

Blue Ridge Behavioral Healthcare

Donna Henderson *Chair*
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Executive Director
Debbie Bonniwell

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 from Blue Ridge Behavioral Healthcare, the Community Services Board (CSB) serving five jurisdictions in the Roanoke Valley of Virginia.

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.
- 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.

- 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.
- 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.
- 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.
- 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.
- 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!

Best regards,



Debbie Bonniwell, MBA, MSSW, LCSW
Executive Director

Va. Dept. of Behav. Health Project

Town Hall Mtg
5/11/15

May 10, 2015

Good Afternoon,

My name is [REDACTED] and I have a long history of working with the mentally ill as a rehab counselor with the state for 45 years. I retired from my job in Feb. 2015. I worked at a rehab unit at ESH from 1970-80 and have a 31 year son with mental illness [REDACTED] who has had several private hospitalizations and has been in ESH since October 2015 and is now on the discharge ready list. I have been dealing with the mental health system with my son since 2002. It is a shame that when you are in a private facility you will be kicked out on the street or to a homeless shelter once your insurance runs out or if they deem you cured in as little as 2 weeks even though you are still hallucinating or manic. That's why so many mentally ill people are homeless or in jail today.

My major concern is the lack of mental health programs and facilities in Virginia. I have seen how it used to be at ESH where they had a Print Shop, Vocational Center, Work Shop, Food Service Training, etc and patients were allowed to participate in these and get jobs while residing at the hospital. That all changed years ago and they are now put in group homes or assisted aging homes where they basically sit and smoke all day long because there is nothing else to do. Young mentally ill people do not belong in old age assisted living facilities. These places are sub standard. I have been in some of these group homes, boarding homes and assisted living facilities and know from first hand experience how bad they are. I have even had a social worker at ESH tell me they are not very good but yet they are placing people in them because they have no where else to place them.

At ESH it seems that once your status changes from Court Ordered to Voluntary they deem you discharge ready and start looking for a place to get you out. Many times your age and what is best for you is not taken into consideration or your goals and plans that were in place when you were on the former unit. I am told Richmond says they have to get you out.

I am also very very concerned about what a parent has to go through to get a person into a hospital that is mentally ill. I know they have to be a danger to themselves or the community. It is very difficult to get them the help they need. I know this from my personal experience with my son and the fact that after his insurance ran out or after sometimes in just 2 weeks he would be discharged as "well" when he was as sick as he was when he was admitted involuntary. This happened at Riverside Center for Behavior Health in Hampton and the Pavilion in Williamsburg.

I think Virginia needs to have some transitional apts or treatment programs in the community that will help the mentally ill, not just place them in run down boarding houses and group homes or run down assisted living programs with no programs. I have talked to social workers at ESH, case managers, CSB workers and have been told the same thing, that they do not have

anything else. There is a program I heard about called Discovery House in Urbanna that is supposed to be a good place but they only hold 6 people as it is a house which was started for the mentally ill who were incarcerated. I have also heard about a good place in Chesterfield called Gateway which appears to be toward the right direction to help the mentally ill. Both of these programs have waiting lists and ESH will not always allow a patient to stay there until they can go to these programs, telling the parents that they will place them in a assisted living facility or group home because they have to get them out, and then you, the parent can get them in where you want to. This is not satisfactory. The CSB years ago had supervised apts in the Hampton/NN./Wmsbg where clients would live and possibly work. I had some of my clients in these apts but now CSB tells me they have all been closed.

The mental health profession's hands are tied as they have no decent structured, supervised places to place these patients. They are under pressure they tell me from Richmond to get them out of ESH once their status is changed to voluntary. I attended the court hearing on April 9th, 2015 for my son which was a joke. Everything was pre-decided before we walked into the court hearing meeting and our opinion, as parents was not taken into consideration as well as the independent psychiatrist who stated that my son's status should not be changed to voluntary. Immediately after his change to voluntary there was a push to get him out even though he had been in the new unit approximately a month.

I would like to see something done so we don't have mentally ill individuals living under bridges, in jail in despicable groups homes, boarding homes and assisted living facilities which were built for the elder population and not a dumping ground for the young mentally ill. It is not fair to treat them this way. They deserve better.

I was hoping after the Craig Deeds tragedy that something good would happen about the care for the mentally but I have not seen it. Lengthening the time they have to get a person into a hospital will help somewhat but keeping them and providing a decent plan and decent housing when they leave is the key to keeping them hopefully from being out on the street and being arrested or homeless, etc.

