Principles, Vision, and Policy Priorities for Virginia's System Transformation

NAMI Virginia envisions a world free of stigma and discrimination where all people affected by mental illness get the help, hope, and support that they need. In a perfect world, mental illness would be treated the same as other illnesses: there would be ample and prompt services and treatment, the goals of resilience and recovery would be infused throughout the mental health care system, there would be promising research developments to inform practice, the criminal justice system would play a minimal if non-existent role, and the mental health care system would be user-friendly and welcoming. Sadly, we are not there yet. Our vision has not yet been achieved but it does give us a foundation from which to spring and a framework from which to operate.

Fortunately, we are in the midst of several opportunities that can help propel us closer to our vision including the Mental Health Services in the Twenty-First Century, Joint Subcommittee to Study, DBHDS System Transformation Initiative, Delivery System Reform Incentive Program (DSRIP), and others. These initiatives offer important opportunities for stakeholders to provide input into the vision and future of the mental health care system. As such NAMI Virginia offers the following principles and guidelines for achieving a transformed system. Specifically, in this position paper we will share our perspectives on some of the pressing policy questions being asked in the system transformation discussions including:

10 Principles of a Transformed Mental Health System[1]

1. Comprehensive;
2. Integrated;
3. Adequately funded;
4. Focused on wellness and recovery;
5. Safe and respectful;
6. Accessible;
7. Culturally competent;
8. Person-centered and person- and family-driven;
9. Well-staffed and trained; and
10. Transparent and accountable.

1. Is the community services board (CSB) system adequate or should the system be fundamentally altered? If so, in what way?
2. What is the role of private providers in the public system?
3. What do people with mental illness, their families and caregivers, and youth and young adults with mental health disorders and their parents want from the mental health care system?
4. How can accountability within the system be improved?
5. What is the role of state hospitals in the mental health care system?
6. Ultimately what would a transformed system look like?
7. What are our policy priorities to achieve a transformed system?

First, we believe that ensuring a strong mental health care system is a core function of government. It is essential that a community-based system of care be able to provide services to those who are uninsured, poor, living with chronic and complex health conditions, and living with serious mental illness or serious emotional disturbance for children and adolescents. Responsibility lies at the local, state, and federal levels to

develop and maintain comprehensive community support systems that include treatment and services, as well as to have short-and long-range plans for ensuring appropriate infrastructure, workforce, and financing of services. Further, the system of care should be funded and organized with components that assure the prioritization of services to those with mental illness and mental health problems who are the most seriously disabled whether services are needed on an involuntary or voluntary basis.

The public sector, specifically the community services boards (CSB), should serve as the safety net for individuals with severe and complex disorders. The private sector should also play an important role in the service delivery system. For example, the private sector can provide services when there is limited or no capacity in the public sector, can fill gaps in services, and can partner with the public sector to bring about innovations. The importance of public-private partnerships is especially true in Virginia for children and adolescents due to very limited capacity to serve this population. The bottom line is that public and private sector cooperation and planning are in order if the public interest is to be served in addressing the needs of Virginians with mental illness and children with serious emotional disorders. More to the point, there must be coordination and communication between the public and private sectors, and these systems must be transparent and accountable to the public.

All of this being said, while the CSB system is not as strong as it needs to be, we do not think it should be dismantled, as some policy makers have contemplated. Instead, there must be a systematic approach to address the numerous challenges in the CSB system that cause problems for individuals, parents, and families seeking help for mental illness. In other words, we think it is prudent to build on what exists rather than to completely replace and start anew.

We also recognize and affirm that the mental health care system is greater than just the CSB system: it involves schools, Children's Services Act (CSA), private inpatient hospitals, state hospitals, private providers of community-based services, and more. The positive in this is that there are many resources that can be brought to bear in addressing an individual's mental health needs. The challenge is that multiple layers create complexity, a difficult system to navigate, and lack of clarity about responsibility, accountability and oversight roles.

One of the chief complaints about the mental health care system is inconsistencies in services across Virginia. Because of the variability in resources from locality to locality, services that are available in one community aren't necessarily available in other communities. As a result, families and individuals feel frustrated about inequities in services, report disparate experiences with the mental health care system, and often face different outcomes. More to the point, it doesn't make sense to those outside the system seeking help why there is such variability. Further, this disparity causes the "system" to have a patchwork structure instead of being a comprehensive system that works seamlessly to provide treatment and services.

