Governor's Taskforce on Improving Mental Health Services and Crisis Response

August 11, 2014
1 p.m. – 4 p.m.
Board Room 2, Perimeter Center

Agenda

1:00 p.m. – 1:10 p.m.	**Welcome and Approval of Minutes** *The Honorable Ralph S. Northam, Lieutenant Governor, Chair* *The Honorable William A. Hazel, Jr., Secretary of Health and Human Resources, Co-Chair* *The Honorable Brian Moran, Secretary of Public Safety, Co-Chair*
1:10 p.m. – 1:25 p.m.	**DBHDS Update** *Debra Ferguson, Ph.D., Commissioner, DBHDS*
1:25 p.m. – 1:30 p.m.	**Discussion of June Recommendations** *Chair and Co-Chairs*
1:30 p.m. – 3:45 p.m.	**Cumulative Workgroup Recommendations** *Meghan McGuire, Communications Director, DBHDS*
	Discussion and Determination of Taskforce Recommendations
3:45 p.m. – 4:00 p.m.	**Public Comment**
4:00 p.m.	**Adjourn**

Notes:
* *Members will be invited to take needed breaks as they choose during the course of the meeting.*
* * *Materials provided to the task force members are available at* www.dbhds.virginia.gov/MHSCRTTaskforce.htm. *Comments from the public may also be made through the same webpage.*

Governor's Taskforce on Improving Mental Health Services and Crisis Response

June 16, 2014
12 p.m. – 3 p.m.
Board Room 2, Perimeter Center, Henrico, Virginia

MEETING MINUTES

Members Present
Chair
The Honorable Ralph Northam, Lieutenant Governor of Virginia
Co-Chairs
The Honorable Bill Hazel, MD, Secretary of Health and Human Resources
The Honorable Brian Moran, Secretary of Public Safety
Members
The Honorable Mark Herring, (proxy), Attorney General of Virginia
The Honorable Cynthia Kinser (proxy), Chief Justice of Virginia Supreme Court
The Honorable Emmett Hanger, Senate of Virginia
Debra Ferguson, PhD, Commissioner**,** Department of Behavioral Health and Developmental Services
Cindi Jones, Commissioner**,** Department of Medical Assistance Services
Colonel Steven Flaherty, Superintendent, Virginia Department of State Police
The Honorable James Agnew, Sheriff, County of Goochland, Goochland
John Venuti, Chief, VCU Police Department, Richmond
Mike O'Connor, Executive Director, Henrico Area Community Services, Henrico
Chuck Walsh, Executive Director, Middle Peninsula-Northern Neck CSB, Saluda
Lawrence "Buzz" Barnett, Emergency Services Director, Region Ten CSB, Charlottesville
Kaye Fair, Emergency Services Director, Fairfax-Falls Church CSB, Fairfax
Melanie Adkins, Emergency Services Director, New River Valley Community Services, Blacksburg
Jeffrey Lanham, Regional Magistrate Supervisor, 6th Magisterial Region
Daniel Holser, Chief Magistrate, 12th Judicial District
Bruce Lo, MD, Chief, Department of Emergency Medicine, Sentara Norfolk General Hospital, Norfolk
William Barker, MD, Emergency Medicine**,** Fauquier Hospital, Warrenton
Douglas Knittel, MD, Psychiatric Emergency Services Portsmouth Naval Hospital, Portsmouth
Thomas Wise, MD, Dept. of Psychiatry**,** Inova Fairfax Hospital, Falls Church
Anand Pandurangi, MD, VCU, Richmond
Cynthia McClaskey, PhD, Director, Southwestern Virginia Mental Health Institute, Marion
Joseph Trapani, Chief Executive Officer, Poplar Springs Hospital, Petersburg
Ted Stryker, Vice President, Centra Mental Health Services, Lynchburg
Greg Peters, President and CEO, United Methodist Family Services, Richmond
Teshana Henderson, CAO, NDUTIME Youth & Family Services, Richmond
Becky Sterling, Consumer Recovery Liaison, Middle Peninsula-Northern Neck CSB
Ben Shaw, Region 1 Coordinator, Virginia Wounded Warrior Program, RACSB, Virginia Dept. of Veterans Services, Fredericksburg

Rhonda VanLowe, Counsel, Rolls Royce North America, Fairfax
Tom Spurlock, Vice President, Art Tile, Inc., Roanoke

Staff Present
Suzanne Gore, Deputy Secretary, Health and Human Resources
Victoria Cochran, Deputy Secretary, Public Safety
Drew Molloy, Chief Deputy Director, Department of Criminal Justice Services
Jim Martinez, Director of Office of Mental Health Services, DBHDS
Mellie Randall, Director of Office Substance Abuse Services, DBHDS
Michael Shank, Director of Community Support, Office of Mental Health Services, DBHDS
Maria Reppas, Deputy Director of Communications, DBHDS
Meghan McGuire, Communications Director, DBHDS
Allyson Tysinger, Senior Assistant Attorney General, Office of the Attorney General
Karen Taylor, Assistant Attorney General, Office of the Attorney General

Members Absent
The Honorable Cynthia Kinser, Chief Justice of Virginia Supreme Court
The Honorable Janet Howell, Senate of Virginia
The Honorable Rob Bell, Virginia House of Delegates
The Honorable Joseph Yost, Virginia House of Delegates
Margaret Schultze, Commissioner, Department of Social Services
The Honorable Gabriel Morgan, Sheriff, City of Newport News

Welcome and Approval of Minutes
Ralph Northam, Lieutenant Governor of Virginia
Bill Hazel, Secretary of Health and Human Resources
Brian Moran, Secretary of Public Safety

Lt. Governor Northam called the meeting to order at 12:10 p.m. He and Secretaries Hazel and Moran welcomed the taskforce and members of the public.

The minutes were accepted and approved without objection.

Secretary Hazel updated the members on General Assembly action on the budget, specifically on Medicaid and how the budget affected the Health and Human Resources Secretariat, Department of Justice settlement agreement implementation and the mental health package.

Lt. Governor Northam discussed that each presenter from the workgroups will refresh the taskforce on the March recommendations and then will present the May recommendations. Following each workgroup presentation the taskforce would discuss and then vote.