Thank you for allowing me to speak.

[REDACTED]

[REDACTED]

RE: Virginia Department of Behavioral Health Project for Transformation of the Virginia State Mental Health System

Request for public comment - May 11, 2015 Williamsburg "town hall" meeting

My son, [REDACTED] has suffered from mental health issues since 2001, his freshman year in college. [REDACTED] left school at the beginning of his 2nd semester on "medical" leave at the recommendation of the college. He has been under psychiatric care off and on ever since, including several involuntary admissions at various private psychiatric hospitals in Virginia. He was also hospitalized at Johns Hopkins in Baltimore for 56 days in 2005. Currently, [REDACTED] is a patient (since October 9, 2014) at Eastern State Hospital in Williamsburg. My comments below are based on my son's experiences in the Virginia mental health environment since 2005.

My primary concern is the apparent institutionalized reluctance to make "long term" psychiatric in-hospital treatment reasonably available when needed. With two exceptions, the private psychiatric hospitals where my son has been admitted in effect treated him "by the calendar" rather than based on his personal needs. Except for [REDACTED] 2005 hospitalization at Johns Hopkins and his September/October 2014 hospitalization at the Pavilion at Williamsburg Place, he has always been quickly discharged 3-5 days after the hearing ordering his involuntary admission. It's as if treatment is based on some standard calendar-type formula rather than the patient's individual needs. One size does not fit all regardless of what political correctness may dictate. When I questioned my son's quick discharge from one psychiatric hospital, the hospital director in essence said it was required unless the legislature could be persuaded otherwise. My son was discharged from an October 2013 hospitalization at the Pavilion within 4 days after his involuntary admission was ordered - according to his mother, sicker than when he was admitted. This "revolving door" hospitalization culture apparently discourages all but the most courageous doctors from challenging the system. Luckily, the last psychiatrist who treated my son at the Pavilion immediately before his "bed-to-bed" transfer to Eastern State Hospital on October 9, 2014 was a fighter - a retired US Navy psychiatrist (previously a US Navy "tail-hook" jet fighter pilot) who had just recently arrived at the Pavilion. After taking time to actually get to know my son and evaluating the effectiveness of different medications and dosage levels, this doctor determined

that my son needed long term hospitalization. This doctor even laughed about his colleagues questioning why my son hadn't been discharged since he'd been at the Pavilion longer than a week. After significant effort, this doctor was eventually able to get my son admitted to Eastern State. The first ESH board review put [REDACTED] case on hold pending an independent evaluation. When we questioned what would happen if Eastern State ultimately denied [REDACTED] case - the doctor said he would appeal. In the interim before the next ESH board hearing, the doctor exerted extensive additional effort to put together the best case for [REDACTED] admission. However, a couple of days prior to the next ESH hearing, we were advised that [REDACTED] had been accepted and was being transferred to Eastern State that day at 1:30PM. I mention the foregoing summary of events leading up to [REDACTED] current in-hospital treatment at ESH as an indication of the extensive effort required to obtain long term in-hospital psychiatric treatment (non-criminal cases) in Virginia.

Sincerely,

[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

**Town Hall Meeting Input
Transformation Team Recommendations
Virginia Department of Behavioral Health and Development Services
Williamsburg Regional Library
Williamsburg, Virginia
May 11, 2015**

Good afternoon. My name is [REDACTED]. My youngest son, 25, my wife and I live in Williamsburg. We are members of NAMI Williamsburg. Over the past year and half, I have received NAMI's Family-to-Family (12-week) training; attended the NAMI Annual Conference; taken part in weekly support group meetings; become a member of our board; and started a daily investigation into options for providing or facilitating care provision. Our group facilitators, family and recovery, are dedicated and excellent.

My son has suffered from serious mental illness for probably most of his life, experiencing acute episodes over the past 4 years. He's been hospitalized for mental illness only twice, but seen a half dozen psychiatrists. In January, he was released after 9 days of a potential maximum of 30 days by judicial mandate; he was in a terrible state and we have simply managed the situation, but we could have easily called the police. Like many of our loved ones, he is highly intelligent. He is very kind and considerate to people and animals. He does not necessarily accept that he's sick; he falls into the diagnosed but untreated category (60% of the people with serious mental illness). He came within months of having his college degree in renewable energy engineering. In that year, he miraculously escaped death or permanent paralysis. He, and we, his loved ones, are on a long, long journey. We accept that and accept our familial responsibility. When it goes poorly, sadly, it can be exhausting. Still, every day that he's with us is a good day.

