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Date: January 29, 2020

Re: Public comments received for Act 200 Listening Tour/ Think Tank/ Vision 2030 Report

These comments have been received via e-mail from various stakeholders after reviewing the Draft Vision 2030 report from the Department of Mental Health.

- *Please note that the Page numbers or Action Areas have changed since these comments were received but the content has been addressed in the Reponses.*

Comment 1: **Fully support and fund the re-emergence of a robust peer-run workforce development coalition (as previously functioning under the name, Workforce Wellness Coalition)**

Response 1: *Action Area 6- Peer Services are Accessible at All Levels of Care* of the Vision 2030 Report includes recommendations of ongoing collaboration with the peer community, and the goal of creating a more robust and collaborative relationship with the Department of Mental Health as we move toward a more inclusive system of care.

Comment 2: **Commit funding resources to sponsor access to training in Intentional Peer Support and WRAP, including "train the trainer" opportunities to solidify sustainability. The peer/survivor work group (PSWG – see #4) will assess and recommend for whom trainings are targeted.**

Response 2: Intentional Peer Support training and WRAP are highlighted in several different areas in The Plan with specific attention in *Action Area 6 – Peer Services are Accessible at All Levels of Care.*

Comment 3: **Re-establish an expectation that all planning and decision-making related to DMH programs and services involve representation of consumer/survivor/peer or persons with lived experience at all stages**

Response 3:
This was specifically called out in *Action Area 6 - Peer Services are Accessible at All Levels of Care*, as ongoing throughout the entirety of the 10-year plan.

Comment 4: **Fund and empower a peer/survivor work group (PSWG), organized and facilitated by the workforce development coalition, to make specific recommendations to inform the additional needed milestones to further the end goal for accessible peer support. The work group membership should be broadly inclusive of various viewpoints and of participation by both people who function in peer support roles and by people who would be eligible for those supports. PSWG will be time-limited and clearly articulate its scope and goals. It should be self-directed and tasked with making recommendations that include (but are not limited to):**

- **Articulate advantages and disadvantages of creating optional certification for peer support staff, including resourcing a robust review of reimbursement implications and the practices in other states;**
- **Establish core competencies (including an evaluation of the current WWC curriculum), whether or not tied to certification;**
- **Identify and offer mitigation strategies for systemic coercive pressures or limitations that are placed on peer support staff;**
- **Determine how to best engage peer workforce with established provider systems such as designated agencies and hospitals;**
- **Reinforce need to develop the peer center and respite proposal as submitted by the team of Alyssum, Another Way, VPS and Pathways.**

Response 4: These areas are identified as strategies in *Action Area 6 - Peer Services are Accessible at All Levels of Care* as an ongoing need throughout the course of the 10-year plan.

Comment 5: **We are pleased to see support for the expansion of peer support, but recommend using the term, "available and accessible" instead of "embedded," since embedded could have specific, unintended interpretations (e.g. use of "embedded in title of Action Area 4).**

Response 5: We changed the title to "Peer Services are Accessible at All Levels of Care," and wherever "embedded" had been used in the document referring to peers, it is now "available and accessible."

Comment 6: **Review existing advisory group opportunities (e.g. State Standing Committees) in the state to assess whether they are meeting their intended roles as a voice for consumer/survivor/peer or persons with lived experience**

Response 6: This change has been incorporated into *Action Area 7- Ensuring Service Delivery is Person-Led,* of The Plan.

Comment 7: **Contribute fully to developing the milestones for the Action Area 9 related to stigma and discrimination, recognizing that those who feel stigma and experience discrimination have a critical role in assessing causes and solutions. This could be incorporated within the subjects addressed by the work group identified under milestone #2 above.**

Response 7: There have been significant enhancements in the strategies for *Action Area 3- Eliminating Stigma and Discrimination*, which address these concerns.

Comment 8: Ensure that the voices of those that made the recommendations in this letter (Workforce wellness coalition) are actively involved in the further development of the milestones in the other Action Areas identified in the plan.

Response 8: This recommendation has been addressed in *Action Area 6 – Peer Services are Available and Accessible at all Levels of Care*.

Comment 9: Since Vermont has no formal Peer Support Certification, there should be no reference to "Certified Peer Support Specialist" or similar titles.

