

# **Josiah H. Beeman Commission**

## **Draft Report to the Fairfax County Board of Supervisors**

**Draft Report for Input  
via Email, Mail, and Stakeholder Sessions**

This report is available electronically at [www.fairfaxcounty.gov/beemancommission](http://www.fairfaxcounty.gov/beemancommission)

October 27, 2008  
[Tentative date for final report]

## COMMENTS ON RECOMMENDATIONS

For individuals unable to attend the input sessions, comments on recommendations may be given **between July 18 – August 8, 2008** via:

Email: **beemancommission@fairfaxcounty.gov**

Postal Mail:

**Josiah H. Beeman Commission  
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Fairfax, VA 22035**

The Commission is very interested in your response to their draft recommendations. To ensure that your comments can be used in the revision of the recommendations, please state the **Recommendation #** that your comments relate to in your message. Comments related to the recommendations will be summarized and presented to the Commission at their September meeting for consideration in the final Commission report.

Questions related to the recommendations can be answered at the input sessions listed at [www.fairfaxcounty.gov/beemancommission](http://www.fairfaxcounty.gov/beemancommission)

Questions received through email or postal mail will be noted, but may not receive personal response.

Please keep in mind that the purpose of the comments is to provide input on how the Commission recommendations can be improved. Your comments, including identifying or individual information, can be available to the public through the Freedom of Information Act.

**THANK YOU!**

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## Executive Summary

*A high level overview of findings and recommendations  
will be added when draft recommendations  
are finalized pursuant to stakeholder input.*

## Commission Membership

- **Mary Ann Beall**, Chair, Fairfax-Falls Church Community Services Board, Fairfax, VA
- **Mary Ann Bergeron**, Executive Director, VA Association of Community Services Boards, Glen Allen, VA
- **Gary Cyphers**, Deputy Executive Director, American Public Human Services Association, Washington, DC
- **David Dangerfield, D.S.W.**, President/CEO, Avalon Health Care, Inc., Salt Lake City, UT; and former Chief Executive Officer, Valley Mental Health, Salt Lake City, UT
- **Larry Davidson, Ph.D.**, Associate Professor of Psychology in Psychiatry; and Director, Program for Recovery and Community Health, Yale University School of Medicine, New Haven, CT
- **Joan Dodge, Ph.D.**, Senior Policy Associate, National Technical Assistance Center on Children's Mental Health, Georgetown University, Washington, DC
- **Robert Drake, M.D., Ph.D.**, Professor of Psychiatry and Community and Family Medicine, Dartmouth Medical School and Dartmouth Psychiatric Research Center, Lebanon, NH
- **Diane Grieder, M.Ed.**, Owner/President, AliPar, Inc./Quality Behavioral Health Resources, Suffolk, VA
- **Charles Hall, M.Ed.**, Executive Director, Hampton-Newport News Community Services Board, Hampton, VA; and Member of Commonwealth of Virginia Commission on Mental Health Law Reform
- **Ronald Manderscheid, Ph.D.**, Director of Mental Health & Substance Use Programs, Constella Group, Inc., Rockville, MD; and Secretary of the U.S. Department of Health and Human Services' Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020
- **Mattie Palmore**, Vice Chair, Fairfax-Falls Church Community Services Board; and, Special Magistrate, Fairfax, VA
- **Russell Pierce, J.D.**, Regional Coordinator of Recovery and Inclusion Services, Pathway Homes, Fairfax, VA
- **Sherry Rose**, Peer Advocate, Fairfax, VA
- **Yvette Sangster**, Program Director, Protection and Advocacy for Individuals with Mental Illness (PAIMI), Georgia Advocacy Office, Decatur, GA
- **James Scott**, Delegate, 53<sup>rd</sup> District, Virginia House of Delegates, Richmond, VA; and Assistant Vice President for Community Affairs, INOVA Health Systems, Fairfax, VA
- **James Stewart, III**, Inspector General for Mental Health, Mental Retardation and Substance Abuse Services, Richmond, VA; and Member of Commonwealth of Virginia Commission on Mental Health Law Reform
- **Carol Ulrich, Esquire**, President, National Alliance on Mental Illness of Northern Virginia (NAMI-NoVa), Reston, VA; and Member of Commonwealth of Virginia Commission on Mental Health Law Reform

# Acknowledgements

Other contributors to our work ...

- **Sonia Jurich, M.D., Ed.D.**, Research Associate, RMC Research Corporation, Arlington, VA
- **Thomas Kirk, Jr. Ph.D.**, Commissioner of the Connecticut Department of Mental Health and Addiction Services
- **Ruth Ralph, Ph.D.**, Senior Research Associate (Retired), Edmund S. Muskie School of Public Service, University of Southern Maine, Portland, ME
- **James Reinhard, M.D.**, Commissioner, Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services
- **Mary E. Smith, Ph.D.**, Consultant

# Introduction

“The 21st century promises new hope and opportunity for persons diagnosed with mental illness”.<sup>1</sup>

“To improve access to quality care and services”, the President’s New Freedom Commission on Mental Health recommended “fundamentally transforming how mental health care is delivered in America”.<sup>2</sup> “Transformation is happening...From California to Connecticut, promising models of transformation in behavioral health are being developed and piloted”.<sup>3</sup>

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<sup>1</sup> Bassman, Ronald, Ph.D. (2006). The Evolution from Advocacy to Self-Determination. In Ronald W. Mandescheid, Ph.D. and Joyce T. Berry, Ph.D., J.D. (eds.) *Mental Health, United States, 2004*. 14. Rockville, MD: Substance Abuse and Mental Health Services Administration. Accessed 15 July 2008. <http://www.samsha.gov/>

<sup>2</sup> New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. DHHS Pub. No SMA-03-3831. Rockville, MD: US Department of Health and Human Services. 6.

<sup>3</sup> SAMHSA. (2005 May-June). Transformation is now. *Mental Health transformation trends*. 1(2), 2. Accessed 16 June 2008. <http://www.samsha.gov/>

This report conveys a series of recommendations for transforming the Fairfax-Falls Church system of mental health care. The reader of this report may find new and unfamiliar concepts or terms. A few of those concepts require a prominent place in this report and are therefore defined below:

**“Stigma** refers to a cluster of negative attitudes and beliefs that motivate the general public to fear, reject, avoid, and discriminate against people with mental illnesses...Responding to stigma, people with mental health problems internalize public attitudes and become so embarrassed or ashamed that they often conceal symptoms and fail to seek treatment”.<sup>4</sup>

**“Resilience** means the personal and community qualities that enable us to rebound from adversity, trauma, tragedy, threats, or other stresses – and to go on with life with a sense of mastery, competence, and hope. We now understand from research that resilience is fostered by a positive childhood and includes positive individual traits, such as optimism, good problem solving skills, and treatments. Closely-knit communities and neighborhoods are also resilient, providing supports for their members”.<sup>5</sup>

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<sup>4</sup> New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. DHHS Pub. No SMA-03-3831. Rockville, MD: US Department of Health and Human Services. 7.

<sup>5</sup> New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. DHHS Pub. No SMA-03-3831. Rockville, MD: US Department of Health and Human Services. 7.

**“Recovery** is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential”.<sup>6</sup>

**Hope** refers to the notion that “recovery provides the essential and motivating message of a better future – that people can and do overcome the barriers and obstacles that confront them. Hope is internalized; but can be fostered by peers, families, friends, providers, and others. Hope is the catalyst of the recovery process”.<sup>7</sup>

For definitions of other key terms and concepts, refer to Appendix A.

## Commission Charter

As outlined in its charter (see Appendix B), the Josiah H. Beeman Commission was established to advise the Board of Supervisors on the future direction and design of the mental health services delivery system serving Fairfax County, the City of Fairfax, and the City of Falls Church. This Commission was named in recognition of the late Josiah H. Beeman, former chairman of the Fairfax-Falls Church Community Services Board, and his dedication to the recipients of mental health services and supports. The Commission was asked to recommend a vision for the service delivery system and to develop recommendations for facilitating the transformation to achieve this vision. As we developed our recommendations, we focused on the following deliverables as

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<sup>6</sup> SAMHSA. (2004). *National consensus statement on mental health recovery*. [Brochure]. Accessed 17 June 2008. <http://mentalhealth.samhsa.gov/publications/>.

<sup>7</sup> SAMHSA. (2004). *National consensus statement on mental health recovery*. [Brochure]. Accessed 17 June 2008. <http://mentalhealth.samhsa.gov/publications/>.

identified in the charter: Roles of Public Mental Health Services; Service Delivery Design; Populations to be Served; Assessment of Current System against Recommended Design; System Transformation Roadmap; Outcomes and Performance Measures; and Financing Strategies to Optimize Resources.

## Recovery-Oriented Accomplishments

As we plan for the future, we want to recognize accomplishments of the CSB and its progress toward a recovery- and resilience-oriented system. Highlights from among the many accomplishments include:

- Crisis Care at Woodburn Place hired Peer Specialists who have designed an “Introduction to Wellness Recovery Action Plan (WRAP)” program. To date, approximately 390 individuals receiving mental health services have participated in this program.
- The Program of Assertive Community Treatment (PACT) significantly reduced hospital bed days and has begun turning apartment leases over to individuals receiving services.
- The CSB deploys psychiatric resources to Community Health Care Network clinics managed through a contract with the Health Department. Alternatively, primary care is provided to individuals in crisis care at CSB’s Woodburn Place and to those with co-occurring disorders at two residential programs. The CSB also conducts psycho-educational groups with a focus on wellness, nutrition, and smoking cessation.
- A system-wide Mental Health Services Recovery Workgroup, comprised of advocates, individuals receiving mental health services, family members and staff, was established to guide transformation to a recovery- and resilience-oriented system.

- Despite challenges in finding housing in the costly Fairfax market (see the Optimized Integration section of this report), Adult Residential Services expanded housing capacity over the past decade with 298 new beds, including 22 beds which were added in 2008.
- The CSB worked with individuals to establish three Drop-in Centers operated by persons receiving mental health services.
- The CSB partnered with contract providers (Psychosocial Rehabilitation Services and Service Source) and the Virginia Department of Rehabilitation Services to eliminate the waiting list for vocational services.
- The CSB collaborated with police and other system partners to divert from jail to treatment persons with mental illness who would otherwise be arrested for nonviolent misdemeanors (e.g., loitering).
- As a pilot in the Virginia Service Integration Program, aimed at integrating and improving mental health and substance abuse assessment and treatment, the CSB completed an exhaustive system survey and organized change agents to address system issues in achieving dual diagnosis capabilities in all programs.
- The CSB collaborated with system partners to launch Leland House which provides short-term intervention and stabilization to youth ages 12-17. Staff works extensively with youth in crisis and families to prevent out-of-home or out-of-community placements.
- The CSB overhauled the “front door” of the system and decreased waits for initial assessments from months to 2-10 business days.
- The CSB’s Youth and Family Services partnered with George Mason University to develop an instrument to examine direct service experience (e.g., timely access to service, collaborative goal setting) and outcome of services (e.g., doing better in school, getting along better with family and friends).

- The CSB, working with the Area Agency on Aging, developed a plan to enroll as many people as possible in Medicare, Part D. This effort resulted in more than 90% of eligible individuals being enrolled. The program is ongoing and continues to help individuals receiving mental health services with Part D decisions as their life circumstances change.
- The CSB, working with the Department of Family Services (DFS), developed a tool that helps staff determine who may be eligible for Medicaid benefits. DFS deployed staff to three mental health outpatient sites to assist eligible individuals with Medicaid applications.

While recovery- and resilience-oriented efforts of the CSB began before the inception of the Commission, the work of the Commission has accelerated those efforts. CSB leadership has reported that their experience with the Commission has facilitated a better understanding of recovery principles and practices, has led to greater emphasis on the importance of resilience, and has enabled greater “traction” with staff for transformational work. In short, the Commission seems to have amplified, energized, and validated the progress of the CSB toward a transformed system and our recommendations are designed to build upon that progress.

In addition, other agencies in the county have responded to the re-orientation of the mental health system and it is anticipated that on-going partnerships will be evident in the future. One example of partnership is the work with the Fairfax County Police Department related to persons with mental illness. A team of police officers trained in crisis intervention is available to respond and serve as a resource for cases when mental illness is suspected. The curriculum for this training was developed by reviewing evidence-based jail diversion practices and includes presentations by individuals receiving mental health services and families.

# I. Foundation for Recommendations

As a Commission, we began by building a foundation for our recommendations. This foundation includes the following: Vision, Philosophy, Values and Guiding Principles, Stakeholder Input on the system, and the current System Structure.

## A. COMMISSION VISION

This Commission has adopted as its vision the following vision statement from the *New Freedom Commission on Mental Health*:

*“We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports – essentials for living, working, learning and participating fully in the community”.*<sup>8</sup>

## B. COMMISSION PHILOSOPHY

Mental health is fundamental to overall health and it is a shared community responsibility.

Anyone with, or at risk for, mental illness should have access to a comprehensive and coordinated

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<sup>8</sup> New Freedom Commission on Mental Health. (July 2003). *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. (DHHS Pub. No. SMA-03-3831). Rockville, MD. 1.

system of services and supports including prevention and early intervention services. This system should include treatment and other critical supports such as affordable and safe homes, meaningful work opportunities and/or education, primary health care, and supports for families and children. This shared community responsibility is comprised of services and supports provided by public, nonprofit, and private entities and by partnerships among them, as well as services and supports provided by families, peers, friends, advocates and other groups and individuals in the community. Services and supports should be designed to build resilience and facilitate individualized recovery.

## C. COMMISSION VALUES and GUIDING PRINCIPLES

In framing the values and principles to guide the Commission's work, members referred to *Improving the Quality of Health Care for Mental and Substance-Use Conditions*<sup>9</sup>, *From Study to Action: A Strategic Plan for Transformation of Mental Health Care*<sup>10</sup>, *Building Systems of Care: A Primer*<sup>11</sup>, and *Recovery Core Values*<sup>12</sup>. Not surprisingly, there was much commonality among the values and principles identified in these references. While each member brought his or her own

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<sup>9</sup> Institute of Medicine, Board on Health Care Services. (2006). *Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series*. Washington: The National Academies Press. 57-58.

<sup>10</sup> Daniels, A., Ed. D., and Adams, N., M.D., MPH. (Feb 2006). *From Study to Action: A Strategic Plan for Transformation of Mental Health Care*. Accessed 17 June 2008. [www.healthcarechange.org](http://www.healthcarechange.org).

<sup>11</sup> Pires, Sheila. (Spring 2002). *Building Systems of Care: A Primer*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

<sup>12</sup> Advocacy Unlimited, Inc. (2 Oct 2001). *Recovery Core Values for the Mental Health and Addictions Recovery (Treatment) System*. Accessed 16 June 2008. [http://www.mindlink.org/recovery\\_core\\_values.html](http://www.mindlink.org/recovery_core_values.html).

set of values to guide this work, we were heartened by the commonality of values among members.

As a group, we agreed to the following set of primary values upon which to build our recommendations:

- **ACCESS**  
Assurance that services and supports are timely, appropriate to needs, and sufficient to reach the identified outcomes in order to restore and sustain individual and family integration in the community.
- **COMMUNITY-BASED SERVICES and SUPPORTS**  
Services and supports which are located in the community, for which management and decision-making responsibility rest at the community level, and which are directed by the individual along with the individual's choice of persons in his or her natural support system.
- **CULTURAL AND LINGUISTIC COMPETENCE**  
All persons providing services and support will have an understanding of, and responsiveness to, cultural, racial, ethnic or linguistic differences in all areas of services and supports.
- **EFFECTIVENESS and MEASURABLE RESULTS**  
Services based on the best scientific evidence at the time resulting in the achievement of desired outcomes of choice for the individual.
- **EQUITY**  
Provides services and supports that do not vary in quality because of personal characteristics of the individual such as severity of disability, gender, ethnicity, geographic location and socioeconomic status.
- **FAMILY INVOLVEMENT, SUPPORT and EDUCATION**  
Individuals and their families are participants in all aspects of the planning, delivery of services and supports as chosen by individual and appropriate by age and circumstance. A robust system of support for families experiencing the mental illness of a family member is an important part of a service delivery system.
- **INVOLVEMENT with NATURAL COMMUNITY SUPPORTS**  
Individuals and families are seen as having important social connections with other organizations, services and affiliations that are in their community and these connections serve as a network and resources for supports, activities and education.
- **PERSON-CENTERED SERVICES and SUPPORTS**  
A highly individualized and family directed approach used to understand each individual's and family's history, strengths, needs and vision of their own treatment and needed natural supports to promote resiliency and recovery.

- **PREVENTION and EARLY INTERVENTION**  
Maintenance of wellness, early identification, and early intervention that builds protective and resiliency factors and enhances the likelihood of positive outcomes for everyone.
- **RESPECT**  
Deference and honoring of the unique preferences, strengths, and dignity of each person in their choice of services and supports.
- **SAFETY**  
Services and supports are provided in an emotionally and physically safe, compassionate, trusting and caring treatment/working environment for all persons with a mental health disability, family members, staff, and the community.
- **SERVICE INTEGRATION**  
Coordinated and collaborative services and supports with consistent practice models and strategies and cooperation across systems and among mental health providers to ensure the appropriate and timely exchange of information and coordination of effective services and supports.
- **TRANSPARENCY**  
All stakeholders in the service system have the information necessary to support both person/family-centered and systems-level informed decision-making. The policies, priority setting, and practices of the mental health delivery system should be transparent and accessible to members of the community.

