prevention model at Rochester, which uses paraprofessionals working under supervision of professionals.

6. Explore the integration of PBIS within Texas schools.

7. Examine Project Mainstream as model for teacher training in mental health.

8. Review evidence-based school mental health curricula and skill-based interventions.

Goal 4.3. Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Today in Texas

- Reorganization of agencies will integrate mental health, health, and substance use agencies.
- Texas has adopted a rule governing services to people with co-occurring and substance use disorders, which requires cross-training of mental health and substance use providers.
- The Texas Commission on Alcoholism and Drug Abuse (TCADA) has the COSIG grant for infrastructure.
- Screening for co-occurring psychiatric and substance use disorders (COPSD) is already mandated at local authority and TCADA treatment sites.
- COPSD training already underway.

- A.J. Ernst is co-employed by TDMHMR and TCADA.
- The state is blending funding in NorthSTAR.
- Federally qualified health centers (FQHCs) are integrating (funded) mental health into services at three sites: Nacogdoches, Austin, and San Angelo.
- The FQHCs are expanding in Texas.
- Juvenile probation departments use a nationally recognized screening instrument (MAYSI_II) to screen all youth coming into detention settings.
- HB 2292 requires jail diversion pilots and several jail diversion programs currently exist.
- HB 2292 mandates disease management.

Barriers

- Inconsistencies in expectations, implementation, and methods exist statewide.
- Statutory inconsistencies continue in reimbursement responsibilities (county versus state).
- Unfunded mandates continue.
- Gaps exist in professional preparation.
- Gaps continue in ongoing training.
- Agencies compete for turf and for funding.
- The evidence base in this area is smaller.
- Silos and compartmentalization exist in training.
- Consumers must endure double stigmatization.
- Suicide prevention is a challenge.

Action Steps

1. Increase web-based training for integrated treatment. Add CEUs and degree credits.
2. Change training requirements at the pre-license level.
3. Require staff to demonstrate knowledge through licensing examinations and competency requirements.
4. Disseminate information about evidence-based practices and promising practices through a variety of mechanisms.
5. Provide incentives for training and for providing integrated services.
6. Develop a telemedicine consultation system and provider reimbursement mechanisms.
7. Identify integrated screening tools for different venues.
8. Use the term "behavioral health."
9. Conduct a major media campaign (public and professionals).
10. Provide web-based screening.
11. Utilize a blended or braided funding approach.

12. Develop substance use treatment algorithms.

13. Move to a continuing care, disease management, public health model.

14. Investigate the Australian "Beyond the Blue" school model.

Goal 4.4 Screen for mental disorders in primary health care, across the life span, and connect to treatment and supports.

Today in Texas

- Project Mainstream is being conducted.
- FQHCs are providing behavioral health services.
- IMPACT is being conducted.
- EPSDT has a behavioral tool.

Barriers

- Traditional silos perpetuate the lack of communication.
- The cultural bases for stigma have not been addressed.

Action Steps

1. Investigate the Baylor Senior Clinic model.

2. Ensure behavioral health screening at multiple points.

3. Develop strategies to ensure continuity of care across transition points.

4. Integrate behavioral health into all allied health training, licensing, and continuing education requirements.

5. Liaison with Higher Education Coordinating Board.

6. Expand co-location of services.

7. Coordinate services for those older than age 60 with AAA.

8. Implement individualized care plans.

9. Coordinate services between primary health and behavioral health.

10. Liaison with Texas Department of Insurance.

GOAL 5. EXCELLENT MENTAL HEALTH CARE IS DELIVERED AND RESEARCH IS ACCELERATED

Our Vision for Texas	
M. Lynn Crismon, Facilitator **Marcia Toprac, Co-facilitator** **Michael Arambula** **Roddy Atkins** **Miriam Feaster** **Joel Feiner** **Claudette Fette** **Pam Gionfriddo** **Mike Katz** **Alexander Miller** **Stacey Stevens** **Connie Turney**	Research is conducted on how to translate research findings into practice. Mental health and general health services are integrated. All reputable scientific research is considered in defining evidence-based practices (EBPs). There is private sector support for non-pharmacological research. The "workforce trained" about mental illness includes school staff and teachers.

Goal 5.1 Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

Today in Texas

- Research funding has been cut, e.g., San Antonio State Hospital Clinical Research Unit, Mental Health Connections, Harris County Psychiatric Center research functions. The state has moved backward on reaching this goal.
- Implementation of evidence-based practices (EBPs) is inconsistent.
- Several examples of good, longstanding public-academic relationships are available.
- The provider system exhibits willingness to be involved in research.
- A shift has occurred toward conducting medication (pharmaceutical) research in the private sector (for profit).
- Mandates for research/evaluation have been included in legislation, although they have been narrowly focused.

Assets

- A critical mass of talented researchers in the state is focused on the issues.
- Policymakers in Texas are interested in research and in promoting EBPs.
- Pressures (incentives) exist to do research to improve efficiency (make better use of scarce dollars).
- Texas has more data accessible for research than it has had in the past (although there are issues regarding the data's quality).
- Recent legislation encourages value-added services (HB 2292) which will stimulate research support by the private sector.

Barriers

- ✯ Involvement from academic institutions in a broader array of research (psychosocial, multi-disciplinary) is less than optimal.
- ✯ The state has either a lack of resources or commitment for research in the serious mental illnesses.
- ✯ Funding streams do not stimulate collaboration.
- ✯ Resources to analyze the data that we already have are lacking.
- ✯ Resources to ensure the quality of the data we collect are lacking.
- ✯ Uniformity in outcomes collected (measures used) is lacking.
- ✯ Agreement in operational definitions of outcomes and processes (services) is lacking.

