VIRGINIA'S VISION AND ACTION

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Today, I will talk about the Virginia vision and actions toward an improved service system for persons with mental illness. The Virginia vision includes an array of services, sometimes called a continuum, erroneously, because an array means that we have a plethora of services available to meet any number of needs that any number of consumers may have, and what we ought to be thinking about is that consumers' lives are not linear lives, anymore than our lives are linear. They are not predictable. They do not progress through a series of needs in a methodical way. We cannot have a system as we have had in the past of moving from the less intensive services, for example a group home, to a supervised apartment, to independent living. Consumers have various needs at various times in their lives and they need a service system that is able to be dynamic, able to flex according to their individual needs at any given time.

We believe mental health services should be flexible and reflect the needs of the individual. Therefore, Virginia's vision includes a comprehensive array of services for the consumers' changing needs. However, we allow treatment professionals, in conjunction with the consumers being served, to design an individualized continuum that meets the need of the consumer at any given time. The continuum, therefore, may change depending on the needs of the person at that time. Consumers, as I said, do not move smoothly through life in a linear manner and neither do those persons who are not considered consumers. We must be flexible and must make sure we provide the

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supports that are critical to allow an individual to progress to a system of recovery.

The services and supports I will discuss already exist in many Virginia communities. However, an important part of the Virginia Vision is to expand the necessary services and supports to all communities over a reasonable period of time based on sound demand and outcome studies. Most of these services are provided directly by community service boards (CSBs) or through contract from the CSBs to private providers also at state facilities, clubhouses, pact teams and other similar services as a part of the service array. In the area of mental health, a comprehensive array of services and supports will promote risk reduction, timely interventions, and appropriate treatment. Studies show that quick intervention dramatically improves the quality of life of the mentally ill. That is what we are striving to achieve. An array of services work to restore and maintain the functional skills of consumers, support stable living arrangements and encourage recovery, personal growth, and increasing capacity for self-responsibility. In addition, that system will encourage and support families as primary caregivers.

In Virginia, a comprehensive planning process has been established over a course of years that establishes what the need is for Virginians. Through a collaborative approach with consumers, advocates and providers, it is this process, in combination with the Governor's Commission, which Mr. Anderson represents for us today, that has fueled and led the development of the services that are now available in Virginia. Governor Gilmore's priorities for the publicly funded system of mental health and substance abuse services are predicated on two primary qualitative outcomes: improvement in the quality of care, conditions, and consumer protections at Virginia's mental health facilities and a strengthening of community-based resources for the care and treatment of individuals and families coping with mental disabilities and substance addiction.

The Governor's commission interim report, *Crossroads of Reform*, in Principal Four states: "Virginians should strive to improve the possibilities for people with mental disabilities to lead independent lives in their home communities." Study after study has supported the principal of community based care as a priority, with state facility-based care designed to support the community and to provide specialized psychiatric treatment that is not available in the commu-

nity served by the state facility. There have been a number of studies; I will not go into all the names of the studies. There is a list of about six or seven.

For example, we all know the significant advances in medical psychiatric treatment especially in the area of psychopharmacology have led to community based psychosocial rehabilitation programs, a third of community treatment methods, residential support, advanced crisis services and human rights. It has allowed almost all persons with mental illness to effectively reside in the community with support, but the important caveat to remember is that *with support* the persons live productively in their communities. Access and availability of services are essential. That cannot be underscored enough. *They are essential.* In 1955, Virginia had over 11,000 people in state institutions; today we have just over 1,700 people in state psychiatric institutions. Not a small task to reduce, over this period of time, and that is not a reduction that has come just because we have said, "We are not allowing people in." It is the advances of psychopharmacology and community effort. The advances in what we know works in a community, that has led us to this point.

There have been other initiatives in Virginia that have led us to this point. We know that the majority of consumers and families prefer high quality and accessible community-based services instead of state hospitalization. Additionally, the public demands the effective and efficient use of their tax dollars. Cost and sustainability are critical in linking the needs of the mentally disabled with the support of the general public. As Inspector General of Illinois, the banner that we carried was that of public accountability. It is why I took the job in Illinois. It is why I took the job here. I believe that this Governor is very committed not only to improving the mental health system, but also to ensuring that the public sees that there is a fair amount of public accountability for the dollars entrusted to us. The most significant opportunity and challenge we face is to work together — consumers, families, advocates, facility directors, medical directors, clinical staff, as I have experienced with the Northern Virginia Mental Health Institute. We must work together as a team to modernize the current system of care that has focused too long on dependence and illness and to refocus that system and the public's resources on independence and recovery.