## D. STAKEHOLDER INPUT

As we built the vision, philosophy, and values elements of the foundation for our recommendations, we conducted a parallel process of gathering input from various stakeholder groups through conversations and surveys. These stakeholder groups included:

- Individuals (including both youth and adults) receiving mental health services. (In the survey, these persons are referred to as **consumers**)
- Family members and Significant Others of individuals receiving mental health services

- Service Providers, and by that we mean Fairfax-Falls Church Community Services Board (CSB) staff as well as employees and volunteers associated with organizations that provide mental health services in Fairfax County
- Leaders of other county departments in the human services system

To ensure stakeholder input in the process of developing recommendations, the Commission conducted the following activities:

## **1. Conversations with individuals receiving services and staff**

Commission members, working in pairs, conducted conversations with stakeholders, including CSB staff members and individuals receiving mental health services at the following facilities: Consumer Wellness Center of Falls Church, Franconia Road Treatment Center, Juvenile Detention Center, Leland House Youth Crisis Care, Residential Extensive Dual Diagnosis, and Stevenson Place. Comments from individuals receiving services and staff at all of these sites were combined, summarized, and organized according to reoccurring theme areas, as listed below.

Overall, participating **individuals receiving services** expressed satisfaction with:

- **Program effectiveness:** program content and applicability
- **Person-centered manner of treatment:** staff friendliness and compassion, involvement of individuals receiving services in treatment and decisions, choice of outside activities
- **Resources:** variety available to individuals receiving mental health services

Participating **individuals receiving services** suggested greater emphasis be placed on:

- **Being person-centered:** more skill development (training) and employment/volunteer opportunities for individuals receiving services, respect for individuals receiving services, wellness promotion (nutrition and healthy living)
- **Providing transparency:** more education for individuals and families on programs, processes, medication, the Medicaid application process, and rights of those receiving services.
- **Ensuring timeliness:** time to get into programs
- **Providing access:** transportation for individuals receiving services
- **Promoting effectiveness:** individual-therapist relations, community-based programs, consistency of information and treatment to individuals receiving mental health services, number and range of outside activities
- **Ensuring safety:** physical conditions of facilities, supporting safe individual behavior

Overall, participating **staff** members expressed satisfaction with:

- **Program effectiveness:** variety and range of services, quality and dedication of staff, family involvement and therapy effectiveness
- **Person-centered manner of treatment:** involvement of individuals receiving services and families in treatment and goal setting
- **Collaboration and coordination:** integrated systems approach, collaboration of staff, crisis management, and creative problem solving
- **Internship Programs:** quality and potential of interns as future staff

Participating **staff** members suggested greater emphasis be placed on:

- **Providing access:** housing and program admittance, transportation, number of available psychiatrists, insurance/benefits assistance, referral process for care continuity, reaching out to culturally diverse populations
- **Ensuring efficiency:** amount of paperwork, information technology system and support, clear work processes, clarification of staff responsibilities
- **Promoting collaboration:** partnerships with government agencies to improve benefits processing, and collaboration within the CSB, with other county agencies and outside organizations
- **Supporting Staff:** organizational staffing needs, training and development, performance evaluation system, and staff wellness
- **Ensuring strong leadership:** organizational priorities in line with mission, leadership training, leadership structure, staff input and involvement in decision making
- **Promoting effectiveness:** number and range of outside activities, more day treatment and step down programs, follow up with individuals receiving services
- **Ensuring safety:** physical conditions of facilities, supporting safe behavior of individuals receiving services, safety of program locations
- **Providing transparency:** more education for individuals receiving services and families on programs and processes
- **Supporting free flow of information:** communication between leadership and staff (response time, information sharing)
- **Ensuring timeliness:** intra-agency responsiveness

## **2. Survey on mental health system**

The Commission utilized the Recovery Oriented Systems Indicators (ROSI) survey to gather input from individuals receiving mental health services (referred to as **consumers** of mental health services in the survey instrument) and similar surveys for family members/significant others of individuals receiving services and for providers of mental health services. The ROSI survey is a tool currently available through the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services and was developed by individuals receiving mental health services in cooperation with Columbia University.

The type of sampling that was used for the ROSI survey was a non-probability sampling. Self-selected samples were collected from Library sites and Web-based responses. Opportunity samples were taken from mental health service and support locations. Therefore results may or may not be representative of the general mental health population. The survey was meant to provide direction for further information gathering and aid in the formation of recommendations for the future direction of the mental health services delivery system serving Fairfax-Falls Church area residents.

As highlighted in the summary of the survey results (see Appendix C), participating **individuals receiving mental health services (consumers), family members/significant others, and providers** gave the highest percentage of positive responses to survey statements related to:

- The respect shown by staff in terms of the cultural background of individuals receiving mental health services
- The lack of pressure, threats or force used in treatment

- The non-interference of staff in the personal relationships of individuals receiving mental health services
- Being treated as a person, not a psychiatric label
- Belief shown by staff that the individual receiving services can grow, change, and recover
- The complete information given to them in words they understand before having to consent to treatment and medication

Participating **individuals receiving mental health services (consumers), family members/significant others,** and **providers** gave the highest percentage of negative responses to survey statements related to:

- Having enough income to live on
- Having enough good service options to choose from
- The presence of a peer advocate when needed
- Having affordable housing
- Family members getting the education and support needed

### **3. Conversations with families of individuals receiving services**

Two activities expanded opportunities for input from families. Working in pairs, Commissioners met with parents of youth in the Teen Alternative Program (a comprehensive day treatment program for students in grades 9 to 12) and, through NAMI-NoVa, families of adults who had experience with emergency services. Comments from both of these sessions were summarized, with the topics that engaged the most interest listed below.

Families of youth in the CSB's Teen Alternative Program shared positive remarks about the program and provided key suggestions that included:

- Increasing the education of staff members in the school system on available options for students experiencing mental health issues
- Improving the availability of information to the general public on youth mental health programs and resources
- Improving the transition process for youth leaving a psychiatric hospital or mental health program

Again, in addition to positive remarks, a few of the key suggestions made by the families of individuals who had experience with emergency services included:

- Examining the restrictions that prevent individuals from receiving emergency services unless they are deemed a threat to themselves or others
- Increasing the availability of the Mobile Crisis Unit
- Ensuring a consistent follow-up process after each crisis visit
- Assessing the methods of support available for families and significant others of individuals receiving mental health services

#### **4. Conversation with county human services leaders**

At a regularly scheduled meeting of the Human Services Leadership Team, the agenda included a conversation regarding the opportunities and challenges for greater service integration in serving people with mental illness. Two Commissioners attended this meeting and had the opportunity to hear from the Directors of Family Services, Community and Recreation Services, the Office for

Women, the Department of Housing, and the Court Services Unit of the Juvenile and Domestic Relations District Court; they also heard from the Deputy Director of the Community Services Board (CSB) and the Deputy County Executive for Human Services.

One strong theme which emerged from this meeting was the need to strengthen collaborative relationships between agencies in order to provide complete services to people with mental illnesses. It was noted that there is a need for increased mental health services and supports provided by the CSB for elderly, homeless, and multicultural populations. Connection points between the CSB and the housing agency need improvement in order to assist adults with mental health disabilities in accessing and maintaining homes. Conversely, the assistance of therapeutic recreation services for youth and adults is underutilized in the mental health arena.

The need for greater willingness to be flexible on the part of CSB staff who are assisting people in other agencies was noted, particularly in reference to scheduling around the educational needs of children and youth. A more rapid hiring process for filling CSB vacancies is desired. In terms of the broader community of the Human Services system, there is a need for the following: 1) a better system-wide response for families and significant others of individuals receiving mental health services; 2) a more collaborative approach to prevention; and 3) assistance for individuals receiving mental health services on quality of life issues such as housing, health care, and employment.

## **5. Overall themes from stakeholder input activities**

Overall, when looking at all stakeholder input gathering activities, some reoccurring themes across these various participant groups and input methodologies include the need for:

- Growth opportunities for individuals receiving mental health services (employment, education, community activities)
- Support and education for families/significant others of individuals receiving mental health services
- Use of peer advocates and peer service providers
- Assistance and process modifications for benefits and insurance related issues
- Greater collaboration among service providers and partners in the county
- Availability of public information on county services and processes
- Improved access including the process to receive services and housing, as well as increased contact with staff

After drafting our initial recommendations, we created an opportunity for feedback from representatives of all stakeholder groups and other interested individuals.

*A summary of stakeholder input sessions will  
be added following completion of these sessions.*

Our draft recommendations were subsequently refined and reshaped based on this input.

## E. CURRENT SYSTEM STRUCTURE

In addition to stakeholder input on the current system, the Commission gathered information about the mental health system from Community Service Board (CSB) service providers. In reply to our many questions, staff provided responses in the form of categorized portfolios of data and information. In response to our request to visit some service delivery sites, we were given the opportunity to tour sites including Consumer Wellness Center of Falls Church, Crisis Care Program at Woodburn Place, Crossroads, Eleanor Kennedy Shelter, Program of Assertive Community Treatment, PRS, Inc., Project to Assist Transition from Homelessness Team, and Woodburn Center for Community Mental Health. Finally, we listened to presentations by, and had multiple conversations with, CSB staff regarding mental health services and supports.

In gathering information about the system, we learned how the CSB is structured and how that structure impacts individuals receiving mental health services as they initially access services and flow through the system. Listed below is a brief summary of elements related to the current system structure. In our discussions and in this list we have used a “door” metaphor to capture the entry and exit flow of individuals through the system.

- The primary “front door” for adults entering the system is through the Access Unit. Other portals of entry include, but are not limited to, Emergency Services, Crisis Care, Homeless Outreach, Hospital Discharge, and Day Treatment.
- Approximately 50% of adults who enter the system through the Access Unit complete CSB care because their needs are met or they are referred to other community resources. The remaining 50% transfer deeper into the system.

- Most adults transitioning from the Access Unit deeper into the system of services and supports are uninsured or underinsured and are:
  - Persons in psychiatric crisis
  - Persons experiencing a serious mental illness
  - Persons experiencing a serious mental illness with a concomitant substance use disorder
  - Persons who are functioning poorly in the community as a result of mental health symptoms and need a service not otherwise available (primarily case management)
- While the CSB has the ability to serve persons with private insurance (through participation on many insurance panels) the number of individuals receiving services who have private insurance represents a statistically low percentage of the total served.
- The “back door” for adults to exit the system is utilized less often than the front door. This is because many persons require ongoing psychotropic medication and/or experience complex disorders and, even in the context of improvement, may continue contact with case managers or psychiatrists/nurse practitioners
- Currently the system is structured with separate “doors” for adults and for children, youth, and their families.
- Children, youth, and their families in need of services call the same Access Unit phone number, where they are screened by a designated Youth & Family staff member. Callers are then given an intake appointment or referred to other appropriate services or agencies. Other portals of entry for children, youth, and their families include, but are not limited to, Emergency Services, Adolescent Day Treatment, Youth & Family Residential Services, Psychiatric Inpatient units, Juvenile and Domestic Relations District Court, Comprehensive Services Act, Fairfax County Public Schools and the Department of Family Services.
- Children, youth, and their families have fewer eligibility constraints to access system services

- The CSB is structured in discrete disability areas which include Mental Health, Alcohol and Drug Services, Mental Retardation, and Infant Toddler Connection.
- A significant effort is underway to build co-occurring capable programs able to treat co-occurring substance abuse and mental health disabilities and to establish a “no wrong door” policy for individuals with co-occurring disorders. Several years ago, the CSB established a “no wrong door” within its Homeless Services Unit, integrating staff from Mental Health and Alcohol and Drug Services.



## II. Recommendations for a Transformed System

Included in this section are the Commission's recommended roles for the public mental health system, design of the system, and roadmap for transforming the system.

### A. ROLES OF PUBLIC MENTAL HEALTH SYSTEM

Outlined below are recommended roles for the public system. The *2007 Overview of Community Services Delivery in Virginia* served as a resource for this recommendation.

#### *Recommendation 1*

**The public mental health system would function as a(n):**

- **Planner** of services and systems to meet identified needs.
- **Advisor** to local government and the community about unmet needs, future service trends, and public policies related to mental health.
- **Advocator** for individuals not receiving needed services; community acceptance of and support for individuals receiving mental health services; the elimination of stigma associated with mental illness.
- **Capacity Builder** to coordinate the development of needed services and support networks (including peer support) by working with public and private organizations, individuals receiving mental health services, families and advocacy groups.
- **Single Point of Entry** into publicly funded mental health services to include care coordination (case management), coordination of services, and access to state-funded hospital services through preadmission screening.
- **Manager** of access to services and integration between services.
- **Provider** of services directly by mandate (care coordination or case management, emergency services, discharge planning), directly by choice, and

indirectly through partnerships or contracts with other organizations and providers.

- **Communicator** to expand knowledge through ongoing training on the recovery and resilience framework for services; to increase public understanding of the need for services and supports in the community; to actively seek and value input from and participation by individuals receiving mental health services, family members, and advocates.
- **Evaluator** to assure the accountability and effectiveness of services provided and to inform policy makers and management of those services with emphasis on quality, feedback mechanisms and measurable outcomes, continuous improvement and learning.

While not specifically listed as a role, we believe the CSB and its board are **leaders** in assuring a balanced, collaborative, and systemic approach to meeting community needs. Recommendations to enhance the governance and leadership of the CSB are outlined in the Transformation Roadmap section of this report.

As a Commission, we spent considerable time discussing the role of managing access to mental health services and the complementary roles of direct provider and capacity builder of services. We believe a successful transformation of this system will require re-conceptualization of these roles and continuous attention to assure that they are adequately balanced. This re-conceptualization will be apparent in our recommendations for a design with increased access to services and supports, a more business-focused approach to the management of access, productivity standards to demonstrate the expectation of shared accountability for outcomes, financing strategies that maximize revenue from all sources, and scaling of the system to determine what services the CSB provides itself as a public entity, and what services it purchases or partners with others to provide.

## **B. SYSTEM DESIGN AND POPULATIONS SERVED**

“Recovery is an “everybody wins” scenario”.<sup>13</sup> In a recovery- and resilience-oriented system, individuals receiving mental health services “rebuild meaningful lives while decreasing their dependence on the system...Rather than creating long term users of a system...individuals will receive services that will enable them to recover and decrease their dependence on the system”.<sup>14</sup>

It is our intention that the following design recommendations build upon the values and guiding principles identified in this report. As outlined below, elements of the transformational design include enhanced access, optimized service, and increased utilization of peers.

### **1. ACCESS**

While our discussions about enhancing access to mental health care covered the landscape of possibilities, we ultimately focused on the need for assuring: access to information, public care or a care network referral, and benefits assistance and advocacy.

#### **a. Information**

Public awareness and education efforts are necessary not only to increase knowledge about mental health and wellness but also to reduce the stigma about mental illness and to promote the positive effects of best practice in prevention and treatment. As identified in our values,

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<sup>13</sup> Crowley, K. (1997). Excerpts from the *Report to the Wisconsin Blue Ribbon Commission on Mental Health*. Accessed 17 June 2008. [http://www.procovery.com/files/blueribbon\\_article.htm](http://www.procovery.com/files/blueribbon_article.htm).

<sup>14</sup> Crowley, K. (1997). Excerpts from the *Report to the Wisconsin Blue Ribbon Commission on Mental Health*. Accessed 17 June 2008. [http://www.procovery.com/files/blueribbon\\_article.htm](http://www.procovery.com/files/blueribbon_article.htm).

maintenance of wellness, early identification, and early intervention build protective and resiliency factors and enhance the likelihood of positive outcomes for everyone.

We believe it is the responsibility of the public mental health system to provide mental health education and to raise public awareness about mental health issues, and that all residents of the Fairfax-Falls Church area should have easy access to this information. While the CSB currently conducts education and public awareness activities, we understand that these activities are loosely organized in the service delivery system. We believe Fairfax-Falls Church area residents would benefit from enhanced access to information about mental health, wellness, recovery, and resilience.

We also believe that all residents of the Fairfax-Falls Church area should have access to information about public mental health services and supports through outreach and publicity efforts. As with the public awareness and education activities, it is our assessment that the CSB's publicizing of its mental health services is a loosely organized effort.

Further, we believe that increased focus is needed on easing access to information for individuals whether it is by phone, computer, written material, or in person. It is very important that an individual's first contact with the mental health system, regardless of where that contact is made, is welcoming, informative, and comfortable. A transformed, integrated system will not only meet the primary needs of the individual seeking assistance, it will also "create an environment in which

other basic desires for comfort, convenience, safety, and information are anticipated and addressed”.<sup>15</sup>

**Recommendation 2**

- a. Organize and deliver education and public awareness activities and campaigns about mental health and wellness.**
- b. Actively publicize information about public mental health services and supports to the community.**
- c. Assure that access to information is a customer-friendly, culturally-sensitive and welcoming process.**

**b. Public Care or Care Network Referral**

“The public mental health system serves as a safety net for people who are poor, uninsured, or for those whose private insurance benefits run out during their illness. The public system ensures that mental health treatment is available for those in need, enabling individuals to return to their communities and lead more productive lives”.<sup>16</sup> In addition to serving those in the safety net, we believe that the public system has an obligation to assure either access to public mental health services and supports or linkage to private or nonprofit mental health services and supports. In a transformed system, every resident of the Fairfax-Falls Church area would have a path into the public mental health system or a referral to a nonprofit or private provider in the care network. This belief is based on our philosophy that mental health is a shared community responsibility.

