

**Transformation Team Public Comment
April 15 – May 15, 2015**

Sent: Monday, April 20, 2015 7:00 PM
Subject: reduce stigma

<http://www.dailypress.com/health/dp-nws-behavioral-health-comment-20150418-story.html>

? Public comment invited on state's mental health policy

If the state's policy is to assert a "stigma", I would say that is the first thing for them to stop.

? The team examining care for children and adolescents recommends mandating prevention and wellness services, conducting a public awareness campaign to reduce stigma, and promoting in-home and tele-medicine services.

Sent: Thursday, April 23, 2015 11:04 AM
Subject: Transformation Team Public Comment

Good Morning,

The efforts and recommendations of the transformation teams are valuable and appreciated. Please continue to look at this system in its entirety as you have already started to do. Thank you for your hard work on this huge task! Here are some of my recommendations/thoughts after reading the recommendations and themes.

1. It appears that many areas in the state government are attempting to do similar things (transform the system). For example, SJ47 and the JCHC, these are just a few. Working with these taskforces and workgroups might eliminate duplicate work and encourage joint efforts. With each workgroup working separately it can often lead to competing ideas, competing legislation, and duplication of research.
2. DD crisis response in Virginia is very limited at the moment. By looking at the recommendations I am not sure if this area is being furthered looked into or has been identified as an area of concern. The main thing people rely on currently with DD crisis is Reach.
3. Could the use of crisis stabilization units/programs play a part in the solution to preventing hospitalization? General Assembly has noted that they would like to see the expansion of crisis stabilization services at the CSBs and within DBHDS. Has anyone considered expanding the use of non-residential 23 hour crisis stabilization services for both children and adults? This model could also be useful within ID/DD as well.
4. I would also consider having some discussions about using evidence based primary supportive housing as an option of providing wrap-around services in the community.
5. Has any National Best Practice standards been reviewed or are they driving these recommendations? If so, it would be helpful to describe the standards or best practices that are being followed or modified. Stating the research behind recommendations often provide validity and serves as a guide to what the system transformation may look like (the end product). I am sure other states transformation efforts are being researched and reviewed and the standards they used to transform their system.

Thank You!

Sent: Wednesday, April 29, 2015 9:39 PM

Subject: Transformation Team Public Comment - DEAFNESS AND SYSTEM ACCESS

Thank you for a chance to comment on the Transformation Team's efforts to date.

COMMENT: There is no mention in ANY of the team documents about how communication, cultural, and language issues prevent consumers from accessing the service system. There is no discussion of the challenges or barriers in using our system for persons who are deaf and fluent in American Sign Language or for persons of Hispanic origin who are fluent in Spanish. Person's with Limited English Proficiency are largely unable to even access our broken system, which we know needs transformed. The lack of awareness of this issue on the Transformation Teams shows the lack of understanding in our state of the mental health, intellectual disability, and substance abuse needs of persons who do not speak English.

COMMENT: DBHDS has decreased funding for the provision of services to persons who are Deaf, Hard of Hearing, Deafblind and Late Deafened. DBHDS has not increased funding for Regional Deaf Services Program since 1986, and as a result programs are collapsing. DBHDS closed a nationally known inpatient treatment center for the deaf community at Western State Hospital and as a result persons who would have formally been treated there have killed themselves (2015) or killed others (2012).

COMMENT: Persons who are unable to access the system are largely unable to advocate for changing the system due to their communication needs and mental health issues. This should not prevent the system from addressing their needs. Mental illness impacts the Deaf and Hispanic Community in the same proportion that it impacts people who are white and speak English. Our service system needs to be accessible to everyone.

RECOMMENDATION: Improving system access for persons with communication barriers and LEP individuals should be a required component of EVERY transformation team or addressed by a stand alone CULTURE AND LINGUISTIC TRANSFORMATION TEAM that looks at this issue.

Sent: Thursday, April 30, 2015 10:18 AM

Subject: Transformation Team Public Comment

I would like to offer comments on specific aspects of the Transformation Team recommendations. Using the matrix as a reference, these are the services to which my comments relate:

1) **Prevention and Treatment Services**

The Adult Behavioral Health, Developmental Disability, and Children & Adolescent categories of services all specify a need to promote "wellness" (via activities, education and services). A key risk factor in morbidity and mortality among individuals receiving services from CSBs is tobacco use. While prevention of youth initiation has traditionally been addressed by CSBs, very little is done to provide evidence-based treatment for those who are using and are dependent on tobacco/nicotine, including youth. Since this risky behavior is actually driven by an underlying *drug addiction*, CSBs already have staff who are qualified to apply the same treatment strategies to address this addiction as they do for alcohol and other drug addictions. There is, however, no mandate to treat nicotine addiction (tobacco use disorder) on par with all other substance use disorders even when it is known that the individual receiving services uses tobacco. There is no excuse for this oversight and consequent gap in services - the same screening, assessment, diagnosis, and treatment planning services (using the same cognitive-behavioral therapy and motivational interviewing interventions) as are applied to alcohol and other drugs should be required services for this drug as well when individuals are admitted to or provided with CSB services. In addition, CSB staff should be required to document case management/referral out to the state's free phone-based tobacco treatment service (Quit Now Virginia). Even if the referral is not accepted by the individual receiving services, the staff have a professional responsibility to make the referral (and since over half of all callers to the state quitline self-report having at least one mental health or substance use

problem/issue, there is reason to believe many individuals would be interested and benefit from this resource if CBSs routinely provided effective case management/referral).