Action Steps

1. Standardize measures (for services, outcomes, etc.).
2. Involve families and consumers in defining measures in meaningful ways.
3. Keep measures simple (KISS).
4. Direct research toward simplifying measures.
5. Develop centers of excellence, especially around psychosocial areas.
6. Develop strategies to enhance public-private collaboration around research.
7. Align data collection efforts across agencies; develop an agreed upon minimum data set.
8. Pursue funding for research through joint efforts.
9. Create other policies/mandates (like HB 2292) that will stimulate relevant research by the private sector.

Goal 5.2 Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation

Today in Texas

- ✯ Many stakeholders (clinicians, consumers, policy makers) do not understand the language or meaning of evidence-based practices.
- ✯ A number of demonstrations of evidence-based practices and dissemination efforts in the public system have been conducted.
- ✯ Funding sources, e.g., Medicaid and private insurance, do not support implementation of evidence-based practices.
- ✯ The Benefit Design initiative promotes evidence-based practices.
- ✯ HB 2292 promotes implementation of evidence-based practices.

Assets

- ✯ Texas has a track record of demonstration of evidence-based practices (ACT, TMAP, supported employment).
- ✯ The Benefit Design initiative and HB 2292 promote implementation of evidence-based practices.

Barriers

- ✯ Funding is lacking.
- ✯ Funding streams are sometimes hard or impossible to direct toward implementation of evidence-based practices.
- ✯ The scope of demonstrations of evidence-based practices has thus far been limited to priority population (three disorders).
- ✯ Research findings are not easily accessible to the public and consumers.
- ✯ Texas does not employ strategies to *sustain* and enhance implementation (beyond initial training).
- ✯ Texas has no system for dissemination of evidence-based practices.
- ✯ The results and costs of using evidence-based practices in "real world" settings (outside research contexts) are unknown.
- ✯ Service providers are not trained in evidence-based practices.
- ✯ Service providers often lack understanding of or training in serious mental illnesses.
- ✯ Funding streams and other distinctions between inpatient and outpatient services create barriers to smooth and consistent implementation of evidence-based practices across settings.
- ✯ Operational definitions of priority population (diagnosis, GAF scores) create barriers to recovery.
- ✯ It is often difficult to implement evidence-based practices in rural settings (research is often conducted in urban sites).

Action Steps

1. Align funding streams to the requirements of evidence-based practices.

2. Structure funding methodology so that funding follows consumers.

3. Initiate legislation to combine funding streams, e.g., Texas Commission on Alcoholism and Drug Abuse, criminal justice, schools, mental health community services, state mental health facilities, to eliminate silos.

4. Promote and fund a wellness model (early intervention) rather than an illness model.

5. Develop dissemination strategies or modalities other than in-person approaches, e.g., video connectivity, web-based services.

6. Conduct a demonstration of the integration of mental health services with *primary care* services to establish evidence-based practices that go beyond screening to treatment.

7. Conduct demonstrations within faith-based and other community-based settings, such as schools, i.e., making use of where people naturally go for support, and link achievement of this goal to the goal of achieving cultural proficiency.

8. Extend the Texas Integrated Funding Initiative (TIFI) approach beyond children and families. Give "teeth" to combining funding streams.

9. Identify public and private funds to support dissemination and implementation of evidence-based practices.

10. Identify statutes and rules that are barriers to implementation of evidence-based practices and work toward eliminating them.

11. Bring community leaders from outside of the mental health system into these efforts.

12. Create a broad stakeholder group to identify dissemination issues and to help prioritize evidence-based practice demonstration efforts.

13. Bring together payors, i.e., legislative staff, private employers, Texas Department of Criminal Justice, Texas Department of Health, Texas Education Agency, Medicaid, Veterans Affairs, private insurers, to promote evidence-based practices. Responsibility for dissemination and implementation must go beyond TDMHMR and must be a collaborative effort.

14. Extend Medicaid disease management demonstrations to mental health as appropriate, i.e., this may not be appropriate for children and adolescents.

Goal 5.3 Improve and expand the workforce providing evidence-based mental health services and supports.

Today in Texas

- Psychiatrist turnover rates are high. The professional environment is not conducive to attracting and retaining exemplary staff.
- Lack of continuity with specific providers affects consumer engagement and therapeutic relationships.
- The attitude and morale of providers are negative, e.g., budget cuts impact morale and a therapeutic culture.
- Staff are often ill prepared (educationally, culturally) for working with the population served by MHMR.
- Training is not oriented towards working in interdisciplinary teams.
- Some training programs that prepare clinicians to work in the MHMR system have been eliminated, e.g., psychiatry, psychiatric pharmacy, psychology, mental health chaplaincy.
- Some professional disciplines are not utilized effectively, e.g., psychiatry, psychology, psychiatric pharmacy, occupational therapy, in the MHMR system.

- Most professional training programs do not contain education regarding evidence-based practices within their curricula, e.g., schools of medicine, nursing, social work.
- Most mental health professionals are not oriented toward using evidence-based practices.
- Continuing education often does not focus on evidence-based practices.
- Professionals often lack training with the seriously mentally ill.
- Training programs lack orientation toward recovery and resiliency, i.e., comprehensive, consumer-focused orientation.
- Availability of mental health professionals in rural areas is limited.
- Lawmakers and the public perceive mental health services as lacking in value.
- Other health professionals, e.g., primary care physicians, nurses, and educators are not trained in screening, early intervention, or treatment of mental illnesses.
- MHMR does not use families and consumers effectively as providers.