Part of Virginia's challenge is that community services boards are only mandated by code to provide certain services, yet the public's expectation and need is that they do more; certainly most go above and beyond code-mandated services by providing a more robust set of services or contracting with private providers, or a combination. In the end, the structure is almost bound to fail if the community services system is only expected and funded to provide a small range of services. Further, the services that are required are on the crisis end of the spectrum. In short, Virginia has not fully planned for and funded a broad, comprehensive system. That must happen, and then the leaders of the system must hold providers accountable for how well they are achieving the expectations set forth by lawmakers and the public.

Another challenge is the lack of oversight of community services board and private providers. The public mental health system is a largely decentralized system. They are locally governed entities that also have a contractual relationship with the state mental health authority (DBHDS) through individual CSB-by-CSB performance contracts. DBHDS is also the licensing entity that licenses programs and services operated by CSBs and private providers. Further, CSBs are funded through a combination of local, state, and federal dollars. Additionally, DMAS (the state Medicaid agency) is the financing arm of many of the services provided by CSBs and private providers. In short, it is a complex system.

An appropriate step for Virginia to take in achieving a transformed system is to clearly articulate the oversight role and responsibility of DBHDS in relation to the community services boards and private providers. There must be clear lines of accountability, appropriate oversight, and sound policies and adequate capacity around monitoring and enforcement. Performance contracts between DBHDS and CSBs should be revised to reflect expectations for meaningful outcomes, as they are barely adequate in their current form. Private providers must be held to high standards with regards to their use of public funds to administer services; coordination with CSBs must be an expectation. Strong leadership is an essential element in bringing all of this to fruition despite the level of complexities involved.

Virginia must also clearly define a consistent set of services to be available statewide, whether publicly or privately, for children, youth and young adults, adults, and older adults. The public and private sector should work together in a coordinated manner to ensure that the following services, at a minimum, are available:

- Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization
- Screening, assessment, and diagnosis, including risk assessment
- Patient-centered treatment planning or similar processes, including risk assessment and crisis planning
- Outpatient mental health and substance use services
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk
- Targeted case management
- Psychiatric rehabilitation services
- Peer support services and family supports
- Intensive, community-based mental health care

Beyond these core services, there are other essential services that must be part of a resiliency and recovery-oriented system of care including peer and family supports, supportive housing, transportation, and supportive employment.

Another frustration that parents, individuals, and families have with the current system is the difficulty in accessing the community services system. CSBs are considered the safety net providers but their ability to serve as the safety net is often compromised. The large uninsured population in Virginia has a significant impact on the CSB system. Without a reimbursement source for uninsured clients, CSBs are left to either subsidize the cost of care for an uninsured client, provide unreimbursed care, or not provide care at all. Also, there are some services CSBs perform that are not reimbursable through Medicaid which means that other sources, primarily local and state government, must fund those services.

Despite these realities, community-services boards should provide services to all who seek help:

- Regardless of condition

- Regardless of ability to pay
- Regardless of insurance

Further community services boards- either through their own staffing or by contracting with private providers- must be able to provide same day access to a clinical diagnostic assessment, and they should not be able to refuse service to any individual based on ability to pay or residence outside of the CSB's catchment area. Lastly, they should be able to provide service for individuals who are court-ordered to services.

Much has been discussed in recent months and years about the role of state psychiatric hospitals in the continuum of care. Our position is that inpatient care will always be a part of the necessary spectrum of services that a person with mental illness might need and it should be available when needed without financial, legal, geographic, or other barriers that are too often felt by those in need of inpatient care. Further, we believe that Virginia's state psychiatric hospitals must serve the crucial role of safety net provider.

At the same time we recognize that most people will only spend a short amount of time in hospital-based care compared to the time they will spend in the community, and inpatient care is a small sliver of what someone experiencing a mental health crisis needs to become stabilized and experience long-term recovery. Therefore, hospital care needs to be accessible and effective, but it needs to be viewed in relation to the host of other services and supports that a person needs to gain stability and long-term recovery from mental illness.