2) **Adopt Best Practice Standards and Work to Appropriately Fund Services**

The Adult Behavioral Health category specifies several peer-related services and needs:

- Offer peer provided services and recovery supports
- Establish rotating discretionary fund to provide one-time assistance to peer-run organizations
- Create a Medicaid benefit for peer services.

I would simply like to emphasize the importance of the above. Peer-based services offer remarkable opportunities to enhance the positive outcomes of professional services in ways that not only fill gaps but do so in a more effective manner. DBHDS should pursue all avenues available for supporting the development and implementation of peer-based services, including direct funding and advocacy of third-party reimbursement (especially Medicaid). Initial steps have been taken but this needs to continue to be a focus and apply to peer-based services for those with substance use disorders as well as those with mental health and co-occurring disorders.

These comments are offered by someone who has relevant "lived experience" as 1) an individual in long-term recovery from substance use disorders (both alcohol and tobacco dependencies), 2) an individual who received formal professional treatment for one of these disorders: alcohol dependence, 3) an individual who used a peer-based program for the other disorder, since there was no professional treatment for it: nicotine dependence, and, 4) an individual who worked as a substance abuse counselor at a CSB for ten years. I believe all of this experience gives me a unique perspective that would be of value to DBHDS.

Thank you for considering these comments,

Sent: Thursday, April 30, 2015 8:26 PM
Subject: Transformation Team Public Comment

Crisis services for children and teens with ID/MH issues.

Sent from my iPhone

Sent: Friday, May 01, 2015 10:40 AM
Subject: Transformation Team Public Comment

Please include deaf and hard of hearing services in your Statewide Plan. It is most important to address the cultural differences and needs of this population and having providers who can sign. Using interpreters in this setting are not conducive to positive outcomes.
Thank you.

Sent: Friday, May 01, 2015 3:39 PM)
Subject: Transformation Team Public Comment

As both a peer and a provider I will offer the following thoughts;

1. I see one recommendation under the Adult team about Medication Assisted Treatment. I am unsure what this means, however to me it sounds like a newly minted word that describes MOT. If this is the case, then I have strong reservations about including this. Please do your homework and examine this issue in states that have used MOT. Dig underneath the Treatment Advocacy

Center and NAMI rhetoric, and you will find that the research facts do NOT support widespread inclusion of MOT into the system. It is not an evidence based practice, is significantly more expensive and above all it encroaches on the civil liberties of a person.

2. I support peer services in the system 100 percent. It is both cost effective and recovery orientated. It's a win-win. My recovery happened through the use of peer programs supported by tax dollars
3. Fully fund and support discharge planning, as a former employee at a state facility, I was dismayed by the lack of discharge assistance and funding available for community integration. NO ONE should currently reside in a facility, be deemed ready for discharge but then wait because of a lack of discharge assistance funding. Not Acceptable!! Patients were often discharged with instructions to follow up with their CSB's, yet there was no coordinated effort at follow up care by the hospital to make sure that the person was able to access community support as needed. Nor was there an emphasis placed on providing a patient with a support person who could assist in helping a person to transition back to the community. Indeed, prior to budget cuts there was person in place. As consequent, patients were returning to the facility at high rates and high cost.
4. I am concerned that there are no specific recommendations on addressing housing or transportation needs. These are two of the biggest challenges and obstacles facing the peer community. There must be a committed effort to addressing these challenges. Failing to address Maslow's hierarchy of need before providing services is like putting an ACE bandage on a broken leg.

Sent: Monday, May 04, 2015 11:50 AM

Subject: Transformation Team Public Comment

I looking over the current recommendations there seems to be no indication that a strategy to strengthen Language Access Services is in place. In this would include Interpreter Services, Translations Services, training for bilingual employees and resources such as VRI (Video Remote Interpreting) or telephone interpreting.

This can and would be included in a curriculum on Cultural Competence.

Thank you for the opportunity.

Sent: Wednesday, May 06, 2015 11:09 AM

Subject: Transformation Team Public Comment

"I believe that curiosity, wonder and passion are defining qualities of imaginative minds and great teachers; that restlessness and discontent are vital things; and that intense experience and suffering instruct us in ways that less intense emotions can never do. I believe, in short, that we are equally beholden to heart and mind, and that those who have particularly passionate temperaments and questioning minds leave the world a different place for their having been there."

Kay Redfield Jamison, Psychiatrist, Writer - National Public Radio

"Jamison posits that mental illness is less an unfortunate aberration than a necessary asset enriching the human experience. Like the discarded term "disabled," those with mental illness are also "differently-abled," contributing insight, creativity and intensity to the world." **National Public Radio**

Studies have shown that there are much higher instances of mental disorder in political leaders and creative geniuses than the general population. Creative, intelligent and intense people? These people are needed more now than in any time in our history to help us pivot to a new world of innovation and discovery.

And here the state commission, composed of many well meaning people, are trying to

put the genies back in their bottles!