The reason you are here is to receive feedback and personalize your groups' recommendations. My remarks today address serious mental illness among adults, but I believe the same thought process is germane to what appears to be a brewing epidemic among children. Let me offer three suggestions that will lead to measurable outcomes and put the Commonwealth, and perhaps more importantly, communities on a path to sustainable care. They are (1) mobile crisis care through *Open Dialogue*, (2) longterm recovery through *Fairweather Lodge*, and (3) the enlistment of Corporate America as a partner and in the revenue mix to help normalize the commitment to mental health care in our state.

Last week was the Kentucky Derby. Probably the most famous horse race in the world. If for a moment, you imagined all the diseases were horses, racing for successful outcomes. Then, you solicited bets on the likely winners. Promoted those horses in TV commercials and media. Wrote stories about tragedy and triumph of each in programs. The least considered, funded, talked about, but feared would be serious mental illness. In the month of May, people don't wander around with green ribbons on and talk openly about this illness. They are ashamed. Why? It does not tug at the heart strings like a young burn patient, cancer at any age, or a returning veteran who suffered battle injuries. Intense betting is placed on these victims and their families. We watch tear-jerking commercial during the news hour, which request only \$19.95 per month.

For many diseases, with care, there are outcomes that bring the prospect of joy or least some eventual peace and comfort. Tom Insel, the Director of National Institute of Mental Health gives a presentation that shows incredible results of research, techniques,

treatments of once incurable diseases. It's thrilling. Then, he points to the curve for suicide. Instead of descending, it's rising. Imagine *Suicide* is the name of a horse in the Kentucky Derby and we can plainly see the problem we have in attracting attention to our life's mutual work. Your work. And, the situation we are trying to change.

Mobile Crisis Care - The Open Dialogue Approach (Western Lapland, Finland)

This brings me to my first suggestion. Mobile crisis care and *Open Dialogue*. In an age when technology is ever present in a smart phone. Ideas such as tele-health. The latest neuroleptics. In vogue theories such as Cognitive Enhancement Therapy (CET), which require a yearlong commitment. And, high-end treatment centers, post-acute care hospitalization, an economic option for very few, with hit-and-miss results, we miss the most valuable opportunity of all. The crisis: It is a "high touch" opportunity to provide intense care at the very outset.

Finland has the world's highest incidence of schizophrenia. In one community, an approach called *Open Dialogue* has produced incredible outcomes, including the resumption of work and school and lower requirements for neuroleptics. It all begins with a phone call by a person in crisis or family in crisis and the arrival of a team made up professionals (psychiatrists, psychologist, family counselors) to work with the family on-site. It is without a doubt a labor-intensive approach with positive, reproducible, measured, and sustained outcomes. (Mary Olsen, Phd is the acknowledged US expert. (Mass General Hospital) The method was tried by a Harvard skeptic and has worked in the US with comparable results. He spoke at the NAMI Convention in September 2014.)

To refer back to the Kentucky Derby analogy, the horse *Open Dialogue* is a worthy bet to win the race. If we are going to measurably change outcomes, we have to think and act differently. This is one way that brings the fight and the care directly to the home and makes it personal. Isn't that what true care is? Personal. Now, how can we adapt this Finnish approach to an American application?

(I will further add that mobile crisis services are available in Virginia, paid for under Medicaid, not health insurance, and these are private services. But again, I believe, if mobile care service was integrated into community care and Community Service Boards, the outcomes would be more pervasive and inclusive.)

Longterm Recovery - Fairweather Lodge

Since last July, my top priority has become my son. It's my job. While I can do this, most cannot. A break for most caregivers would be coming to a weekly NAMI Support Group meeting. For our loved ones, they live a life we cannot possibly understand. Self-isolating. Without friends. Incapable of finding or keeping paying work. If a person is fortunate, they have a home to live in, regular nutrition, and a family member to care for them. If they live remotely, they have outside financial support. Most of our NAMI family caregivers are afraid of several things: (1) running out of money and having to declare bankruptcy (some have); (2) they are older, concerned about dying and leaving their loved ones behind; or (3) that their loved ones will wind up on the street or jail because they are incapable of managing them. Not new problems. But, if one thought about the rise of single parent households and that one in five children experience a mental disorder, the future is disconcerting.