Crisis Response Workgroup Recommendations
Cynthia McClaskey,Ph.D., Task Force Member, Southwestern Virginia Mental Health Institute
Ms. McClaskey reviewed the recommendations from the March meeting and presented the recommendations from the May meeting. Lt. Governor Northam opened the discussion. The members' discussion focused primarily on current efforts surrounding veterans' issues, the COPN

process, workforce development, and recovery-based tools. The Lt. Governor called for a motion and the recommendations were approved. (Handout provided)

Ongoing Treatment & Supports Workgroup Recommendations
Greg Peters, Task Force Member, United Methodist Family Services
Mr. Peters reviewed the recommendations from the March meeting and reviewed the guiding principles developed by the workgroup. Lt. Governor Northam opened the discussion. The members' discussion focused primarily on recommendations to make the system more user-friendly, models for the system, progress in housing, the concept of the "No Wrong Door," coverage gap, and the possibility of whether subgroups were needed. It was decided staff would determine subgroups for the next workgroup meeting among the Ongoing Treatment & Supports Workgroup. The Lt. Governor charged the workgroup with moving ahead to develop its recommendations. (Handout provided)

Public Safety Workgroup Recommendations
Victoria Cochran, Deputy Secretary, Public Safety
Ms. Cochran reviewed the recommendations from the March meeting and presented the recommendations from the May meeting. Lt. Governor Northam opened the discussion. The members' discussion focused primarily on transportation issues, therapeutic courts, magistrate roles, and the Center of Excellence. The Lt. Governor called for a motion and the recommendations were approved. (Handout provided)

Technical & Data Infrastructure Workgroup Recommendations
Betty Long, Virginia Hospital & Healthcare Association
Ms. Long reviewed the recommendations from the March meeting and presented the recommendations from the May meeting. Lt. Governor Northam opened the discussion. The members' discussion focused primarily on telepsychiatry, workforce capacity and development, and advance directives. The Lt. Governor called for a motion and the recommendations were approved. (Handout provided)

Lt. Governor Northam discussed next steps, including the upcoming July 15 workgroup meeting and the last meeting of the taskforce on August 11.

Public Comment – Lt. Governor Northam invited public comment at this time, but there was none.

Adjourn
The meeting adjourned at 1:54 p.m.

***Note**:*
** Materials provided to the task force members are available at*
www.dbhds.virginia.gov/MHSCRTTaskforce.htm
Comments from the public may also be made through the same webpage.

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

DBHDS Update

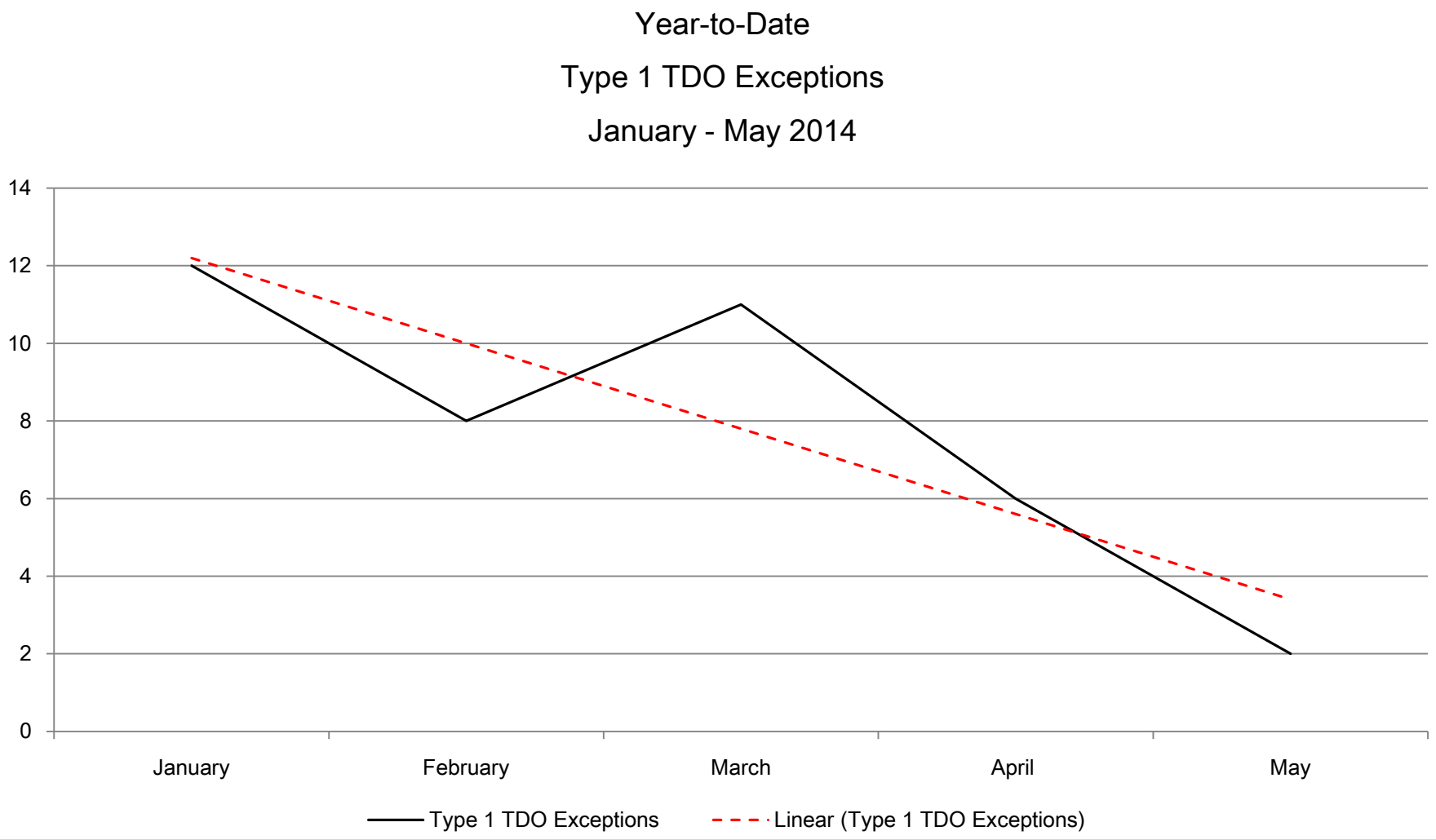
Governor's Taskforce on Improving Mental Health Services and Crisis Response

August 11, 2014

Debra Ferguson, Ph.D.
Commissioner
Virginia Department of Behavioral
Health and Developmental Services

