

The North Carolina Vision for Mental Health System Reform: People, Communities, and Outcomes

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NORTH CAROLINA IS MOVING FORWARD with a comprehensive mental health, developmental disabilities and substance abuse system reform effort. Everything is changing. We are developing the capacity of local public systems to be managers of public policy. We are divesting public service delivery to the private sector. We are developing supports, services, treatment and care that are best practice. We are building community service capacity in order to transition us away from a reliance on state facility-based services.

There is much we need to closely examine as we evolve this system reform effort. This is a strategic change process; we hold steady to our vision while maintaining flexibility to make informed and planned adjustments as we advance reform. The foundation of the vision is threefold—people, communities and outcomes.

People

Reform requires that people with disabilities and their families are the driving force. This “force” is to occur at both the individual and systems level. At the individual level, person-centered planning, or person-centered family-focused planning, ensures that the manner in which we support and serve people is derived from a plan and process that reflects the intentions of the individual. This process involves people who have been identified as important by the individual through a process of identifying, across life domains, what they desire to achieve—life outcomes. Individuals are also central to the development of the strategies that are intended to get them the life outcomes they have identified. Strategies are made up of natural supports and community resources as well as specialized supports, services, treatment and care. Person-centered planning considers reasonable concerns of the individual and public health and safety, as well as the development of pro-active and re-active crisis contingency plans. Person-centered planning requires negotiation and includes identification of the individual’s responsibilities. Fundamentally, person centered planning is much like the life planning process we all engage in with the addition of disability-related specialized supports, services, treatment and care.

At a macro level, reform is intended to offer additional opportunities for people with disabilities and their families to influence and take increasing command of the system. Membership on governance boards and the Consumer and Family Advisory Committees (CFACs) represent leadership opportunities. Involvement in continuous quality improvement, customer services, community education, provider network monitoring and service procurement are examples of opportunities for influencing systems planning, development, implementation, monitoring and management. These types of involvement may be voluntary or paid, but they serve two interrelated fundamental concerns—(1) the need to include the experiential expertise of people with disabilities and their families at all systems levels and (2) the need to shape a system culture that is oriented to the people it is intended to support and serve.

Communities

Reform requires that the community value a system of services and supports that allows people to remain in and be an integral part of the community. Management of public policy through a local public system is very different from traditional managed care. The management of public policy requires not only the assurance that “the right people are served, with the right amount, at the right time, in the right place and at the right cost,” but it also requires community collaboration and engagement. The people supported and served through the system have life circumstances, conditions and situations that typically require long-term and comprehensive responses that extend beyond the characteristics of their disability. These are the matters of life—housing, employment and relationships. The role of public policy management therefore extends deep into a partnership within the community. At the broadest level it involves matters of promoting real citizenship opportunities. At a more discrete level it includes community collaboration in matters such as housing and employment. At a more operational level it involves the establishment of specific programs such as jail diversion. It includes considerations of both individual and public health and safety—it is the assurance of the “safety net”.

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The community derives benefit from the creation of a local accountable public system.

Providers are part of this community—a collection of people and organizations working in concert as a collective endeavor. Providers are mission-driven; their existence and values correspond with the intentions of public policy. Providers are community-based; they are part of and have a sustained commitment to the community. Providers are competent; their gifts and talents lend to both increased efficacy and efficiency. Being valued by the community is realized through the contribution providers make to benefit the community.

Outcomes

Reform is intended to be outcome oriented—making public policy expectations, achievements and performance, measurable. Outcomes apply at an individual level. Strategies are developed and applied that are intended to improve an individual's life conditions, circumstances and situations. At a community level, strategies are developed and applied that are intended to change the nature of the community supports and services. The concept of being “outcome oriented” is indeed an overwhelming endeavor. The challenge that we face is not simply related to the elusive nature of outcomes, gaining consensus on what is important to measure, and developing the corresponding necessary competencies and capacity. We also need to empirically define desired outcomes and develop and implement the means to move us to these ends. In addition, we need an ongoing mechanism to examine how the means are contributing to or detracting from the achievement of the ends.

Our strategies are to be based on “Best Practice.” Best practice is evidence-based; (i.e., models of practices that have been systematically tested). Best practice may include emerging or promising models of practice. These models have had some study,

but, at the present time, have not been scientifically evaluated at the same level as what is considered sufficient systematic inquiry to constitute an evidence-based best practice. Best practice applies to our efforts of individual-based support, service, treatment and care. Best practice also applies to systems-based efforts, such as the functions of the public management entity. Continuous quality improvement is our mechanism to examine our “means to the ends”. Continuous quality improvement is not a function of a management or provider organization, but a part of their culture—“the way of doing business”. This process includes methods to evaluate practice model fidelity as well as to examine other relevant processes—the means, which serve as the path to the outcomes—the ends. This process includes the expectation of a system's ability to empirically identify problems and pursue corresponding planned actions, including pilot approaches, in an effort to diminish or eliminate identified problems. Continuous quality improvement is dynamic, comprehensive, and integrated, both within and between systems.

Closing

There remains a great deal of discussion and critical evaluation regarding the manner in which we move our reform effort forward. This recognizes that both the dialog as well as the systematic inquiry will provide us with greater collective knowledge and understanding of reform itself. This process will serve us well in efforts to make necessary adjustments as the system evolves in a planned manner. Our adherence to the foundations of reform—people, communities and outcomes—will assure that adjustments are made to best support the vision. Central to this foundation is people. The realization of our vision is the ultimate test—have we positively contributed to the lives of people with disabilities and their families?