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).

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.

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

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.

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.

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).

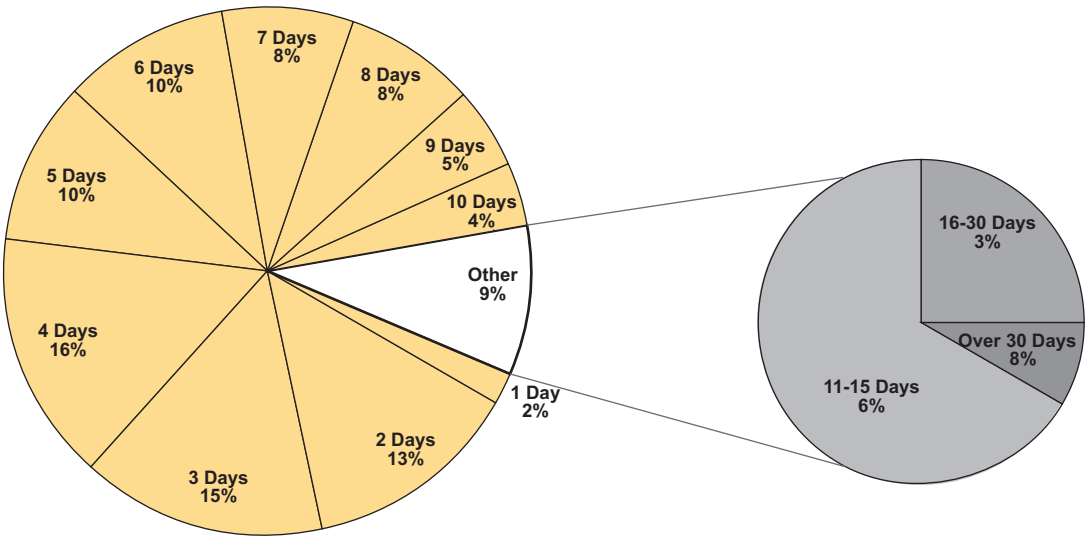
The primary "front door" for nonemergent adult callers entering the mental health CSB system is through the Access Unit. This unit was established in 2006 in response to unacceptably long waits for an assessment appointment. Other portals of entry for adults include, but are not limited to, Emergency 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)

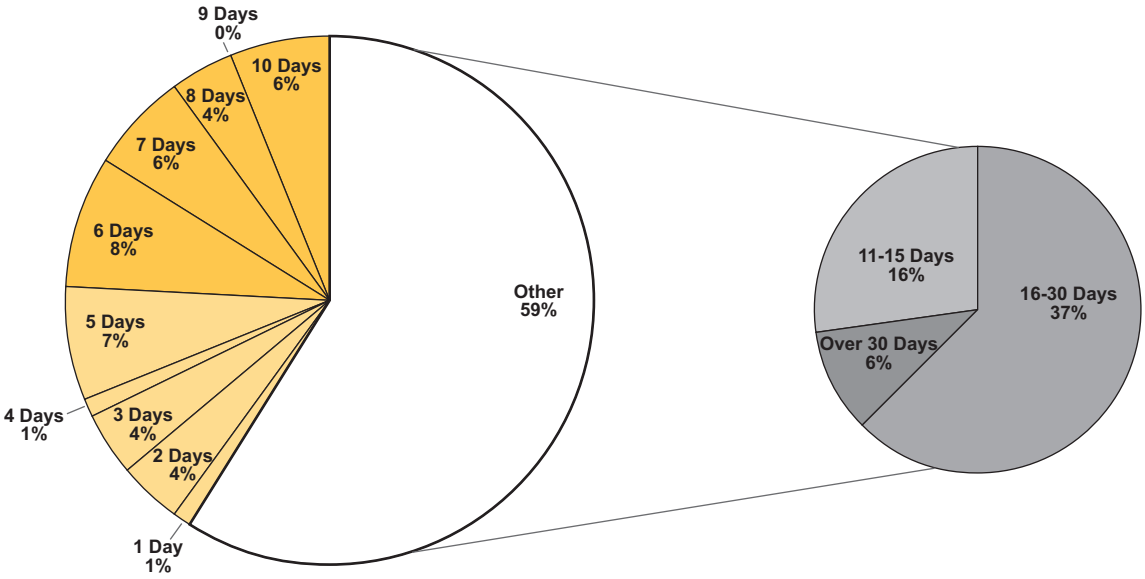
ADULTS



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 *(Youth needing other residential placements wait depending on availability of nonmandated funds)*

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).

WE BELIEVE THAT CARE COORDINATION IS FOUNDATIONAL TO THE DESIGN OF A MENTAL HEALTH SYSTEM.

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

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.

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.

RECOMMENDATION 5:

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

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

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).

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.

Stronger connections with local universities, colleges, vocational schools, and General Educational Development (GED) programs, and utilization of FCPS Adult Education opportunities will aid in serving the adult population and further support the empowering notion of a recovery- and resilience-oriented system.

RECOMMENDATION 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]

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

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.