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<sup>15</sup> Ford, F. and Fottler, M. (Fall 2000). Creating Customer-Focused Health Care Organizations. *Journal of Healthcare Management*. 18-33.

<sup>16</sup> Burns, Robert J. National Governor’s Association. (7 Dec 2001) Issue Brief: Strengthening the Mental Health Safety Net: Issues and Innovations. Accessed 14 July 2008. <http://www.nga.org/>

## **i. Public Care**

Public mental health care currently provided by the CSB includes an extensive array of services and supports. For example, some individuals have brief access to public care (e.g., relatively short-term supportive counseling, participation in a psycho-educational group). Others may have longer term access to public care (e.g., intensive care coordination or case management, medication management). The CSB estimates that approximately 50% of adults who enter the system complete public care because their needs are met through short-term, time-limited services and supports or they are referred to other community resources; the remaining 50% transition deeper into the system of public care for continuing care.

We strongly believe that Fairfax-Falls Church area residents benefit from the extensive and rich array of public mental health services and supports. However, as we considered our recommendations about the populations to be served by the public sector, we returned more than once to our definition of the mental health system outlined in the Commission Philosophy section of this report:

“Mental health is a shared community responsibility...[and]...is comprised of services and supports provided by public, nonprofit, and private entities and by partnerships among them, as well as services and supports provided by families, peers, friends advocates and other groups and individuals in the community”.<sup>17</sup>

Our focus, as we grappled with the difficult decisions around populations to be served, was on this broadly defined system and its capacity to serve Fairfax-Falls Church area residents.

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<sup>17</sup> This report, 14-15

To promote mental health and wellness in the community, we believe that any Fairfax-Falls Church area resident seeking care, regardless of insurance or ability to pay, would have access to time-limited public care or a referral/assessment for connection to nonprofit or private mental health services and supports. Those served longer term by the CSB would include adults, children, and youth who:

- are uninsured or underinsured or are unable to pay and are:
  - experiencing psychiatric crisis
  - experiencing a serious mental illness (adults), serious emotional disturbance (up to 18 years of age), or at risk of developing a serious emotional disturbance (birth to age seven)
  - experiencing a serious mental illness with a concomitant substance use disorder, or
  - functioning poorly in the community as a result of mental health symptoms and in need of a specific service or a constellation of services provided by the CSB and otherwise not available
- regardless of insurance and ability to pay:
  - are determined to be in need of public mental health services and supports to prevent further decompensation and/or reliance on the public system.

In accordance with our value of person-centered care, the duration of longer term service and supports would be dependent on the individual.

***Recommendation 3***

**Assure that all who seek access to the mental health system secure either access to public mental health services and supports or linkage to private or non-profit mental health services and supports.**

## **ii. Care Network**

The Commission believes that the capacity of the public system would be enhanced through a robust network of care which brings together public, private and nonprofit providers, insurers, employers, and people in recovery to address the needs of the community. An optimized network of care would bring the various entities (public, private and nonprofit) closer together and could potentially increase both contractual relationships with private practices and capacity in the nonprofit community. Additionally, as the CSB forges stronger relationships with insurance companies, there may be potential for increased insurance collections by the CSB.

The unique capacities of the public system (such as emergency coverage and service, care coordination or case management services, and skill in assisting people with severe psychiatric disabilities) are a major asset to the community. The CSB must educate others in the network as to its unique capacity to serve. Similarly, the private and nonprofit entities in the care network enrich the community with assets which could be better understood by all network partners.

Building a robust network would require the development of more focused business policies and practices with built-in accountability and follow-up as essential components of the process. Partners in the network would not only be responsible for making referrals, but also for ensuring that connections in the care process are secured. Business practices regarding referrals between primary health care providers may serve as examples for enhancing accountability among system partners.

Our recommendation to increase collaboration and accountability would not be complete without some assurance of system incentives to accomplish the transformation. We hypothesize that a

robust network of care would enhance cross-system access to services and supports and would increase opportunities for cross-system referrals. As an initial step in building this network, we recommend that a detailed market analysis be conducted in order to map network assets, test the hypothesis regarding incentives for collaboration and shared accountability, and evaluate current system capacity against projected need.

***Recommendation 4***

**Build a robust network of care with practices that ensure cross-system accountability for referral connections. Begin with a market analysis to map network assets, identify incentives for shared accountability and collaboration, and evaluate current capacity against projected need.**

**c. Benefits Assistance and Advocacy**

Many challenges exist in the Virginia benefits administration environment for persons with behavioral health care needs who want to access Medicaid benefits and other entitlements including Medicare, Supplemental Security Income (SSI) and Social Security Disability Income (SSDI). Multiple applications may be made before eligibility is approved. Follow up with, and advocacy for, the service recipient until such time as the individual is enrolled or disqualified is critical.

***Recommendation 5***

**Deploy Benefits Coordinator positions to mental health service sites in order to assist and advocate for individuals seeking benefits**

## **2. SERVICE**

The manner in which services are provided to individuals receiving mental health services is fundamental to creating and maintaining a recovery- and resilience-oriented system of care. The Commission believes that ensuring care coordination (case management), person-centered care, prevention and early intervention, the use of peers throughout the system, and shifting care into the community are essential design practices of a transformed system. Additionally, optimized integration between mental health and primary health care, housing, employment, education, and criminal justice, will ensure that the services provided are meeting the needs of the whole individual in one collaborative system.

### **a. Care Coordination and Continuity of Care**

As a Commission, we believe that care coordination is foundational to the design of a mental health system. For the purpose of this report, care coordination or case management is defined as the process of assisting those with mental health disabilities in identifying, securing, and sustaining the environmental and personal resources needed to live, work, and recreate as part of the larger community.<sup>18</sup>

Strengths-based care coordination (case management), “was developed on the central premise that persons with mental health disabilities can engage in recovery and develop their full potential when given the opportunity to garner the necessary material and emotional supports needed to achieve their goals...This model focuses on strengths or assets, rather than the deficits

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<sup>18</sup>Corrigan, P., Mueser, K., Bond, G., Drake, R., and Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press.138-139.

or problems, of the person with a psychiatric disability and utilizes an individual's natural community supports to facilitate community integration".<sup>19</sup>

**Recommendation 6**

**a. Assure that care coordination (or case management) is a centerpiece of the mental health service delivery design.**

**b. Utilize a strength-based model for delivering care coordination.**

Continuity of care is a fundamental requirement of the model for providing care coordination. Continuity is how the individual experiences the integration of services and coordination of care. "It is the degree to which a series of discrete care events is experienced as coherent and connected and consistent with the individual's needs, values and personal context".<sup>20</sup> Continuity of care will be evidenced in processes that strictly limit transfers of service recipients from one provider to another.

**Recommendation 7**

**Build continuity of care into the model for delivering care coordination.**

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<sup>19</sup> Corrigan, P., Mueser, K., Bond, G., Drake, R., and Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 143.

<sup>20</sup> Haggerty, J., Reid, R., Freeman, G., Starfield, B., Adair, C., McKendry, R. (2003). Continuity of Care: a Multidisciplinary Review. *British Medical Journal*. 327, 1219-1221.

## **b. Person-Centered Care**

"The ideas of recovery, wellness, and resiliency embody a functional model of what it means to be person-centered; they simultaneously address both process and outcome. The creation and implementation of an individual plan are the points at which these values should be most evident in practice...Planning is the foundation upon which the provision of person-centered services is built".<sup>21</sup>

The primary focus of recovery- and resilience-oriented care is to offer people with psychiatric disabilities a range of effective interventions, from which they construct a personal plan by choosing the services and supports which they believe will be most useful in their own recovery journey.<sup>22</sup> "In order to be meaningful and effective, a plan must truly be the individual's road map. [It becomes] the focal point of each session with the individual. [The plan] needs to include personally defined goals along with realistic objectives that address relevant and immediate barriers and impediments. Plans need to be practical and reasonable in specifying specific services and interventions consistent with the individual's preferences and values....The plan must be culturally relevant and outcome-oriented".<sup>23</sup>

The utilization of individual treatment plans, which are strongly shaped by the opinions and choices of the individual receiving mental health services, is a vital component of a recovery- and

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<sup>21</sup> Adams, N., and Grieder, D. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Academic Press. 20.

<sup>22</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 32.

<sup>23</sup> Adams, N., and Grieder, D. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Academic Press. 30.

resilience-oriented system. Because “changing current practices in service planning can be a powerful strategy for effective overall systems change”, ensuring that mental health care becomes completely person-centered is an important step on the journey toward a transformed system.<sup>24</sup>

**Recommendation 8**

**Assure integration of person-centered practices and processes in working with individuals on the journey of recovery.**

**c. Care in the Community**

“Due to the stigma that continues to accrue to mental illness in popular culture, the lack of education or information provided to the lay public regarding psychiatric disorders, and the denial and disbelief that accompanies the onset of many serious illnesses, people often struggle with serious mental illness for many years before coming to understand that what they are struggling with is a psychiatric disorder. It then may be another prolonged period before they can muster the courage and trust to accept their need for treatment and support. As a result, community-based practitioners cannot assume that people will come to them of their own volition”.<sup>25</sup>

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<sup>24</sup> Adams, N., and Grieder, D. (2005). *Treatment Planning for Person-Centered Care: The Road to Mental Health and Addiction Recovery*. Burlington, MA: Elsevier Academic Press. 3.

<sup>25</sup> Davidson, L, Tondora, J., Staeheli M., O’Connell M., Frey, J., & Chinman, M. (2005). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. 21. In Lightburn, A., & Sessions, P. (Eds.) (2006). *Community Based Clinical Practice*, 476-501. London: Oxford University Press.

Providing mental health services and supports in an individual's natural community setting, as opposed to the provider's office, involves a paradigm shift. Mental health providers must shift the locus of their efforts to offer practical assistance in the community environments in which individuals receiving mental health services live, work, learn, and play. In order to effectively address basic needs for housing, food, work, and connection with the community, providers must be willing to go where the action is (i.e., they must get out of their offices and into the community).<sup>26</sup> With this shift, services and care coordination would be less scheduled in an office-based setting, and more as needed in the home, at work, and in the school setting. The shift would ultimately be evidenced in processes, skills and technology that support working in the community.

One example of care in the community is the CSB's Mobile Crisis Unit, which provides emergency care for individuals experiencing psychiatric disorders. Emergency care, which is mobile (provided in the community) can reduce the involvement of law enforcement and prevent re-traumatization and hospitalization of persons with mental illness. In addition to the Mobile Crisis Unit, and as part of the overall shift of care from the office into the community, we recommend that Emergency Services expand its capacity for mobile response and care in the community.

It is our understanding that the CSB has begun to make this shift toward care in the community. To facilitate completion of this shift, we believe a policy about care in the community must be clearly and broadly articulated.

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<sup>26</sup> Curtis, L. and Hodge, M. (1994). Old Standards, new dilemmas: Ethics and boundaries in community support services. *Psychosocial Rehabilitation Journal*, 18, 13-33. As cited in *Community Based Clinical Practice* (2006).

**Recommendation 9**

**Implement a policy that completes the shift from office to community-based provision of care. Care in the community would include, but not be limited to, care coordination (case management) and emergency mental health services.**

**d. Optimized Integration**

In a transformed system, “stigma and discrimination against people with mental illnesses will not have an impact on securing health care, productive employment, or safe housing”.<sup>27</sup> In a transformed system, all systems contribute to the recovery of individuals with mental health disabilities. Furthermore, in a transformed system, there are no wrong doors; integration in a transformed system is supported by an “any door is a good door” philosophy. Outlined below are our recommendations for optimized and effective service integration between mental health and primary health care, housing, employment, education, and the justice system.

**i. Primary Health Care**

“In 2006, the Medical Directors Council of the National Association of State Mental Health Program Directors (NASMHPD) reported that people with serious mental illnesses served by the public mental health system die on average 25 years earlier than people in the general population...NASMHPD found that the high morbidity and mortality rates for persons with serious mental illnesses are largely due to preventable medical conditions and modifiable risk factors

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<sup>27</sup> New Freedom Commission on Mental Health. (2003). *Achieving the Promise: Transforming Mental Health Care in America. Executive Summary*. (DHHS Pub. No SMA-03-3831). Rockville, MD.14.

that may be addressed with medical support and interventions such as appropriate food selection and better nutrition, stress reduction and smoking cessation”.<sup>28</sup>

Primary care is a prime portal for access to mental health services. Many individuals who make contact with the health system do not necessarily make contact with the mental health system because of the stigma surrounding mental illness.<sup>29</sup> Primary care has the potential to increase the early identification of symptoms, as well as strengthen the coordination and continuity of care for both mental and somatic disorders.

“Primary care is not only where individuals receive care; it is also where family members receive care. By establishing relationships with the family, primary care providers have the advantage of tapping the family as a source of support”.<sup>30</sup> These relationships with the family are key for children and older individuals with psychiatric disabilities.

**Support of integration efforts:**

The CSB has collaborated with the Health Department in a pilot program to provide psychiatric services at one of the county’s three Community Health Care Network (CHCN) clinics. These clinics

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<sup>28</sup> Virginia State Mental Health, Mental Retardation and Substance Abuse Services Board, Department of Mental Health, Mental Retardation and Substance Abuse Service. (6 Dec 2007). *Policy Manual*. 1.

<sup>29</sup> Department of Health and Human Services (2001). Report of a Surgeon General’s working meeting on the integration of mental health services and primary health care. Nov 30-Dec 1 2000. Atlanta, GA. Rockville, MD: U.S. Department of Health and Human Services, Public Health Services, Office of the Surgeon General. 1-2. Accessed 1 May 2008. <http://www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.html>.

<sup>30</sup> Department of Health and Human Services (2001). Report of a Surgeon General’s working meeting on the integration of mental health services and primary health care. Nov 30-Dec 1 2000. Atlanta, GA. Rockville, MD: U.S. Department of Health and Human Services, Public Health Services, Office of the Surgeon General. 4. Accessed 1 May 2008. <http://www.surgeongeneral.gov/library/mentalhealthservices/mentalhealthservices.html>.

provide primary health care to individuals who are indigent (less than 200% of the Federal Poverty Level) and have no private or public health insurance. A CSB psychiatrist goes to the Community Healthcare Center to evaluate, consult, and provide psychiatric treatment for individuals identified/referred by the CHCN medical staff and/or the CHCN mental health clinician. In addition, the CSB psychiatrist provides education for the CHCN medical staff with the goals of increasing the awareness of mental illness and to increase the capacity of the CHCN medical staff to diagnose and treat mental illness. The pilot has been very successful and the CSB plans to expand to the other two CHCN clinics. Additionally, a pilot program has been developed in which a CHCN primary care physician will travel to the Woodburn Mental Health Center to provide primary health care and enroll individuals in CHCN.

***Recommendation 10***

**Support and expand the existing examples of cross-system collaboration between primary and behavioral health care providers.**

**Modification of health care status:**

We understand and support another effort underway in the county which would strengthen the interface between primary and behavioral health care. Fairfax County currently has three primary care centers that are integral parts of the safety net and provide critical care to residents. Medicaid is not accepted at these locations, which means that the centers are financed completely by local dollars. A modification of the status of these three centers to a Federally Qualified Health Center (FQHC) Look-Alike would allow Medicaid recipients, including those with psychiatric disabilities, to access the affordable health care system and receive primary health care. FQHC Look-Alike status is an official federal program. FQHC Look-Alike status would allow the county to establish Medicaid reimbursement rates directly with the federal government, which

would cover the cost of services rendered and thereby leverage Medicaid dollars to increase access to behavioral health care.

***Recommendation 11***

**Support modification of the affordable health care system to a Federally Qualified Health Center Look-Alike.**

**Expansion of alternative approaches:**

The Commission believes that in addition to well established practices, persons with mental illness should have access to alternative approaches to care which emphasize the mind-body connection (for example: wellness programs, lifestyle enhancement groups, nutrition, acupuncture, meditation, Mindfulness-Based Cognitive Therapy, Seeking Safety, and pet therapy).

Like wellness programs, many different kinds of alternative treatments have been used, some more successfully and wide-spread than others. While research is limited and “finding an expert can be difficult”, there is an increasing appreciation for the effectiveness of alternative treatments for individuals with certain psychiatric disabilities.<sup>31</sup> The decision about which approach or combination of approaches to use would be based on an individual’s circumstances and preferences and by what is known about the approaches. We understand that the CSB currently utilizes all of the alternative approaches mentioned above, and encourage expansion of these approaches where appropriate.