Response 9: This has been changed to incorporate short, mid, and long-term strategies to explore and work with peer networks to discuss the opportunities for creating credentialing for peer support specialists in Vermont.

Comment 10: **Use the term "dignity" whenever appropriate. And express the idea that mental health is a human rights/social justice issue.**

Response 10: We have taken this feedback an incorporated the word "dignity" into The Plan. We also note the importance of social justice in the guiding principles and in *Action Area 1 – Promoting Health & Wellness*.

Comment 11: **Mention/explore the inappropriate role of police in often being first contact with people experiencing altered and extreme states of mental health. The police and [their] need for training is currently only mentioned once in the entire 10-year Plan, and only in regard to "student mental health." But it is a lot more than just the need for training.**

Response 11: Training for law enforcement in trauma informed practices and mental health was woven throughout The Plan with specific attention focused in *Action Area 3- Eliminating Stigma and Discrimination*.

Comment 12: I think is very important that law enforcement, especially with their lack of training and implicit coercion (power dynamic, uniforms, weaponized), are *not* the ones who should have a "central role" in program development.

Response 12: The Department of Mental Health does not have authority to determine what law enforcement does in terms of program development. The Department takes an active role in training and expansion of models like Team Two and Street Outreach to create more opportunities for Mental Health Professionals to be involved with law enforcement.

Comment 13: Since we are trying to build on strengths, let's instead focus on mobile crisis teams, and other forms of accessible pro-active, peer and person-led holistic health care.
Related, the 10-year Plan should expressly state the need for statewide mobile multidisciplinary integrated outreach teams (not just for crisis intervention), including peer advocates/supports, *instead* of using police.

Response 13: Mobile Outreach is discussed in the 10-year plan as an interest of Vermonters and the Department of Mental Health. Governor Scott also identified this as a priority in his budget address on 1/21/2020. Similarly, enhancing peer involvement has been addressed in *Action Area 6 – Peer Services are Available and Accessible at all Levels of Care*.

Comment 14: The need to prioritize (comfortable, non-institutional-feeling) community-based respite houses, preferably peer run, both as an alternative to hospitalization, and also just as a place to go when feeling life is becoming unmanageable, as a way to be pro-active - and hopefully de-escalate situations and avoid the need for ED and police. Here are some articles about the respite house model in NYC….

Response 14: The 10-Year plan has created Action Areas and strategies to incorporate all of the ideas listed above. Additionally, we added the Parachute Program in NYC as an example of evidence-based models adopted in other states with success.

Comment 15: The role of the criminal justice system (how does Mental Health Court fit in? ONH's?) and the Department of Corrections needs to be addressed in this 10-year Plan, even if it is solely in the current state. e.g., How many incarcerated Vermonters (a highly underserved part of our population) have mental health needs? How many are actually receiving care for their mental health issues? Or perhaps it is clearly stated that these are Action Areas of concern that are not addressed in this 10-year Plan but that they need to be because they are currently part of the System of Care.

Response 15: Enhanced collaborations with mental health stakeholders is a key factor throughout the plan. Specifically partnering with Department of Corrections has been addressed in the Promising Practices section of the 10-year plan.

Comment 16: Ironically, in the Action Area 3 - Eliminating Stigma, "mental illness" is the terminology used in the draft. I request you carefully note where you use "Mental illness" or "illness" and take care that it serves the idea of an "integrated, holistic system of care" and does not further the stigma attached to mental health. "We all have mental health."

Response 16:
The Department of Mental Health uses the term mental illness, according to the definition as laid out in statute:

> A substantial disorder of thought, mood, perception, orientation, or memory any of which grossly impairs judgment, behavior, capacity to recognize reality, or ability to meet the ordinary demands of life, but shall not include intellectual disability[1].

[1] 18 V.S.A. § 7101(14)

We realize there is a debate within the mental health field regarding use of the term “illness” and that many, out of concerns about stigma, speak of “mental health” when what is meant is that someone is suffering – from depression or anxiety, from schizoaffective symptoms, or perhaps an acute psychotic break.

There are concerns that this practice of not using the term “illness” is stigma in action. In the physical health world, there doesn’t appear to be a parallel concern with naming when we are “ill.” As we continue to work on integration of concepts of health, it seems that clear language is necessary.