Assets

- A critical mass of people want to be involved and are well-networked (advocacy organizations).
- There are good, trained people (potential providers) who we do not use.
- Relatively low cost resources exist for training on some evidence-based practices – Federation of Families, TDMHMR.
- As the body of knowledge in mental health evolves, the field is becoming more interesting and attractive to enter, e.g., more physicians are interested in psychiatry.
- Good training programs are available with opportunities for training in public sector mental health settings.

Barriers

- Capacity is lacking within educational institutions, e.g., faculty, resources.
- TDMHMR lacks resources or commitment for training mental health care professionals.
- Reimbursement systems engender disincentives to practicum training.
- Considerable burn-out occurs within the existing workforce.
- Multiple documentation demands are imposed by multiple payors.
- It is very difficult to add new approaches to academic training curricula.
- No real reward system exists for good performance (career ladder, performance incentives).
- The system engenders disincentives for effective and efficient performance.
- A lack of expertise exists within academia to teach evidence-based practices for serious mental illnesses.
- MHMR pay levels are a disincentive for some professionals.
- Access to and costs of evidence-based practices impact effective performance of professionals (in both private and public sectors).

Action Steps

1. Maximize the use of professionals who have appropriate expertise and training.

2. Train health professionals to practice as part of interdisciplinary teams.

3. Make efforts to influence continuing educational requirements for mental health professionals,

4. Reassess the definition of "qualified mental health practitioner" in community mental health standards and the Medicaid state plan (to include additional educational backgrounds).

5. Work within HHSC to broaden definitions of who can be reimbursed for providing services, e.g., other professionals, consumer and family providers, and explore waiver possibilities.

6. Mandate consumer and family member involvement in training professionals within academia and the mental health system.

7. Include seminars on interdisciplinary teamwork within medical and professional school training programs.

8. Promote the utilization of peers (consumers and families) as providers.

9. Educate providers in the use of technologies that can enhance implementation of evidence-based practices.

10. Educate the public and policymakers about the value of mental health services and treatments.

11. Create stakeholders groups to assess the appropriateness and utility of existing training curricula (professional schools, internship, residency, and in-service training) for public mental health sector service.

12. Change the rules of managed care to allow reimbursement for training.

5.4 Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma, and acute care.

Today in Texas

- ✯ No evidence-based practices are identified for diagnoses other than the priority population disorders. The knowledge base on other disorders is more limited.

Action Steps

1. Collect needs assessment data for other disorders (panic disorder, obsessive-compulsive disorders, post-traumatic stress disorder, etc.).

2. Develop the evidence-based practice knowledge base for other disorders.

3. Create algorithms and guidelines for other disorders.
4. Do more research in the area of developing culturally proficient providers.

5. Conduct research related to improving access and removing barriers to care for under-served (minority) groups, e.g., qualitative research on barriers.

6. Expand research on effectiveness of current evidence-based practices for ethnic minority groups.

7. Create a diverse stakeholder group to explore utilizing the existing research regarding services for under-served populations.

8. Assess utilization of different modes of acute care, e.g. hospital, crisis stabilization units, respite, etc..

9. Research the financing of acute care alternatives.

10. Explore what other states have done regarding funding (removing barriers) for acute care alternatives, e.g., waivers.

11. Conduct additional research demonstrations on acute care alternatives (crisis respite, crisis residential).

12. Conduct research on alternatives to the current commitment process.

13. Conduct research on cost-effectiveness of alternative acute care modalities.

14. Conduct research on transition to and from acute care settings.

15. Examine work already done (including research) in this area by the U.S. Department of Veterans Affairs.

16. Conduct research on the impact of trauma on the development and treatment of mental disorders (including resiliency factors).

17. Conduct research on the incidence of trauma among people with serious mental illnesses.

18. Conduct research on effective treatments and services for people with serious mental illnesses who have experienced trauma.

19. Explore the existing research base in broader ways to examine current evidence on these issues (trauma and serious mental illnesses).

20. Explore existing data bases to answer questions about the long-term effects of medication.

21. Work toward further standardization and quality improvement of existing data systems to enable the examination of long-term effects of medication and other treatments.

22. Do research on minimum monitoring parameters for pharmacotherapy.

GOAL 6. TECHNOLOGY IS USED TO ACCESS MENTAL HEALTH CARE AND INFORMATION

	Our Vision for Texas
Kim McPherson, Facilitator **Perry Young, Co-facilitator** **Spencer Bayles** **Brian Carr** **Bruce Frankel** **Jerry Grammer** **John Hoelzel** **Michael Jenkins** **John Keppler** **David Young**	The New Freedom Commission Goal 6 has been adopted and implemented, with Texas consumers, providers, and end users trained to make full use technology to access both care and information. Advanced communications and information technology empower consumers and families. Communications are increased between consumers and providers. Electronic health records improve quality of care. Access to care is improved through the use of telemedicine. Reimbursements are available for services available through new technologies. The integration of information technology and communications infrastructure provides critical support in realizing the other New Freedom Commission goals. Records are transferable and are based on a standardized system for mental health and substance abuse services. The integration of the system is not based on centralization but on standardization. Accurate, comprehensive information follows the consumer from one provider to another.

Goal 6.1. Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in remote areas or in under served populations.