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Reported Type I Events



DBHDS
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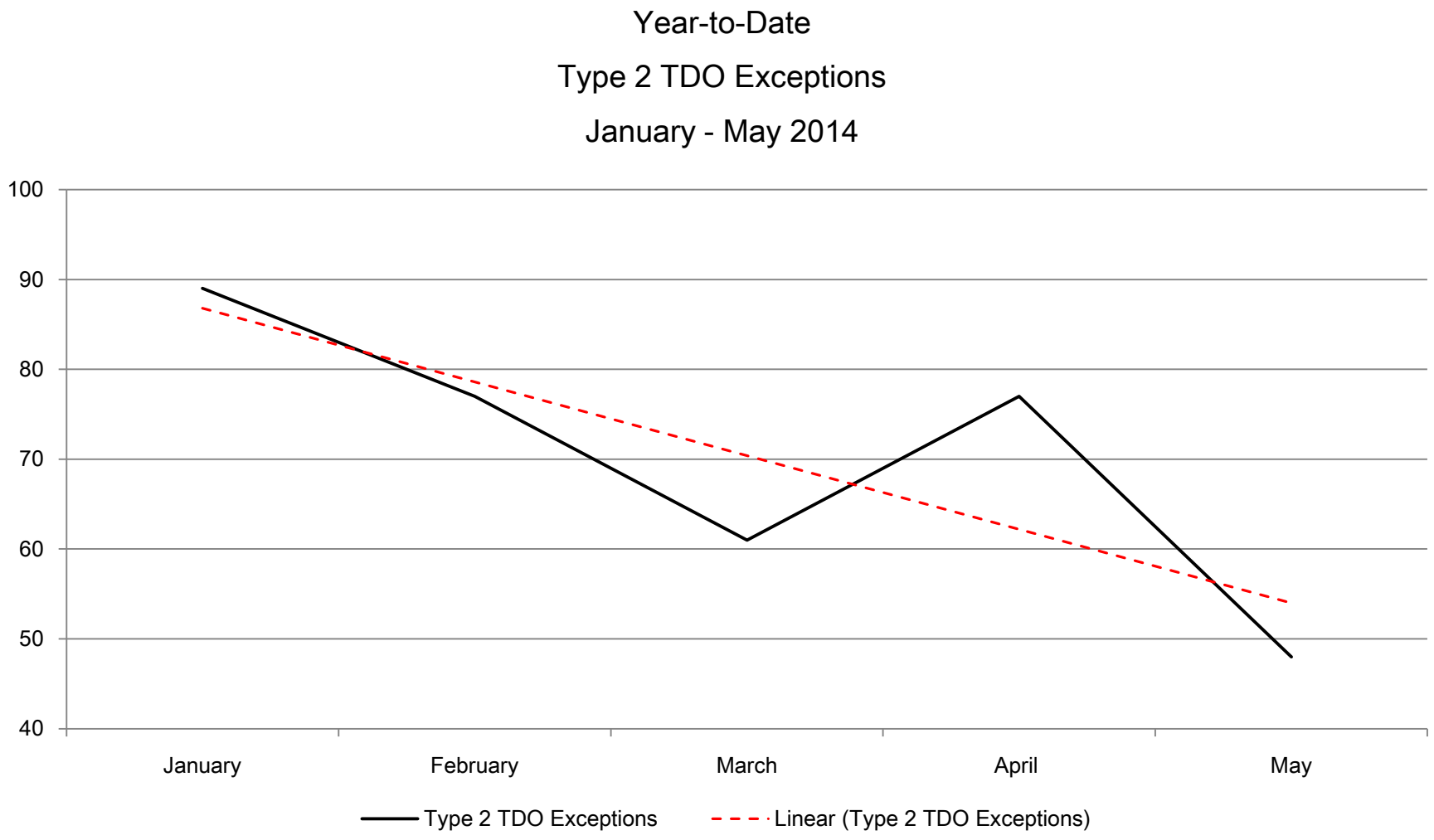
Developmental Services

Reported Type II Events:



DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

DBHDS Vision for Mental Health

- Grounded in the principles of recovery and resiliency.
- Provides access to high quality services across Virginia.
- Includes a well-functioning and responsive emergency services.
- Commits to prevention and early intervention.
- Deflects individuals with mental illnesses from inappropriate service systems (like criminal justice).
- Increased emphasis on children's behavioral health issues: particularly transition age youth.

DBHDS
Virginia Department of Behavioral Health and Developmental Services

DBHDS Transformation

- Accountability
  - New Performance Contract Addendum
  - Bed registry implementation and monitoring
- Transparency
  - Information available on new DBHDS website
- Communication
  - Commitment to regular communication with stakeholders about changes in practice and policy
- Collaboration
  - Working with system partners to incorporate their input
- Commitment to Best Practices Implementation
  - Calling on national expertise
  - Incorporating lessons learned from other states
  - Utilizing previous data, studies, and recommendations from former and current task forces and commissions

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Transformation Method

- Commissioner-convened small transformation teams focused on four areas (initially):
  - Adult behavioral health
  - Adult developmental services
  - Children's behavioral health
  - Justice-involved behavioral health and developmental disability services
- Identify structures and processes to aid, enhance and expand services delivery
- Report on key deliverables in 6, 12, 18 and 24 months

DBHDS
Virginia Department of
Behavioral Health and
Developmental Services

Virginia as Model System

Virginia can be a model system:

- Invests in children's mental health
- Prioritizes prevention and early intervention
- Commits to best practices

Governor's Taskforce on
Improving Mental Health Services
and Crisis Response

Taskforce Recommendations

June 16, 2014

Final Taskforce recommendations are due October 1, 2014

1) Virginia needs to create a Coordinating Center of Excellence. The vision of the Center should be to use Virginia's resources (both public and private) to address behavioral health needs within the Commonwealth. One significant goal/objective would be address the behavioral healthcare needs of individuals involved in the criminal justice system and this goal/objective should be addressed collaboratively by a team of profession to include staff from DBHDS, DCJS, private & public universities, CSBs, law enforcement, representatives from Virginia's court system, individuals with lived experience with the behavioral healthcare/ criminal justice system(s), community members, and family members. In addition to the Center of Excellence, each community should be required to establish a position/ committee/ group to ensure best practices are actually implemented and analyze instances when treatment/criminal justice/ diversion programs do not work as intended. Virginia also needs a statewide oversight system to make sure communities are engaged in oversight review and the state should make funding to a community contingent on demonstration that the community is providing oversight of programs.

2) Virginia needs to invest in CIT programs (to include CIT Assessment Centers) so that every community in Virginia has a functional CIT program and Assessment Center. Investment needs to include ongoing funding for CIT training, CIT coordinators, and related expenses associated with operating a CIT program. Communities should be encouraged to incorporate college and campus safety/ police departments into their CIT programs. In addition DBHDS/ DCJS (and others) should work to develop a CIT like training curriculum for jail personnel to enhance the identification and treatment of individuals with mental illness in jails.

3) Virginia needs to effect a paradigm shift away from having law enforcement be primary transporters for mental health issues (from ECO to TDO). Virginia should develop a mechanism whereby alternative transportation (via ambulance, EMS, secure cab, etc) is available in all communities. Recommendation is that both law enforcement and CSB Emergency Services clinician make recommendations and that Magistrate would determine whether individual should be transported by law enforcement or could safely be transported via alternative transportation. While the Code of Virginia does currently allow for alternative transportation, it is restricted to occasions when individual is incapacitated and additionally there is no funding mechanism to support alternative transportation. Virginia would need to invest in funding this service but would also need to ensure transportation providers are trained/qualified to provide service. Code of Virginia would also need to give transportation providers the authority to detain individuals and the Commonwealth would need to address liability issues.

4) Improve access to consistent psychiatric services in a timely manner, using a benchmark standard, as exists in other health care, and make resources available to accomplish this goal. At a minimum, emergency service providers statewide should have access to a prescriber, if not a psychiatrist, to reduce the use of hospitalization as the means to access medication.

5) Currently, there appears to be a need for more psychiatric beds in some areas, but the COPN process can prevent providers from opening more beds in these areas. The Workgroup recommends that the COPN process be refined so that it more effectively addresses state needs, and incentivizes providers to respond to state needs, particularly specialized services for complex or challenging cases.

6) Explore technological resources: Develop a single consistent statewide process for data and oversight structure to maximize the use of telepsychiatry and video-technology. Work with established workgroup using existing resources to develop technology and implementation plan. Consider development of a telehealth office in DBHDS as a point of coordination. Look at the scope of practice issues that could impact the use of this technology.

