



Josiah H. Beeman Commission

Report to the
Fairfax County Board of Supervisors

**Presented to the
Human Services Committee
of the Board of Supervisors
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Executive Summary

Background

This report conveys to the Fairfax County Board of Supervisors a series of recommendations for transforming the Fairfax-Falls Church system of mental health care. As outlined in its charter, 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 (CSB), 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 and strategies for facilitating the transformation to achieve this vision.

The Fairfax-Falls Church area is not alone in seeking to transform its system of mental health care. Transformation has been happening across the country. Many of these efforts are following guidance of the 2003 New Freedom Commission on Mental Health to reduce the stigma that surrounds mental illness, build individual and community resilience, and strengthen the hope of recovery for every individual with mental illness. Few would dispute the value of achieving these goals.

We believe that mental health is fundamental to overall health. As with primary health care, mental health care is shifting toward practices that are supported by research, providers who are skilled and up-to-date in these practices,

and individuals who are partners in decisions about their care. Technology is an essential support of these three components of quality health care.

REDUCE THE STIGMA THAT SURROUNDS MENTAL ILLNESS, BUILD INDIVIDUAL AND COMMUNITY RESILIENCE, AND STRENGTHEN THE HOPE OF RECOVERY FOR EVERY INDIVIDUAL WITH MENTAL ILLNESS.

Timing

We are well aware that this report is being delivered to the Board of Supervisors at a time when local, state and federal resources are greatly constrained due to economic conditions. However, we must emphasize the long-range nature of our recommendations for this transformation. As with most successful change efforts, the organizational, infrastructural, and business process changes we have recommended will require several years to complete. This would be the case even if our recommendations were delivered at a time of great prosperity. Successful transformation takes time: time to mark the end of old behaviors and practices, time to navigate new paths toward a new vision, and time to celebrate and build on successes that demonstrate improved results. We commend the Board of Supervisors for chartering this transformation and strongly encourage each member to take the “long view” in supporting our recommendations.

Finally, we were pleased to note that the CSB began to make recovery- and resilience-oriented changes before the

inception of this Commission and has accelerated changes during the time this Commission has met. We believe that the very existence of this Commission has amplified early progress toward transformation, and our recommendations are designed to build upon this early progress.

Transformation **Recommendations**

Our road map for transforming the mental health system is described below in seven broad themes followed by general recommendations that are supported by specific strategies. Imbedded in our recommendations and supporting strategies are service and business practices that reflect the goals of system transformation. Just as they have in other states and localities, we believe these practices will improve access, optimize efficiency, enhance financing mechanisms, and promote favorable outcomes for adults, children, youth, and their families.

Leadership and Governance

► **Recommendation:** *Promote effective leadership and governance to attain and sustain the vision for the mental health system.*

Among the strategies to support this recommendation are reviewing the structure of the CSB board; documenting needed skills for the board; strengthening public and private partnerships; recruiting, developing, and assuring accountability of leaders; and establishing an Office of Consumer and Family Affairs.

Fiscal Management

► **Recommendation:** *Maximize and leverage all potential sources of funding for the system and for individuals with psychiatric disabilities.*

Strategies include maximizing revenue and reimbursements from Medicaid and other entitlements, improving assistance for individuals seeking federal and state benefits, seeking grant funding for initiatives that are sustainable after the term of the grant, and exploring the establishment of a foundation.

Prevention and Early Intervention

► **Recommendation:** *Increase prevention and early intervention efforts for children, youth, and adults in order to decrease the need for mental health services.*

Strategies include raising public awareness of mental health and related services and supports, assuring that prevention is a responsibility of all providers, integrating fully with the schools to support the mental health of children, and expanding early intervention practices to prevent the need for emergency care.

Services and Supports

► **Recommendation:** *Build a service delivery system that, in its entirety, supports recovery and resilience.*

Strategies include essential design practices of a transformed system such as ensuring access to care, person-centered care and care coordination; using peers throughout the system; shifting care into the community; and increasing support to families of children, youth, and adults with psychiatric disabilities.

► **Recommendation:** *Assure safe, affordable, and stable housing for persons with psychiatric disabilities.*

Strategies include supporting the Housing First approach, expanding housing options with support services, creating a housing development fund, and optimizing collaboration between mental health and housing services.

► **Recommendation:** *Expand employment and education support for persons with psychiatric disabilities.*

Among the strategies to expand employment and education are implementing services consistent with the principles of evidence-based supported employment, accessing federal and state funding for employment programs, and strengthening connections with local educational institutions.

► **Recommendation:** *Facilitate connection with primary health care for persons with psychiatric disabilities.*

Strategies include supporting cross-system collaboration in providing primary and behavioral health care, exploring modification of the affordable healthcare system, and exploring the possibility of a locally developed group health insurance plan.

Workforce and Training

► **Recommendation:** *Assure a workforce that possesses skills, values, and attributes consistent with the vision of a recovery- and resilience-oriented system.*

Among the strategies to support this recommendation are developing a recovery- and resilience-oriented workforce, demonstrating expectation for accountability through productivity standards, assuring training for persons interested in providing peer support, and using person-first language throughout the system.

Data and Outcomes

► **Recommendation:** *Ensure cross-system accountability with performance and outcome measures, and use the data to improve the system.*

Strategies include adopting a system of performance measures and assuring that data is used to improve system effectiveness; seeking information on successful service approaches to serving children, youth, and adults; and conducting periodic analyses of system functioning to identify points for improvement.

Technology and Information Sharing

► **Recommendation:** *Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management.*

Strategies include purchasing technology that supports service and business practices and facilitating access to electronic information.

WE STRONGLY BELIEVE THERE ARE COMPELLING BUSINESS REASONS FOR ACTION . . .

Compelling Reasons to Act

The primary objective of our recommendations is to promote increased wellness and employment of individuals with psychiatric disabilities, and decreased reliance on the public system of mental health care. In addition, we strongly believe that there are compelling business reasons for action, and risks associated with inaction or failure to implement our recommended strategies. Fairfax is currently not maximizing nonlocal sources of revenue and reimbursements. A significant number of our recommended strategies were designed to produce additional state, federal, and nonpublic financial resources for the mental health system. We believe that many of our strategies to transform and improve the system can be implemented at no additional cost, by reallocating existing resources or staff. Finally, we believe that many of our strategies — designed to strengthen efficiency and effectiveness as well as enhance prevention and

early intervention — will assure that Fairfax-Falls Church area residents are getting the most value for their tax dollars and will ultimately decrease demand for expensive and traumatic emergency services and hospitalization.

Next Steps

We understand that an implementation plan will be developed for our recommended strategies and have outlined, in this report, the next step for the CSB board and staff. That next step is to conduct a high-level analysis, with initial estimates of level of investment required, degree of difficulty anticipated, and timeline needed for implementation of each recommended strategy. Additionally, because we have recommended a series of strategies to maximize potential sources of funding, we propose that this analysis also capture estimated levels of additional funding.

Complementary Initiatives

The work of this Commission is complementary to, but not inclusive in scope of, state and regional mental health initiatives. At the state level, the Commission on Mental Health Law Reform (charged with conducting a comprehensive examination of Virginia's mental health laws and services) has been identifying gaps in mental health services and developing ways to use the law more effectively to serve the needs of persons with mental illness. That commission's preliminary report identified recommendations for the 2008 session of the General Assembly. A final report, which will include recommendations for addressing gaps in the service delivery system, will be submitted this winter. Three members of the Josiah H. Beeman Commission serve as members of the Commission on Mental Health Law Reform. At the regional level, the local Health Planning Region is charged with regional planning, service coordination, and service delivery. Mental health efforts of this region have included utilizing local hospitals for purchase of inpatient beds, providing regional hospital discharge assistance, enhancing services for older adults, and building regional crisis stabilization capacity.

Introduction

In 2003, the New Freedom Commission on Mental Health recommended “fundamentally transforming how mental health care is delivered in America.”¹ The commission noted that “advances in research, technology, and our understanding of how to treat mental illnesses provide powerful means to transform the system,”² and that transformed care focuses “on facilitating recovery and on building resilience, not just on managing symptoms.”³ Recovery is the “process in which people are able to live, work, learn, and participate fully in their communities.”⁴ Resilience is “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.”⁵ In order to fulfill its charge from the Fairfax County Board of Supervisors, the Josiah H. Beeman Commission began its work by crafting a vision, philosophy, and set of values that reflect recovery and resilience as the goals of the transformed system of mental health care.

The Commission examined extensively the Fairfax-Falls Church Community Services Board (CSB) mental health system. We found that, in many cases, people feel well-served. Others have had negative experiences. Persons who feel well served say that they have:

- Been listened to in terms of their needs early in their CSB experience.
- Experienced respect in their CSB interactions.
- Been participants in decisions about their own treatment.

- Learned or are learning to manage the symptoms of their illness and become well.
- Been assisted with employment, health care, housing needs.
- Been supported in identifying and fulfilling their goals.
- Become more and more independent.

These are outcomes of a recovery/resiliency-focused system and are fully present in the Ohio, Utah, Rhode Island, and Connecticut state systems; in some CSB systems in other parts of Virginia; and in some aspects of the Fairfax-Falls Church CSB system.

Similarly, many states and communities across the country have developed comprehensive, community-based systems of care for children with or at risk for mental health disorders. These systems have demonstrated positive outcomes for children and their families. We asked youth and families about their needs and experiences with the mental health system. As with adults, we heard positive as well as negative experiences. When youth and families have felt well-served, we found that CSB has:

- Responded quickly to their needs.
- Provided family support and education about the mental health conditions of youth.
- Assisted them in becoming more resilient and less dependent upon intensive services.
- Utilized the latest evidence-based or promising practices.
- Helped them identify and fulfill their goals.

- Provided an array of culturally and linguistically competent services and supports.

We understand that this commission was formed to create a blueprint for transformation of the mental health system consistent with recovery and resilience principles that are being adopted by cities, counties and states across the nation. We also understand that challenges to accessing mental health services in the Fairfax-Falls Church area, including unacceptably long waits for service, created a sense of urgency around this goal of system transformation. The overarching recommendation of the Commission is to structure the CSB and transform the system around the business, governance, and service practices that characterize a recovery/resiliency-focused system. Just as they have in other states and localities, these practices will improve access, optimize

efficiency, enhance financing mechanisms, and promote favorable outcomes for adults and children, youth and their families. In transforming its system of mental health care, the Fairfax-Falls Church area will experience the tangible benefits of increased wellness and employment, decreased reliance on the public system, and reduced need for expensive emergency and crisis services.

The New Freedom Commission noted that the “process of transforming mental health care in America drives the system toward a delivery structure” that will give individuals with psychiatric disabilities “broader discretion in how care decisions are made.”⁶ We agree with the commission that this shift will give these individuals “more confidence,” which will “enhance cooperative relationships with mental healthcare professionals who share the hope of recovery.”⁷

JUST AS THEY HAVE IN OTHER STATES AND LOCALITIES, WE BELIEVE THESE PRACTICES WILL IMPROVE ACCESS, OPTIMIZE EFFICIENCY, ENHANCE FINANCING MECHANISMS, AND PROMOTE FAVORABLE OUTCOMES FOR ADULTS, CHILDREN, YOUTH, AND THEIR FAMILIES.

Foundation for Recommendations

As a Commission, we began by building a foundation for our recommendations. This foundation includes our recommended Vision, Philosophy, Values and Guiding Principles, and Roles of the Public Mental Health System, as well as input from stakeholders and our assessment of the current system.

Vision

The Commission adopted as its vision for the system this 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.”¹

Philosophy

Mental health is fundamental to overall health and is a shared community responsibility. Anyone with, or at risk for, mental illness should have access to a comprehensive, coordinated system of services and supports including prevention and early intervention. 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 comprises 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 individuals and groups in the community. Services and supports should be designed to build resilience and facilitate individualized recovery.

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,² From Study to Action: A Strategic Plan for Transformation of Mental Health Care,³ Building Systems of Care: A Primer,⁴ and Recovery Core Values for the Mental Health and Addictions Recovery (Treatment) System.⁵ Not surprisingly, the values and principles in these references had much in common. While each member brought his or her own 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 values and principles for guiding our recommendations and the transformation of this system:

Access: Services and supports are timely, appropriate, 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 are located in the community, keeping management and decision-making responsibility at the local level, and are directed by the individual along with the individual's choice of persons in his/her natural support system.

Cultural and Linguistic Compe-

tence: Persons providing services and support have a full understanding of, and responsiveness to, cultural, racial, ethnic, and linguistic differences.

Effectiveness and Measurable Re-

sults: Services are based on the best available scientific evidence, resulting in the achievement of desired outcomes of choice for the individual.