Today in Texas

- The infrastructure for statewide health information systems is lacking. Necessary infrastructure exists at many community mental health and mental retardation centers but systems are largely isolated and non-interactive due to lack of coordination.
- Medicaid reimbursement for telehealth for many potential providers, including MHMR centers, does not exist in Texas.
- A central database of IP addresses does not exist.
- Multiple information systems are used depending on the locus and funding of services (CARE, BHIPS, city public health departments). These systems do not communicate or share common standards.
- A state plan for how to use technology in health services, including behavioral health (mental health and substance abuse) services, does not exist.
- Mild to moderate treatment of mental illness occurs mostly in the primary care arena (FQHCs, RHCs, medical policy).

- The computerization of medical documentation of evidence-based practices has been developed as part of Comp TMAP, but the technology is not used statewide.
- Public and private systems do not communicate.

Assets

- Younger doctors are open to using information technology and telehealth.
- Texas can build on homeland security network.
- Federal agencies have dollars to build capacity.
- BHIPs is scaleable.

Barriers

- Public and private information technology systems cannot communicate.
- There is not a readily available means of financing an initiative to consolidate and standardize information technology for health services.
- Confidentiality laws that have not contemplated telemedicine may require updating to protect patient's privacy rights while not unduly impeding the use of the newer technologies.
- A universal health record has not been developed and does not exist.
- The core infrastructure for statewide health information technology is lacking.
- Providers resist state efforts to standardize practices.
- Standard medical records procedures and standard business rules do not exist.
- MHMR centers do not use uniform software.
- There is a perception that information technology requirements increase the burden on private providers.

Action Steps

1. Address financing to secure necessary reimbursement for telehealth services.

2. Define the essential content of the information to be collected. Inventory information technology resources currently used in the health community; identify overlap to avoid duplication.

3. Collect information about information technology practices. Survey Texas Best Practices from TIF grants. Compare expenditures on information technology in public and private sectors.

3. Develop acceptable open architecture for software including identification of a set of common data fields and security standards and levels of permission.

4. Use the information technology committee developed by HHSC as a vehicle to disseminate this plan and expand as necessary to build business process rules. Clinical staff and consumers should be involved in all phases of the process.

5. Mandate compliance with common standards across the publicly funded system. Regardless of vendor, software must comply. Adopt "play to get paid" approach for standard information technology.

6.2. Develop and implement integrated electronic health record and personal health information systems.

Today in Texas

- Comp TMAP is not used statewide.
- There is no EMR, but building blocks exist—specifically CARE, the NorthSTAR Data Warehouse and analysis tools, and BHIPs.

Assets

- Innovation is valued.
- Comp TMAP and DANSA provide models.
- The CARE system has collected a great deal of information.
- Data is being collected by the Data Warehouse in NorthSTAR and encounter data is now being collected statewide by MHMR.
- BHIPs technology (chemical interview relative) is an asset.

Barriers

- **Ownership of the record is an issue.**
- **Protection of patient privacy poses difficulties in a technological environment.**
- **The issue of a public EMR may be premature. Has Texas analyzed the benefits and risks and determined that it wants to do this now?**
- **The CARE system is very restrictive.**
- **Physicians are reluctant to use information technology.**
- **Funding for an initiative is lacking.**

Action Steps

1. Actively seek funding to develop an information sharing system that will achieve savings. Find a way to lease or rent infrastructure instead of purchasing.

2. Create a template for the structure of an electronic record, beginning with a crosswalk of existing fields/systems. Line up information content of existing system with attributes. etc. Explore integration of physical and behavioral healthcare systems. Create uniform standards for content of child and adult mental health and substance use records. A single entry system should be developed to create a record which is scaleable and/or appendable.

3. Identify key reports what are to be generated by the system. The record must meet both the needs of clinicians and data reporting entities.

4. Work with the information technology subgroup at HHSC to ensure coordination and information sharing occurs, i.e., don't start over. Ensure mental health, health, and substance abuse data collection systems communicate at least at a high level.

5. Build on developmental steps worked out by the Veterans Administration and the Network of Care.

6. Explore university-state and private-state partnerships. Use new Texas State Health Department to establish broad coordination – explore university involvement.

7. Guiding principals of development of system: openness, flexibility, and collaboration. Involve consumers, providers, and policy makers.

Appendix: Model Program Descriptions[1]

1. New Freedom Commission on Mental Health, *Achieving the Promise: Transforming Mental Health Care in America. Final Report.* DHHS Pub. No. SMA-03-3832. Rockville, MD: 2003.

FIGURE 1.4. MODEL PROGRAM:

Suicide Prevention and Changing Attitudes About Mental Health Care

Program	Air Force Initiative to Prevent Suicide
Goal	To reduce the alarming rate of suicide. Between 1990 and 1994, one in every four deaths among active duty U.S. Air Force personnel was from suicide. After unintentional injuries, suicide was the second leading cause of death in the Air Force.
Features	In 1996, the Air Force Chief of Staff initiated a community-wide approach to prevent suicide through hard-hitting messages to all active duty personnel. The messages recognized the courage of those confronting life's stresses and encouraged them to seek help from mental health clinics - actions that were once regarded as career hindering, but were now deemed "career-enhancing." Other features of the program: education and training, improved surveillance, critical incident stress management, and integrated delivery systems of care.
Outcomes	From 1994 to 1998, the suicide rate dropped from 16.4 to 9.4 suicides per 100,000. By 2002, the overall decline from 1994 was about 50%. Researchers also found significant declines in violent crime, family violence, and deaths that resulted from unintentional injuries.[1] Air Force leaders have emphasized community-wide involvement in every aspect of the project.
Biggest Challenge	Sustaining the enthusiasm by service providers as the program has become more established.
How other organizations Can adopt	The program can be transferred to any community that has identified leaders and organization, especially other military services, large corporations, police forces, firefighters, schools, and universities.
Sites	All U.S. Air Force locations throughout the world