Taskforce Recommendations from January 31, 2014

1) The Taskforce recommends a 12-hour emergency custody order period that includes tiered levels of notification every four hours. Four hours after execution of the emergency custody order, if the CSB prescreener believes that the individual meets the commitment criteria and has not been able to locate a bed, the prescreener shall notify the state hospital serving the region. Eight hours after execution of the emergency custody order, if neither the CSB prescreener nor the state hospital serving the region has been able to locate a bed, the Department of Behavioral Health and Developmental Services Central Office shall be notified. DBHDS Central Office may assist in the search for a bed and as a safety net, the state hospital serving the region will ultimately be designated as the facility of temporary detention if a private bed cannot be located.

2) The Taskforce endorses the Governor's proposal to extend the period of temporary detention from the current 48 hours to 72 hours with a minimum period of 24 hours prior to a commitment hearing.

3) The Taskforce recommends that the law enforcement agency that executes the emergency custody order notify the applicable community services board upon execution.

4) The Taskforce endorses the Governor's budget for new mental health funding but also agreed that the amount of funding was a step in the right direction, but not substantial enough to make a significant, positive impact on the system. More funding would need to be included in the future.

5) The Taskforce supports expanding secure assessment centers (drop-off centers) and crisis stabilization units for children and adults across the Commonwealth as the highest priorities for funding.

6) The Taskforce supports expanding access to telepsychiatry.

7) The Taskforce supports expanding funding for CIT training for law enforcement officers throughout the Commonwealth.

8) The Taskforce also recommends including a two year sunset clause on its recommendations to ensure that any new laws are meeting the needs of the Commonwealth.

Governor's Taskforce on Improving Mental Health Services and Crisis Response

Workgroup Recommendations for Consideration

August 11, 2014

A. READY for ACTION

ID	Proposal	Workgroup/ Subgroup
1A	**PHI Disclosures** - Develop legislation that (a) authorizes sharing of PHI between CSBs, law enforcement agencies, health care entities and providers, and families and guardians about individuals who are believed to meet the criteria for temporary detention (whether or not they are in custody or ultimately detained) and (b) contains a "safe harbor" provision for practitioners and law enforcement officers who make such disclosures and act in good faith. The workgroup also recommends that DBHDS develop a disclosure "toolkit" for practitioners and law enforcement that can support effective, consistent understanding of disclosure and information sharing in the emergency context.	Crisis Response
2A	**Veterans Collaboration -** Improve coordination between private hospitals and VA hospitals, and support crisis response clinicians to collaborate with veterans to meet their needs by (a) establishing a "point person" at each CSB to coordinate between VA and CSB, (b) increasing financial support to the Virginia Wounded Warrior Project, and (c) continuing to educate the public and CSBs about the needs of veterans and military families.	Crisis Response
3A	**Jail Services -** All jails in Virginia should be required to have readily accessible, evidenced based, trauma informed treatment for individuals in jail across the continuum of the criminal justice system. Such services should either be available in all jails and/or there should be mechanisms in place to transfer the inmate to a jail which has these services. The Coordinating Center of Excellence should be tasked with identifying the resource needs to accomplish this goal along with the cost to provide this level of care.	Public Safety
4A	**Jail Discharge Notification -** Virginia should develop a computerized notification system so that CSBs and other community providers (who request notification) can be advised when an individual with behavioral health needs is discharged from jail with the goal of increasing post-release engagement in treatment and to enhance continuity of care.	Public Safety
5A	**Improving Communication Throughout System -** Establish a process and a structure that ensures regular communication among the public and private agencies and organizations involved in the mental health delivery system at both the state and regional level. The purpose would be to enhance communications, identify and share best practices and provide a regular venue for problem-solving. The Department of Behavioral Health and Developmental Services would be the lead agency for this effort. DBHDS needs to be staffed to support this recommendation.	Technical Infrastructure & Data
6A	**Resources for families -** Look at mechanisms of support for families and individuals in crisis through support of psychiatric advanced directives, complete with education on what should be included. Educate as to other forms of support through technology like apps for mental health support, electronic brochures, resource information, mental health first aid, healthy lifestyles information and other electronic forms of communication. Consider having all information available on existing web pages with links to other pages as needed. Consider a registry for advanced directives/clearinghouse. VDH maintains a registry so code change should be considered to add mental health. We should strive for no wrong door or path to get information.	Technical Infrastructure & Data

7A	**Mental Health First Aid (MHFA) -** Implement MHFA in every planning district. Create a partnership with the Department of Education with the goal of training primary and secondary public school teachers in Virginia. This could be incorporated within the offices of disability services at the schools. A partnership with the State Council of Higher Education for Virginia is strongly encouraged to implement this initiative.	Family/Loved Ones Subgroup
8A	**Recruiting and Retention -** Implement recommendation #18 of the Joint Commission on Health Care's "Impact of Recent Legislation on Virginia's Mental Health System" Final Report [SJR 42 (2008)] to "Support and facilitate the creation of programs to aid in recruiting and retaining mental health professionals in specialties that are in short supply, and particularly in areas of the State where supply is lowest or where turnover is highest. Such programs should include repayment for educational loans, psychiatric fellowships, tax credits and other innovative means of developing and keeping mental health professionals in the State." Enhance efforts to increase the diversity of mental health providers to more closely reflect the ethnicity of the populations being served.	Workforce Subgroup
9A	**Direct Support Professional -** Implement recommendation #12 of the Supreme Court Commission on Mental Health Law Reform's 2010 Report of the Workforce Development Committee of the Task Force on Access to Services to expand the DBHDS Direct Support Pathway Program "to create a new level of direct service position, entitled Direct Support Professional, in Virginia for state facilities, CSBs and private providers." The Commonwealth should consider requiring completion of the online training component of this program by all direct care staff providing services in licensed community behavioral health programs.	Workforce Subgroup
10A	**MH Nurse Practitioner/PA Training and CME -** Promote Psychiatric-Mental Health Nurse Practitioner and Physician Assistant training and behavioral health oriented continuing medical education programs in Virginia and consider expanding the Nurse Practitioner's and Physician Assistant's scope of practice to provide additional psychiatric services, particularly in underserved areas.	Workforce Subgroup

B. DISCUSSION NEEDED

ID	Proposal	Workgroup/ Subgroup
1B	**Regional Psychiatric Emergency Centers -** The Commonwealth should establish regional psychiatric emergency centers within a two-hour distance for all citizens of the Commonwealth. These centers would combine elements of CSB crisis stabilization units, 23-hour stabilization centers, CIT secure assessment centers, and hospital emergency departments into a single coordinated care center under one roof and attached to a medical facility.	Crisis Response
2B	**Alternate Transportation/Informational Toolkit -** Increase compensation for transportation, to encourage and support increased use of alternative transportation providers such as family, friends, EMS, etc., and to cover the uncompensated costs of transportation to police. Also, DBHDS should develop an informational toolkit to help communities build collaborative relationships between behavioral health emergency services providers and law enforcement, including information exchange while protecting privacy of individuals.	Crisis Response
3B	**Physician TDO Requests -** Allow physicians in Emergency Departments to request a temporary detention order directly from a magistrate. In pursuit if this, the Workgroup recommends that the U.Va. Institute of Law, Psychiatry and Public Policy be requested to study the feasibility of this proposal, and to craft possible legislation in a timely fashion.	Crisis Response
4B	**Strengthen Best-Practice Programs -** Strengthen what works among existing best practices, such as the following existing programs: (1) Crisis Intervention Teams (2) Peer-to-Peer (3) Mental Health First Aid (4) Programs of Assertive Community Treatment (5) Discharge Assistance Programs (6) Permanent Supportive Housing (7) Suicide Prevention Programs (8) Integrated Primary Care Teams.	Ongoing Treatment

