

Beyond the Commission Charter

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

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

In support of advocacy efforts already underway in the Federal government, the Commission also encourages the Board to write letters, sign petitions, and make contact with delegates. There is important legislation concerning parity in mental health insurance coverage pending in Congress. The Senate passed its version of the law, the Mental Health Parity Act of 2007 (S.558.RRH) on September 18, 2007.⁸¹ The House of Delegates passed a similar law, the Genetic Information Nondiscrimination Act of 2008 (HR1424) on March 5, 2008.⁸² This bill generally requires that health plans which provide mental health coverage offer mental health and substance abuse benefits that are equal to the medical and surgical benefits offered. The benefits controlled by this law include deductibles, co-payments, coinsurance, out-of-pocket expenses, and annual and lifetime limits. The current presidential administration, health insurers and employers support the

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

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

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

As the Board finalizes its enhanced safety net system, it may consider raising the income level of those covered by the safety net to include families earning 300% of the Federal poverty level (up from 200%). These new guidelines would mean that families of four earning up to \$63,600 would be included in the health safety net.⁸⁴ As a comparison, the 2006 median income level for families in Fairfax County was \$119,800.⁸⁵

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

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

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

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

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

Conclusion

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

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

Appendix A: Glossary

Access: the pathway individuals seeking mental health services follow to obtain care.⁸⁷

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.⁸⁸

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”.⁸⁹

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

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”.⁹¹

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

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

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

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

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

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

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”.⁹³

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”.⁹⁴

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

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

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

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

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

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

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

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

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

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

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

Peer Specialist: a peer who is trained and employed to offer peer support to persons with psychiatric disabilities.¹⁰⁰

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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”.¹⁰⁸

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

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

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

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

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

Wellness Recovery Action Planning (WRAP): a self-help approach to psychiatric illness management and promotion of wellness developed by Mary Ellen Copeland.¹⁰⁹ 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.¹¹⁰

ACRONYMS USED IN THIS REPORT:

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

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

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

Appendix B: Commission Charter

Josiah H. Beeman Commission

On The Fairfax-Falls Church Mental Health Service Delivery System

Charter and General Work Plan

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

The Commission will:

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

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

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

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

Commission Deliverables

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

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

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

(2) Recommendations on Service Populations

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

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

(3) Recommendations on Service Delivery Design

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

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

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

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

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

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

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

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

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

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

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

(7) Transformation Roadmap and Strategies

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

Commission Timetable and Resources

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

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

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

Commission Composition

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

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

Commission Work Plan and Activities

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

Appendix C: Survey on Mental Health Services

is available electronically at
www.fairfaxcounty.gov/beemancommission

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