In 1955, hospital beds began rapidly declining in favor of community center-based, walk-in care. Only few walked in. That hospitalization was bad is acknowledged. If we have 155,000 today, it should be closer to 1.3 million, based on current population. But this would not solve the problem, it would help with acute care and could provide a safer place to live and receive care. In principle, people in recovery find little difference between jails and hospitals. Your group is trying to figure out how to identify existing beds for acute care, which is necessary. And, more facilities, it seems, would ultimately be needed. Unless programs significantly curb the influx.

In 1963, a man named George Fairweather – a social psychologist with the Veterans Administration Hospital in Palo Alto, California – saw the future as it was unfolding. He devoted his life to one thing, A life for people with serious mental illness after the hospital. He envisioned a house, people living together as a family, interdependently, accountably, operating a business, coached from the outside under fidelity standards and practices. The idea was studied by NIMH, worked, and today there are over 90 Fairweather Lodges located around the country. Many have been living in these homes for up to 30 years.

I visited 5-lodges across the border in Pennsylvania last Fall. For a part of a day, I participated in one very successful business, transportation. Pennsylvania has the most at 35 homes. What was obvious – for at least a portion of the population of people in recovery – this is an answer. It's opportunity to live a, no apologies, interdependent and fulfilling life. The board for Fairweather Lodge – the Coalition for Community Living – met in Williamsburg in March. They held a workshop session for our community. We reached out to the Governor's Office, who thought this was rather neat idea, as did NAMI Williamsburg, but the

Assistant Commissioner of Behavioral Health Services was detained on an emergency, but reaffirmed his interest.

It was an enlightening to learn about what is possible when a community decides to ride the Fairweather Lodge horse. It's not uncommon for neighborhoods to rise up against them at first. Then, when they become the best house, best neighbors in the community, everyone forgets their original concerns. At the session, we heard from lodge residents themselves. How their lives had gone from prison, or despair, to realizing self-worth, earning a paycheck, having a family and friends who cared about them regardless of their illnesses. Lodge coordinators spend on average 10-hours per week per lodge supporting the needs of the program. This is much more than housing, which is clearly a need in our state. It costs \$800 per person per month. Lodges are designed for 5 - 7 people, male and female adults live together. The association collects data and reports regularly on compliance with their fidelity standards. These self-governed homes would not be considered group homes under state regulation. That's important. A couple of noteworthy outcomes: very low re-hospitalization rates and only one-in-four require Social Security Disability Income (SSDI). Could we imagine 100 lodges in Virginia, providing socialization, self-worth, jobs, and value in a community, and changing the demand curve for acute care services? *Fairweather Lodge* has over 50 years of track record and it is another horse on wish to bet to win the race.

Corporate Stakeholders - Partners - Smoking

When we examine the history of serious mental illness in this country, since the mid-1800s, we get stuck. Our intentions are good, but when federal government, states, and locals find

themselves in budgetary pinches, what are the first cuts made? The only constant, so far, is the police. Everything you recommend to increase crisis intervention training and managing the logistics of emergency room, prison, and acute care will help. I know many police, now, in our area, and they have been a tremendous help to our family, beyond measure.

The problem the legislature and local communities have is NO MONEY. If our economy was truly improving more than our labor participation rate would be much higher than 62.9 percent. We are near historic low rates and a skyrocketing number of people on SSDI and food stamps. Yet, we have everyday people in America, who want to counsel and be involved in caring, regardless of whether it is mobile crisis intervention or Fairweather Lodge support. We have willing and trained workers looking for jobs who would make excellent lodge coordinators. If they manage to land a mental health care job, the question is, Will it last?

Corporate America knows the problem of serious mental illness. Besides autism, can anyone name one corporate spokesman for the illness? Outside of a very small number of donors, research into the brain and psychosis would have little notoriety. Even then, it is a small community of us that know. This research will help the future but not the present.

Let me make an outrageous suggestion that before you reject it, you think about it.

Most people in recovery smoke (upwards of 90%). You can call it a bad habit, harmful, a contributor to a shortened life, but it's reality. People drink alcohol and use drugs, legal and

otherwise. I doubt anyone can make a convincing argument that legalization of marijuana will reduce the incidence of psychosis. The contrary is quite possible for a small segment.

So, where is the money from taxing cigarettes (sins) going when it comes to supporting mental health programs? Or, alcohol? Medications that bear warning labels like “may cause suicidal thoughts.”