Equity: Services and supports do not vary in quality based on individual characteristics such as severity of disability, gender, ethnicity, geographic location, and socioeconomic status.

Family and Individual Involvement, Support, and Education:

Individuals and their families participate in all aspects of the planning and delivery of appropriate services and supports as chosen by the individuals. A robust support system for families is important to service delivery.

Involvement with Natural Commu-

nity Supports: Individuals and families are seen as having important social connections with other people, organizations, and services in the community. These connections are resources for supports, activities, and education.

Person-Centered Services and

Supports: A highly individualized and

family-directed approach that recognizes each individual's and family's history, strengths, needs, and vision of their treatment, and the needed natural supports to promote resiliency and recovery.

Prevention and Early Intervention:

Early identification, early intervention, and maintenance of wellness to build protection and resiliency and enhance the likelihood of positive outcomes.

Respect: Honoring the unique preferences, strengths, and dignity of each person in his/her 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.

Service Integration: Services and supports are coordinated and collaborative, 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 the coordination of effective services and supports.

Transparency: All stakeholders 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 the community.

Roles of the Public Mental Health System

The Commission's recommended roles for the public mental health system are outlined below. The 2007 Overview of Community Services Delivery in Virginia served as a resource for recommended roles.⁶

The public mental health system (CSB and its board) would function as a(n):

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.

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; for community acceptance of, and support for, individuals receiving mental health services; and for 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; i.e., integration between mental health care and other services including primary health, housing, employment, and education.

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; and to seek and assess 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 policymakers and management of those services, with emphasis on quality, feedback mechanisms and measurable outcomes, continuous improvement, and learning.

The Commission spent considerable time discussing the role of **manager** of 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 itself provides as a public entity and what services it purchases or partners with others to provide.

Stakeholder Input

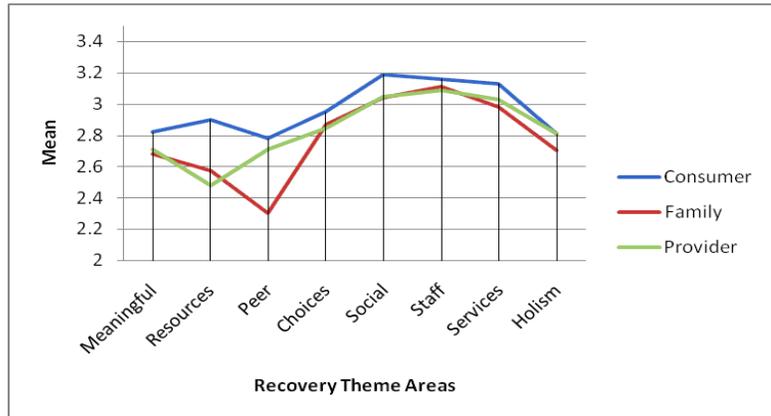
As we built the vision, philosophy, and value elements of the foundation for our recommendations, we conducted a parallel process of gathering input from various stakeholder groups through conversations and surveys. These stakeholder groups included individuals (youth and adults) receiving mental health services, family members and significant others, service providers, leaders of county human services departments, advocates for individuals receiving mental health services, and the general public.

To ensure stakeholder input in the process of developing recommendations, the Commission heard from individuals during the guest forum component of each scheduled meeting. Additionally, we conducted a variety of input activities, which are described below, followed by a list of overall themes from all stakeholder

AS WE BUILT THE VISION, PHILOSOPHY, AND VALUE ELEMENTS OF THE FOUNDATION FOR OUR RECOMMENDATIONS, WE CONDUCTED A PARALLEL PROCESS OF GATHERING INPUT FROM VARIOUS STAKEHOLDER GROUPS.

input activities. (See Appendix C for detailed findings of the survey we conducted, and Appendix D for a summary of themes from each input activity.)

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.



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) and similar surveys for family members/significant others of individuals receiving services and for providers of services. The ROSI survey is 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.

As noted earlier, Appendix C provides a detailed summary of survey findings. Overall, the survey ratings were more favorable than unfavorable. As illustrated in the above graph from Appendix C, mean responses across stakeholder groups in the eight recovery theme areas were, with one exception, above the midpoint of 2.5 (highest possible score of 4 and lowest score of 1). Additionally, this graph illustrates the relative consistency among ratings of the three stakeholder groups.

The type of sampling 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.

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 (National Alliance on Mental Illness - Northern Virginia), families of adults who had experience with emergency services.

Conversation with County Human Services Leaders: At a meeting of the Human Services Leadership Team, the agenda included a conversation regarding the opportunities and challenges for greater integration in providing services to 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 CSB and the Deputy County Executive for Human Services.

Stakeholder Input on Draft Recommendations: After drafting our initial recommendations, we sought feedback

from representatives of all stakeholder groups and other interested individuals. Specifically, draft recommendations were posted for comment on the Josiah H. Beeman page available through the Fairfax County Government website. Additionally, three public input sessions were conducted to solicit in-person comments. Based on this input, our draft recommendations were refined and reshaped.

Overall, when looking at all stakeholder input-gathering activities, including input on the draft recommendations, some recurring themes across these various participant groups and input methodologies include the need for:

- Improved access to mental health services and supports.
- Improved assistance for individuals seeking benefits.
- Increased availability of public information on mental health services and supports.
- Greater collaboration among service providers and system partners.
- Increased contact with staff (i.e., psychiatrists, psychotherapists, and case managers).
- Increased support and education for families of individuals receiving services.
- Greater number of meaningful activities (employment, education, community activities).
- More prevalent use of peer advocates and peer service providers.
- Expanded housing options with mental health services and supports.

Current System Assessment

In addition to stakeholder input on the current system, the Commission gathered information about the mental health system from CSB service providers. Staff responded to our questions by providing 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,

NEARLY 60% OF PERSONS SERVED BY THE MENTAL HEALTH SYSTEM IN THE FAIRFAX-FALLS CHURCH AREA HAVE INCOMES UNDER THE FEDERAL POVERTY LEVEL OF \$10,400.

CSB staff regarding mental health services and supports.

Highlights of this assessment are 2007 demographics of persons served by the CSB, early CSB recovery- and resilience-oriented accomplishments, and issues relating

to transformation progress. Specific findings of our assessment of the current CSB system of mental health are imbedded in our recommendations and strategies.

2007 DEMOGRAPHICS

The CSB is structured in discrete disability areas that include Mental Health, Alcohol and Drug, Intellectual Disabilities (formerly known as Mental Retardation), and Infant and Toddler Connection. The following chart shows the number of individuals served in 2007 for each area. These numbers clearly indicate the magnitude of need for mental health services and supports relative to other disability areas.

CSB Area	Persons Served
Mental Health	11,190
Alcohol and Drug	5,458
Intellectual Disabilities (MR)	2,026
Infant & Toddler Connection	1,850

The chart below shows the age distribution for individuals served by CSB Mental Health in 2007.

Age	Percent of Persons Served
0 – 17	17%
18 – 22	10%
23 – 59	65%
60 and over	8%

Income levels for persons served by CSB Mental Health in 2007 are illustrated on the following page. These figures indicate that nearly 60% of persons served by the mental health system in the Fairfax-Falls Church area have incomes under the federal pov-

erty level of \$10,400.⁷ In comparison, 4.9% of all Fairfax County residents fall below the federal poverty level.⁸ These income figures are further amplified by responses to the survey item “I have enough income to live on,” which received the most negative responses from all stakeholder groups. (Appendix C: Survey Summary, p. 31.)

Income	Percent of Persons Served
\$0 – \$9,999	58%
\$10,000 – \$24,999	25%
\$25,000+	17%

CSB ACCOMPLISHMENTS

Highlights from among the many accomplishments of the CSB and its progress toward a recovery- and resilience-oriented system include:

- A system-wide Mental Health Services Recovery Workgroup — comprising advocates, individuals receiving mental health services, family members, and staff — was established to provide guidance in transforming the system.
- Crisis Care at Woodburn Place hired Peer Specialists who have designed an Introduction to Wellness Recovery Action Plan (WRAP) program that emphasizes overall wellness and health.
- Individuals receiving services, with support from CSB mental health staff, established three peer-operated drop-in centers.
- The Program of Assertive Community Treatment (PACT) significantly reduced hospital bed days and has begun turn-

ing apartment leases over to individuals receiving services.

- The CSB deploys psychiatric resources to Community Health Care Network clinics; alternatively, primary care is provided to individuals in crisis care at CSB’s Woodburn Place and to those with co-occurring disorders (COD) at two residential programs.
- The CSB overhauled the “front door” of its system for adults and decreased waits for initial assessments from months to an average of six business days.
- 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 co-occurring 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, 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 CSB, working with the Department of Family Services (DFS), developed a tool that helps staff determine who may be eligible for Medicaid ben-

efits. DFS deployed staff to three mental health outpatient sites to assist eligible individuals with Medicaid applications.

These achievements are many; however, they seem to have been accomplished more as a series of initiatives than as an integrated approach to system transformation. As CSB continues its transformative work, we encourage leaders to be mindful of the need to communicate to all involved an overall design and how changes are integrated as elements of that design.

ISSUES

In assessing the current system, we found issues that must be addressed to assure that transformation is achieved. Overall we found that the Fairfax-Falls Church CSB:

- Has a multiplicity of initiatives versus a refined focus on priorities.
- Has significantly reduced wait time for initial access of adults but continues to be challenged in providing timely access to services and supports.
- Lacks a clear operational philosophy to achieve the vision.
- Collects a substantial amount of data but does not use it to drive performance and outcomes.

- Lacks focus on individuals in their entirety, including their goals of health, housing, income, and relationships.
- Has been challenged in optimizing integration with systems partners.
- Lacks prevention and early intervention strategies to reach individuals before they seek emergency care.
- Does not maximize state, federal, and nonpublic funding to the fullest extent.
- Lacks up-to-date information technology to support evolving service and business practices.

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 on that progress.

Recommendations For a Transformed System

Our road map for transforming the mental health system is described in seven broad themes with ten general recommendations (listed below). Specific strategies to support each recommendation follow in the report.

Leadership and Governance

RECOMMENDATION: Promote effective leadership and governance to attain and sustain the vision for the mental health system.

Fiscal Management

RECOMMENDATION: Maximize and leverage all potential sources of funding for the system and for individuals with psychiatric disabilities.

Prevention and Early Intervention

RECOMMENDATION: Increase prevention and early intervention efforts for children, youth, and adults in order to decrease the need for mental health services.

Services and Supports

RECOMMENDATION: Build a service delivery system that, in its entirety, supports recovery and resilience.

RECOMMENDATION: Assure safe, affordable, and stable housing for persons with psychiatric disabilities.

RECOMMENDATION: Expand employment and education support for persons with psychiatric disabilities.

RECOMMENDATION: Facilitate connection with primary health care for persons with psychiatric disabilities.

Workforce and Training

RECOMMENDATION: Assure a workforce that possesses skills, values, and attributes consistent with the vision of a recovery- and resilience-oriented system.

Data and Outcomes

RECOMMENDATION: Ensure cross-system accountability with performance and outcome measures, and use the data to improve the system.

Technology and Information Sharing

RECOMMENDATION: Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management.

THEME

Leadership and Governance

RECOMMENDATION 1:

Promote effective leadership and governance to attain and sustain the vision for the mental health system.

Strategy 1.1: Review and, as needed, restructure the CSB board to promote service integration and system effectiveness.

Strategy 1.2: Document the skill set needed for overall CSB board member composition and advise the Board of Supervisors accordingly.

Strategy 1.3: Strengthen partnerships within the public and private sectors.

Strategy 1.4: Encourage and recognize creativity and innovation while balancing risk with results.

Strategy 1.5: Recruit or promote leaders who possess competencies required to manage evolving service and business practices.

Strategy 1.6: Provide ongoing leadership development.

Strategy 1.7: Assure a mechanism for accountability of leaders.

Strategy 1.8: Require and model respect in all interactions throughout the system.

Strategy 1.9: Establish an Office of Consumer and Family Affairs with well-defined responsibilities and a leader who reports directly to the CSB Executive Director.

THEME

Leadership and Governance

RECOMMENDATION 1:

Promote effective leadership and governance to attain and sustain the vision for the mental health system.

“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.”¹ It is the governance of the system (i.e., the Board of Supervisors and the CSB board) 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 that the organization attains and sustains the vision.

Strategy 1.1: Review and, as needed, restructure the CSB board to promote service integration and system effectiveness.

The CSB board is currently structured by service disability areas — intellectual disability (formerly known as 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 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, 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.