Seriously, we applaud this mammoth undertaking of concerned minded organizations to seek a top down, integrated reform effort. At the least in memory of the innocent victims of the Virginia Tech shooting and Craig Deeds son. But also for all those suffering family members who have just given up on the system and gone on to discover their own methods of support in keeping their loved ones well and in 'recovery.' Something has to be done to improve this dysfunctional mental health system.

Here are our comments to the report and recommendations:

1. Before the final report is submitted, we strongly suggest a panel of customers be convened to vet, review and comment on the recommendations and to offer their own suggestions for reform. Who better knows the functions of the 'system' than those who have experienced it directly? Who knows, new insights might be recommended from the customer viewpoint? (ie. Patient-centered treatment)

2. Could all acronyms and jargon be eliminated from the report to allow comprehension from the general public?

3. We did not detect any representation or reference to the pharmaceutical industry. Pharmacology is a huge cost driver to the current mental health system. The revolving door of drug sales reps peddling the 'latest' (expensive) magic pills to doctors and therapists are costing patients, families and the government huge sums of money.

Bribing practitioners with fancy lunches and outings are a direct conflict of interest and should be stopped.

4. To replace this current insidious drug sales practice, we recommend a State 'drug board' be convened with pre-imminent doctors to review once a year the drugs that are acceptable for prescription in the state. The drug board could also develop uniform patient testing protocols such as genetic/DNA testing. The money saved from the six figure drug sales representatives salaries could be redirected by the drug companies to the underfunded CSB's for community services.

5. Delighted to read the recommendations include an emphasis on holistic wellness and illness control and prevention. Recovery takes many forms and can be a different journey of self discovery and learning for each customer. Having a purpose in life to replace ego-sapping dependency can move many customers to wellness.

6. Reference Access, page 8 of the Adult Behavioral Health Transformation Team recommendations: clients denied admission. This is particularly problematic for the transition aged 16-25 year old age group who are away at college and experience their first episodes of mental illness alone.

Case example: We are aware of a case of a 22 year old honor roll student who was attending James Madison University and was denied access to Rockingham Memorial Hospital in Harrisonburg during an emergency psychotic crisis because the family Anthem HealthKeepers insurance did not cover this hospital, even though there was a bed available at this facility. The scared and distraught student was subsequently sent in the middle of night alone to Richmond. The attendant CSB worker could not tell the parents where their child was sent because of HIPPA. This experience traumatized the whole family. We wonder if a heart attack patient would have been treated the same way.

Thank you for this opportunity to submit these comments. We will be closely following the outcomes of this report and trust it will not be just another expensive study exercise

that is not implemented.

Sent: Saturday, May 09, 2015 9:41 AM

Subject: Transformation Team Public Comment

There is a serious and dire need for increasing culturally sensitive mental health services for persons who are deaf, provided by clinicians who are fluent in sign language

Sent: Sunday, May 10, 2015 7:31 PM

Subject: Transformation Team Public Comment

My suggestion to encourage more people to seek mental health help, is to stop newspapers like the Virginia gazette from printing your loved ones name in the police blotter when a TDO is obtained. Families are already going through tremendous pain, this information should be hipaa protected. Would they place in the newspaper someone newly diagnosed with cancer? Thank you for your time.

Sent: Monday, May 11, 2015 1:51 PM

Subject: feedback on recommendations

Good afternoon –

I recently reviewed your recommendations for adult behavioral health. As a Program Administrative Specialist at a state psychiatric hospital, I was surprised to see little mention of housing. It seems clear to me that the need for a hospital bed is so very often preceded by the need for any bed, a precursor to psychiatric crisis as well as an inhumane situation. And of course, lack of housing is a huge barrier to discharge, once admitted to a hospital. Supervised residential services in communities would go far to ease the need for hospital beds. And yet as hospital beds were drastically decreased, with funding diverted to communities, there was little or no focus on residential services and/or safe housing. Should we be surprised that mentally ill adults so often are sheltered in jails?

Thanks for letting me have a voice.

Sent: Monday, May 11, 2015 4:44 PM

Subject: Feedback on recommendations from the Teams

I am a Healthcare Provider and a parent of a Bipolar/Substance Abuse/ Impaired Adult. I believe that actual input from primary caregivers of such individuals, regarding their experiences with VA hospitals and County Mental Health Programs, may provide valuable insight in developing **useful** intervention and/or programs that may actually affect the outcome of exacerbations of their illness and perhaps prevent a downward spiral that so often ends at the cemetery or local jails.

Sent: Monday, May 11, 2015 10:12 PM

Subject: Transformation Team Public Comment

Dear Department of Behavioral Health,

I appreciate your efforts to improve the statewide mental health system for those people that are able to access the system and use it.

However, I noticed that not one word, in any of your plans, addresses those people who can not access the system due to communication barriers.

There are MANY people in Virginia who can not access services, or don't even try, because they know that services are not accessible.

Deaf people who use American Sign Language are losing access every year, Spanish speaking people have no access across the state in any coordinated fashion, and the many other Virginia Citizens who speak foreign languages, especially in Northern VA, have no chance to get therapy (let alone attend a day program or day services).

Can YOU imagine using a different interpreter each week to talk about your past sexual trauma with someone that doesn't understand your culture. Would YOU go to a Russian speaking therapist who had an english interpreter? Doesn't having one Spanish fluent provider at each service board make sense, or at least in each Region?