Yet many who work or get services in the mental health system of care take issue with use of the term “mental illness” for any purpose. At least some who feel that the term is harmful argue that we should be talking about “brain disorders,” or, in some cases, “functional neurological disorders.”

Others, however, have warned that characterizing challenges to mental health as strictly biological in nature neglects “the social, cultural, moral, or spiritual significances—of mental illness or interventions.” It takes the person out of the equation, in other words, and treats human experience as unimportant.

We strive to use all language in a clear, forthright manner that does not “other” or stigmatize people, and we have re-written the report with a careful eye to these issues. Please continue to let us know when or if we fail to maintain that standard.

Comment 17: It is important for any organizations specifically mentioned in Action Areas be aligned with recommendations in the 10-year Plan. For example, NAMI's family-to-family curriculum is extremely limited and focused solely on an outdated medical model of mental health. I am concerned that recommending them is counterproductive to the goals of this Integrated, Holistic System of Care we are trying to develop.

> Response 17: We did not include the NAMI Family to Family program in The Plan, however we did list NAMI as an advocacy program and resource for people in Vermont.

Comment 18: Whenever WRAP is mentioned, it is important that it is somehow addressed that WRAP means working through the curriculum and not just using it as a quick tool for, e.g., criteria for hospital discharge (which is another example of implicit coercion). I reached out to the folks from WRAP and I am forwarding emails from them discussing evidence for WRAP’s effectiveness, and that is based on a "co-facilitated WRAP peer group model, which is how WRAP was designed" and that is very different from how it is currently being used, and how it appears to be recommended in the 10-year Plan.

> Response 18: Every time we included WRAP in The Plan, we added a footnote with a link to https://mentalhealthrecovery.com/wrap-is/. The WRAP Program is distinct from wrap--around services, and we have tried to make that clear in The Plan.

Comment 19: Include a glossary for those of us (like the Legislators) who are lay people. So many acronyms!

> Response 19: We have included a comprehensive glossary of terms with The Plan.

Comment 20: **I saw notes on alcohol but didn't see the opioid crisis or drug crisis mentioned.**

Response 20: A proper response to the opioid crisis is paramount to achieving The Plan. For that reason, DMH has included more discussion of the impact of the opioid crisis in Vermont as well as the importance of collaboration with partners and stakeholders in addiction prevention, treatment, and recovery.

Comment 21: What about poverty, affecting so many Vermonters?

Response 21: We have included strategies that focus on Social Contributors to Health which includes poverty in Action Area 2 of The Plan.

Comment 22: With SNAP food benefits being cut, I also didn't see a mention of how expensive food & good nutrition are.

Response 22: Food and nutrition are also addressed in Action Area 2 Influencing Social Contributors to Health.

Comment 23: Loneliness is an epidemic. Sometimes this is connected to technology addictions....

Response 23: Although technology addictions are not directly addressed, we have included language that reflects this concern in Action Area 2 – Influencing Social Contributors to Health. Additionally, social isolation is noted in the introduction.

Comment 24: What about chronic physical pain? Chronic illnesses?

Response 24: This issue has been noted in the demographics section: mental health across the lifespan.

Comment 25: I also didn't see the traumatic effects domestic violence has on people/families.

Response 25: Domestic violence is a part of the discussion of mental health across the lifespan, the effects of childhood trauma and Adverse Family Experiences.

Comment 26: Loss of the primary focus on integration of mental health into health care.

"Articulation of a common, long-term vision of *full integration of mental health services within* a comprehensive and holistic health care system" would seem to include three components:

a. **Identifying the elements that are required in order to achieve parity: equal access to quality services that are equivalently reimbursed. *Overall, this is well addressed by***

describing needed components to enhance services, although not always stated within that context.

b. Defining the components of a holistic system of health care. *This is superbly addressed, thanks to robust inclusion of discussion on social contributors and population health.* However, a deep dive into what comprises a holistic system is not the focal point of the stated goal, and there seems to be a lot of repetition.

c. Identifying what is necessary in order to assure <u>full integration</u> of mental health, specifically, <u>within</u> the end goal of a holistic, whole health system. *This fundamental component – the very focal point -- has been lost.* (a) -- the quality components -- are focused primarily on *quality* mental health services, without addressing integration. (b) -- the holistic components -- do not articulate the specific element of how *mental health* will be incorporated and integrated into that holistic health care system.