FIGURE 2.1. MODEL PROGRAM:

Integrated System of Care for Children with Serious Emotional Disturbances and Their Families

Program	Wraparound Milwaukee
Goal	To offer cost-effective, comprehensive, and individualized care to children with serious emotional disturbances and their families. The children and adolescents that the program serves are under court order in the child welfare or juvenile justice system; 64% are African American.
Features	Provides coordinated system of care through a single public agency (Wraparound Milwaukee) that coordinates a crisis team, provider network, family advocacy, and access to 80 different services. The program's $30 million budget is funded by pooling child welfare and juvenile justice funds (previously spent on institutional care) and by a set monthly fee for each Medicaid-eligible child. (The fee is derived from historical Medicaid costs for psychiatric hospitalization or related services.)
Outcomes	Reduced juvenile delinquency, higher school attendance, better clinical outcomes, lower use of hospitalization, and reduced costs of care. Program costs $4,350 instead of $7,000 per month per child for residential treatment or juvenile detention.[2]
Biggest Challenge	To expand the program to children with somewhat less severe needs who are at risk for worse problems if they are unrecognized and untreated.
How other organizations Can adopt	Encourage integrated care and more individualized services by ensuring that funding streams can support a single family-centered treatment plan for children whose care is financed from multiple sources.
Sites	Milwaukee and Madison, Wisconsin; Indianapolis, Indiana; and the State of New Jersey

FIGURE 2.2. MODEL PROGRAM:

Supported Employment for People with Serious Mental Illnesses

Goal	To secure employment quickly and efficiently for people with mental illnesses. Alarmingly, only about one-third of people with mental illnesses are employed,[3] yet most wish to work.
Features	An employment specialist on a mental health treatment team. The employment specialist collaborates with clinicians to make sure that employment is part of the treatment plan. Then the specialist conducts assessments and rapid job searches and provides ongoing support while the consumer is on the job.
Outcomes	In general, about 60% to 80% of those served by the supported employment model obtain at least one competitive job, according to findings from three randomized controlled trials in New Hampshire; Washington, DC; and Bultimore.[4] Those trials find the supported employment model far superior to traditional programs that include prevocational training. The cost of the supported employment model is no greater than that for traditional programs, suggesting that supported employment is cost effective.
Biggest Challenge	To move away from traditional partial hospital programs, which are ineffective at achieving employment outcomes but are still reimbursable under Medicaid.
How other Organizations Can adopt	Restructure State and Federal programs to pay for evidence-based practices, such as Individual Placement and Support (IPS)[5] that help consumers achieve employment goals rather than pay for ineffective, traditional day treatment programs that do not support employment.
Sites	30 states in the United States, Canada, Hong Kong, Australia, and 6 European countries

FIGURE 2.3. MODEL PROGRAM:

Integrated Services for Homeless Adults with Serious Mental Illnesses

Program	AB-34 Projects - Named after California Legislation of 2000
Goal	To "do whatever it takes" to meet the needs of homeless persons with serious mental illnesses, whether on the street, under a bridge, or in jail.
Features	Outreach (often by formerly homeless people), comprehensive services, 24/7 availability, partnerships with community providers, and real-time evaluation. Flexible funding, not driven by eligibility requirements.
Outcomes	66% decrease in number of days of psychiatric hospitalization, 82% decrease in days of incarceration, and 80% fewer days of homelessness.[6]
Biggest Challenge	To change the culture, attitudes, and values around treating difficult populations with different strategies. Traditional services and providers tend to want to continue "business as usual" and follow funding streams rather than integrate services or share responsibility.
How other Organizations Can adopt	Change infrastructure to integrate services. This concept is a different way of doing business and requires links to a broader array of services, not just mental health.
Web sites	www.ab34.org (The web site is currently being developed and will be expanded soon.) www.dmh.ca.gov (click on *Community Mental Health Services*, *Homeless Mentally Ill Programs*, and then *Integrated Services for the Homeless Mentally Ill).*
Sites	38 California counties

FIGURE 3.1. MODEL PROGRAM:
A Culturally Competent School-Based Mental Health Program

Program	Dallas School-based Youth and Family Centers
Goal	To establish the first comprehensive, culturally competent, school-based program in mental health care in the 12th largest school system in the Nation. The program overcomes stigma and inadequate access to care for underserved minority populations.
Features	Annually serves the physical and mental health care needs of 3,000 low-income children and their families. The mental health component features partnerships with parents and families, treatment (typically 6 sessions), and follow-up with teachers. The well-qualified staff, who reflect the racial and ethnic composition of the population they serve (more than 70% Latino and African American), train school nurses, counselors, and principals to identify problems and create solutions tailored to meet each child's needs.
Outcomes	Improvements in attendance, discipline referrals, and teacher evaluation of child performance.[7] Preliminary findings reveal improvement in children's standardized test scores in relation to national and local norms.
Biggest Challenge	To sustain financial and organizational support of collaborative partners despite resistance to change or jurisdictional barriers. Program's $3.5 million funding comes from the school district and an additional $1.5 million from Parkland Hospital.
How other Organizations Can adopt	Recognize the importance of mental health for the school success of all children, regardless of race or ethnicity. Rethink how school systems can more efficiently partner with and use State and Federal funds to deliver culturally competent school-based mental health services.
Site	Dallas and Fort Worth, Texas