Historically, we have resisted attempts to downsize and close state-run psychiatric hospitals, despite the philosophical trend driven by law (*Olmstead* Supreme Court ruling; Americans with Disabilities Act) and advances in treatment that have paved the way towards treating people in the least restrictive environment possible. There is a lot of skepticism in the mental health community about closing state hospitals. Often downsizing and closure is made with the promise of reinvesting funds into the community but that ends up not happening. Families and individuals are still paying the price of the failed promise of deinstitutionalization- lack of services, a fragmented system, homelessness, incarceration, and death. Our fear is that we will once again be abandoned with no state responsibility for care or treatment of people with mental illness.

At the same time, we do not wholesale reject the notion that there should or could be less reliance on state-run psychiatric hospitals. We understand that the millions of dollars spent operating state hospitals is also money that could be spent building up a community-based system of care. Yet we maintain that the community must be funded and the infrastructure must be in place *before* hospital closure is even considered. We also think that the system needs to be improved and community services built up so that there is better use of the beds that do exist. In summary, we do not believe that *either* closing hospitals *or* having a stronger community-based system is the proper approach in Virginia at this time. The sensitive and important issue of hospital closure and downsizing must be treated with the care and caution is deserves and any conversation at the policy level about the future of state hospitals must ensure that the opinions and experiences of family members and people who have received services, including patients and former patients, are part of decision-making processes.

<u>Call to Action: Policy Recommendations</u>

Virginia has been wrestling for years with how to achieve a transformed system. Over the years changes have been made but at times it feels as though we are still far from realizing a truly transformed system. To us, the vision of a transformed system is rather simple: it would be comprehensive, built on solid scientific research and evidence, focused on resilience, recovery and wellness, focused on early intervention, and centered

around people living with mental illness and children with serious emotional disorders and their families. It would reach underserved areas and neglected communities and be fully integrated into the broader health care system. A transformed system requires new attitudes, new investment, strong leadership, effective laws, and political will[i].

Our recommendations for achieving a transformed system:

1. Require that a consistent core set of services be available in every community through CSBs and/or private providers (working in coordination). Further, require same day access, and assistance to all who seek help regardless of condition, ability to pay, type of insurance, or area of residence. Additionally, fund the system of care with components to assure the prioritization of services to those with mental illness and mental health problems who are the most seriously disabled whether services are needed on an involuntary or voluntary basis.
2. Clarify the oversight role and responsibility of DBHDS towards CSBs and private providers. This includes institutionalizing the expectation that DBHDS bears the responsibility of developing uniform practices, policies and procedures in the mental health care system to promote a uniform and consistent system across Virginia.
3. DBHDS, with input from stakeholders, must establish and measure meaningful recovery-oriented outcomes that reflect a well-functioning and transformed system such as reduced hospitalization and criminal justice involvement and access to supportive housing, and then incorporate those measures in performance contracts with community services board as well as private providers that utilize public funding. Further, DMAS must align financing with these recovery-oriented outcomes.
4. Virginia should set a concrete goal to address the number of inmates with mental illness who are in Virginia's local and regional jails. For example, a reduction of 25% by the year 2020.
5. Close the coverage gap for adults who are at 133% of the Federal Poverty Level. This can be done through expansion and enhancement of the existing GAP program, expansion of Medicaid as articulated in the Affordable Care Act, or other initiatives that accomplish the intended goal.
6. Provide new funding to expand on the existing eight First Episode Psychosis (FEP) treatment models.
7. Provide new funding to expand the array of services for those under age 18 with serious emotional disorders.
8. Provide new funding, update state laws, and pursue waivers at the federal level around the nontraditional yet critical services that facilitate recovery in the community and fosters resiliency in children and families including peer education and support, family education and support, supported employment, and supportive housing.
9. Through the enactment of legislation and local and investments of state and other funding sources develop a statewide plan to implement all intercepts on the Sequential Intercept Model in all localities within the next 10 years.
10. Ensure that no state hospitals is downsized or closed unless and until it is proven that there is adequate capacity in the community to fully function without that safety net resource. Further, any savings realized from the downsizing or closure of state hospitals must be reinvested into the community to develop, expand, or strengthen community services.
11. Identify inefficiencies in the current system and revamp them through legislative or other initiatives. Examples include the barriers to discharge list and Discharge Assistance Planning (DAP) funds.

[i] A Vision for Transforming State Public Mental Health Systems; NAMI *Grading the States*; 2009