These are obvious products, that in some way touch mental health, and the purveyors could be a source of consistent funds for programs. Or, and I doubt it, they could be willing corporate stakeholders in caring for human beings. We don’t have to always rely on the state income tax and property taxes, which come and go in huge chunks. Alcohol, cigarette products, and common drugs, for pennies on a sale, could generate vast and more stable revenue for programs.

Dual Diagnosis and co-morbidity, which in your recommendations, is reality. It’s serious for people in recovery who currently seek SSDI, especially now, with the high demand, and could be a basis for denial.

It’s not a willing horse, but *Tobacco, Alcohol, and Drugs* is good bet for normalizing the revenue stream that is available to provide a place to live, nutrition, work and care.

More uplifting sponsors would Apple, Microsoft, Oracle – literally every High Tech company located in Silicon Valley. They all know about serious mental illness. Books have been written by people who had bipolar and once wrote code for well known software companies.

From the outside looking in, companies have been taking advantage of workers during periods of mania.

As I close this presentation, my purpose is to suggest, as you move forward, that we are surrounded by opportunity. If we could only have one horse race, where the only participants are those connected to the disease of mental illness, then we'd look at things differently. We'd take the Eastern State Hospital, which is destined for sale, we are informed, and ask a serious question: If this land was bought for purposes of behavioral health, how are we using it to solve those problems through living, working, training, coaching, and providing access to care. If we hold one race for the care, and cure, for mental illness, we would pursue high-touch approaches that bring care, like *Open Dialogue*, to the suffering and their families; that think in terms of entrepreneurial models like *Fairweather Lodge*; and recruit *Corporate America* to participate openly and actively. Thank you very much for your time and your work.

[REDACTED]

My son was in
Jail for 20 years.
He was pleased
with no re entry
help except to
meet with his
probation officer,
after 7 months
of being in/out
of custody &
reporting to the
prison warden to
the D. William.
They found an
admitted living place
for him. His
was needed for
after being in
jail for a long
making decisions
and asking for help
was too often
also not done well
in case of being
~~to~~ removed

It is in the hood,
and he is shooting
to work outside.
There are drunk
people and drug
dealers all around
the area. This is
not good for
someone in
the hood. He needs
to be in a safe
place, he may
or may not ever
be able to move
out but help them
in a safer place,



Commissioner

Dear Members of the Committee:

Thank you for allowing me to speak to you today. My name is Cristy Gallagher and I live in Fairfax.

I am the mother of a 13 year old child living with bipolar disorder and I am here today to share my story and to ask for your support in strengthening Virginia's mental health system for children and adolescents.

~~Like 1 in 5 children in America, my daughter has a brain disorder,~~

For our family, our daughter's mental illness has caused us to live in a life of instability. ~~We never know when her illness will strike.~~ We are hypersensitive to whether her illness might be leading us to hospitalizing her - as we have had to do twice.

~~It was at the end of her last hospitalization,~~ ^{during her} when our family qualified for Virginia's Comprehensive Services Act funding. Through Fairfax County's intensive

children who have mental health disorders. Because of the stigma that surrounds these children's illness, families are also reluctant to search for help, and sometimes those they reach out to do not know how to navigate the system.

Whether this is from a lack of ~~coordination~~, ~~of~~ the existence of a coordinated system, or confusion among those who are in a position to help these families - it needs to be addressed.

In particular, I appreciate the committee's recommendations to establish ~~the~~ consistency in the availability, quality and accountability of core services.

~~to~~ ~~access~~ ~~to~~ ~~access~~ ~~and~~

I also agree with the recommendation to establish one state entity to be responsible for the needs of children with a mental illness. Finally, the recommendation to establish a statewide system of navigation for families to improve access is long overdue and needed.

As you work together to fine tune these recommendations, I ask that you remember families like mine, families with children who have a serious mental illness that will

heard from families around the Commonwealth, current services are not only inadequate, but they are inconsistent.

Funding is also inadequate and inconsistent across the state. Beyond mandating core services, augmenting existing funding would ensure that additional children are reached with a more comprehensive array of services.

a strong proponent

In particular, I am ~~an advocate~~ for better crisis response and intervention services for families.

twice

Our family has ~~twice~~ had to call the police to our home ~~in a crisis~~ - because there was no crisis mobile team available at the time.

And

I talk to parents all the time that ~~could also benefit from crisis intervention supports~~ *who have ed* ~~rather than~~ resorting to calling the police or driving to the Emergency Room with their child during a crisis. *MM*

an advocate

I am also a big proponent of access to core services. In my experience I have heard from families that there is a lack of understanding of what services are available for

wraparound services we were able to receive home-based therapy, parent training and respite care.