Please address this on each of your transformation teams, or make a new transformation team to address this issue.

This issue isn't going away. Please get out in front of language access.

Thanks for listening.

Sent: Tuesday, May 12, 2015 7:45 AM

Subject: Spring 2015 Transformation Public Comment

Hi, I was hoping to discuss the moral values instilled in mental health treatment and how they should not be of the guardianship of doctors. I believe it is wrong for doctors who are eskewers of technical medical knowledge to be given the seat of authority to make moral decisions for their patients. When it comes to moral values I seek Congress' moral values and I seek the patient's moral values. I do not seek the values instilled by someone who has gained trivial technical knowledge.

For example, video games are often viewed as unhealthy by the mental health therapist because they believe them to be socially isolating, but as a video game programmer I can tell you that it is possible to be completely encompassed by other people who enjoy video games. When the mental health therapists instills their values about video games engendered by their technical information about mental health, they are actually impairing my livelihood, which is wrong.

Thank you.

Sent: Tuesday, May 12, 2015 10:56 AM

Subject: Transformation Team Public Comment

Mental Health services for the Deaf, Deaf blind, Hard of Hearing population is needed in this state and there are not enough providers that are fluent in ASL (American Sign Language) to communicate directly with Deaf populations.

Sent: Tuesday, May 12, 2015 3:28 PM

Subject: Comments on DBHDS Transformation Team Recommendations

We appreciate the opportunity to participate in the Transformation Team Advisory Council and to provide this additional comment. I have organized our comments by Recommendation topics. While the Board understands that the process will be continuing, we are including some additional suggestions for improvement.

CORE THEMES:

The Board supports and applauds the systems approach evident in several of the themes (e.g., # 5, 7, 9, & 10). Partnering with other state agencies which impact the lives of Virginians served through DBHDS is a critical task to building a more effective service system capable of improving the quality of life for our citizens. Several themes are inter-related: seek strengthened core services statewide (see #1, 3, 4), improve the quality and availability of services (# 4) and improve the workforce (#8). Doing so requires a concerted effort across the HHR Secretariat at both the state and local levels. The Joint Commission on Health Care – in addition to various studies and reports on healthcare access – point out that localities with high poverty/high unemployment or a large proportion of citizens relying on Medicaid or Medicare have had, and continue to have, significant difficulty attracting or maintaining providers. Ensuring that Virginians with disabilities have available, appropriate, affordable and accessible healthcare is a priority for the Board. In its 2014 Assessment of the Disability Service System in Virginia (Vol. I, p. 16) the Board advocates for interagency collaboration among the Commonwealth’s HHR and other related agencies in developing a vision and strategic plan to address the varied needs of residents in “provider deserts.” Orchestrated partnerships with non-profit “safety net” providers and state medical/dental/ nursing schools additionally are needed to develop systemic, long-term solutions to ensure service availability for individuals – especially the most vulnerable populations – in underserved areas.

The teams for youth and the adults with behavioral health needs recommended efforts to strengthen the workforce in availability and quality. There is a critical need to expand incentives for young people to enter health/behavioral health fields which either now have shortages or are likely to have significant shortages in near future. Again, as noted in the 2014 Assessment, the Board recommends that HHR agencies work together strategically to:

- maximize resources and advocacy for additional funding for student loans/scholarships or work study programs;
- develop/maintain tracking mechanisms to monitor provider availability by region;
- strengthen partnerships with medical, nursing and dental schools to expand the number of healthcare providers skilled, knowledgeable and willing to serve various populations with disabilities; and
- develop a monitoring system to evaluate the impact of Medicaid reimbursement rates on provider capacity.

While DBHDS is engaged in this transformational process, two other parallel planning processes are underway: the Department of Health (VDH) is developing its “Population Health Plan for Virginia” and the Division on Aging within the Department for Aging and Rehabilitative Services (VDA/DARS) is developing its next four year Aging Plan. This is an opportune time for DBHDS leadership to strengthen its partnership with these state agencies towards addressing unmet service needs and service quality issues.

Adult Behavioral Health Team Recommendations:

One of the Team’s recommendations is to “convene a workgroup with private hospitals, CSBs and DBHDS to develop strategies to better serve clients denied admission due to co-morbid conditions or behavioral health challenges”. The Board urges DBHDS to broaden the scope of this laudable idea to address admission denials of individuals with an intellectual or other developmental disability (ID/DD) and Traumatic Brain Injury. Over the years, the Board has received anecdotal reports from parents or caregivers of hospitals minimizing health problems or denying admission to individuals with ID/DD,

especially those with poor social or verbal skills. The Board further recommends that such a workgroup include representatives from the Virginia Department of Health, especially the Office of Licensure & Certification, as well as from the Board of Health Professions, since issues of education, training and quality of care must be addressed.

Another systemic approach would be to expand the workgroup by including other HHR service agencies. The workgroup discussions could additionally strategize ways in which to improve:

- hospital identification of individuals with substance abuse and psychiatric disorders as contributing factors to health crises, including car accidents;
- improvement in referrals to and follow-up by CSBs at hospital discharge;
- identification of “high utilizers” across service systems and development of strategies to increase use of primary care as well as available disability-related services and supports and decrease emergency room (ER) and hospital use.