FIGURE 4.1. MODEL PROGRAM:
Intervening Early to Prevent Mental Health Problems

Program	Nurse-Family Partnership
Goal	To improve pregnancy outcomes by helping mothers adopt healthy behavior, improve child health and development, reduce child abuse and neglect, and improve families' economic self-sufficiency.
Features	A nurse visits the homes of high-risk women when pregnancy begins and continues for the first year of the child's life. The nurse adheres to visit-by-visit protocols to help women adopt healthy behaviors and to responsibly care for their children. In many states, Nurse-Family Partnership programs are funded as special projects or through State appropriations.
Outcomes	*For mothers:* 80% reduction in abuse of their children, 25% reduction in maternal substance abuse, and 83% increase in employment. *For children (15 years later):* 54% to 69% reduction in arrests and convictions, less risky behavior, and fewer school suspensions and destructive behaviors. This is the only prevention trial in the field with a randomized, controlled design and 15 years of follow-up. The program began in rural New York 20 years ago and its benefits have been replicated in Denver and in minority populations in Memphis.[8-10]
Biggest Challenge	To preserve the program's core features as it grows nationwide. The key feature is a trained nurse, rather than a paraprofessional, who visits homes. A randomized, controlled trial found paraprofessionals to be ineffective.[11]
How other Organizations Can adopt	Modify requirements of Federal programs, where indicated, to facilitate adopting this successful, cost-effective model.
Sites	270 Communities In 23 States
For Additional Information	http://www.nccfc.org.NurseFamilyPartnership.cfm

FIGURE 4.2. MODEL PROGRAM:
Screening Program for Youth

Program	Columbia University TeenScreen® Program
Goal	To ensure that all youth are offered a mental health check-up before graduating from high school. TeenScreen® identifies and refers for treatment those who are at risk for suicide or suffer from an untreated mental illness.
Features	All youngsters in a school, with parental consent, are given a computer-based questionnaire that screens them for mental illnesses and suicide risk. At no charge, the Columbia University TeenScreen® Program provides consultation, screening materials, software, training, and technical assistance to qualifying schools and communities. In return, TeenScreen® partners are expected to screen at least 200 youth per year and ensure that a licensed mental health professional is on-site to give immediate counseling and referral services for youth at greatest risk. The Columbia TeenScreen® Program is a not-for-profit organization funded solely by foundations. When the program identifies youth needing treatment, their care is paid for depending on the family's health coverage.
Outcomes	The computer-based questionnaire used by TeenScreen® is a valid and reliable screening instrument.[12] The vast majority of youth identified through the program as having already made a suicide attempt, or at risk for depression or suicidal thinking, are not in treatment.[13] A follow-up study found that screening in high school identified more than 60% of students who, four to six years later, continued to have long-term, recurrent problems with depression and suicidal attempts.[14]
Biggest Challenge	To bridge the gap between schools and local providers of mental health services. Another challenge is to ensure, in times of fiscal austerity, that schools devote a health professional to screening and referral.
How other organizations Can adopt	The Columbia University TeenScreen® Program is pilot-testing a shorter questionnaire, which will be less costly and time-consuming for the school to administer. It is also trying to adapt the program to primary care settings.
Web site	www.teenscreen.org
Sites where Implemented	69 sites (mostly middle schools and high schools) in 27 States

FIGURE 4.3. MODEL PROGRAM:

Collaborative Care for Treating Late-Life Depression in Primary Care Settings

Program	IMPACT-Improving Mood: Providing Access to Collaborative Treatment for Late Life Depression
Goal	To recognize, treat, and prevent future relapses in older patients with major depression in primary care. About 5% -10% of older patients have major depression, yet most are not properly recognized and treated. Untreated depression causes distress, disability, and, most tragically, suicide.
Features	Uses a team approach to deliver depression care to elderly adults in primary care setting. Older adults are given a choice of medication from a primary care physician or psychotherapy with a mental health provider. If they do not improve, their level of care is increased by adding supervision by a mental health specialist.
Outcomes	The intervention, compared to usual care, leads to higher satisfaction with depression treatment, reduced prevalence and severity of symptoms, or complete remission.[15]
Biggest Challenge	To ensure that the intervention is readily adapted from the research setting into the practice setting.
How other Organizations Can adopt	Be receptive to organizational changes in primary care and devise new methods of reimbursement.
Sites	Study sites in California, Texas, Washington, North Carolina, Indiana

FIGURE 5.1. MODEL PROGRAM:
Quality Medications Care for Serious Mental Illnesses

Program	Texas Medication Algorithm Project (TMAP)
Goal	To ensure quality care for people with serious mental illnesses by developing, applying, and evaluating medication algorithms. An algorithm is a step-by-step procedure in the form of a flow chart to help clinicians deliver quality care through the best choice of medications and brief assessment of their effectiveness. The target population is people with serious mental illnesses served by public programs.
Features	Development of algorithms as well as development of consumer education materials and other tools for treating serious mental illnesses. Public sector-university collaboration with support of stakeholders, education and technical assistance, and administrative supports to serve the most medically complex patients. Early phases of the project developed the algorithms and tested the benefits of their use; the program's latest phases focus on implementing TMAP in mental health treatment settings throughout the State.
Outcomes	The algorithm package implemented by Texas was more effective than treatment-as-usual for depression, bipolar disorder and schizophrenia. It reduced symptoms, side effects and improved functioning.[16-18] The package's benefit for reducing incarceration is being studied. In addition, medication algorithms have been developed for treating children with depression or attention deficit hyperactivity disorder (AD/HD). TMAP algorithms have also been adapted to treat adult consumers who have co-occurring mental and substance use disorders.
Biggest Challenge	To ensure that the entire algorithm package - patient education, frequent medical visits, medication availability, and consultation - is properly implemented in other States and localities.
How other organizations Can adopt	Conduct an active planning process, including meetings with stakeholders, to examine what organizational changes are needed to make the algorithm work best.
Sites	Texas; Nevada; Ohio; Pennsylvania; South Carolina; New Mexico; Atlanta and Athens, Georgia; Louisville, Kentucky; Washington, D.C.; San Diego County, California; and private sector in Denver, Colorado