We are the lucky ones -- we have been able to find a hospital bed when my daughter has needed it and to access CSA funding when our family has been in crisis after her hospitalizations.

But there are many families in Virginia who are not lucky.

With an estimated 100,000 children and youth in Virginia living with mental illness, we know that there are parents and children who are suffering and not talking about it.

Virginia's mental health care system needs sustained, long-term support. A comprehensive array of services — case management, outpatient, and emergency — is needed.

The draft recommendations included in the ~~Child and Adolescent Behavioral Health~~ Transformation Team report are a positive step in the right direction. As I have

continue into adulthood. Our children need treatment NOW, while they are young,
and they will continue to need support as they transition into adulthood.

With appropriate services and supports, our children can live up to their potential,
be successful, and contribute to society.

Thank you for your time.



Recommendations for additions to the current DBHDS plan for Transforming Mental Health Accessibility and Services:

1. Add an additional transformation team to explore and provide recommendations regarding how to eliminate access barriers related to race, ethnicity, and language spoken.
2. There needs to be greater representation and input from minority and multicultural communities as well as ethnic organizations. Please set times and places to specifically address these populations in coordination with spokespersons for these communities who are willing to help you organize such events. Then involve them in your existing Transformation Teams.
3. Virginia, as one of the top 15 recipients of refugees in the country, the transformation teams should be looking at specific issues that arise with refugees and their unique needs in mental health and developmental disabilities.



Thank you,



The Changing Face of Virginia - Immigration and the Humanities

Less than fifty years ago, in 1970, only one in every 100 people living in Virginia had been born outside the United States. In 2012, the figure was one in nine.

Current estimates place the number of foreign-born Virginians at just under one million, out of a total population of 8.26 million, and nearly half of these new residents of the state are between the ages of 25 and 44—prime years for work as well as child-bearing.

In recent months, the surge of unaccompanied, undocumented children entering the United States from Central America has received widespread publicity and sparked intense public debate. We don't yet know the full impact of this *particular* immigrant stream on Virginia, but we do know that among the children of adult immigrants in Virginia, including documented as well as undocumented migrants, 96 percent today are U.S. citizens. In 2014, in Arlington County alone, 6,755 public school students spoke a language at home other than English, and two-thirds of these were born in the U.S. to immigrant parents.

From Virginia Foundation for the Humanities' website

<http://virginiahumanities.org/2014/10/the-changing-face-of-virginia-immigration-and-the-humanities/>

POPULATION GROWTH TRENDS According to the 2010 US Census, Virginia's population in 2010 was 8,001,024, accounting for 2.6% of the national total of 308,745,538. Virginia's population increased by nearly one million from 2000 to 2010, for a growth rate of 13%, higher than the national growth rate of 10%, and higher than expected according to inter-centennial estimates. Virginia's growth rate also surpassed that of neighboring jurisdictions of West Virginia, Maryland and District of Columbia. The majority of this growth, more than 80%, occurred in Northern Virginia, the Richmond area, and Hampton Roads. Northern Virginia alone grew by half a million, which represents more than half of Virginia's total increase. Half of the population increase was natural population growth, while the other half is being attributed to net migration (US Census, 2010).

From *Virginia Socio-Demographic Characteristics*

https://www.vdh.virginia.gov/epidemiology/DiseasePrevention/Profile2011/VA_Population_Demographics_2011.pdf

Restorative Justice An Overview

In recent years there has been a renewed interest in the concept of restorative justice in community-based corrections programs. In simple terms, restorative justice is a community corrections approach that focuses on "restoring" the victim and the community while at the same time educating the offender about the consequences of his or her criminal conduct.

This "restorative" approach differs from the traditional criminal justice approach which uses the retributive model where guilt for a violation against the state is established. In the retributive model, the state is the instrument of retribution which holds the view of punishment as repaying a debt to the state.

The restorative model, on the other hand, recognizes that most crimes are violations of one person or entity by another. This orientation facilitates a problem solving focus between the offender and the victim and the community.

The ultimate goal in restorative justice is for the victim and the community to be restored and for the offender to gain insight into the consequences of their criminal behavior.