Adult Developmental Team Recommendations:

“Tiered approach to Case management” - There does not appear to be much difference between “active” and “follow-along case management. Clarification is needed. One explicit distinction should be that “active” CM is required to be conducted face-to-face rather than by indirect means.

Another Team recommendation is “Coordination of Services across the System”, first of which is expanding the service array. Inadequate emphasis is given to the need for accessible, affordable housing options (including rent subsidies) and for accessible, reliable transportation. Strong partnerships among HHR agencies as well as other Secretariats and local Planning Districts is essential to system expansion in housing and transportation for Virginians with disabilities. In addition, the need for expanded crisis intervention services and behavior supports should be included as a core service. We recognize that these and many related issues are, at least in part, being addressed by other workgroups, including those addressing the Department of Justice Settlement Agreement and Waiver redesign. The work and recommendations of the Transformation Teams must be integrated and coordinated with the many other efforts taking place both within DBHDS and within and between other HHR agencies.

Children & Adolescent Behavioral Health Recommendations:

The Board strongly supports development of crisis response services for youth as well as expansion of behavioral supports through in-home services. The needs of youth with ID/DD and challenging behaviors or co-occurring mental illness must be addressed. A recommendation from the 2014 Assessment (vol. 1, p. 20) urges DBHDS development of: “...an integrated, statewide crisis intervention system that ensures service access regardless of diagnosis(es), type of disability, age, or locality of residence.” Additionally, it seems premature at this time to mandate standards for maximum wait times for services until workforce capacity is adequate at least on a regional basis. (See comment on page 1 regarding workforce development.)

More broadly, the Board urges DBHDS to establish a formal planning process with other key agencies serving at-risk youth (Office of Comprehensive Services, Department of Juvenile Justice, Department of Education, and the Department of Social Services’ Foster Care Division). As noted in our 2014 Assessment (vol. 1, p. 20), this interagency process would:

“Proactively develop and implement a comprehensive plan for service referrals and behavioral interventions at earlier stages to prevent hospitalizations, loss of placements or incarceration. This comprehensive plan should include identification of service gaps, transition issues, improvements to interagency collaboration, funding needs and infrastructure needs”.

Justice involved Services:

The focus of this group appears to have been solely on individuals with psychiatric or substance abuse disorders. The Board strongly urges inclusion of individuals with ID/DD in service planning regarding criminal justice issues, especially application of the identified diversion strategies to prevent incarceration of individuals with ID/DD with challenging behaviors or poor communication and social skills. The Board has heard numerous anecdotes regarding individuals with ID/DD who are arrested for nuisance crimes when behavioral interventions were more appropriate.

Development of the Crisis Intervention Team (CIT) programs should include assessment and diversion of individuals with ID/DD.

Conclusion

In general, the Board hopes that the Transformation Teams will be tasked to take a systems approach to resolving the service gaps and issues. Although each team performed a much needed role, the team configuration reinforces the disability based silos that exist system-wide. An important future step will be to build on the core themes so that individuals with co-occurring conditions can be served more readily.

Thank you for the opportunity to provide comments.

Sent: Tuesday, May 12, 2015 4:24 PM

Subject: Spring 2015 Transformation Public Comment

Dear Commissioner Ferguson:

I am submitting my public comment I presented today at the Transformation Team Town Halls session held at the Ferlazzo HS Bldg.

I work for the Fairfax-Falls Church Community Services Board, as a clinical supervisor and substance abuse counselor. I am not here representing the CSB, but I am here representing as a member of the minority population. I am requesting that the Commissioner and the Transformation teams help reduce and/or eliminate disparities in our behavioral healthcare system.

Decades of research have repeatedly confirmed the ongoing problem of disparities in our healthcare system. If I may, I will cite two studies that illustrate this. Harvard (2013) concluded a study that analyzed 1 million discharges from substance abuse programs that the disparity exists when measuring successful discharges. Compared to the white population, the Latino and African-American have a disproportionate discharge rates. African-Americans were 13,000 less likely to successfully complete treatment, whereas Latinos were 8,000 less likely.

University of Iowa (2013) confirmed this finding by comparing to successful discharge rates among Whites, African-Americans and Latinos. The white patients were successfully discharging at 46.25%; African-Americans were at 45.6% and Latinos were 37.5%. The bottom line is that minorities do worse than Whites.

These dismal outcomes are predictors to dramatic increased recidivisms which will lead to re-offending and re-incarceration for drug-related offenses. These will also create an overwhelming strain on the healthcare system and other community services/supports – judicial system, jails, hospitals, local CSBs, grassroots organizations, businesses, families, etc. This is not also including the other growing and fast approaching epidemic-level issues such as the insurgence of opioid and Heroin dependence, which exponentially escalate the problem to a crisis level.