Strategy 1.2: Document the skill set needed for overall CSB board member composition and advise the Board of Supervisors accordingly.

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. 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.

Strategy 1.3: Strengthen partnerships within the public and private sectors.

Mental health is a shared community responsibility. This shared responsibility comprises 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. To strengthen these partnerships, CSB board members and the executive director must focus outside the CSB and

develop partnerships with organizations and individuals with a commonality of purpose. We encourage exploration of public-private partnerships in the provision of services (e.g., in the areas of outpatient, residential, and day-treatment services) to amplify public resources and build behavioral healthcare capacity in the community.

Strategy 1.4: Encourage and recognize creativity and innovation while balancing risk with results.

According to the National Institute of Mental 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.”² A work environment that encourages recovery demands innovation and requires creative thinking at all levels of the organization.

We recognize that innovation increases risk. 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 anxious that they will be blamed if things go wrong and are therefore reluctant to take initiative.³ 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.

Strategy 1.5: Recruit or promote leaders who possess competencies required to manage evolving service and business practices.

As new leaders are chosen, the CSB must hire or promote individuals with leadership attributes that are consistent with the vision of a recovery- and resilience-oriented system. Inherent in the shift to a more business-focused model is the need for business management skills at all levels of leadership. Additional competencies needed to manage evolving services and business practices include, but are not limited to, change and transition management, external awareness, strategic planning, and systems thinking. While some CSB leaders already possess these competencies, a consistent skill set is needed among leaders across the organization.

Strategy 1.6: Provide ongoing leadership development.

To successfully imbed a recovery- and resilience-oriented philosophy throughout the system, leadership development needs to be part of the organization’s DNA. We understand that the county has invested in a leadership/management development program that focuses on personal competencies needed to realize vision-driven, values-based organizations. We encourage the CSB to take full advantage of this program for its organizational leaders and to imbed its principles in the work culture. Effective succession planning will anticipate upcoming transitions and include development and mentoring as part of staff members’ evolution into leadership roles.

Strategy 1.7: Assure a mechanism for accountability of leaders.

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.

We have learned that the county has a 360 evaluation tool available to all managers, which involves ratings by supervisors, peers, and direct reports, as well as by the individual. The competencies and performance rated in this instrument have been aligned with the competencies adopted by the county for managers. With the addition of a mechanism to receive feedback from individuals receiving mental health services, this tool would be a valuable asset for leadership accountability.

Strategy 1.8: Require and model respect in all interactions throughout the system.

In our values for the transformed system, we emphasized the need 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.

Strategy 1.9: Establish an Office of Consumer and Family Affairs with well-defined responsibilities and a leader who reports directly to the CSB Executive Director.

Forward-looking states and localities across the country have been establishing Offices of Consumer Affairs since the early 1990s. As of January 2007, thirty-seven states had established these offices, several of which subsequently changed their name to Office of Consumer and Family Affairs.⁴ Because we believe that persons with psychiatric disorders and their families should be involved in all aspects of CSB services, we support efforts already under way to establish an Office of Consumer and Family Affairs. 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. The leader of this office should be a person with lived experience of mental illness, as is the case in many states and localities.

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.”⁵ We envision that this office would seek and encourage a healthy advocacy process.

THEME

Fiscal Management

RECOMMENDATION 2:

Maximize and leverage all potential sources of funding for the system and for individuals with psychiatric disabilities.

Strategy 2.1: Maximize revenue and reimbursements from Medicaid and other entitlements for individuals receiving mental health services, including Medicare, State Children's Health Insurance Plans (S-CHIP), Comprehensive Services Act (CSA), Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) to complement local, state, and federal grant/tax dollars.

Strategy 2.2: Deploy Benefits Coordinator positions to mental health service sites in order to assist and advocate for individuals seeking benefits.

Strategy 2.3: Seek opportunities for grant funding and assure that the CSB is prepared to sustain initiatives originally financed by grants after the grant money is depleted.

Strategy 2.4: Explore the establishment of a foundation whose purpose would be to assure an accessible, affordable, and integrated mental health system.

THEME

Fiscal Management

RECOMMENDATION 2:

Maximize and leverage all potential sources of funding for the system and for individuals with psychiatric disabilities.

As the county grows in population and complexity, the most advanced policies and procedures for increasing revenues must be utilized. County general funds contribute 67% of funding for the CSB's mental health services. The Commission recommends that the CSB maximize existing federal and state safety-net revenue and track progress in this area. After consideration of the current financing of the CSB, the Commission recommends the following financing strategies:

Strategy 2.1: Maximize revenue and reimbursements from Medicaid and other entitlements for individuals receiving mental health services, including Medicare, State Children's Health Insurance Plans (S-CHIP), Comprehensive Services Act (CSA), Supplemental Security Income (SSI), and Social Security Disability Insurance (SSDI) to complement local, state, and federal grant/tax dollars.

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 33%. We believe that the CSB can improve this rate to match, and perhaps exceed, the state enrollment rate.

People in need of mental health services are considered disabled, and some income can be provided to them through Social Security Disability Insurance (SSDI) for workers and families and/or Supplemental Security Income

(SSI). The eligibility process for utilizing these programs is daunting. Only one out of three claims for SSDI is initially approved.¹ Sometimes multiple appeals are required. We found through our conversations with people that those receiving services are perplexed and troubled by the plethora of rules, which may result in loss of benefits. In order to maximize the independence of individuals receiving services, and to assure continuity in provision of income, individuals with psychiatric disabilities will need enhanced assistance.

To maximize revenue and reimbursements from SSI and SSDI, the Commission encourages Fairfax

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 33%.

County to work to increase access to benefits for its homeless population. It is important to reach this 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.² A federal program, SSI/SSDI Outreach, Access, and Recovery (SOAR), may be helpful in this endeavor. This program for homeless individuals is supported by the Substance Abuse and Mental Health

Services Administration (SAMHSA) and the Health Resources and Services Administration. SOAR helps states and communities “develop strategies and provide training to caseworkers who counsel individuals in preparing accurate and complete SSI or SSDI applications.”³

Currently, Comprehensive Services Act (CSA) funds support residential placements of children and youth with serious emotional disturbances. However, CSA has been underutilized as a financing mechanism for nonresidential services such as day treatment, care coordination (case management), and psychiatric services.

Maximizing revenue and reimbursements will begin the transformation to a more business-focused model of mental health care with greater emphasis on optimizing available sources of funding.

Strategy 2.2: Deploy Benefits Coordinator positions to mental health service sites in order to assist and advocate for individuals seeking benefits.

The need for improved assistance for individuals seeking benefits was a recurring theme among stakeholders during activities we conducted to gather input. Many challenges exist in the Virginia benefits administration environment for persons with behavioral healthcare needs who want to access Medicaid benefits and other entitlements including Medicare, SSI and SSDI. Follow-up with, and advocacy for, the service recipient until such time as the individual is enrolled or disqualified is critical. Given the poverty level of service recipients (nearly 60% of those served have incomes under the federal

poverty level), eligibility for other federally sponsored programs such as food stamps should also be assessed.

We believe that deployment of Benefits Coordinators from the Department of Family Services to mental health service sites will enable more individuals to qualify for needed state and federal benefits.

Strategy 2.3: Seek opportunities for grant funding and assure that the CSB is prepared to sustain initiatives originally financed by grants after the grant money is depleted.

Overall, we believe that grants offer opportunity to enhance mental health services and supports; however, careful analysis is needed before initiating an application to determine if sustainability of an initiative would be an issue after the term of the grant. 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. Currently, the CSB has a number of federal and state grants that are subject to renewal or reconsideration. CSB leaders acknowledge that the system has been challenged in knowing whether to bypass grant opportunities when grant expiration would result in service reduction.

Strategy 2.4: Explore the establishment of a foundation whose purpose would be to assure an accessible, affordable, and integrated mental health system.

A robust system of mental health care requires the collaboration of public, private, and nonprofit service

providers and the utilization of all funding streams. Private philanthropic donations are an important aspect of overall funding, and we believe the establishment of a foundation is one way to maximize philanthropy for this population.

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.

THEME

Prevention and Early Intervention

RECOMMENDATION 3:

Increase prevention and early intervention efforts for children, youth, and adults in order to decrease the need for mental health services.

Strategy 3.1: Organize and deliver education and public awareness activities and campaigns about mental health and wellness. Actively publicize information about public mental health services and supports to the community.

Strategy 3.2: Assure that prevention is a fundamental responsibility of every provider in the system.

Strategy 3.3: Integrate more fully with Fairfax County Public Schools to support the mental health of children and youth.

Strategy 3.4: Expand early intervention practices to prevent the need for crisis and emergency care, and to mitigate further progression of the illness.

THEME

Prevention and Early Intervention

RECOMMENDATION 3:

Increase prevention and early intervention efforts for children, youth, and adults in order to decrease the need for mental health services.

We have included prevention and early intervention in our values because we believe that early identification, early intervention, and maintenance of wellness build protection and resilience, and enhance the likelihood of positive outcomes for all individuals with, or at risk for, mental illness. This belief is based on our collective understanding that a system that supplies prevention, early identification, and early intervention services will minimize demand for more expensive emergency and crisis services. Growing awareness of the mental health benefits of prevention and early identification is evidenced in services provided by public and private organizations across the country.

Strategy 3.1: Organize and deliver education and public awareness activities and campaigns about mental health and wellness. Actively publicize information about public mental health services and supports to the community.

Education efforts are necessary to increase public awareness of mental health and wellness, which in turn will reduce the stigma surrounding mental illness and promote the positive effects of prevention practices and early intervention. The Commission believes that the CSB and its system partners have a responsibility to provide education about mental health issues, thus raising the public's awareness. Information about mental health, wellness, resilience, and recovery should be easily

accessible so that all residents of the Fairfax-Falls Church community can benefit by knowing more about these issues.

Education efforts should include outreach and publicity to inform the public about mental health services and supports. Access to such information was a theme in our stakeholder input-gathering activities. We believe that the CSB's publicizing of its mental health services could be more effective. The CSB has begun to address this by hiring a new Communications Director.

Strategy 3.2: Assure that prevention is a fundamental responsibility of every provider in the system.

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

- **Al's Pals:** A resiliency-based prevention curriculum and teacher training program that develops personal, social, and emotional skills in children ages 3 to 8.
- **Girl Power:** A nationally recognized program developed by the CSB for girls ages 9 to 13 that teaches mental health promotion through skill-building groups and activities, community service projects, and other activities.
- **Leadership and Resiliency:** A nationally recognized licensed model program developed by the CSB for 14- to 18-year-old high school students that 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 that teaches high-school-age youth how to identify symptoms of depression, self-injury, and possible suicide in themselves or their friends, and to respond effectively by seeking help from a trusted adult.

We applaud these prevention and early intervention efforts, which focus on children and youth; however, prevention and early intervention should include adults as well. We believe that all mental health services must be built around the premise that prevention is a fundamental function of the system. This will require the CSB to integrate a prevention philosophy throughout its system of services and supports and to develop and train its workforce accordingly.

Strategy 3.3: Integrate more fully with Fairfax County Public Schools to support the mental health of children and youth.

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.”¹ The need may be even greater in Fairfax County: In its 2005 Youth Survey, 32.3% of students reported that in the previous twelve months they had experienced extended periods of sadness or hopelessness every day for weeks at a time, which

had prohibited them from performing their usual activities. Additionally, 12.9% of students indicated that they had seriously considered suicide in the previous twelve months, and 3.4% reported that they had actually attempted suicide.²

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 partners with the mental health system.³ The Commission, supported by comments from stakeholders, 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.

CSB’s Infancy and Early Childhood program partners with Fairfax County Public Schools (FCPS) to offer comprehensive mental health services to young children (birth through six years) and their parents in seven preschools throughout the county. A therapist goes to the schools to identify and serve young children with behavioral, emotional, and/or developmental problems that affect their daily functioning at home or school. Additionally, the CSB partners with the school system to offer Student Assistance Programs, a comprehensive model for the delivery of prevention, early intervention and support services, primarily for high-school-aged youth. Student assistance services are designed to reduce student risk factors, promote protective factors, increase asset development, and create a bridge to needed services.

Optimized integration with the school system would include the provi-

sion of mental health services in the schools; strengthen the overall supports available to children, youth, and their families; and increase the likelihood of families caring for their children and youth at home.

Strategy 3.4: Expand early intervention practices to prevent the need for crisis and emergency care, and to mitigate further progression of the illness.