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<sup>31</sup> Royal College of Physicians. Alternative Treatments in Mental Health. Accessed 10 July 2008. <http://www.mental-health-matters.com/articles/>

**Recommendation 12**

**Expand access to information about, and, where appropriate, use of, alternative approaches to care.**

**ii. Housing**

Securing a home and housing are crucial to the recovery process for adults as well as a critical issue for young adults transitioning from their family's home to independent living. Research has shown that "assistance in finding safe and affordable permanent housing, which is consistent with [the preferences of those receiving mental health services], leads to better outcomes – most notably, reduction of homelessness and hospitalization".<sup>32</sup>

In addition to helping individuals on the journey of recovery, reliable housing is also cost-effective; it costs essentially the same amount of money to provide for a person in stable, supportive housing as it does to keep the same person homeless and provide him or her with expensive crisis care and emergency housing. The University of Pennsylvania's Center for Mental Health Policy and Services Research conducted a study which tracked the cost of nearly 5,000 persons with mental illness in New York City for four years (two years when they were homeless and two years after they had reliable housing). The study concluded that supportive and transitional housing saved an annual average of \$16,282 by reducing the use of public health services, shelters, and jails.<sup>33</sup> Data collected locally by Pathway Homes, Inc. supports the national

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<sup>32</sup> Corrigan, P., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 193.

<sup>33</sup> Corporation for Supportive Housing. (n.d.) *Supportive housing saves money – and benefits our communities!*. Retrieved June 27, 2008, from <http://www.csh.org>

data.<sup>34</sup> It is our understanding that Pathways Homes staff will continue to collect and refine their data. At this time, we believe that the local savings to the public system are quite substantial. Unsatisfactory housing increases an individual's reliance on emergency and public services and enervates the pursuit of recovery goals.<sup>35</sup>

Despite the proven, critical role housing plays in the rehabilitation process for persons with psychiatric disabilities, the Commission understands that the supply of housing in the Fairfax-Falls Church area which meets the needs of the lowest income families and single adults is sorely inadequate. Issues impacting homelessness include the occurrence of mental illness, substance abuse, or both. As noted in the 2008 Point in Time Survey Summary Report, 72% of single homeless individuals had serious psychiatric disabilities and/or substance abuse disorders.<sup>36</sup> A February 2008 CSB survey of housing needs found that an estimated 1000 adults enrolled in CSB mental health services were waiting for housing. This number does not include "aging out" youth who have turned 18, but are being served through Comprehensive Services Act funds.<sup>37</sup>

### **Support of Housing First:**

We are aware that the Fairfax County Board of Supervisors has endorsed a strategic plan to prevent and end homelessness within ten years in the Fairfax-Falls Church community and has chosen to adopt the "Housing First" approach in its efforts to end homelessness. Housing First

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<sup>34</sup> McNair, Joel. Personal communication. 1 July 2008.

<sup>35</sup> Corrigan, P., Mueser, K., Bond, G., Drake, R., & Solomon, P (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 174.

<sup>36</sup> Fairfax County Department of Systems Management for Human Services. (Mar 2008) *2008 Point in Time Survey Summary Report*, Fairfax- Falls Church Annual Homeless Count. 6. Accessed 17 June 2008. <http://www.fairfaxcounty.gov/homeless/>.

<sup>37</sup> Gannon, Pam. Estimated Consumer Housing Needs (from January 2008 Available CSB Data). Revised 29 Jan 2008.

places people in stable housing as rapidly as possible. We endorse the Housing First approach in which “housing becomes the first step in moving out of homelessness, not the last. The housing is based on adherence to a lease (payment of rent, upkeep of unit, peaceful and orderly conduct), not compliance with a ‘service plan’”.<sup>38</sup>

***Recommendation 13***

**Support the Housing First model and efforts to maximize housing as outlined in the county’s Ten-Year Plan to End Homelessness.**

**Expansion of housing with support services:**

While successful implementation of the Housing First initiative will satisfy the needs of many Fairfax-Falls Church residents, not all persons who need housing are capable of independent living. The county must work to assure housing for individuals needing assistive services at all points on the spectrum of care—from the largely independent to those needing daily services.

Consistent with recovery principles, the CSB is increasing the number of leases which are held by individuals receiving mental health services and providing these individuals with the accompanying support services that they need to live independently in the community. This involves no loss in overall unit capacity and results in a reduction in CSB leased dwellings. In this arrangement, an agency or individual serves as the third-party representative or ‘mentor payee’ and handles the finances for the person who is receiving mental health services. The role of mentor payee is modeled after the Social Security Administration’s third-party money manager, where

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<sup>38</sup> Planning Committee to End Homelessness of the Community Council on Homelessness. (Dec 2006). *Blueprint for Success: Strategic Directions for the Plan to Prevent and End Homelessness in the Fairfax-Falls Church Community*. 12. Accessed 16 June 2008. [www.fairfaxcounty.gov/homeless](http://www.fairfaxcounty.gov/homeless).

the representative is paid directly by the Social Security Administration and is responsible for the financial obligations of the person receiving services.<sup>39</sup> Expansion of leases held by individuals receiving mental health services, in order to assist them with the financial stability that leads to long term success in permanent housing, will require the development of community-based mentor payee capacity, through either non-profits or the families of individuals receiving services.

We have learned of one local non-profit that can serve as an example of collaboration between two organizations to serve individuals who are able to live independently with minimal services. The Brain Foundation raises funds to purchase homes for persons experiencing mental illness and then contracts with Pathway Homes to provide services to residents in the home.<sup>40</sup> Each Brain Foundation home houses four to six individuals and each tenant pays a portion of his or her income (between \$175 and \$300, usually provided by SSI or SSDI). The Brain Foundation pays the balance of the rent and utilities, as well as the cost of the services, which are provided by Pathway Homes employees.<sup>41</sup> The Commission supports the expansion of supportive housing models like this one, and also believes that parents and other family members of persons with psychiatric disabilities would be able and willing to collaborate with the county in providing housing within their private homes if the CSB brought services to individuals in the home. Given the size and scope of housing needs in Fairfax County, we recommend a working relationship with

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<sup>39</sup> Elbogen, Swanson, Swartz, Wagner. (Aug 2003) Characteristics of third-party money management for persons with psychiatric disabilities. *Psychiatric Services*, 1136. Accessed on June 13, 2008. <http://psychservices.psychiatryonline.org>

<sup>40</sup> Hobbs. (20 Sept 2007). Giving to the brain foundation: Centreville UMC donates money for home for the mentally ill. *The Connection Newspapers, CentreView South*. Accessed 12 June 2008. <http://www.connectionnewspapers.com/>.

<sup>41</sup> Jackson. (19 Apr 2007). In one niche, housing market is up. *The Washington Post*, VA24. Accessed 12 June 2008. <http://www.washingtonpost.com/>.

large organizations, such as the Corporation for Supportive Housing, in addition to local groups. The Corporation for Supportive Housing is a national non-profit intermediary organization that helps communities create permanent housing with services to prevent and end homelessness.<sup>42</sup>

***Recommendation 14***

**Engage individuals receiving services, families of individuals receiving services, and national and local nonprofit organizations in expanding housing options with accompanying support services.**

**Optimization of collaboration:**

While the Commission recognizes that the CSB and the Department of Housing have different and distinct responsibilities, they share the common goal of providing safe, secure, affordable, and accessible housing for persons with psychiatric disabilities. In order to achieve this goal, collaboration between the governing bodies of each agency, as well as between staff of each agency, must be strengthened. Increased collaboration will result in recognition and appreciation of the assets, strengths, and contributions of all involved.

To optimize collaboration between both agencies, the CSB may need to increase care coordination (case management) efforts and the Department of Housing may need to give preference for housing to persons with psychiatric disabilities. The Commission recommends establishing a staff-level work group to explore the existing systemic challenges between housing and mental health services, benchmark best practices in collaboration on the issue of housing, and develop innovative solutions to these challenges.

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<sup>42</sup> The Corporation for Supportive Housing. Accessed 3 July 2008. <http://www.csh.org>.

**Recommendation 15**

**Designate staff in both CSB and the Department of Housing to explore existing systemic challenges between housing and mental health services in order to optimize collaboration for the benefit of persons with psychiatric disabilities.**

**iii. Employment**

“We now know that most people with mental illness want to work competitively and can do so. Moreover, employment seems to help them in other areas of their lives and long-term benefits appear to be even better than short-term benefits”.<sup>43</sup> The term “employment” is highly individualized and comes in a variety of forms, with some individuals seeking full-time employment and others seeking volunteer opportunities or short-term work experiences.

Some individuals have employment skills, but need support in the home, while others need support on the job. We believe a priority of the mental health system is to meet individuals wherever they are in their lives and provide them with the resources and supports that will enable them to participate fully in the design and implementation of their own growth and development. In order to assist individuals in pursuing their personal goals, the mental health system needs to provide an array of services and supports (i.e., paid, unpaid, full-time, part-time employment, as well as volunteer activities).

**Implementation of evidence-based services:**

The Commission supports the strategy of supported employment which “has emerged rapidly since the 1980s as an evidence-based service that supports recovery” for persons with mental health

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<sup>43</sup> Corrigan, W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 209.

disabilities.<sup>44</sup> Supported employment focuses on empowering individuals to make decisions, encourages persons to search for jobs of their choice directly, and ensures ongoing support for individuals from service providers, through the integration of mental health and vocational services. “Supported employment fundamentally shifts vocational rehabilitation from a train-and-place to a place-and-train orientation...the goal [of supported employment] is to help [individuals] find jobs they are interested in as quickly as possible and to provide the training and supports they need in order to succeed on the job”.<sup>45</sup>

Principles of evidenced-based supported employment include the following:

- **Zero exclusion:** “Rather than professionals making decisions about readiness, individuals themselves should make such decisions”.
- **Integration:** “Mental health and vocational staff should work together on multidisciplinary teams. The services should appear seamless to [individuals].”
- **Benefits counseling:** “In order to make good decisions about vocational goals and pursuits, [individuals] need to have an accurate understanding of their benefits, including Social Security payments, health insurance, housing assistance and food assistance.”
- **Individual preferences:** “Vocational goals, supports, and timing should be highly individualized according to the [individual’s] preferences.”
- **Rapid job search:** “Assessment is minimized in favor of rapidly helping the individual to pursue a job that he or she chooses.”

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<sup>44</sup> Drake, R., M.D., Ph.D., Becker, D., M.Ed., C.R.C., Goldman, H., M.D., Ph.D., and Martinez, R., M.D. (2006) Best Practices: The Johnson & Johnson-Dartmouth Community Mental Health Program: Disseminating Evidence-Based Practice. *Psychiatric Services*, 3 (57), 302. Accessed 17 June 2008. <http://www.psychservices.com>.

<sup>45</sup> Corrigan, W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 196.

- **Follow-along supports:** “Services to help ensure vocational success are individually tailored...and provided as needed without time limits.”
- **Team-based services:** “Supported employment services are most effective and efficient when they are provided by a multidisciplinary team that works with the [individual] closely to identify a vocational plan, find a job, and help ensure success on the job”.<sup>46</sup>

**Recommendation 16**

**Implement employment services, consistent with the principles of evidence-based supported employment.**

**Liaison with employment partners:**

In a transformed system which provides person-centered care, care coordination (case management) staff will be capable of, and expected to, individually assist persons seeking employment. In order to successfully expand employment opportunities and reduce barriers that hinder employment for individuals with psychiatric disabilities, collaboration is needed at the system level. The VA Department of Rehabilitation Services, the Fairfax Department of Family Services, the Fairfax-Falls Church CSB, and the Workforce Investment Board must work together to assure adequate employment opportunities for this population. The Commission recommends that the CSB identify an employment liaison to facilitate this cross-system collaboration and assure the availability of employment opportunities which meet of needs of individuals receiving mental health services.

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<sup>46</sup> Corrigan, W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 197.

**Recommendation 17**

**Identify employment liaison to facilitate collaboration between the Department of Rehabilitation Services, the Department of Family Services, the Workforce Investment Board, and others in order to reduce barriers that hinder employment and expand opportunities that promote employment.**

**iv. Education**

With a nationally estimated “20% of children having a mental health disorder and 1 in 10 youth having a serious mental health problem that is severe enough to impair how they function at home, school, or in the community, there is tremendous need to target services effectively and efficiently for youth and their families”.<sup>47</sup> In Fairfax County, the need may be even greater. In the 2005 Youth Survey, 32.3% of students reported that, in the past twelve months, they had experienced extended periods of sadness or hopelessness every day for weeks in a row which prohibited them from performing their usual activities. Additionally, 12.9% of students indicated that they had seriously considered attempting suicide in the past twelve months, and 3.4% reported that they had actually attempted suicide.<sup>48</sup>

**Integration with public schools:**

Since “the majority of children attend school...schools are one of the best locations in the community to reach young children, youth, and their families” – making the schools essential

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<sup>47</sup> Sebian, J., Mettrick, J., Weiss, C., Stephan, S., Lever, N. & Weist, M. (2007). Education and systems-of-care approaches: solutions for educators and school mental health professionals. Baltimore, MD: Center for School Mental Health Analysis and Action, Department of Psychiatry, University of Maryland School of Medicine. 1. Accessed 18 June 2008. <http://csmh.umaryland.edu/resources>.

<sup>48</sup> Dawson, Chaney, White. (13 June 2006). 2005 Fairfax County Youth Survey: Results and Data Tabulations. 113. Accessed 17 June 2008. <http://www.fairfaxcounty.gov/demogrph/youthpdf.htm>.

partners with the mental health system.<sup>49</sup> The Commission envisions stronger integration with the school system, where the school system, as part of an individual's natural community, shares in responsibility for mental health care. Currently, in order to get their children the care they need, many families seek options outside of the county, as appropriate community supports are not readily available to them. Optimized integration with the school system (including the provision of mental health services in the schools) would strengthen the overall supports available to children, youth, and their families, and would increase the likelihood of families caring for their children and youth at home.

***Recommendation 18***

**Integrate more fully with Fairfax County Public Schools in serving children and youth, with support to their families.**

**Connections with educational institutions:**

Mental health issues may begin very early in life; half of all lifetime cases of mental illness begin by age fourteen, and three-quarters of these cases have begun by age 24. Young people with mental disorders therefore “suffer disability when they are in the prime of life, when they would normally be the most productive”.<sup>50</sup> As a consequence of the usual age of onset, many of the adults whom the CSB serves have missed some of the important educational opportunities which typically occur during late adolescence and early adulthood, such as high school graduation and

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<sup>49</sup> Sebian, J., Mettrick, J., Weiss, C., Stephan, S., Lever, N. & Weist, M. (2007). Education and systems-of-care approaches: solutions for educators and school mental health professionals. Baltimore, MD: Center for School Mental Health Analysis and Action, Department of Psychiatry, University of Maryland School of Medicine. 2 Accessed 17 June 2008 <http://csmh.umaryland.edu/resources>.

<sup>50</sup> National Institute of Mental Health. (6 June 2005) Mental illness exacts heavy toll, beginning in youth. Press Release. Accessed 7 July 2008. <http://www.nimh.nih.gov/science-news/2005/>

entrance into vocational schools or college. There are also many adults receiving mental health services who wish to further develop their skills and knowledge through various educational opportunities. Both of these adult populations report difficulty in finding and accessing educational opportunities. Stronger connections with local universities, colleges, vocational schools, and General Educational Development (GED) programs, and utilization of FCPS Adult Education opportunities, will aid in serving the adult population and further support the empowering notion of a recovery- and resilience-oriented system.

***Recommendation 19***

**Strengthen connections with local educational institutions in order to support adults wishing to further their education.**

**v. Justice System**

“People with mental illness are falling through the cracks of this country’s social safety net and are landing in the criminal justice system at an alarming rate. Each year, ten million people are booked into U.S. jails; studies indicate that rates of serious mental illness among these individuals are at least three to four times higher than the rates of serious mental illness in the general population”.<sup>51</sup>

“In some jurisdictions, the greatest challenge to initiating successful cross-system collaboration is simply getting prospective partners to the table”.<sup>52</sup> As noted in the Recovery-Oriented

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<sup>51</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. Xii.

<sup>52</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. 17

Accomplishments section of this report, Fairfax County has met that challenge. Recognizing the county's lack of a coordinated response for individuals with mental illness who had committed minor, non-violent offenses, the Jail Diversion Coalition was formed in 2003 to develop a systemic approach to diverting persons from jail to treatment and support services. After sponsoring a summit, coalition sponsors (including representatives from NAMI-NoVa, area police departments, the Sheriff's office, the CSB, the Public Defender's office, and county shelters, among others) tasked a work group to develop a diversion program which was launched in 2005. Sponsors meet annually to review progress of this effort. As part of this effort, the Police Department partners with individuals receiving services and families in conducting crisis intervention training for its officers. We understand that 8% of the department's patrol officers have participated in this training and encourage the department to conduct crisis intervention training for all officers.

In a briefing on the many services provided to juveniles in the justice system, the Commission learned that in an eight month period of study, 41% of youth detained at the Juvenile Detention Center were identified as having serious mental health concerns. As noted in the Stakeholder Input section of this report, we had the opportunity to hear from participants in the Beta Post-Dispositional Program at the Juvenile Detention Center. This is another example of cross-system collaboration in that these youth are served by representatives from the CSB, Juvenile and Domestic relations District Court, and the Fairfax County Public School system.

***Recommendation 20***

**Support and expand existing examples of cross-system collaboration that emphasize treatment in lieu of or in addition to incarceration.**

**Optimized integration for transitioning youth:**

As a final note in this focus on service integration, we must emphasize the need to optimize integration for transitioning youth.

“For most teenagers, turning 18 or 21 years old is a milestone of accomplishment and hope, ushering in the start of advanced education or a career. But for young adults with severe mental health conditions...the transition from adolescence to adulthood can be much more difficult –the dangers of ending up jobless, homeless or even in jail loom large”.<sup>53</sup>

When employment, incarceration, and post-secondary education statistics are measured, youth with mental health conditions have the worst long-term outcomes across all disability groups. In the long-term, failure to help youth successfully transition to adulthood can be costly to individuals as well as governments.