I am recommending that the Commissioner and the Transformation Teams incorporate and analyze ways to reduce or eliminate disparities in the behavioral healthcare system. These recommendations may include:

- Increase funding for Integrated Services;
- Increase Medicaid coverage
- Increase Recovery-based Services to expand support and case management for Employment, Housing and Mental Health Care
- Increase Community Engagement and Education to available services and other community supports

There are no members who are looking at the disparities issues. Fifteen (15%) percent of Virginians are foreign born. There are more than 10% of the population speaks a language other than English in the home. It is critical to be inclusive with the transformation process to increase representatives from minority or multicultural communities and ethnic organizations. I am also requesting that the Commissioner considers creating a Transformation team to examine and address the disparity issues of our healthcare system.

I appreciate this opportunity to provide comments to you and the transformation teams as DBHDS is undergoing systemic transformation to improve quality service throughout the Commonwealth.

Thank you,

Sent: Tuesday, May 12, 2015 4:38 PM
Subject: Transformation Team Public Comment

I would like to bring attention to the lack of beds at Eastern State because of a lack of structured housing for forensic patients to transition to. Therefore there is no room for those in the community to get long-term care. We need structured, supportive housing for people with mental illness in order to avoid more intensive treatment as well as a follow-up to intensive treatment. Without this piece of the puzzle, treatment becomes an endless cycle of crisis and acute care.

Sent: Wednesday, May 13, 2015 5:32 PM
Subject: Feedback on Transformation Teams

Please ensure that brain injury survivors are addressed/considered in this process. The Centers for Disease Control and Prevention (CDC) in their report on "Traumatic Brain Injury in Prisons and Jails: An Unrecognized Problem" says, "According to jail and prison studies, 25-87% of inmates report having experienced a head injury or TBI as compared to 8.5% in a general population reporting a history of TBI" (link: http://www.cdc.gov/traumaticbraininjury/pdf/Prisoner_TBI_Prof-a.pdf). This problem does not get resolved if brain injury is omitted from the solution.

Please consider safeguards so that "medical homes" do not eventually translate into the ghettoization of health care for the mentally ill.

Thank you all for your efforts on this serious issue.

Sent: Friday, May 15, 2015 2:00 PM
Subject: Transformation Team Public Comment

May 14, 2015

Commissioner Debra Ferguson, PhD

Department of Behavioral Health and Developmental Services

P.O. Box 1797

Richmond, VA 23218-1797

Via Email

Dear Commissioner Ferguson:

Thank you sincerely for the opportunity to publicly comment on the first round of draft recommendations from the Virginia Department of Behavioral Health and Developmental Services Transformation Teams. Please find below comments.

Adult Clinical Services

- While we endorse the Transformation Teams' emphasis on the need to ensure comprehensive emergency services and a crisis continuum of care, including medically supervised detoxification, it is equally important to recognize the need for services that provide early intervention and on-going community supports. Counseling, case management, psychiatry, medication assisted treatment, and other outpatient services can provide opportunities to prevent crisis events for those with behavioral healthcare needs. A comprehensive array of services allowing for prompt early intervention can prevent the need for more costly services and we would recommend additional emphasis and particularly resources to focus on early intervention for mental illness and substance abuse.
- CSBs as "health homes", capable of addressing both physical and behavioral healthcare needs, can be one method of early intervention, ensuring better outcomes and again saving more costly resources at a later time.
 - o While important to review the services funded by DMAS, it is imperative to recognize that some CSBs provide over half of their services to individuals without any insurance. We support efforts such as the Governor's Access Plan (GAP), and encourage continued exploration of other methods to fund the behavioral healthcare needs of our uninsured consumers and ensure the allocation of sufficient resources to meet the behavioral health needs in our communities.

Executive Offices 301 Elm Avenue SW Roanoke, Virginia 24016-4001 (540) 345-9841 Fax (540) 345-6891

The Community Services Board serving the Cities of Roanoke and Salem, and the Counties of Botetourt, Craig and Roanoke

® We endorse the recommendation to expand substance use disorder treatment capacity. The costs to the Commonwealth of inadequate treatment resources for substance disorders is staggering.

e We appreciate your recognition that justice-involved individuals are often people with significant unmet behavioral healthcare needs. There are proven methods for diverting low-risk offenders from the criminal justice system, but such diversion is effective only if there are processes for engaging these individuals in receiving behavioral healthcare services. For those for whom incarceration may be needed, attention to mechanisms for notification and ongoing communication between jails and other correctional

institutions, and CSBs, and resources to provide the services needed, is another form of preventive care that is both compassionate and cost-effective.

Prevention Services (listed under the Child and Adolescent Behavioral Health Team)

® We agree that prevention needs to be a core mandated service for the following reasons

1. Prevention services can greatly reduce the need for more expensive and intensive treatment services.
2. Prevention professionals have experience and expertise in community needs assessment, identifying factors that increase the likelihood of risky behaviors, building capacity to address the risk factors at both individual and community levels, strategic planning, and measurable impact evaluation.
3. Prevention staff have the knowledge and capability to promote consistent wellness messaging that is based on local community needs.

