

2. SERVICE

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

a. Care Coordination and Continuity of Care

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

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

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

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

Recommendation 6

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

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

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

Recommendation 7

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

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

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

b. Person-Centered Care

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

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

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

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

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

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

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

Recommendation 8

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

c. Care in the Community

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

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

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

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

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

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

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

Recommendation 9

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

d. Optimized Integration

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

i. Primary Health Care

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

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

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

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.²⁹ 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”.³⁰ These relationships with the family are key for children and older individuals with psychiatric disabilities.

Support of integration efforts:

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

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

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

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

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

Recommendation 10

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

Modification of health care status:

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

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

Recommendation 11

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

Expansion of alternative approaches:

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

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

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

Recommendation 12

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

ii. Housing

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

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

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

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

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

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

Support of Housing First:

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

³⁴ McNair, Joel. Personal communication. 1 July 2008.

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

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

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

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

Recommendation 13

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

Expansion of housing with support services:

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

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

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

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

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

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

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

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

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

Recommendation 14

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

Optimization of collaboration:

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

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

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

Recommendation 15

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

iii. Employment

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

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

Implementation of evidence-based services:

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

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

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

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.”

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

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

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

Recommendation 16

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

Liaison with employment partners:

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

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

Recommendation 17

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

iv. Education

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

Integration with public schools:

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

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

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

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

Recommendation 18

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

Connections with educational institutions:

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

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

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

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

Recommendation 19

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

v. Justice System

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

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

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

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

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

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

Recommendation 20

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

Optimized integration for transitioning youth:

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

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

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

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

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

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

Recommendation 21

Benchmark successful approaches to serving the needs of transitioning youth.

e. Prevention and Early Intervention

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

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

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

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

Recommendation 22

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

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

3. PEERS

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

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

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