“If youth with mental illnesses are to become responsible adults, they may need access to “developmentally appropriate” services – programs that are geared toward helping this age group become fully functioning, responsible adults. Such programs...include mental health services, as well as assistance in finding employment and housing, job training and education in daily living skills”.<sup>54</sup>

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<sup>53</sup> Herman, Michelle. (1 May 2006). A difficult passage: helping youth with mental illnesses transition into adulthood. *National Conference of State Legislatures: State Health Notes*. Accessed 17 July 2008. <http://www.ncsl.org/programs/health/shn/index.htm>

<sup>54</sup> Herman, Michelle. (1 May 2006). A difficult passage: helping youth with mental illnesses transition into adulthood. *National Conference of State Legislatures: State Health Notes*. Accessed 17 July 2008. <http://www.ncsl.org/programs/health/shn/index.htm>

***Recommendation 21***

**Benchmark successful approaches to serving the needs of transitioning youth.**

**e. Prevention and Early Intervention**

We have learned that prevention programming for youth includes, but is not limited to:

- **AI's Pals:** a resiliency-based prevention curriculum and teacher training program that develops personal, social, and emotional skills in children three to eight years old.
- **Girl Power:** a nationally-recognized program developed by the CSB for girls ages nine to 13 which teaches mental health promotion by skill building groups and activities, community service projects and alternative activities.
- **Leadership and Resiliency:** a nationally-recognized licensed model program developed by the CSB for 14 to 18 year old high school students, which enhances resilience by teaching about goal setting, healthy relationships, and coping strategies, while preventing involvement in substance use and violence.
- **Signs of Suicide (SOS):** a program which teaches high school age youth how to identify symptoms of depression, self-injury, and suicidality in themselves or their friends and to respond effectively by seeking help from a trusted adult.

Additionally the CSB funds and partners with Fairfax County Public Schools (FCPS) to provide Student Assistance Programs (SAP), a comprehensive model for the delivery of prevention, early-intervention and support services. Student assistance services are designed to reduce student risk factors, promote protective factors, increase asset development, and create a bridge to more intensive services if needed. CSB staff coordinate a team of key school employees who develop interventions to help students achieve academic success.

We applaud these efforts which focus on the county's children and youth, and believe that all mental health services must be built around the premise that prevention is a fundamental role of every provider in the system. Prevention and early intervention must permeate the culture throughout the entire mental health system.

***Recommendation 22***

**Shift the organizational culture as needed to assure that the system:**

- **works to prevent the onset of disorders**
- **reaches individuals in need, or at risk, long before they seek emergency care**

### **3. PEERS**

“Peer” refers to an individual who publicly acknowledges that he/she has a mental illness and has used or is using mental health services. “Peer services and supports are, by their very nature, recovery oriented, as these services and supports engender empowerment and are based on the principles of self-determination”.<sup>55</sup> “An underlying assumption here is that there is value added to any service or support provided by someone who discloses his or her own recovery journey, as such disclosure serves to combat stigma and inspire hope”.<sup>56</sup>

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<sup>55</sup> Corrigan, W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 359.

<sup>56</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (May 2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 10.

## **a. Peers as Support**

Peers can boost performance and outcomes as they:

- reach out and engage people reluctant to use behavioral health services,
- work alongside professional staff to provide evidence to service providers that people can and do recover,
- free up professional staff to do other tasks that can be done only by professionals because of licensing issues and regulations, and
- add their first-person knowledge and stories of recovery to the service mix.<sup>57</sup>

Utilization of peers imbeds the principles of a recovery- and resilience-oriented environment. We believe the system will have achieved significant progress towards a recovery- and resilience-oriented system when peers are present in every part of the organization. The Commission envisions the use of peers as support: at the point of access, in emergency and crisis situations, for care coordination (case management), in jails and hospitals, for those transitioning back to the community after hospitalization, and to families of children and youth.

### ***Recommendation 23***

**Assure that peer services and supports permeate the mental health system.**

## **b. Peers as Employees**

Some mental health systems hire peers in their existing positions. The terminology “personal experience preferred” or “lived experience preferred” in position advertisements sets the tone

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<sup>57</sup> Ashcraft, L., Ph.D. and Anthony, W., Ph.D. (May 2007). The Value of Peer Employees. Behavioral Healthcare. 27(5), 8-9.

that personal experience with mental health is viewed as an asset, not a deficit. Furthermore, viewing a person's lived experience with mental disability as an additional qualification during the hiring process would set an organizational precedent that reduces stigma.

**Recommendation 24**

**View personal experience with mental illness as an asset when recruiting applicants for positions.**

**c. Peer-Operated Service**

As noted in the Recovery-Oriented Accomplishments section of this report, the CSB worked with individuals receiving mental health services to establish three Drop-in Centers. Drop-in centers are one example of peer-run or peer-operated services, where individuals with mental illness plan, operate, administer, deliver, and evaluate the services. The services are provided within a formal organization which “conforms to peer values of freedom of choice and peer control”.<sup>58</sup> Peer-operated services are especially valuable in the community as they tend to attract peers from ethnic minority groups<sup>59</sup>, dually diagnosed individuals<sup>60</sup>, and peers who are hesitant to utilize the formal mental health system<sup>61</sup>.

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<sup>58</sup> Corrigan, W., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 372.

<sup>59</sup> Davidson et al. (1999). Peer support among individuals with severe mental illness: A review of the evidence. *Clinical Psychology Science and Practice*, 6, 165-187. Cited in Corrigan et al, (2008), *Principles and Practices of Psychiatric Rehabilitation*, 373.

<sup>60</sup> Segal. (1995). Characteristics and service base of long-term members of self-help agencies for mental health clients. *Psychiatric Services*, 46, 269-274. Cited in Corrigan, *Principles and Practices of Psychiatric Rehabilitation*, 373.

<sup>61</sup> Hodges et al (2003). Use of self-help services and consumer satisfaction with professional mental health services. *Psychiatric Services*, 54, 1161-1163. Cited in Corrigan, *Principles and Practices of Psychiatric Rehabilitation*, 373.

Peer-operated services are unique because programs are planned, delivered, and evaluated by persons who have experienced, or currently are experiencing, psychiatric disorders. The Commission strongly believes that these individuals bring an important point of view and invaluable lived experience to their work with persons currently struggling with mental health issues. Peer-operated programs enable those with lived experience to share their stories with others and use their own experience to offer guidance, support, and assistance to others.

***Recommendation 25***

**Continue support of Drop-In Centers.**

**d. Peer Training**

The use of peers in the provision of mental health services has many benefits, but does require a number of unique support systems in order to be as successful and purposeful as possible. These support systems include the proper training and quality supervision of peers, an atmosphere that is friendly and accepting towards individuals receiving services, and opportunities for discussion among peer and non-peer providers.<sup>62</sup> The Commission strongly believes in the use of peers in the recovery process, but acknowledges that some of these supports are lacking in the Fairfax-Falls Church area. One challenge is that peer training programs are not available locally, making it time-intensive and expensive for peers to get the training they need. Peer training programs, such as the Peer-to-Peer education course offered by the National Alliance on Mental Illness (NAMI),

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<sup>62</sup> Carlson, L., M..S.W., Rapp, C., Ph.D., McDiarmid, D., M..S.W (June 2001). Hiring Consumers-Providers: Barriers and Alternative Solutions. *Community Mental Health Journal*, 199-213.

could be brought to local colleges so that willing peers can get the training they need.<sup>63</sup> As the Northern Virginia Regional Recovery plan also recognized the need for local training opportunities, it is possible that more training options will become available in the years to come, in which interested Fairfax-Falls Church individuals could participate.<sup>64</sup> As the Fairfax-Falls Church mental health system expands in its utilization of peers, more training opportunities will be needed. The Commission would also encourage the county to explore the possibility of establishing a local institute to provide training, ongoing education, and a continual support network for peers serving in the community.

**Recommendation 26**

**Assure training opportunities for persons interested in offering peer support.**

**e. Office of Consumer and Family Affairs**

Because we believe that persons with psychiatric disorders and their families should be involved in all aspects of CSB services, we support the establishment of an Office of Consumer and Family Affairs, which is already underway. This office will be a resource to individuals, families, and staff in system transformation, service quality assurance, and the leadership and engagement of individuals receiving mental health services.

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<sup>63</sup> National Alliance on Mental Illness. (n.d.) Peer-to-Peer: NAMI's Recovery Curriculum. Accessed 27 Jun 2008. <http://www.nami.org/>.

<sup>64</sup> The Northern Virginia Regional Strategic Planning Partnership. *Recovery Services Funding Application FY 07-08*. 11.

We agree with the National Association of State Mental Health Program Directors that a core element of a successful Office of Consumer Affairs is that its “establishment, planning, and hiring must be supported by and involve consumers”.<sup>65</sup>

*Recommendation 27*

**Support the establishment of an Office of Consumer and Family Affairs.**

## C. TRANSFORMATION ROADMAP

We have assessed the current system against our recommended service delivery design. As compared with the current system, the model we propose is more business-focused and has a greater emphasis on maximizing revenue, measuring results or outcomes, and stressing productivity. Our recommended strategies to achieve the transformation include: financing strategies to optimize resources, outcomes and performance measures, and key supports for governance/leadership, workforce, and technology.

### **1. FINANCING STRATEGIES TO OPTIMIZE RESOURCES**

The Code of Virginia defines three types of community services boards: **administrative policy**, **operating**, and **policy-advisory** boards. Fairfax-Falls Church has an **administrative policy** board that was established to set policy for, and administer the provision of, mental health, mental retardation, and substance abuse services. Services are provided through local

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<sup>65</sup> NASMHPD. Core elements of a successful office of consumer affairs. Accessed 14 July 2008. [http://www.nasmhpd.org/general\\_files/CORE.HTM](http://www.nasmhpd.org/general_files/CORE.HTM)

government staff or through contracts with other organizations and providers. Financing options may differ based on the type of board.

Fairfax County's overriding interest is to assure the provision of appropriate services and supports to residents with psychiatric disabilities in order to promote recovery and resilience. As the county grows in population and complexity, it becomes obvious that the most advanced policies and procedures for increasing revenues must be utilized, and measures of efficiency and results must become drivers in the operations of the system.

After consideration of the current financing of the CSB, the Commission recommends the following financing strategies:

**a. Maximize Non-Local Revenue**

County general funds contribute 67% of funding for CSB's mental health services. The CSB should maximize existing federal and state safety net revenue and track progress in this area.

In Virginia, 50% of adults receiving mental health services are enrolled in Medicaid; within the Fairfax-Falls Church CSB, however, the Medicaid enrollment rate is only 33%. We believe that the CSB can improve this rate to match, and perhaps exceed, the state enrollment rate.

In order to maximize revenue and reimbursements from Social Security Income (SSI) and Social Security Disability Income (SSDI), the Commission encourages Fairfax County to work to increase access to Social Security benefits for its homeless population. It is important to reach the county's homeless population because 72% of homeless individuals were identified in a 2008 Point in Time

Survey as having serious mental illnesses and/or substance abuse disorders, which may qualify them for SSI or SSDI.<sup>66</sup>

Social Security Benefits: Outreach, Access, and Recovery (SOAR) is a program for people who are homeless that is supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the Health Resources and Services Administration which might enable the county to achieve increased access. SOAR helps states and communities “develop strategies and provide training to case workers who counsel individuals in preparing accurate and complete SSI or SSDI applications”.<sup>67</sup>

**Recommendation 28**

**Maximize revenue from Medicaid and other entitlements for individuals receiving mental health services, including Medicare, State Children’s Health Insurance Plans (S-CHIP), CSA, Supplemental Security Income (SSI) and Social Security Disability Insurance (SSDI) to complement local, state, and federal grant/tax dollars.**

**b. Maximize Grant Opportunities**

We recommend a strategic approach in seeking grant funding, to include adequate planning in order to assure the CSB’s readiness to take on and sustain the work.

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<sup>66</sup> Fairfax County Department of Systems Management for Human Services. (Mar 2008) *2008 Point in Time Survey Summary Report*, Fairfax-Falls Church Annual Homeless Count. 6. Accessed 17 June 2008. <http://www.fairfaxcounty.gov/homeless/>.

<sup>67</sup> Clay, Rebecca A. (Mar/Apr 2007) Social Security Benefits: Outreach, Access, and Recovery. *SAMHSA News*. Accessed 8 July 2008. [http://www.samhsa.gov/samhsa\\_news/VolumeXV\\_2/article1.htm](http://www.samhsa.gov/samhsa_news/VolumeXV_2/article1.htm)

***Recommendation 29***

**Maximize opportunities for grant funding and assure that the CSB is prepared to sustain initiatives which are originally financed by grants after the grant money is depleted.**

**c. Maximize Philanthropic Endeavors**

A robust system of mental health care would require the collaboration of public, private, and nonprofit service providers and utilization of all funding streams. Private philanthropic donations are one important aspect of overall funding and there are a number of different ways to maximize the philanthropic initiatives within the community. These strategies include: exploring the establishment of a foundation, facilitating development of privately-funded organizations, and creating a housing development fund.

**i. Foundation**

Virginia Code would allow Fairfax County to establish and operate a foundation as a regional entity. The purpose of establishing an outside foundation is to receive private contributions for which only 501(c)(3) entities are eligible (monies for which Fairfax County government organizations, including the CSB, are not eligible). The foundation would function as a repository for funds, increase opportunities for working with other foundations such as the Greater Washington Council on Foundations, and work to develop public and private partnerships and resources that will promote and assure an accessible, affordable, and integrated mental health system for Fairfax-Falls Church area residents.

We understand that there are similar nonprofit charitable organizations such as CareFaxLTC (long term care) and Fairfax Futures (early childhood education) with strong commitments to

targeted county populations. We believe creation of a foundation would help facilitate support from the county's large and diversified business community.

***Recommendation 30***

**Explore the establishment of a foundation whose purpose would be to assure an accessible, affordable, and integrated mental health system.**

**ii. Privately-funded organizations**

Privately-funded service delivery organizations, as well as the creation of new privately-funded service delivery organizations, create increased community capacity to deliver mental health services and supports. Privately-funded organizations also represent another mechanism to generate financing through the fees they charge, the grants they receive, the contracts into which they enter, and the charitable donations they receive.

***Recommendation 31***

**Facilitate development of new, and continue to utilize existing, privately-funded organizations.**

**iii. Housing development fund**

A tool that may aid in the housing specific recommendations of this report is the establishment of a fund that is dedicated to housing for persons with psychiatric disabilities. Financing mechanisms that could be explored to establish this housing development fund include, but are not limited to, proceeds from zoning proffers, general fund appropriation transfers, and grant money.

***Recommendation 32***

**Create a housing development fund to support housing for persons with psychiatric disabilities.**

**d. Safety Net Enhancement**

As noted in the Primary Health Care section of this report, we support the modification of the status of the county's primary care centers to Federally Qualified Health Center (FQHC) Look-Alike. This would allow the county to establish Medicaid reimbursement rates directly with the federal government, which would cover the cost of services rendered and thereby leverage Medicaid dollars to increase access to behavioral health care. While modification to FQHC Look-Alike status would enhance the safety net, there would still be individuals unable to access behavioral health care because they have neither Medicaid coverage nor private insurance. The Commission therefore recommends that Fairfax County explore, perhaps through the Fairfax Health Safety Net Commission, the possibility of a locally-developed, group health insurance plan. This would require collaboration with the Commonwealth of Virginia, small businesses, hospitals, private insurance companies, and nonprofit organizations.

***Recommendation 33***

**a. Utilize Medicaid resources to finance the delivery of mental health services in a primary care setting.**

**b. Explore the possibility of a locally-developed group health insurance plan.**

## **2. OUTCOMES AND PERFORMANCE MEASURES**

Individual and system outcomes and performance measures are a key component of the framework or foundation for our system design recommendations. We began work on this deliverable by reviewing the National Outcome Measures (NOMs) developed by the Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services. To develop these measures, SAMHSA worked with state mental health authorities, individuals receiving mental health services, and family members. Example NOMs include increased Access to Services, Employment, and Stability in Housing.

To assure that we had the benefit of the latest research, we commissioned Mary Smith, Ph.D., to develop an up-to-date compendium of outcome and performance measures for mental health. This work, along with input provided by Ron Manderscheid, Ph.D., and Trevor Hadley, Ph.D., served as a base for our recommendations.

In developing our recommendations for this deliverable, we considered measures that have been broadly adopted and implemented in the public mental health sector, yet focused on some initial goals and measures specific to Fairfax County. This would enable the CSB to compare performance by benchmarking performance indicators of other comparison groups. In addition to selecting indicators of performance that can be easily benchmarked, we believe it will be critical to set realistic and achievable targets for each measure.

While there are multiple audiences for performance measures, our recommendations focus on availability of data for decisions by those who drive the system (mental health leaders, Community Services Board members, the Deputy County Executive for Human Services, and the Fairfax County Board of Supervisors). We envision a "dashboard" of measures selected as

indicators of system performance. The system will measure many aspects of performance but for this dashboard, we recommend more selectivity in order to focus on those indicators of performance that are key to transforming the system. This system of measures would be facile enough to provide timely input to system leaders and decision makers. In keeping with the value of transparency, we recommend that these key indicators be publicized to system stakeholders.