5B	**Programs of Assertive Community Treatment (PACT) Expantion -** PACT services should be expanded across the Commonwealth and services should be provided across the lifespan- not just to adults. PACT is not set up for those under 18, but could help young adults 18 to 25 in transition. Two additional teams could be funded during the biennium.	Ongoing Treatment
6B	**Reinvent System -** Reinvent the system by conducting a needs assessment to determine current capacity and gaps, develop pilots, foster community collaboration, incorporate an integrated community system of care – public-private partnership, make the system more user-friendly for people across the lifespan, address the under-funded system, reinvest savings, address rising costs of services over time and reform health care coverage reform.	Ongoing Treatment
7B	**Capture savings -** There should be exploration of ways to keep savings in the system. Hold on the rate reduction for mental health skill building until there can be a determination as to the impact the changes in regulations will have.	Ongoing Treatment
8B	**Comprehensive Analysis -** DBHDS should conduct a comprehensive analysis of the behavioral health service needs in Virginia, identify a core set of services that should be available across the Commonwealth, complete a gap analysis that includes public and private service sectors, and recommend a consistent, multi-year funding strategy that would ensure timely access to core services for all Virginians. The SAMHSA principles and implementation road map for a "Good and Modern" behavioral health system should be incorporated in the analysis and recommendations of DBHDS.	Ongoing Treatment
9B	**Special Advisor -** The Governor should appoint a special advisor to implement a modern behavioral health system built upon the findings and recommendations of DBHDS described in 8B and the SAMHSA principles and implementation road map for a "Good and Modern" behavioral health system.	Ongoing Treatment
10B	**Jail Screening/Evaluation -** All jails should be required to use a standardized, evidence based, screening and evaluation process to identify individuals with behavioral healthcare needs who are detained in local and regional jails. Virginia needs to invest sufficient funding to enable all jails to accomplish this task.	Public Safety
11B	**Behavioral Health Resources for Veterans, Service Members and Their Families -** Virginia needs to identify and examine the availability of and improvements to behavioral health resources for veterans, service members, and their family and children. There needs to be greater cooperation between Virginia's service providers and the VA system and a streamlining of the referral process. Enhancement of services should include better linkages to community resources for Veteran's who are incarcerated. Virginia should investigate the feasibility/ utility of developing Veteran's Courts/ dockets.	Public Safety
12B	**Problem-Solving Courts -** Virginia should encourage the funding of and expansion of problem solving courts across the Commonwealth. Each community should have the option to develop such a model if it is felt to meet the community needs and there is sufficient interest (on the part of the judiciary, the Commonwealth Attorney's office, the defense bar, pre-trial services, and the Community Services Board) to make the program successful.	Public Safety
13B	**Specialty Courts -** Look at use of specialty courts for behavioral health and veterans as a means to look at how recipients get involved in and agree to services to minimize entry at crisis levels of care.	Tech. Infrastructure & Data, ref to Public Safety
14B	**VCIN and PBR Data Reporting -** Examine adjustments to ECO/TDO- Enable first responders (police officers) to gain access to the TDO database already in VCIN. Add training requirements for VCIN. Fully utilize the data reporting capacity of the psychiatric bed registry and add data fields as necessary to automate data collection to better understand where the gaps or pressure points are.	Technical Infrastructure & Data

15B	**MH Ombudsmen -** Investigate the feasibility of Mental Health Ombudsmen being established at DBHDS, the Office of the State Inspector General (OSIG), or another third identified option. Mental Health Ombudsmen would serve all individuals, including those with public, private or no insurance, as well as those not referred to the CSB. Mental Health Ombudsmen primary focus would be on client rights and following up on complaints, helping the families work with the hospitals to resolve any concerns. The individuals functioning as Ombudsmen would be able to hold local agencies accountable for their services. Mental Health Ombudsmen could also be individuals that provide follow-up calls to check on the individuals and their families after the patient leaves the hospital. In addition, they could find additional resources in the community, before the loved one is discharged.	Family/Loved Ones Subgroup
16B	**Family Resource Services Center -** In order to help provide access to patients and their families across the lifespan, funding should be provided to each regional CSB to assist with setting up a Family Resource Services Center. This Center will provide patients and their families with a place to learn about available services, receive recommendations or referrals, as well as obtain a clinical intake assessment. The service would be available for patients and their families whom are not necessarily considered priority, may not already be in the system, and may/or may not be in a crisis. The patients or family could use this service if they carry private insurance and are looking for available services in the area or want to apply for services not covered by their private insurance. The Family Resource Services Center would have the capability of hosting family resource meetings upon completion of an assessment to help them connect to appropriate private or public services and be referred to the FAPT process. Staff of the Family Resource Services Center could serve as a liaison to the local publicly funded providers, especially the local hospitals in the area to insure patients are connected at discharge with further resources. The amount of time and expenses dedicated to establishing Family Resource Services in a region would be proportionate to the regions' population density.	Family/Loved Ones Subgroup
17B	**Primary Care Education and Incentives -** Strengthen the capacity of primary care physicians and other clinicians practicing in primary care settings to effectively serve individuals with more complex behavioral health needs across the lifespan by promoting inter-professional clinical education, offering financial and other incentives to practices that adopt this collaborative model, assigning peer support specialists to serve as navigators and case managers to assist with linkages to behavioral health service providers. The Commonwealth should consider providing such supports to primary care physicians and private outpatient clinicians in exchange for their participation in the Medicaid program.	Workforce Subgroup

Governor's Taskforce on
Improving Mental Health Services
and Crisis Response

Public Comment to the Governor's Task Force on Improving Mental Health Services and Crisis Response

Received as of Wednesday, June 11, 2014

From: Adrienne Griffen
Sent: Thursday, April 10, 2014 10:37 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Hello,

I was pleased to learn this morning (via National Public Radio about this Mental Health Task Force.

After looking over the membership of the full task force as well as the committees, I would like to point out that one particular focus of mental health is missing:

Women's mental health, particularly perinatal mental health (during pregnancy and the first year postpartum).

Anxiety and/or depression are the #1 complication of pregnancy and childbirth, affecting up to 1 in 5 new or expectant mothers. These illnesses can change a joyful time into a period of loneliness, desperation, and frustration. Left untreated, these illnesses can have a lasting negative impact on mother, baby, and entire family.

Given that approximately 100,000 babies are born in Virginia each year, this means approximately 20,000 women will experience anxiety and/or depression each year during pregnancy or after giving birth.

In 2003, the Commonwealth recognized this issue and passed § 32.1-134.01. which requires hospitals to give maternity patients information about postpartum depression before being discharged. However, few -- if any -- hospitals actually comply with this law.