FIGURE 5.2. MODEL PROGRAM:
Critical Time Intervention with Homeless Families

Program	Family Critical Time Intervention model (FCTI). The program is jointly funded by NIMH and the Center for Mental Health Services/Center for Substance Abuse Treatment Homeless Families Program.
Goal	To apply effective, time-limited, and intensive intervention strategies to provide mental health and substance abuse treatment, trauma recovery, housing, support, and family preservation services to homeless mothers with mental illnesses and substance use disorders who are caring for their dependent children.
Features	The Critical Time Intervention model (CTI) was developed in New York City as a program to increase housing stability for persons with severe mental illnesses and long-term histories of homelessness. Its principle components are rapid placement in transitional housing, fidelity to a Critical Time Intervention CTI model for families (i.e., provision of an intensive, 9-month case management intervention, with mental health and substance use treatments), a focused team approach to service delivery, with the aim of reducing homelessness, and brokering and monitoring the appropriate support arrangements to ensure continuity of care.
Outcomes	Data indicate that mothers in this group tend to be poorly educated, have meager work histories, and face multiple medical, mental health, and substance use problems. Their children's lives have lacked stability in terms of housing, education, and periods of separation from their mothers. African-American and Latina women were over-represented in study sites in proportions greater than the national average for homeless populations. (An NIMH-funded study of this project is ongoing; additional outcomes will be available at its conclusion.)
Biggest Challenge	The CTI model for families challenges the assumption that homeless mothers with children who are have mental health or substance use disorders require confinement and extended stays in congregate shelter living before they can independently manage their own households. This can be addressed by acquiring buy-in from collaborators and involved agencies, acquiring needed housing resources, evaluating the project with respect to model fidelity, and attaining ongoing involvement of practice innovators to establish thoughtful compromises within local contexts.
How other organizations Can adopt	The program is transferable to any community that can align resources needed for housing and conduct relevant training for providers in a CTI model for families. (A manual to guide program replication will be available at the conclusion of the current study.)
Sites	Westchester County, New York

For Additional Information	http://www.rfmh.org/csipmh

FIGURE 6.1. MODEL PROGRAM:

Veterans Administration Health Information and Communication Technology System

Program	U.S. Department of Veterans Affairs (VA), Veterans Health Administration (VHA): Use of Health Information and Communication Technology
Goal	Improve the quality, access, equity and efficiency of care by using a fully integrated electronic health record system, personal health information systems, and telemedicine.
Features	VHA is the largest integrated health care system in the U.S. with approximately 1,300 sites providing a full continuum of health care services. VA provided mental health services to more than 750,000 veterans in 2002. All VHA medical facilities (clinics, hospitals, and nursing homes) use a fully integrated electronic medical record that is capable of supporting a paperless health record system. The VA system incorporates clinical problem lists, clinic notes, hospital summaries, laboratory, images and reports from diagnostic tests and radiological procedures, pharmacy, computerized order entry, a bar-code medication administration system, clinical practice guidelines, reminders and alerts, and a specialized package of mental health tools. In addition, VA uses innovative information technology and communication systems to give beneficiaries information on benefits and services, allow web-based enrollment, support a national electronic provider credentialing system, provide veterans and their families access to health information and support health care provider education. Telemedicine is used to increase access to primary and specialty care for rural and underserved populations. VA provided approximately 350,000 telemedicine visits and consultations last year. Telemedicine mental health consultations and follow-up visits provide access to these services at locations where they would otherwise be unavailable.
Outcomes	In 2002, the Institute of Medicine reported, "VA's integrated health care information system, including its framework of performance measures, is considered to be one of the best in the nation."[19]Utilizing an electronic health record with a clinical reminder system, VA screens 89% of primary care patients for depression and 81% for substance abuse. In VA, 80% of patients hospitalized for mental illnesses receive follow-up outpatient appointments within 30 days; the next best reported performance by NCQA is 73% and the Medicaid average is only 55%.
Biggest Challenge	The public's lack of confidence in the privacy and security of the electronic health record and the lack of national standards for data and communications represent the biggest challenges to implementing such a system.