**Recommendation 34**

**Adopt a robust system of performance measures (as identified below) and ensure performance data is used to improve effectiveness.**

The following goals and measures are the initial performance outcome measures for:

- Strengthening living, learning, working, social connectedness and supports for individuals receiving mental health services to live self-determined and productive lives;
- Meeting access to service standards;
- Measuring adult, children, youth, and their family's satisfaction with services received;
- Reducing uncompensated care;
- Measuring the transformation of the service delivery system to a strengths-based, and recovery-and resilience-oriented model for delivering services, and
- Supporting the current strategic plan for transforming the Children and Youth Systems of Care under CSA.

Data in support of these goals and measures can be collected from surveys completed by individuals receiving services and information collected in data elements contained in the CSB's Management Information System (MIS). Modifications to the MIS will be made to collect

information needed for measures related to some of the transformation goals for the system of care.

Information gathered from these measures will be published in the CSB's Dashboard, communicated to stakeholders, individuals receiving services, and providers, and will be used as needed for continuous quality improvement initiatives for enhancing service delivery and business practices.

### **Overview of Dashboard Measures**

It is recommended that the following measures be included in the initial dashboard of measures:

1. Percentage of adults indicating they are participating in the design and implementation of their service plan
  - Percentage as of September 30, 2008, once initial individual service plan is designed and signed
  - Target: 100% by September 30, 2009
2. Percentage actively participating in the annual review of their service plan
  - Percentage as of September 30, 2008 with a signed service plan
  - Target: 100% by September 30, 2009
3. Percentage of adults reporting positively about social connectedness at admission and discharge
  - Measure under development using SAMHSA Social Connectedness Scale
  - Target: TBD
4. Percentage of individuals served involved (incarcerated) with the criminal justice system at admission and at discharge
  - Number of adults and youth incarcerated as of September 30, 2008
  - Target: Reduce by 25%

- Adults involved with jail diversion program in adult detention center (ADC)
- Youth involved with prevention programs in juvenile detention center (JDC)
- Link individuals in ADC, JDC with staff assigned to the ADC and JDC for crisis intervention, education-prevention, and a case manager upon release from the ADC and JDC in effort to reduce recidivism

5. Percentage of individuals with a medical home

- Presence or absence of a medical home at admission
- Target: 100% of individuals served have a medical home, including access to general medical, vision, and dental services

6. Number of individuals served moving from housing waitlist to housing

- CSB waitlist for housing as of September 30, 2009
- Target: TBD

7. Percentage of adults employed at admission and at discharge

- Percentage as of July 30, 2008
- Target: 22%

8. Percentage of adults receiving mental health services who receive an appoint with the Access Unit within ten business days of their first call for service

- Percentage as of July 30, 2008
- Target: 100%

9. Percentage of youth who receive an intake appointment within five business days of their first call for service

- Percentage as of July 30, 2008
- Target: 100%

### **Overview of All Initial Measures**

The following information outlines the overall initial recommended goals and measures related to individuals served, transformation of mental health services and programs to a recovery- and resilience-based system of care, meeting service access standards/benchmarks, and reduction of uncompensated care. Some of these goals, measures and indicators are included in the CSB's Transformation Dashboard. All goals and measures will be collected and

evaluated with implications for continuous improvement planning relative to the overall goals for the system of care.

**Goal: Strengthen living, learning and working skills and supports for living self-determined and productive lives**

Adult Measures: Sampling of individuals receiving outpatient or residential services

- Percentage of adults employed at admission and discharge
- Percentage of adults reporting positively about social connectedness at admission and discharge
- Percentage of adults with a Medical home (including vision and dental care) upon admission and discharge
- Percentage of adults involved with criminal justice system at admission and discharge: decreased criminal justice involvement
- Percentage of individuals moving off the CSB housing waitlist into housing: annually

Youth and Family Measures: Sampling of individuals receiving outpatient, day treatment and in-home services

- Percentage of youth attending school at admission and discharge
- Percentage of youth living in the community at admission and discharge
- Percentage of youth with a Medical home upon admission and discharge
- Percentage of youth involved with juvenile justice system at admission and discharge

**Goal: Meet Access to Service Standards**

Adult Measures:

- Percentage of non-emergency outpatient appointments kept by individuals within seven business days from hospital discharge

- Percentage of individuals who receive an appointment with the Access Unit within ten business days of their first call for service
- Percentage of no shows for initial appointments
- Percentage of direct service staff meeting CSB performance standards of hours of services provided and number of individuals served

Youth and Family Measures:

- Percentage of youth who receive an intake appointment within five business days of their first call for service
- Percentage of non-emergency outpatient appointments kept by individuals after first contact within ten business days
- Percentage of direct service staff meeting CSB performance standards of hours of services provided and number of individuals served

**Goal: Increase satisfaction of adults receiving mental health and substance abuse outpatient services. Increase youth and family satisfaction with youth services and programs.**

Adult Measure:

- Percentage of individuals reporting positively about their experience via annual surveys
- Quarterly Sampling of Satisfaction surveys after most recent appointment

Youth and Family Measure:

- Percentage of individuals reporting positively about their experience via annual surveys
- Quarterly Sampling of Satisfaction surveys after most recent service appointment

**Goal: Reduction of Uncompensated Care**

Adult Measures:

- Become a Community SSI Initiative Partner under the federal program SOAR (SSI/SSDI Outreach, Access, and Recovery) which will expedite disability determination for homeless population, which will translate into Medicaid reimbursement of CSB services.
- Percentage of adults using Medicaid funds to access mental health services
- Percentage of adults using Medicaid Part D funds to access mental health services
- Ensuring proper documentation for billing Medicaid services

Youth and Family Measures:

- Percentage of children and youth with Medicaid
- Percentage of children and youth in State's Children Health Insurance Program (S-CHIP)
- Ensuring proper documentation for billing Medicaid services
- Maximizing all funding streams

**Goal: Transformation of mental health services and programs to a recovery- and resilience-based system of care**

Adult Measures - ratings from selected items listed below from the ROSI:

- My treatment plan goals are stated in my own words
- Staff do not use pressure, threats or force in my treatment
- Staff treat me with respect regarding my cultural background
- Staff give me complete information in words I understand before I consent to treatment and medication
- There was not a consumer peer advocate to turn to when I needed one
- I do not have enough good service options to choose from

- Staff sees me as an equal partner in my treatment program
- Overall ROSI Profile

Youth and Family Measures - ratings from selected items from the State Youth and Family Survey, and from the survey George Mason University developed for the CSB:

- Youth & family members treated with respect by program staff
- Youth & family members feeling welcomed and comfortable by reception staff
- Youth and family members reporting staff discussed what's important to them
- Youth and family members receiving information about medication
- Youth and family members accessed needed services to help maintain the youth in the home and community

**Goal: Youth and Family Community Based Treatment and Outcomes under Development by the Comprehensive Services Act (CSA)**

Youth and Family Proposed Measures Under Development

- Access to youth system of care
- Access to Primary Healthcare
- Criminal Justice Involvement
- School Performance
- Children need to be present in treatment meetings—within school system
- Stability at Home/Community
- Improved child and family functioning
- Improved parenting skills
- Suspensions/expulsions, school attendance over enrollment
- Increased school attendance
- Access to services for youth who are homeless

- Access to services for children with a parent who has a mental illness and/or substance use disorder
- Access to services for foster care parents

### **3. KEY SUPPORTS FOR TRANSFORMATION**

As outlined below, a successful transformation towards a recovery- and resilience-oriented system requires visionary leadership, a workforce that embraces the principles of recovery and resilience, and technical supports to increase system efficiency and productivity.

#### **a. Governance and Leadership**

“The vision of a transformed mental health system has created a national imperative to recognize the importance of effective leadership in initiating change and sustaining each step towards making the vision a reality”.<sup>68</sup> It is the governance (i.e., CSB board) of the system that will oversee movement of the CSB from vision to results. Effective governance holds the system accountable for outcomes. Transformational leadership (at all levels) sets the organizational tone and works to ensure the organization sustains and attains the vision.

#### **i. Board Structure and Competencies**

The CSB board is currently structured by the disability areas which provide services—mental retardation, mental health, and alcohol and drug services. The Commission encourages the board to move away from this segregated structure as we believe these divisions promote separation

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<sup>68</sup> SAMHSA. (2005 May-June). Leadership is Everyone’s Business. *Mental Health transformation trends*. 1(2), 5. Accessed 16 June 2008. <http://www.samsha.gov/>

instead of integration of services. We acknowledge that the disability structure may promote advocacy efforts; however, advocacy is only one role of the CSB board, among many others, including management of the business of service delivery. The Commission recommends that the CSB board work with the Deputy County Executive for Human Services, the County Executive, and the Human Services Committee of the Board of Supervisors to assure a board structure that promotes service integration and system effectiveness.

***Recommendation 35***

**Review and, as needed, restructure the CSB board to promote service integration and system effectiveness.**

To further promote service integration and improve effectiveness, we believe the skill set of the CSB board should be broadened. Competencies and skills that reflect the needed roles of the board must be sought as new members are appointed. A recovery- and resilience-oriented board will require competencies such as business acumen, systems thinking, strategic planning, and outcome measurement to assess system performance in serving youth, adults, and families.

***Recommendation 36***

**Broaden the skill set of the CSB board as new members are appointed to reflect needed competencies for governance.**

**ii. CSB Leadership Competencies, Development and Accountability**

As new leaders are chosen, the CSB must hire or promote individuals who possess leadership attributes that are consistent with the vision of a recovery- and resilience-oriented system.

Inherent in the philosophical shift to a more business-focused model is the need for business management skills at all levels of leadership.

***Recommendation 37***

**Assure that leadership positions are filled by individuals who possess leadership attributes that are consistent with the vision of a recovery- and resilience-oriented system.**

To successfully imbed a recovery-and resilience-oriented philosophy throughout the system, leadership development, including a drive to be more innovative and creative at all levels, needs to be part of the DNA of the organization. We understand that the county has invested in a leadership/management development program which focuses on personal competencies needed to realize vision-driven, values-based organizations. We encourage the CSB to take full advantage of this program, and to imbed its principles in the work culture. Effective succession planning will include this development program and mentoring to assist staff in evolving into leadership roles.

***Recommendation 38***

**Provide ongoing leadership development.**

Leadership and accountability are essential ingredients for sustainable change. Leaders must embrace accountability and establish clear systems for checking progress throughout the system. Similarly, there must be a mechanism for assessing the effectiveness of leadership.

**Recommendation 39**

**Assure a mechanism for accountability of leaders.**

As a final note on governance and leadership, we believe that movement towards independence can apply to systems as well as individuals. Parallel to the development of self-reliance and independence of individuals with mental illness is the enhancement of self-reliance and independence of system leadership. As leaders adopt a more business-focused model of service delivery (which maximizes revenue, measures results, and incentivizes productivity), there would be reduced system dependence on local tax dollars.

**b. Workforce**

As the system shifts to a transformed culture focused on recovery and resilience, new and different competencies are required. This shift necessitates a transformed approach to recruiting, retaining, and training the behavioral health care workforce.

SAMHSA commissioned the Annapolis Coalition to develop a national strategic plan on workforce development. Strategic goals in this national plan focus on broadening the concept of the workforce, strengthening the workforce, and instituting structures to support the workforce.<sup>69</sup>

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<sup>69</sup> The Annapolis Coalition on the Behavioral Health Workforce for SAMSHA. (2007). An action plan for behavioral health workforce development: a framework for discussion. pp. 2-3, 13-14. Accessed 17 June 2008. <http://www.samsha.gov/workforce/annapolis/workforceactionplan.pdf>

### **i. Staff Competencies**

Competency identification, development, and assessment are receiving increased attention in all areas of health care, including behavioral health. “This trend is driven by the compelling notion that, for a field to advance, there must be more precision in specifying the optimal attitudes, knowledge, and skills of the workforce”.<sup>70</sup> Additionally, linguistic competency—or the communication of information in a manner that is easily understood by diverse audiences including the deaf population as well as persons of limited English proficiency, low literacy skills, and/or linguistic disabilities—is becoming an essential trait for providers in today’s behavioral health care workforce.<sup>71</sup>

Once competencies unique to a recovery- and resilience-oriented system “have been identified, the objective is to build them into the workforce [through ongoing competency-based education/training] and to demonstrate, using various assessment strategies, that the competencies have been acquired by individual providers”.<sup>72</sup>

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<sup>70</sup> The Annapolis Coalition on the Behavioral Health Workforce for SAMSHA. (2007). An action plan for behavioral health workforce development: a framework for discussion. 120. Accessed 17 June 2008. <http://www.samsha.gov/workforce/annapolis/workforceactionplan.pdf>

<sup>71</sup> Bronheim, S., Goode, T., and Jones, W. (Spring 2006). Rationale for Cultural and Linguistic Competence in Family Supports. *Policy Brief: Cultural and Linguistic Competence in Family Supports*. 4. Washington, DC: National Center for Cultural Competence, Georgetown University Center for Child and Human Development.

<sup>72</sup> The Annapolis Coalition on the Behavioral Health Workforce for SAMSHA. (2007). An action plan for behavioral health workforce development: a framework for discussion. 120. Accessed 17 June 2008. <http://www.samsha.gov/workforce/annapolis/workforceactionplan.pdf>

***Recommendation 40***

**Assure that staff competencies reflect and support the vision and values of a recovery- and resilience-oriented system.**

**ii. Productivity Standards**

Productivity can be incentivized by building productivity measures into the county's pay for performance system. These productivity standards would be established through benchmarking other system standards, and conversations with staff and individuals receiving mental health services. These standards would be periodically re-evaluated to assure that they are reasonable, but challenging. These standards will also be affected by advances in technology which impact the work.

***Recommendation 41***

**Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards.**

As a final note, in a transformed system that operates according to the values and beliefs established by the Commission, we believe that staff who have experienced mental illness should feel safe identifying their disability, and find comfort in the knowledge that they will be treated as an asset to the organization because of their personal experience. Individuals who choose to self-disclose their history of mental illness are expected in, and evidence of, a recovery-and resilience-oriented system. In a transformed system, staff will understand the purpose and importance of being up-front about their own lived experience, and will recognize that, by

sharing their story, they are helping to reduce the stigma surrounding mental illness and providing invaluable support to other individuals.

### **iii. Workforce Planning**

The design elements of this system transformation require increased emphasis on care coordination (case management) and peer support. To accomplish this transformation, the agency needs flexibility in the workforce planning process to create and reallocate positions as necessary to meet the changing needs of individuals receiving mental health services. This will include the provision of new positions when funding to cover the costs is within the CSB budget.

#### ***Recommendation 42***

**Create, within the defined budget, flexibility to authorize and reallocate positions in order to respond to the needs of individuals receiving mental health services.**

### **iv. Transportation Support**

Care coordination (case management) is the core of an improved system of mental health care in Fairfax County. The objective of recovery requires that persons are served in their natural communities, assisted in developing daily life strategies, and supported prior to a crisis. Both emergency and care coordination staffs need the capacity to be mobile and responsive.

Ideally, the CSB would have a fleet of vehicles with take home privileges for those staff whose need for mobility is clear. Less ideally, the County would develop a mechanism to assist the staff in obtaining the appropriate insurance coverage on their private vehicles. Some options include: the county purchasing an appropriate rider, making the purchase of additional insurance a

reimbursable expense, or, at minimum, increasing the mileage rate for community transportation so that staff are able to purchase coverage individually.

**Recommendation 43**

**Enable persons to be served in their natural communities by assisting staff in transportation needs.**

**c. Organizational Culture**

Establishing a recovery- and resilience-oriented work culture involves a creative mix of risk acceptance and mutual respect for fellow employees and all those who are served.

**i. Innovation and Respect**

According to the National Institute of Health, an idea is “innovative” if it “challenges existing paradigms or clinical practice, addresses an innovative hypothesis or critical barrier in the field, [and/or] develops or employs novel concepts, approaches, methodologies, tools, or technologies”.<sup>73</sup> A work environment that encourages recovery demands innovation and requires innovative thinking at all levels of the organization.

A risk-averse environment is not compatible with the values or beliefs of a transformed, recovery- and resilience- oriented mental health system. Staff in a risk-averse system are often

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<sup>73</sup> Division of Services and Intervention Research and Division of Extramural Activities of the National Institute of Mental Health. (17 Oct 2005) Innovation in Mental Health Research: What? How? How Much? Potomac, MD. Accessed 15 July 2008. <http://www.nimh.nih.gov/research-funding/scientific-meetings/2005/>

anxious that they will be blamed if things go wrong and are therefore reluctant to take initiative.<sup>74</sup> Even with “the best of intentions, providers [can] act in a controlling and limiting fashion, offering a limited menu of choices for action that appear to be reasonable and protective”, but which leave the individual feeling constrained and limited.<sup>75</sup> To assure an environment where innovation is welcomed and expected, the CSB board and leadership must support staff and continually encourage them to pursue innovative treatment options.