Postpartum Support Virginia (PSVa) was founded in 2009 with the mission of helping new and expectant mothers and their families to overcome anxiety, depression, and other perinatal mood and anxiety disorders. Learn more at www.postpartumva.org). In the past 5 years, PSVa has helped over 500 women and families, providing support, encouragement, information, and resources.

Perinatal mood and anxiety disorders are relatively easy to diagnose and treat. Unfortunately, many new or expectant mothers do not know where to turn for help. And although these women see a medical provider approximately 30 times in the two years from conception to baby's first birthday, NO ONE has the responsibility to talk about these illnesses or screen mothers for them.

I hope that the Governor's Mental Health Task Force will look at the issue of maternal mental health. I am happy to assist in any way.

Sincerely,
Adrienne Griffen
Founder and Executive Director
Postpartum Support Virginia
www.postpartumva.org

From: ann hayden
Sent: Thursday, May 01, 2014 2:11 PM

To: Task Force MH WorkGroup (DBHDS)
Subject: bravo

Can't tell you how refreshing it was to open a note from our lieutenant governor addressing mental health reform. I look forward to following and supporting your work in this area. Regards,

Ann Hayden

From: Marcella Fierro
Sent: Thursday, May 01, 2014 2:41 PM
To: Task Force MH WorkGroup (DBHDS)
Cc: Gormley, William (VDH); Powell, Virginia (VDH)
Subject: Mental health and suicide
Importance: High

Hello. Thank you for convening a task force to address mental health awareness. Please make sure the task force utilizes the data compiled by the Office of the Chief Medical Examiner, specifically the OCME's annual report and case reports. All suicide deaths in Virginia are investigated by the Medical Examiner and OCME reports are rich with information on the sequence of events, prior psychiatric care, drug use, alcoholism, family and interpersonal violence, method of suicide and the immediate circumstances. The complete record contains on each case, (over 800 per year), police reports, medical records, toxicology etc. Virginia Medical Examiners sign the death certificate on every suicide but the OCME case record is much richer than the death certificate alone. The records can be accessed for legitimate research projects provided the data is aggregated and no one individual is identified in the final study(s). Contact person is Dr. William T. Gormley, Chief Medical Examiner at 804-786-1033. The Medical Examiner System has been crying in the wind for years about suicide as a preventable disease and a public health problem.

I also suggest inviting from the Virginia Psychiatric Association some old timer community psychiatrists who have the most experience in treating patients in the community. I say old timers because most psychiatrists/psychologists see very few patients who COMMIT suicide in their individual practices. These doctors are the ones best suited to assess what works and what doesn't work in terms of system recommendations, deficits in the care structure, and distinguishing suicide gestures and equivalents from those who are likely to be successful at committing suicide etc.

My own assessment over the years is that there is a lethal triad of 1) acute upset/perturbation, 2) alcohol and 3) easy access to a firearm. Many suicides are impulsive and interrupting this triad could save lives. A second observation is when people are in crisis they need help at the moment not an appointment two weeks from now. Third, there is poor recognition of the risk factors for suicide – a chaotic life, drugs, interpersonal stress, domestic violence etc.

Another resource for the task force is the Family and Interpersonal Violence review team reports and the Team staff. This team is administered by the OCME and has published reports for years. Contact person is Virginia Powell at the OCME 804-786-3174.

Statistical reports with narrative generated by the OCME and the Review teams are accessible at the OCME web site at www.vdh.state.va.us/medexam/ and then under the side headings of Annual Reports Facts and Figures and Fatality Review and Surveillance Programs and Reports.

I hope the task force will take full advantage of the best data collected in Virginia by its stellar Medical Examiner System. Thank you very much.

Marcella F. Fierro, MD, Emerita Chief Medical Examiner, Commonwealth of Virginia.

From: Renee M. Hughes
Sent: Thursday, May 01, 2014 2:52 PM

To: Task Force MH WorkGroup (DBHDS)
Subject: mental health

One thing that needs to be improved is access to mental health medication and health care. I was shocked to find out that there are many patients that are discharged from a mental health facility and then have no way to get there medication prescriptions renewed due to a lack of health insurance or an inability to see a doctor at a free clinic who can write the prescriptions. People cannot control their illness or start a new life without proper medical supervision. No wonder we have people committing crimes because they are not on their medication.

From: Camille Harris
Sent: Thursday, May 01, 2014 4:45 PM
To: Task Force MH WorkGroup (DBHDS)
Cc: Dennis LaMountain
Subject: Treatment for HS Youth & College Young Adults with AD/HD

Hi, Ralph – Thank you for your good work on the Governor's Task Force on Mental Health. As you may recall, my business partner (Dennis LaMountain) and I specialize in coaching high school students, college students, and young adults with AD/HD. I am writing to let you and the Task Force know of a gap that we see in Virginia's mental health system that is directly related to the clients that we coach (and their families). As a former CSB emergency services clinician, CSA Coordinator, and Child & Adolescent Mental Health Program Specialist at DBHDS (when it was DMHMRSAS), I also have first-hand experience with these youth/young adults, who usually do not receive "mandated" services in the state's system of care.

From our experience in working with Virginia's high school and college youth with AD/HD over the past 6 years, there appears to be a lack of public information and of student/parent information and resources at both the high school and college level about challenges that these students face due to their AD/HD neurobiological condition. Many (in fact, most) of our young coaching clients also have co-existing mental health conditions, along with AD/HD. These students often succeed or even excel in high school because of dedicated parents and the support and structure of loving homes. However, they often fail miserably in their first year in Virginia colleges because they do not have the necessary resources and support to succeed.

We find that many students and parents do not understand the AD/HD brain or the challenges it presents once the older teen/young adult leaves home, resulting in high rates of college dropouts, unemployment, substance abuse issues, mental health crises, and criminal justice problems in this population. We feel that it is important to develop additional educational and treatment resources for Virginia's students, parents, and institutions of higher learning in order to reduce these rates. We are committed to helping Virginia strengthen its resources so that Virginia's promising young people with AD/HD can become fully productive citizens. Much-needed wraparound resources include mental health treatment, AD/HD coaching, family counseling or coaching, psychiatric treatment, and educational/support groups.

Please let us know if there is anything we can do to help with the efforts of the Task Force on Mental Health. Thanks again for your good work!

Camille

Camille Harris, LCSW
Senior Associate/Professional Coach
LaMountain & Associates

From: m salasky
Sent: Friday, May 02, 2014 8:15 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Suggestions for Mental Health Task Force

Sir:

(1) Virginia should expand Medicaid, which would help to provide services to a population vulnerable to mental illness (i.e., young adult males);

(2) Find a way to restore Medicaid coverage IMMEDIATELY to those being released from an institution -- state hospital, jail, etc. -- so they can have continuity of treatment and access to medications. (Currently it can take up to 3 months to restore coverage)

(3) Focus on expanding supportive community housing on the model of Virginia Supportive Housing.

(4) Make auxiliary grants portable.

(5) Currently the policy maker, DBHDS, has no funding authority; that disconnect creates problems.

(6) STOP TREATING JAILS AS DEFAULT MENTAL HOSPITALS!

Thank you.