How other Organizations Can adopt	High-performance, reliable electronic health record and information systems are currently available for use by any provider, clinic, hospital, or health system. Incentives for adopting electronic health records would speed wider use.
Sites	All VHA clinics, hospitals, and nursing home facilities nationwide

FIGURE 6.2. MODEL PROGRAM:
Individualized Mental Health Resource Web Site

Program	Network of Care for Mental Health
Goal	To help ensure "No Wrong Door" exists for those who need mental health services.
Features	The user-friendly Web site enables consumers and families to find pertinent mental health information; identify available services, supports, and community resources; and keep personal records on secure servers. Consumers and families can search the site's comprehensive *Service Directory* - by age group, diagnosis, program or agency name, key word, or by using the 20-category menu-for mental health treatment and supportive services provided by the county and other organizations. The site also offers up-to-date information about diagnoses, insurance, and advocacy, as well as daily news from around the world concerning mental health.
Outcomes	Gathering and organizing an enormous amount of information while making it easily accessible to Network of Care for Mental Health Web site users represents the major challenge.
Biggest Challenge	The Network of Care Web site can be easily and cost-effectively replicated in any location because the entire infrastructure - and many of the data components; e.g., the library and national links - are identical from one region to another. Only certain county-specific data (e.g., available mental health treatment and support services) must be developed for each new site.
How other organizations Can adopt	The San Diego Network of Care for Mental Health Web site was launched April 30, 2003; another is now being developed for Los Angeles County, California.
Sites	http://www.networkofcare.org

Appendix References

1. Littis, D. A., Moe, K., Roadman, C. H., & et al. (2000). Suicide prevention among active-duty Air Force personnel--United States, 1990-1999. *Morbidity and Mortality Weekly Report, 48,* 1053-1058.

2. Wisconsin Department of Health and Family Services & Bureau of Community Mental Health (2001). 2001 Annual Report for Integrated Services Projects. Madison, WI: The Children Come First Advisory Committee.

3. Kaye, H. S. (2002). Employment and Social Participation Among People with Mental Health Disabilities. In San Francisco: CA: National Disability Statistics & Policy Forum.

4. Drake, R. E., Becker, D. R., Clark, R. E., & Mueser, K. T. (1999). Research on the individual placement and support model of supported employment. Psychiatric Quarterly, 70, 289-301.

5. Cook, J. A. (2003). Results of a multi-site clinical trials study of employment models for mental health consumers. Employment Intervention Demonstration Program (EIDP). Available: http://www.psych.uic.edu/EIDP/eidp-3-20-03.pdfhttp://www.psych.uic.edu/EIDP/eidp-3-20-03.pdf

6. California Department of Mental Health, David, G., Johnson, G., & Mayberg, S. W. (2002). Effectiveness of Integrated Services for Homeless Adults with Serious Mental Illness: A Report to the Legislature as Required by Division 5, Section 5814, of the California Welfare and Institutions Code. Sacramento, CA: California Health and Human Services Agency.

7. Jennings, J., Pearson, G., & Harris, M. (2000). Implementing and maintaining school-based mental health services in a large, urban school district. Journal of School Health, 70, 201-205.

8. Kitzman, H., Olds, D. L., Sidora, K., Henderson, C. R., Jr., Hanks, C., Cole, R. et al. (2000). Enduring effects of nurse home visitation on maternal life course: A 3-year follow-up of a randomized trial. Journal of American Medical Association, 283, 1983-1989.

9. Olds, D., Henderson, C. R., Jr., Cole, R., Eckenrode, J., Kitzman, H., Luckey, D. et al. (1998). Long-term effects of nurse home visitation on children's criminal and antisocial behavior: 15-Year follow-up of a randomized controlled trial. Journal of the American Medical Association, 280, 1238-1244.

10. Olds, D. L., Eckenrode, J., Henderson, C. R., Jr., Kitzman, H., Powers, J., Cole, R. et al. (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. Fifteen-year follow-up of a randomized trial. Journal of the American Medical Association, 278, 637-643.

11. Olds, D.L., Robinson, J., O'Brian, R., Luckey, D. W., Pettit, L. M., Henderson, C. R., Jr. et al. (2002). Home visiting by paraprofessionals and by nurses: A randomized, controlled trial. *Pediatrics, 110,* 486-496.

12. Shaffer, D., Fisher, P., Lu8cas, C. P>, Dulcan, M. K., & Schwab-Stone, M. E. (2002). NIMH Diagnostic Interview Schedule for Children Version IV (NIMH DISC-IV): Description, differences from previous versions, and reliability of some common diagnoses. *Journal of the American Academy of Child and Adolescent Psychiatry, 39,* 28-38.

13. Shaffer, D. & Craft, L. (1999). Methods of adolescent suicide prevention. Journal of Clinical Psychiatry, 60, Supplement 2, 70-74.

14. Leslie McGuire, personal communication, June 24, 2003.

15. Unutzer, J., Katon, W., Callahan, C. M., Williams, J. W., Jr., Hunkeler, E., & Harpole, L. et al. (2002). Collaborative care management of late-life depression in the primary care setting: A randomized controlled trial. Journal of American Medical Association, 288, 2836-2845.

17. Rush, A. J., Shon, S. P., Crismon, M. L., Miller, A. L., Trivedi, M. H., & Suppes, T. (2000). Presentation of the Texas Medical Algorithm Project (TMAP): Results of a three-year study, American College of Neuropsychopharmacology.

18. Rush, A. J. (2001). Presentation of results from the Texas Medical Algorithm Project, American Psychiatric Association.

19. Suppes, T., Rush, A. J., Dennehy, E. B., Crismon, M. L., Kashner, T. M., Toprac, M. G. et al. (2003). Texas Medication Algorithm Project, phase 3 (TMAP-3): Clinical results for patients with a history of mania. Journal of Clinical Psychiatry, 64, 370-382.

16. Institute of Medicine Committee on Enhancing Federal Healthcare Quality Programs, Corrigan, J., Eden, J., & Smith, B. M. (2003). Leadership by Example: Coordinating Government Roles in Improving Healthcare Quality. Washington, DC: National Academies Press.
183. Weilert, M. & Tilzer, L. L. (1991). Putting bar codes to work for improved patient care. Clinics in Laboratory Medicine, 11, 227-238.