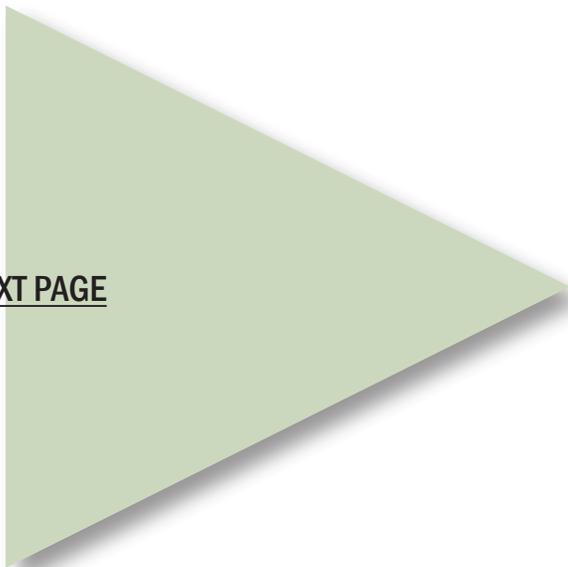
By making information on mental health more readily available to those in the community – specifically through awareness activities, more prevalent prevention initiatives through providers, and stronger collaboration with the school system – mental health issues can be addressed before a crisis arises and emergency care is needed. Furthermore, we have learned from the consumer movement that individuals

can and have developed early intervention strategies that help them avoid crisis services and hospitalization. These strategies include Wellness Recovery Action Planning (WRAP), psychiatric advance directives, and a community of support. Practitioners who are sensitive to strategies that prevent crisis can facilitate such planning for people as a standard component of care.

Overall, the Commission believes that prevention and early intervention activities in the community as well as the development of individual plans for relapse prevention are fundamental to mitigating the progression of mental illness to a point of crisis.

OPTIMIZED INTEGRATION WITH THE SCHOOL SYSTEM WOULD INCLUDE THE PROVISION OF MENTAL HEALTH SERVICES IN THE SCHOOLS; STRENGTHEN THE OVERALL SUPPORTS AVAILABLE TO CHILDREN, YOUTH, AND THEIR FAMILIES; AND INCREASE THE LIKELIHOOD OF FAMILIES CARING FOR THEIR CHILDREN AND YOUTH AT HOME.

SERVICES AND SUPPORTS, NEXT PAGE



THEME

Services and Supports

RECOMMENDATION 4:

Build a service delivery system that, in its entirety, supports recovery and resilience.

ACCESS

Strategy 4.1: 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 nonprofit mental health services and supports. Build a robust network of care with practices that ensure cross-system accountability for referral connections.

PERSON-CENTERED CARE

Strategy 4.2: Ensure integration of person-centered practices and processes in working with individuals with psychiatric disabilities.

CARE COORDINATION

Strategy 4.3 Make care coordination (case management) a centerpiece of the mental health service delivery design. Utilize a strengths-based model for delivering care coordination.

Strategy 4.4: Build continuity of care into the model for delivering care coordination.

CARE IN THE COMMUNITY

Strategy 4.5: 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.

Strategy 4.6: Enable persons to be served in their natural communities by assisting staff in transportation needs.

Strategy 4.7: Increase support to families of children, youth, and adults with psychiatric disabilities as part of the shift to care in the community.

PEER INVOLVEMENT

Strategy 4.8: Assure that peer services and supports permeate the mental health system.

Strategy 4.9: Invest in and enhance peer-run drop-in centers.

INTEGRATED TREATMENT

Strategy 4.10: Continue efforts to integrate mental health and substance abuse assessment and treatment for individuals with co-occurring disorders.

Strategy 4.11: Support and expand existing examples of cross-system collaboration that emphasize treatment in lieu of or in addition to incarceration.

RECOMMENDATION 5:

Assure safe, affordable, and stable housing for persons with psychiatric disabilities.

HOUSING

Strategy 5.1: Support the Housing First model and efforts to maximize housing as outlined in the county's Ten-Year Plan to End Homelessness.

Strategy 5.2: Engage individuals receiving services, families of individuals receiving services, and national and local nonprofit organizations in expanding housing options with accompanying support services.

Strategy 5.2: Create a housing development fund to support housing for persons with psychiatric disabilities.

Strategy 5.4: Explore existing systemic challenges between housing and mental health services in order to optimize collaboration for the benefit of persons with psychiatric disabilities.

RECOMMENDATION 6:

Expand employment and education support for persons with psychiatric disabilities.

EMPLOYMENT

Strategy 6.1: Implement employment services, consistent with the principles of evidence-based supported or individualized employment.

Strategy 6.2: Identify an employment liaison to facilitate collaboration at the system level in order to reduce barriers that hinder employment and expand opportunities that promote employment.

Strategy 6.3: Access the federal funding for Ticket to Work by creating an employment network.

EDUCATION

Strategy 6.4: Strengthen connections with local educational institutions in order to support adults wishing to further their education.

RECOMMENDATION 7:

Facilitate connection with primary health care for all persons with psychiatric disabilities.

PRIMARY HEALTH CARE

Strategy 7.1: Support and expand the existing examples of cross-system collaboration between primary and behavioral healthcare providers.

Strategy 7.2: Explore modification of the affordable healthcare system to a Federally Qualified Health Center Look-Alike to strengthen the interface between primary and mental health care.

Strategy 7.3: Explore the possibility of a locally developed group health insurance plan.

THEME

Services and Supports

RECOMMENDATION 4:

Build a service delivery system that, in its entirety, supports recovery and resilience.

“Recovery is an ‘everybody wins’ scenario.”¹ 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.”² “Long-term follow-up research that tracks people with serious mental illnesses for 30 years or more shows that large numbers of individuals overcome their disabilities and recover.”³

The way 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 access to care, person-centered care, care coordination (case management), continuity of care, the use of peers throughout the system, and shifting care into the community are essential design practices of a transformed system. These design concepts are intended to be equally applicable to adults as they are to children and youth. As indicated in our vision statement, we envision a future when everyone, at any stage of life (from infants and children to aging adults), will have access to effective services and supports.

While this report does not address treatment and medication options, we believe that choices among alternatives should be based on research with demonstrated effectiveness. For example, Dialectical Behavioral Therapy (DBT) is

an evidenced-based practice with demonstrated improvement in outcomes that is currently provided by the CSB. We were pleased with survey results for the items “Staff give me complete information in words I understand before I consent to treatment and medication” and “Staff (do not) lack up-to-date knowledge on the most effective treatments,” both of which were among the top 10 positive responses for individuals receiving services (Appendix C: Survey Summary, p. 32). It also should be noted that the survey item “The doctor worked with me to get on medications that were most helpful for me” was among the top 5 positive responses from individuals receiving services (Appendix C: Survey Summary, p. 26).

ACCESS

Strategy 4.1: 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 nonprofit mental health services and supports. Build a robust network of care with practices that ensure cross-system accountability for referral connections.

“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

RECOVERY IS AN ‘EVERYBODY WINS’ SCENARIO.... RATHER THAN CREATING LONG-TERM USERS OF THE SYSTEM, INDIVIDUALS WILL RECEIVE SERVICES THAT WILL ENABLE THEM TO RECOVER AND DECREASE THEIR DEPENDENCE ON THE SYSTEM.

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.

more productive lives.”⁴ 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 for the system that mental health is a shared community responsibility.

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 psychoeducational group). Others may have longer-term access to public care (e.g., intensive care coordination or case management, medication management).

The primary “front door” for non-emergent adult callers entering the mental health CSB system is through the Access Unit. This unit was established in 2006 in response to unacceptably long waits for an assessment appointment. Other portals of entry for adults include, but are not limited to, Emergency Services, Crisis Care, Homeless Outreach, Hospital Discharge, and Day Treatment. Children, youth, and their families in need of services are screened at first contact and given an assessment 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

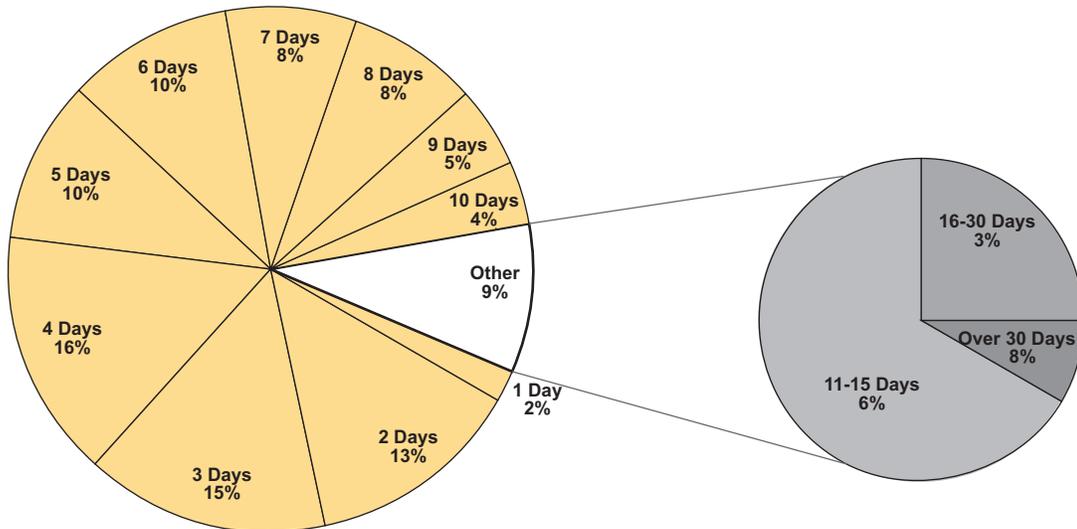
Services, Adolescent Day Treatment, Youth & Family Residential Services, Psychiatric Inpatient units, Juvenile and Domestic Relations District Court, Comprehensive Services Act, Fairfax County Public Schools, and the Department of Family Services. Emergent callers are referred for immediate attention to Emergency Services.

As illustrated in Figure 1 on the next page, 91% of adults are scheduled for an assessment in the Access Unit within ten business days of initial contact, and the average wait for adults from initial contact to assessment appointment in the Access Unit is six business days. As illustrated in Figure 2, the average wait for children, youth, and their families from initial contact to assessment (intake) appointment is fourteen business days; 41% are scheduled within ten business days, and 17% within five business days. CSB staff indicated that wait time for families of children and youth is negatively affected by staff vacancies and availability of Spanish-speaking staff.

We understand that the standard wait within the behavioral health industry (i.e., managed behavioral healthcare organizations) for routine access to services is within ten business days.⁵ The CSB may strive to comply with the industry standard (for routine access within ten business days), and this may be a realistic target for the system at this time. However, we believe the CSB should ultimately set its target based on benchmarked targets of high-performing public behavioral healthcare systems and an assessment of the needs of adults, children, youth, and their families in the Fairfax-Falls Church area. Whatever the chosen target, we believe that analysis of the process for accessing services and supports may

**Business Days Between Initial Contact and Assessment Appointment
4/1/08 to 6/30/08 (90-day period)**

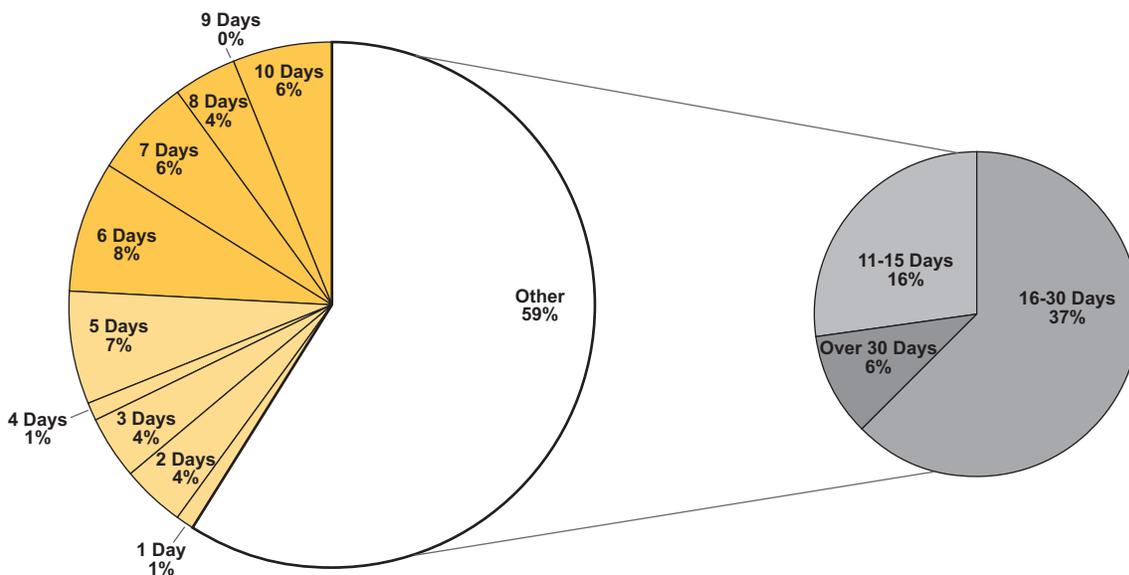
ADULTS



Number of individuals: 454
 Scheduled within 10 business days of request: 91%
 Average wait: 6 business days

FIGURE 1

CHILDREN, YOUTH AND THEIR FAMILIES



Number of individuals: 200
 Scheduled within 5 business days of request: 17%
 Scheduled within 10 business days of request: 41%
 Average wait: 14 business days

FIGURE 2

SERVICE	ADULT WAIT TIME	YOUTH WAIT TIME
Outpatient and Case Management	1-3 weeks or within 1 week of hospital discharge	0-12 weeks, depending on site, program and staff vacancies
Day Treatment	4-8 weeks (routine) or within 1 week (urgent)	No wait
Crisis Care	3 days or less for hospital diversion or 7 days or less for hospital step-down	No wait
Psychiatrist or Nurse Practitioner	1-4 weeks for initial appointment or within 1 week of hospital discharge	4 weeks for initial appointment
Residential	Varies by setting and preference: range is 9 months to multiple years	Varies depending on setting and preference <i>(Youth needing other residential placements wait depending on availability of nonmandated funds)</i>

identify steps that could be altered or eliminated.