What does "mental health integrated within health care" <u>mean</u>? What things are necessary to achieve it? This core question is not addressed.

<u>Response 26</u>: This overlaps with question#52, below, and the responses are therefore similar.

a. Parity - *Action Area 8 – Committing to Workforce Development and Payment Parity* addresses this issue.

b. We have edited the plan a great deal and hope the repetition has been eliminated!

c. Integration of care - We have added the Quadruple Aim of healthcare reform as an overarching guide to our work. Also, new material in *Action Area 2 – Influencing Social Contributors to Health*, *Action Area 5 – Enhancing Intervention and Discharge Planning Services*, and *Action Area 8 - Committing to Workforce Development and Payment Parity* address various aspects of integration. There are also recommendations through-out the plan for further work to develop strategies and goals in these areas.

<u>Comment 27</u>: Inaccurate representation of the Think Tank membership.
There were 3 (or 4, at most) – 12-15% -- members who identified as representing a person with lived experience of a mental health diagnosis. By including others in a joint grouping (which also includes an advocate who does not represent consumer *or* family), a lack of clarity that could be perceived as misrepresentation is created. *DMH should identify the list of persons who were on the Think Tank who identified as participating as a person with lived experience, separate from family or advocates*.

<u>Response 27:</u>. Since getting feedback along these lines, we have changed how we represent the structure of the membership and acknowledgements section of The Plan to no longer use the language from the charging legislation.

Comment 28: Despite identification of the importance of addressing stigma, in one spot (p. 22) use of the stigmatizing term "behavioral health" has crept into the draft. The report also uses the term ACES rather than childhood trauma, which reinforces a specific study that includes implicit bias regarding mental health. (p. 17) You can't fight stigma if you contribute to terminology that perpetuates it.

Response 28: We have removed any uses of "behavioral" that aren't in the name of an organization or document, or that don't specifically reference behavior (not mental health). We reference the ACE study for its importance in making the links between early adversity (or trauma) and later health and wellbeing outcomes. We have removed any other use of "ACEs."

Comment 29: The draft fails to adopt the recommendation from last meeting to include "and discrimination" under the Action Area on stigma. This impact of stigma (discrimination) is the reason it needs to be addressed! Yet discrimination is not even referenced in the body of the Action Area. (p. 9)

Response 29: We have changed the title of this Action Area to read "Eliminating Stigma and Discrimination," and we have included discrimination in the discussion points.

Comment 30: Nothing was added to highlight the specific needs of children. The specific acute need for geographic access to inpatient care (for both quality and parity) is left out.

Response 30: *Action Area 5 – Enhancing Intervention and Discharge Planning Services to Support Vermonters in Crisis* addresses the need for additional inpatient services for children

Comment 31: There is virtually no reference to the role of inpatient care within a system of health care (which is part of why the integration of inpatient psychiatric care, noted above, has been lost in this draft.)

Response 31: *Action Area 5 - Enhancing Intervention and Discharge Planning Services to Support Vermonters in Crisis* addresses the importance of inpatient care. There are also other recommendations through-out the plan (see *Action Area 1 – Promoting Health and Wellness, Long-Term Strategies- Practice Improvements*) or gap analysis for inpatient care (*Action Area 5 – Enhancing Discharge Planning and Interventions for Vermonters in Crisis).*

Comment 32: The specific "bridging"-type function, in terms of discharge from inpatient care to community services, has been lost in this draft. The broad category of discharge planning omits it as a strategy, despite it being identified as a key "end state." (p. 43) The overall discussion of care transitions – a key element – also seems to be lost.

Response 32: *Action Area 5 - Enhancing Intervention and Discharge Planning Services to Support Vermonters in Crisis*, noted above, also includes a specific section on transitions and care coordination.

Comment 33: The report should not identify specific named programs that do not have consensus for implementation or expansion. Pre-emptively doing so, particularly when concerns come from the consumer/survivor community, would contradict the wellness strategy to "include people with lived experience in wellness and health promotion policy development." (p. 27) See, "Mental Health First Aid" (p. 34), which could simply be named as an example, instead. Why is this the only program being presumptively adopted?