We recognize that innovation increases risk. However, because most individuals without psychiatric disabilities “learn and grow from taking risk and learning from both their successes and failures”, we believe that a person-centered approach to mental health care should allow individuals on the road to recovery the same opportunities.<sup>76</sup>

**Recommendation 44**

**Encourage and recognize creativity and innovation while balancing risk with results.**

In our values we emphasized the need, in a transformed system, to honor the unique preferences, strengths, and dignity of each person. While we believe it is critical that respect be demonstrated to all individuals receiving services, we also believe that a culture of mutual respect among those providing services is a key element of this transformation. Respect amongst

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<sup>74</sup> Campling, Penelope, Davies, Steffan, and Graeme Farquharson. (2004) *From toxic institutions to therapeutic environment: residential settings in mental health services*. London: Gaskell. 179.

<sup>75</sup> Adams, Neal, and Diane M. Grieder. (2005) *Treatment planning for person-centered care: the road to mental health and addiction recovery*. Burlington, MA: Elsevier Academic Press. 150.

<sup>76</sup> Adams, Neal, and Diane M. Grieder. (2005) *Treatment planning for person-centered care: the road to mental health and addiction recovery*. Burlington, MA: Elsevier Academic Press. 150.

providers, and mutual encouragement, is especially important in transformed mental health system, as courage and excitement will be needed to pursue innovative treatment options.

**Recommendation 45**

**Foster a culture of respect in all relationships.**

**ii. System Language**

“Creation of a recovery-oriented system of care requires behavioral health care practitioners to alter the way they look at persons with mental illness and addiction, their own roles in facilitating recovery from these conditions, and the language they use in referring to individuals they serve”.<sup>77</sup>

“ ‘Person first’ language is used to acknowledge that the diagnosis is not as important as the person’s individuality and humanity, e.g., ‘a person diagnosed with schizophrenia’ versus ‘a schizophrenic’”.<sup>78</sup> Person-first language recognizes that the person to whom one is referring is firstly a multidimensional human being like everyone else, and secondarily, has a disability with which he or she is dealing. Employing person-first language does not mean that a person’s diagnosis is hidden or seen as irrelevant; however, it also is not the sole focus of any description about that person.<sup>79</sup> The intentional use of person-first language helps to promote an environment

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<sup>77</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 97.

<sup>78</sup> Tondora, J., Pocklington, S., Gorges, A., Osher, D., and Davidson, L. Yale Program for Recovery and Community Health. (2005). Implementation of person-centered care and planning: how philosophy can inform practice. 6.

<sup>79</sup> Tondora, J., Pocklington, S., Gorges, A., Osher, D., and Davidson, L. Yale Program for Recovery and Community Health. (2005). Implementation of person-centered care and planning: how philosophy can inform practice. 6.

in which people with mental illness are valued, motivated to gain hope for the future, and reach their goals.

**Recommendation 46**

**Promote person-first language that is consistent with a recovery- and resilience-oriented system of care.**

Other changes in system language may promote changes in thinking and practice. For example, the titles of Care Coordinator, Recovery Guide<sup>80</sup>, or Recovery Support Specialist may be more strengths-based, recovery- and resilience-oriented alternatives to the title of Clinical Case Manager when referring to those providing service.

**c. Technology**

The successful implementation of changes to programming, structure, and philosophy identified in this report is critically linked with the leveraging of appropriate technology solutions. Technology can bring alive the set of values established by this Commission, affording the opportunity to improve efficiency, facilitate access to services and information, provide data for measuring effectiveness, and promote transparency and participation. More specifically, efficiency gained through the real time entry of information via a variety of hardware into an electronic health record rather than on paper, or paper to electronic transfer, ensures that information is available across physical sites and between CSB providers of service. For the individuals receiving service, the end result is better coordination and quality of care, not to mention the efficiency gained by

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<sup>80</sup> Davidson, L, Tondora, J., Staeheli M., O'Connell M., Frey, J., & Chinman, M. (2003). Recovery guides: An emerging model of community-based care for adults with psychiatric disabilities. 4. In Lightburn, A., & Sessions, P. (Eds.) *Community Based Clinical Practice* (pp. 476-501). London: Oxford University Press.

not having to reiterate information already provided (both clinical and administrative). Likewise, for staff it affords the opportunity of time savings and enhanced decision support. Data that is generated on service type and amount can be utilized to review what is being provided up against demand and need, evaluate productivity and realign resources as needed. Having information available on outcomes and productivity on a regular basis is itself an important management tool for system improvement.

Across the nation, technology is playing an increasingly important role in the delivery of health care, behavioral health care and most significantly, the integration of the two. Key to this are ePrescribing, the electronic health record (EHR) and the personal health record (PHR) that support health information exchange (HIE), and supportive technologies that improve the efficiency and quality of service. An EHR is an individual's health record in digital format that is accessed on a computer, often over a network. Typically an EHR is generated by the service provider, while a PHR is maintained by the individual receiving service. A PHR is a vehicle for the individual to organize and retrieve his or her own health information, including emergency contact information, a description of problems, history of treatments, and preferences. The integration of EHR and PHR information promotes a person-centered approach to services. On a larger scale, the EHR and PHR are facilitators of HIE, which is the electronic movement of clinical information between information systems. Ultimately, HIE will improve the safety, efficiency, and effectiveness of services.

The development of an electronic health record and related infrastructures is required by both state (target date for Virginia Health Information Exchange initiative is 2012) and federal initiatives (target date for Federal EHR and Interoperability initiative is 2014) to facilitate the movement of information. The Fairfax-Falls Church CSB has set a goal of full electronic

connectivity by 2010. Anasazi Software, behavioral health care software, was implemented in 1999 as the CSB Electronic Health Record. As a county agency, the Fairfax-Falls Church CSB relies on the county Department of Information Technology (DIT) for infrastructure support of its 1100 staff, more than 80,000 consumer records, connectivity for 75 main sites and additional smaller sites where individuals receiving CSB services reside, as well as policy implementation/guidelines.

Use of a strong EHR, integration of that EHR with a PHR, procurement of state-of-the-art software, and consistent network connections are critical success factors in supporting the CSB's service delivery system. The following basic principles underlie the CSB technology development:

- The Fairfax-Fall Church CSB must meet the federal and state guidelines for implementation of EHR and HIE in a timely manner
- Privacy and confidentiality must be maintained
- The EHR of the CSB should have the capacity for integration with a PHR and meet the needs of individuals receiving services and staff alike
- Adequate infrastructure and staff resources should support the EHR
- The type and implementation of this technology should be consistent with transformation principles
- The use of technology should be embraced and championed by CSB leadership, and understood and supported by county management as well

A critical juncture exists that could be capitalized on. The CSB is facing expensive upgrades to Anasazi Software over the next two years that involve ePrescribing and changes to the Assessment and Treatment Planning module of the product. Newer products on the market have

additional features that would enable the CSB to best support the transformation. In addition, a large number of the CSB's in Virginia are currently evaluating their software systems and, as a result, there is timely information available about these products and their ability to meet the needs of a transforming behavioral healthcare system. Through the county IT funding process, the CSB is currently allocating funds to build additional server capacity to meet an increased user base. The possibility exists that these funds, coupled with the anticipated costs for upgrade, could be redirected into a product that supports the system reform underway. Strategic implementation opportunities, such as hosting the EHR with the vendor, could provide more efficiency and potential better use of county resources.

***Recommendation 47***

**Support improvements in efficiency and recovery through the purchase and support of a new EHR/PHR following county funding and procurement procedures. A very rough estimate for this purchase is a one time cost of approximately \$3M over 3 years.**

To meet the requirements for the future, the EHR software for the CSB should be:

- A Web based application (uses a browser) that is secure, user friendly and intuitive
- Accessible by individuals who receive services to view and update information in the EHR; capable of integration with PHRs maintained by individuals receiving services for self-management
- Capable of health information exchange with other software, including medical practices and laboratories, and meet software guidelines for this interoperability
- ePrescribing capable
- Document management ready, including the scanning and indexing of information generated in paper or coming in electronically and its interface with the CSB EHR

- Structured to integrate data collection and reimbursement functions
- Capable of robust reporting to ensure that information in the system can be reported out and analyzed. This includes producing a dashboard of daily indicators for executive/manager/supervisor/staff
- Includes decision support opportunities that enhance the skills of staff and those receiving services

The first steps to secure this EHR/PHR include the CSB, county staff, and as appropriate outside experts, working together to:

- Assess current support from the county to the CSB for the implementation of the EHR/PHR. Large scale purchases or upgrades of software and related infrastructure are not included in the CSB budget, but rather handled through a process of county prioritization and funding
- Issue a Request for Information (RFI) to assess the availability of EHR software to meet the future needs and requirements of the CSB. The process of review of respondents to this RFI should involve not only the staff supporting the CSB EHR efforts, but also line staff, individuals receiving CSB services, and county IT staff
- In conjunction with this RFI, review the current application used by the CSB and upcoming upgrades to determine the most effective use of the funds to either upgrade or purchase a new software product, as well as the degree to which this application meets the needs of the CSB and those who receive services from the CSB
- Analyze the possibility for hosting the current or future EHR application at the vendor site as an Application Server Provider (ASP) as opposed to within the county to take advantage of more effective back up of the vital information of individuals receiving CSB services, as well as consistency in support for the software

- Identify other hardware and network needs required for the CSB to realize the implementation of a state-of-the-art EHR and PHR, HIE, and adequate support for individuals receiving CSB services through the use of technology

To effectively support this EHR/PHR, the right hardware and infrastructure must be in place.

These items include:

- A system that is available 24/7 with sufficient redundancy to avoid down time.
- Purchasing flexibility to benefit most from state-of-the-art technology (computers, laptops, PDAs)
- Consistent network, regardless of location, that allows quick and remote access
- Public access at CSB sites so that individuals receiving services can access not only the EHR/PHR at a CSB site, but also websites that support their job seeking, information gathering, and connection with others
- Sufficient CSB support staff for ongoing training and real time support to clinical staff
- Service Level Agreement with DIT that supports the ability of the CSB to maintain the EHR, including business continuity

Ultimately it is the right combination of software and hardware and support for system reform that will lead to an increased efficiency of business practice. There are some specific items that when implemented would immediately have a positive impact and these are highlighted below.

Technology can clearly support the move away from an office based approach to service delivery to working in the community. Use of laptops and other similar portable devices would improve the usability of the EHR and maximize its efficiency. Although a transition has occurred

from desk tops to laptops for certain identified positions within the CSB, rapid changes in technology are making available many different options that might prove more efficient and cost effective.

***Recommendation 48***

**Purchase hardware (laptops and similar portable devices) that supports changes in business practice.**

In their daily work, staff encounter technology issues that need to be resolved quickly and efficiently. Support for these issues is frequently slowed by the fact that the CSB is spread out across many sites. The CSB has staff identified by the county as “super users” who could assist with some of these common technical issues with computers and applications.

***Recommendation 49***

**Modify existing IT rules to give permission for administrative rights for desktops, to include laptops, for identified CSB staff.**

The Internet has spawned a wealth of information that is a critical support to individuals receiving mental health services and their families. Websites are helpful in getting information about jobs and living arrangements. Other sites, including the Network of Care, provide opportunities for research on the latest medications, help groups, and connection with others seeking support. Some EHR products currently have methods for individuals receiving services to complete information online as they wait for scheduled appointments. This information is then used to focus the time

with staff, as well as aid in overall decision support. For those individuals residing in CSB facilities, as well as those participating in outpatient activities, access to this type of information where they get service further supports their recovery and resilience. Computers and kiosks at sites, as well as staff computers with both staff and public access capacity, are required to realize this goal.

***Recommendation 50***

**Modify existing IT rules to allow access to public domains at sites for the use of individuals receiving services and purchase computer kiosks for key CSB service sites**

## Beyond the Commission Charter

The following suggestions are outside the scope of, but related to, chartered deliverables:

For continued, lasting reform to be possible, it is imperative that mental health issues are prioritized at all levels of government. The Commission encourages legislative liaison staff from Fairfax County to help develop mental health advocates in the VA General Assembly and the federal delegation.

In support of advocacy efforts already underway in the Federal government, the Commission also encourages the Board to write letters, sign petitions, and make contact with delegates. There is important legislation concerning parity in mental health insurance coverage pending in Congress. The Senate passed its version of the law, the Mental Health Parity Act of 2007 (S.558.RRH) on September 18, 2007.<sup>81</sup> The House of Delegates passed a similar law, the Genetic Information Nondiscrimination Act of 2008 (HR1424) on March 5, 2008.<sup>82</sup> This bill generally requires that health plans which provide mental health coverage offer mental health and substance abuse benefits that are equal to the medical and surgical benefits offered. The benefits controlled by this law include deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. The current presidential administration, health insurers and employers support the

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<sup>81</sup> Govtrack.us. S. 558-110<sup>th</sup> Congress (2007): Mental Health Parity Act of 2007, *GovTrack.us (database of federal legislation)*. Accessed 3 July 2008. <http://www.govtrack.us/>

<sup>82</sup> Govtrack.us. H.R. 1424—110<sup>th</sup> Congress (2007): Genetic Information Nondiscrimination Act of 2008. *GovTrack.us (database of federal legislation)*. Accessed 10 July 2008. <http://www.govtrack.us/>

Senate version of the bill but have concerns about the House version.<sup>83</sup> More work needs to be done to reconcile the two versions of the bill, and the Commission encourages the Board of Supervisors to advocate for continued discussion and action on this bill as it awaits discussion in the joint conference committee.

As the Board finalizes its enhanced safety net system, it may consider raising the income level of those covered by the safety net to include families earning 300% of the Federal poverty level (up from 200%). These new guidelines would mean that families of four earning up to \$63,600 would be included in the health safety net.<sup>84</sup> As a comparison, the 2006 median income level for families in Fairfax County was \$119,800.<sup>85</sup>

Barrier crime laws in Virginia prohibit persons convicted of certain crimes from obtaining employment with certain employers, specifically those employers specializing in the care of particular populations (including children, the elderly, and those with psychiatric disabilities). As many persons with psychiatric disorders encounter the criminal justice system during their lives for various crimes, these barrier crime laws sometimes severely limit the kinds of jobs they can hold—often prohibiting them from holding direct service positions, including those offered by the CSB. A screening process has been added to these laws to allow CSBs to consider employing, in adult substance abuse treatment programs, individuals who have been convicted of certain barrier

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<sup>83</sup> Kaiser Daily Health Policy Report. (6 Mar 2008) Capitol Hill watch: House passes mental health parity legislation. Accessed 10 July 2008. [http://www.kaisernetwork.org/Daily\\_Reports/](http://www.kaisernetwork.org/Daily_Reports/)

<sup>84</sup> US Department of Health and Human Services. (23 Jan 2008). The 2008 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure. Accessed 17 July 2008. <http://aspe.hhs.gov/poverty/08poverty.shtml>

<sup>85</sup> Department of Systems Management for Human Services and U.S. Census Bureau, 2002-2006 American Community Survey. Estimates of Median Household Income and Median Family Income. Accessed 17 July 2008. <http://www.fairfaxcounty.gov/demogrph/gendemo.htm#inc>

crime offenses, but have sufficiently progressed in their recovery journey to the point where they can offer assistance to others. There is currently no similar provision in Virginia law to allow individuals with mental illness who have committed certain barrier crimes to be assessed for their rehabilitative status and then offered employment in the mental health system. We would encourage the CSB to advocate in the Virginia General Assembly for exemptions to certain barrier crime laws in mental health programs that would allow for CSBs to evaluate the rehabilitative state of individuals with psychiatric disabilities and possibly offer them employment in peer roles. Other states which have adopted statutes that allow for exemptions to certain barrier crime laws in mental health programs and to which the Fairfax-Falls Church CSB can look for guidance include Illinois, Florida, and New Jersey.<sup>86</sup>

## Conclusion

*Concluding statements will be added when draft recommendations are finalized, pursuant to stakeholder input sessions.*

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<sup>86</sup> Hoyle, Jaime. Final report: Impact of barrier crime laws. SJ106. Accessed 30 June 2008. <http://jchc.state.va.us>.

## Appendix A: Glossary

**Access:** the pathway individuals seeking mental health services follow to obtain care.<sup>87</sup>

**Care coordination (case management):** the process of assisting those with mental health disabilities to identify, secure, and sustain the environmental and personal resources needed to live, work, and recreate as part of the larger community.<sup>88</sup>

**Choice:** “refers to the central role people with psychiatric disabilities and/or addictions play in their own treatment, rehabilitation, recovery, and life. Within the behavioral health system, people in recovery need to be able to select services and supports from among an array of meaningful options based on what they will find most responsive to their condition and effective in promoting their recovery. Both inside and outside of the behavioral health system, people in recovery have the right and responsibility for self-determination and making their own decisions, except for those rare circumstances in which the impact of the illness or addiction contributes to their posing imminent risks to others or to themselves”.<sup>89</sup>

**Comprehensive Services Act:** A 1993 VA Law that pooled eight specific funding streams into one which is used to purchase services for high-risk youth. The purpose of this money is to provide high quality, child-centered, family-focused, cost-effective, community-based services to high-risk youth and their families.<sup>90</sup>

**Continuity of Care:** “phrase used to underscore the importance of sustained, consistent support over the course of recovery. Such support can come from living within a community of shared experience and hope, but also can refer to the reliable and enduring relationship between the individual in recovery and his or her recovery coach. Such sustained continuity is in marked contrast to the transience of relationships experienced by those who have moved through multiple levels of care or undergone multiple treatment relationships”.<sup>91</sup>

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<sup>87</sup> Pires, Sheila. (Spring 2002). *Building Systems of Care: A Primer*. Washington, DC: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center. 50.

