

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

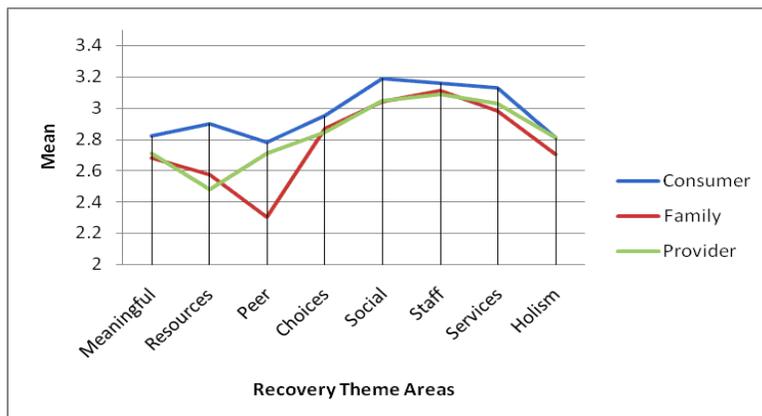
As we built the vision, philosophy, and value elements of the foundation for our recommendations, we conducted a parallel process of gathering input from various stakeholder groups through conversations and surveys. These stakeholder groups included individuals (youth and adults) receiving mental health 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

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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,

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

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

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.