Response 33: We have changed the language in The Plan to reflect this feedback

Comment 34: There are multiple areas of duplication. If shortened by enhanced cross-references, there could be much less duplication and improved organization, without loss of components. (The current organization is quite confusing, but could be improved by use of headings and subheadings that are outlined more graphically – for example, starting a new page for a new topic area, etc.)

Response 34: The Policy team has spent countless hours refining the language, reducing duplication, and improving the organization and flow of this document. We are hopeful that the final draft will create the flow and organization of an easy to read, and comprehensive 10-year vision.

Comment 35: AA 2 See pg. 24 of report: Following "Take a person-led approach," add "which includes participation of family members, when appropriate."

Response 35: *Action Area 8, Committing to Workforce Development and Payment Parity*, includes this language under the training section.

Comment 36: AA2- Add strategy that was discussed and supported by group during early November meeting but was not added to The Plan: "Assess the patient for medical home and primary care provider. If patient is found not to have a primary care provider, ED staff will make such a referral and will ensure first appointment is scheduled."

Response 36: We have added language about a medical home in *Action Area 2 – Social Contributors to Health.*

Comment 37: AA6 See p. 36 of report, Section 1: In subsection "h," following "expansion in peer workforce," add "and emerging health professions such as community health workers."

Response 37: We have added this language to *Action Area 7 – Ensuring Service Delivery is Person-Led*

Comment 38: See p. 36 of report, Section 2: In first paragraph, following "…beyond specialty providers of mental health services," add "to primary care and hospital settings."

Response 38: This language was changed in the final Plan.

Comment 39: See p. 37 of report, Section 2-b.: A critical component of evidence-based and best practices for mental health and other health providers is trauma-informed and culturally and linguistically appropriate care, including the national CLAS Standards. We recommend adding this type of evidence-based practice (and related federal and state legal requirements) to this or another section in the report.

Response 39: We have added the need for cultural and linguistic competency throughout The Plan.

Comment 40: See p. 37 of report: Insert a new Section 2-c: *Training and support for mental health personnel in burnout prevention.* In order to create supportive workplace cultures and practices to recruit and retain qualified and committed personnel, the following needs to be intentionally addressed on both statewide and local levels:

a. Continuing professional development activities, which address individual and organizational
factors that contribute to burnout and investment in prevention strategies.
b. High standards of clinical supervision and mentoring programs and appropriate levels of such supervision/mentoring.

Response 40: We have added language about preventing burnout for providers in *Action Area 8 – Committing to Workforce Development and Payment Parity*.

Comment 41: I think there could be a *bolder statement about reducing coercion: involuntary procedures are often traumatizing, undermine treatment relationships, and can feed long term distrust that interferes in getting needed help*. No mental health system in the world has been able to eliminate coercion, but there are places where vastly better results have been achieved – such as the Trieste region of Italy where their involuntary admission rate is 1/10 of ours in Vermont. I view it is an ethical imperative that we assess what aspects of such models could be generalized to our context and implement them accordingly. There are some relevant related examples included in your report in the ER section.

Response 41: We have updated and included stronger language about the reduction of coercion throughout The Plan.

Comment 42: The report could say more about prioritizing *relational and community connectedness* in our service models. There is some good stuff along these lines in the stigma section, but I think a bolder statement *about bringing community into community mental health and/or prioritizes a "connectedness paradigm" over an illness paradigm.* I am pretty certain this will lead us in some promising directions regarding outcomes for Vermonters.

Response 42: We have added more language about community inclusion throughout The Plan. We have also added this language in our Community-Based Services section

<u>Comment 43</u>: Please list *open dialogue* as a practice to consider – it has promising implications for many of your action areas including *reducing inappropriate use of ER's, discharge planning begins on admission, peer involvement, person led services, and eliminating stigma.* We're also finding that these practices can have a catalyst effect that activates much broader implications for community service system transformation. In my 34 years of community mental health work I have not come across anything else that has such promising and potentially wide-reaching impact.