Mike Salasky

From: Nicholas Shah
Sent: Wednesday, May 07, 2014 1:00 PM
To: Task Force MH WorkGroup (DBHDS)
Cc: Pavitra Kotini
Subject: suggestions

Reduce stigma is a main one.

in Canada, they have a campaign: 'let's talk' for depression awareness.

Thanks,

Nicholas Shah, MD

From: Janet E Girardi
Sent: Wednesday, May 14, 2014 10:26 AM
To: Task Force MH WorkGroup (DBHDS)
Subject: Mental illness and families

May 14, 2014

To whom it may concern:

My family began the journey 40 years ago toward finding answers and solutions for a son with mental illness. He was diagnosed at 3 years with ADHD. Since then he has been diagnosed with borderline personality disorder, bi-polar disorder and schizo-effective disorder.

My son went to 13 different schools in 13 years. He was forever in trouble for disruption and inattention but his IQ was well above average. We consistently took him to psychiatrists, psychologists and therapists over the years and they prescribed therapies, medicines and programs. Nothing was covered by insurance. Nothing worked very well.

As time went on he began to get into bigger trouble and we lost all control when he became 18. At 21 he was arrested and shortly after had a terrible car accident that left him in the hospital for over a month and took 2 years to heal. His attorney felt that he was trying to commit suicide. At this time, doctors could not legally talk to us - and they also stopped listening.

During the hospitalization he became addicted to pain medication and life for the entire family was a nightmare for 8 years. He has now been drug free for 3 years. He has been hospitalized for suicide prevention for the maximum days allowed four times. His

treatment is inconsistent and fractured at best without medical insurance. There is no consistent psychiatric care, counseling nor is there anyone for family members to call when he is spiraling out of control. He gets his meds from the Daily Planet in Richmond.

After his last hospitalization in August of 2013 the hospital would not allow him to come home because they felt he could be a danger to himself, our family and possibly others. Their only option was a homeless shelter. We felt that option would not be appropriate for him at all - not ever - he could not handle it. We tried to get other housing but no one could help until he had been "on the streets" for a year. We pay for an apartment close by.

He has never been able to obtain the requisite quarters to qualify for Social Security and never will be. It took two years to get him on disability which began two years ago. We have applied for Medicaid and food stamps but, to this date, he has been turned down. He is not able to afford any other insurance - Medicaid expansion is critical and it needs to be easier to access and easier to stay enrolled for people with mental illness.

Our family is a strong, middle class, hard working, college educated family but what are we to do? We love our son and want to keep him and others safe but his father and I are approaching 70 years old. We both work full time and we will need to retire. We are his only advocates. We are his only support. We are well connected activists but I wonder, what do others do?

Creigh Deeds' story is one that millions of people all over this country face. I empathize and feel his pain sharply - I have been in his place. We have faced his anguish - our outcome has been that we were not hurt and we all lived. But ours is not a happy-ever-after story. We know we will face the crisis again.

People with mental illness need services for life. They need help that is easy to find, easy to access and easy to afford on disability - the maximum is $720 per month. They need an affordable place to live. People with mental illnesses cannot advocate for themselves - they need someone to help for life.

Mental illness has been with us since the beginning of human time. The treatment of mental illness is imperative and as urgent as any disease on the planet.

Sincerely,

Janet E. Girardi

From: Helen Jaeger
Sent: Tuesday, June 10, 2014 3:57 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: comment

We have a 42 year old son who has been suffering from substance abuse and mental illness for the last 4 years. He has been hearing voices. He has been in jail, is on probation, has been in a 90 day rehab program, and has been admitted 2X to the Loudon County LAMPS program. He is now under court order to live with us. He keeps us away from his psychiatrist and counselor. If we call either with concerns we are told to call 911 which sends a police officer to our home. At that point our son is calm and shows no signs of issues. We did manage to get the police to convince our son to admit himself into LAMPS about 4 weeks ago. He was there for 10 days plus a week of partial out patient care. However, after that there is little guidance for us. We are his caregivers and we are working in the dark. He had side effects from his medications, I called psychiatrist and did not receive a return call. Two weeks later our son had his appointment and the psychiatrist reduced the dosage of Abilify as that was the cause of the slurring of words. I know the psychiatrist can't talk to me, but he could speak to our son as a result of the call.

The bottom line is there needs to be another means of admitting mental health patients into care besides calling 911. We tried to have our son admitted into LAMPS a year ago, but he was not deemed eligible for residential care. He was admitted to the partial program. After a week, the counselors saw how ill he was and after a meeting with us and our son realized that he had to be admitted.

This was after he tormented us every night for a week. They walked him from their office to the emergency room for admittance. That was a year ago. He is very lucid, conversational and does not look ill. However, when he hears the voices he gets uncontrollable. He's been in Jail and is on probation.

Again there has to be a better vehicle to get help for the mentally ill than 911, jail, and short admittance to mental health facility. When he was in LAMPS a month ago, they wanted to release him after 3 days. We asked for a meeting with psychiatrist and counselor and told them our experience with our son. After speaking with us they kept him for 10 days. Apparently, the insurance company(Anthem BCBS) and the hospital push the psychiatrists to release patients within a few days.

Please feel free to call is you have any questions.

Please help those of us with adult children who are mentally ill.

Helen Jaeger

From: SR
Sent: Wednesday, June 11, 2014 1:21 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Comments

Hello,

I wanted to provide comments derived from my personal experience with Major Depressive Disorder, Insomnia, and Anxiety Disorder. Please do not use my name in any communications; however, you may contact me if you have further questions.

I encountered many issues with my employer when I became ill and I believe that my honesty about what I was experiencing was the ultimate cause for the loss of my job. I not only feel that employers need to be better educated on mental illness but I also believe that the EEOC needs this as well. After the problems with my employer, I filed a claim with the EEOC and after their Dr concluded that I was suffering from the same disorders as my Dr and that I was unable to work, they followed me around and because I had taken out the trash and gone with my mom for a brief shopping trip, they determined that I was not ill and closed the case. Clearly, there is a lack of understanding as to what people with mental disorders are capable of doing and should be doing to get better. My Dr and family wanted me to get out of the house and participate in as many "normal" day to day matters as possible to help me get out of bed and start feeling better. All in all, there needs to be more communication about how these disorders affect people and how to treat them in all aspects of life. The stigma needs to be removed through education efforts.

On a separate note, the treatment available for the disorders that I had/have are brutal and my "limited benefit plan" doesn't cover any mental health treatments, leaving me with mounds of debt. The medications all have terrible side effects or make symptoms worse. I have taken every class of medications recommended and multiple within each group without success as well as doing ECT. After the last medication started making my teeth crumble, I quit all but one medication that is a sedative for anxiety and insomnia. Since then, I've focused on eating whole foods, getting fresh air, and taking a buddist approach to life which has been more effective than the medications or ECT. I still have many issues and have to take time off of work and can't attend many functions when I don't feel well. I have to live with the memory loss from ECT, chipped teeth from the medications, debt from medical bills, and a career backslide since losing my job. After all that I have been through and all of my family and Dr's research, I still don't know where else to turn for help. Mental disorders need more attention to find causes, cures, treatments and to ensure education is provided to those that need it most.

I appreciate your time and your efforts.

