

Expert Advisory Panel on System Structure and Financing
Initial Report on System Governance Structure

June 23, 2016

The Panel has considered whether the basic architecture of Virginia’s system for delivering publicly funded mental health services should be significantly modified. Since the 1960’s, when de-institutionalization began, states have adopted one of three basic models for funding and operating systems for delivering community mental health services:

- In 4 states, all publicly funded mental health services, including community services, are **provided directly by the state**.
- In 15 states, community mental health services are largely state-funded but they are **provided by local government entities** (directly or by contracting with private/non-profit organizations)
- In 31 states, community mental health services are state-funded but are **provided by private entities** (for-profit or non-profit) without local government involvement

See generally Guinn Center, *Mental Health Governance: A Review of State Models & Guide for Nevada Decision Makers* (December, 2014).

In Virginia, localities have operational responsibility for providing community-based public mental health services and the public funding for these services is provided largely, though not entirely, by state funds (general funds and Medicaid-match funds). Notably, the substantial additional funding provided by a few county and city governments has resulted in significant disparities in services across jurisdictions.

A threshold question discussed by the Panel is whether Virginia should abandon its current structure and embrace one of the two alternative models instead.

The Panel has provisionally concluded that the current system requires substantial modification, characterized by greater state direction and control and a strengthened partnership with local governments; however, the Panel also believes that the Commonwealth should retain the system’s current structure rather than abandoning it in favor of one of the other two models.

The Panel’s reasons for reaching this conclusion are summarized below in two steps.

1. Is greater state direction and oversight over public mental health services desirable?

In the Panel’s view, all states with decentralized systems are essentially confronting the same problems, whether or not local governments are responsible for service delivery. Greater direction and oversight by the state is increasingly needed to achieve cross-system alignment (i.e.,

with courts, corrections, schools, and social services);¹ to disseminate and support best practices at lower cost; to ensure uniform statewide implementation of needed programs and services that have proven efficacy; and to integrate mental health care with treatment for substance use disorders and with medical care. Two other important factors tending to favor an augmented state role are the increasing role of Medicaid in paying for mental health services, as well as the growing federal role in health care delivery, all of which highlight the need for coordination.

In Virginia, it is clear that a more substantial state role will be necessary to address the major concerns that led to SJ 47 and the creation of the Joint Subcommittee –

- Lack of consistent array of services across the Commonwealth
- Need for uniform measures of performance and outcomes
- Lack of accountability for performance and for achieving desired outcomes

2. Is a fully state-operated system a viable option for Virginia?

Only Idaho, Nevada, South Carolina, and North Dakota have state-operated systems for delivering community mental health services. This approach has both significant advantages and significant disadvantages compared to a less centralized system. On the one hand, system-wide state operation can achieve greater efficiency, standardization, and consistency, and it strengthens accountability by locating all authority in a single state agency; on the other hand, such a fully centralized approach sacrifices flexibility, responsiveness to local needs and conditions, and community engagement, and it may also retard innovation. Given its disadvantages, the likely loss of local funding, and the transition costs of shifting to a model of exclusive state control, ***the Panel is not inclined to consider this option any further.*** If the Joint Subcommittee wants to learn more about the experience of the four states with a fully centralized model, the Panel can explore recent developments in Nevada where a proposal to shift to a regional model is now under legislative consideration.

3. Should the role of local governments in delivering public mental health services be eliminated?

As already noted, the vast majority of states have opted for state-funded but decentralized administration of public mental health services. However, the main structural difference among them is that ***15 states (about a third, including Virginia) have reposed responsibility in local governments to deliver the state-funded services.*** Key advantages of local government involvement in service delivery are greater responsiveness to local needs, community

¹ It is worth noting that these four systems have the same basic structure as the mental health/substance use/intellectual disability systems: state “oversight” and funding but locally controlled operations, and they are similarly characterized by significant disparities across jurisdictions in regard to the level of additional local funding and services.

engagement, and, in theory, stable local support for funding of services. However, this approach also has some disadvantages: combining state funding with local political control can weaken the accountability of the local agencies and providers (to the state) for both the quality and efficiency of the system. It is possible that direct contracting between the state and private provider organizations can lower costs and achieve better quality, but there is no guarantee that this would be so. Moreover, if local governments were no longer involved in service delivery, local funding would likely disappear and services would be less responsive to local needs. Restructuring the system would also carry considerable transition costs.² ***The Panel is not inclined to eliminate the role of local governments in system governance, given the advantages of the model and the possibility of overcoming disadvantages through increased state direction and oversight.***

4. Conclusion: The Panel is inclined to retain the basic principle of local responsibility for delivery of public mental health services while strengthening the state-local partnership, bolstering state oversight, achieving greater efficiency, and making local entities more accountable for their performance to the state and to the populations they serve.

The vision here is one of shared responsibility and leadership with greater state oversight and guidance than now exists. If the Joint Subcommittee agrees with this approach, the Panel intends to concentrate on identifying and evaluating the different approaches for filling the gaps in accessible services, measuring outcomes and enhancing accountability. In so doing, the Panel will use other states as case studies in how comparable states are coping with the challenges of delivering public mental health services in a rapidly changing health policy environment. We are likely to select one or more that embrace local governance (e.g., Oregon) and one or more (e.g., North Carolina) that do not. In addition, the Panel will carefully review the DBHDS initiative already underway to establish “certified community behavioral health clinics” (CCBHCs) under the federal Excellence in Mental Health Act (2014).

² Moreover, experience suggests that the line between the two models can become blurry, particularly if local funds from sales and property taxes are used to supplement state funding for mental health services (see, e.g., Missouri).