<u>Response 43</u>: We have added Open Dialogue in The Plan as a service delivery model that is currently being used.

<u>Comment 44</u>: Finally, regarding the discussion of *combatting stigma*, I hope there can be some *review of the research* as there have been findings suggesting anti stigma efforts based in language of mental illness are getting some undesired results of reifying fears and assumptions about people coping with mental health issues. What is working are activities that get people together to experience each other on a more human level, also approaches that have language that describes mental health challenges from a normalizing continuum approach. At CSAC we have discontinued Mental Health First Aid due to these concerns and are looking at developing or adopting other models.

<u>Response 44:</u> We have taken out identifying specific programs and shifted out language to include language about identifying effective community resilience building initiatives.

<u>Comment 45</u>: I would like to see DMH develop protocols to prevent iatrogenic effects and preserve work capacity whenever possible in the context of mental health care, and develop public education materials, including but not limited to a .gov web page and print media posters and flyers to be posted in all Vermont community mental health centers and pharmacies.

<u>Response 45</u>: While iatrogenic effects is an important issue, it did not come up during the Listening Tour or during Think Tank/Advisory Committee discussions, so it does not appear in The Plan. The Action Areas, however, provide a great deal of room for additional work given the workgroups and other stakeholder-engagement processes that are called for under the strategies. This is an issue that could be brought up in one of those groups.

Regarding preserving work capacity, *Action Area 8 – Committing to Workforce Development and Parity Payment*, addresses worker burnout and taking steps to protect and promote resilience.

And for public education materials, *Action Area 1- Promoting Health & Wellness* includes strong public education goals.

Comment 46: The DMH will take steps to prevent psychiatric misdiagnosis and overmedication in individuals with a history of untreated childhood mild, minimal or single sided deafness (MMSSD) or hearing loss, or other communication disorders.

Response 46: This has not been directly addressed however we noted that partnering with Vermont Department of Health as well as supporting the increase of mental health workers available and accessible in Primary Care Practices.

Comment 47: The DMH will develop a workforce of Certified Peer Specialists (CPSs), and recruit a CPS training curriculum and technical assistance from a state whose peer support workforce has been successful and closely matches Vermont's culture and goals.

Response 47: Peers figure prominently through-out the plan, and a peer-led workgroup is recommended to address development of the peer workforce. Please see *Action Area 6 – Peer Services are Accessible at all Levels of Care* for more detail.

Comment 48: Among the overarching areas where we recommended changes to re-establish the goal were adding it as one of the specific principals and restoring the section "Opportunities in the System" [former page 14] from draft 1. The discussion of the interrelationships between mental health and other health conditions in this section was particularly important in terms of understanding the importance of integration, as well as underscoring the stigma that is the root of the separation, and how it impacts health. In addition, under implementation recommendation (1)(c), page 12, (and repeated other places later in the draft), the work group clarified its intent regarding the proposed Council and recommended restating its purpose to distinguish between a subdivision A) -- developing consensus on implementation of mental health integration, and then B) -- developing a common vision regarding the multiple sectors necessary for whole person health.

Response 48: *Action Area 6- Peer Services are Available and Accessible at all Levels of Care* includes a peer-led work group to make recommendations about whether and how credentialing and Medicaid reimbursement should be considered or implemented. Regarding stigma and discrimination, there is *Action Area 3- Eliminating Stigma and Discrimination* which more fully address those issues.

The importance of integration of services and of a holistic approach to care is woven through-out the Plan.

Comment 49: AA 1 *I recommend adding phrases to make that connection explicit in its immediate text:*
Primary prevention—measures that prevent the onset of illness or injury before the disease process begins. For physical health & wellness, we often hear about the importance of exercise and eating well; this applies equally to mental health.
Secondary prevention—measures that lead to early diagnosis and prompt treatment of a disease, illness or injury to prevent more severe problems from developing. In the world of

physical health, we are told we should have regular screenings of our blood pressure, for example; <u>likewise, this applies to mental health as well.</u>

Tertiary prevention—measures aimed at rehabilitation following significant illness. In the physical health world, we might think of someone in a rehabilitation program following a heart attack, or physical therapy for regaining strength in a broken limb; <u>the same applies to "step-down" residential programs after hospitalization for a serious psychiatric illness.</u>

<u>Response 49</u>: This area has been reworked and moved into the glossary. We have kept the physical health examples.