Contact Information

For more information
concerning the
Restorative Justice Program
please contact

Andrew Lightner
Restorative Justice
Probation Officer

Blue Ridge Court Services
White Star Mill
125 South New Street
Staunton, Virginia 24401

Office - (540) 886-1008
Fax - (540) 886-8029

Blue Ridge Restorative Justice Program



Serving the Courts of
Staunton, Waynesboro,
Highland and Augusta

125 South New Street
Staunton, VA 24401

(540) 886-1008

The Restorative Justice

Process

Restorative Justice Program referrals are made through the local courts. Criminal cases proceed through the normal court process until adjudication, at which time the presiding judge may refer the offender to the Restorative Justice Program to be interviewed by the Restorative Justice Probation Officer (RJPO). The RJPO determines if the offender meets the program eligibility criteria.

Once the offender is accepted into the program:

- ◆ The RJPO contacts the victim to obtain a victim impact statement and invite him or her to a restorative conference session.
- ◆ The offender is scheduled for an intake appointment where background information is gathered and the rules and goals of Restorative Justice are explained.
- ◆ The offender is brought before the next scheduled Restorative Justice Conference Session to discuss the nature and circumstances of the criminal act. Victims are encouraged to attend the session or, in the event they can not, to supply a victim impact statement.
- ◆ After receiving information from the offender and the victim, the RJPO outlines what restorative justice activities the offender must complete in order to restore the victim and the community. The offender signs a behavioral contract with the RJC to complete these restorative justice activities within a specified period of time.

Mission

The mission of the Blue Ridge Court Services Restorative Justice Program is to provide the Courts of Staunton, Waynesboro, Highland and Augusta County with community sentencing alternatives emphasizing restoration of the victims of crime and the community.

Program Eligibility

Participation in the program is voluntary. While restorative justice may be ordered as part of a criminal sentence or as a probation condition, the referral will not be pursued if either the victim or offender is unwilling to participate.

Criteria for eligibility includes:

- ◆ Non-violent, non-sexual offenders.
 - ◆ Property and larceny offenses.
 - ◆ Offenders must admit their guilt.
 - ◆ Offenders must be willing to participate in restorative justice activities.
- Failure to complete the Restorative Justice Program will result in the case being returned to Court for a Show Cause Hearing.

Restorative Activities

- ◆ Victim/Offender Mediation
- ◆ Restitution to the Victim(s)
- ◆ Service on Community Service Work Crew
- ◆ Apology Letters
- ◆ Writing a Research Paper
- ◆ Public Speaking About Crime Issues
- ◆ Conflict Resolution/Anger Management Class

Offender-Based Goals

- I. To restore victims and allow them to regain a sense of control.
- II. To make amends to the community.
- III. To accept responsibility for their crime and understand the harm that their actions have caused.
- IV. To learn ways to avoid reoffending.

**Our mission is to help children and adults
with a brain injury build the skills and
confidence they need to lead a fulfilling
and productive life.**

OUR CORE VALUES

- ⇒ *Respect:* We respect the individuals we serve, ourselves and our community, believing that people have a right to control their own lives and make their own choices.
- ⇒ *Partnerships:* We believe in bringing together diverse resources in order to maximize the opportunities available to individuals and the community.
- ⇒ *Integrity:* We are committed to being honest, accountable and professional in our relationships and communications.
- ⇒ *Catalyst:* We strive to create innovative solutions to the challenges faced by those affected by brain injury.
- ⇒ *Cost-Effective:* We aim to provide the most effective services at the least cost to the client and the community.

LEADERSHIP, EDUCATION, ADVOCACY

- BIS is a model program in the field of brain injury, statewide and on a national level.
 - BIS is accredited by CARF International for its Community Services including Case Management/ Services Coordination and Community Integration.
 - BIS partners with Virginia Commonwealth University and other organizations to present an Annual Conference on Brain Injury for professionals.
 - BIS is affiliated with many community organizations and brain injury support groups. The award-winning BIS Speakers Bureau supports survivors who choose to speak publicly on their own behalf and to educate community and school groups about the consequences of brain injury.
 - BIS works closely with elected representatives at the local, state and national levels to make sure voices and needs of survivors with brain injury are heard.
- FOR MORE INFORMATION**
- Please call our Main Office at 703.451.8881 or visit our website at www.BrainInjurySvcs.org.