The CSB estimates that approximately half of adults who enter the system complete public care because their needs are met through time-limited services and supports or they are referred to other community resources; the remaining 50% transition deeper into the system of public care. Children, youth, and their families have fewer eligibility constraints to access deeper end services.

As of September 1, 2008, the wait from assessment appointment to receipt of deeper end services varies by service type and level of care, as outlined above. Individuals with emergent needs can receive immediate attention through Emergency Services.

The need for improved access to service was a theme among stakeholders, which we believe reflects perceived challenges to accessing services. Based

on our review of wait times, we would encourage analyses of processes associated with initial contact with the system as well as with accessing more intensive services. Emphasis on measurement to include regular monitoring of the metrics associated with access will be critical in assuring sustained improvement in accessing mental health services.

The “back door” for adults to exit the system is utilized less often than the front door. This is because many adults 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. The “back door” for youth to exit the system is utilized by youth who have benefited by care coordination (case management), supportive counseling, and psychotherapy. As with adults, however, a significant percentage of youth receiving medication services remain in the system. Currently,

62% of youth receive medication.

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, should 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), a serious emotional disturbance (up to 18 years of age), or are at risk of developing a serious emotional disturbance (birth to age 7).
- Experiencing a serious mental illness with a concomitant substance use disorder.
- 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.

► **Who, regardless of insurance and ability to pay, are:**

- Found 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's needs

and preferences.

The Commission believes that the capacity of the public system would be enhanced through a robust network of care that 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 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 CSB currently has the ability to serve persons with private insurance (through participation on many insurance panels); however, the number of individuals receiving services who have private insurance represents a low percentage of the total served.

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 that 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

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.

primary healthcare 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 (i.e., referrals between public, private, and nonprofit providers). As an initial step in building this network, we recommend that a detailed market analysis be conducted in order to map network assets, identify barriers to access (e.g., the practice of requiring full payment at time of service), identify incentives for shared accountability and collaboration, and evaluate current system capacity against projected need.

PERSON-CENTERED CARE

Strategy 4.2: Ensure integration of person-centered practices and processes in working with individuals with psychiatric disabilities.

“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.”⁶

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 that they believe will be most useful in their recovery journey.⁷ “[The plan] needs to include personally defined goals along with realistic objectives that address relevant and immediate barriers and impediments.... The plan must be culturally relevant and outcome-oriented.”⁸

CSB leaders have indicated that individuals receiving services are involved in the development, monitoring, and changing of their treatment plans. Survey item ratings confirm involvement, with 69% responding positively (i.e., “Almost Always/Always” and “Often”) to “Staff see me as an equal partner in my treatment program,” and 58% responding positively to “My treatment plan goals are stated in my own words” (Appendix C: Survey Summary, p. 21). CSB should be commended for these results. By way of comparison, in an ongoing Yale study on people’s involvement in the development of their own plan, 24% of participants report never having a treatment plan. Of those who had experienced a treatment plan, half felt involved only “a little” or “not at all.” Only 21% report being “very much” involved.⁹

The maintenance of person-centered practices in the CSB will be evidenced by ongoing measurement of involvement in treatment plans.

CARE COORDINATION

Strategy 4.3: Make care coordination (case management) a centerpiece of the mental health service delivery design. Utilize a strengths-based model for delivering care coordination.

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.¹⁰ Example resources include housing, primary health care, and employment.

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 or problems, of the person with a psychiatric disability and utilizes an individual’s natural community supports to facilitate community integration.”¹¹

Our recommendation to build mental health care around care coordination will necessitate an examination of workforce resources. As public entities in Virginia and across the nation are finding, the path to transformation requires changes to the mix of care coordination, peer support, and psychiatric and psychotherapeutic resources.

Strategy 4.4: Build continuity of care into the 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.”¹² The Commission envisions processes that make the receipt of services and supports as seamless as possible for individuals seeking mental health care. Continuity of care will be evidenced in processes that limit transfers of service recipients from one provider to another.

Comments received through the survey process, as well as during the stakeholder input sessions, suggest that individuals receiving services would like to see improvements in the transitioning of individuals to a new therapist, in the follow-up process after individuals leave hospitalization, and in the transferring of individuals between programs (Appendix C: Survey Summary, pp. 37, 39 & 41).

CARE IN THE COMMUNITY

Strategy 4.5: 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.

“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

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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.”¹³

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).¹⁴ 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 to care in the community would ultimately be evidenced in processes, skills, and technology that support working in the community.

An existing example of care in the community is the CSB’s Mobile Crisis Unit, which provides emergency care for individuals experiencing psychiatric disorders. Emergency care that is mobile (provided in the community) can reduce the involvement of law enforcement and prevent re-traumatization and hospitalization of persons with mental illness. It is our understanding that the CSB is making the shift toward care in the community for adult and youth outpatient and care coordination services. To facilitate completion of this shift for

these services and to expand mobility of emergency services, we believe a policy about care in the community must be clearly and broadly articulated.

Strategy 4.6: Enable persons to be served in their natural communities by assisting staff in transportation needs.

Care coordination (case management) is the core of an improved system of mental health care in the Fairfax-Falls Church area. 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. As an alternative, the county could consider utilizing staff personal vehicles with mileage reimbursement. Issues such as insurance, mileage, and transportation of individuals with psychiatric disabilities would have to be addressed from a policy perspective by the county. The Commission recommends that transportation assistance for staff in providing care in the community be studied systemically as part of the budget planning process.

Strategy 4.7: Increase support to families of children, youth, and adults with psychiatric disabilities as part of the shift to care in the community.

At least 75% of persons with psychiatric disabilities have some variety of ongoing interaction with their families, and between 30% and 65% of persons with a psychiatric disability are estimated

to live with their families. Regardless of whether an individual lives with his or her family, the family often provides some support or assistance.¹⁵

Natural supports may be diminished for families of children with psychiatric disorders due to stigma, embarrassment, or the lack of time and energy on the part of the caregivers to seek help from others. Many “parents report that limited social support decreases their quality of life” and that they feel “less competent, more depressed, worried, and tired, and have more problems with spouses and other family relationships than other parents [do].”¹⁶ In order to care for their children at home and within the child’s natural community, families may need support.

Family members desire information about an individual’s psychiatric disability (specifically, information about diagnosis, prognosis, and treatment), as well as skills to cope with the illness, and resources about support options available to help them deal with the stresses and strains they might encounter. Many families report a lack of understanding from mental health practitioners about the care-giving experience and the kinds of burdens experienced by the family.¹⁷

The need for increased family support was a theme among stakeholders. As an illustration, approximately 30% of family members responded “Never/Rarely” to a survey item asking if they get the education or supports they need to be helpful (Appendix C: Survey Summary, p. 27). The CSB currently conducts some support groups for families of children, adolescents, and adults served by the CSB. Additionally, the CSB refers families to support groups conducted by community partners including the National Alliance on Mental

Illness - Northern Virginia Family to Family Education Groups.

The Commission recommends an increase in family support consistent with the shift to care in the community.

PEER INVOLVEMENT

Strategy 4.8: Assure that peer services and supports permeate the mental health system.

“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.”¹⁸ 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.
- Add their first-person knowledge and stories of recovery to the service mix.¹⁹

The need for peer support was a recurring theme across our stakeholder input activities. The CSB has begun to hire peers as support in several areas including Emergency Services, Crisis Care at Woodburn Place, the Program of Assertive Community Treatment (PACT) Team, and the Pharmacy Assistance Program. Responses to the survey item “There was a consumer peer advocate to turn to when I needed one” suggest the need to accelerate progress in utilization of peers. When compared

with all 42 survey items, this item was among the top six negatively rated items for all stakeholder groups served (Appendix C: Survey Summary, p. 33).

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.

Strategy 4.9: Invest in and enhance peer-run drop-in centers.

Peer-operated services are planned, delivered, and evaluated by persons who have experienced, or are experiencing, psychiatric disorders. These services enable those with lived experience to share their stories with others and use their own experience to offer guidance, support, and assistance to others. Peer-operated services are provided within a formal organization that “conforms to peer values of freedom of choice and peer control.”²⁰ These services are especially valuable in the community as they tend to attract peers from ethnic minority groups,²¹ dually diagnosed individuals,²² and peers who are hesitant to utilize the formal mental health system.²³

Drop-in centers are an example of peer-run or peer-operated services, where individuals with mental illness plan, operate, administer, deliver, and evaluate the services. Individuals with

psychiatric disabilities worked with the CSB and established three drop-in centers. Our survey results indicated that the system is promoting use of these centers. All three categories of respondents gave mostly favorable responses to the item “I am encouraged to use consumer-run programs.” To state this finding more specifically: 77% of recipients of services, 86% of service providers, and 54% of family members agreed or strongly agreed with this statement (Appendix C: Survey Summary, p.13).

INTEGRATED TREATMENT

Strategy 4.10: Continue efforts to integrate mental health and substance abuse assessment and treatment for individuals with co-occurring disorders.

“Numerous studies of substance abuse and mental health treatment populations and two major studies of the general population document significant rates of co-occurrence of substance use with certain other mental disorders.”²⁴

A significant effort is under way in CSB to build co-occurring capable programs able to treat co-occurring substance abuse and mental health disorders and to establish a “no wrong door” policy for these individuals. 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 with the Compass instrument that provided data about practice and policy changes to better serve individuals with these needs. All of these results are being addressed. The CSB organized staff change agents to work collectively

around systemic changes, to engage individuals receiving services and their families for guidance and input, and to improve the care provided by their teams. The goal is to ensure dual diagnosis capable services throughout the system. The Commission supports and recommends continuation of this effort.

Strategy 4.11: Support and expand existing examples of cross-system collaboration that emphasize treatment in lieu of or in addition to incarceration.

“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.”²⁵

“In some jurisdictions, the greatest challenge to initiating successful cross-system collaboration is simply getting prospective partners to the table.”²⁶ Fairfax County has met that challenge. Recognizing the county’s lack of a coordinated response for individuals with mental illness who had committed minor, nonviolent 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 10% of the department’s patrol officers have participated in this training, and we 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 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, the Juvenile and Domestic Relations District Court, and the Fairfax County Public Schools.

We believe that support of collaborative efforts such as these two examples, which emphasize mental health treatment, will improve the potential for recovery among individuals involved with the justice system and can serve as the basis for expanded collaboration.

THE NEED FOR IMPROVED ACCESS TO HOUSING WAS A RECURRING THEME ACROSS ALL STAKEHOLDER INPUT ACTIVITIES.

RECOMMENDATION 5:

Assure safe, affordable, and stable housing for persons with psychiatric disabilities.

Securing a home and housing are crucial to the recovery process. 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.”²⁷ 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. A study by the University of Pennsylvania’s Center for Mental Health Policy and Services Research concluded that supportive and transitional housing is no more expensive than the use of public health services, shelters, and jails.²⁸ Data collected locally by Pathway Homes, Inc., supports the national data.²⁹

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 that meets the needs of the lowest-income families and single adults is sorely inadequate. The need for improved access to housing was a recurring theme across all stakeholder input activities. As an illustration, the survey item “I have housing that I can afford” was among the top 10 negative responses of all stakeholder groups, with family members and service providers responding in relation to individuals receiving services (Appendix C: Survey Summary, p. 33). The 2008 Point in Time Survey found that 72% of single homeless individuals had serious

psychiatric disabilities and/or substance abuse disorders.³⁰ A February 2008 CSB survey of housing needs found that an estimated 1,000 adults enrolled in CSB mental health services were waiting for housing.³¹

HOUSING

Strategy 5.1: Support the Housing First model and efforts to maximize housing as outlined in the county’s Ten-Year Plan to End Homelessness.