<u>Comment 50</u>: AA2- ***Additional introductory points that would highlight joint impacts:***
Existing mental health and health care systems have much they can learn from each other in recognizing, and incorporating the resources to respond to, broader life circumstances and needs that affect health and wellness Social contributors to health affect both mental and other health conditions, which can each result in exacerbation of the other.

<u>Response 50</u>: The introduction has been rewritten. More language about social contributors to health has been added to discuss overlapping impacts.

Comment 51: AA3- *There is very little in the strategies that directly addresses stigma and discrimination. Perhaps it is assumed to be addressed implicitly through the development of a whole person health and wellness focus, but it is far too entrenched to rely on subtle approaches like those alone. There is a strong "cart and horse" element: eliminating stigma requires actions that have barriers because of stigma.*

Recommended direct strategies:

Stigma and Discrimination

1. *Create a statewide public education campaign to familiarize and educate people about the importance of health and wellness for employers, schools, colleges, elders with a strong focus on cultural diversity,* <u>including education on the interrelationship of mind and body in concrete ways, such as the ways that stress can affect both mental and physical health conditions, or that exercise can improve both mental and physical conditions.</u>
2. DMH should model and educate about use of language that is inaccurate, stigmatizing or hurtful to those with mental health conditions or psychiatric diagnose and require appropriate language from designated or contracted providers.
3. Create common understanding of analogous levels of care that may be provided in different settings (e.g., post-surgery rehab; post psychiatric hospitalization residential recovery)
4. Develop care that is integrated at all levels, with physical co-location for delivery of services for primary, emergent and inpatient care.
5. Ensure that funding sources are not segregated and provide equal coverage for all health conditions, and that care providers have equal stature and compensation for equivalent work.
6. Address opportunities to rebut media and public inaccurate perceptions that dangerous behaviors are a common symptom of mental illness; use appropriate educational opportunities

to identify the rarity of aggression, and the need for involuntary care being restricted to those limited circumstances.

A useful citation to consider as a footnote on the impact of stigma on access to health care was published this past August; it reported finding that nearly half of all patients withhold critical information about their mental health out of embarrassment and fear both of stigmatization and the possible long-term implications of sharing such information. "These findings suggest that concerns about potential negative repercussions may lead many patients who experience imminent threats to avoid disclosing this information to their clinician," the study concluded. Assessment of Patient Nondisclosures to Clinicians of Experiencing Imminent Threats, *JAMA Netw Open.* 2019;2(8):e199277.

Response 51: We have created *Action Area 3 – Eliminating Stigma and Discrimination* to address these types of issues. In addition, *Action Area 1 – Promoting Health & Wellness* includes public and provider training in trauma-informed practice, which is another tool for eliminating stigma and discrimination.

Comment 52: AA 4/5 ***Incorporating integration principles under emergency care***

Ensure emergency rooms have the capacity and parity of resources to address psychiatric crises with the same level of quality and urgency as all other health emergencies

Ensure that emergency room protocols address the relationship between psychiatric and other health conditions to reduce the risk of diagnostic misconceptions that attribute behavioral symptoms to mental illness based on a patient's prior history when emergent symptoms are being assessed. An example named is the "clinical pathways" tool used for consistent responses in other medical emergencies.

Ensure that emergency rooms have the information readily available for rapid referral ability to the full range of community resources that can address symptoms in need of urgent response or rapid follow-up, but that do not require hospitalization.

Note: I would recommend that "embed" should not be the term used for having mental health professionals and peers accessible in the ED, as it may be interpreted to mean that these resources would come from another entity and be "inserted into" the ED setting – rather than the hospital having the responsibility to ensure appropriate care for all its patients. (It does not preclude making them available through a contractual relationship rather than a staff position, but it remains the hospital's responsibility for parity of care.) "Ensure access to within" might be more encompassing.