Sara

Governor's Taskforce on
Improving Mental Health Services
and Crisis Response

Public Comment to the Governor's Task Force on Improving Mental Health Services and Crisis Response

Received as of Monday, August 11, 2014

From: Argenbright, Susan (DBHDS)
Sent: Friday, June 13, 2014 5:00 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Deaf people not coming to WSH

Concerns that Deaf consumers are not being getting the best care as there have been no admission to Western State for over a year! Western State does have a Deaf Mall for Deaf clients and offers groups for treatment. One client, who suffers from depression tried to get in and was sent home, by another local hospital! It seems money is an issue when it comes to getting a Deaf person into Western State. This is from one of the Clients perspectives! Another statement made by a Deaf client was "the state hates us deaf people"! It is sad to hear statements made like this when you work in the mental health field!

Thank you

From: Lu Ann McNabb
Sent: Wednesday, July 02, 2014 1:47 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment

Dear Members of the Task Force:

Thank you for taking on this herculean task of improving mental health services in the Commonwealth. I am President of Angel Fund, a non-profit created in memory of Reema Samaha, one of the 32 killed at Virginia Tech on April 16, 2007. We identified mental health as one of the key factors in that tragedy and have focused our efforts on creating a safe environment for all young people.

We are working with Beth Hilscher, who also lost her daughter, Emily, that day, to fund a pilot program for transitional services for emotionally disabled young adults upon graduation from high school. Too many of these young people end up jobless, homeless, and lost in the criminal justice system. We are grateful that the General Assembly allocated funding to young people, aged 16-25, as they are the most vulnerable to the on-set of mental illness and struggle with substance abuse, depression, anxiety and suicidal ideation. We understand that Community Service Boards will be able to submit RFPs to create programs to address this age cohort.

We hope that the funding and focus goes beyond the counseling services and medications needed by young people struggling with mental health or substance addiction. These young people need mentors or liaisons to find jobs, pursue higher education, and acquire a place to live: basically a transition from being a high school student to being a productive adult. Those services are virtually absent now.

It was clear to many of us that Seung Hui Cho, who had received services at Stone Middle School and Westfield High School, received none at Virginia Tech. Further, his family was unaware of his struggles at Virginia Tech, a factor that

may have made a difference had they known. Similarly, the family of Daniel Kim, who committed suicide at Virginia Tech the fall of 2007, also was unaware of his intent to commit suicide because no one told them. We understand the privacy concerns of young adults but clearly families need to be involved, absent any evidence of abuse or neglect. We request that the task force research this issue of balancing a young adult's right to privacy with the need of family members to know of their loved one's struggles because maybe, just maybe, that knowledge may make the difference.

The sadness of suicide haunts us. We in Fairfax County are acutely aware of the many suicides we have witnessed at a number of our high schools. Indeed, various groups have formed to address this issue and we hope that the Commonwealth also focuses on the prevention of suicide and allocates necessary funding to this issue.

Thank you for focusing on this complex, yet critical issue of mental health. We look forward to working with you.

Sincerely,

Lu Ann Maciulla McNabb
President, Board of Directors
www.angelfundva.org

From: Brennan, Kristen
Sent: Wednesday, July 09, 2014 12:52 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Public Comment for the MH Task Force

Hello and Thank You for the work you are doing. I have a comment regarding the challenge that individuals and families in crisis encounter as they try to find a therapist or counselor that is qualified to effectively treat them, who works with insurance or Medicaid. Typically, only families who can pay out of pocket or who qualify for free services can easily identify and access effective treatment. Families who rely on insurance encounter waiting lists, treatment that is not helpful, or other barriers.

The VA Employment Commission (Workforce Connection) has a job search website that pulls comprehensive job listings in from many of the places they're posted: companies, state and local governments, etc. Users can do a search on this website, rather than looking at 100 different websites, saving them a great deal of time.

Is it possible for DBHDS to create a similar website that lists licensed mental and behavioral health providers, searchable by type of care (traditional, CBT, DBT, ABA, etc.), and insurance carriers accepted, and/or Medicaid? Families in crisis could be able to search by their location, condition, "symptom", etc. There are many ways this could be done. The providers themselves could be responsible for keeping their listings updated.

A website like this could simplify what can be an almost insurmountable process for individuals and families in crisis, and those who are attempting to prevent crisis.

Thank you for your consideration,

Kristen

Kristen E. Brennan
Project Manager
Fairfax County Government

From: Joanna Walker
Sent: Thursday, July 10, 2014 10:40 PM
To: Task Force MH WorkGroup (DBHDS)
Subject: Comments from a Northern Virginia Resident

I am the mother of a 27 year old male who suffers from Bipolar Disorder with psychosis. The last few years have been a nightmare for me and for my family. My son spent 4 weeks at the adult detention center when he was psychotic, 3 of them in isolation. He was discharged to an Intensive Community Services (jail diversion) program, which we hoped would get him the treatment he needed. His application for Medicaid was denied, and therefore many programs were not available to him. In spite of the best intentions of the staff, my son was unwilling to meaningfully engage in his treatment. After 2 weeks in a hotel, he was told to go to the shelter. The shelter was full. The staff, instead of engaging him, was dismissive. They felt that if he was't ready for treatment that he should be allowed to walk away from the program, despite a court order.

The jails desperately need safe housing for mentally ill people who do not have options to live with family. Every mentally ill person who cannot stay with family or friends should be discharged to supervised shelters designed for specifically for the mentally ill. More money is needed for mental health housing in the Commonwealth!

The wait for intake and assessment at the Fairfax/Falls Church Community Services Board is too long. There are not enough therapists and psychiatrists. More money needs to be spent in training and keeping doctors in the Commonwealth, and encouraging them to stay in public health. The state needs to provide more funds to the Community Services Boards.

Staff at the jail need training about mental illness and how to talk to individuals who are in crisis, so that potential blow-ups are diffused. Many police officers in our county now have Crisis Intervention training, and this should be required by all jail personnel.

Last May my son was arrested for trespassing. This is a common occurrence for those with bi-polar disorder. He didn't hurt anyone. He wasn't threatening anyone. He was dressed in a strange way, and he had rapid speech. He was psychotic, and didn't understand the directions of the officer about where he could and couldn't be. Why wasn't he taken to a treatment center, where he could calm down and get some help? Or if we had been called, we could have taken him home. Now he has another charge on his record. Guilty of being ill.

Parents and friends are often turned away from County and State services and even the suicide help lines.. If their loved one is over 18 and unwilling to engage, they are told that there is nothing that can be done. To a parent whose son was suicidal for 9 months - without a plan - this was devastating news. My husband and I called many times for help and even the Suicide Crisis lines had no answer. We were 9 months on suicide watch, unable to leave the house together. These are the unanswered cries for help. Community health workers should be dispatched to the home to engage with those who are too ill to realize they need help. To provide this service, the Communities need more funding.

Virginia has not been a leader in mental health expenditures. Some programs like the ones mentioned above are worth paying for. Spending money on treatment, rather than on incarceration has been a proven strategy: It helps the budget and and helps those who are vulnerable and in need of our help.

Sincerely,

Joanna Walker
Oakton, VA