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. We endorse the Housing First approach, in which “housing becomes the first step in moving out of homelessness, not the last, and is based on adherence to a lease (payment of rent, upkeep of unit, peaceful and orderly conduct), not compliance with a ‘service plan’.”³²

Strategy 5.2: Engage individuals receiving services, families of individuals receiving services, and national and local nonprofit organizations in expanding housing options with accompanying 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 as-

sure housing for individuals needing assistive services at all points on the spectrum of care — from the largely independent to those needing daily services. The long waiting list for the Stevenson Place Assisted Living Facility, which provides housing and support to persons with mental illness, is evidence of the continuing need for housing at the intense end of spectrum of care.

Consistent with recovery principles, the CSB is increasing the number of leases 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 the representative is paid directly by the Social Security Administration and is responsible for the financial obligations of the person receiving services.³³ 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 nonprofits or the families of individuals receiving services.

One local nonprofit serves as an example of collaboration between two organizations to assist 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.³⁴ Each Brain Foundation residence 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 Commission supports the expansion of supportive housing models such as this one and 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 in 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 large organizations, such as the Corporation for Supportive Housing, in addition to local groups.

Strategy 5.3: Create a housing development fund to support housing for persons with psychiatric disabilities.

A tool that may aid in assuring housing is the establishment of a fund 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, endowments, and grant money.

Strategy 5.4: Explore existing systemic challenges between housing and mental health services in order to optimize collaboration for the benefit of persons with psychiatric disabilities.

While the Commission recognizes that the CSB and the Department of Housing have different and distinct

responsibilities, they share the goal of providing safe, secure, affordable, and accessible housing for persons with psychiatric disabilities. Achievement of this goal requires optimal collaboration between staff of each agency, their governing bodies (i.e., CSB board and Redevelopment Housing Authority), and the Disability Services Board. The need for greater collaboration was a recurring theme across stakeholder groups (e.g., the Consolidated Community Funding Advisory Committee noted that greater

cross-system collaboration is needed in the areas of information exchange and service coordination.³⁵) The Commission recommends establishing a work group, with representatives of each of these entities, to explore the 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.

RECOMMENDATION 6:

Expand employment and education support for persons with psychiatric disabilities.

“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.”³⁶ 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.

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 support an array of options including full-time and part-time employment as well as educational and volunteer opportunities.

EMPLOYMENT

Strategy 6.1: Implement employment services, consistent with the principles of evidence-based supported or individualized employment.

The Commission supports the strategy of supported employment that “has emerged rapidly since the 1980s as an evidence-based service that supports recovery” for persons with mental health disabilities.³⁷ 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.”³⁸

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.”
- **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.”³⁹

The need for a greater number of employment opportunities for individuals receiving mental health services

THE COMMISSION SUPPORTS THE STRATEGY OF SUPPORTED EMPLOYMENT THAT HAS EMERGED RAPIDLY SINCE THE 1980s AS AN EVIDENCE-BASED SERVICE THAT SUPPORTS RECOVERY FOR PERSONS WITH MENTAL HEALTH DISABILITIES.

was a recurring theme in stakeholder input activities. Additionally, in the survey we conducted, the item “Mental health services helped me get or keep employment” received the second-most-negative response for both individuals receiving services (consumers) and family members (Appendix C: Survey Summary, p. 33). In the six months following this survey, the CSB has begun to emphasize the importance of employment for individuals receiving services and has expanded pre-employment workshops to all mental health outpatient sites.

Stigma remains a serious barrier to the employment of individuals with psychiatric disabilities. Enhanced focus on supported employment, followed by assessment of the effects of employment on recovery, would create additional opportunities for individuals with psychiatric disabilities to be seen as contributing members of the community.

Strategy 6.2: Identify an employment liaison to facilitate collaboration at the system level in order to reduce barriers that hinder employment and expand opportunities that promote employment.

In a transformed system that provides person-centered care, care coordination involves individually assisting persons in 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 Virginia Department of Rehabilitation Services (DRS), 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.

Currently, the Integrated Referral and Transition Team, consisting of CSB staff, contract vocational specialists, and a representative from DRS, meets weekly to match individuals who are ready to work with contracted vocational services in the community. In FY2008, 253 individuals receiving mental health services were connected with supported employment. The Commission applauds the efforts of this team. However, we believe that as the scope of care coordination is expanded to more actively involve supported employment, there will be a need for a liaison at the system level to facilitate collaboration across all system partners.

Strategy 6.3: Access the federal funding for Ticket to Work by creating an employment network.

As we gathered input from stakeholders, we learned that many people fear becoming employed because they might lose their health coverage and other benefits. Both the Ticket to Work program (through an Employment Network) and the VA Medicaid Works Initiative are designed to address this issue.

The goal of Ticket to Work, a program run by the Social Security Administration (SSA), is to assist individuals with disabilities who are receiving Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) “to become self-sufficient. The program is completely voluntary. One benefit is that current participation in the program will keep beneficiaries from medical continuing disabilities reviews as long as they are making ex-

pected progress towards self-supporting employment. Also, during participation in the program services are received at no extra cost.”⁴⁰

In the federal Ticket to Work program, services are provided through employment networks, which consist of private (for-profit and nonprofit) organizations, government agencies, employers, and others that agree to provide services and supports to assist beneficiaries in entering or re-entering the workforce. The SSA pays participating employment networks for milestones and outcomes that beneficiaries achieve in moving towards self-supporting employment. Examples of network services include, but are not limited to, counseling/guidance, education/training, job search/placement, and job coaching.⁴¹

The Virginia Medicaid Works Initiative is a new work-incentive opportunity offered by the Virginia Medicaid program for individuals with disabilities who are employed or want to work. The program is available to current and new Medicaid enrollees who are disabled and have countable income in 2008 of no more than \$694 per month (\$934 for a couple) and resources of no more than \$2,000 (\$3,000 for a couple). Individuals enrolled in Medicaid Works are entitled to the standard benefits available to full-benefit Medicaid enrollees.⁴²

We understand that CSB is currently exploring the creation of an Employment Network. We recommend gaining access to the funding for these programs so that potential barriers to seeking employment can be removed, and individuals can make work-related decisions based on work readiness rather than benefits availability.

EDUCATION

Strategy 6.4: Strengthen connections with local educational institutions in order to support adults wishing to further their education.

Mental health issues may begin very early in life; half of all lifetime cases of mental illness begin by age 14, 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.”⁴³ 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 that typically occur during late adolescence and early adulthood, such as high school graduation and 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. Responses to the survey item “I have a chance to advance my education if I want to” were among the top 10 negative responses from individuals receiving services (consumers) and service providers who completed the survey (Appendix C: Survey Summary, p. 33).

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.

MENTAL HEALTH ISSUES MAY BEGIN VERY EARLY IN LIFE; HALF OF ALL LIFETIME CASES OF MENTAL ILLNESS BEGIN BY AGE 14, AND THREE-QUARTERS OF THESE CASES HAVE BEGUN BY AGE 24.

**PEOPLE WITH
SERIOUS MENTAL
ILLNESSES
SERVED BY THE
PUBLIC MENTAL
HEALTH SYSTEM
DIE ON AVER-
AGE 25 YEARS
EARLIER THAN
PEOPLE IN THE
GENERAL
POPULATION.**

RECOMMENDATION 7:

Facilitate connection with primary health care for all persons with psychiatric disabilities.

“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 that may be addressed with medical support and interventions such as appropriate food selection and better nutrition, stress reduction and smoking cessation.”⁴⁴

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.⁴⁵ 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.”⁴⁶ These relationships with

the family are key for children and older individuals with psychiatric disabilities.

PRIMARY HEALTH CARE

Strategy 7.1: Support and expand the existing examples of cross-system collaboration between primary and behavioral healthcare providers.

We were encouraged with results for the survey item “The mental health staff (do not) ignore physical health,” which was among the most favorable responses from all three stakeholder groups (Appendix C: Survey Summary, p. 31).

The CSB has collaborated with the Health Department to provide psychiatric services at the county’s three Community Health Care Network (CHCN) clinics. These clinics 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 Health Care clinic 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 increasing the capacity of

the CHCN medical staff to diagnose and treat mental illness. The effort has been very successful. 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.

Strategy 7.2: Explore modification of the affordable healthcare system to a Federally Qualified Health Center Look-Alike to strengthen the interface between primary and mental health care.

One possible strategy to strengthen the interface between primary and behavioral health care would be to explore modification of the status of the county's primary care centers to a Federally Qualified Health Center (FQHC) Look-Alike. We understand that Fairfax County currently has three primary care centers that are integral parts of the safety net and provide critical care to residents. A Federally Qualified Health Center (FQHC) is a mechanism the federal government has utilized to bring primary and behavioral health care to communities that lack access to medical care and have a high level of poverty. The level of poverty in Fairfax is not high enough to qualify for a FQHC. However, the county could seek FQHC Look-Alike status, an official federal program. Behavioral healthcare services are required to be delivered in an FQHC, and Medicaid is the primary reimbursement for such services.

Currently, Medicaid is not accepted at the three centers in the Community

Health Care Network, which means that the centers are financed completely by local dollars. 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.

The Commission recommends that CSB and Health Department staff, working with the CSB board and the Health Care Advisory Board, jointly explore the feasibility, benefits, and implementation strategies of this modification.

Strategy 7.3: Explore the possibility of a locally developed group health insurance plan.

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 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 non-profit organizations.

THEME

Workforce and Training

RECOMMENDATION 8:

Assure a workforce that possess skills, values, and attributes consistent with the vision of a recovery- and resilience-oriented system.

Strategy 8.1: Create, within the defined budget, flexibility to authorize and reallocate positions in order to respond to the needs of individuals receiving mental health services.

Strategy 8.2: Recruit and develop a workforce that possesses competencies that support and sustain the vision for the system.

Strategy 8.3: View personal experience with mental illness as a preferred qualification in recruiting applicants for positions.

Strategy 8.4: Assure training opportunities for persons interested in offering peer support.

Strategy 8.5: Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards.

Strategy 8.6: Promote person-first language that is consistent with a recovery- and resilience-oriented system of care.

THEME

Workforce and Training

RECOMMENDATION 8:

Assure a workforce that possesses skills, values, and attributes consistent with the vision of a recovery- and resilience-oriented system.

The Substance Abuse and Mental Health Services Administration (SAMHSA) commissioned the Annapolis Coalition to develop a national strategic plan on behavioral health workforce development. Strategic goals in this national plan focus on broadening the concept of the workforce, strengthening the workforce, and instituting structures to support it.¹ As the Fairfax-Falls Church mental health system shifts to a transformed culture focused on recovery and resilience, new and different workforce skills and competencies are required. This shift will necessitate a transformed approach to recruiting, developing, and evaluating the behavioral healthcare workforce.

We fully expect that as the system is transformed, changes will occur in how positions are used and how staff members are deployed. As public entities in Virginia and across the nation are finding, the path to transformation requires changes to the mix of care coordination, peer support, psychiatric, and psychotherapeutic resources.

Strategy 8.1: Create, within the defined budget, flexibility to authorize and reallocate positions in order to respond to the needs of individuals receiving mental health services.

Currently, the Board of Supervisors exercises legislative control over an agency's appropriated funds and allocated number of positions. Adjustments to either require board action. 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. For example, if an assessment determines that two peer support positions would achieve greater results than one mental health therapist position, individuals served would benefit by system flexibility to make that change as long as CSB manages within its overall funding allocation.

Strategy 8.2: Recruit and develop a workforce that possesses competencies that support and sustain the vision for the system.

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."² 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."³

STAFF MEMBERS WHO HAVE EXPERIENCED MENTAL ILLNESS WILL BE TREATED AS AN ASSET TO THE ORGANIZATION. BY SHARING THEIR STORY, THEY ARE HELPING TO REDUCE THE STIGMA SURROUNDING MENTAL ILLNESS.

As a specific example, linguistic competency – 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 skill for providers in today’s behavioral healthcare workforce.⁴ Recognizing the diversity of cultures in the Fairfax-Falls Church area, we were pleased to note that all stakeholder groups represented in the survey gave a 65% or greater positive rating (i.e., “Almost Always/Always” and “Often”) to the item “Staff treat me with respect regarding my cultural background” (Appendix C: Survey Summary, p. 20). The challenge of this system, as previously noted in this report, appears to be in attracting bilingual staff to serve an increasingly multicultural population.