This year we will spend over two million dollars to attempt to reduce or eliminate acute psychiatric hospital stays at Central State Hospital, and we have already moved toward success in this area. Acute psychiatric stays are described in the terminology as 'length of stay,' in this particular case, for a person staying twenty-eight days or less. We are eliminating that type of service at Central State and using the two million dollars to support hospitalization in community psychiatric facilities. The rationale is that the closer you have a person being served to their home community and their families, the more expedient their discharge, the less opportunity for them to languish in the state facility.

Additionally, Dr. Torrey in his book *Out of the Shadows*[1] indicates that one of the solutions to developing an appropriate system, an adequate system, is to be sure to measure outcomes. In Virginia, we have the Performance Outcome Measurement System (POMS) that is being implemented statewide. The POMS pilot projects for adult and child adolescent mental health services for the CSBs and state hospitals and the adult substance abuse services have been completed. Based on the results of the pilots, POMS has been refined and statewide implementation activities have been initiated. Most recently, a series of six regional meetings has been conducted with the CSBs and state facilities to present the POMS design and procedures. In Fiscal Year 1999, each CSB has received an additional forty thousand dollars to help prepare for the July 1, 2000 POMS implementation. These funds may be used in a flexible manner by the CSBs for software adjustment, staff hiring, anything necessary to enhance our existing MIS systems and a data collection method, in order for us to be sure that it is the outcome of the service system that guides any future development of that system. And I am pleased that this is something that we are doing in Virginia. Even though it happened before I got here, I was very pleased, because I knew that was a principle in Dr. Torrey's book.

We have also instituted in Virginia the Office of Health and Quality Care, and before I go any further I think it is important to recognize that all of the work being done in the Department of Mental Health is being done by numerous dedicated professional staff across the system.

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[1] E. FULLER TORREY, OUT OF THE SHADOWS: CONFRONTING AMERICA'S MENTAL ILLNESS CRISIS (1997).

The Office of Health and Quality Care was newly created to make sure that the medical director of the Department of Mental Health had access to opportunities for improving the quality of care across the departmental system. Within the Office of Health and Quality Care, Dr. Evans serves as the Medical Director and the Director of Health and Quality Care. Within that office, we have the offices of Quality Management, Consumer Affairs, Utilization Review, Forensics, Clinical Program Training, Investigations Management and Research and Evaluation. I probably have left out a couple of things, but those are the primary pieces that I wanted to target.

In the Office of Consumer Affairs, we are working with consumers to design an advisory group of consumers and advocates to assist us in making sure that outreach to consumers across the service system is accomplished with the input of the consumers. We are hiring a consumer to help in that action. We are also working diligently to develop an independent team of abuse/neglect investigators who are not reportable to the facility directors, who next week will be trained by a national certification organization on conducting abuse/neglect investigations. I am glad you are pleased. Keep sending those letters, and we will know what to do.

Also, we are working toward the availability of clinical training across the continuum in terms of applied behavioral analysis and psychosocial rehabilitation. We are developing treatment models and have developed treatment models at our state facilities. We are working to expand the availability of PACT and clubhouse models across the continuum. In addition, the Commission also recommended that we work to make sure that we have psychiatrists available in the underserved areas of Virginia. We have been working with the medical school, and one-half million dollars was budgeted for working toward increasing medical school opportunities in the public psychiatric sector. Right now we are working on the development of underserved area designations in Virginia, so that we can recruit more psychiatrists.

We also have developed and are working on implementing standardization, and I hate that word, of departmental instructions. What we want to have is an approach to the service delivery system that is consistent across all of our facilities. Therefore, if you get services in one matter at one facility, you are assured that given the mobility of

the consumers, if a consumer goes to another facility, the service they receive will be the same.

Finally what I want to make sure that I touch on is the development in the department of initiating the "Administrative Service Only" organization concept. We plan to use those parts of managed care technology that have been the most effective for managing systems of care. We do not intend to develop a system that gives the authority and the responsibility for service delivery to a managed care organization. We simply want to make sure that the services that are delivered and funded by the Department are managed in the most efficient and effective way possible and that would be through our managed care technologies.

In Virginia, we keep in mind that one measure of a civilized society is the care that it provides to its disabled members. We have the knowledge that is needed to do much better. Whether or not we have the will is the question. I believe in Virginia we have the will; we have the leadership in our Governor; we have the leadership in the Commission; and we have the leadership of our consumers and advocacy organizations, but do not let my words serve as your promise. Let our actions seal the charter.