Incorporating integration principles under urgent care

Address the structural gap in urgent care services for mental health conditions through… *[follow here with the examples already listed of alternatives] [our workgroup identified urgent care as a missing structural component for mental health – distinct from the needs for more emergency room diversion programs]*

Have urgent care centers become "mental health competent" so that they have the same capacity for rapid response and referral for urgent psychiatric conditions as for other health conditions. Under the concept of "no wrong door," potential development of urgent care resources that specialize in mental health should not be a rationale for urgent care providers to not also have the capacity to respond appropriately when needed.

Incorporating integration principles within primary community care:

[Note that this was one of the most frequent comments identified in the listening tour notes.]

Co-locate primary care and primary mental health care, with direct same day access and "warm hand off" for brief solution-focused work or other short-term needs.

Create integrated resource information for primary care providers for identifying and directly connecting patients who need referrals to higher levels of mental health care, including knowledge of providers who are accepting new patients

Create primary care standards that treat all conditions to be inclusive of interrelationships between body and mind

Incorporating integration principles within transitions to and from and within inpatient care:

Ensure that all care transitions include cross-disciplinary teams that address both psychiatric and other health conditions with connected referrals to services and supports that will help avoid rehospitalization.

Ensure that discharge planning includes all necessary follow-up care for both psychiatric and other health conditions.

Require any new inpatient psychiatric capacity be delivered within a general hospital setting, both to ensure access for medical comorbidities and to diminish the stigma associated with use of standalone psychiatric institutions.

Establish designation standards that require existing non-integrated psychiatric hospitals to provide the same level of access to medical care that would be available at a general hospital; ensure that reimbursement parity provides adequate resources to deliver this level of care.

When statewide inpatient capacity is reduced through enhanced community supports, prioritize reductions in use based upon integrated settings and geographic access in line with population distribution.

Develop means for children to have access to integrated psychiatric inpatient care that meets the standard of reasonable geographic access for other specialty inpatient care.

Monitor the use of the all payer model of health payment reform to establish reimbursement equity among types of hospital services so that the costs to provide quality care receive reimbursement.

Incorporating integration principles in transitions to other levels of care:

Support enhanced psychiatric services and accommodations to ensure non-discrimination in access to long term care facilities.

Establish parity in access to home health services for mental health care

Incorporating integration in other components of community services that address social contributors to health (notes for inclusion) --

Addressing food and housing stability is essential to both mental health and other health conditions.

Lack of stable housing is a frequent contributor to worsening of mental health status, unnecessary hospitalization and hospital stays that exceed medical necessity.

Isolation and lack of social connectivity is a key contributor to mental health status that has been shown to sometimes lead to unnecessary emergency room use.

Response 52: We have added the Quadruple Aim of healthcare reform as an overarching guide to our work to assist in many of the areas outlined above. In addition, these points are addressed either directly in specific Action Areas (such as *Action Area 2 – Influencing Social*

Contributors to Health, Action Area 5 – Enhancing Intervention and Discharge Planning Services, and *Action Area 8 - Committing to Workforce Development and Payment Parity*. There are also recommendations through-out the plan for further work to develop strategies and goals in these areas.

<u>Comment 53:</u> AA8 - **Committing to Workforce Development and Payment Parity**
Incorporating Integration Principles of Funding
Change funding structures so that resources are not segregated into capped resources for mental health and uncapped resources for other care.
Identify mental health services that are not being resourced adequately to meet evidence-based practice standards, and work through the Green Mountain Care Board, the Department of Financial Regulation and DHVA to enforce parity in coverage with other services.
Identify mental health provider groups that are not being reimbursed on a par with equivalently trained health care providers, and work through the Green Mountain Care Board, the Department of Financial Regulation and DHVA to enforce parity in provider reimbursement.
Utilize the All Payer Model waiver to ensure that essential services that are not individually billable, such as maintaining community-based crisis services, are allocated equitably for support by all payers.

Suggestions for revising the title to be consistent with incorporating integration:
"Ten Year Plan for a Holistic System That Fully Integrates Mental Health,"
or even – to help make "holistic" more explicit, as the Think Tank defined it –
"Ten-Year Plan for a Whole Person Health System That Fully Integrates Mental Health."

<u>Response 53</u>: *Action Area 8 – Committing to Workforce Development and Payment Parity* addresses these points either directly or by creating space for future exploration and development of such goals.

The title of the plan comes from the charging legislation; the only change we have made is to add "Vision 2030."