The Commission encourages the CSB to build into the recruitment and development processes a continuous assessment of identified workforce competencies and ongoing development to update thinking, skills, and practices.

Strategy 8.3: View personal experience with mental illness as a preferred qualification in recruiting applicants for positions.

Some mental health systems hire peers to fill existing positions. The terminology “personal experience preferred” or “lived experience preferred” in position advertisements sets the tone that personal experience with mental illness 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 sets an organizational precedent that reduces stigma.

In addition to viewing personal experience with mental illness as an asset in the recruitment of applicants, the Commission believes that staff members 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 open 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.

Strategy 8.4: Assure training opportunities for persons interested in offering peer support.

The use of peers in the provision of mental health services has many benefits but requires 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 toward individuals receiving services, and opportunities for discussion among peer and non-peer providers.⁵ 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.

As the Fairfax-Falls Church mental health system expands its utilization of peers, more training opportunities will be needed. Programs such as the Peer-to-Peer education course offered by the National Alliance on Mental Illness (NAMI) could be brought to local colleges so that willing peers can get the training they need.⁶ 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.⁷ The Commission also would encourage the county to consider establishing a local institute to provide training, ongoing education, and a continual support network for peers serving in the community.

Strategy 8.5: Demonstrate high expectations for efficiency and accountability through clear performance and productivity standards.

Productivity can be encouraged by building productivity measures into the county's pay-for-performance system. These productivity measures would serve as incentives and would be established through benchmarking other system standards and having conversations with staff and individuals receiving mental health services. These standards would be periodically re-evaluated to assure that they are reasonable but challenging. Advances in technology that impact the work would also affect these standards.

Strategy 8.6: Promote person-first language that is consistent with a recovery- and resilience-oriented system of care.

“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.”⁸

“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.’⁹ 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.¹⁰ The intentional use of person-first language helps to promote an environment in which people with mental illness are valued, motivated to gain hope for the future, and reach their goals.

“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’.”

THEME

Data and Outcomes

RECOMMENDATION 9:

Ensure cross-system accountability with performance and outcome measures, and use the data to improve the system.

Strategy 9.1: Adopt a robust system of performance measures and ensure that the performance data is used to improve system effectiveness.

Strategy 9.2: Seek information from other organizations about successful approaches to serving the mental health needs of children, youth, and adults.

Strategy 9.3: Conduct periodic analyses of system functioning to identify points for improvement.

THEME

Data and Outcomes

RECOMMENDATION 9:

Ensure cross-system accountability with performance and outcome measures, and use the data to improve the system.

As previously identified in this report, we believe the CSB collects a substantial amount of data but does not use it to drive performance. Consequently, we spent considerable time developing our recommendations related to measuring performance and outcomes.

We began 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 Ronald Manderscheid, Ph.D., served as a base for our recommended measures.

Strategy 9.1: Adopt a robust system of performance measures and ensure that the performance data is used to improve system effectiveness.

In developing this recommended strategy, 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 the Fairfax-Falls Church area. This would enable the CSB to compare performance by benchmarking performance indicators of other comparison groups. Tracking

OUR RECOMMENDED MEASURES FOCUS ON AVAILABILITY OF DATA FOR DECISIONS BY THOSE WHO DRIVE THE SYSTEM.

or benchmarking indicators at regular intervals allows leaders to focus on those aspects of the organization that are critical to achieving the desired out-

comes. In addition to selecting indicators of performance that can be easily benchmarked, we believe it is critical to set realistic and achievable targets for each measure.

While there are multiple audiences for performance measures, our recommended measures focus on availability of data for decisions by those who drive the system (mental health leaders, members of the CSB board, 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 (see Appendix E for a list of the larger universe of measures), but for this dashboard we recommend more selectivity in order to focus on those indicators of performance that are key to transforming the system, including measures related to evidenced-based practices.

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.

The following measures are recommended for inclusion in the initial dashboard of measures. Status and tentative targets, provided by CSB staff, are listed below each recommended measure:

INITIAL DASHBOARD OF MEASURES

1. Percentage of adults indicating they are participating in the design and implementation of their service plan
TARGET: 100% by June 30, 2009
2. Percentage of adults actively participating in the annual review of their service plan
TARGET: 100% by June 30, 2009
3. Percentage of adults reporting positively about social connectedness at admission and discharge
TARGET: TBD
4. Percentage of individuals receiving services who are involved (incarcerated) with the criminal justice system at admission and at discharge
TARGET: TBD
5. Percentage of individuals with a medical home (consistent provider of health care)
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
TARGET: TBD
7. Percentage of adults employed at admission and at discharge
TARGET: by June 30, 2009: 22%
8. Percentage of adults receiving mental health services who receive an assessment appointment within ten business days of their first call for service
TARGET: 100% by June 30, 2009 (last quarter of FY2008: 91%)
9. Percentage of youth who receive an assessment appointment within five business days of their first call for service
TARGET: 100% by June 30, 2009 (last quarter of FY2008: 17%)

The CSB has initiatives under way that involve performance and outcome measures including, but not limited to, requirements in the State Performance Contract related to both process and data, the county performance measures required in the yearly budget process, and the county's recent balance score-card initiative. We understand that work is already under way to integrate these initiatives with our recommended initial dashboard of measures. The first challenge to the CSB in utilizing this dashboard will be to define and test methods for collecting the measures.

Strategy 9.2: Seek information from other organizations about successful approaches to serving the mental health needs of children, youth, and adults.

We know that the CSB studies and compares its service practices with those of other organizations in the state. We would encourage expansion of such efforts as part of developing a learning culture in the organization.

As an example, the system may benefit by reviewing successful approaches in other jurisdictions to serving the needs of 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."¹ 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. "Long-term, failing to help youth suc-

cessfully transition to adulthood can be costly to individuals as well as governments."²

Strategy 9.3: Conduct periodic analyses of system functioning to identify points for improvement.

In addition to routine outcome and performance measurement, we believe the CSB would benefit by implementing a continuous process improvement approach ensuring periodic analyses of its processes. As an example, earlier in this report we recommended analysis of processes associated with initial contact with the system. The goal of periodic analyses would be continuous improvement and maximized efficiency. In advance of implementing a continuous process improvement approach, it is recommended that a thorough process analysis of key customer service processes takes place. This analysis might include documenting current process steps; documenting timeframes such as cycle time (length of time to deliver a service from beginning to end), and touch time (actual amount of time spent working with or for the individual being served); looking for ways to reduce cycle time in relation to touch time by designing inefficiencies out of the process (rework loops, delays, unnecessary handoffs, and non-value-added steps) and by designing into the process value-added steps such as feedforward (providing information about the process before it happens) and feedback (gathering information about the process after it happens).

THEME

Technology and Information Sharing

RECOMMENDATION 10:

Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management.

Strategy 10.1: Support improvements in efficiency and recovery through the purchase and support of a new electronic health record/personal health record (EHR/PHR) following county funding and procurement procedures. Funding for this recommendation would be considered through the county's IT Enhancement fund.

Strategy 10.2: Purchase hardware (laptops and similar portable devices) that supports changes in business practice.

Strategy 10.3: Establish, through a collaborative effort with the county Department of Information Technology, CSB-specific security guidelines and procedures that provide CSB greater flexibility to grant authorized staff certain system administrative rights when using desktops, laptops, and related peripherals.

Strategy 10.4: Facilitate access to information for individuals receiving services by extending public access to CSB sites and purchasing computer "kiosks" for key CSB service sites.

THEME

Technology and Information Sharing

RECOMMENDATION 10:

Utilize technology to support providers in delivering quality care, individuals in participating in their care, and the system in collecting data for effective management.

The successful implementation of changes to practices, 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 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. For individuals receiving service as well as for staff, support for decisions about care is enhanced through access to the most current research and information on service practices. Data that is generated on service type and amount can be utilized to compare what is being provided with demand and need, to evaluate productivity, and to realign resources as needed. Having information available on outcomes and productivity on a regular basis is itself an important management tool for system improvement.

Strategy 10.1: Support improvements in efficiency and recovery through the purchase and support of a new electronic health record/personal health record (EHR/PHR) following county funding and procurement procedures. Funding for this recommendation would be considered through the county's IT Enhancement fund.

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.

TECHNOLOGY CAN BRING ALIVE THE SET OF VALUES ESTABLISHED BY THIS COMMISSION BY IMPROVING EFFICIENCY, FACILITATING ACCESS TO SERVICES AND INFORMATION, PROVIDING DATA FOR MEASURING EFFECTIVENESS, AND PROMOTING TRANSPARENCY AND PARTICIPATION.

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 1,100 staff, more than 80,000 consumer records, connectivity for 75 main sites and additional smaller sites where individuals receiving CSB services reside, and policy implementation/guidelines. The county has a modern enterprise-wide communications network connecting all agencies to data center resources. Most agency applications are on servers in the county's data center, including the current CSB system. DIT provides desk-top support and security standards. DIT also has provided funding for technology improvements including a more secure and improved database environment to comply with HIPAA (Health Insurance Portability and Accountability Act) regulations as well as expansion of the infrastructure to support increased capacity requirements. These enhancements have enabled the CSB to expand its user base (growing from 300 current users to 1,100 by the spring of 2009) without

increasing DIT support staff. The transformation of the behavioral health-care business model and advances in technology support the acquisition of a product that provides an up-to-date supportable system architecture capable of serving the CSB's evolving business needs.

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 that is more suitable for the unique and dynamically evolving requirements of the CSB and behavioral health industry should be embraced and championed by CSB leadership and incorporated in county technology strategic directions.

A critical juncture exists that could

be capitalized on. The CSB is facing expensive upgrades to its current system 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 CSBs 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 funds have been approved to build additional server capacity and corresponding software licenses to meet an increased user base. Strategic implementation opportunities, including an upgrade of the system and/or the EHR with the vendor, could provide more efficiency and potential better use of county resources, while also ensuring that the CSB EHR supports the system reform that is under way.

To meet future requirements and in keeping with trends in technology, 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 what is used by medical practices and laboratories, and meet software guidelines for this interoperability
- ePrescribing capable.
- Document management ready, including the scanning and indexing of information generated on paper or 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.
- Inclusive of 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 outside experts, as appropriate, working together to:

- Assess current agreement, funding, support structure and capacity (including county IT, CSB and vendor staff) 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 through the county's IT Investments Fund.
- 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. This includes identifying gaps with the CSB's evolving behavioral healthcare business model requirements as well as the degree to which this application meets the needs of the CSB and those who receive its services.

- Analyze the possibility for hosting the current or future EHR application at the vendor site as an Application Service Provider (ASP) as opposed to within the county.
- Identify other hardware and connectivity requirements for the CSB to realize improved system performance at all sites and enhanced user capabilities in the implementation of a state-of-the-art EHR and PHR, and HIE; and provide adequate support for the system and individuals receiving CSB services through the use of technology.

To effectively support this EHR/PHR, the appropriately specified hardware and infrastructure that support the system and CSB business requirements must be in place. These items include:

- A system that is available 24/7 with sufficient redundancy to avoid down time.
- Increased funding and purchasing flexibility to determine and efficiently implement an appropriate system life-cycle so that the CSB can benefit most from state-of-the-art technology (computers, laptops, PDAs).
- Expanded network bandwidth regardless of location, allowing fast, consistent and reliable system response and facilitating secure 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 Internet sites that support their job seeking, information gather-

ing, and connection with others.

- Sufficient CSB support staff for ongoing training, and real-time support for clinical staff.
- Service Level Agreement with the service provider and county IT that provides a comprehensive support and system management capability based on roles, benchmarks, and best practices to enhance the ability of the CSB to maintain the EHR, including business continuity and disaster recovery.

Strategy 10.2: Purchase hardware (laptops and similar portable devices) that supports changes in business practice.

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

Strategy 10.3: Establish, through a collaborative effort with the county Department of Information Technology, CSB-specific security guidelines and procedures that provide CSB greater flexibility to grant authorized staff certain system administrative rights when using desktops, laptops, and related peripherals.