BRAIN INJURY SERVICES

8136 Old Keene Mill Road, Suite B-102
Springfield, VA 22152
703.451.8881 • www.BrainInjurySvcs.org



Designation #8237

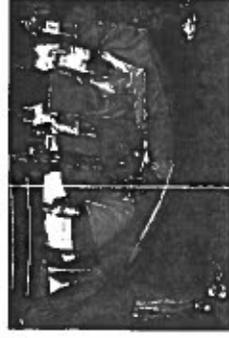
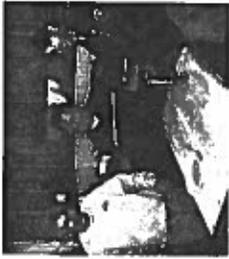
Brain Injury Services, Inc. is a 501(c)(3) non-profit organization supported by the generosity of donors and general funds administered by the Department of Rehabilitative Services.

OVERVIEW OF SERVICES *Community-Based Solutions for Living with Brain Injury*



BRAIN INJURY SERVICES

*Repairing Lives. Recovering Possibility.
Restoring Hope.*



INDIVIDUALIZED COMMUNITY-BASED SERVICES

- *Case Management Program for Adults*
Individuals are served through a community-based case management system that supports person-centered planning and a survivor directed approach.
- *Case Management Program for Children/Adolescents*
The pediatric program is family centered. Our comprehensive services allow children with brain injuries to maximize their capabilities and achieve personal success at school and in their community. BIS is there for families, siblings, schools and the community to provide long term support and reduce gaps in service provision.
- *Supported Living Program*
BIS contracts with Community Systems, Inc. to provide support and assistance to individuals who are at risk of losing their ability to live in the setting of their choice. Individuals are provided in-home residential supports.
- *Volunteer Program*
Individualized services that facilitate success in accomplishing goals and finding meaningful productive activities in the community, including volunteer job placement, Speaker's Bureau, PALS and Person-Centered Volunteering.

CASE MANAGEMENT

- **Brain Injury Services, Inc. – Main Office**
8136 Old Keene Mill Road, Suite B-102,
Springfield, VA 22152
Phone: 703.451.8881 Fax 703.451.8820
Serving residents of Arlington, City of Alexandria, City of Fairfax, and Fairfax, Prince William and Fauquier Counties.
- **Brain Injury Services, Inc. – Leesburg Office**
Loudoun Cares partner
8B South Street SW, Leesburg, VA 20175
Phone: 703.737.3150 Fax 703.737.3180
Serving residents of Loudoun and Western Fairfax Counties.
- **Brain Injury Services, Inc. – Fredericksburg Office**
927 Maple Grove Drive, #107, Fredericksburg, VA 22407
Phone: 540.785.6122 Fax 540.785.8837
Serving residents of Fredericksburg City, Spotsylvania, Stafford, Culpeper, Caroline, Louisa, and King George Counties.

"Brain Injury Services has supported my recovery tremendously, every step of the way. Thanks to BIS, I love my life and I see a productive, fulfilling future."

– Erika B., client since 2003

CLUBHOUSES

- BIS Clubhouses give survivors the opportunity to practice and develop important life skills in a supportive work ordered environment. The daily routine is based on communication/business, gardening and kitchen/maintenance units that prepare participants for volunteer and paid employment.
- **ADAPT**
4100 Mohawk Lane, Alexandria, Virginia 22309
Phone: 703.799.9410 Fax 703.799.1295
Hours: Monday – Friday 9:00 a.m. – 3:00 p.m.
Serving residents within the Northern Virginia region.
- **The Westwood Clubhouse**
927 Maple Grove Drive, #107
Fredericksburg, VA 22407
Phone: 540.785.8836 Fax 540.785-8837
Hours: Monday – Friday 9:00 a.m. – 3:00 p.m.
Serving residents within the Fredericksburg region.

VIRGINIA WOUNDED WARRIOR PROGRAM - NORTHERN REGION

A Department of Veteran Services program through the Loudoun County Community Services Board in partnership with BIS, provides treatment and case management services to veterans and their families for stress-related issues, substance abuse, or Traumatic Brain Injuries.

→ For information call 571.233.0336

Serving residents of City of Alexandria, City of Falls Church, Fairfax, Prince William, Loudoun and Arlington Counties.

Name:

[REDACTED]

Affiliation:

~~DB~~ Steering Committee for DBHDS Office of Cultural & Linguistic Competence

There are well-researched and documented disparities in medical & ^{behavioral} ~~mental~~ health care for racial, ethnic, and linguistic minorities. Given these disparities and ^{the} ~~a~~ challenges that minority populations face with regard to access, I would urge you to consider developing a separate transformation team focused on ^{addressing access &} disparities in care for minorities. Ensuring that members of minority communities are well represented on the existing teams is also an important consideration. Thank you for the opportunity to provide public comment.