Child and Family Services

® We endorse the transformation teams' recommendation to "mandate prevention and wellness services, as well as fund and implement public awareness campaign to decrease stigma and increase awareness of services" in our communities.

e We recommend the inclusion of and sufficient funding for early intervention services to provide services prior to the point in which a family is in crisis would save children from unnecessarily being pathologized and traumatized, while focusing on a family's strengths and resiliency factors in following with the Systems of Care philosophy.

e We agree with the initial list of core services suggested by the Transformation Team, but would expand the list of critical core services needed in every community to include some levels of the following services: outpatient services, school-based services, and parent education services. These are services that we find are frequently in demand in our communities by many of our sister public agencies to serve children and families with behavioral health needs.

e We support a statewide, coordinated system of navigation for families to improve family access to services for their children and ensure a sustainable array of standard services in all communities. While we support the long-term concept of a single accountable

entity, we believe that discussion and formulation of this strategy should occur with a much wider array of constituents at the table, both from the state and local level, including additional parents/youths, CSBs, local departments of social services, local court services units, local schools systems, local health departments, local juvenile and domestic relation court judges, and their various counterparts at the state level to ensure the meaningful creation of a truly effective system of care. While an acceptable level of consistency and accountability is certainly needed, we would also advocate for enough flexibility for local communities to shape, tailor and enhance their systems based on local needs and local collaborations.

Comments across all Recommendations:

- For the entire continuum of services, we suggest that significant attention is paid to ensure the adequate reimbursement and/or funding of all case management services across the entire spectrum of community services, especially for those who are not covered or inadequately covered by insurance or Medicaid. If consistency is an agreed core value, the very basic ability to provide case management services that are funded should be an intrinsic guiding value across the system and across all disabilities.

- We would recommend that all teams address clearly and specifically how access to services will be addressed for all Virginians, both those with insurance/resources and those many that we serve without resources or access to insurance.
- As citizens and service providers in local communities, many of us serving for decades in community behavioral health, we have been concerned for many years about the shrinking access to early intervention services in the public Virginia system of care along with the increased shift of resources to the crisis and intensive end of the service spectrum without similar investment in services much farther upstream for our stakeholders. We believe we are "speaking to the choir" when we share our sincere hope that the transformation will significantly change this dynamic so that we do not continue to insure a self-perpetuating and growing crisis system to the detriment of an earlier and more accessible system for less severe conditions.

Again, thank you for the work of the various Transformation Teams and the intent to improve the system of care for behavioral health needs and intellectual disabilities for all Virginians. If I or my staff can be of any further assistance in the process, or if you would like additional clarification of our comments, please do not hesitate to contact me. Thank you again for the opportunity to provided input into this important effort!

Sent: Friday, May 15, 2015 7:02 AM

Subject: Town Hall meeting share

My share for the Town Hall Meeting

I have worked in the Behavioral Health field as a front line worker for over 20 years. I have over 25 years of personal recovery from substance use; clean and sober 19+ years. I am CSAC, and have a Masters in Public Administration. I currently work as a counselor in a CSU.

My experience in outpatient substance abuse services has shown me that many "offenders" are faced with enormous challenges when they try to redeem themselves. People who have numerous charges often feel "what's the use?" because the system is against them. They are punished for having a disease which is chronic, progressive, and fatal. Research shows that a combination of treatment, self-help (peer support) and medications (if indicated) can help them recover. However, when the system continues to punish people, by restricting their freedoms, they have a very slim chance for recovery. Although some recovery and transformation can take place in jail or prison, very little does. The environment is not conducive to emotional, mental, physical, or spiritual growth; these environments are oppressive. Over half of substance abusers have a co-occurring mental health disorder; again prisons and jails are not treatment centers; people do not get the help they need. Better treatment opportunities are required, and the legal system needs to stop punishing people for having these issues.

Another problem in the system:

When I first started working in the CSB's, front line workers were able to bill for the time that was needed to document their services, and bill for many more types of face to face services. It seems that there are so many obstacles now, that Medicaid has created which prevent providers from being reimbursed. It appears to get stricter and stricter with each year, the documentation parameters change constantly and this burden falls on the agencies; especially the managers and front line workers who are required to meet quotas. My supervisor spends approx. 50% of her time just trying to appease Magelland/Medicaid. They are still changing things. My overall impression of Medicaid is that they are going out of their way to "not have to reimburse agencies who provide services..." I thought they were charged with providing funds for services; not prohibit them.

Thank you,

Sent: Friday, May 15, 2015 9:25 AM

Subject: Transformation Team Public Comment

These are my comments (I have elaborated a bit on some of them) from the Town Meeting held in Woodbridge on May 12. My notes were not organized enough to turn in at that time!

I'm a LPC, LMFT, and Board Certified in Neurofeedback (BCIA). I am a senior clinical supervisor at Prince William Community Services. I have a number of comments but with a 3-minute time limit, I will have to pick a couple of major points and talk about an intervention that needs attention and support.

Access to mental health services in this state is a major problem -- and is compromised by a growing shortage of private providers willing to take Medicaid -- *or any insurance, for that matter...* because of complex requirements and poor reimbursement rates.

- Growing numbers of private providers take cash-only clients, or severely limit what insurance they will accept
- Fewer private providers strains the CSBs, which are typically underfunded, with lengthy wait lists for services.
- Many people go without services unless they reach a crisis point and need much more costly crisis services or hospitalization

Attention needs to be paid to streamlining the bureaucracy -- it is strangling the public agencies and probably private providers.