In their daily work, staff encounter technology issues that need to be resolved quickly and efficiently. Support for these issues is frequently slowed

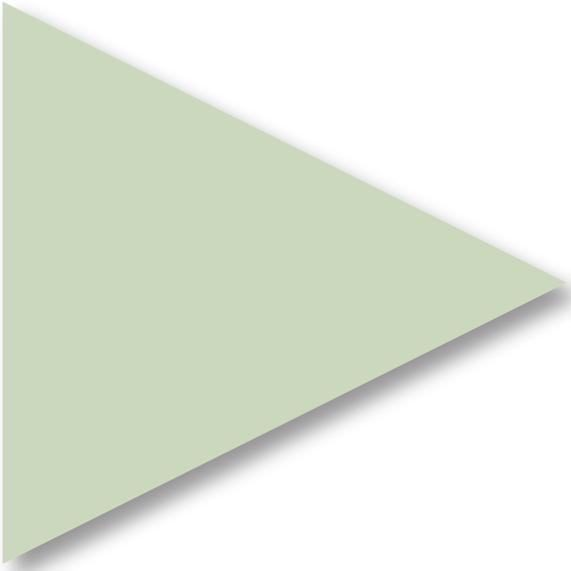
by the fact that the CSB is spread out across many sites. The CSB has staff identified by the county as “super users” who could assist with some of these common technical issues with computers and applications.

Strategy 10.4: Facilitate access to information for individuals receiving services by extending public access to CSB sites and purchasing computer “kiosks” for key CSB service sites.

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. Additionally, adequate training for individuals receiving services and their families around the use of computers and kiosks, relevant websites, and the use of the EHR will be critical to assure access to information.

Ultimately, the right combination of technology capabilities, software and hardware, and support for system reform will lead to increased efficiency.



Conclusion

In summary, we have recommended a vision for the mental health system and developed recommendations and strategies for facilitating the transformation to achieve this vision. We believe that the Fairfax-Falls Church area will experience tangible benefits by transforming the mental health system to a recovery- and resilience-oriented model of care as outlined in this report.

Specific outcomes that can be expected as a result of this shift include:

- Increased wellness and employment
- Decreased reliance on the public system of mental health care
- Reduced demand or need for expensive emergency and crisis services

These outcomes can be achieved through the adoption of business-focused strategies including:

- A data-driven approach to the management of access to mental health services and supports
- Ongoing feedback mechanisms to assure system accountability and effectiveness
- Maximized state, federal, and nonpublic revenue and reimbursements
- Productivity standards that demonstrate the expectation of shared accountability for outcomes

We strongly believe that there are compelling reasons for action, and would-be risks associated with inaction or failure to implement our recommended strategies. Fairfax is currently not maximizing non-local sources of revenue and reimbursements. A significant number of our recommended strategies were designed to produce additional state, federal, and nonpublic financial resources for the mental health system. Another reason to act is we believe that many of our strategies to improve and transform the system can be implemented at no additional cost and by reallocating existing resources or staff. Finally, we believe that many of our strategies — designed to strengthen efficiency and effectiveness as well as enhance prevention and early intervention — will assure that Fairfax-Falls Church area residents are getting the most value for their tax dollars and will ultimately decrease demand for expensive and traumatic emergency services and hospitalization.

Next Steps

Implementation Preparation

As we deliver our report, we understand that an implementation plan will be developed for the strategies we have recommended. To prepare for work on this plan, we would encourage the CSB (board and staff) to conduct over the next few months a high-level analysis of the strategies, including initial estimates of the level of investment required, the degree of difficulty anticipated, and a timeline for implementation of each recommended strategy. Outlined below are criteria from another source⁴ that we believe would be useful in making this initial analysis.

LEVEL OF INVESTMENT:

The funding required to implement the strategy through redirection of funds and/or identification of new funds.

 **NONE:** Would require reallocation of existing resources or staff at no additional cost.

 **LOW:** Would require reallocation of existing resources or staff at no additional cost, and minimal amounts of new funding at a cost of up to \$250,000.

 **MEDIUM:** Would require reallocation of existing resources or staff at no additional cost, and moderate amounts of new funding at a cost of \$250,000 to \$1 million.

 **HIGH:** Would require reallocation of existing resources or staff at no additional cost, and a large investment of new funds of \$1 million or more.

DEGREE OF DIFFICULTY:

The complexity, volume of work required, and degree to which the strategy necessitates changes in how people work together in the Fairfax-Falls Church area.

 **LOW:** Somewhat or not difficult to begin implementation due to the complexity of the issue, degree to which people need to change how they work together, and/or volume of work needed prior to implementation.

 **MEDIUM:** Moderately to somewhat difficult to begin implementation due to the complexity of the issue, degree to which people need to change how they work together, and/or volume of work needed prior to implementation.

 **HIGH:** Very to moderately difficult to begin implementation due to the complexity of the issue, degree to which people need to change how they work together, and/or volume of work needed prior to implementation.

TIMELINE FOR IMPLEMENTATION:

Proposed start of implementation. (Note: Does not imply completion of the strategy in year 1, 2 or 3, but rather that the strategy will be initiated during that timeframe.)

1 Year 1 (FY09)

2 Year 2 (FY10)

3 Year 3 (FY11)

A significant number of our recommended strategies were designed to generate additional state, federal, and nonpublic financial resources for the mental health system. While we understand that these additional resources will not be readily available to the system at the initiation of implementation, we would encourage that this analysis include estimated increases in system funding. We believe that some of the initial costs of implementing transformation strategies may eventually be offset by increased sources of system funding. Therefore, we propose that this analysis also capture estimated Level of Additional System Funding (low, medium, and high).

Appendix A: Glossary of Terms

ACCESS: The pathway individuals seeking mental health services follow to obtain care.¹

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.²

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.”³

COMPREHENSIVE SERVICES ACT: A 1993 Virginia 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.⁴

CONSUMER: An individual receiving mental health services. In accordance with the Commission’s emphasis on person-first language, the phrases “individuals receiving mental health services” and “individuals with psychiatric disabilities” have been substituted for the term “consumer” in this report. “Consumer” is used in Appendix C (the survey summary).

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.”⁵

CO-OCCURRING DISORDERS: “refers to co-occurring substance-related and mental disorders. Clients said to have COD have one or more substance-related disorders as well as one or more mental disorders.”⁶

CORPORATION FOR SUPPORTIVE HOUSING: A national nonprofit intermediary organization that helps communities create permanent housing with services to prevent and end homelessness.⁷

CULTURAL COMPETENCE: “The level of knowledge-based skills required to provide effective clinical care to [individuals] from a particular ethnic or racial group.”⁸ Specifically, “cultural competence is an approach to delivering mental health services grounded in the assumption that services are more effective when they are provided within the most relevant and meaningful cultural, gender-sensitive, and age-appropriate context for the people being served. The Surgeon General defined cultural competence in the most general terms as ‘the delivery of services responsive to the cultural concerns of racial and ethnic minority groups, including their languages, histories, traditions, beliefs, and values.’ In most cases, the term cultural competence refers to sets of guiding principles, developed to increase the ability of mental health providers, agencies, or systems to meet the

needs of diverse communities, including racial and ethnic minorities.”⁹

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.”¹⁰

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.”¹¹

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.”¹²

LINGUISTIC COMPETENCE: 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.¹³

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.”¹⁴

MEDICARE: “Federal health insurance program primarily for older Americans and people who retired early due to disability.”¹⁵

MENTAL HEALTH: “Mental health is more than the absence of mental disorders.... Mental health can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community. Mental health is the foundation for well-being and effective functioning for an individual and for a community.”¹⁶

PEER: Refers to someone “who has experienced first-hand, and is now in recovery from, a mental illness and/or addiction.”¹⁷

PERSON-CENTERED CARE: Care that is built around an individual’s personal assessment of hopes, aspirations, desires, and goals.¹⁸ A person-centered care plan is highly individualized, established in conversation with the individual being served, and respectful of the unique preferences, assets, strengths, and dignity of the individual.¹⁹

PRIMARY HEALTH CARE: Care “provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern.... Primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, and diagnosis and treatment of acute and chronic illnesses in a variety of health care settings.”²⁰

RECOVERY: 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.”²¹

RECOVERY ORIENTED SYSTEMS INDICATORS (ROSI): A survey tool 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 toward 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.”²²

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.”²³

SOCIAL SECURITY DISABILITY INSURANCE (SSDI): “Individuals who worked are ‘insured’ by the Social Security taxes...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.”²⁴

SSI/SSDI OUTREACH, ACCESS, AND RECOVERY (SOAR): A federal program that can expedite disability determination for the homeless population.

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.”²⁵

SUPPLEMENTAL 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.”²⁶

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.”²⁷

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.”²⁸

WELLNESS RECOVERY ACTION PLANNING (WRAP): A self-help approach to psychiatric illness management and promotion of wellness developed by Mary Ellen Copeland.²⁹ 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.³⁰

Acronyms Used in This Report:

ASP: Application Service Provider

CHCN: Community Health Care Network

COD: Co-occurring Disorders

CSA: Comprehensive Services Act

CSB: Community Services Board

DBT: Dialectical Behavioral Therapy

DFS: Department of Family Services

DIT: Department of Information Technology

DRS: Department of Rehabilitation Services

EHR: Electronic Health Record

FCPS: Fairfax County Public Schools

FQHC: Federally Qualified Health Center

HIE: Health Information Exchange

HIPAA: Health Insurance Portability and Accountability Act

MIS: Management Information System

NAMI: National Alliance on Mental Illness

NASMHPD: National Association of State Mental Health Program Directors

NOMs: National Outcome Measures

PACT: Program of Assertive Community Treatment

PHR: Personal Health Record

RFI: Request for Information

ROSI: Recovery Oriented Systems Indicators

SAMHSA: Substance Abuse and Mental Health Services Administration

S-CHIP: State Children's Health Insurance Program

SOAR: SSI/SSDI Outreach, Access, and Recovery

SSA: Social Security Administration

SSDI: Social Security Disability Insurance

SSI: Supplemental Security Income

WRAP: Wellness Recovery Action Planning

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 faci-

tating 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, in collaboration with the Community Services Board, to 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 healthcare 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 opportuni-

ties 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 and 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 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 ser-

vice 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 that 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 that 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 Re-

sources: 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 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 advo-

cates, 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

This appendix is a separate document.



Appendix D: Stakeholder Input

For ease of reference, input activity descriptions from the Stakeholder Input section of the report are repeated as an introduction to themes from each stakeholder activity.

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 recurring 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 about programs, processes, medication, the Medicaid application process, and the 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 condition 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 processing of benefits; and collaboration within the CSB, with other county agencies, and with 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 making decisions

Promoting effectiveness: number and range of outside activities, more day-treatment and step-down programs, follow-up with individuals receiving services

Ensuring safety: physical condition of facilities, supporting safe behavior of individuals receiving services, safety of program locations

Providing transparency: more education for individuals receiving services and families about programs and processes

Supporting free flow of information: communication between leadership and staff (response time, sharing of information)

Ensuring timeliness: intra-agency responsiveness

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) and similar surveys for family members/significant others of individuals receiving services and for providers of services. The ROSI survey is 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 (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 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

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 (National Alliance on Mental Illness – Northern Virginia), families of adults who had experience with emergency services. Comments from both of these sessions were summarized. The topics that engaged the most interest are 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, 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

Conversation with County Human Services Leaders: At a 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 CSB and the Deputy County Executive for Human Services.

One strong theme that 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 under-utilized 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.

Stakeholder Input on Draft Recommendations: After drafting our initial recommendations, we sought feedback from representatives of all stakeholder groups and other interested individuals. Specifically, draft recommendations were posted for comment on the Josiah H. Beeman page available through the Fairfax County Government website. Additionally, three public input sessions were conducted to solicit in-person comments from stakeholders. Based on this input, our draft recommendations were refined and reshaped. Topics that engaged the most interest were:

- Care network
- Care coordination
- Continuity of care
- Service integration
- Peer support and advocacy
- Peer-operated services
- Publicizing of services
- Financing a transformed system

Appendix E: Universe of Measures

The following information outlines the overall goals and universe of 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. 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.

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.

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 the criminal justice system at admission and discharge; decreased criminal justice involvement

- Annual percentage of individuals moving off the CSB housing waitlist into housing

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 nonemergency 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 who meet CSB performance standards for 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 nonemergency outpatient appointments kept by individuals within ten business days of their first contact

- Percentage of direct-service staff who meet CSB performance standards for 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 Measures:

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

Youth and Family Measures:

- 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), expediting 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
- Ensure proper documentation for bill-

ing Medicaid services

Youth and Family Measures:

- Percentage of children and youth with Medicaid
- Percentage of children and youth in State Children's Health Insurance Program (S-CHIP)
- Ensure proper documentation for billing Medicaid services
- Maximize 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 and family members treated with respect by program staff

- Youth and family members feel comfortable and welcomed by reception staff
- Youth and family members report that staff discussed what is important to them
- Youth and family members receive information about medication
- Youth and family members access 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 health care
- Criminal justice involvement
- School performance
- Children need to be present at treatment meetings in the 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

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