<sup>88</sup> Corrigan, P., Mueser, K., Bond, G., Drake, R., and Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press.138-139.

<sup>89</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 99.

<sup>90</sup> *Virginia Comprehensive Services Act for At Risk Youth and Families*. Commonwealth of Virginia. Accessed 16 July 2008. <http://www.csa.state.va.us/>

<sup>91</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 99.

**Decompensation:** “Temporary return to a lower level of psychological adaptation or functioning, often occurring when an individual is under considerable stress or has discontinued psychiatric medication against medical advice”.<sup>92</sup>

**Evidence-based practices:** “clinical, rehabilitative, and supportive practices that have scientific support for their efficacy (under ideal conditions) and effectiveness (in real world settings). Advocacy of evidence-based practice is a commitment to use those approaches that have the best scientific support, and, in areas where research is lacking, a commitment to measure and use outcomes to elevate those practices that have the greatest impact on the quality of life of individuals, families, and communities”.<sup>93</sup>

**Medicaid:** a “jointly funded, federal/state health insurance program for low-income and disabled people who meet needs-based eligibility requirements. Nationally, it covers approximately 36 million individuals including children, the aged, the blind, and/or disabled and people who are eligible to receive federally assisted income maintenance payments”.<sup>94</sup>

**Medicare:** “Federal health insurance program primarily for older Americans and people who retired early due to disability”.<sup>95</sup>

**Mindfulness Based Cognitive Therapy:** A therapy system developed by Zindel Segal, Mark Williams, and John Teasdale that is “designed to help people who suffer repeated bouts of depression and chronic unhappiness. It combines the ideas of cognitive therapy with meditative practices and attitudes based on the cultivation of mindfulness”.<sup>96</sup>

**Parity laws:** “Federal and state laws that remove limits imposed by insurance providers on access to mental health care that are more restrictive than limits imposed on access to physical health care. Legislation requiring insurers to cover access to mental and physical health care under equivalent terms and conditions is referred to as parity legislation”.<sup>97</sup>

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<sup>92</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. 308.

<sup>93</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 100.

<sup>94</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. 311.

<sup>95</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. 311.

<sup>96</sup> Mindfulness Based Cognitive Therapy Accessed 10 July 2008. <http://www.mbct.com/Index.htm>

<sup>97</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project*. New York: Council of State Governments. 312.

**Peer:** refers to someone “who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction”.<sup>98</sup>

**Peer-Operated Program:** “a behavioral health program that is developed, staffed, and/or managed” by persons in recovery. These programs are usually focused on providing services and supports such as respite care, transportation to appointments, recovery education, and advocacy.<sup>99</sup>

**Peer Specialist:** a peer who is trained and employed to offer peer support to persons with psychiatric disabilities.<sup>100</sup>

**Person-Centered Care:** care that is built around an individual’s personal assessment of hopes, aspirations, desires, and goals.<sup>101</sup> A person-centered care plan is highly individualized, established in conversation with the individual being served, and is respectful of the unique preferences, assets, strengths, and dignity of the individual.<sup>102</sup>

**Recovery Oriented System Indicator (ROSI):** a survey tool currently available through the Virginia Department of Mental Health, Mental Retardation, and Substance Abuse Services that was developed by individuals receiving mental health services in cooperation with Columbia University to measure the extent to which a mental health system is oriented towards recovery goals.

**Recovery-oriented practice:** “a practice oriented toward promoting and sustaining a person’s recovery from a behavioral health condition...a recovery-oriented practice is one that identifies and builds upon each individual’s assets, strengths, and areas of health and competence to support the person in managing his or her condition while regaining a meaningful, constructive, sense of membership in the broader community”.<sup>103</sup>

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<sup>98</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 103.

<sup>99</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 104.

<sup>100</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 104.

<sup>101</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 104.

<sup>102</sup> Daniels, A., Ed. D., and Adams, N., M.D., MPH. (Feb 2006). *From Study to Action: A Strategic Plan for Transformation of Mental Health Care*. Accessed 17 June 2008. [www.healthcarechange.org](http://www.healthcarechange.org). 22.

<sup>103</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 105.

**Seeking Safety:** “a present-focused therapy to help people attain safety from trauma, post-traumatic stress syndrome, and/or substance abuse”.<sup>104</sup>

**Social Security Disability Income (SSDI):** “Individuals who worked are ‘insured’ by the Social Security taxes (F.I.C.A.) that are withheld from their earnings to replace part of a person’s earnings upon retirement, disability, or for survivors with a worker dies. If insured workers (and, in some cases, their dependents or survivors) become disabled, they may become eligible for SSDI benefits. The amount received is dependent upon how many years an individual has worked and the individual must apply to determine if (s)he is eligible for benefits”.<sup>105</sup>

**Social Security Income (SSI):** “The SSI program was established in 1974 as a mechanism for incorporating various state programs into one federal program. SSI is a program that provides direct federal payments to the aged, blind, and disabled people who have limited income and resources”.<sup>106</sup>

**SSI/SSDI Outreach, Access, and Recovery (SOAR):** a Federal program which can expedite disability determination for the homeless population

**Supportive housing:** “A system of professional and/or peer supports that allows a person with mental illness to live independently in the community. Such supports may include regular staff contact and assistance as needed with household chores, as well as the availability of crisis services or other services designed to prevent relapse, such as mental health, substance abuse, and employment. Also known as supported housing”.<sup>107</sup>

**System-of-care:** a system of care “incorporates a broad array of services and supports...[in] a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, and builds meaningful partnerships with families and youth at service delivery and policy levels”.<sup>108</sup>

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<sup>104</sup> *Seeking Safety: A model for Trauma and/or Substance Abuse.* Accessed 10 July 2008.  
<http://www.seekingsafety.org/>

<sup>105</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* New York: Council of State Governments. 314.

<sup>106</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* New York: Council of State Governments. 315

<sup>107</sup> Council of State Governments. (2002). *Criminal Justice/Mental Health Consensus Project.* New York: Council of State Governments. 315.

<sup>108</sup> Pires, Sheila. (Spring 2002). *Building Systems of Care: A Primer.* Washington, DC: National Technical Assistance Center for Children’s Mental Health, Georgetown University Child Development Center. 3.

**Wellness Recovery Action Planning (WRAP):** a self-help approach to psychiatric illness management and promotion of wellness developed by Mary Ellen Copeland.<sup>109</sup> This is a structured program in which an individual works with a case manager to develop a personal written plan aimed at managing or reducing troubling symptoms and making other desired changes in his or her life. WRAP plans emphasize overall wellness and health, and avoid providing information about specific disorders.<sup>110</sup>

### **ACRONYMS USED IN THIS REPORT:**

**ASP:** Application Server Provider  
**CHCN:** Community Health Care Network  
**CSA:** Comprehensive Services Act  
**CSB:** Community Services Board  
**EHR:** Electronic Health Record  
**FCPS:** Fairfax County Public Schools  
**FQHC:** Federally Qualified Health Center  
**HIE:** Health Information Exchange  
**IEP:** Individualized Education Plan  
**IT:** Information Technology  
**MIS:** Management Information System  
**NAMI:** National Alliance on Mental Health  
**NOM:** National Outcome Measures  
**PHR:** Personal Health Record  
**ROSI:** Recovery Oriented System Indicator  
**SAMSHA:** Substance Abuse and Mental Health Services Administration  
**SAP:** Student Assistance Programs  
**S-CHIP:** State's Children Health Insurance Program  
**SOAR:** SSI/SSDI Outreach, Access, and Recovery  
**SSDI:** Social Security Disability Income  
**SSI:** Supplemental Security Income

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<sup>109</sup> Connecticut Department of Mental Health and Addiction Services, Yale University Program for Recovery and Mental Health. (2006). *Practice Guidelines for Recovery-Oriented Behavioral Health Care*. 107.

<sup>110</sup> Corrigan, P., Mueser, K., Bond, G., Drake, R., & Solomon, P. (2008). *Principles and Practice of Psychiatric Rehabilitation*. New York: The Guilford Press. 132.

# Appendix B: Commission Charter

Josiah H. Beeman Commission

On The Fairfax-Falls Church Mental Health Service Delivery System

## Charter and General Work Plan

The Fairfax County Board of Supervisors is establishing a blue-ribbon commission, designated the Josiah H. Beeman Commission in honor of the former Chairman of the Fairfax-Falls Church Community Services Board, to advise the Board of Supervisors on the future direction and design of the mental health services delivery system serving Fairfax County, the City of Fairfax, and the City of Falls Church. The Josiah H. Beeman Commission will consist of a mix of national, state, regional, and local mental health service delivery experts and consumers, consumer advocates, and/or family members of consumers to bring fresh knowledge and perspective to the task of recommending a vision and blueprint for revamping/transforming the local mental health delivery system for Fairfax County, Fairfax City and the City of Falls Church. The Josiah H. Beeman Commission shall make recommendations to the Board of Supervisors on changes to the mental health service delivery system that it believes are necessary to enhance the system of care to be more coherent, responsive, efficient, and effective for adults of all ages and children and families in need of public mental health services.

The Commission will:

- Recommend a vision and blueprint for the direction for public mental health service delivery.
- Establish a broad roadmap for the transformation of the County's mental health care system required to achieve this vision.
- Recommend key strategies for facilitating this transformation.

In general, the Board of Supervisors desires recommendations that will:

- Focus the system on services and treatments that are consumer and family centered – that provide consumers with reasonable and timely access to services, meaningful and appropriate choices about treatment options, and supportive services and providers that are consistent with highly effective public mental health service delivery.
- Facilitate and maximize consumer recovery, resiliency, and the ability to successfully cope with life's challenges and not just symptom management.

- Assist the Board to, in collaboration with the Community Services Board, clarify priority populations to be served through the public mental health system as well as those populations who may not be able to be served or are best not served or served less extensively by the public system given limited resources.
- Assist the Board in identifying the potential for linkages with the County's primary health care programs to support certain types of mental health service delivery that can be offered in a primary care environment.
- Assist the Board in identifying additional partnership opportunities with the Commonwealth of Virginia to better collaborate on mental health service delivery policy and funding, and with other Community Services Boards in the region to address such issues as inpatient bed shortages and opportunities for collaborative programming.
- Identify best practices and service strategies for integrating mental health and substance abuse treatment for persons with co-occurring disorders.
- Identify clear and measurable standards and consumer outcome measures that focus on recovery, resilience, and success.
- Highlight best practices for public mental health service delivery linkages and integration with other public service functions (social services, public education, homelessness services, family and child services, child welfare services, juvenile and domestic relations, housing services, etc.) to better enable an integrated approach to meeting citizen service needs.
- Facilitate integration with the Commonwealth's Integrated Strategic Plan for transforming Virginia's publicly funded mental health, mental retardation, and substance abuse services systems and are consistent with the State's ongoing review process related to compulsory treatment and medication.

## **Commission Deliverables**

### **(1) Recommendations on the Appropriate Role of Public Mental Health Services in the Fairfax County Service Delivery System**

Drawing on best practices in public mental health service delivery at the local level from around the nation, recommend the appropriate role(s) for the County's mental health system in the

provision of services to individuals and families in need of services. Include recommendations on proven strategies for optimum collaboration with partners in the service community such as the local school system, the county's housing, social services, juvenile justice and other human service agencies, to best meet the needs of both adults and children and families.

## **(2) Recommendations on Service Populations**

Based on best practices in local public mental health services delivery from around the country, the recommended roles for local public mental health identified in (1) above, and the general resource levels currently being invested in mental health service delivery:

- a. Identify critical service populations whose needs must receive priority attention and resources from the local mental health system.
- b. Identify those populations who should/can be served outside of the public system and summarize the potential impacts, if any, of not serving these populations in the public system.
- c. Identify any populations who might receive more limited services from the public mental health system.

## **(3) Recommendations on Service Delivery Design**

Recommend a core service delivery model and mix of service offerings with proven effectiveness in achieving optimal outcomes for populations to be served and which:

- a. Are best suited to implement a consumer-driven, recovery-based approach to meeting the needs of consumers.
- b. Are consistent with providing timely access to services and providing acceptable levels of service choice to consumers.
- c. Outline a general mix of publicly provided services - directly operated services, contracted services, and consumer-operated services - necessary to implement the recommended practice model.
- d. Are evidence based and will result in a coherent efficient and effective service system for both adults and children and families.
- e. Are consistent with the appropriate role of the mental health system in the overall service delivery system.
- f. Can be implemented within the general level of public investment that the system currently enjoys as well as determine priority services should additional resources become available in the future.
- g. Address a best practices approach to integration of mental health and substance abuse services that best meet the needs of consumers with co-occurring disorders.

- h. Explore opportunities for regional collaboration in mental health service delivery.
- i. Provide for service delivery in settings appropriate for the various consumer populations to be served.

**(4) Recommend Strategies for Funding and Resource Development to Support the Service Delivery Design**

The Fairfax Board of Supervisors and the other partner governing bodies make a significant investment of local resources in support of public mental health service delivery. While it is anticipated that current levels of local investment will be sustained, long-term local revenue forecasts suggest that opportunities for expansion of local investment are very limited. The Board desires recommendations on financing strategies that optimize federal, state, and other resources to sustain the service delivery system and seeks to learn about additional creative financing approaches that may have been developed in other areas.

**(5) Recommend Outcomes and a System of Measures to Gauge Performance**

Drawing on best practices, recommend a system of both consumer and system outcomes as well as a relevant set of program and process measures that will facilitate assessment of the ongoing performance of the mental health system in terms of efficiency, effectiveness, access to services, and consumer recovery and which will support ongoing accountability, transparency, and continuous improvement in the system and promote a passion for operational excellence in delivery of mental health services.

***Together, deliverables 1 through 5 will establish a vision and framework for a revamped mental health delivery system grounded in best practices. Using this framework as a baseline against which the current system of mental health service delivery can be assessed, the following deliverables are designed to provide the Board of Supervisors with a blueprint which can be used to design and implement necessary changes in the system.***

**(6) Assessment of the Current System of Mental Health Services Delivery**

Provide an assessment of the current system of care in terms of treatment approach, service offerings, financing, resource allocation, service system partnerships, service integration, and populations served against the system blueprint envisioned in deliverables 1-5 above. This assessment should identify:

- a. The strengths of the current system of care which should be preserved.
- b. Necessary changes in the fundamental role the mental health system of care plays in the overall human services delivery system.
- c. Proposed changes in the system's response to the various key populations in need of mental health services.
- d. Proposed changes in the overall design, delivery, measurement, and management of the system of care in light of the best practices framework.
- e. Essential workforce core competencies required for the recommended system of care and the necessary changes, if any, in the general staff skill sets necessary to implement the system of care.
- f. New partnerships and service delivery relationships that are required for the best practices framework.
- g. Proposed changes in the financing of the system. This should include a review of the current allocation of resources for mental health services and an assessment of resource allocation changes that would be required to implement the proposed system blueprint.
- h. Necessary changes in the system of measures for assessing the ongoing performance of the system.

#### **(7) Transformation Roadmap and Strategies**

Provide recommendations on the staging, sequencing, and key strategies necessary to implement the system transformation.

#### **Commission Timetable and Resources**

It is anticipated that preparatory work for Commission meetings will begin in November of 2006 and that the Commission's first meeting will be held in January. The Commission will deliver an interim report to the Board of Supervisors within 180 days of its initial meeting and updates to the Board every 90 days until such time as its work is completed. To accomplish this work, the County Executive shall:

1. Identify a staff director who will be responsible for facilitating the Commission's work and deliberations and will assure that the necessary County staff and contractual service resources (including administrative support resources) are brought to bear on the Commission's activities.
2. Working with the Commission, identify other staff resources necessary to complete the Commission's work plan and deliverables. An interagency staff team will be identified that will provide research and analysis support to the Commission. Working with the staff director, this interagency team will

- identify, assemble, and send information for Commission member review prior to the initial meeting of the Commission.
3. In conjunction with the Community Services Board and the staff director to the Commission, engage mental health employees in the process by assuring an opportunity for them to express their ideas about service populations, service delivery design, funding, and measures of success.
  4. Identify appropriate work space and other support resources that the Commission should require.
  5. Assure, in conjunction with the Executive Director of the Community Services Board, timely access to Community Services Board staff, data, and other resources necessary for the Commission's work.

### **Commission Composition**

Commission membership will include national, regional, state, and local mental health leaders; mental health consumers, consumer advocates and/or family members of consumers; recognized experts in mental health law and the criminal justice system; experts in workforce development; experts in mental health quality and accountability; and recognized experts in specific mental health populations.

As the Commission progresses in its work, it is expected that individuals will be needed to serve as part of a growing cadre of expert resources. Similarly, the Commission may wish to assemble a group of consumers, consumer advocates, and/or family members of consumers to serve as resources on an as-needed basis.

### **Commission Work Plan and Activities**

There is no prescription for specific Commission work activities. Rather, it is expected that a detailed work plan will be determined by the Commission itself in consultation with the County Executive and the designated staff director of the Commission. The Board does desire that the Commission consult with key stakeholders throughout its process.

## **Appendix C: Survey on Mental Health Services**

is available electronically at  
[www.fairfaxcounty.gov/beemancommission](http://www.fairfaxcounty.gov/beemancommission)

A print copy may be requested by calling  
**(703) 324-2400**