- It is crazy-making to deal with the 60+ insurance companies with differing requirements that are not always clear -- and may not even be best practices.
- Clients see a lot of paperwork, especially initially -- they complain that the paperwork gets in the way of the treatment they want and need right away
- CSBs losing staff in our area because of excessive paperwork requirements, better incomes offered at private clinics (paperwork less onerous in private practice)

Integrated Care model -- good idea in theory for many -- but not all -- individuals

- Should go even further and include nutritionists
 - Most MDs have a very limited knowledge of nutrition, which has a profound effect on how our nervous system works.
- **Not everyone needs physician-directed treatment** -- ineffective parenting or abuse, for example, resulting in children with serious behavior issues: these are not particularly well-served by psychiatrists
- While most psychiatrists did not go to medical school to become primarily prescription writers, this is indeed what happens with most psychiatrists in community mental health. Most are not up to date on new Evidence-Based Practices in behavior therapy.
- **The requirement that new clients must see the doctor before therapy can start (regardless of whether they need prescription drugs) is a barrier to services...**
 - **Delays therapy**, as most agencies have a significant wait list for psychiatrists
 - **Uses scarce psychiatric appointments needlessly**, when individuals really needing to see the doctor may have to wait a month -- or 2 -- or 3 -- for an appointment. Private psychiatrists taking Medicaid are also a rapidly shrinking pool.
- Moreover, **this requirement is likely to feed the idea that one needs to see a psychiatrist, needs meds** -- the pharmaceutical industry has been extremely successful in convincing us that the secret to happiness in life is finding the right pill -- or combination of pills.

Lastly I want to draw attention to the **NEED TO EXPLORE AND SUPPORT EMERGING INTERVENTIONS** such as **neurofeedback**, or brain training. Biofeedback has been around for decades with good ratings for efficacy -- but is not supported by reimbursement schemes. The incredible influence of the pharmaceutical companies -- in both politics and public policy as well as the public consciousness fed by the endless stream of TV commercials for problems that didn't exist before a drug was developed to fix it -- disproportionately affects medical treatment today.

Many of those drugs -- the antipsychotics prescribed to children for behavior management, for example -- create serious health issues. Neurofeedback -- which focuses on affecting the brain's electrical activity rather than the chemistry -- offers much better effectiveness than many drugs for many common psychiatric problems, without creating new problems with side effects. But the support for this is extremely limited among insurance companies, even though it could save them a lot of money in the long run (reference Abilify, which costs over \$900/month). A therapist can do 30 minutes of guided imagery during a therapy session without any billing issues -- but 20 minutes of neurofeedback would not be allowed.

(TIME RAN OUT!)

Sent: Friday, May 15, 2015 7:24 PM
Subject: Town Hall Meeting-5/20/2015

Debra Ferguson,

I'm a concerned grandmother expressing my concern regarding the limited services available for the Deaf and Mentally Impaired in our Rural area. My grandson is deaf and suffers from Mental Illness. He requires frequent sometimes multiple admissions to the State Mental Facilities per year. He requires 24/7 supervision in a private home now, but should he require a group home they are very limited if any available at all.

Due to such limited services his accommodation are not often able to be met. Interpreter services which are also extremely limited and he often has to communicate via notepad and pen. This is NOT an acceptable means of communication especially in the Psychiatric facilities given his deafness and mental condition. Therefore I feel there is much needed room for improvement with these services being made more available.

He is certainly not alone as there is a huge amount of Mental Illness in this area with the number increasing daily that would benefit from the added services. Job opportunity is also lacking in this area. I feel many of these affected with Mental Illness or Deafness would remain in private homes with less Hospital admissions if jobs were made more available.

Your immediate attention and assistance in the above matters will be greatly appreciated.

Thank You,

Antje E. Huck
2849 Bennett's Pond Rd.
Williamsburg, VA 23185

Virginia Department of Behavioral Health & Developmental Services
P.O. Box 1797
Richmond, VA 23218



May 14, 2015

To Whom It May Concern

This comment pertains to the meeting held on May 11, 2015 in Williamsburg and falls under the category of proposed legislative initiatives.

SSDI vs. SSI Benefits

Disabled mentally ill individuals are entitled either to SSDI (Social Security Disability Insurance) or to SSI (Supplemental Security Income) benefits. SSI benefits are significantly lower than SSDI benefits. The reason behind the difference is that the SSI eligible person has not earned the requisite number of work credits to qualify for SSDI benefits. However, it should be fully recognized that it often takes years to be finally diagnosed and treated correctly. It is frequently the disability which caused the shortfall of work credits. Does it really make sense, therefore, to punish the disabled mentally ill person for not having been able to hold down a job for the requisite number of work credits?

Inadequacy of SSI Benefits

SSI benefits are currently set at an unreasonably low amount of \$730 per month (plus food stamps). As a practical matter one can not live on that amount. This artificial ceiling amount must be increased. An apartment for \$500 is difficult if not impossible to find. Once the utilities are paid, there is often not enough left for toothpaste, toilet paper etc. which are not covered by food stamps. A mentally disabled person is not getting better by constant worry over debts and evictions.

Housing

There are not enough designated subsidized apartments or homes available for those mentally ill people who would be able to live independently. Would it not make sense to have a housing subsidy program, similar to the food stamp program, or a voucher program where the money to be spent is restricted to housing but could be used in any apartment complex? It would be much more cost effective than assisted living facilities or even group homes.